Merton Council
Health and Wellbeing Board

Date: **28 November 2017**

Time: **3.00 pm – 5.00pm**

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

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

1	Apologies for absence		
2	Declarations of pecuniary interest		
3	Minutes of the previous meeting		1 - 4
		Time	
4	MSCB Annual Report	3.05 – 3.20	5 - 80
5	Motor Neurone Disease	3.20 – 3.35	81 - 90
6	Local Plan	3.35 – 3.45	91 - 94
7	CCG Commissioning Intentions	3.45 – 4.00	95 - 104
8	Diabetes Strategic Framework work plan	4.00 – 4.30	105-124
	4.30pm Close of Public Meeting. Board Members Workshop Discussion		

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

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

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

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

Note on declarations of interest

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

Health and Wellbeing Board Membership

Merton Councillors

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

Council Officers (non-voting)

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

Statutory representatives

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

Non statutory representatives

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

Quorum

Any 3 of the whole number.

Voting

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

HEALTH AND WELLBEING BOARD
19 SEPTEMBER 2017

(3.00 pm - 5.00 pm)

PRESENT Dr Andrew Murray (in the Chair),
Councillor Gilli Lewis-Lavender, Councillor Katy Neep,
Hannah Doody - Director of Community and Housing
Chris Lee - Director of Environment and Regeneration
Yvette Stanley - Director of Children, Schools and Families
Dr Dagmar Zeuner - Director of Public Health
Dr Karen Worthington- Merton CCG
Dr Doug Hing - Merton CCG
Brian Dillon and Dave Curtis Merton Healthwatch
James Blythe - Managing Director of Merton and Wandsworth CCG's

ALSO PRESENT Tara Butler – Future Merton LBM (for Agenda Item 4)
Daniel Elkeles - Chief Executive of Epsom St Helier University Hospital Trust,
Lisa Jewell – Democratic Services Officer

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for absence were received from the Chair, Councillor Tobin Byers. The Vice-Chair, Dr Andrew Murray, chaired the meeting.

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of interest.

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

RESOLVED: That the minutes of the meeting held on 20 June 2017 are agreed as an accurate record.

4 ESTATES REGENERATION AND HEALTH AND WELLBEING - PRESENTATION AND DISCUSSION (Agenda Item 4)

The Board received a presentation from the Director of Environment and Regeneration on Estates Regeneration and Health and Wellbeing. In describing the planned regeneration projects in the Borough he asked Board members to consider:

1. What more planners could do to build in Healthier Lifestyles
2. What more could your organisation could do to encourage Healthier Lifestyles.

The presentation gave details of the expected growth in Merton in the next 10 years, and then detailed the healthy streets initiative to encourage walking and cycling. It continued by providing a project showcase of regeneration projects in the borough including Morden and the Clarion Estates regeneration.

The Board discussed issues related to the presentation and noted:

- the predicted increase in new businesses could include a large number of small businesses and self employed people and so would not necessarily cause an increase in the demand for premises.
- The cost of keeping fit will be kept affordable – the new leisure centre will be reasonably low cost and free green gyms already exist in the borough
- Infrastucture including Healthcare and other support services will be considered and built into the Core Strategy/Local Plan
- Councillor Neep asked officers to reach out to residents' groups and young people to ensure that they owned the regeneration projects in their community.
- Councillor Neep was concerned that the growth in private rental, and potential problems associated with this; tenancy problems, eviction, and overcrowding, would affect mental health and wellbeing of residents. Officers mentioned schemes that aim to combat tenancy problems.
- There was a big challenge in London to provide key worker accommodation – now known as intermediate housing.
- Dr Andrew Murray asked about improving air quality, and noted that there were initiatives such as green buses and Merton's Diesel Levy, but with an increasing number of journeys predicted consideration of air quality will be part of regeneration projects and will need to be covered by additional initiatives.

The Board welcomed the presentation and thanked Officers, and asked that they be kept involved in, and offered their support to, this long term process.

RESOLVED
The Board noted the presentation by The Director of Environment and Regeneration.

5 OFSTED FEEDBACK - PRESENTATION AND FEEDBACK (Agenda Item 5)

The Director of Children's Services gave a presentation on the recent OFSTED inspection of her department. The Board gave her huge congratulations on the outcomes of this inspection – an overall rating of Good, with Outstanding achieved in Adoption performance, leadership, management and governance and the Review of local Safeguarding Children's Board. She thanked all involved and said how proud she was of the outcome.

The Board noted the positive comments made by the OFSTED inspectors and that only 4 recommendations for improvement were made.

The Cabinet Member for Children's Services thanked all partners around the table for their part in children's safeguarding. Ofsted were encouraged by the work of our partnerships. HWBB had a role in keeping a focus on issues of neglect.

RESOLVED

The Health and Wellbeing Board welcomed the presentation on the OFSTED Outcomes for LBM Children's Services.

6 FIRE SAFE AND WELL (Agenda Item 6)

Darren Tulley, London Fire Brigade (LFB) Borough Commander, presented his report on LFB Fire Safe and Well. The Board noted that public trust in the Fire Brigade gave them access to vulnerable people within the community, and that this scheme was an opportunity for partner organisations to explore referral pathways and to implement local initiatives. The visits would look at home fire safety and also three initiatives: winter warmth, smoking cessation and slips, trips ands falls prevention. However additional initiatives could be added, for example childhood obesity, befriending and healthy eating.

The Chair said that it was an excellent scheme and that the CCG would engage. He suggested that it was an opportunity to work together to reduce strokes and to increase use/awareness of defibrillation. He also suggested that thought be given to evaluation so that the benefits can be quantified. The Managing Director of Merton CCG agreed that evaluation and should be built into the system, and that referral routes should be considered. GP records could be used to identify and target those at greatest risk of admittance to hospital.

The Director of Environment and Regeneration suggested that the visits could identify homes that would benefit from the energy conservation measures funded by a scheme run by the big energy suppliers. He and the Borough commander agreed to talk to about this possibility.

The Board welcomed the visits as an opportunity to tackle loneliness and isolation, and as a route to social prescribing. Councillor Lewis-Lavender reported that residents in her ward had found the visits to be very valuable.

RESOLVED

The Health and Wellbeing Board noted the report for information and were supportive of assisting with referral pathways for smoking cessation, falls prevention and winter warmth.

7 PHARMACEUTICAL NEEDS ASSESSMENT (PNA) (Agenda Item 7)

The Board received the report on the Pharmaceutical Needs Assessment.

RESOLVED

A. That Health and Wellbeing Board members note the collaborative, cost saving approach being taken to re-fresh the Pharmaceutical Needs Assessment (PNA).
B. That the HWB agree to receive the completed PNA at its March 2018 meeting for adoption; in advance of the statutory deadline of 1st April 2018.

8 PROVIDING HIGH QUALITY HEALTHCARE SERVICES 2020 TO 2030 (Agenda Item 8)

Daniel Elkeles, Managing Director of Epsom St Helier University Hospital Trust, gave the board a presentation entitled 'Providing High Quality Healthcare Services 2020 to 2030. The video to accompany his presentation is available here: https://www.youtube.com/watch?v=0sNTZEUTUeY#action=share

Board Members asked about engagement process in Merton. Daniel Elkeles replied that he felt he was engaging well with the communities that use Epsom and St Helier Hospitals. 10, 000 people had viewed the video or been to one of his meetings. He stressed that at the moment the conversation was not about sites, and that would come later on in the exercise.

The CE of CCG asked what the insight of the engagement exercise would be, and how is this information being collected so that it is robust and can support the way forward. DE replied that the purpose of the current engagement was to inform a lot of people that the trust cannot carry on as it is with 80% of the buildings not fit for purpose and that this is not clinically or financially viable. He wants people to understand this point and to appreciate that his vision for the future would see 85% of patients continue to receive care as they do now from their local hospital.

The information being gathered will be written into an engagement report and this will take account of Merton Councillor's points regarding deprivation and access to hospital services.

Dr Andrew Murray asked about timescale, DE replied that the consultation will be finished in October then a draft strategic outline proposal will go to the Trust Board. A business case could be completed by next Summer 2018 , and a decision made by the NHS in Spring 2019. The planning and building could then take a further 3 years, with a new hospital in 2024. The Board noted that the ultimate decision maker would be the Secretary of State.

RESOLVED
The Board noted the presentation by The Chief Executive of Epsom St Helier Hospital Trust

Committee: Health and Wellbeing Board

Date: 28 November 2017

Subject: Safeguarding Children Board (MSCB) Annual Report 2016/17

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

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

Contact officer: Paul Bailey MSCB Safeguarding Development & Policy Manager

Recommendations:

A. To note the MSCB annual report 2016/17.

B. For the Heath and Wellbeing Board to continue to contribute to the MSCB priorities and to ensure that safeguarding children is a golden thread that is maintained through all the work of the Health and Wellbeing Board.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

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

2 DETAILS

2.1 The MSCB annual report 2016/17 is produced on behalf of the safeguarding partnership involving all key agencies and supports the council and the Chair of the MSCB in assuring local arrangements.

2.2 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?

2.3 The report shows how the work we are doing as the MSCB seeks to answer these questions. The Board's strengths are identified as:

- The MSCB is a mature partnership that is open to learning and challenge
- Senior representation and engagement from agencies
- A relentless focus on working together to keep children safe
- A strong performance focus including the annual QA process
- Annual conference and comprehensive training programme

- An improved connection between the Board and frontline practitioners which has and will continue to improve; this includes the Board's responsiveness to and influence on multi- agency frontline practice
- The Board has clear priorities and the work programme has been aligned to support their delivery.

2.4 Our agreed areas of focus during 2016-2017 included:

i. Think Family
ii. Supporting Vulnerable Adolescents
iii. Early Help

With neglect as a cross-cutting theme throughout these priorities.

2.5 The Annual Report was approved by the MSCB on 26th September 2017

3 ALTERNATIVE OPTIONS

3.1 None

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1 All key agencies contributed.

5 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

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

6 LEGAL AND STATUTORY IMPLICATIONS

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

7 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

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

8 CRIME AND DISORDER IMPLICATIONS

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

9 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

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

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

Appendix 1: MSCB Annual Report 2016/17

Appendix 2: OFSTED Report

Merton
Safeguarding
Children Board

Annual report of the

Merton Safeguarding Children Board 2016/17

Contents

1.0
Chair's Introduction

2016-2017 has been a busy and challenging year for Merton Safeguarding Children Board (MSCB) yet the Board has continued to rise to meet these challenges. Over the course of this year the Board has worked with the Children's Trust, partners and stakeholders to review the Merton Child and Young Person Well-Being Model. We have also recommitted to and extended the Board's three key priorities.

We are pleased to say that the Board remains on a journey of continuous improvement that seeks to place children, the families and the practitioners who support them at the very heart of what we do. The vision of the MSCB is that the Board works to ensure that *Everyone in Merton does Everything they can to ensure that Every Child is Safe, Supported and Successful*. This annual report is an evaluation of our progress towards achieving this aim as well as an assessment of the overall impact of the Board especially with regards to our three key priorities.

The MSCB, like other LSCBs, operates in the context of shrinking resources and expanding expectations and commitments. We have worked hard with partners to prioritise where limited resources can be targeted in order to have the maximum impact on the quality of safeguarding across the system. In October 2015, the MSCB commissioned a Serious Case Review (SCR), following an incident in which a young person who was known to Merton services, experienced significant harm as a result of being attacked by a parent with a mental health condition. This review has been completed, the report was published in February 2017 and we report in detail on the learning coming out of this SCR in Section 8.5.1. The MSCB is committed to learning the lessons from this SCR.

The Board also took the decision to commission a Learning and Improvement Review (LiR) into a case of long-term neglect. This case did not meet the statutory threshold for a SCR; however, the Board considered that there was significant learning for the multi-agency safeguarding system in this case. We report in detail on the outcomes of the LiR in Section 8.5.2

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

The Board's strengths are identified as:

- The MSCB is a mature partnership that is open to learning and challenge
- Senior representation and engagement from agencies
- A relentless focus on working together to keep children safe
- A strong performance focus including the annual QA process
- Annual conference and comprehensive training programme
- An improved connection between the Board and frontline practitioners which has and will continue to improve; this includes the Board's responsiveness to and influence on multi-agency frontline practice
- The Board has clear priorities and the work programme has been aligned to support their delivery.

Our agreed areas of focus during 2016-2017 included:

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

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

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

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

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

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

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

Merton has had a long-established child and young people Well Being Model which we last reviewed in 2013. With changes in local providers and agencies and with changing levels of resources available we need to ensure our Model continues to be fit for purpose. We report in detail on the review of the model in Section 3 of this report.

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.

Shortly after the end of the financial year 2016/17 and before the publication of this report the LA were inspected under Ofsted's Single Inspection Framework and the MSCB was reviewed alongside the inspection.

A copy of Ofsted's report, findings and judgments is appended to this report as an external evaluation of the Board's work over the period 2016/17 and into 2017/8.

In relation to the Board's work, members of the Board are proud and pleased with Ofsted's "Outstanding" finding and their judgment that our "Working Together" as agencies on children's safeguarding and protection is "Good".

These findings, whilst welcome, do not reduce our ambitions or our shared commitment to continuous improvement so that "every child is Safe, supported and successful".

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

Keith Makin
MSCB Chair
July 2017

2.0
Progress of MSCB Business Plan 2016–17

As part of our commitment to continuous improvement, the Board took the decision to extend the three key priorities from 2016-2017 to run from 2016-2019; as such, we are half way through a four-year programme. This section is a progress update regarding what has been achieved so far as well as an indication regarding the work to be done in relation to the Business Plan.

2.1 Think Family –Supporting families with particular vulnerabilities

2.1.1 For the Board to continue to be assured that there are robust and effective strategies, procedures, protocols in place in relation to safeguarding children in cases where parental mental health is a significant factor.

Children's Social Care and South West London and St George's Mental Health NHS Trust have worked together around adult mental health and substance misuse. A Think Family Coordinator has been appointed, as a result of this work. Part of the role of the Think Family Coordinator is to ensure that Think Family is embedded across children's and adult services. This work includes the review of the Mental Health Protocol to ensure that there is clear agreement between adult mental health services and Children's Social Care and that children are safeguarded in cases where parental mental health is a factor.

2.1.2 To continue Work With the VAWG Board to review and refresh the Domestic Abuse (DA) Protocol to increase professional awareness and capacity to effectively intervene in cases of domestic abuse.

The MSCB has worked closely with the VAWG Board on a range of initiatives to ensure that the VAWG strategy is implemented across the MSCB partnership a detailed account of this work is included in section 7 of this report which outlines the key achievements of the VAWG Board in 2016-2017. A task and finish group has been established to develop a Domestic Abuse Protocol. This group will meet in the autumn of 2017 and present a protocol for approval by the Board in early 2018.

2.1.3 The Board will review its guidance to professionals regarding parental substance misuse.

The review of the MSCB Guidance on parental substance misuse is in progress part of the work of the Think Family Coordinator and the Policy Sub-Group. It is expected that a suite of Think Family Protocols, including parental substance misuse, will be presented to the Board for approval by the 31st March 2018.

2.1.4 Merton Safeguarding Children Board, (MSCB), is committed to reducing the incidence of childhood neglect within the borough. This is a key priority for the Board.

The Board undertook a baseline multi-agency audit of neglect cases in 2015-2016. A follow-up audit of neglect cases will take place in early autumn 2017. The Board has refreshed its Neglect Strategy and a multi-agency briefing pack has been made available to practitioners and their managers. In 2016-2017 we saw an increase of nearly 10% in neglect cases which indicates that professional recognition and identification of neglect is improving across the safeguarding system.

2.1.5 The MSCB is assured that the multi-agency Female Genital Mutilation (FGM) Strategy is being implemented and young people at risk of FGM are being identified and supported.

The Board has refreshed its Guidance on Female Genital Mutilation (FGM) and provided a range of briefings and multi-agency training sessions on FGM. The Board has also prepared an FGM leaflet which has been made available to parents and professionals both online and in print. The Board also provides 'red alert' briefings to Merton schools around Easter and Summer holidays, which have been identified as key risk periods for FGM due to the length of the holiday period.

2.1.6 To ensure that children and young people continue to be protected from radicalisation and violent extremism.

The Board has refreshed its guidance for professional working with children and young people who are vulnerable to the messages of

radicalisation and violent extremism. Merton has a thriving multi-cultural and multi-faith community. The guidance on preventing radicalisation and violent extremism is not aimed at any particular faith, cultural or political group. We recognise that extremism takes many forms including far right extremists, left wing extremist groups, extremist animal rights groups as well as other terrorist groups. The Board's Promote Protect Young People Strategic (PPYPS) Sub-Group works with Safer Merton to ensure that there is strong grip and clear oversight of all prevent cases involving young people.

2.1.7 For the Board to continue to seek assurance regarding the quality of frontline practice through themed multi-agency audits.

The Board has undertaken a range of themed multi-agency audits. During 2016-2017 the Board undertook multi-agency audits on the following themes:

- Children with Disabilities and Learning Needs
- Child Sexual Abuse Cases and Threshold Decisions where Sexual Abuse is a Factor
- Domestic Violence (this audit took the form of a live learning event involving multi-agency practitioners and managers in two domestic violence cases).

The learning from each of these audits is discussed at a meeting of the Board's Quality Assurance Sub-Group; from these discussions a view is taken regarding the quality and effectiveness of multi-agency practice. In each audit we ask each auditor to review the following:

- How well have agencies worked to engage difficult parents?
- How do agencies provide challenge and support to parents with learning difficulties?
- How are we challenging parents around substance misuse?
- How is the team around the child keeping the focus on the needs of the child and not allowing the needs of the parents to detract from this task?
- What is the quality of care planning?
- Were there any gaps or delays in case work and if so what impact did this have on our work with this family?

The findings of each audit are then gathered into a key learning report which makes recommendations regarding improving the quality of multi-agency practice. These are then shared with the strategic leads in each agency; who then shares the learning with team managers and frontline practitioners. The MSCB also

provides a range of briefings which highlights the themes and key learning coming out of multi-agency audits. Learning from audits is also shared with the Learning and Development Sub-Group and is used to inform the MSCB's training and continued professional development offer.

2.1.8 To explore the use and application of Signs of Safety and Signs of well-being across partner agencies as part of the review of the Merton Well-Being Model.

The Signs of Safety approach is being embedded in Children's Social Care with partners in Community Health and Early Years Services being trained in the approach. In order to establish clear governance arrangements for the multi-agency roll out of the approach a task and finish group has been set up in order to agree the terms of reference, governance arrangements and a project plan for the multi-agency implementation of the approach across the safeguarding partnership. It is expected that the work of the task and finish group will be completed in March 2018.

2.2 Supporting Vulnerable Adolescents

2.2.1 Strategic oversight of CSE

The Board works to ensure that there is robust grip and conspicuous oversight of all young people at risk of CSE and to improve the identification and support of young people who are victims of CSE. The Board's work in relation to CSE is covered in detail under Section 4.3 in this report.

2.2.2 Contextual Safeguarding and Young people at risk from gang and serious youth violence.

Through the work of PPYPS, the Board maintains an oversight of gangs and serious youth violence. As part of this work the Board has partnered with

The London Borough of Merton is part an innovation partnership with the London Borough of Hackney working on the issue of Contextual Safeguarding. This is an exciting new project, funded by the Department for Education Innovation Fund, which will run for two years. Through this project Hackney will be working closely with the contextual safeguarding network throughout the project to share learning with network members. For members of the Contextual Safeguarding network, the project will provide excellent learning and insight into contextual safeguarding in practice for practitioners and local authorities across the country.

Contextual safeguarding promotes the idea that young people's behaviours, levels of vulnerability and levels of resilience are all informed by the social/public, as well as private, contexts in which young people spend their time. Drawing upon research into adolescent development, it recognises that as children grow they spend increasing amounts of time socialising with peers, at school and in public environments independently of parental/ carer supervision. When spending time in these extra-familial contexts young people may be exposed to healthy norms which promote pro-social relationships or they may encounter harmful norms that are conducive to abusive and exploitative relationships. As a result local responses need to identify, assess, and intervene in all of the social environments where the abuse and exploitation of young people occurs – in essence to take a 'contextual' approach to safeguarding.[1]

The Contextual Safeguarding approach recognises that there are a number of share categories of adolescent risk and/or harm including:

- Children and young people going missing from home, school and care
- Radicalisation
- Harmful sexual behaviour
- Teenage relationship abuse
- Gangs
- Serious youth violence
- Online risks including grooming for sexual, financial or other forms of exploitation.

2.2.3 Listening to Children and Young People

Hearing the voice and reflecting the views of young people is a core value of the MSCB. The Board continues to seek to ensure that young people's voices and experiences are heard and reflected in its work. A detailed account of the work related to listening to, reflecting and acting upon young people's voice and views is provided in section 10 of this report.

2.3 Ensuring the Effectiveness Early Help

2.3.1 Finalise the review of the Merton Child, Young Person and Family Well Being Model. An overview of the Board's actions as part of this review is provided in detail under section 3 of this report.

2.3.2 The Board will oversee the implementation of our MASH Action Plan.

The MASH Action Plan is overseen by the MASH Strategic Board which report to the MSCB. The MASH Action Plan is being implemented and we are beginning to see improvements in service delivery and partner engagement as a result of these changes.

2.3.3 The Board will oversee the review of the service offer in early help.

The review of the early help service offer was part of the wider review of the Merton Child, Young Person and Family Well Being Model. Early help is provided at different levels of our longstanding Merton Child and Young Person Well-Being Model developed with our Safeguarding Board and Children's Trust partners.

In Merton we use the C4EO definition of Early Help:

Intervening early and as soon as possible to tackle emerging problems for children, young people and families….early help can take place early in a child's life or early in the development of a problem….effective early help prevents escalation of need and reduces severity of problems…early help can be provided to individual families, particular vulnerable groups or whole populations (C4EO 2012).[2]

This approach aims to enable and empower families, reducing an escalation of need. Merton's Children's Trust Partnership delivers, commissions and brokers early help services through the voluntary sector, schools, Public Health, Merton CCG, Safer Merton, the council and other key partners.

[1] *What is Contextual Safeguarding, Contextual Safeguarding Network, 2017,* https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding

[2] *Early intervention and prevention in the context of integrated services: evidence from C4EO and Narrowing the Gap reviews,* Centre for Excellence and Outcomes in Children and Young People's Services (C4EO 2012)

Merton's Early Years early help offer includes strong local partnerships between community health and early year's services. Our early years sector include 100% good and outstanding Children's Centres and 97% good and outstanding Private Voluntary and Independent nurseries. Our community health services were recommissioned in 2016 strengthening the universal service offer and services for more vulnerable children and young people. Our transformative approach delivered changes in Early Years including reconfiguring the Children's Centres offer and the co-location of Community Health services staff into children's centres to enable better collaborative working. We have targeted the take-up of Children's Centre services to families from deprived areas in the borough and have reviewed our under 5s work between health and children's centres to secure better safeguarding, health and wider outcomes for under-fives, including redesigning pathways and specialist health provision and to fund perinatal adult mental health direct work. 100% of all children who are in receipt of free 2 year old funding are placed in good or outstanding provision. Common And Shared Assessment work undertaken in our Early Years Supporting Families Service and Children Centres is overseen by a qualified Social Work Team Manager, bringing additional value and risk management to pre safeguarding threshold casework. Both early year's settings and Schools have been supported with a Safeguarding guidance and audit tool which is in good use across all primary and secondary schools.

2.3.4 The MSCB's Escalation Protocol

The Board has approved an escalation protocol so that all professionals within the multi-agency system have a clear framework for resolving professional differences in a timely way so that children are effectively safeguarded.

3.0
Early Help: The Review of the Merton Child, Young Person and Family Well-being Model

The Merton Child and Young Person Well-being Model (MCYWBM) has been in place since 2013. The Model is own by the Children's Trust and the MSCB Partnerships. There have been a number of demographic, financial and organisational changes over the last 4 years that meant that a review of the model was timely and necessary.

The key challenges include:

- Demographic growth and changes in Merton's local population
- Organisational changes in agencies such as the Metropolitan Police Service and changes in Health services
- Increasing numbers of Free Schools and Academies
- Increasing demand on local services in the context of contracting budgets.

The drivers for the review of the model include the need to maximise the opportunities to increase understanding between partners, this includes a shared a understanding of our varying statutory responsibilities and thresholds for intervention; also, the need to provide better tools and shared approaches for improving the capacity of practitioners to engage in effective interventions with families. It is also essential that we are able to work together to make the very best use of our collective resources to deliver our continuous improvement agenda, including our highest ambitions for our children, the families and the services and practitioners who support them.

The MCYWBM task and finish group met three times. The task and finish group consisted of a broad range of services including:

- Adult Mental Health
- Adult Social Care
- Central London Community Health Care
- Child and Adolescent Mental Health
- Children's Social Care Education
- Children's Services Commissioning
- Early Years
- Education (Primary, Secondary and Special Schools)
- Merton Clinical Commissioning Group
- Merton Children's Trust
- Merton MASH and First Response
- Merton Public Health
- Merton Safeguarding Children Board
- Merton Youth Inclusion
- Safer Merton
- The Metropolitan Police Service (MPS) Borough Command
- The MPS Child Abuse Investigation Team
- Voluntary Organisations (including Merton Voluntary Service Council)

One of the key themes highlighted throughout these meeting were the increasing demand and pressure on local services. For example in MASH and First Response Teams, there were:

- 5662 initial contacts in Merton
- 1507 referrals (27% of initial contacts)
- 1311 assessments (87% of referrals)
- Resulting in 204 new Child Protection Plans and
- 128 new episodes of care.

Another theme was demographic changes in the local population. For example, it was reported that 8% of the child population, that is, children and young people under 18 population in Merton (approximately 47,499 young people) have had an initial contact made about them. Merton has an East West divide in terms of the indices of deprivation and 5 super output areas. The child population (pupils in Merton Schools) is approximately 67% BAME; this is higher than Merton's adult population and national averages. The top 3 non-English languages spoke in Merton are Tamil, Polish and Urdu.

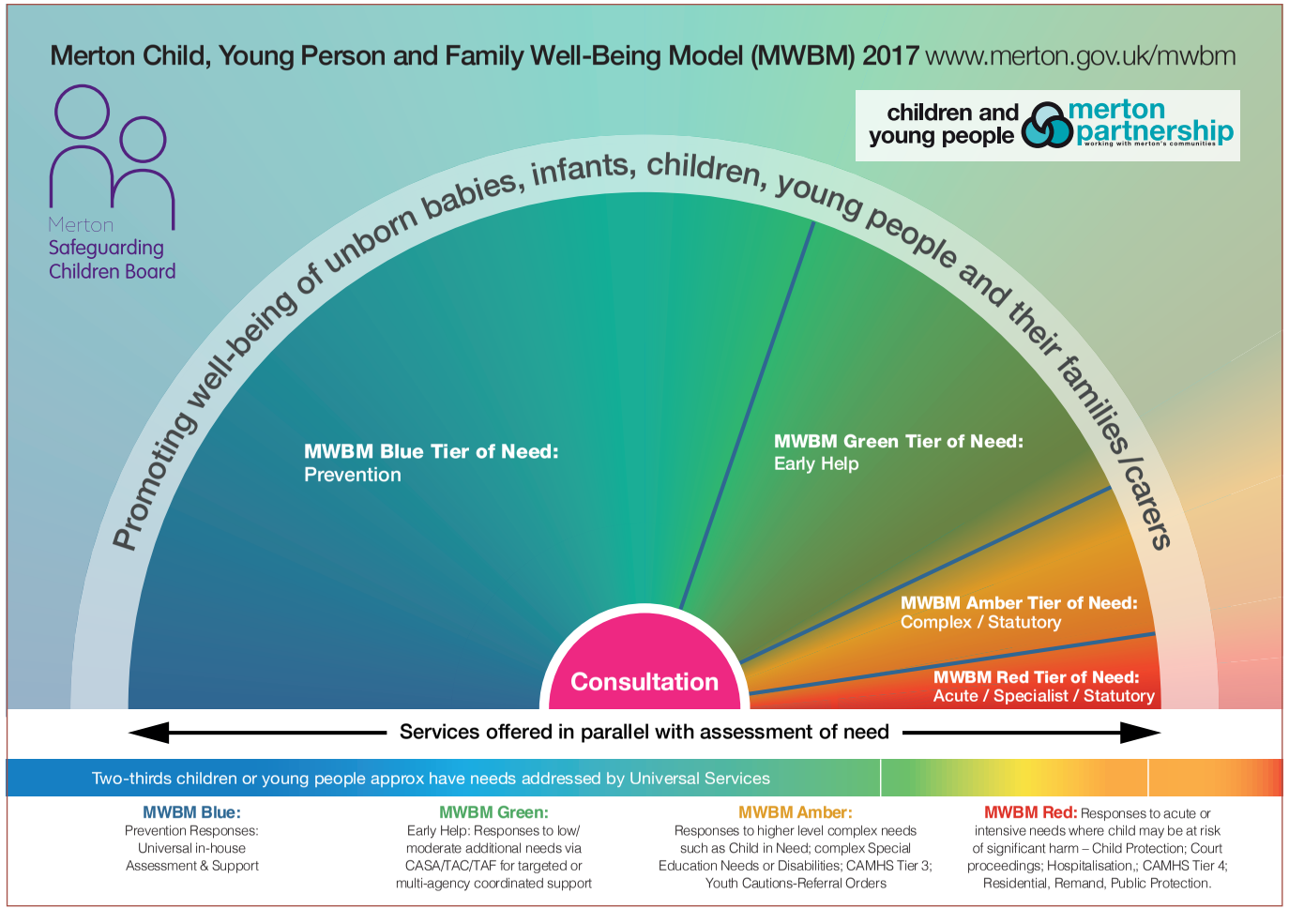
It was noted that Children's Social Care works with 800 children from 400 families. There are 350 Child in Need cases (100 of these are children with disabilities whose situations are mostly fixed; 50 of these cases are children with no recourse to public funds). 100 families have a Child Protection Plan. Children's Social Care's capacity means that they can work with 66 families at a given time. It was noted Transforming Families works with 60 families – however, funding for this service is being reduced by the government. This highlights the fact that Merton's social care system is relatively small as a multi-agency safeguarding partnership we need to improve access to early help and intervention so that levels of need and concerns regarding children's welfare do not escalate.

The MCYWBM task and finish group highlighted the need to reaffirm the following core values of the Children's Trust and the MSCB, which underpin our work. These reaffirmed values are outlined as follows:

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

The MCYWBM task and finish group also revised the visual representation of the Model.

The task and finish group also recommended that the Children's Trust and the MSCB approved Merton's Social Work Practice Model (see Appendix 2) and that Signs of Safety is extended beyond Children's Social Care. It was also propose that the name of the Model be change from the Merton Child and Young Person Well-Being Model, to the Merton Child, Young Person and Family Well-being Model to reflect the need for all agencies and services to 'think family' in accordance with the Board's Think Family priority.



4.0
Local context and need of the childhood population for Merton[3]

4.1 Merton the place

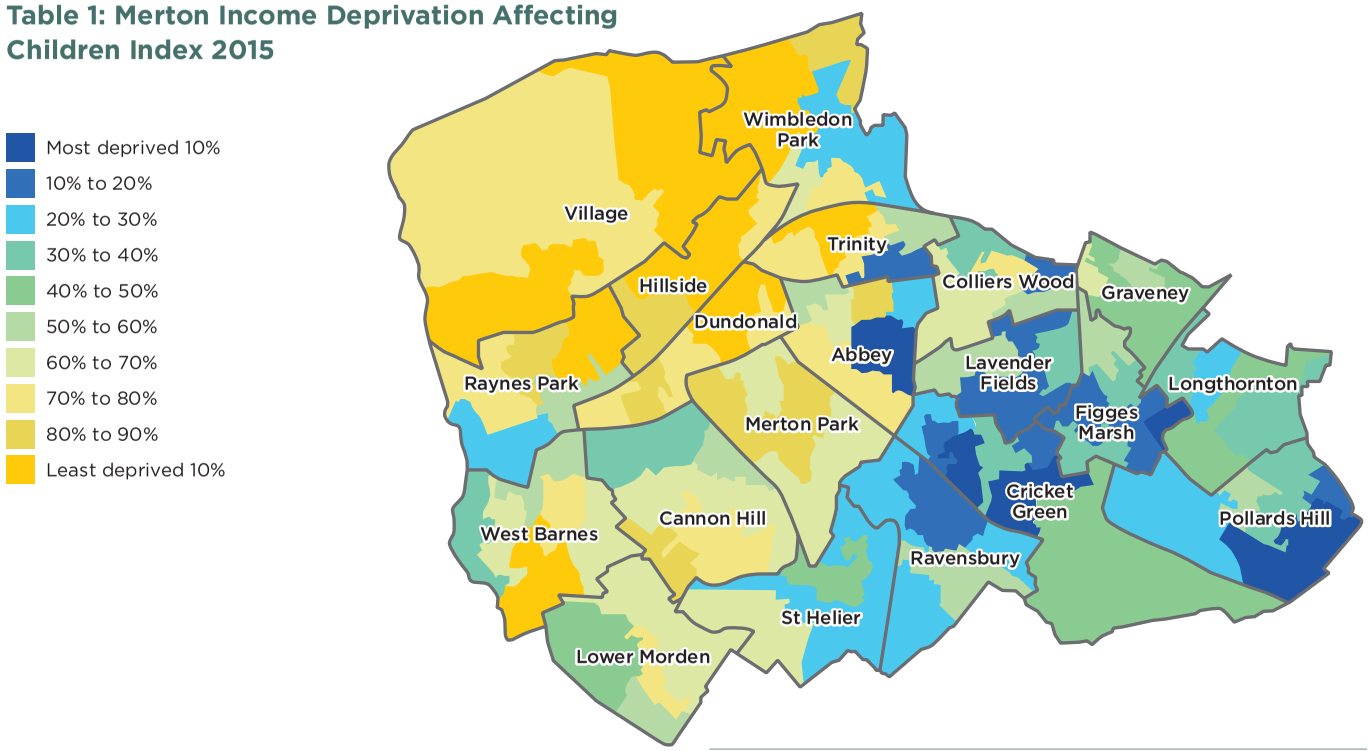
Merton has a total population of 200,543 including 47,499 children and young people aged 0-18 (Census 2011) between 2012 and 2016 the 0-18 population increased by 4%. This growth is predicted to increase by between 4% and 6% by 2020, based respectively on the GLA population projections for its Strategic Housing Land Availability Assessment and its alternative Trend forecasts, which take additional factors into account. Within the whole CYP population increase, there are variations for different age groups, between 2011 and 2020 we can estimate the population of (based on SHLAA 2015):

- Primary school children aged between 5 and 10 will have increased by 20%
- Secondary school aged children aged 11 to 15 will have increased by 13%.

Historically there was a 40% net increase in births from 2,535 in 2002 to a peak of 3507 in 2012 and is approximated at 3178 by 2020. This increase in births, together with other demographic factors such as migration of families into the borough, has already created the need for more school places, put pressure on early years and pre-school services, children's social care and early intervention.

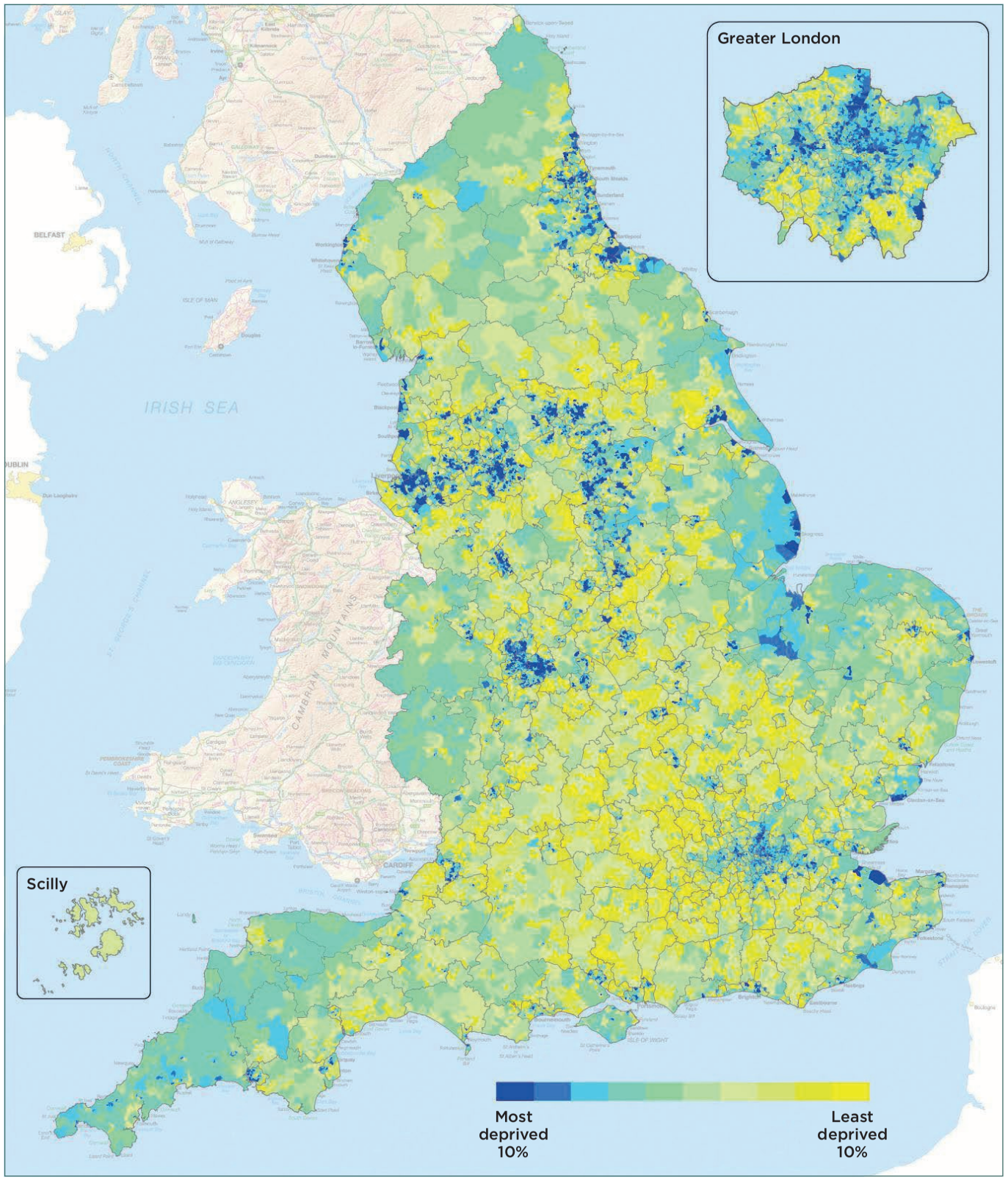
Predominantly suburban in character, Merton is divided into 20 wards and has three main town centres; Wimbledon, Mitcham and Morden. There are a number of pockets of deprivation within the borough mainly in the eastern wards and some smaller pockets in the central wards (Mitcham and Morden towns). These wards have multiple deprivations, with high scores on income deprivation, unemployment and limited educational attainment. Five of Merton's 20 wards are amongst the 30% most deprived areas across England for children. This means 37% of Merton school pupils are living in an area of deprivation (30% most deprived, IDACI 2015). Since 2010 we have seen an increase of 32% of children who are eligible for free school meals (2010, 2881 FSM children, 2016, 3817 FSM children).

Table 1: Merton Income Deprivation Affecting Children Index 2015



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

UK Indices of Deprivation



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 67% from BAME communities, 44% with a first language which is not English, speaking over 120 languages (2016). The most prominent first languages for primary pupils apart from English are Tamil 7%, Polish 7% and Urdu 6%.

The SEND Resident population has increased by 16% between 2012 and 2016 (1078 CYP in 2016). The number of pupils attending Merton mainstream (inc. Academies) and Special Schools with a Statement of SEN or EHC Plan has also increased significantly over the last four years. This cohort is growing at a faster rate than the Merton School Population, with a 14 percentage point increase over the last five years. The number of Merton pupils with a Statement of SEN or EHCP has grown over the last five years at a faster rate than London, Statistical Neighbours and National. As at January 2016 there were 1148 pupils attending Merton Schools with a Statement of SEN or EHCP.

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

4.2.1 Children In Need

Our published DfE CIN census data shows an increase in the rate per 10,000 as at 31 March (2015-16) compared to our trend and statistical neighbours. This data has been subsequently review and updated, in fact Merton's Children in Need (CIN) rate per 10,000 (2015-2016, 333.3) remains in line with 2014-15 (338.3), and statistical neighbours (336.91), the London average (355.3) and the National average (337.7). See Table 2 below.

Table 2: Increases in CIN rate between 2011 and 2016

Year	2011-12	2012-13	2013-14	2014-15	2015-16	SN 2015-16	London 2015-16	National 2015-16
Rate per 10,000	371.3	336.8	355.1	338.3	333.3 R	336.91	355.3	337.7

4.2.2 Children Subject to a Child Protection Plan

Rate of Children Subject to a Child Protection Plan

The rate of Children subject of a child protection plan on the 31 March 2016 (29.9) was unusually low, compared to Merton's trend and against the benchmark of SN (36.20), London average (36.20) and national average (43.1). This was due to a number of large families with multiple siblings on child protection plans being deregistered days before the national Child In Need census was taken. Merton's average CP rate per 10,000 is 40 with approximately 160-180 child subject of a plan at any one time. See Tables 3 and 4 below.

Children Subject to a plan for the second or subsequent time

In the past 5 year to 2016, locally, regionally and nationally the numbers of children subject to a plan for the second or subsequent time have been steadily increasing. In Merton as at the end of 2015/16, 46 children or 22.5% of children became subject of a child protection plan for a second or subsequent time. Whilst both national and London outturns have similarly increased gradually in preceding years, Merton's 2015-16 outturn is noticeably higher than SN average (16.2%), national average (17.9%) and London (14%) average (2015/16).

During 2015/16 Children Social Care completed an extensive review of all cases where child protection plans had been initiated for a second or subsequent time, a number of recommendations were agreed to deliver improvements through 2016/17. Actions included strengthening the quality of CP planning through focused training with CP Chairs and social workers in Signs of Safety; more effective safety planning particularly in relation to domestic violence; strengthened processes for consultation and review where children have previously been subject to a plan. The impact of this improvement work as evidenced in the 31 March 2017 outturn at which point 13% of children were subject of a second or subsequent CP plan, drawing the authority back in line with the London average. See Table 5 overleaf.

Table 3: Rate of Children Subject to a Child Protection Plan

Year	2011-12	2012-13	2013-14	2014-15	2015-16	SN 2015-16	London 2015-16	National 2015-16
Rate per 10,000	39.8	37.9	40.3	38.8	29.9	36.20	37.9	43.1

Table 4: Children subject to a child protection plan

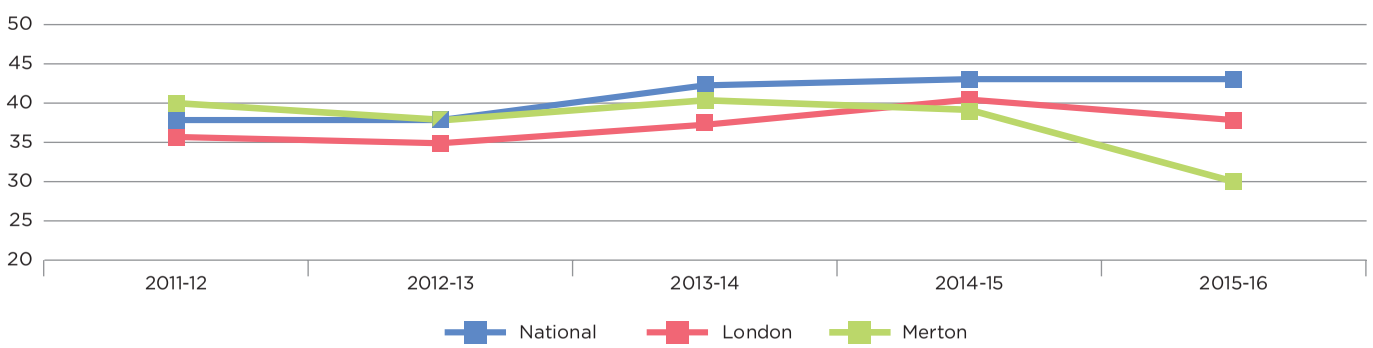


Table 5: Children Subject to a plan for the second or subsequent time

Year	2011-12	2012-13	2013-14	2014-15	2015-16	SN 2015-16	London 2015-16	National 2015-16
Number	15	17	24	37	46	49.10	1250	11,350
Percentage	7.8%	10.6%	11.3%	16.4%	22.5%	16.2%	14.0%	17.9%

Children subject of a plan lasting for 2 or more years (children who ceased to be the subject of a child protection plan)

Nationally 3.8% (2015/16) of children were subject of a child protection plan lasting two years or more, in Merton this was 5.9% (2015/16) relating to 14 children, which is a 40% increase from the previous year 2014-15. See Table 6 below.

4.2.3 Looked After Children

At 31 March 2016, the looked after children rate per 10,000 of the population aged under 18 was 35.00. This is in line with the rate of 34.00 obtained in 2014 and 2015. Similarly both London and national averages held a steady course at 51.0 and 60.0 respectively. Overall, Merton's rate is lower than both national and London averages.

Table 6: Children subject of a plan lasting for 2 or more years (children who ceased to be the subject of a child protection plan)

Year	2012-13	2013-14	2014-15	2015-16	SN 2015-16	London 2015-16	National 2015-16
Number	6	7	10	14	13.29	400	2410
Percentage	3.5%	3.6%	4.3%	5.9%	4.4%	4.3%	3.8%

Table 7: Looked After Children In Merton

	2011-12	2012-13	2013-14	2014-15	2015-16
Merton	30.00	31.00	34.00	34.00	35.00
London	57.00	54.00	54.00	52.00	51.00
National	59.0	60.0	60.0	60.0	60.0

Table 8: Looked after children by 10,000 population

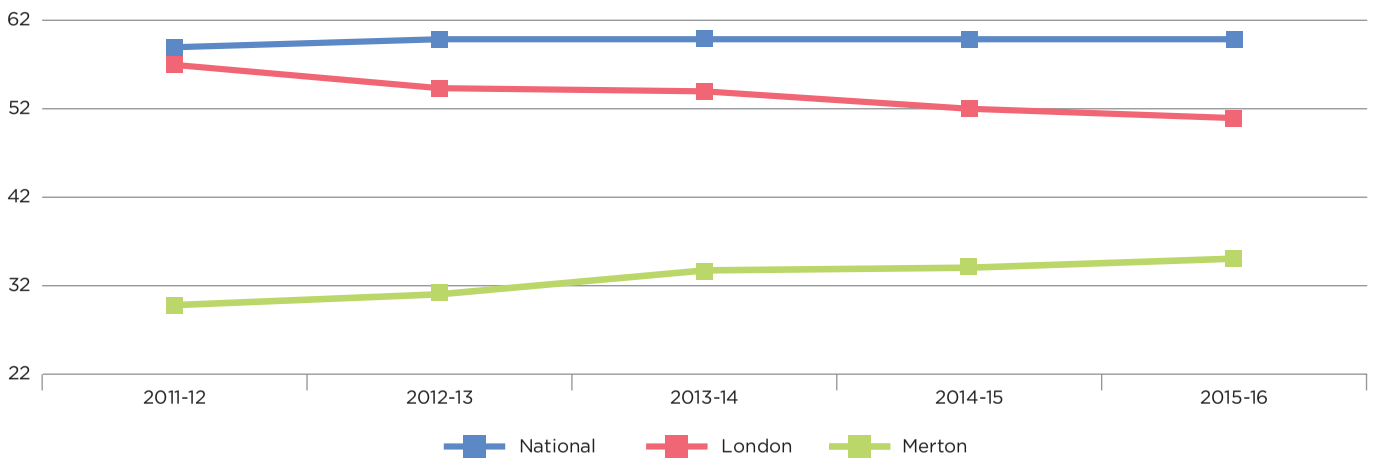
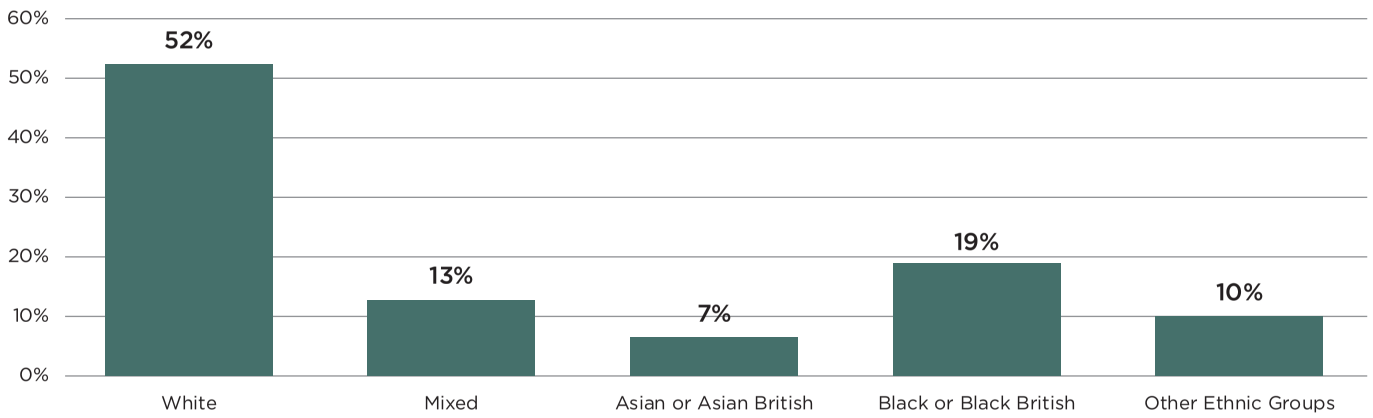


Table 9: Ethnic Group of Looked After Children



It is noteworthy that although the rate per 10,000 has remained stable, due to increase in overall population, the actual number of children coming in to care in Merton has continued to rise year on year thus placing extra pressure on services and caseloads. There were 130 looked after children in Merton in 2012 this increased to 165 in 2016, an increase of 27%. Some this growth can also be attributed to on average 20-25 UASC entering care in Merton each year. See Tables 7, 8 and 9 above.

Looked After Children with Stability in their placement

As at 31st March 2016, 68% of Children who had been looked after continuously for at least 2.5 years, were living in the same placement for at least 2 years. This is an improvement on the 54% outturn in 2015 and places Merton on par with national averages. See Table 10 below.

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

We were in were in touch with 89% of our young people during 2015/16. See Table 11 below.

66% of our care leavers are in education, employment or training (2015/16) this is a significant improvement on 2014/15, 45% and can be attributed to actions delivered against our Care Leavers Strategy, placing us well above the national average of 49%. See Table 12 opposite.

96% of care leavers (aged 19, 20, 21) were living in 'suitable accommodation' in 2015/16 this is a significant improvement on 2013/14 (66%) and better than the national average 81% (2014/15). See Table 13 opposite.

Table 10: Percentage of Looked After Children with Stability in their placement

	2011-12 (31st March)	**2012-13** (31st March)	**2013-14** (31st March)	**2014-15** (31st March)	**2015-16** (31st March)
Merton	68%	64%	55%	54%	68%
National	68%	67%	67%	67%	68%

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

Table 11: Care Leavers in Touch

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

Source: SSDA 903

Table 12: Percentage of Care Leavers in Education, Employment or Training

	2012 (31st March)	**2013** (31st March)	**2014** (31st March)	**2015** (31st March)	**2016** (31st March)
Merton	70.6%	60.0%	47.0%	45%	66%
SN	64.3%	67.8%	55.15%	52.2%	50.10%
National	58%	58%	45%	48%	49%

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

Table 13: Percentage of Care Leavers in Suitable Accommodation

	2012 (31st March)	**2013** (31st March)	**2014** (31st March)	**2015** (31st March)	**2016** (31st March)
Merton	88%	85%	66%	76%	96%
SN	89.86%	89.30%	85.33%	83.20%	81.10%
National	88%	88%	78%	81%	83%

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

4.3 Children at Risk of Sexual Exploitation

From 1 April 2016 to 31 March 2017 40 young people were presented to the Multi-Agency Sexual Exploitation (MASE) Panel. The majority of the children discussed at the MASE are aged 13 to 16, during 2016-2017; these are further broken down as follows:

- 96% were female
- 62% were from Black Asian or Minority Ethnic Background (BAME)
- 39% of these who had a MASE referral also had a Missing episode, however this is only a small proportion of all those who go missing from home or care
- The majority of children known to the MASE live in our most deprived wards Pollards Hill, Figges March, Ravensbury and St Helier

- As at 31st March 2017 40 children were Open to the MASE
- 25% were LAC (10 young people)
- 20% were care leavers (8 young people) and
- 10% were CP (4 young people)
- The majority of CSE cases are open to the MASE panel for a year.

Merton's Child Sexual Exploitation (CSE) strategy was re-launched in 2013 and refreshed in 2015 and 2017 supported by intelligence from our Joint Strategic Needs Assessment and peer review on CSE. Our Strategy provides clear and practical guidance for social workers and other practitioners dealing with cases where there is suspected and confirmed child/young person sexual exploitation.

Merton's management oversight of children who are at risk/subject of sexual exploitation, children missing from home or care and children missing education is maintained at three multi agency panels where information is shared and triangulated. Officers join up the 'risk dots' between these panels.

- Multi Agency Sexual Exploitation Panel (MASE)
- Missing from Home or Care Panel (Multi agency representation)
- Children Missing Education Panel (Multi agency representation).

Strategic thematic issues are identified by officers and during audits. These are discussed and challenged at a senior management level and at the Promote and Protect Young People (PYPP), a thematic subgroup of the MSCB and at the executive group of the MSCB in Merton referred to as the Business Implementation Group (BIG).

4.3.1 Summary Activity to address CSE in 2016 and 2017:

- Refreshed and re-launched strategy, protocol and tools in March 2015 and refreshed in 2017
- Increased identification of young people at risk, including more males, referred to and discussed at MASE
- Learned from our London CSE peer reviews and developed a JSNA CSE chapter: refreshed our CSE strategy, guidance and support tools
- Improving connectivity between CSE and Children Missing from Home, Care or Education; strengthened data, tracking & triangulation and appointing a CSE operational lead
- Appointed CSE Operational Lead to support the CSE Strategic Lead in autumn 2016
- Delivered CSE champions in Secondary Schools and within Health agencies
- Undertaken extensive awareness raising including: CSE awareness weeks, targeted events for Foster Carers and ongoing development for Primary and Secondary schools including training to Heads/ Designated teachers and health champions
- Strengthened MSCB PPYP links to children missing from home, care and education
- Audited cases to inform our CSE improvement agenda and reviewed and strengthened dataset
- Continued work with Redthread in St Georges Hospital in relation to young people who have presented with injuries from knife/gunshots and CSE/Sexual injuries. New screening process in place between local Sexual Health GUM clinics and Social Care
- MOPAC funded Young Women and Girls Worker in place – with complex caseload of very vulnerable young women
- Development of Gangs and CSE victims mapping which includes cross-border activity
- Completed refreshed CSE self-evaluation in the context of Ofsted guidance on the 'deep dive' theme for targeted local authority inspections
- Ongoing commitment to Schools Police Officers with a proactive prevention programme and key link role
- Reviewed CSE partnership arrangements
- Maintained commissioned service
- Extended cross borough liaison locally in London and ensuring specific liaison with authorities in whose areas Merton LAC are placed
- Participating in new developments – a 'child house'.

4.3.2 CSE and Looked After Children

There is a strong grip on the issue of looked after children and CSE. Seventeen looked after children were identified as being at risk of CSE. The Promote and Protect Young People Strategic Sub-Group (PPYPS) has strategic oversight of CSE and looked after children and reviews multi-agency performance of this issue at each meeting. In addition to this looked after children who are at risk of CSE are reviewed at each MASE meeting. Ten looked after young people were identified as being at risk of CSE.

4.3.3 CSE and Out of Borough LAC Cases

We have placed young people away from the borough because of our concerns about LAC. For some young people placements away from their home community are a key part of the care plan as a result of anti-social behaviour and or risk taking behaviours. For some the needs of the young people are such that they require specialist placements which are not available in Merton or surrounding boroughs. For all children being placed outside of the borough the DCS is required to sign off agreement for the placement. Care plans for these children and young people are reviewed to ensure that where possible young people are supported to return to their home community at the earliest opportunity. During 2016-2017 there were 165 looked after children who were placed out of borough who were identified as being at risk of CSE.

4.4 Children Missing from Home and School

On average 400 to 500 episodes of missing from home or care are reported each year in Merton. This equates to between 60 and 80 unique children in each quarter with some seasonal episode increases around school holidays. The majority of the children who go missing are aged 14 to 17, male and White British. A large number of missing episodes reported in Merton relate to children looked after by other Local Authorities, but are placed in Merton. A small proportion of those who go missing from home are known to be at risk of child sexual exploitation or are known to be missing education, however almost half of those who go missing from care are known to be subject of these other vulnerabilities.

Actions to Address Children Missing From Home and Care

- Ongoing strengthening of 'Multi Agency Missing from Care and Home Panel' supported by a 'Missing dataset' which identifies other vulnerabilities including CSE and CME
- 'Weekly Missing Meeting' established in April 2016 and embedded in response to a need to strengthen multi agency operational working to ensure that children receive timely support from appropriate services including a return home interview
- Policies and procedures are in place to deliver a well-coordinated response to children who are reported as missing from home or care (Refreshed April 2016)
- Ongoing utility of Police Missing Person Co-ordinators analysis of repeat locations and individuals for MBC meetings
- Two thematic audits of children aged 11 to 14 who were reported as missing completed (November 2013 and March 2015) provided baseline intelligence and reassurance of the quality of assessments
- Independent organisation (Jigsaw4U) commissioned to work as part of a wider interagency team to provide practical and emotional support and prevent/reduce episodes of going missing. Jigsaw4U also provide 'return home interviews'
- With regards to children/young people known to Children's Social Care, case management of CIN/CP CYP missing from home is improving and recording and case management of Looked after Children missing or absent has improved over the last 12 to 18 months
- All in-house foster carers have received 'missing and absent' procedure training
- 'Children Missing' policies and procedures are checked as part of the placement commissioning process. Agency foster carers and residential placements are required to report missing episodes in a timely way to the Council and Police and are required to support the Council to implement safety plans.

Children Missing Education(CME)

On average 130 to 150 Off Roll children and young people are discussed at the CME Panel each year academic year. During 2015/16 the off roll CME are summarised as follows:

- The majority were children and young people in years 7 to 10
- 55% were male
- Only 5% were subject of a SEN Statement or EHCP
- 5% were Merton LAC, none were subject of a child protection plan and
- 3% were subject of a Child in Need Plan
- 96% of all CME Off roll cases during 2015/16 were actioned and closed by the panel within three months.

CME policies and procedures, comply with the revised Statutory Guidance (January 2015). Merton's Education Welfare Service (EWS) promote and enforce regular and punctual school attendance. EWS support schools, parents and students to ensure that a child of compulsory school age has access to education and attends school regularly and punctually or receives a suitable education other than at school as well as ensuring that risks are well understood and minimised.

CME Multi-agency panel reviews all children who are missing education and tracks actions to return them to full time education, this panel meets monthly.

All referrals to the MASH are screened by an education officer to check if they are known to be missing education, this intelligence factors into MASH RAG rating. Briefings are provided to primary and secondary school head teachers on safeguarding risks associated with absence from school and are reinforced in termly designated teachers' events.

Action Taken To Address Children Missing from School

- Strengthened the partnership approach of the multi-disciplinary Hard to Place and CME Panels
- Implemented a Chronic Absence Project in response to an SCR finding with a focus on pupils with chronic absence pre-transition to secondary school. Undertook a post implementation impact review to take forward the learning
- Maintained our strong performance with low levels of NEET and achieved significant reduction of numbers of young people in the "Not Known" category
- CME/PA protocols between Education and Social Care services strengthened with regular reporting to CSF Continuous Improvement Board
- Briefings provided to Primary and Secondary School head teachers on safeguarding risks associated with absence from school and reinforced as appropriate in termly designated teachers' events
- Specific guidance provided to schools on forced marriage, female genital mutilation, child trafficking and Prevent
- Continued to improve school attendance and maintained our strong focus on preventing permanent exclusions
- Developed schools and early year's settings safeguarding audit tool and guidance
- Adopted a vigilant approach to the quality of alternative education provision in the borough and the identification and notification of unregistered schools
- Strengthened Education Welfare Service focus on the home education process where families opt to educate children other than at school (EOTAS). Action is taken by the authority in relation to unregistered schools, we are activity monitoring and liaising with Ofsted where necessary
- Ongoing commitment to Schools Police Officers with a proactive prevention programme and key link role

- Rolled out changes in relation to Pupil Registration Regulations 2016 regarding on and off rolling
- Further developed the CME panel dataset and intelligence analysis
- Consolidated school partnerships and further developed the Merton Education Partnership, used forums to highlight Safeguarding. Developed schools and early years Safeguarding audit tool and guidance (In early years all funded support and targeted support settings).

4.5 Prevent

The Board has refreshed its guidance for professional working with children and young people who are vulnerable to the messages of radicalisation and violent extremism. The Board's Policy Sub-Group works with Safer Merton to ensure that there is strong grip and clear oversight of all prevent cases involving young people. The MSCB has worked hard, along with Safer and Stronger, to achieved strong engagement with the 'Prevent' agenda involving key partners including police, schools, early years settings and with faith, voluntary sector and wider communities.

4.6 Female Genital Mutilation

The Board has refreshed its Guidance on Female Genital Mutilation (FGM) and provided a range of briefings and multi-agency training sessions on FGM. The Board has also prepared an FGM leaflet that has been made available to parents and professionals both online and in print. The Board also provides 'red alert' briefings to Merton schools around Easter and Summer holidays, which have been identified as key risk periods for FGM due to the length of the holiday period. There have been two cases where FGM has been identified as a risk factor.

5.0
Statutory and Legislative Context

Merton Safeguarding Children Board (MSCB) is the Local Safeguarding Children Board for Merton. Local Safeguarding Children Boards (LSCBs) have a range of roles and statutory functions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Children and Social Care Act 2017 received Royal Ascent on 27th April 2017. The Act will abolish LSCBs, replacing them with Safeguarding Partnerships, and the 2004 legislative framework. It is expected that a revised Working Together to Safeguard Children and statutory regulations will be provided in late 2017 or early 2018.

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 2017-2019, agreed by the Board in June 2016, is attached as Appendix 1. The Business Plan outlines the Board's priorities for 2017-2019 and was agreed by the Board at its annual Away Day in March 2017. 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 at each Board meeting.

Membership[4] of the Board includes the following statutory partners:

- The Metropolitan Police Service, Borough Commander
- The National Probation Service and London Community Rehabilitation Companies
- The Youth Offending Team
- NHS England and Merton Clinical Commissioning Groups including representation from commissioned Health Services
- CAFCASS.

Membership of the Board also includes:

- Assistant Director of Children's Social Care and Youth Inclusion
- Assistant Director of Education
- The Director of Public Health, Merton
- Representation from the Voluntary and Community Sector
- Adult Social Care
- Representatives from Housing, including Housing Associations.

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

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

[4] The structure and membership of the Board is included in this report as Appendices 4 and 5.

7.0
MSCB Sub-Groups

The work of the MSCB is delivered and overseen through each of its Sub-Groups.

7.1 Quality Assurance Sub-Group

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

The QA Sub-Group undertook the following activities in 2016-2017:

- Completed 3 themed multi agency audits. The themes for each multi-agency audit are as follows:
  - Children With Disabilities May 2017
  - Child Sexual Abuse and Threshold Decisions in Child Sexual Abuse Case October 2017
  - Live Learning Practice Audit on the Theme of Domestic Abuse January 2017
- Reviewed the MSCB's Multi-agency Performance Dataset
- Monitored learning from SCRs, LiRs, and the Action Plans coming out of the Child B SCR and the Baby C LiR
- Disseminated learning from multi-agency audits
- Maintained an overview of multi-agency escalations to the Board.

7.2 Promote and Protect Young People Sub-Group

The Promote and Protect Young People (PPYP) Sub-Group met 8 times in 2016-2017. The purpose of the PPYP is to take overall lead responsibility on behalf of the MSCB to ensure that there are effective and up-to-date multi-agency policies, protocols and procedures to ensure children and young people are safeguarded and protected and their welfare is promoted; *concentrating on **extra-familial** abuse* where there is *risk of abuse outside the family*. PPYP is responsible for policies relating to issues like CSE, children missing from home, care or education, child on child abuse, other forms of exploitation (such as 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 (Local Authority Designated Officer (LADO) referrals).

In 2016-2017 PPYP undertook the following pieces of work on behalf of the Board:

- Reviewed and updated *Guidance for Professionals Working with Children and Young People who May Be Vulnerable to the Messages of Radicalisation and Violent Extremism*
- Oversaw the work the MASE Panel and Persons of Concern Panel
- Maintained strategic oversight of Children Missing from home, school and care
- Oversaw the Merton Adolescent Review
- Reviewed and updated the MSCB's *CSE Protocol* for approval by the Board
- Reviewed and updated the MSCB's *CSE Strategy* for approval by the Board
- Monitored and ensured the implementation of the CSE Action Plan
- Ensured the delivery of the CSE Awareness Events across the Borough
- Revised and Updated the MSCB's Missing Panel Terms of Reference for approval by the Board
- Reviewed and updated the MSCB's *Online Safety Strategy* for approval by the Board
- Prepared the MSCB's *Harmful Sexual Behaviour Protocol* for approval by the Board.

7.3 Learning and Development Sub Group

The purpose of the Learning and Development Sub-Group is to take the overall lead responsibility, on behalf of the MSCB, to ensure that there are effective arrangements in place so that the multi-agency workforce is up to date in knowledge and

skills for safeguarding children and promoting their welfare. The Learning and Development Sub-Group also plans and delivers the Joint MSCB/CSC/CSF Multi-Agency Annual Conference for practitioners and managers. The aim of the conference is to increase awareness developments in safeguarding and to engage in dialogue with frontline practice. We also aim, where possible, to involve children and young people.

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

The MSCB and CSF Joint Conference, *Behind Closed Doors: Working the Complexities of Domestic Abuse* included over 140 attendees from a range of multi-agency backgrounds, including health, that is, the Clinical Commissioning Group, Central London Community Health Care, Public health, education, youth inclusion, children's social care, safeguarding adults, mental health, probation, the metropolitan Police Service, and voluntary organisations.

The event featured a Keynote Address from Jo Keogh MBE. Jo has been committed to supporting the victims and survivors of Domestic Abuse for over 15 years. She was awarded an MBE in 2013 and the Commissioners Commendation for the Domestic Abuse Achievement awards in 2014. Jo's address focused on coercive control and the need for services to be sensitive to the experiences of victims who should be recognised as survivors. Jo's presentation came alive with the contribution of Victoria, who is a survivor of domestic abuse. Victoria bravely shared her story with the conference and explained the need to balance compassion with a robust approach to working with both victims and perpetrators. She highlighted the need to build trust, and for practitioners to understand the level of control exerted by perpetrators and the level of fear and trauma experienced by survivors and to be professionally curious and ask the difficult questions.

The conference also featured six workshops by professionals and services which work with families in the Merton area:

- Working with Multi-Agency Risk Assessment Conferences (MARAC) High Risk Victims and Response
- Children's Social Care Impact of DV on Family Life
- Working with Perpetrators, Building Better Relationships
- Housing for Women – Life in the Refuge
- Domestic Violence and Mental Health – Supporting Victims on their journey
- Domestic Violence and Health Outcomes – Impact of DV on Health.

The Conference was concluded with a Dramatic presentation by AlterEgo Creative Solutions. The drama, entitled *Behind Closed Doors*, helped practitioners to understand:

- The complexities of Domestic Abuse, Coercive Control & Stalking
- The Warning Signs/Risk Factors
- Why victims may not tell anyone, may not wish to prosecute, may retract statements, may justify what is happening to them, may not even see themselves as victims in the first place and may fight against any intervention
- The importance of effective Risk Assessment
- How to sign-post to relevant services.

Some of the comments from the conference state that:

- *"Merton is doing some excellent work in tackling DV issues and in recognising people's lived experienced and improving services' responses through training and development"*
- *"Thanks for an excellent day"*
- *"Excellent Conference - ...powerful account by Victoria..."*
- *"Powerful... Emotional"*

7.3.2 MSCB Training

The table below gives a quick overview of the number of planned and run training events from April 2016 to March 2017.

The tables overleaf indicate attendance per course and per agency.

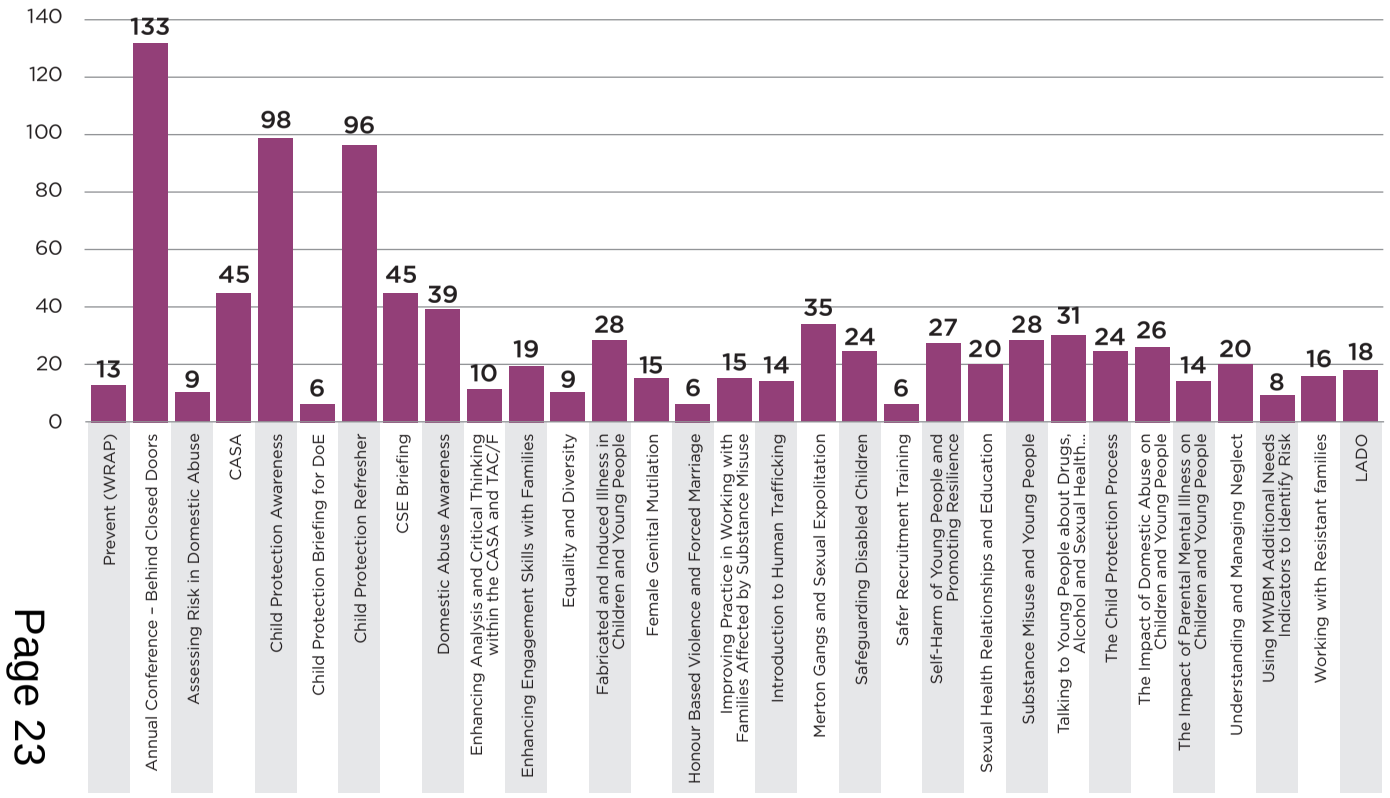
The MSCB has a responsibility to monitor and evaluate the effectiveness of training including multi-agency training to safeguard and promote the welfare of children. As part of this responsibility the MSCB offers a comprehensive programme of multi-agency training.

The MSCB's Learning and Development Strategy outlines the MSCB's approach to Multi-agency Learning and Professional Development.

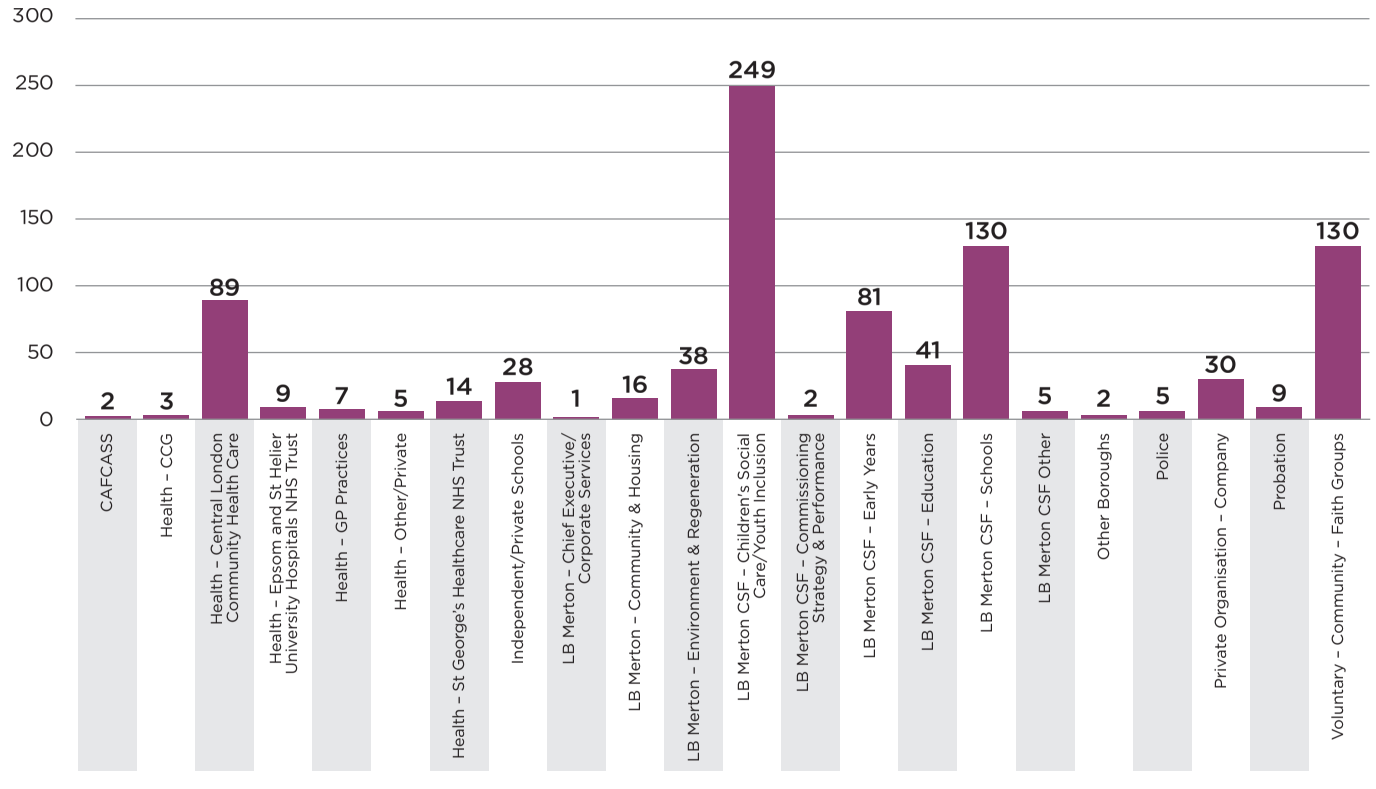
Table 11: MSCB Training for 2016-2017

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Planned events	6	7	13	6	0	10	8	11	3	7	7	9	87
Added events							1	2		1	1	1	6
Cancelled events	4	2	5	0	0	0	2	4	1	1	0	4	23
Actual events	2	5	8	6	0	10	7	9	2	7	8	5	69
Booked	28	59	93	77	0	200	121	144	20	107	113	185	1147
Actual number of attendees	**20**	**69**	**69**	**53**	**0**	**167**	**90**	**115**	**23**	**98**	**98**	**191**	**993**

Attendance per Course 2016-17



Attendance per Agency 2016-17



The provision of learning and development will be based on:

- Lessons from serious case reviews, learning and improvement reviews, management reviews
- Learning needs identified as part of multi-agency audits
- The MSCB key priorities as outlined in the MSCB business plan and other requirements as arising during the course of the year
- It will also link to requirements from other Boards (e.g. Safeguarding Adult Board, the Health and Well-Being Board etc.) and where appropriate share with other Safeguarding Boards and agencies so as to avoid duplication with single agency programmes and maximise the use of resources and shared expertise
- System wide Developments in multi agency safeguarding practice, for example, the Merton Social Work Practice Model, including the multi agency implementation of Signs of Safety and the review of the Merton Child and Family Well-being Model)
- Multi-agency training needs identified as part of reviews and/or inspections.

The MSCB's programme is one of the most comprehensive multi-agency safeguarding training programmes in London, offering a wide range of training opportunities for multi-agency safeguarding practitioners.

The Learning and Development Sub-Group reviewed the figures from 2015-2016 and as a result the Sub-Group took the decision to refresh the programme and training offer. The current training programme is aligned to the Board's key priorities and reflects the learning coming out of our SCR and LiR as well as learning emerging from analysis of SCRs nationally.

We are working closely with partners in Children's Social Care (CSC) to ensure that there is consistency and minimal overlap between the MSCB training offer and the CSC programmes.

7.3.3 E-Learning

Merton SCB renewed their membership with Virtual College in September 2016 and paid £8,000 for their e-Learning package and self-registration system, allowing learners and institutions to create their own e-Learning account.

In October 2016, Merton SCB upgraded their membership with Virtual College and upgraded to unlimited licences to the Total Training Package, paying an additional £8,000. The membership dates run from 30/09/2016 to 29/09/2017.

7.4. Policy Sub-Group

The Policy Sub-Group is focused on policies and procedures and the purpose of the Policy Sub-Group is to take overall lead responsibility on behalf of the MSCB to ensure that there are effective and up-to-date multi-agency guidance, policies, protocols and procedures to ensure children and young people are safeguarded and protected and their welfare is promoted. The Policy Sub Group also has lead responsibility for policies in relation to *safeguarding children from harm and neglect within their families or substitute families*. This includes core early intervention and child protection procedures and looked after children procedures; private fostering; the Sub-Group also leads on specialist areas such as parental mental ill-health, parental alcohol and substance abuse, and parental disabilities; FGM, cultural-based abuse and so-called 'honour' violence.

In 2016-2017 the Policy Sub-Group drafted or refreshed the following policies/strategies/ protocols for approval by the Board

- The FGM Strategy
- The Neglect Strategy
- The Bruising in Pre-mobile Babies Protocol
- The Multi-Agency Escalation Protocol.

7.5 Merton Child Death Overview Panel (CDOP)

In January 2017, the Merton CDOP took the decision to disaggregate from the London Borough of Sutton. Merton CDOP established local arrangements to respond to and review child deaths in Merton; these include:

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

In all, 36 cases were reviewed and completed by the CDOP during the period 1st April 2015 to 31st March 2016. 15 Cases were from Merton and 21 cases from Sutton. From 1 April 2015 to 31 March 2016, there were 28 child deaths reported to the Sutton and Merton CDOP. 16 deaths were of children resident in Sutton and 12 in Merton.

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

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

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

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

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

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

7.6 Youth Crime Executive Board (YCEB)

The Youth Crime and Prevention Executive Board (YCPEB) is chaired by the Director of Children's, Schools and Families Services and the vice chair is the Chief Inspector of the Metropolitan Police (Merton). The YCPEB is the governance structure for Merton in relation to the work of the Youth Justice Team (the local Youth Offending Team), including the Youth Justice Annual Plan, performance and Quality Assurance. It also oversees the partnership response to Serious Youth Violence, Gangs and Troubled Families (known locally as Transforming Families) (TF). Membership includes Children's Schools and Families (CSF): Children's Social Care (CSC); Youth Justice; LAC, Education Inclusion, Police, Probation and the Clinical Commissioning Group (CCG). The YCPEB reports to the MSCB. The Safer and Stronger Partnership reviews the performance of the partnership, the Youth Justice Team as well as wider youth crime issues.

The YCPEB's key priorities over the past year have involved maintaining and monitoring the strong performance of the YJT, particularly in relation to the Youth Justice Board's three key performance indicators of reducing first time entrants to the Youth Justice system, sustaining low numbers of young people who are sentenced to custody and reducing the number and rate of young people who reoffend. The YCPEB priorities have also been in regard to delivering the TF programme and reducing the serious youth violence and gang activity in the borough.

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

YCPEB oversees Merton's response to new legislation, the Inspection regime, its local crime reduction & prevention initiatives, monitor issues concerning risk and safeguarding and ensure staff & resourcing levels are in place to maintain performance and effectiveness within the delivery of the youth crime and prevention services.
As part of our commitment to continuous improvement, the YCPEB monitors the delivery of any improvement plans following inspections or audits. In 2016 an audit was completed on 20 cases by Cordis Bright, who have previous audited the team. This was in light of anticipated changes to Her Majesty's Inspectorate of Probation (HMIP) framework for inspection of Youth Offending Teams and following implementation by the YJT of the Youth Justice Board's new assessment framework, AssetPlus, in March 2016. The audit evidenced an improvement since their last visit in August 2013 and the subsequent SQS in October 2013. They examined 8 YROs and 11 Referral Orders. They presented the results separately as the results were different for each cohort. All YROs had sufficient risk management and effective oversight by managers and improvements were identified in regard to home visits and in a number of areas for Referral Orders. An Action Plan was developed and is reviewed by the YCPEB. Cordis Bright also recommended the Trauma Recovery Model to support the team's proactive approach with young people but to have a structure for responding to more complex / chaotic cases and increase the use of outreach and home visits.

The Youth Justice Board's annual National Standards audit was completed with most standards met or met with some improvements required. The YCPEB has endorsed recommendations, and will seek a partnership response from Service Managers for Youth Justice, Emergency Duty and Access to Resources Teams to create a plan for how LA responsibilities for a 'PACE bed' can be met, within the remit of practicable and fully supervised care, supported by transport. Training for EDT and frontline social workers will support awareness of responsibilities during different stages of young people's involvement in the criminal justice system.

The YCPEB remains committed to the core value of ensuring the voice of the child (VOC) and that this is captured and acted upon. The Youth Justice Annual Plan includes an Action Plan developed and reviewed by a youth board consisting of young people currently or previously on orders with the team. The latest youth board reported positively on the improvements to the recommendations, which are shared in team meetings. The Online Viewpoint Questionnaire was a requirement of HMIP and has now ceased. The last report from Viewpoint showed favourable satisfaction of service delivery. An 'exit questionnaire' as been developed by the team to capture the views of young people as they end their orders and the results will continue to be reported to the YCPEB and Youth Justice Plan reviews.

The YCPEB continues to have a focus on the Ending Serious Youth Violence agenda and this year Merton was involved in a Local Assessment

Process, delivered by the Institute of Community Safety. The recommendations from this report have been presented to both YCPEB and Safer and Stronger. The priorities will be to consider senior leadership oversight and collaboration in regard to the local profile and mapping of gangs, violence and exploitation. This will include oversight of the increase in County Lines drug dealing and a pilot project funded by the Home Office to engage young people through offering alternative pathways and access to legitimate income through apprenticeships. The YCPEB has also endorsed the combining of the Youth Offending Management Panel (YOMP) with the Gangs Multi-Agency Panel (GMAP) to ensure a streamlined multi-agency oversight, which will also reduce duplication of complex cases previously discussed at both panels. Reports from YOM-GMAP and case examples are to be represented to YCPEB to allow senior strategic oversight.

MOPAC funding for the gangs, restorative justice and CSE workers has been retained, this is now monitored by the Safer Merton manager, which has seen an increase in joined up working between the relevant services and Safer Merton and this joint working approach will continue to be fostered through networking events, representation at relevant panels and responding to the LAP review.

The Youth Justice Team has worked with the MSCB on a Harmful Sexual Behaviour Protocol, which aims to improve a multiagency response to young people who are involved in inappropriate or harmful sexual behaviour with appropriate assessment routes. The YCPEB and the MSCB QA Sub-Group were sighted on and approved the actions from a Critical Learning Report in regard to a critical incident involving a Rape charge, which includes the commissioning of a consultancy service to support workers on a regular basis in regard to their engagement and supervision of young people involved in harmful sexual behaviour (whether on court orders or under safeguarding processes). The Assessment Intervention and Moving on (AIM) tool will continue to be utilised to support screening and assessment. Other assessment frameworks are also being considered through the commissioning and training programme.

Merton CSF also focuses on the Child Sexual Exploitation agenda especially with regards to reducing the vulnerability of children and young people. This is done through the work of the Multi-Agency Sexual Exploitation (MASE) Panel and the Persons of Concern Panel (POC). These panels report to the Promote and Protect MSCB Sub-Group. The YCPEB also has oversight of this significant work and the Youth Justice Team Manager ensures representation from the YJT is maintained at all panels and groups. The cross-over of the serious youth violence and CSE agendas will increase next year with the YJT Manager being the lead for 'Contextual Safeguarding' agenda and having management responsibility for the CSE Lead.

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

The MSCB is committed to addressing the violence against women and girls. The VAWG Sub-Group is Chaired by the Director of Children, Schools and Families and the Vice-Chair is from the Borough Police. The strategic aims outline four priority areas in tackling VAWG and domestic abuse, which are:

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

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

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

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

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

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

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

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

Key achievement highlights for 2016-2017

The Merton VAWG board oversaw a range of work during 2016-17. As the work of the four year strategy was overseen and year one outcomes delivered we discharged the following:

- The London Borough of Merton is now a fully accredited partner in a national campaign to tackle Domestic and Sexual Violence
- Work has been completed with Merton becoming the second London borough to adopt the UK Says NO MORE campaign. Merton is the biggest supporter of this work and now has an employee as one of their faces for their national 2017-18 campaign
- Merton was also the first London Borough to adopt the "Ask Angela" campaign which works to address sexual violence within the night time economy. Based on our work this campaign has now been adopted by the Metropolitan Police who are now rolling this out across the city
- The Safer Merton Partnership to launch our revised VAWG mission statement
- Work completed with the introduction of a four year strategy developed and signed off in conjunction with partners
- The Safer Merton Partnership to work with victims of Domestic Violence and Abuse (DVA) and encourage reporting of incidents to achieve our ambition of increasing victims' access to services year on year
- Work undertaken through the campaigns resulted in some increases in reports for quarters 1-3 however reporting in quarter 4 reduced. The reduction may coincide with there being no sustained promotion during these months to undertake a full DVA profile for the borough.

Alongside this we successfully delivered work around:

- Merton's Police achieve 40% SD rate for Violence with Injury (Domestic Abuse) the second best in the MPS
- More Domestic Violence Protection Orders are being applied for and granted
- Police MARAC referrals are up significantly
- Operation Dauntless approach with higher risk suspects is now routine
- All repeat cases are reviewed regularly by the Police
- MARAC learning days have been carried out and the most recent MARAC self-assessment provided some positive results
- Presentation provided at the annual MSCB conference which was focused on DVA
- Delivered a full programme of activities for the 16 Days of Activism 2016.

As we move forward through 2017-18 we will continue to build on this work by:

- Recruiting a VAWG co-ordinator to ensure that all nine strands of VAWG are fully developed and embedded across the partnership
- Completing an overview profile of all VAWG strands in Merton and updating the DVA profile
- Discharging our year two priorities from the VAWG strategy and developing the detail around our year three ambitions
- Continue to build on our successes of the NO MORE and Ask Angela campaigns to further improve reporting rates within the borough

- Commission a new DVA service for 2018-20201 to ensure that Merton can meet the needs of our DVA victims moving forward
- Develop and deliver an improved programme of events during the 16 Days of Activism campaign 2017, deliver a robust programme of events for NO MORE week 2018 and ensure that the VAWG partnership acknowledge all international, national and/or local days around VAWG.

7.8 MASH Strategic Board

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

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

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

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

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

7.9 Structure and Effectiveness of the MSCB

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

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

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

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

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

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

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

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

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

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

- 7 serious incident notifications have been submitted to Ofsted by the MSCB
- completed two SCRs (the Tia Sharpe SCR and the Child B SCR)
- The MSCB have completed 3 learning and improvement reviews (Child J, Baby PP and Baby C).

7.10 MSCB Budget

The MSCB has an agreed budget and all agencies contribute. Its income for 2016/17 was £248,470. The MSCB Budget for 2016-2017 is detailed as follows:

Brought forward from 2014-2015	£18,642
Income for 2015-2016	
Agency Contributions	
CAFCASS	£550
London CRC	£1,000
London Probation Service	£1,000
London Borough of Merton	£142,030
Merton CCG	£55,000
Metropolitan Police	£5,000
Sub-total	**£204,580**
London Borough of Merton Baseline supplement[5]	£43,890
Total	**£248,470**
Expenditure	
Staffing	£144,170
Premises	£2000
Supplies and Services	£100,460
Transport	£1,840
Totals	**£248,470**
Brought forward from 2016-2017	£0.00

[5] In 2016-2017, the MSCB Expenditure exceeded income from Agency contributions; LB Merton therefore supplemented the MSCB Budget.

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

8.1 Harmful Sexual Behaviour Task and Finish Group

The PPYPS Sub-Group commissioned a task and finish group to develop a multi-agency protocol to address the issue of harmful sexual behaviour. The task and finish group included representation from:

- Children's Social Care
- Health
- The Police
- The Youth Justice Team
- Child and Adolescent Mental Health Practitioners with the Youth Justice Team
- Education

The task and finish group also consulted with schools and young people. The Harmful Sexual Behaviour was developed in accordance with the relevant chapters in the *London Child Protection Procedures*[6], drawing upon the following local and national guidance:

- *Merton Safeguarding Children Board's Child Sexual Exploitation Strategy 2017*
- *Merton Safeguarding Children Board's Child Sexual Exploitation Protocol 2017*
- *Harmful Sexual Behaviour Among Young People*, Guideline September 2016 (National institute for Health and Care)
- Hackett, S, Holmes, D and Branigan, P (2016) *Operational Framework for Children and Young People Displaying Harmful Sexual Behaviours*, London, NSPCC
- AIM2 Model of Initial Assessment (G-Map, 2012).

[6] The London Child Protection Procedures, 5th Edition: Chapter 7. Safeguarding Children from Sexual Exploitation (Part B3 Safeguarding Children Practice Guidance); Chapter 8. Organised and Complex Abuse (Part A: Core Procedures). In cases where there is more than one victim and/or perpetrator Chapter 8 must be followed; Chapter 10 Safeguarding Sexually Active Children (Part B3 Safeguarding Children Practice Guidance) Chapter 15 Children Harming Others (Part B3 Safeguarding Children Practice Guidance).

The Harmful Sexual Behaviour Protocol was recommended to PPYPS and was presented to the Board for Approval in June 2017.

8.2 CSE Protocol and CSE Strategy Task and Finish Group

The PPYPS also commissioned a task and finish group to revise Merton's CSE Protocol and our CSE Strategy. The task and finish group included the CSE Lead Practitioner, representation from the Police, Health (including Merton CCG), Children's Social Care, Education, Commissioners

8.2.1 The CSE Protocol

The CSE Protocol has been reviewed to ensure that it is in line with the London Child Protection Procedures Chapter 7 in light of the Merton context. The revised protocol highlights peer on peer abuse and makes reference to contextual CSE and harm in a range of public environments/ contexts. The protocol has added additional clarity regarding interventions at each level of need. As a result, we have outlined our approach in the following:

- Cases that are pre-threshold in early help and that require enhanced support
- CIN Cases
- CP Cases
- LAC Cases

Throughout the protocol we have highlighted the role of the CSE Lead to provide consultations to professionals on all cases relating to CSE. The revised CSE Protocol was approved by the Board in March 2017.

8.2.2 The CSE Strategy

The CSE Strategy was last updated in January 2015. Since that time the Board has reviewed its CSE protocol, the DfE has also refined its definition of CSE, the London Child Protection Procedures have been updated, and there is also a growing body of evidence and practice development around contextual safeguarding. The Strategy sets out the MSCB's response to CSE.

The statutory definition of CSE has been updated. The strategy makes the link between CSE, Harmful Sexual Behaviour and other shared categories of harm/exploitation including missing; Harmful Sexual Behaviour, teenage relationship abuse, serious youth violence, CSE and radicalisation (see pages 5-7). The CSE Strategy was approved by the Board in May 2017.

The strategy also highlights the significance of contextual safeguard drawing on the work of Carlene Firmin (2013 and 2016). Information regarding the local context has been updated. Related to this is a new section on working with children and young people affected by CSE drawing on the work of University of Bedfordshire, the International Centre for Researching CSE, Violence and Trafficking and Research In Practice (2017).

8.3 Online Safety Strategy Task and Finish Group

The Policy Sub-Group commissioned a task and finish group to revise and update the MSCB's Online Safety Strategy. We were grateful for the support and expertise of Derek Crabtree, the Schools ICT Support Manager who worked on drafting the strategy. The task and finish group included representatives from the Police, Health, Children's Social Care, Education, Voluntary Organisations. The aim of this strategy is to provide guidance and inform frontline practitioners to:

- Guide children, young people and others to the best sources of information and support and not duplicate the great range of advice and resources already available
- Help organisations to develop their own solutions, and incorporate the principles and priorities in this strategy into those
- Identify those young people potentially vulnerable
- Make sure that risk is assessed and managed effectively
- Make sure that young people understand their own risks in using online services.

The strategy covers the following aspects of online safety:

- Inappropriate content
- Cyber-bullying, including sexual bullying
- Online Grooming
- Youth Produced Sexual Images
- Online Reputation
- Privacy
- Self-Harm
- Online Pornography
- Radicalisation

The Strategy was approved by the Board in June 2017.

8.4 Bruising In Non-Independently Mobile Infants and Children Task and Finish Group

The Policy Sub-Group commissioned a task and finish group to prepare a protocol on Bruising In Non-Independently Mobile Infants and Children. The task and finish group met and prepared guidance designed to support professionals' practice in the assessment and management of bruising in non-independently mobile infants (usually less than 6 months old). The aims of the guidance are to:

- Outline pathways in Merton for the referral and assessment of bruising in non-independently infants and children
- Ensure that all partners are responding to bruising in non-independently mobile infants and children in a consistent way
- Support practitioners to effectively respond to concerns about non –accidental injury in non-independently mobile infants and children.

The guidance is part of MSCB's implementation of recommendation 5 of the Baby C Learning and Improvement Review. The guidance was approved by the Board in June 2017.

8.5 Learning and Improvement Reviews (LiR) and Serious Case Reviews (SCR)

8.5.1 Learning from the Child B SCR

In 2015-2016 the Board commissioned a Serious Case Review, known locally as the Child B Serious Case Review (SCR). In September 2015, B (age 16) was seriously assaulted by her Mother during the night while B was asleep. The sustained attack resulted in significant damage, requiring surgery. B's Mother had a long history of mental illness, including in-patient and community based mental health services.

Child B was seriously harmed by her Mother who had an on-going history of poor mental ill-health; at times, she was well and, at times, she deteriorated rapidly. The work shows the need to understand parental mental health, alcohol, and possible domestic violence and their impact on young people. These are not new themes in serious case reviews. This review helped the Board to identify the work that needs to be done locally to ensure that practitioners recognise and understand this 'trigger' trio.[7]

The Key Lessons from the SCR are outlined as follows:

- **Embedding Think Family in Assessments and Work with Families.** Work with children and families needs to take into account the family dynamics of family history, relationships, different belief systems, or culture. Practitioners need to be equipped and supported through training and supervision to understand the possible significance of the cultural and religious dynamics.
- **Understanding the needs of Young Carers.** The needs of Young carers need to be recognised, understood and attended to by the whole multi-agency system. This requires appropriate joint assessments
- **The use of written agreements.** There is a need for clarity regarding the use of written agreements. This includes ensuring that the use of such agreements follows the London Child Protection Procedures and best practice guidance.
- **Leadership and Quality Assurance of multi-agency meetings and processes.** Step-down from child protection the children in need processes need to be well planned and carefully managed from a multi-agency perspective. This includes clarity about who should be involved, what the goals were and timing of meetings.

The report of this was published in February 2017 and is available on the MSCB website.[8] The recommendations coming out of the SCR are included in this report as Appendix 1.

[7] The term 'Trigger Trio' is used in Merton to describe the issues of domestic abuse, mental ill-health and substance misuse.

[8] https://www2.merton.gov.uk/health-social-care/children-family-health-social-care/safeguardingchildren/lscb/serious_case_reviews.htm

The Board has an action plan in place to ensure that the recommendations coming out of this SCR are implemented. In addition to this, the Board has provided a range of briefings to over 120 multi-agency members of staff; to Designated Safeguarding Leads across the primary and secondary school sector, including academies; the Board has also briefed colleagues in the private and voluntary section to ensure that messages about effective multi-agency working are communicated. The Board is in the process of reviewing its Young Carers' Strategy and a Mental Health Protocol.

8.5.2 Learning from Baby C Learning and improvement Review

This was a case which was escalated to the Board by the Named Nurse for the Community Health Provider. The concerns included neglect (including physical neglect and failure to attend medical appointments), parental mental health, parental learning difficulties, and parental substance misuse.

The Board met in November 2015 to consider if the threshold for a SCR was met or if there was a need to commission another type of learning review. At that meeting it was agreed that the criteria for a serious case review were not met however, this case would provide an opportunity for a Learning and Improvement Review.

This Review has demonstrated the importance of recognising the indicators and impact of chronic neglect on children. The need for professionals to view a home environment from the child's perspective cannot be overemphasised. This case has highlighted the importance of the need for professionals to take account of the childhood experiences of a parent with mental health concerns and the impact of such experiences on the safeguarding risk to children. Such information needs to be shared with other agencies working with the family.

The key learning coming out of the review is summarised as follows:

- **The need to understand Neglect:** The signs and indicators of chronic neglect need to be recognised and acted upon by multi-agency professionals. Neglect remains the theme running across each of the Board's three key priorities. The Board has reviewed and updated its Neglect Strategy and will be conducting an audit of neglect cases in early autumn 2017. We are also developing a neglect toolkit which will assist practitioners in identifying and assessing cases of neglect.
- **Physical Abuse:** Unexplained physical injuries in children should trigger child protection procedures; especially when there are conflicting accounts given by the child, the parents. There also needs to be clear guidance regarding the significance of bruising in pre-mobile or non-mobile children and what to do in cases of unexplained injuries. As part of the learning coming out of this review the Board has approved multi-agency guidance on bruising in pre-mobile and non-ambulant children.
- **Child Sexual Abuse:** Disclosures of sexual abuse need to be acted upon and investigated as fully investigated as possible. In order establish a baseline of the quality of safeguarding practice in relation to child sexual abuse; the Quality Assurance Sub-Group undertook a multi-agency audit of child sexual abuse. As a part of this audit partners reviewed two child protection cases and 12 threshold cases that did not result in a child protection plan. The findings of this audit were shared with partners and practitioners.
- **Safeguarding Adults:** The report found that the vulnerability of parents to exploitation by other adults needs to be recognised by practitioners; this includes recognition that adults with additional needs, as well as their children, can be at risk of abuse and exploitation. These factors need to be considered holistically by those agencies working with families. Supporting vulnerable adults is part of the Board's Think Family priority and a Think Family Coordinator has been appointed to assist partners in embedding the think family approach across adults and children's services.
- **Childhood Experiences of Parents:** We know from research that the childhood history of neglect, abuse and poor mental health can have an adverse impact on parental capacity and the ability of parents to provide good enough care to children. It is essential that assessments take into account the childhood experience of parents and the impact of adverse childhood experience on parents' ability to provide good enough care for children.
- **Thresholds and Monitoring:** The review highlighted the need that all plans to monitor cases should have:
  a. a named lead professional;
  b. a clear support plan outlining which services will be providing support and expected outcomes;
  c. such plans should also state how cases will be escalated where improvements have not been made or sustained, and
  d. Plans should have clear timescales and review periods.
- **The Impact of the Home Environment on a Child's Life:** the need to view a home environment from the child's perspective is crucial to professional understanding of a child's experience. The Board is addressing this finding as part of its work on the issue of neglect.

The Board has an action plan in place to ensure that the recommendations coming out of this Baby C LiR are implemented. In addition to this, the Board has provided a range of briefings to over 120 multi-agency members of staff; to Designated Safeguarding Leads across the primary and secondary school sector, including academies; the Board has also briefed colleagues in the private and voluntary section to ensure that messages about effective multi-agency working are communicated. As a result of this LiR the Board has refreshed its Neglect Strategy, approved a protocol for *Bruising In Pre-Mobile Babies and Non-ambulant Children*.

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

9.1 Section 11

The Board holds partners to account through its Section 11 Quality Assurance and Peer Challenge Process. The Board also receives annual reports from the Children's Trust, the VAWG Group and Public Health.[9]

At the Business Implementation Meeting held on 2nd February 2016 it was agreed that the Section 11 process for 2015-2016 would involve a review and update of each agency's Section 11 Self-Audit for 2014-2015. A Quality Assurance and Peer Challenge meeting would be considered for the new health provider for Community Health Services (Central London Community Health Care; which started in Merton in April 2016) and those agencies where there are specific issues identified in their Section 11 self-audit return.

The Board agreed to use the Pan-London Section 11 Audit Tool, developed by the London Safeguarding Children Board. The audit tool allows each agency or organisation to assess the quality of its safeguarding practice against eight agreed safeguarding standards providing supporting evidence where appropriate. These standards are as follows:

STANDARD 1 – Senior management have commitment to the importance of safeguarding and promoting children's welfare

STANDARD 2 – There is a clear statement of the agency's responsibility towards children and this is available to all staff

STANDARD 3 – There is a clear line of accountability within the organisation for work on safeguarding and promoting welfare

STANDARD 4 – Service development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of children & families

STANDARD 5 – There is effective training on safeguarding & promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children & families

STANDARD 6 – Safer recruitment procedures including vetting procedures and those for managing allegations are in place

STANDARD 7 – There is effective inter-agency working to safeguard & promote the welfare of children

STANDARD 8 – There is effective Information Sharing

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

Agency Returns

The MSCB has received completed returns from the following agencies:

1. CAFCASS
2. Carer Support Merton
3. LBM Adult Social Care
4. LBM CSF Children's Social Care
5. LBM Early Intervention and Prevention Commissioned Services
6. LBM Early Years, Childcare and Children's Centre Services
7. LBM Education Inclusion
8. LBM Public Health
9. Housing Needs
10. LBM Safer Merton
11. LBM Youth Justice
12. London CRC Probation
13. Metropolitan Police Service (Borough and CAIT) Safeguarding Report (Service Wide)
14. Metropolitan Police Service Safeguarding Report (SOECA Service Wide)
15. Merton Voluntary Service Council (MVSC)
16. NHS Central London Community Health Care
17. NHS Epsom and St Helier NHS Trust
18. NHS Merton CCG
19. NHS South West London and St George's Mental Health NHS Trust (CAMHs)
20. NHS St George's Hospital (Section 11 Report)
21. National Probation Service (a regional, pan-London return)
22. London Ambulance Service (annual report addressing safeguarding children)

Overall, the Section 11 returns provide the Board with good assurance regarding the quality of safeguarding practice across the MSCB multi-agency partnership.

The section 11 self-audit returns received provide the Board with good assurance regarding the quality of safeguarding practice across the MSCB partnership. Where agencies assessed that standards were met there were, in most cases, action plans, with clear timescales and named persons to address this.

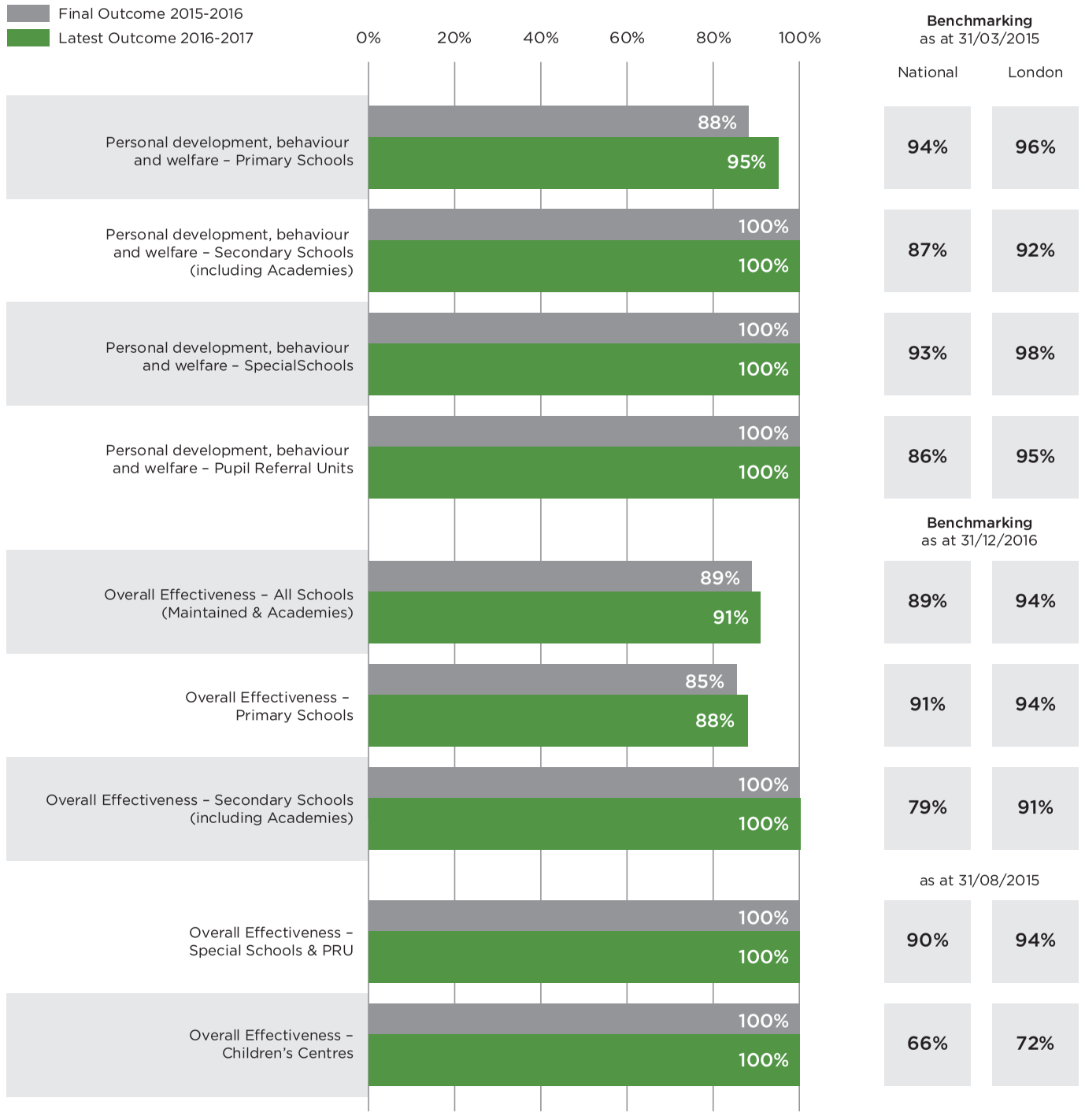
National or regional services (such as, CAFCASS and Probation) submitted more 'global' self-assessments were asked to ensure that there is an addendum which gives assurance for Merton.

Schools were not asked specifically to complete a section 11 audit in this round. A safeguarding systems audit for each school had been undertaken in the autumn term 2016 and reported to the MSCB in January 2017.

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

9.1.1 Schools

Ofsted inspection outcomes rated Good or Outstanding



9.2 Children, Schools and Families (CSF) Department

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

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

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

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

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

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

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

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

9.3 Acute Trusts

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

9.3.1 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.

9.3.2 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.

9.3.3 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.

9.3.4 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.

9.3.5 Central London Community Healthcare NHS Trust

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

9.3.5 Public Health

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

9.4 Community and Housing Dept. – London Borough of Merton

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

9.5 Corporate Service – HR – London Borough of Merton

A section 11 audit of the council's safer recruitment and employment practices was undertaken. The council has also re-issued advice to schools in the period covering revisions to the vetting and barring arrangements and on the new DfE guidance on disqualification by association. In addition to this, the Board provides safeguarding training to all new members of staff as part of the Corporate Induction process.

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. The Borough Command and CAIT are strong partners in the work of the Board and its Sub-Groups.

10.0
Views of Children and Young People and the Community

10.1. The Help Keep Us Safe Research Project with the London South Bank University

Merton's Local Safeguarding Children's Board and London South Bank University commissioned a research project into hearing young people's concerns about their safety and well-being. It aimed to gather the views of children and young people in Merton about their safeguarding concerns.

The research was conducted in two parts: Part 1 consisted of a survey of one hundred and forty eight young people in the general population who attend secondary schools in the area. Part two consisted of semi-structured interviews with ten young people who were the subject of a child protection plan.

The most commonly cited source of fear was gangs or groups of young people. Four of ten participants (42%) said that they were afraid of gangs or groups of young people sometimes, often or very often. The second most cited source of fear was bullying. One quarter (25%) said that they were afraid of bullying sometimes, often or very often.

Ranked in third place was a range of risks that were rated at a similar level (between 8% to 13%). These can be categorised into several clusters.

a) Online victimisation.
b) Child sexual exploitation.
c) Physical harm.
d) Risks related to their own behaviour.

One of the strongest themes was that young people saw other young people as the greatest source of threat. By contrast, a strong majority stated that they 'never' or 'rarely' felt afraid of adults, whether this was in relation to being hurt (approximately 90%) or being forced to do things sexually (89%). The PPYPS Sub-Group is overseeing the Board's response to this research.

10.2 Merton's Children's Trust User Voice Strategy

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

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

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

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

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

Ninety per cent of LAC participated in their LAC review either through attendance, completion of consultation papers, or through an advocate.

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

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

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

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

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

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

Other vulnerable cohorts of Young People

- As a result of feedback from young people in the Youth Justice System, in their sessions with young people, workers have increased their to focus on the needs of the young person, identifying the skills they need and signposting to local projects that can help build these skills
- Feedback from the forum for young people who are supported by the Education, Training and Employment team highlights that staff have an increased understanding that user views are key to ensuring that assessments and plans are as comprehensive as possible
- In response to feedback from parents involved in the Transforming Families programme practitioners are now revisiting the 'family plan' at more regular intervals so that families are fully aware of targets and expectations
- LGBTQI+ young people attended a meeting of the Board in order to highlight issues affecting them. Young people highlighted the need for a person centred approach and the importance of listening to LGBTQI+ young people with regard to the use of personal pronouns and in understanding gender non-conformity and the need for non-binary understanding of sex and gender.

11.0
Conclusions and Priorities for 2016–18 Business Years

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

Our partnership is mature and robust and is characterised by respectful challenge and accountability. The Sub-Groups are purposeful and targeted on delivering on the Board's agreed priorities. The Board's Performance Dataset allows the Board to analyse trends and identify risk or gaps as well as prioritise areas for development.

At the Board's Annual Away Day it was agreed that the Board would focus on fewer priorities whilst continuing to deliver on a range of key 'Business a Usual' safeguarding issues. In agreeing the Board's priorities for 2016-2018, there was a robust discussion with presentations from partner agencies on their agency's strategic priorities. Members of the Board then agreed the Board's agreed priorities for 2016-2018 be extended and deepened to for the period 2017-2019.

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1a
Recommendations from the Child B Serious Case Review

Recommendation 1: The MSCB and its Partner Agencies should review how the principles of the holistic Think Child, Think Parents, Think Family approach are operating in Merton and how they are embedded in commissioning and leadership of front-line practice and its management, with joint-working and understanding of mental ill-health and parenting.

Recommendation 2: The MSCB should recommend to the Children's Trust that it should review the Merton Young Carers' Strategy and draw up a clear multi-agency Young Carers' Protocol, for all sectors, to clarify the nature and arrangements for Young Carer's Assessments, following the duties set out in The Young Carers (Needs Assessments) Regulations 2015.

Recommendation 3: The MSCB and its Partner Agencies should review their processes for ensuring staff awareness in analysing family history and dynamics, including the understanding of how culture and belief systems impact on their understanding and (risk) assessments of mental health and parenting. This should include staff awareness of listening to family members.

Recommendation 4: Children's Social Care should review the competency of staff responsible for drafting written agreements and the detailed Child Protection Plans, in the light of relevant research, guidance and case law; to ensure that such staff and their supervisors are well-equipped to negotiate and draw up realistic and achievable agreements, based on thorough risk assessments.

Recommendation 5: Children's Social Care and the SW London Mental Health Trust should seek to ensure that the staff (and their immediate line-managers) who have responsibility for chairing multi-agency meetings, particularly Core Groups, Child in Need and Care Programme Arrangements meetings are competent in the facilitation of meetings and have an understanding of the holistic Think Family approach and the principles set out in the London Child Protection Procedures for Core Groups London Child Protection Procedures, Part B, section 9.

Recommendation 6: The MSCB Policy Sub Group should review guidance on 'step down' from child protection or child in need thresholds to ensure that it covers a review of the relevant case history, including the original risk and any other risks subsequently identified, not only recent progress; and an assessment of risk or need in the longer term, including the risk of relapse and contingency plans – including the recognition of potential breakdown or non-compliance; or future significant changes in the family composition.

Recommendation 7: The MSCB Policy Sub Group should review guidance on 'step down' from child protection or child in need thresholds to ensure that it covers a review of the relevant case history, including the original risk and any other risks subsequently identified, not only recent progress; and an assessment of risk or need in the longer term, including the risk of relapse and contingency plans – including the recognition of potential breakdown or non-compliance; or future significant changes in the family composition.

Appendix 1b
Recommendations from the Baby LiR

Recommendation 1: MSCB to give consideration to reviewing and refreshing its Neglect Strategy in the light of the learning coming out of this review.

Recommendation 2: MSCB to seek assurance regarding the level of professional awareness of the Neglect Strategy and its implications for practice in cases of neglect.

Recommendation 3: MSCB to seek assurance from all partner agencies that the following are embedded in practice and underpinned by policy:

- Practitioners working with families, young people and children access regular safeguarding supervision from a trained safeguarding supervisor
- Safeguarding supervision includes case management, professional learning and development and promotes reflective practice
- Chronologies are maintained and reviewed as part of clinical practice and at supervision.

Recommendation 4: MSCB to give consideration to undertaking an audit of 'physical abuse' with the aim of gaining a better understanding of the picture of physical abuse in Merton. The remit of the work to be children in Merton identified as having experienced physical abuse, those who are at risk of physical abuse and those children where the risk of physical abuse is 'masked' by other concerns.

Recommendation 5: MSCB through the policy subgroup to oversee the development of a multi-agency protocol for bruising in pre-mobile babies and children.

Recommendation 6: MSCB to seek assurance from all partner agencies that the importance of listening and taking seriously any disclosure of abuse by a child is embedded in practice and underpinned by policy.

Recommendation 7: MSCB and MSAB to work together promote closer partnerships between agencies on both a strategic and operational level.

Recommendation 8: MSCB to seek assurance from partner agencies that practitioners working with families, children and young people are trained and supported to recognise the signs and indicators that an adult is vulnerable, fully understand the need to share information with adult services and, where required make a referral to adult social care.

Recommendation 9: MSCB to seek assurance from partner agencies that practitioners, in addition to internal agency safeguarding supervision, have access to specialist advice and support in managing cases where there are complex issues, such as parental learning difficulties, mental health and ADHD.

Recommendation 10: MSCB to seek assurance from partner agencies that where an adult is known have mental health issues or learning disabilities and is a parent, the impact on their parenting role and risk to children is considered as part of any assessment undertaken and this is shared with other professionals working involved with the family.

Recommendation 11: MSCB to seek assurance from partner agencies that practitioners working with adults who are known to have mental health issues or learning disabilities, and who are parents understand the potential risk to children, the need to share information with adult services and where required make a referral to Children's Social Care.

Recommendation 12: MSCB to seek assurance from partner agencies that:

- The MSCB Escalation Procedure has been cascaded to staff and is accessible
- Escalation is included as part of each agency safeguarding policy/procedure.

Recommendation 13: MSBC to reinforce to partner agencies that the sharing of information on a multi-agency basis is crucial, if children are to be safeguarded.

Appendix 2

Merton Safeguarding Children Board Business Plan 2017–19

Progress of this Plan will be updated monthly & monitored at each MSCB Meeting.
Approved by the Board 27th June 2017.

Objectives		Outcomes	Actions (who and what)		Resources	
					Who? (Governance/ oversight)	When?
Priority 1: Think Family: An Effective, Seamless Approach to Supporting Children and Families						
1.1	To embed the Think Family Approach across the multi-agency partnership	For a Think Family Co-ordinator to work across Children and Adult facing services	**What** To appoint a Think Family Coordinator For a Think Family Task and Finish Group to develop Multi Agency Protocols for approval	**Who** CSC and Southwest London and St George's Mental Health Trust	PPYPS Sub-Group and BIG Paul Angeli & Gillian Moore	March 18
		To deliver a suite of Think Family Multi Agency Protocols for Mental Health, Substance Misuse, Learning Disabilities, Learning Difficulties and Domestic Abuse	Protocols should include a communication strategy, a learning and development plan for the workforce and an implementation plan	PPYPS and BIG CSC ASC Community Health CCG Public Health CSF Commissioners MSCB	Policy Sub-Group and BIG Think Family Coordinator Chris McCree	March 18
		To Launch the Think Family Protocols at the Joint CSF and MSCB Annual Conference	MSCB Joint Conference around 'Think Family' with reference to neglect and the trigger trio?	MSCB and CSC PD Team CT Think Family Coordinator	Learning and Development Sub-Group	March 18
		To embed Think Family into the broader culture of multi-agency working	Think Family Coordinator to lead on promoting effective Think Family Work	All partners The Leads from each agency	Policy Sub-Group	March 19
1.2	The MSCB is assured of the multi-agency awareness of neglect and its impact and the quality of frontline practice in cases of neglect	For the MSCB to undertake a re-audit of neglect To feedback key practice lessons from the audit To integrate these lessons into current training and practice development initiatives	**What** QA Sub-Group and MSCB partners to conduct a multi-agency audit of neglect cases To add Neglect to the Section 11 Self-audit	**Who** All relevant MSCB partners including Health (CCG, CLCH, acute trusts, Mental Health Trust), Education, Police, CSC, Voluntary Orgs	QA Sub-Group and BIG Head CSC &YI QA Chair Paul Angeli	March 18
		To have in place a range of approved practice tools to address the incidence of neglect	MSCB to adopt and promote a range of practice tools to address neglect	Carla Thomas CSC Health Police Education Early Years	Policy and Learning and Development Sub-Groups MSCB BSU	March 18
		For the Board to be assured that there is a clear link between the work on neglect including the trigger trio and Think Family	Multi-agency partners to demonstrate an understanding neglect as an effect, with the trigger trio, in many cases, being the cause	MSCB partners including, SAB Health (CCG, CLCH, acute trusts, Mental Health Trust), Public Health Education, Police, CSC, Voluntary Orgs	Policy and Quality Assurance Sub-Group Chair	March 18
1.3	The Board is seeking assurance regarding the quality of multi-agency practice in relation to Domestic Violence & Abuse	The Board has in place a multi-agency Domestic Abuse Strategy	A Task and Finish Group to Develop a multi-agency Domestic Abuse Strategy	VAWG CSC Health Police Voluntary Orgs	Policy Sub-Group with, MSCB Chair	March 19
		The Board has approved a range of assessment and practice tools to be used across the multi-agency partnership	To develop/adapt an appropriate child-centred tool for assessment in DVA cases	MSCB Trainer and MSCB Partners	CSC & YI	March 19
		The Board has assurance that the strategy is being implemented across the multi-agency partnership		All Agencies	Policy Sub-Group with, MSCB Chair	March 19

Objectives		Outcomes	Actions (who and what)		Resources	
					Who? (Governance/ oversight)	When?
Priority 2: Supporting Vulnerable Adolescents						
2.1	To Maintain Strategic grip on CSE and related forms of harm including Missing from Home Education and Care	The Board has conspicuous oversight on the issue of CSE locally	**What** To review multi-agency responses to CSE	**Who** CSE Lead CSC and YI MASE, SD NC	PPYPS	On-going
		To develop a strategic response to Harmful Sexual Behaviour; with a communication strategy and implementation plan	To develop guidance for professionals, parents and young people	Harmful Sexual Behaviour Task and Finish Group To include CSC, YJT, CCG, Police, Education, SD NC	PPYPS	July 17
		To review and refresh the MSCB Online Safety Strategy, with a communication strategy and implementation plan	To develop guidance for professionals, parents and young people	MSCB Manager and Schools ICT Support Manager, DC/ MSCB BSU	PPYPS Chair	July 17
		To communicate clearly to practitioners and parents the parenting support available local for parent of children ages 10-15	To increase community awareness and access to support	Family Information Service, Bond Road MSCB	PPYPS	October 17
		To maintain a strategic grip on children missing from home, education and care	For PPYP to receive and Annual report on the work regarding missing children	CSC (including LAC, MASH,) Education Commissioned services NM NC	PPYPS	June 17
		To ensure that there is increased awareness of the range of risks faced by adolescents	Explore the feasibility of an audit of contextual safeguarding to review the intersections between CSE,HSB, radicalisation, SYV and gangs	MSCB and partners	PPYPS supported by Learning Development and QA Sub-Group	March 19
		For the Board to maintain conspicuous oversight of multi-agency performance in relation to children mission home education/ school and care	To review the MSCB Performance Dataset to include data vulnerable adolescents including CSC/CME/Missing	Head of Policy, Planning and Performance	PPYPS Head of R & I	June 17

Objectives		Outcomes	Actions (who and what)		Resources	
					Who? (Governance/ oversight)	When?
Priority 2: Supporting Vulnerable Adolescents						
2.2	To Maintain Strategic grip on self-harm, para-suicide and adolescent mental health	To ensure oversight self-harm, para-suicide and adolescent mental health	**What** CAMHs and commissioned services to report on their work with young people For acute trusts to report on YP in Emergency Departments presenting with self harm	**Who** CAMHs Commissioned services St George's NHS Trust Named Nurse Epsom and St Helier Named Nurse	PPYPS Director of Public Health	March 18
2.3	To ensure that the Board has a strategic multi-agency response to high-risk, high concern adolescents (i.e. old LAC young people, young people who repeatedly go missing, those a risk of CSE, young people known to Criminal Justice System)	Maintain and strengthen oversight of missing young people in Merton	To continue to improve practice around children and young people missing from home/ school/care	CSC & YI YJT CSE Lead FAS Commissioned Services Police	PPYPS RE (YOT) CSE Lead	March 18
2.4	For the Board to develop a range of responses to adolescent risk through the adopting a Contextual approach to safeguarding	To work with partners in the London Borough of Hackney and the University of Bedfordshire as part of the Innovation Project	To undertake an audit of contextual safeguarding To pilot a range of tools and approaches	MSCB Partners Led by CSC RE (YJT)	PPYPS	March 19

Objectives		Outcomes	Actions (who and what)		Resources	
					Who? (Governance/ oversight)	When?
Priority 3: Ensuring the Effectiveness of Early Help						
3.1	Finalise the review of the Merton Child and Family Well Being Model	Threshold Document has been revised in accordance with the review of the Model To provide multi-agency guidance in relation to Step-up and Step Down	**What** Update the Threshold document and clarify Step-Up and Step down processes	**Who** Head of Policy, Planning and Performance CSC HoS Task and Finish Group, CASA Manager Early Years CSC	Board via BIG	Sept 17
		CASA tools, protocols and training materials are updated	To review the current CASA tools and materials and align to the new model and the signs of safety	CASA Task and Finish led by CASA Manager	Board via BIG	Sept 17
		The reviewed Merton Child and Family Well Being Model is launched	To plan launch event and communication strategy	MSCB Business Unit and Children's Trust	Board via BIG	Sept 17
		Determine the Governance arrangements for the multi-agency implementation of the Signs of Safety	To prepare the terms of reference for Signs of Safety multi-agency roll out	CSC & Practice Leader Signs of Safety CLCH CCG Early Years FAS	Board via BIG	March 18
3.2	To ensure that the early help offer is clearly on the Family Services Directory	To ensure that Early Help provision is mapped and publicised across the partnership and community	Map Early Help Pathways and develop a communication strategy to ensure awareness	Led by Early Years Manager and the FSD Lead	Board via BIG	March 18

Appendix 3
London Borough of Merton Social Work Practice Model

Merton Safeguarding Context

This section reviews trends and progress with safeguarding children with high levels of vulnerability. This includes children who need to be supported by a child protection plan and those who need to be in the care of the local authority to keep them safe.

Children in need population

There was a significant increase in open child in need episodes as at 31 March 2016, 1901 compared to 1544 (March 2015). The rate per 10,000 413 was also significantly higher than National 337, London 370 and Merton trend over last three years 336, 335, 338.

There was an increase across the board with our Statistical Neighbours recording an increase of 23.27 from a rate of 313.64 in 2015 to 336.91 in 2016.

The number of children in need episodes starting in the year has increased by 10.6% in Merton and by 1.9% in London whilst decreasing by 0.4% nationally from last year to 2015-16.

Episodes of need are lasting longer in Merton than nationally and in London. Of the episodes ending in the year 2015-16, 34% lasted a year or more compared to national 21.1% and London 20.6%.

'Abuse or neglect' is the most common primary need at first assessment in Merton with 47% of the children in need at the 31st March 2016. This is fractionally below London (48%) and under national proportions of 51%. Nationally and in Merton, 'Family dysfunction' is the second most common need, yet Merton (21%) exceeds London (13%) and national (17%) percentages.

In Merton, the gender gap of children in need has narrowed from 2015 figures of 54% male and 45% female to 2016 with 53% male 47% female. This is broadly reflective of national figures. Nationally there has been little movement in the gender proportions from 2015 to 2016 with 52.5% male and 45.5% female in 2015 to 52.7% male and 45.3% female in 2016.

Referrals

There was a small increase in referrals 1507 in 2015/16 from 1477 in 2014/15. Rate per 10,000 (328) remains in line with Merton's usual trend but lower than National (548) and London (477) benchmark.

Referrals sources, top referrer Police (31%) is in line with National (27%), London (26%) and Merton trends (32%). Referrer "other" (31%) outlier compared to National (7%), London (7%) and Merton 2014/15 (13%)

Single Assessments

The number of completed assessments in line with last year (1630 2015/16, compared to 1658 2014/15). Rate per 10,000 (354) remains in line with Merton's usual trend, lower than National (475) and London (442).

And of the completed single assessments, 92% were completed within 45 days, which is better than Merton's performance last year 90% and better than National (80%) and London (82%)

Domestic violence, which includes that aimed at children or other adults in the household, was the most common factor identified, flagged in 58.6% of episodes assessed in the year and with assessment factors recorded. This is higher than the 49.6% reported nationally and the 43.5% for London. However, this has dropped from the substantially higher 71.5% recorded in 2015.

This was followed by mental health which incorporates mental health of the child or other adults in the family/household at 38.2 % which is another significant drop from the 52.1% reported in 2015. This is also slightly higher than the 36.6% nationally and London's 29.4%

Section 47's

An increased numbers of Children subject to S47 enquires (719) compared to 648 2014/15. Increase and significant outlier in S47 rate per 10,000 (156) compared to Merton 2014/15 (142), National (137) and London (138)

There was a reduction in ICPC (217) compared to 267 2014/15. The rate per 10,000 (47) lower than Merton trend (58) and benchmark National (61), London (56).

Merton's ICPC 15 working day's timeliness (79%) better than National 75%, London 72% (2014/15) and Merton 73%.

Child protection

138 children were subject to a child protection plan as at 31 March 2016 , this is lower than trends for Merton (162, 182, and 177 for the last three years).

Rate per 10,000 as at the end of March (30) now an outlier against National 43 and London 41 (historically Merton's rate per 10,000 has not been lower than the benchmark). Could be attributed to fewer plans starting during the year (204) compared to 226 last year.

Where concerns are substantiated and the child judged to be at continuing risk of harm then an initial child protection conference should be convened within 15 working days. Merton convened 75.8% within the 15 days, this is higher than the 72.6% achieved in 2015. The 2016 outturn is below national (76.7%), yet above the London average (75.3%).

A higher proportion became the subject of a plan for the second or subsequent time. Our 2016 CPP 2nd or subsequent (23%), is higher than Merton 2014/15 16% trend and National 16% and London benchmark (13%)

Child Protection plans reviews within timescales came to 98% , this is an improvement on 91% 2014/15 and better than National 94% and London 96%.

Child seen in accordance with CP plan (visits), no longer a statutory census performance item.

Appendix 4
Summary of Key Indicators

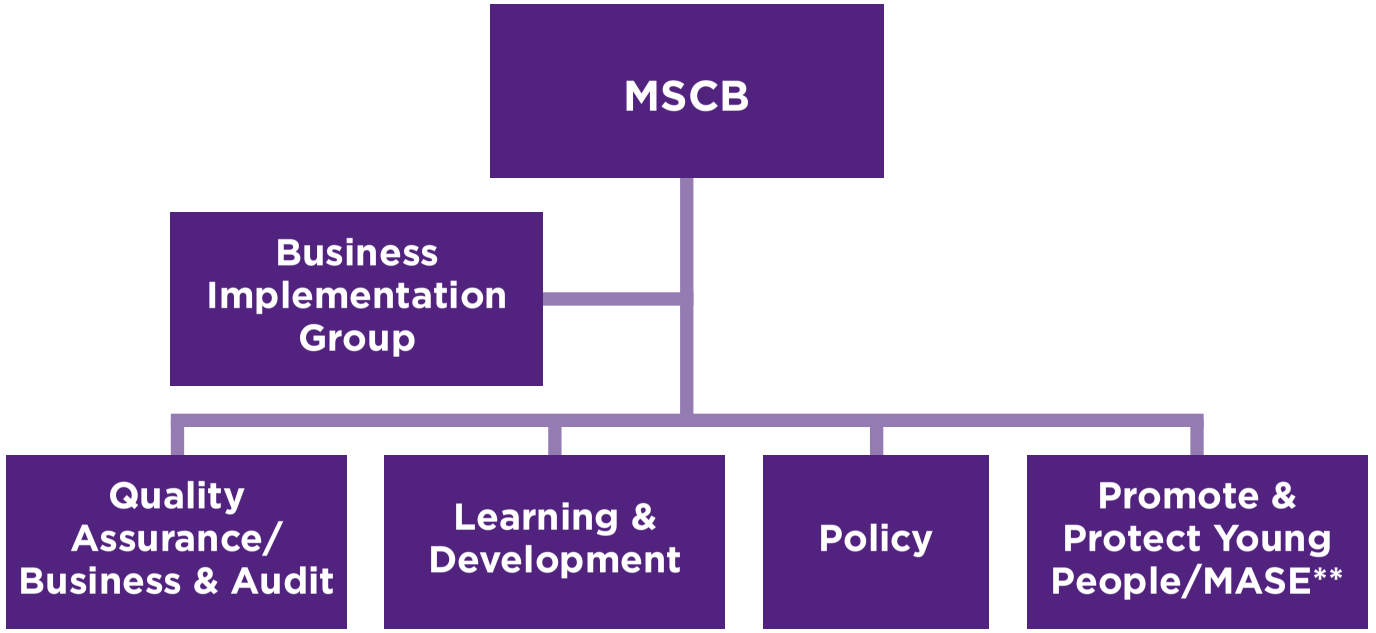
Indicators	Merton 2012-13	Merton 2013-14	Merton 2014-15	**Merton 2015-16**	National 2013-14	National 2014-15	**National 2015-16**
Children In Need							
Number of children starting an episode of need	1222	1407	1083	**1198**	427,700	403,400	**401600**
Rate per 10,000 children aged under 18 years	277.0	311.7	237.3	**259.3**	371.7	348.0	**343.9**
Number of children in need throughout the year	2373	2513	2517	**2690**	781,200	781,700	**778980**
Rate per 10,000 children aged under 18 years	537.9	556.7	551.5	**582.1**	678.9	674.4	**667.1**
Number of children ending an episode of need	887	910	973	**789**	384,100	390,800	**384580**
Rate per 10,000 children aged under 18 years	201.1	201.6	213.2	**170.7**	333.8	337.1	**329.3**
Number of children in need at 31 March	1486	1603	1544	**1901**	397,600	391,000	**394400**
Rate per 10,000 children aged under 18 years	336.8	355.1	338.3	**411.4**	345.6	337.3	**337.7**
Referrals and assessments completed							
Number of referrals	1372	1745	1477	**1507**	657,800	635,600	**621,470**
Rate per 10,000 children aged under 18 years	311.0	386.5	323.6	**326.1**	573.0	548.3	**532.2**
Number of Referrals which resulted in No Further Action	33	35	61	**83**	92,400	87,500	**61,800**
Percentage of Referrals which resulted in No Further Action	2.4	2.0	4.1	**5.5**	14.1	13.8	**9.9**
Continuous Assessments (Single Assessment) completed (from 2013-2014)							
Continuous Assessments (Single Assessment) completed		1,533	1658	**1,630**	175,300	550,800	**571,640**
Rate per 10,000 children aged under 18 years		333.2	363.3	**352.7**	n/a	475.2	**489.5**
Section 47 enquiries and initial child protection conferences							
Number of Children subject to s.47 enquiries which started during the year ending 31 March	493	593	648	**719**	142,500	160,200	**172,290**
Rate per 10,000 children aged under 18 years	111.7	131.4	142.0	**155.6**	123.8	138.2	**147.5**
Number of Children who were the subject of an initial child protection conference which started during the year ending 31 March	177	239	267	**227**	65,200	71,400	**73,050**
Rate per 10,000 children aged under 18 years	40.1	52.9	58.5	**49.1**	56.7	61.6	**62.6**

Number of children in need at 31 March and primary need at assessment

	2015			2016		
	England	London	**Merton**	England	London	**Merton**
N1 - Abuse or neglect	49%	47%	**40%**	51%	48%	**47%**
N2 - Child's disability or illness	10%	10%	**11%**	10%	10%	**9%**
N3 - Parent's disability or illness	3%	4%	**4%**	3%	4%	**3%**
N4 - Family in acute stress	9%	11%	**14%**	9%	10%	**13%**
N5 - Family dysfunction	18%	14%	**24%**	17%	13%	**21%**
N6 - Socially unacceptable behaviour	2%	3%	**1%**	2%	3%	**2%**
N7 - Low income	1%	1%	**0%**	0%	1%	**0%**
N8 - Absent parenting	3%	6%	**6%**	3%	6%	**5%**
N9 - Cases other than children In need	1%	1%	**0%**	1%	1%	**0%**
N0 - Not stated	5%	4%	**0%**	4%	4%	**0%**

Indicators	Merton 2011-12	Merton 2012-13	Merton 2013-14	**Merton 2014-15**	National 2012-13	National 2013-14	**National 2015-16**
Children who were the subject of a child protection plan							
Children who were the subject of a plan at the end of March	162	182	177	**138**	48,300	49,700	**50,310**
Rate per 10,000 children aged under 18 years	36.7	40.3	38.8	**29.9**	42.0	42.9	**43.1**
Children who became the subject of a plan throughout the year	160	212	226	**204**	59,800	62,200	**63,310**
Rate per 10,000 children aged under 18 years	36.3	47.0	49.5	**44.1**	52.0	53.7	**54.2**
Number who became the subject of a plan for the second or subsequent time	17	24	37	**46**	9,400	10,300	**11,350**
Percentage who became the subject of a plan for the second or subsequent time	10.6	11.3	16.4	**22.5**	15.8	16.6	**17.9**
Children who ceased the subject of a plan throughout the year	171	192	231	**238**	54,400	60,400	**62,750**
Rate per 10,000 children aged under 18 years	38.8	42.5	50.6	**51.5**	47.3	52.1	**53.7**
Number who were the subject of a plan for 2 or more years (who ceased to be the subject of a child protection plan)	6	6	10	**14**	2,500	2,300	**2,410**
Percentage who were the subject of a plan for 2 or more years (who ceased to be the subject of a child protection plan)	3.5	3.3	4.3	**5.9**	4.5	3.7	**3.8**
Child protection cases which were reviewed within required timescales							
Children who were the subject of a plan at 31 March and who had been the subject of a plan for 3 or more months	121	141	116	**88**	33,100	34,600	**34580**
Number reviewed within the required timescales	118	131	106	**86**	31,300	32,600	**32,410**
Percentage reviewed within timescales	97.5	92.9	91.4	**97.7**	94.6	94.0	**93.7**
Child Protection Plans throughout the year where the child was seen in accordance with the timescales specified within their plan by the lead social worker (DfE NOTE: Each local authority sets their own timescales, usually they are between two and six weeks, therefore where a local authority measures to a shorter timescale, it is more likely they will see fewer cases within their timescales.)		200	291	**n/a**	60,000	70,200	**n/a**
Percentage visited within timescale		53.5	71.3	**n/a**	58.4	63.7	**n/a**

Appendix 5
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.

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

HR Sub-Group
- once per year

MASH Strategic Board
- meets monthly

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

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 6
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.

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

Contact Details

Merton Safeguarding Children Board
12th Floor, Civic Centre
London Road
Morden
SM4 5DX

Tel: 020 8545 4866

Email: mertonlscb@merton.gov.uk

This page is intentionally left blank

London Borough of Merton Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 12 June 2017 to 6 July 2017

Report published: 25 August 2017

Children's services in the London Borough of Merton are good.		
1. Children who need help and protection		Good
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Outstanding
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Outstanding

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Children in Merton benefit from services that are dynamic, ambitious and successful. Exceptional leadership and governance and strong frontline management ensure that children's services are consistently good. All children receive a good service and some receive an outstanding service. Inspectors saw that significant and sustained improvements had been achieved since the last inspection in 2012, when all services were judged as good. Staff are very effective in improving outcomes for children.

The director of children's services (DCS) and all senior leaders have created and sustained a highly effective culture of clear strategic planning alongside warmth and compassion for each and every child. The leadership style offers an ideal balance of rigorous attention to outcomes combined with sensitivity, humility and a sound understanding of the vulnerability experienced by children and their families. This was described by one partner as a 'productive and human way of working' that is both 'very respectful and challenging'.

Leaders and managers are highly visible and show care and concern for children and staff. They provide a strong culture of learning and a determination to improve further on outcomes that are already good. Innovative and creative thinking ensures that Merton achieves maximum impact from the resources available. This includes a coherent practice model to assist social workers in their analysis, manageable caseloads, frequent supervision, reflective auditing and mature partnerships. This results in an environment in which social work practice continues to develop and flourish despite a turnover of staff.

A strong and embedded culture of review and learning enables robust analytical understanding of all aspects of services in Merton. Regular wholescale reviews of services or local case and threshold reviews result in a local authority that knows itself well. This was described by one manager as, 'If we spot a problem, we dig,' and this professional curiosity was strongly evident during the inspection. The small areas of practice requiring additional work that were seen by inspectors were already known and were being actively addressed by senior managers.

Children are protected through an outstanding early help offer and a robust 'front door', to consider which intervention would help them best. A review in 2016 of the multi-agency safeguarding hub (MASH) and regular threshold testing audits ensure a rounded multi-agency response to protect children when their needs first become known. Responses are timely and proportionate to risk. Thresholds are clearly and consistently applied for children, including when their circumstances and needs change. Child protection plans and child in need plans help to protect and support children and their families well and are based on thorough assessments. Some plans are not sufficiently clear, and so families may not fully understand what is required of them.

Children who are looked after by Merton benefit from good-quality placements, social workers who visit them often and strong support from the virtual school. Comprehensive assessments and support enable children to return home safely

when this is their plan. Applications to court reflect timely planning and strong social work practice, as reflected in very positive feedback from the judiciary and court partners. The role of the corporate parent is well embedded and is taken very seriously. The lead member for children, the chief executive and senior managers consider all children to be 'their' children and they are determined to do their best for them. Parents and carers feel included, leading to positive partnership working. Letters to parents and children, including pre-proceedings letters or complaints, are carefully personalised.

Permanence is secured quickly for children and progress is closely tracked. Children placed in permanent foster care receive a certificate from the assistant director, affirming their sense of belonging. Adoption performance is outstanding, with all children requiring adoption currently placed and no children waiting. Creative use of the adoption support fund ensures that adoption is well supported. Merton has not had an adoption placement breakdown for over five years.

Care leavers do well in Merton. The vast majority are in touch with staff, and determined efforts are made to re-engage with those who are not. Care leavers feel safe where they live and they achieve well. Young people who have left care recently have benefited from receiving their health histories although not all care leavers have received their health histories yet, despite this being a longstanding issue. Only a few care leavers continue to live with their foster carers beyond their 18th birthday; the local authority is actively trying to increase numbers.

Risks associated with child sexual exploitation, missing children, gang involvement or radicalisation are understood exceptionally well and overseen appropriately from a senior multi-agency perspective. Regular scrutiny is provided through a range of methods, including a weekly 'missing' meeting. However, the response to each child for each episode of missing from home or care is not sufficiently robust.

Accurate data and helpful performance information provide insight and ensure that strategic changes to demand and need are anticipated and met. Service redesign, including a flatter management structure, has enabled a 33% increase in frontline social workers. The redesign has resulted in manageable caseloads and effective spans of control, and has enabled changes to the workload of the MASH and the safeguarding teams, as well as the creation of a dedicated permanence service. The very recent implementation of a replacement information technology and case recording system, just prior to the inspection, is being managed efficiently, and staff are being well supported.

Detailed strategic plans and localised improvement plans are aligned with each other and are overseen by mature and exceptionally strong partnerships. The strong professional partnerships in Merton demonstrate that children and their families are highly valued and that they deserve high-quality services.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority does not operate any children's homes.
- The previous inspection of the local authority's safeguarding arrangements was in January 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in January 2012. The local authority was judged to be good.

Local leadership

- The DCS has been in post since January 2009.
- The chief executive has been in post since March 2004.
- The chair of the LSCB has been in post since March 2014.

Children living in this area

- Approximately 46,697 children and young people under the age of 18 years live in Merton. This is 23% of the total population in the area.
- Approximately 15% of the local authority's children aged under 16 years old are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 14% (the national average is 15%)
  - in secondary schools is 16% (the national average is 13%).
- Children and young people from minority ethnic groups account for 45% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and Black and Black British.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 47% (the national average is 20%)
  - in secondary schools is 36% (the national average is 16%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Child protection in this area

- At 31 March 2017, 1,356 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,901 at 31 March 2016.
- At 31 March 2017, 127 children were the subject of a child protection plan (a rate of 27 per 10,000). This is a reduction from 138 children (30 per 10,000) at 31 March 2016.
- At 31 March 2017, four children lived in a privately arranged fostering placement. This is a decrease from nine at the time of the last published data in 2015.
- In the two years prior to inspection, two serious incident notifications have been submitted to Ofsted and one serious case review (SCR) has been completed.
- There were no SCRs ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2017, 152 children were being looked after by the local authority (a rate of 33 per 10,000 children). This is a reduction from 165 (35 per 10,000 children) at 31 March 2016. Of this number:
    - 102 (or 67%) live outside the local authority area
    - 18 live in residential children's homes, of whom 94% live out of the authority area
    - two live in residential special schools[3], both of whom live out of the authority area
    - 108 live with foster families, of whom 58% live out of the authority area
    - three live with their parents, none of whom live out of the authority area
    - 16 are unaccompanied asylum-seeking children.
- In the last 12 months:
    - there have been 11 adoptions
    - six children became the subject of special guardianship orders
    - 113 children ceased to be looked after, of whom 10% subsequently returned to be looked after
    - 25 young people ceased to be looked after and moved on to independent living
    - two young people ceased to be looked after and are now living in houses in multiple occupation.

[3] These are residential special schools that look after children for 295 days or less per year.

Social work model

- The local authority uses a systemic practice model that includes 'Signs of Safety'.

Recommendations

1. Ensure that all plans, including child in need, child protection, care plans for children looked after and pathway plans, consistently contain specific actions, achievable timescales and clear, measurable outcomes.

2. Improve the use of return home interviews for each episode of missing for children missing from home or care and ensure that risks are understood and reduced for individual children.

3. Ensure that 'staying put' is made available to all care leavers who would benefit from this.

4. Ensure that all former relevant care leavers receive information on their health histories.

Summary for children and young people

- All staff, including senior managers, know children well and work well together to consider how to help each child and their family.
- Although services for children and young people are already good, staff continue to question how they do things and are keen to do even better. They regularly look carefully at what they have done to see what they can learn.
- Planning for children is mostly done well, but in a few cases the plans are not clear enough about what needs to change for children and what families need to do to make children safer.
- Staff work hard to keep children safe in Merton. Any risks or concerns are taken very seriously and acted on quickly. They do this by working closely with other people, such as the police.
- Some children have had a number of different social workers, but managers keep a close eye on what is happening for children, to minimise the impact of changes.
- Children who are looked after by Merton are involved in the planning for their care. They are listened to and they influence planning for the future.
- Children and families who arrive from different countries receive an exceptional service and are supported sensitively to ensure that they feel secure. This includes meeting with other children in similar circumstances so that they do not feel alone.
- Children who are not able to live with their families live in safe and secure homes. Social workers ensure that children who are placed at some distance from Merton do not miss out on things that will be of interest or help to them.
- Care leavers are supported to do well and they feel safe where they live. Only a small number of young people continue to live with their foster carers after their 18th birthday. The local authority is taking action to ensure that more young people can stay with their foster carers if they wish to.

The experiences and progress of children who need help and protection	Good

Consistently good services support children in need of help and protection in Merton, improving their circumstances and keeping them safe. High-quality early help assessments help to identify needs, leading to children and families benefiting from a range of integrated early help support services.

Staff within the MASH effectively assess and prioritise contacts and referrals, ensuring prompt and proportionate responses so that children most at risk receive appropriate and timely services. Strong management oversight and decision-making are evident on all case recording.

Effective multi-agency responses to children at risk of sexual exploitation and children who are missing from home or school help to ensure that they are kept safe. Good outcomes are supported by strong attendance at the multi-agency sexual exploitation panel, weekly multi-agency missing meetings and timely strategy discussions with a range of appropriate services. However, the response to individual children who go missing from home, including the timeliness of return home interviews, is not consistent, so the factors that influence the behaviour are not clear.

Staff have a good understanding of risk. Effective early identification of risks in relation to female genital mutilation, forced marriage, gang affiliation and radicalisation leads to proactive and immediate safeguarding of young people. If necessary, this includes legal orders, accompanied by comprehensive multi-agency support. Strong multi-agency partnership working, including information sharing and attendance at child protection meetings, is protecting children from risk of further significant harm. However, child in need and child protection plans are not clear enough to ensure that parents understand what needs to change, and in what timescales, and to help monitor the progression of each plan.

Timely and effective arrangements are in place to respond to 16- and 17-year-olds at risk of homelessness. The local authority does not use bed and breakfast accommodation for any 16- or 17-year-olds.

Comprehensive awareness raising in relation to private fostering has led to appropriate referrals. Children currently known to be living in private fostering arrangements are appropriately safeguarded and supported well.

There is good use of advocacy, including appropriate advocacy for disabled children and children and young people subject to child protection procedures, enabling careful consideration of their voices within planning.

Inspection findings

5. Children and young people in need of help and protection in Merton receive a good service. Managers and staff know their children well. Manageable caseloads and skilled staff mean that they are able to visit children and their families regularly, build meaningful relationships and undertake purposeful direct work. Effective direct work is widespread, including with children at risk of sexual exploitation, and individualised direct work with disabled children meets the communication needs of each child.

6. The Merton Child and Young Person Well-Being Model guides threshold decisions and is supported by a well-embedded wide range of integrated early help services, commissioned and brokered by the Children's Trust partnership. Thresholds are understood well by partner agencies and applied appropriately, resulting in effective and timely interventions for children.

7. The training and engagement with early help partners contribute to very strong early help assessments, which are undertaken by a wide range of partners. This ensures timely identification of need, with decision-making and work overseen by a social work qualified team manager. Effective intervention at an early stage is having a positive impact on reducing the number of children who require a more specialist service. Families benefit from prompt support from a range of innovative, high-quality early help services, such as a dedicated victim support service for children, and mental health practitioners in schools. Parents spoke very highly of the early help services available and the positive difference that they are making for children.

8. If risks to children change, they experience a relatively seamless transition between early help and statutory services. Step-up and step-down processes are well considered and purposeful, with the vast majority evidencing a clear rationale and decision-making. This ensures that children and their families are receiving the right service at the right level of intervention to meet their needs.

9. Multi-agency information sharing has improved significantly, with increased access to a wide range of multi-agency data. Consent is understood well and is clearly recorded. Children's social care services, the police, health, early help and education are co-located in the MASH, ensuring timely risk analysis of information to inform decision-making to safeguard children. However, consistency is still required in ensuring that information from schools is obtained in a timely manner. The 'vulnerable children's team' is working closely with schools to improve timescales.

10. Additional staffing resources for the MASH and first response teams, as from 2016, are further improving timely responses. The majority of cases are handled within the agreed timescales and are monitored closely via the recently implemented MASH live dashboard. This is enabling timely and

carefully considered responses so that children most at risk quickly receive appropriate services. There is good liaison and handover with the emergency duty team, which is staffed by suitably experienced children's social workers, who provide an effective service to children and families out of normal office hours.

11. The social work model used by children's services is helpfully also applied by partner agencies, and this is leading to improvements in the quality of work to assess risks to children. The vast majority of case recording identifies appropriate safeguarding concerns and safety goals, which are developed in regular child in need meetings, child protection conferences and conference reviews. However, plans are not consistently clear in all cases. This means that a small number of parents are not fully aware of what needs to change and in what timescales, and this makes it more difficult to monitor whether plans are progressing in a timely way. (Recommendation)

12. In the vast majority of cases, escalation of concerns or non-engagement by families leads to appropriate, timely and proportionate responses to risks to children, in line with contingency plans overseen by managers.

13. Child protection enquiries to protect children at risk of abuse, through strategy discussions and section 47 child protection enquiries, are timely. In the majority of cases, a multi-agency response informs the decision-making to protect children. However, there is some variability for a small minority of children, with some agencies not participating consistently. As a result of efforts made by senior managers and the Merton Safeguarding Children Board (MSCB), multi-agency attendance and input to child in need meetings and child protection conferences have significantly improved and continue to be closely monitored.

14. Children's wishes and feelings are strongly heard and clearly reflected in practice. Their views and voices are carefully considered in assessments, strategy meetings and social work records to inform planning. Case records are clear, timely and up to date, including assessments and chronologies. In a very small minority of cases, case recording does not fully reflect the lived experiences of very young children or does not consistently highlight the separate needs of individual children in large family groups. Recording evidences management oversight and decision-making. There is a small amount of inconsistent recording of timescales for actions within assessments and supervisions, which senior managers are aware of.

15. The local authority has undertaken a comprehensive needs analysis to understand the prevalence of domestic abuse, mental ill health and substance misuse within the borough. Recent developments include the appointment of a specialist adult mental health liaison worker to enhance partnership working, to provide training across adults' and children's services and to update the joint protocol for safeguarding children and families who have mental health

needs. The multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment conferences (MARAC) are consistently well attended and effective in supporting timely information sharing, effective risk management and decision-making.

16. There are clear and effective multi-agency responses to identify and respond to children at risk of going missing or missing education. Most cases of children missing education close within three months, as the vast majority of children are effectively supported back into school. Education welfare staff are persistent in their tracking of children missing education, an example being undertaking unannounced visits at known addresses. They liaise and share information effectively with other local authorities and within the council, and escalate cases to social care when necessary, overseen by the multi-agency children missing education panel.

17. Risks associated with child sexual exploitation or missing from home are given a high priority and are understood well. Weekly 'missing' meetings are held in the MASH. The meetings are regularly attended by social workers, the police, a gangs worker, the children looked after nurse, the youth offending service, the child sexual exploitation lead and a representative from the commissioned service that provides return home interviews. Through the combination of the multi-agency sexual exploitation panel, weekly multi-agency 'missing' meetings and timely strategy discussions, children missing from care or home and children at risk of sexual exploitation are effectively identified and responded to. A wide range of appropriate services, including commissioned services, are in place to support and protect children. However, the processes for offering children return home interviews following every episode of going missing, or completing those interviews in a timely manner to fully understand the push and pull factors, are not robust. (Recommendation)

18. Disabled children receive support and services that ensure that they are protected and achieve. There is strong early identification of risks in relation to female genital mutilation, forced marriage, gang affiliation and radicalisation, overseen by the MSCB promote and protect young people (PPYP) steering group. This is leading to proactive and immediate safeguarding of young people, including legal orders, supported by comprehensive multi-agency support.

19. Children living in private fostering arrangements receive a good service. Comprehensive awareness raising has led to appropriate referrals and timely assessments. In cases seen by inspectors, children were seen alone within statutory timescales and they were appropriately safeguarded and supported well.

20. Young people aged 16 and 17 who present as homeless receive timely and thorough joint assessments with housing services. Assessments show that social workers consider their views and those of their family. However,

recording does not consistently reflect social workers' explanations to young people about their legal entitlements in order to demonstrate that young people have made informed choices about their futures. When young people choose not to be looked after, suitable accommodation and support are provided.

21. Arrangements for managing allegations against staff, carers and volunteers who work with children in Merton are timely and appropriate, and thresholds and intervention are applied appropriately. However, inspectors found that a turnover of four different designated officers since April 2016, a change of line management and the implementation of a new recording system had resulted in inconsistent and unclear case recording. The local authority responded promptly and appropriately and was able to evidence the work that had been done, accompanied by a clear management overview of each case.

22. Inspectors saw very effective use of advocacy, including appropriate advocacy for disabled children, when there have been issues of deprivation of liberty. Increasing numbers of advocates are working with children subject to child protection procedures, to ensure consideration of their views in conferences.

23. Social workers carefully consider the diverse needs of the families that they work with. However, case recording is not fully reflective of the range of ways in which this takes place and the thoughtful work undertaken.

The experiences and progress of children looked after and achieving permanence	Good

Children looked after in Merton receive a consistently good service. The needs of each individual child are known well. Children become looked after at the right time and without unnecessary delay. Appropriate support and edge-of-care services are used effectively as an alternative to care. Effective management oversight of pre-proceedings and assessment work adds rigour to decision-making and ensures safe oversight of the experiences for children on the threshold of being looked after. Assessments for children returning home are robust, and ongoing support is provided to the families.

The majority of children looked after enjoy a stable relationship with their social workers. A small number of children have experienced changes of social worker early in their care journey, which has made it more difficult to form trusting relationships. Caseloads are maintained at a manageable level to enable social workers to have time to develop relationships with the children. The service to unaccompanied asylum-seeking children is impressive. It is sensitive and swift and enables the children to settle quickly and to form friendships.

Children's participation is encouraged, their individual needs are known and their voice is evident. Children have access to advocates wherever they are placed, and participation in reviews continues to strengthen. A committed and active Children in Care Council (CiCC) influences service developments and provides consultation and feedback on issues relating to their experiences.

The local authority is aware of the priorities within the children looked after population and continues to work to meet the challenges of placement stability and sufficiency for the significant proportion of older adolescents. Diversity is given careful consideration. Risks associated with going missing and sexual exploitation are known and effectively tracked on a multi-agency basis, and effective work is undertaken to ensure that children are kept safe. However, information gained through individual return home interviews is not always used effectively to inform future planning.

Permanence options are considered early, ensuring that there is no delay in the formulation of long-term plans. The work in the adoption service is outstanding. Skilled and tenacious social work practice ensures good outcomes for children, and prospective adopters receive excellent preparation and training. No children are currently awaiting an adoptive placement.

The vast majority of care leavers are supported well. They develop the skills that they need to live independently and to achieve their career and education goals. Not all care leavers have received a copy of their health history and only a very small number currently remain with their foster carers under a 'staying put' arrangement.

Inspection findings

24. The needs of children looked after are understood well by managers and staff. The local authority has been proactive and rigorous in identifying and understanding the needs of the looked after population, including the large group of children aged over 16. Thresholds to care have been tested through a time-limited edge of care panel and a comprehensive adolescent needs analysis. Thresholds are applied appropriately and children receive the service that they need to ensure that they are kept safe in a timely way. Clear management oversight and accountability ensure that thresholds are consistently applied. The head of service for children looked after agrees all new admissions, adding further rigour to the decision-making.

25. Children are protected well through appropriate use of the court process when necessary. Use of the Public Law Outline is effectively monitored and supported by a court progression officer, who offers guidance and advice to social workers. Progress is monitored well via case progression meetings and a tracker system to ensure a timely response for children.

26. Permanence in all forms has a high priority and is considered early for children. Regular permanency tracking meetings are chaired by the head of service for children looked after and attended by heads of service for safeguarding and resources, the court progression officer and the adoption team manager. This ensures that plans progress in a timely and considered manner. Separate consideration for children under five and over five provides further rigour to permanence planning.

27. All types of placements, including with friends and relatives, are well supported. Assessments of connected persons are completed in a timely way. The number of children in special guardianship placements has increased in the last year, and there have been no breakdowns of extended family placements during this time.

28. The judiciary and the Child and Family Court Advisory and Support Service (Cafcass) are extremely complimentary about the work of the local authority, considering it robust and timely. With proceedings completed within an average of 24 weeks, Merton is exceeding national guidelines and has improved in this area of practice considerably.

29. When children return home to live with their families, a robust assessment and comprehensive support ensure a successful and enduring rehabilitation. Social workers remain involved and plans continue to be monitored.

30. Children experience good and stable relationships with social workers, who are part of a dedicated looked after and permanence service. Greater stability of social workers and manageable caseloads provide stronger social work

relationships to children and a deeper understanding of their needs. For a small number of children, changes of social worker in the early part of their care journey affected the quality of relationships and the formulation of their plan.

31. Care planning is effective for the vast majority of children, and the needs of each child are understood well. For a small minority of children, forward planning is not sufficiently clear and does not include measurable timescales. For a few children, the care plan does not reflect changes in the child's circumstances. (Recommendation)

32. An effective and well-used advocacy service assists children to participate in their reviews and provides support when they are making complaints. This service is also available to children who are placed out of borough, ensuring that no one is excluded. A successful independent visiting service supports children, and more volunteers are currently being trained and already matched to children. Due to the success of this service, in both numbers and the relationship offered, there are still children waiting to be matched with an independent visitor. Senior managers are aware of this and are considering how to ensure that children do not miss out on this valued support.

33. An active CiCC influences and guides services for children looked after. The CiCC has been involved in the development of 'The Pledge' and invites other services and professionals to attend, including the lead member for children's services and a representative from the housing department. The permanence team for children looked after is seeking ways to engage younger children in the CiCC, to ensure that the views of a wider age range are considered.

34. Children benefit from regular review meetings that are well attended and inclusive. The local authority has piloted a new model of looked after reviews, aimed at facilitating greater involvement by the child in the review meetings. This is having a positive effect, with the most recent local authority data showing 99.5% of children participating in their reviews. Independent reviewing officers (IROs) report having access to court bundles and being included more in the planning process. IROs challenge practice when necessary, and disputes are resolved informally when possible. However, the recording of this is inconsistent and, as a consequence, the footprint and influence of the IROs are not evident on children's files.

35. Children's views are taken into account when forward planning, and case records illustrate the work that is being completed with children and discussions regarding their future. Appropriate contact with birth families is supported, and children are assisted to understand their life histories at a time and pace that is suitable for them. Life story work is of a consistently high quality. A skilled and flexible in-house child and adolescent mental health service (CAMHS) team offers consultation and guidance to social workers and foster carers and direct work to children. The quality of this input is high, and

there are clear, improved outcomes for children. This systemic service reflects the wider model of practice used in Merton and workers remain involved for as long as the need remains.

36. The health of children looked after is effectively monitored and overseen. A dedicated health nurse for children looked after has been in post since November 2016 and ensures that the health needs of children looked after are recognised and met. This includes proactive follow up of documents to ensure that an initial health assessment can take place, and travelling to see children out of authority if necessary. Regular reporting to the corporate parenting board and the health strategy board, as well as providing a health presence in child sexual exploitation meetings and 'missing' meetings, results in a widespread awareness of the health needs of children looked after.

37. Children and young people receive good support from the virtual school wherever they live. Staff maintain good oversight of the progress of children looked after. They know the circumstances of individual children and use this information very effectively to work with others, such as social workers, carers and schools, to plan the support that children need to make progress in their learning. The large majority of children looked after (96%) go to a school judged good or better by Ofsted. When they do not, staff carefully consider whether the setting is meeting the individual needs of children.

38. A high proportion (74%) of children looked after have special educational and/or complex needs. Their attainment is often below age-related expectation. However, with the support of the virtual school and partners, the majority of children looked after make good progress in their education. After children leave school, nearly all successfully engage in further education, training or employment.

39. Advisory teachers and the virtual school headteacher take the lead on the planning of the education of children looked after. As a result, children have good-quality, up-to-date and timely personal education plans that reflect their needs well. Their education targets are clear and they help carers and professionals to maintain good oversight of children's progress. The pupil premium grant and additional funding from the virtual school are used well to support children's academic progress and their personal development.

40. The virtual school team closely monitors children looked after who are missing education and is an active partner in supporting their return to education. The team makes strenuous efforts to ensure that children and young people engage in learning. As a result, most children looked after attend school regularly and few experience exclusion from school. There have not been any permanent exclusions from school for the last seven years, and fixed-term exclusions are reducing, both in terms of the number of episodes and the number of children.

41. The majority of children in Merton benefit from secure and stable placements. Sufficient in-house fostering households, with appropriate commissioning arrangements, result in children living in well-matched placements. The number of 16- and 17-year-olds who enter local authority care is increasing and they now constitute 44% of the overall cohort. The local authority has responded to this challenge in proactively analysing the need and tailoring services as required. Despite the considerable effort and planning invested, it remains a challenge to locate placements for teenagers who have complex needs or who are at risk of sexual exploitation or exploitation by gangs. The local authority continues to actively plan and respond. The learning and development strategy is focusing on the skills needed to manage teenagers, to encourage current carers to consider extending their offer.

42. Unaccompanied asylum-seeking children receive an impressive service. The local authority ensures that it exercises its responsibilities without delay and with considerable sensitivity. Regular, informal coffee shop group meetings offer friendship and help to develop confidence and to reduce isolation. Whenever possible, the children are placed in family placements. Good connections with a local college enable the children to access courses to develop their English language skills, and links with solicitors reduce the stress of legal uncertainty.

43. Risks generally are understood, and social workers act quickly to protect children in their care. Children at risk of sexual exploitation are effectively monitored by the child sexual exploitation coordinator. In addition, there has been some good joint work between children's social care and youth offending services, to address the risks associated with involvement with gangs. Children who are missing from care are known, and risks are actively monitored at weekly 'missing' meetings. The recording of return home interviews is not consistently good and, in a small number of cases, it could not be determined what information had been gathered to inform risk management and safety plans. (Recommendation)

44. Family finding for permanent foster placements is tenacious, and children who are waiting for families benefit from the same determined approach as those seeking adoptive families. Approved foster carers safely meet the needs of a range of children, including those who have complex needs or disabilities and groups of brothers and sisters. Within a well-run fostering service, foster carers receive consistent support and regular announced and unannounced visits from supervising social workers, and they are able to access a range of appropriate and regularly available training. Allegations against foster carers are carefully and robustly investigated and result in de-registration if appropriate.

45. Foster carers understand delegated authority, and children are encouraged to access activities that promote their social, educational and recreational needs. Annual reviews are comprehensive and up to date.

The graded judgement for adoption performance is that it is outstanding

46. The local authority gives high priority to identifying and quickly securing adoption for children when adoption is in their best interests. Strategic leaders, managers and social workers have an excellent knowledge about the children in their care, and they are passionate about achieving the very best outcomes.

47. Timely and accurate early identification of children, when adoption is in their best interests, leads to appropriate and prompt family finding. Successful outcomes are driven through case progression, monthly tracking and permanence and care planning meetings. Managers maintain a stringent overview for each child and provide an early alert to the adoption social workers and wider consortium about the children's profiles. Consortium meetings facilitate further exchange and discussion about prospective matches. Children benefit from early identification of potential matches with approved adopters, including before the granting of the placement order, and move swiftly to live with their new families following the court decision.

48. The experienced senior practitioners in the adoption team are highly skilled and know their children and adopters well. Family finding is creative and tenacious and is supported effectively by a skilled publicity officer who provides professional profiling and marketing. Children's drawings form the backdrop to their profiles, which are highly personal and regularly refreshed and updated. An extensive range of local and national family finding methods are used and this results in an equally positive outcome for very young babies through to older children who have complex needs. The success of the service has resulted in there being no children currently awaiting an adoptive match, and all children who require adoption are placed.

49. The assessment, preparation, training and support of adopters are exceptional and are consistently of the highest standard, being insightful, highly effective and responsive. Prospective adopters benefit from hearing powerful histories from birth parents, adopters and adopted adults at introduction and preparation sessions. Feedback from adopters to inspectors reflected the impact of the high-quality preparation, including the increased empathy for birth parents and a balanced expectation of parenting as adopters.

50. The quality of prospective adopter reports is impressive. Child permanence reports are comprehensive and analytical and lead to a logical recommendation for adoption. Social workers comprehensively explore a wide range of potential issues with sensitivity and insight. All assessments seen by inspectors bring out the unique needs of children and the individual skill of adoptive parents, and some are of an outstanding quality. Recruitment is effective and has led to a significant increase in the number of approved

adopters in the last year (from three to 12), which means that there is an increased pool of suitable families waiting to provide children with a permanent home. A well-embedded foster for adoption scheme ensures that social workers discuss this option with all prospective adopters. A specially tailored workshop is then offered to interested adopters to help to prepare them further.

51. Social workers are determined in their efforts to find families for brothers and sisters, children from a range of cultural and religious backgrounds and children who have complex needs. This persistence has achieved successful adoptions for brother and sister groups, for children who have special needs and for older children. All of the 11 children adopted last year moved into their adoptive families in 10 months or under. This is a significant improvement on the previous year. For a very small number of children who have had a change of plan away from adoption, this is well informed and the alternative permanent placement has been secured. Inspectors have seen positive progress for all children, and there are no children currently waiting for a family.

52. Performance against the adoption scorecard demonstrates that the local authority is performing well and has made further significant progress in the past year. The consistently improving trajectory of Merton's performance is evidence of the effectiveness of the authority's sharp focus on timeliness. This is strong practice, confirmed by feedback from the judiciary and Cafcass.

53. Adopters spoke consistently of the excellent quality and timeliness of matching and placement. Success with foster for adoption placements and the fast-track process for second-time adopters contribute to this achievement. Excellent foster for adoption arrangements have resulted in the successful early placement of three babies in foster for adoption families, directly from hospital. Children benefit from particularly resourceful and, where appropriate, culturally sensitive pre- and post-birth work to safeguard mothers and their unborn babies and to ensure a nurturing environment after they are born. Support for birth parents is outstanding in helping them to make difficult decisions and to remain involved through indirect contact and by providing a wealth of information for life story work.

54. A gradual phased introduction to their new family prepares children well for adoption and proceeds at the child's pace. Social workers are creative in supporting and directing the process, using photographs and other resources to help children to make the transition calmly and positively. The timeframe for the transition is led by the child. Foster for adoption introductions are supported sensitively to take place between birth parents and adopters.

55. The independent panel chair and the agency decision maker (ADM) regularly discuss children's plans, and inspectors saw evidence of appropriate strong challenge. Together, they achieve the highest standards in the planning for

children. The highly effective cycle of quality assurance is having a noticeable impact, and panel and ADM decisions are very well considered and thorough. Adoptive parents benefit from meeting with the medical adviser at panel, which gives them the opportunity to discuss the potential health needs of children so that they are well informed.

56. Adoption support is excellent and highly creative. It ensures that adopted children form strong attachments to their families, and potential issues are identified and addressed at the earliest stage. There is a range of provision coordinated by a dedicated social worker post. Annual fun days for adopted children, theraplay and individual parenting sessions are available. The consortium provides a range of established post-adoption support groups for birth parents and adopted adults. There is effective and creative use of adoption support funding (ASF) and this is having a positive impact for children and families. Families are aware of how to access the provision, and all families who have requested support are receiving it. ASF is helping children and families to access therapeutic work and dyadic developmental psychotherapy. Adoption support is extended to all children in the household when required.

57. Later life letters are sensitive, non-judgemental and written so that children can understand how and why they were adopted. Letters are child-focused, compassionate and insightful, with a respectful understanding of the experience of the birth parents. Letterbox arrangements are robust. Compelling life story work helps children to understand and make sense of their past and the reasons that they are unable to live with their birth families. Excellent work is undertaken to enable children to understand identity, including cultural identity. The virtual school recognises the unique education needs of adopted children and provides additional support for children placed for adoption.

The graded judgement about the experience and progress of care leavers is that it is good

58. The majority of young people who leave care receive good support that builds their skills and confidence well as they move towards independence. Social workers and personal advisers in the dedicated 14-plus team are in touch with 96% of their care leavers and form trusting and productive relationships with them through regular face-to-face contact. Young people described their workers as approachable and supportive.

59. If young people disengage, staff make concerted efforts to establish contact through unannounced visits to their homes, via letter, text and email, through known family and friends and through the job centre, if appropriate. In the best instances, this results in young people re-engaging with the support services on offer.

60. Social workers and personal advisers know and understand young people's individual circumstances and needs well. They manage known risks to young people, including sexual exploitation, well. They develop effective plans with partners, such as the police, which are responsive to young people's changing needs, and over time young people stabilise their lives and make good progress. In a small minority of cases, managers do not intervene quickly enough to help staff to consider alternative plans, when young people are not moving forward with their lives.

61. Planning is effective for the large majority of young people who have an up-to-date pathway plan that covers well all aspects of their lives. Plans are detailed, and young people are effectively involved in developing their own plans. A minority of pathway plans are insufficiently detailed, and there is not enough emphasis on the support that the young person will receive to achieve their goals. The pathway plans of a small minority of young people are out of date, and planning to meet the young people's current needs is insufficient, although inspectors did not see any detriment to young people as a result of this. (Recommendation)

62. The virtual school, social workers and personal advisers effectively support young people to navigate the education, employment and training (EET) options available to them. As a result, a good proportion of care leavers are in EET. Within this overall positive picture, senior managers and staff recognise that staff do not sufficiently promote apprenticeships to young people. Managers are developing strategies to ensure that apprenticeships are more widely available to vulnerable young people.

63. Young people seeking to study at university receive particularly good assistance prior to applying for a university place, and they receive practical help with their applications and personal statements. This results in a high number of young people studying at university. The local authority is flexible and creative in extending support. While studying, young people receive good financial support and additional funding, for example, to purchase essential books and for travel to see relatives.

64. The large majority of care leavers live in suitable accommodation. All young people who spoke to inspectors feel that they are safe where they live. With good support from carers, the 14-plus team and housing providers, many young people make a successful transition from care to living independently.

65. There is a good range of accommodation options for young people. Most care leavers live in semi-independent accommodation with support available that is appropriate for their particular needs. Bed and breakfast accommodation is never used; young people who need emergency accommodation are usually housed within the existing housing provider network. However, the use of 'staying put' arrangements is underdeveloped. Managers are aware of this and

are developing plans to improve the opportunities for young people to remain with their foster carers beyond the age of 18. (Recommendation)

66. Young people receive good support in developing the skills and knowledge that they need to live independently and to manage their own affairs. Prior to securing their own tenancies, they attend useful workshops on managing their money, budgeting to run a household and home maintenance. With ongoing help from social workers and personal advisers, young people manage their tenancies successfully. There have been no tenancy breakdowns in the last two years for young people moving into their first homes.

67. Care leavers who arrive as unaccompanied asylum-seeking children receive very good support from the 14-plus team. Young people value highly the support and help that they receive from their foster carers and social workers. Young people settle quickly in foster care, attend school or college and develop well in their spoken English. Their health needs are assessed and met promptly. A monthly drop-in provides excellent opportunities for these young people to develop friendships with their peers, receive informal support and gain new experiences, such as taking part in outdoor activities and restaurant visits. Many make excellent progress in their studies and are highly ambitious for their future.

68. Most young people are aware of their rights and entitlements, such as the support that they will receive while at college or university and the financial help that they are entitled to when they set up their first homes. The advocacy service has recently been extended to include care leavers to support this further.

69. Staff effectively help young people to manage their own health needs independently. On turning 18 years old, young people receive a useful leaflet on important health services and contacts. Most young people register with their local doctors and dentists. Although this year all young people who have turned 18 years old have received a copy of their health history, this is not the case for all those young people currently open to the leaving care team. (Recommendation)

70. Care leavers who are more vulnerable, such as those in custody, are equally well supported by staff, who are sometimes the only regular visitors while they serve their sentences. Most young people have appropriate accommodation available to them on their release from custody. Staff are proactive in trying to secure EET options for young people at the time that they leave custody and, in most cases, work well with other partners, such as the virtual school, to ensure that young people have every opportunity to succeed.

Leadership, management and governance	Outstanding

Senior managers and politicians model a constructive, enquiring and engaging style of leadership and management. It comprises a blend of compassion and concern for the most vulnerable children and families, and conspicuous care and support for frontline workers. A highly visible thread of meaningful children's participation and influence is apparent. These elements are balanced with high expectations for skilled, evidence-based social work that improves the circumstances for children.

This leadership and management landscape creates a lively, challenging and rewarding environment for social workers. Strong frontline managers, carefully managed workloads and an evidence-informed approach create time for social workers to practise creative and effective direct work with children. This leads to well-crafted assessments and interventions, which are concentrated on understanding and improving the experiences of children.

High-quality data and performance information are used well at all strategic and operational groups and across all management layers. The performance and quality assurance frameworks are closely interwoven and provide a wide range of useful information. This leads to services, teams or individual workers that require attention being quickly identified. Equally, senior managers identify and celebrate many examples of good social work, offering practitioners ample exposure to effective social work practice. Leaders and managers are ambitious and driven to continually develop the services that vulnerable children receive. They strive to improve even when evidence indicates that they are already performing well.

Departmental and inter-agency senior management communication is regular and purposeful, ensuring that children's issues are prominent in the Health and Well-being Board and the Safer and Stronger Partnership Board. Relationships and lines of accountability between the Children's Trust Board and MSCB are strong and clear. Strategic partnership and governance arrangements across the spectrum of boards provide a cooperative climate for high-level conversations. This is subsequently reflected in improved or new approaches to operational arrangements, including, for example, young people exposed to extremist influences, gangs and sexual exploitation.

Creative recruitment and detailed and continuous promotion of social workers' professional development at all levels of experience ensure a skilled workforce. The impact of staff turnover is mitigated appropriately by strong operational management oversight.

71. The DCS is highly skilled, dedicated and experienced. As the longest serving DCS in London, she provides a sustained and energetic commitment to continually improving outcomes for the most vulnerable children. The quality of all services is good or better, building further on the 'good' judgements at the last Ofsted inspection in 2012. The leadership style emphasises the core values of compassion, humility, social justice and inclusion. These sit alongside a requirement for the highest standards of frontline practice with children and families, and poor practice is actively addressed. This approach is apparent in the DCS's leadership of the Children's Trust, which maintains an authoritative and informed overview of performance.

72. Strong and impressive early help services, improved educational attainment and high-quality targeted and specialist services are prioritised in equal measure by leaders and senior managers. These include a prominent focus on disabled children and children who have special educational needs. The DCS maintains a variety of formal and informal routes for regularly meeting frontline staff, foster parents and children, including those who are looked after and unaccompanied asylum seekers. This provides the DCS with a comprehensive and well-informed range of insights into the effectiveness of frontline practice.

73. An influential corporate parenting board, chaired by the longstanding and experienced chief executive, illustrates the importance given at the highest level of the local authority to effective cross-council responses to the needs of children looked after. It enables the chief executive to understand directly the performance of frontline services. Successful collaborative working yields results for children. As an example, the formation of an integrated commissioning hub assisted in opening negotiations with local social housing providers. This resulted in the provision of additional priority accommodation for young people leaving care and led to the housing department becoming standing members of the board. The board's priorities are carefully considered and take into account the joint strategic needs assessment (JSNA), performance information and the views of the CiCC.

74. Strong partnership, shared accountability and challenge are clearly evident in Merton. The chief executive, the lead member for children's services and the DCS all have active chair or membership roles in the Safer Merton Partnership Board, the Violence against Women and Girls Group, the Health and Well-being Board and the Children and Young People's Overview and Scrutiny Panel. This has resulted, for example, in the chair of the Health and Well-being Board and the lead member meeting before each board to plan the inclusion of children's priorities in the agenda. Any impact on children's health outcomes is considered in all local authority priorities. Additionally, progress has been made in targeted objectives, such as improving the take-up of immunisations and the joint commissioning of community health services for the under-fives, with the clinical commissioning group. The capacity and availability of CAMHS practitioners in social work teams have increased,

including the provision of more direct support and consultation for children looked after.

75. The DCS chairs the Youth Crime Executive Board. This cross-representation means that domestic abuse services for families, including MARACs and the independent domestic violence advisers, are closely aligned with adult services. Well-devised strategic and operational relationships with the police enable rigorous responses to child sexual exploitation, gangs, missing children and other adolescent vulnerabilities. Similarly, frequent meetings with the chair of the MSCB result in well-aligned single- and multi-agency training programmes and auditing schedules. The assistant director social care and youth inclusion chairs the MSCB's quality subgroup, demonstrating an intent to expand relevant parts of the practice model across partner agencies, and to have oversight of the quality of multi-agency practice.

76. Interventions with children and young people vulnerable to extremist influences are well planned and effective. Arrangements for multi-agency governance, awareness raising, operational oversight and partnership work with the local police and counter-terrorist police are all well designed, including regular work with local schools. A partnership board coordinates intelligence carefully and oversees a wide spectrum of community cohesion work, embracing local mosques and churches through a 'safe faith' approach. Local MSCB guidance for partner agencies is clear and helpful. A Channel panel meets monthly to plan and review interventions with a small number of children where concerns are greater.

77. Children exposed to risks of sexual exploitation receive protective and well-developed strategic and multi-agency responses. Multi-agency governance arrangements are tightly coordinated and led by the MSCB. A multi-agency sexual exploitation panel closely tracks the impact of risk reduction work provided by a range of locally commissioned services. Joint work with the police is highly integrated, and targeted strategy meetings are attended by all involved agencies, chaired by an experienced and knowledgeable specialist child sexual abuse coordinator. The coordinator routinely checks the quality of responses to contacts and referrals into the MASH, and is further developing the use of screening and assessment tools through ongoing consultations with social workers. Multiple risks to missing children are also well understood and evaluated through pan-agency weekly meetings. However, the individual response for each child through completion of return home interviews is inconsistent. This is being carefully monitored and addressed by senior managers.

78. High-quality performance information is closely scrutinised at all management levels and at the children's and young people's overview and scrutiny committee, through weekly, monthly, bi-monthly and quarterly datasets. The chief executive and DCS discuss performance information at their regular meetings. Accessible dashboards provide snapshots of all local and national

indicators across the spectrum of services, and useful hyperlinks allow closer examination of particular teams and individual practitioners. This enables early attention to emerging difficulties.

79. Performance management and reporting are firmly established with a stable team manager group. Remedial actions result in notable improvements, including, for example, additional investment to increase social worker capacity in the first response teams. This resulted in an improvement in both the quality and timeliness of assessments. Following manager attention, participation rates in EET for young people leaving care climbed above national levels.

80. Performance and quality assurance frameworks are closely aligned and mutually reinforcing. Auditing is well targeted, based on sound performance intelligence, resulting in practice learning and improvement. When performance trends require greater exploration, periodic deeper dives are undertaken. An adolescent needs analysis is a recent example of a detailed and probing analysis of factors underlying placement instability, triggered by a surge in the numbers of older young people becoming looked after. A care leavers' service improvement board, chaired by an assistant director, has led to important service improvements. The assistant director children's social care meets regularly with the team manager group to discuss and highlight learning points arising from audits and quality assurance activities, further demonstrating a deeply ingrained learning and development culture.

81. New elements of the practice model are being introduced and piloted, including regular practice observations and a live auditing model to promote coaching for social workers facing difficult, complex issues in their casework. The DCS, assistant director social care and youth inclusion and all managers maintain a high level of interest, curiosity and knowledge about children's cases. Social workers highly value these appreciative inquiries and interest in their work. Regular, high-quality supervision and management oversight are evident across all services. They are largely evaluative, analytical and well recorded, providing helpful direction for practitioners.

82. Developments in children's needs are understood by increasingly bespoke JSNA reports that are regularly updated. Incisive analyses have been undertaken, for example, of child sexual exploitation and children living in families exposed to the higher risks associated with the 'trigger trio' of parenting vulnerabilities: domestic abuse, mental ill health and substance misuse. Joint and single commissioning of universal and targeted services is concentrated on the most deprived parts of the borough, where outcomes for many children are known to be poorer. Young people are both involved and highly influential as 'young inspectors' throughout commissioning programmes. Their participation in the design and development of a forthcoming community hub has been extensive. Commissioned services, and

those provided directly by the local authority, such as parenting programmes, are subject to rigorous and regular contract monitoring.

83. Both the judiciary and Cafcass report a consistently high standard of evidence preparation by social workers in care proceedings, which are completed within the required 26-week timescale. Communication with the local authority is positive and constructive, enabling any issues to be quickly addressed.

84. Merton's social work practice model is at the centre of the continuous development of effective and evidence-based social work with children and families. The model is based on systemic theories and appreciative, critical enquiries to assess the strengths, needs and risks in families. It is led by the assistant director for children's social care, who chairs a social work board and a practice development group. The model features a number of evidence-based practice tools and direct work methods, such as motivational interviewing with older children. Social workers and managers are provided with phased and continuous training in the model through a close and well-established partnership with a local university. Social workers' ongoing professional development is promoted at all stages of their experience. Well-defined career progression pathways encourage committed and talented social workers to progress and flourish. The continuing development of the practice model is supported by additional funding and a well-formulated project plan, illustrating a demonstrable corporate and departmental commitment to high-quality social work with children and families.

85. A restless ambition to continuously develop better practice is discernible, led by the assistant director for children's social care who is a committed, motivational and skilled social work leader. The learning and development programme is centred on the model, providing many openings for social workers to learn new approaches, for example in direct work with adolescents. Senior managers are outward facing and regularly invite external peer reviews of their services. They are actively engaged with, or lead, regional groups and initiatives and are eager to learn about social work practice in other local authorities. This is exemplified in the leadership of the introduction of a Family Drug and Alcohol Court, and the active participation in an evolving social impact bond edge-of-care service, which will include multi-systemic and functional family therapies.

86. Annual turnover of social workers is approximately 25%. This turnover occurs despite a supportive and dynamic professional environment for social workers, positively reported on in their annual survey. Recruitment and retention, a constant senior manager preoccupation, are of critical importance, featuring constructive joint work with human resources. Recruitment initiatives are widespread and continuous. Additional annual funding of £1 million each year over the last three years, through corporate growth and contingency use as well as recycling money within the children's services department, has increased frontline social worker posts by 33% and enabled manageable

caseloads and smaller teams with tighter management oversight. Students and newly qualified social workers are provided with high-quality support and training. The 'Frontline' programme is well established and 'Step Up to Social Work' is being developed. Market supplements and retention incentives are used to attract experienced social workers and to retain them in service areas where turnover is typically greater. Senior managers resist recruiting too many newly qualified social workers, as they are aware that this will add to the responsibilities and pressures on their existing experienced frontline workers. Senior managers remain resolute in their commitment to recruit able and committed social workers, who will continue to provide high-quality services to the most vulnerable children and families.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is outstanding

Executive summary

Merton's Local Safeguarding Children Board (MSCB) is outstanding. It is highly effective in holding agencies to account for their individual safeguarding arrangements in the welfare and protection of children. The strength and maturity of the board are reflected in the established strategic arrangements and the high level of engagement across the partnership and with other strategic boards. The board benefits from decisive strategic leadership by the independent chair and a highly competent business manager. The board is well attended by capable senior strategic leaders who can influence safeguarding in their individual agencies. The contribution and participation of the voluntary sector and lay members greatly enhance the effectiveness of the board's work within the wider community. There is effective communication between the chief executive, DCS, lead member and chair of the MSCB, and accountability for the work of the board is strong.

The board's strategic priorities are relevant and informed by detailed analysis of local need to target the most vulnerable children, including children at risk of sexual exploitation and extremism and children missing from home or care. There is a sustained commitment to and focus on the delivery of the board's safeguarding priorities, including families in which adult mental health, neglect, alcohol, drugs and domestic violence feature in children's lives. The safeguarding needs of children pervade the board's work and business and subgroup plans.

The systems and processes underpinning the work of the board result in the availability of detailed multi-agency performance information of frontline practice, including around the application of thresholds for intervention (known locally as Merton's Well-Being Model) and compliance with the pan-London child protection procedures. The board promotes a culture of continuous development. Learning from SCRs and learning improvement reviews (LiRs) is used to improve safeguarding practice and in the development of multi-agency policies. The routine and innovative use of single- and multi-agency case file audit means that the board can assure itself of the quality and impact of frontline social work practice and take decisive action to drive improvement. The collaboration of partners at both strategic and operational level allows for alerts and trends to be identified and acted on swiftly.

There is a comprehensive suite of training available and attendance is good. The impact of training is actively monitored to ensure that it remains relevant and impacts on raising awareness and changing behaviours in the protection of children. The contribution and participation of children and young people are actively promoted and used well in the design and delivery of training and the development of priorities. There are no recommendations for the MSCB.

87. The MSCB is highly effective. There are strong governance arrangements underpinned by established partnerships with other strategic boards, including the Health and Well-being Board, the Corporate Parenting Board, the Children's Trust and the Safer and Stronger Partnership. Strategic leaders, elected members and partners work collaboratively and focus relentlessly on what matters to children in keeping them safe and promoting their welfare. There is strong engagement between the chief executive, DCS and lead member; roles and responsibilities are clear and accountability is strong. Suitable measures are in place to strengthen the partnership further with the Adult Safeguarding Board.

88. The independent chair provides decisive strategic leadership and challenge to partners. The chair has been central and extremely influential in driving forward the board's priorities and is highly respected by partners. The maturity of partners' relationships is reflected in the mutual trust and respect shown to each other. This is reflected in the sustained focus on ensuring that children's welfare and protection are at the heart of their work. Members expect, receive and are open to challenge, as the board seeks assurance on individual agency safeguarding responsibilities. Partners' contribution to the work of the board is valued and acted on. This supports collaborative and effective working relationships.

89. The business manager is highly experienced and competent and actively monitors the risk and challenge log and drives the business plan forward. His detailed knowledge and experience of MSCB priorities and subgroup work plans is impressive. The work of the board also benefits from excellent business administrators. This supports detailed scrutiny in the monitoring and reviewing of the progress of plans. The establishment of the business improvement group two years ago has enabled additional rigorous scrutiny of the board's priorities and supports partners in challenging each other in delivering against their individual agency's safeguarding responsibilities, on time and to the highest standard.

90. The experience and expertise of board members are used exceptionally well in partners discharging their safeguarding responsibilities and in holding each other to account. This is a notable strength, which permeates the work of the board and subgroups, the impact of which is demonstrated through the maturity of the partnership in collaboratively working to deliver single and joint priorities. There is a shared vision to safeguard all Merton children and a sustained and unyielding commitment in driving forward MSCB priorities: Think Family, vulnerable adolescents and early help. The board's priorities are the result of rigorous analysis of local need and reflect learning from SCRs, LiRs and national issues. The subgroup plans are closely aligned to the board's priorities and crosscutting themes around vulnerable children, including disabled children and children at risk of sexual exploitation. The joint focus on families in which neglect features in children's lives is well managed.

91. The culture of openness across the partnership is established and embedded. This, coupled with effective systems and processes, makes for a powerful force in the board holding partners to account and in understanding the effectiveness and impact of the quality of services in safeguarding children. There is a strong engagement across the partnership, including with schools, the voluntary sector, faith and wider community groups on safeguarding issues. Members are drawn from a wide range of partners who hold strategic safeguarding roles in their agency, and are experienced and influential in their organisations. All partners make a proportionate financial contribution to MSCB.

92. Members, including lay members, actively drive the business planning priorities. Members receive appropriate induction training and are clear about their collective and individual responsibilities. The impact of joint work on increasing awareness and supporting change is well evidenced. The business manager is effective and determined in driving and supporting change within the community to promote and safeguard children.

93. The understanding and application of thresholds by partners are reviewed regularly to ensure that they remain fit for purpose. The influence of the MSCB in evaluating and scrutinising the application of thresholds across frontline practice, including early help, is far reaching and innovative. The routine and detailed audit of frontline practice, including single- and multi-agency case file audit, focuses on the evaluation of the quality of children's lived experience and progress and is exemplary.

94. The wide range of audit activity includes a recent comprehensive audit of private fostering and was undertaken to ensure that practice met required regulatory standards. A recent sexual abuse threshold audit report in October 2016, undertaken by the MSCB quality assurance group and involving the police, children's social care and early years services, effectively reviewed the quality of decision-making. A themed multi-agency audit of child sexual exploitation over a number of years helped the board to determine whether changes in safeguarding practice were sustained. This is an effective approach to evaluating practice and determining the long-term impact of joint work with this vulnerable group. The quality assurance subgroup effectively conducted an audit of the quality of decision-making and practice with regards to children when disability is a feature of their lives. The learning from these audits informs business planning and wider training needs, including joint training.

95. There is an exceptionally effective section 11 process. The incisive analysis through the annual peer challenge and review meeting process ensures appropriate and respectful challenge of partners' compliance with safeguarding standards and seeks assurance of impact on practice. All senior agency representatives attend these annual challenge sessions. Partners

spoken to by inspectors said that they found the process to be rigorous but supportive.

96. The terms of reference for the child death overview panel (CDOP) and all subgroups are clear and link well to the board's priorities. The recently established Merton CDOP, which had been a joint panel with a neighbouring authority, fulfils its statutory responsibilities. The rapid response team convenes within timescales. Membership of the board is at appropriate senior and strategic level. The panel sensitively and appropriately supports the engagement of families. The panel uses learning events well to drive improvement. For example, a presentation to health professionals covering a five-year review of the work of CDOP was received well. Information on trends in cases of child deaths, both locally and nationally, is distributed through articles and has included features on alcohol poisoning, child mental health issues and internet safety.

97. The MSCB Annual Report 2015–16 gives a clear commentary and assessment of the performance and effectiveness of services across the partnership. The report outlines progress in the reporting period and future challenges for the board linked to the Wood Review. Since the last inspection, the board has reconstituted itself, placing greater emphasis on quality assurance. It has sharpened its focus on prioritising work at a time of reducing resources to ensure maximum impact on the welfare and protection of children across the partnership. The report provides an overview of each of the subgroups against the work plans, including the CDOP, and in particular focuses on the SCR in respect of Child B published this year and the LiR for Child C. The report reflects clear links with other strategic boards, and current priorities for 2016–18 are made clear. The annual report is received by the leader, the chief executive, the Children's Trust and the Health and Well-being Board, enabling effective challenge on key areas of improvement.

98. The MSCB has an established learning and improvement framework with statutory partners. The board has recently endorsed a revised learning and development strategy and has aligned learning needs to the board's priorities. This ensures that safeguarding training, including multi-agency training across the workforce, is targeted at the appropriate level. The opportunity for learning through SCRs and LiRs is robust and clearly aligned to the board's strategic priorities, subgroup work plans and frontline practice.

99. There are detailed action plans following the recent SCR and LiR, which appropriately link to recommendations. Progress is closely monitored through the quality assurance subgroup and the business improvement group. The importance of joint working in protecting children and young people where mental health and neglect feature are key priorities of the board. There is increasing joint development work with the adult mental health trust, and a 'Think Family' coordinator has recently been appointed to strengthen strategic and operational integration across children's and adults' services. The impact

of neglect, which featured in the learning review of Child C, is underpinned by the MSCB multi-agency neglect strategy and implementation and action plan to ensure that neglect is recognised and that children's voices are heard and acted on.

100. The local authority uses learning from reviews to effect change. For example, the learning from an SCR in 2014, underpinned by joint research with education colleagues, has been effectively used to drive improvement by promoting a lower tolerance of chronic school absence. This has helped to identify vulnerable children, including children at risk of sexual exploitation and those missing from education or care. This effective joint approach is now established and embedded in practice. This demonstrates the direct link between learning and improving practice. It also reflects the commitment of the board to driving improvement. Social workers and other professionals who spoke to inspectors understand well the findings of reviews and learning from training.

101. The comprehensive range of high-quality, up-to-date policies and procedures are exemplary. These are regularly reviewed by the board and the business improvement group to ensure compliance and to ensure that policies are relevant. The board promotes a strong and transparent learning culture, setting high standards and drawing effectively on independent research. The promote and protect young people subgroup (PPYP) provides strategic and effective oversight of multi-agency policies, protocols and procedures regarding children at risk, including risk from sexual exploitation, radicalisation and extremism.

102. The board has access to a comprehensive suite of multi-agency performance information, which is monitored and regularly and actively scrutinised. Joint performance information is detailed and clearly aligned with audit activity and supported by commentary on progress. The good attendance of partners at MSCB and subgroup meetings supports effective analysis and challenge.

103. Listening to children's views permeates the board's work in ensuring their welfare and protection. The most recent joint annual conference for practitioners and managers, which focused on the complexities of domestic abuse, involved young people. The conference content underpinned the strategic approach to engage partners and professionals, and to raise awareness and understanding.

104. The voice of children and young people is actively encouraged, including through their attendance at MSCB meetings. One example is a research project on young people's views on safeguarding that was commissioned in partnership with the board and London South Bank University. The project took into account the views of 148 young people in secondary schools, including children subject to child protection plans. A training day was held in May 2017 to consider lesbian, gay, bisexual and transgender issues, and those

questioning their sexuality or gender, and young people ran part of the programme. The event focused on mental health, transgender identity and hate crime. A shorter version of the event was recently presented to the board by young people from a local school.

105. There is close alignment between the training programme and strategic priorities, ensuring the effective targeting of programmes to drive improvement in safeguarding practice. Future training needs are identified through the extensive single and joint audit programmes and findings from SCRs, LiRs and national and local issues. Attendance is very good, and feedback at the point of delivery and three months later is sought to evaluate impact on practice and to inform future training needs.

106. The board is actively engaged with the 'Prevent' duty on radicalisation, which includes a wide range of partners, including the police, schools and early years settings, and faith, voluntary groups and the wider communities. MSCB guidance on safeguarding children and young people from the harmful messages of violent extremism and terrorism has been reviewed to ensure its current relevance. The guidance is clear and informs partners of their safeguarding responsibilities. It incorporates helpful lists for recognising risk and links to referral pathways for the MASH and the Channel programme, which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. The board has also consulted with a range of community groups, especially with regard to its strategy on female genital mutilation, which is reviewed appropriately through the policy subgroup.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of six of Her Majesty's Inspectors (HMI) from Ofsted and one Ofsted inspector.

The inspection team

Lead inspector: Louise Hocking

Deputy lead inspector: Nick Stacey

Team inspectors: Tara Geere, Matthew Reed, Kate Malleson, Jon Bowman, Mary Candlin

Senior data analysts: Neil Powling, Stewart Hartshorne

Quality assurance manager: Carolyn Adcock

Any complaints about the inspection or the report should be made following the procedures set out in the guidance, 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.ofsted.gov.uk. If you would like Ofsted to send you a copy of the guidance, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, workbased learning and skills training, adult and community learning, and education and training in prisons and other secure establishments. It inspects services for children looked after and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

To receive regular email alerts about new publications please visit our website and go to 'Subscribe'.

Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk

Committee: Health and Wellbeing Board

Date: 28 November 2017

Wards: All

Subject: Motor Neurone Disease (MND)

Lead officer: Dr Dagmar Zeuner, Director of Public Health.

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

Contact officer: Amy Potter, Consultant in Public Health / Clarissa Larsen, Health and Wellbeing Partnerships Manager

---

Recommendations:

A. The Health and Wellbeing Board are asked to commend the MND Charter for its work and the goals of the Charter.

B. To welcome progress on the actions of the Neurological Conditions Needs Assessment and agree the proposed actions/recommendations to support people with neurological conditions in Merton.

---

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

A Council resolution was made in July 2017 asking the Health and Wellbeing Board to consider adopting the MND Charter. This report briefs the Board so that they can consider the Council resolution. The report provides an update on the Long Term Neurological Health Needs Assessment (2015) and identifies services in Merton that support the MND Charter and other neurological conditions.

2 BACKGROUND

2.1. A Council resolution was made in July this year to 'ask Merton Health and Wellbeing Board (HWBB) to consider adopting the MND Charter, which sets out the care and support that people living with MND and their carers deserve and should expect'.

2.2. The resolution spoke of raising awareness of MND and demonstrating what good care looks like for those living with this devastating disease.

2.3. Key areas of the MND Charter include;

- Early referral, accurate and early diagnosis and timely information
- High quality care and treatment
- Personal care planning
- Access to equipment, adaptations and suitable housing
- Access to care assessments, respite care and welfare benefits

2.4. In response to the request, consideration of the MND charter took place alongside a review of the Long Term Neurological Needs Assessment which was undertaken in 2015. The health, social care and housing services

that are available to support people with neurological conditions including MND (and which respond to elements of the MND Charter) were also examined.

3 DETAILS

3.1. The main findings of the Long Term Neurological conditions Health Needs Assessment (2015) regarding the prevalence of neurological conditions in Merton were:

- An estimated total of 4,626 people in Merton are living with long term neurological conditions (excluding headaches and migraine).
- An estimated 1,753 residents have essential tremor, 1,031 are estimated to have epilepsy, 412 Parkinson's disease, 384 cerebral palsy and 297 multiple sclerosis.
- The prevalence of MND in Merton was estimated to be 14 individuals in the population. [1]

3.2. Motor Neurone Disease (MND) is a fatal, rapidly progressive neuroglial disease. (Appendix 2 contains further information about Motor Neurone Disease, as well as information on diagnosis and treatment).

- Data from the Primary Care Mortality Database revealed that there were 18 deaths associated with Motor Neurone Disease in Merton between 2010-2014.

3.3. The HNA reviewed services available for people with long term neurological conditions. It should be noted that commissioning responsibilities are complex with the CCG, NHS England and LB Merton commissioning a range of important services. These span a spectrum of services, from acute hospital care to social care and support for carers. These complexities stress the importance of health and social care integration, so that patients can experience a seem-less service, one of the ambitions of the Health and Wellbeing Board.

3.4. Key services outlined include;

- Specialist and general inpatient and outpatient care, specialist nursing support and community rehabilitation. In addition, palliative care, end of life care and social services support can be accessed by people with a neurological condition.
- There is an established path for epilepsy patients in place with a two year open review following diagnosis. Formal pathways are not in place for other LTNCs, however informal pathways are followed which reflect best practice guidelines.

[1] NB This figure was derived from national estimates and it is important to treat it with caution due to population variation. For instance, there are a larger number of children and young people living in Merton and fewer people aged 50 and above compared to the average national population, and MND is most common amongst individuals aged 50-70.

- Support can include carers' assessments, advice and signposting for welfare benefits and personal budgets. More detailed information is available in Appendix 3.
- Occupational therapy provides a range of services to people with a permanent and substantial physical disability living in Merton. The service aims to help people to keep as safe and as independent as possible in their own homes. Key services include assessment; offer of services such as equipment and adaptations and Disabled Facility grants. Further information is available in Appendix 3.
- An active voluntary sector who provide support for specific conditions.
- Wheelchair assessment and provision are under NHS and the Wheelchair service is accessed via GP referral.

3.5 The HNA also highlighted gaps in service associated with long-term neurological conditions, and made recommendations to address service areas including;

- There was found to be a lack of personalised care plans across all patients with LTNCs.
- Stakeholders and service users reported difficulty in access to Community Neurotherapy Team (CNTT) services.
- Psychological support was consistently reported by stakeholders and service users as a gap, and it was highlighted that there was no neuropsychologist in Merton

3.6 The HNA also found areas where Merton was doing well including;

- Merton CCG has a slightly higher spend on neurology for marginally better outcomes.
- Merton has a lower rate of emergency bed day use than the London benchmark for all analysed conditions.
- The number of neurology admissions has fallen year on year since 2009/10, with the proportion of emergency admissions reducing more rapidly in Merton CCG than in London as a whole

SERVICE UPDATE SINCE THE LTNC HNA

3.7 Since the original Neurological Conditions Needs Assessment new work has taken place that will help to further support people with long term neurological conditions.

3.8 Merton CCG has commissioned a new rapid access neurology clinic, due to be launched in November 2017. Such a clinic will aid in reducing the time between GP referral and contact with a specialist, leading to early diagnosis, which is of paramount importance for certain conditions including patients with MND.

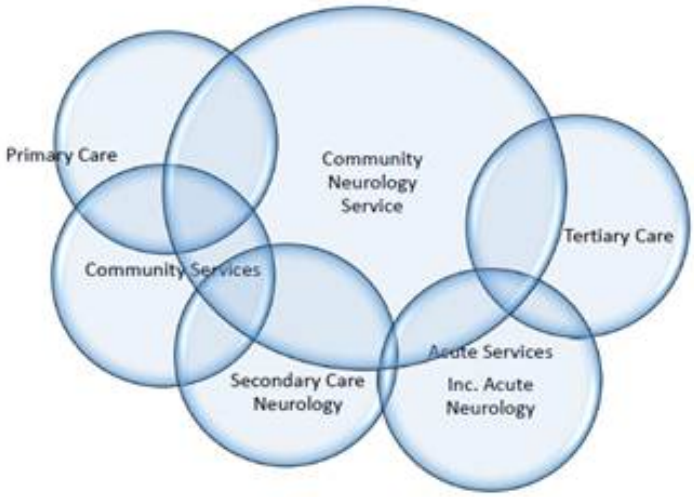


Fig 1: Venn diagram illustrating the multi-tiered coordination of the Integrated Community Neurology Provision Area.

3.9 The CCG is also proposing the formation of an Integrated Community Neurology Provision Area (Merton, Wandsworth, and St George's Hospital). It will involve existing Neurology Services, (acute, primary and community) working together much more closely (initially virtually and later located in locality hub locations). The focus will be on management of long-term conditions with specialist nurse/AHP delivered services but with consultant neurologist support. This new model of care will provide appropriate levels of expertise, taking a proactive approach where high risk individuals are identified earlier through greater collaboration between primary and secondary care. The pilot for this service is expected to take place from April 2018, for a period of six months.

3.10 As part of these programmes of work, Merton CCG is taking into account the other gaps in service associated with long-term neurological conditions highlighted by the HNA. Examples of this include the CCG reviewing neuropsychology provision in the community team and proposing to review the current CLCH neurological conditions service specification in light of the HNA recommendations.

MND Charter

3.11 The Long Term Neurological Conditions Health Needs Assessment has set out the range of debilitating neurological conditions from which people living in Merton suffer. MND is a devastating condition which affects a small but significant number of people locally. The Needs Assessment set out the services in place in 2015 to support people with neurological conditions, and since that time further work has taken place and initiatives, specifically the plans of the CCG, will help to improve that support.

3.12 The provision identified in both the original Needs Assessment and the update conducted as part of this report addresses the goals of the MND Charter and

the HWBB commends those goals and the useful framework that they provide for assessing service provision, as well as the MND charity activity.

3.13 Given the HWBB statutory duty to promote the health and wellbeing of the whole population, and the range of neurological conditions which people can suffer as set out in the needs assessment, we do not think it would be appropriate to sign up to a charter specific to a single neurological condition (such as MND) . However, we do note there is further work to be undertaken on developing the support offer for people with long term neurological conditions, and the CCG will establish a reference group of service users to support this work and will report back to the HWBB in 12 months.

4 ALTERNATIVE OPTIONS

4.1. None.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. As part of the 2015 Assessment consultation was carried out with service users. Key themes included;

- The substantial impact of LTNCs on daily activities
- The diagnosis process and variable degree of personalised care planning
- Communication between professionals
- Access to ongoing care and treatment
- The broader needs of the individual and holistic approach necessary to care

5.2. In updating the Long Term Neurological Conditions Health Needs Assessment consultation took place with officers in Merton CCG, adult social care, CLHC and occupational therapy.

6 TIMETABLE

6.1. The timetable is as set out in the report and the full Health Needs Assessment.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. None.

8 LEGAL AND STATUTORY IMPLICATIONS

None.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Long Term Neurological Conditions Needs Assessment is aimed at understanding the real needs of those with these conditions in order to help address health inequalities.

10 CRIME AND DISORDER IMPLICATIONS

None.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None.

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

Appendix 1 – Information on MND

Appendix 2 – Detailed service information

13 BACKGROUND PAPERS

14.1. Merton Long Term Neurological Conditions Health Needs Assessment 2015 available at https://www2.merton.gov.uk/merton_long_term_neurological_conditions_hna.pdf

APPENDIX 1

15. WHAT IS MOTOR NEURONE DISEASE?

16.1 Background

16.1 Motor neurone disease (MND) is a fatal, rapidly progressing neurological disease. It attacks the nerves that control muscle movement (motor neurones), causing them to weaken, stiffen and waste. This, in turn, leads to progressing issues with walking, speaking, swallowing and breathing.

16.2 Mental abilities and senses are not usually affected by MND and therefore patients generally remain aware of their deteriorating physical condition.[2]

16.3 There are different types of MND, and Amyotrophic lateral sclerosis (ALS) is the most common, accounting for up to 80% of cases.

16.4 We do not currently know what causes MND. Various studies have been carried out around the world and the risk of developing MND does not appear to be affected by race, diet or lifestyle. MND does not occur in epidemics, it is not infectious and it does not appear to be caused by any

[2] Brain Research Trust UK 2015. Accessed October 2017.

other disease. It is more common in men than women, and amongst people aged between 50 and 70 years.

16.5 Motor Neurone Disease affects up to 5,000 adults in the UK at any one time. MND is life-shortening, and at present, there is no cure for the disease. MND kills a third of people within a year and more than half within two years of diagnosis. [2]

Diagnosis

16.6 MND cannot be diagnosed with one specific test and doctors will usually carry out a series of tests and investigations. Early referral from a GP to a specialist is pertinent and diagnosis is confirmed by a neurologist with the aid of a range of tests including MRI scans and nerve conduction tests.

Treatment

16.7 MND is an incurable condition that usually, although not always, leads to death within a few years, with a period of distressing disability preceding it. Thus, the mainstay of management is in supporting the patient, their family and carers through this process and in delivering palliative care at the appropriate juncture.

16.8 A multidisciplinary approach involving GPs, primary care nurses, occupational therapists, physiotherapists, speech therapists, dieticians, respite care providers, home care workers, hospital physicians and neurologists, along with many others, is likely to best serve the patient, and effective communication between all the interested parties is essential.

16.9 As the disease manifest itself, a patient's support needs will increase. Mobility will be reduced due to limb muscle weakness, leading to the requirement of walking aids or a wheelchair. In the later stages of MND, the muscles weaken in the chest, back and neck and people experience difficulties with swallowing and breathing. At this stage, gastrostomy tube feeding and ventilation assistance may be required.

16.10 Riluzole is the only drug treatment specifically for MND. Safety and efficacy of Riluzole has only been studied in ALS. Therefore, Riluzole is currently not licensed to be used in patients with any other form of motor neurone disease.

16.11 The effect of Riluzole is to slow the progression of symptoms of ALS, and to extend the time to mechanical ventilation. Riluzole can increase the life expectancy of people with ALS by three to six months.

16.12 Riluzole does not cure MND, nor can it reverse the damage already caused by the disease.

16.13 In Merton, Riluzole is currently commissioned and is available under shared care (i.e. shared prescribing between specialists and GPs). Access to needs-specific hospice care is a fundamental part of care for patients with life-shortening disease.

16.14 In Merton, St Raphael's Hospice provides services to meet the specific needs of people with Motor Neurone Disease.

APPENDIX 2

Social Care Eligibility

17.1 Eligibility for social care is determined through the criteria of the Care Act 2014 requiring physical or mental impairment and as a result not being able to achieve outcomes (such as personal hygiene or .maintaining nutrition) which has a significant impact on the person's wellbeing. Once deemed eligible, adults including those with MND are offered needs appropriate care such as help with feeding

Carers' Assessments

17.2 Carers of people with MND will be eligible for a Carers' Assessment under the Care Act 2014. Where eligibility criteria for the carer are met the range of support services includes the following:

- to be granted a Carers Budget under Direct Payments (this can be used for sitting service so the informal carer can go out and the cared for person has someone to sit in with them).
- to be granted a Carers Discretionary Grant (up to £100 for essential items such as paying for driving lessons, to pay for a microwave or pay towards a short break for the informal carer).
- to have regular respite breaks for the cared for person.
- to be referred to Carers Support Merton (a voluntary sector organisation, but LBM gives out a grant as well as having a contract for CSM to carry out some of the Carers Act Assessments).

Welfare Benefits

17.3 People with MND may need advice and information on welfare benefits. In Merton Social Services sign post customers/clients or their informal carers to either the Welfare Benefits team who support people with a range of benefit advice and applications or the Citizen Advice Bureau where the full range of benefits will be discussed.

17.4 Most people accessing social care, including those with MND, will usually apply for PIP (Personal Independence Payment) formerly known as Disability Living Allowance. The payment for PIP is made by the DWP (Department of Work and Pension).

Personal Budgets

17.5 Once the cared for person or the informal carer has been assessed as eligible for services to be funded by the local authority, then the care and support could either be met by a) commissioned services (by booking for a care provider contracted with Social Services) or b) under a Personal Budget (usually issued by Direct Payment i.e. Social Services pay an assessed amount of money to the cared for person or informal carer for them to make their own care arrangements. The Personal Budget can be used for employing a Personal Assistant (but not employing relatives living

in the same address). This gives the cared for person or informal carer more choice and control in care provisions.

Housing, Adaptations and telecare

17.6 Disabled facilities grants (DFGs) can be requested to help meet the cost of providing adaptations to enable people with disabilities to access their home and the facilities within it. DFGs are available to people who own their own home and private tenants.

17.7 Adaptation works carried out through DFGs in Merton include external ramping to entrance doors, stair lifts, level access showers and automatic toilets. An assessment must be made by a qualified Occupational Therapist to decide what works are required to meet the needs of the person with disabilities.

17.8 MASCOT Telecare and Community Support Services provide a range of initiatives enabling people to remain at home with independence and security. Offering care line and telecare services to vulnerable people and those with a disability, MASCOT prevents unnecessary admissions to hospital and residential care.

This page is intentionally left blank

Committee: Health and Wellbeing Board

Date: 28 November 2017

Agenda item:

Wards: all

Subject: New Local Plan

Lead officer: Director for Environment and Regeneration, Chris Lee

Lead member: Cabinet Member for Housing Planning and Regeneration, Councillor Martin Whelton

Forward Plan reference number:

Contact officer: Deputy FutureMerton manager, Tara Butler

Recommendations:

That the Health and Wellbeing Board

A. responds collectively and as individual organisations to Local Plan consultations, including this first stage which will finish on 8th January 2018;

B. leads on or engage in gathering evidence to support new planning policies, site allocations or other matters that the Health and Wellbeing Board want to see in Merton's new Local Plan;

C. leads on co-ordinating input on future health and wellbeing capacity needs, particularly primary healthcare, in Merton over the next 5-10 years. This is crucial to support planning officers and the council to negotiate for new healthcare and wellbeing facilities or modernised facilities as part of new developments during the next 10-15 years.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report will update the Health and Wellbeing Board on the new Local Plan, ask for responses to the first stage consultation before 8th January 2018 and request ongoing involvement, particularly on developing policies, allocating new sites and providing information on new infrastructure requirements.

2 BACKGROUND

2.1. In October 2017, Cabinet resolved to start consultation on the borough-wide Local Plan. This started on 31st October 2017 and will run until 8th January 2018. Please see www.merton.gov.uk/newlocalplan

2.2. The new Local Plan will set out the council's strategy for development in Merton. It will contain the planning policies against which all planning applications received by the council will be assessed. It will be a single document which will replace Merton's *Core Planning Strategy* and Merton's *Sites and Policies Plan.* It must be in line with the Mayor's London Plan.

2.3. When the Local Plan is finished, it can cover:

- A vision and objectives for development in Merton

- **Borough-wide strategic policies** on housing, design, flood risk, health and wellbeing, open space, etc) The Local Plan is a key strategic document which can effectively deliver Health in all Policies.
- **Neighbourhood-specific planning policies** covering the town centres and surrounding neighbourhoods of Colliers Wood, Mitcham, Morden, Raynes Park and Wimbledon
- **Setting land designations**: e.g. town centre boundaries, designated open space boundaries, areas for nature conservation, cycle routes etc. (similar to the maps in the Sites and Policies Plan)
- **Allocations of specific sites for development** or potential future expansion (e.g. Wilson Hospital; Birches Close; Morden Health Centre)
- **Infrastructure requirements** to support new homes. The infrastructure requirements will help the council negotiate for space for healthcare and wellbeing facilities and services (for the NHS or other providers) as part of new housing schemes over the next 10-15 years.

2.4. The Local Plan will be taking into account the health impact of its proposals to wherever possible promote healthy life expectancy and reduce health inequalities. In doing so, it will be taking forward the commitment to Health in all Policies which offers a means to optimise the Council and partner's statutory duties for population health and wellbeing. The HiAP approach helps to reduce health inequalities because if focuses attention on the underlying social, economic and environmental causes that the council and partners can influence.

3 DETAILS

3.1. At this very early stage of starting Merton's new Local Plan, the Health and Wellbeing Board is recommended to consider the following:

3.1.1 **To respond to the initial consultation by 8th January 2018**. Responses can be by answering the short surveys www.merton.gov.uk/newlocalplan or by writing to us at future.merton@merton.gov.uk .We would also strongly encourage individual groups and organisations that sit on the HWBB to respond to the consultation too.

3.1.2 To lead on or assist in **gathering evidence to support any new policy approaches** or other Local Plan matters that the HWBB want to put forward or support putting forward.

3.1.3 To take forward (or encourage another organisation to take forward) the **submission of NHS sites for allocation for new uses or for future expansion**. For example, in 2011 the Wilson Hospital and Birches Close were originally submitted to Merton's existing Local Plan (Merton's *Sites and Policies Plan)* by the then Primary Care Trust. If these sites or other NHS sites are to be progressed for redevelopment, then some person or organisation will need to lead on recommending sites to the council and gathering the evidence to support their redevelopment.

3.1.4 To assist us in gathering information on **primary health infrastructure capacity** to support future housing growth, and to include capacity gaps in the Local Plan.

3.2. The latter point is particularly important as this will be the justification for future support from new development towards health services. The council has access to the existing location and different types of primary healthcare facilities (e.g. GP surgeries, dentists) However we currently do not have access to the capacity of these facilities, whether they are fit for purpose, whether they need modernising or are even capable of expansion etc.

3.3. If the new Local Plan does not contain information on any geographic or service area where there is a lack of capacity and the ability to deliver more capacity (subject, for example, to finding an appropriate site or funding) then planning officers can't negotiate with developers to help support this infrastructure by either providing some funding or land.

4 ALTERNATIVE OPTIONS

4.1. None for the purposes of this report.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The current consultation started on 31st October 2017 and will finish on 8th January 2018, although it is expected that engagement on individual issues will continue into spring 2018.

5.2. Further consultation opportunities are set out in the timetable below.

6 TIMETABLE

6.1. The timetable for the production of the new Local Plan is set out below:

6.1.1 8th January 2018 – Stage 1 consultation ends; evidence gathering and meetings etc will continue to spring 2018

6.1.2 Summer 2018 – consultation on Stage 2 new Local Plan for at least six weeks

6.1.3 Winter 2018/19 - Council recommendation to submit new Local Plan to the Secretary of State, followed by six weeks publication

6.1.4 2019 – examination by an independent planning inspector (usually takes at least six months)

6.1.5 2019 – adoption of the new Local Plan

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. Funding to support this work will come from existing resources and officers will seek opportunities for funding bids wherever possible.

7.2. Once adopted, the new Local Plan will have assessed the infrastructure needed to support new development over the next 15 years, which will be essential to enable planning officers to negotiate with developers to help support this funding (e.g. by providing land or finance towards it)

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. None for the purposes of this report

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. Local Plans contain planning policies to improve community cohesion and are subject to Sustainability Appraisal / Strategic Environmental Assessments and Equalities Impact Assessments.

9.2. The Local Plan will be taking into account the health impact of its proposals to wherever possible promote healthy life expectancy and reduce health inequalities.

9.3. In doing so, it will be taking forward the commitment to Health in all Policies which offers a means to optimise the Council and partner's statutory duties for population health and wellbeing. The HiAP approach helps to reduce health inequalities because if focuses attention on the underlying social, economic and environmental causes that the council and partners can influence. The Local Plan is a key strategic document which can effectively deliver Health in all Policies.

10 CRIME AND DISORDER IMPLICATIONS

10.1. None for the purposes of this report.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. None for the purposes of this report..

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

13 BACKGROUND PAPERS

Committee: Health and Wellbeing Board

Date: 28 November 2017

Wards: All

Subject: Merton CCG - Commissioning Intentions

Lead officer: Josh Potter, Director of Commissioning, Merton CCG

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

Contact officer: Josh Potter, Director of Commissioning, Merton CCG

Recommendations:

A. For note

---

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report provides an update to the Health and Wellbeing Board regarding Merton CCG's Commissioning Intentions

2 BACKGROUND

In most years, each CCG will publish a set of Commissioning Intentions to communicate the plan for the coming year. Merton CCG has prepared a summary document which incorporates the most important local areas of focus.

3 DETAILS

See attached presentation

4 ALTERNATIVE OPTIONS

Not applicable

5 CONSULTATION UNDERTAKEN OR PROPOSED

Will apply to individual work programmes where necessary.

6 TIMETABLE

Not applicable.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

The CCG must meet its statutory financial duties. In order to do this, savings of c. £15m are required.

8 LEGAL AND STATUTORY IMPLICATIONS

None noted

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

None noted.

10 CRIME AND DISORDER IMPLICATIONS

Not applicable.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None noted.

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

Commissioning intentions summary

13 BACKGROUND PAPERS

None

NHS
Merton
Clinical Commissioning Group

Merton CCG Commissioning Intentions 2018/19

November 2017

1) Background and Context

Clinical Commissioning Groups are required each year to produce their assessment of where changes and developments can be made in the local system in order to address identified quality, performance and sustainability challenges. This process is known as the development of commissioning intentions and drives changes made to contracts with providers of services and feeds into annual operating plans to NHS England. This paper seeks to outline this process and summarise the CCG's commissioning intentions and impact.

It should be noted that 2018/19 is the second year of a two year operating plan submitted at the end of 2016/17. As such the proposals are developments and amendments to existing strategy in line with the Sustainability and Transformation Plan (STP) across South West London. The STP outlines a number of key areas in planned and unplanned care that areas should seek to deliver. Crucially however, the STP recognises that the majority of delivery should be at a local level, in order to ensure good partnership working and ensure services respond to the local context and needs. This is overseen by a Local Transformation Board, made up of all commissioners and providers of health and care across both Merton and Wandsworth. The intention of this group is to break down barriers that have traditionally existed within the system and come to a shared vision and agenda for change.

This is also the first set of commissioning intentions developed by the new Local Delivery Unit, a shared management team across Merton and Wandsworth CCGs. We believe there are clear benefits to this way of working, with opportunities to share best practice, and work with more impact and scale, particularly where the two Boroughs share major providers such as South West London and St Georges Mental Health Trust, St Georges Hospital and Central London Community Healthcare.

2) Headline Quality, Performance and Sustainability Issues

<u>Population Health</u>

Significant social inequalities exist within the borough. The eastern half has a younger, poorer and more ethnically mixed population. The western half is less diverse, has a higher average age and richer. Largely as a result, people in East Merton have worse health and shorter lives. Life Expectancy at birth in Merton is 80.5 years for males and 84.2 years for females. In East Merton life expectancy in men is 78.9 years compared to 81.9 years in West Merton. Women's life expectancy is 83.3 years in the East compared to 85.1 years in West Merton. There is a gap of 6.2 years in life expectancy for men between the most deprived and least deprived areas in Merton. The gap is 3.9 years for women.

The population is ageing: the number of people aged 65 or over is projected to increase by 13% (from 25,200 in 2017 to 28,400 in 2025). This further increases the challenge of caring for increasing numbers of people living with multiple long term conditions such as heart disease, diabetes, cancer, mental health conditions, and dementia.

Prevention Framework

The CCG recognises its responsibility to be an active and leading partner in the prevention agenda and indeed, many of the commissioning intentions take a preventative approach to healthcare, seeking to avoid exacerbations and further ill health. In addition we also sign up to the South West London Prevention Framework which outlines priority areas for action including Making Every Contact Count, Social Prescribing and creating healthy workplaces. Work is ongoing to ensure this appropriately incorporated into our plans as well as applied to existing services, and is aligned to work being led by Local Authority Public Health Teams.

Quality and Performance

The main performance challenges for the locality are the significant issues facing our largest acute provider St Georges Hospital, particularly in the area of waiting time achievement and A&E performance. On waiting times for elective care, the CCG is working closely with the Trust's management team and regulators on quantifying the scale of the issues and how they can be best addressed to ensure timely access to care for our residents. We expect that the impact of many of our commissioning intentions should help the situation by relieving pressure on the Trust and introducing high quality community pathways. However, given the likely scale of the waiting list backlog, it may mean that we need to find different ways of measuring success of our schemes. On A&E performance we recognise that this can be improved by strong partnership working between and within health organisations, and also with social care.

St Georges Hospital also remain in financial and quality special measures with the CQC judging the organisation as "requires improvement". In addition to the trust's significant financial challenges, the main quality areas are:

- Quality and risk issues arising from long waits for treatment. A Clinical Harm Group was been set up to monitor this.
- Cancer performance with associated clinical risks.
- New leadership team following previous leadership turnover. New team now needs to be embedded and lead the required cultural change and staff engagement agenda.
- Estates & Premises

South West London and St Georges Hospital have been rated overall "good" by the CQC. Quality issues relate mainly to community services:

- Consistency and variation in community services, particularly IAT service
- Pressure with acute care pathway with demand for access to specialist CAHMS PICU in a timely way.
- Recurring theme of suicide from serious incidents review. Suicide review currently being undertaken to identify learning.

Improving Access to Psychological Therapies (IAPT) access remains a challenge, particularly in Merton which has seen significant challenges in performance of our local IAPT service in the last 12 months with access rates and recovery rates not meeting the national standards.

Financial Context

The national picture for NHS funding is reflected in the situation in South West London with expected growth in population, and demand for new treatments and therapies, projected to significantly outstrip any growth in the NHS budget. Our current estimate based on performance in year and likely pressures for next year is that Merton will need to achieve an efficiency of c£15m for Merton, and £36m LDU-wide in 2018/19 in order to meet its financial targets in order to meet its financial targets. This represents a significant challenge for a healthcare commissioner within the current system levers available. Therefore we are also in discussions with our main providers on how current contractual mechanisms can be amended or adjusted to better enable the right scale of change.

In order to deliver the change required to meet this sustainability gap, providers of services will need to deliver significant service redesign on top of the already challenging financial position they face, most notably at St Georges Hospital. Furthermore, key system partners such as Local Authorities continue to face significant financial and sustainability challenges, as do many of their suppliers for example the care market. Therefore it is vital that partners in the public sector work together to achieve the change we need to make for our residents.

Community Engagement

The CCGs commissioning plans and the overarching STP have been subject to significant and ongoing community engagement with a variety of partners within the community and voluntary sector. This has ranged from engagement events on the wider STP to specific intensive engagement for particular areas of work, for example engagement with schools, families and parents in the development of services for neurodevelopment. This engagement will continue as the plans develop and consolidate. For example in Merton there will be multiple community engagements in late November and Early December with organisations such as Merton Tenants and Residents Forum, Raynes Park Community Forum and Kids First.

3) Our Commissioning Intentions

The below table summarises the commissioning intentions across the Merton and Wandsworth Local Delivery Unit. Where the intention only refers to one Borough it is indicated below.

Programme Area	Description	Quality Impact	Current Estimated Financial Impact at LDU level (£000s)
Children and Young People	Paediatric A&E streaming and increased access to ambulatory care Proactive integrated care planning for children with complex needs and LTCs, linking to borough level initiatives such as ThinkFamily Increase rapid response home visits for children 0-5, 24/7 Embed a Hospital at Home model for	Improved quality of care for children with complex needs Improved experience of care for families Fewer visits to A&E and fewer emergency	£896

	admission avoidance and early discharge Embed integrated commissioning arrangements for children with EHC plans and continuing care needs Review school based therapies service Improve community support and capacity for neurodevelopmental condition (diagnosis and support)	admissions to hospital Quicker access to services for those with urgent needs	
Primary Care and Medicines	Strengthening community provision by working (in Merton) with the Federation and CLCH to embed services within Primary Care e.g. wound care, lymphoedema and diuretics; Embedding 8-8 access to Primary Care, including roll out of direct booking for A&E and 111 Extending the scope of the pathology improvement programme to encompass additional tests The continued development and expansion of Social Prescribing models Extend of Primary Care Diagnostic Services Ensuring delivery of high quality primary care through a Primary Care Quality Contract, Protected Learning Time initiatives, use of Resilience funding and leadership of a joint CQRG for Primary Care. Improvement to primary care estates Roll out of e-consultation software and continued promotion of Patient Online.	Improved access to core primary care services More services available in primary care reducing the need for referrals Improved quality in general practice	£2,922
Planned Care	Work with primary care to ensure consistent and high quality referrals Continue to work with SGH on new care pathways in high volume specialties Expand multiple long term conditions clinic model	Reduction in referrals to hospital Reduction in outpatient activity Improvements in waiting list	£6,227

	Community triage and assessment for MSK – for Merton this means building on the already commissioned model to include self referral pathways Implementation of "Effective Commissioning Initiative" guidelines	position Decrease in inappropriate referrals and treatments	
Urgent Care	Deliver agreed "front door" A&E pathways (ambulatory care, older adults, paediatric assessment, psychiatric liaison etc) Extend frequent attenders initiative Embed safer bundle, including consultant review, EDD setting and timely discharge planning Continue to develop the 111 service in line with South West London strategy Connect London Ambulance Service with alternative care pathways	Reduction in A&E attendances Reduction in short stay admissions Reduction in ambulance callouts and conveyances to hospital	£505
Integrated Care and Older People	[Note: these schemes link to a number of initiatives within the Better Care Fund (BCF) which are not laid out in detail here. The CCG and LBM Community and Housing directorate will bring to HWBB, further details regarding the proposed 2018/19 BCF in due course] In Merton, develop a comprehensive Integrated Locality Team which will support integration between general practice, community care and social care around the most complex and frail patients in the borough (c. 300 in the first year). This will be based around current practice MDTs and will include increased access to rapid response home visits. Reduce inequality in healthcare provision to Care Homes by expanding the Care Home Nursing Team and providing an urgent nursing response for seven days a week, including out of hours, as well as levering the development of Primary Care at Scale, as an enabler	Significant reduction in emergency admissions For those that do require an admission to hospital, they can expect to get home quicker More care provided in peoples' homes	£4,861

	to delivering STP priorities Roll out of red bag scheme to cover all care homes Increase access to step up and step down intermediate care, applying HomeFirst principles Integrated Discharge Team to manage all complex hospital discharges Increase % of Continuing Care Assessments conducted in a non-clinical environment Extension of Enhanced Care Pathway /Complex Care model, including all care home residents Extension of rapid access clinics at Nelson Expansion of intermediate care packages at home Access to short term step up beds Integration of End of Life coordination and Enhanced Care Pathway Medicines use reviews		
Mental Health	Evaluation of Crisis Café and PDU to inform 18/19 investment Improve access to IAPT services Improve access to community based CAMHS crisis response Review provision of behavioural support packages CYP Expand primary care plus model Increase uptake of IAPT for people with LTCs Streamline front door pathways to support rapid access to the crisis response home treatment team (CRHTT)	Improved access to services in the community Shorter waits for services Fewer emergency attendances and admissions Improved mental health input for people with long term conditions	£375

The above schemes represents the situation as of 3rd November 2017 and unfortunately means the CCGs need to identify how to meet the residual financial gap at LDU level. This will be addressed through the following means:

- Ensuring that all schemes in the list above are fully developed and that expected benefits are fully analysed and quantified
- Review of performance, quality and benchmarking data for their areas and seek to develop additional schemes within the programmes outlined above
- Review potential for additional corporate savings through development of Local Delivery Unit for example estates and IT savings
- Review of all current contracts and spend to ensure best value

4) Provider Development

One of the key levers for delivering the plans summarised above is to develop a new way of working between community, primary and social care services in the borough. With the Community and Housing directorate of LB Merton, the CCG has established a multi-speciality community provider (MCP) Programme Board to agree priorities for service integration and the future delivery model for integrated care. This programme will look ahead to the future reprocurement of community health services between 2019 and 2021 but will also seek short-term gains, particularly in the development of the ILT model and acceleration of many of the other initiatives set out in the Integrated Care and Older People's, and Children and Young People's, plans above.

The MCP programme will be supported by ongoing work to develop the primary care sector in the borough. The CCG supports Merton Health, a federation of the Merton GP practices, which is running our pilot Referral Management Centre and provides a vehicle for Merton general practice to work together on service provision at scale. We have also supported the East Merton Primary Care Network to become an aspirant Primary Care Home, which is an innovative, nationally recognised model of collaboration between GPs to improve population health.

5) Next steps

The CCG will continue to develop its commissioning plans throughout the autumn and winter. Final Commissioning Intentions across south west London will be complete by early January 2018. Between now and the 1st April 2018 commissioning intentions will be developed into full business case proposals outlining, programme by programme, any investments or changes to current contracts can be delivered, and detailing how the benefits of these programmes translate into real quality improvements for residents, and financial savings for the health economy. At the same time, detailed contractual negotiations with providers will take place, and the CCG will be looking to ensure that financial and staffing resources are in place to start delivery of schemes as soon as possible from April 2018 onwards.

This page is intentionally left blank

Committee: Health and Wellbeing Board

Date: 28 November 2017

Wards: ALL

Subject: Diabetes Strategic Framework (Whole System Approach)

Lead officer: Dr Dagmar Zeuner, Director of Public Health & Dr Andrew Murray, Chair MCCG

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

Contact officer: Amy Potter, Consultant in Public Health / Barry Causer, Public Health Head of Strategic Commissioning & Dr Joanna Thorne, Clinical Lead, Planned Care, Merton CCG

Recommendations:

The Health and Wellbeing Board is asked to:

A. Consider the initial outline of a proposed 'whole system' strategic framework for tackling diabetes.

B. Agree, in principle, to develop and participate in the 'diabetes truth' programme through 2018, noting the fit with other planned activities with clinicians and communities to inform the development of the strategic framework.

C. Agree to support the process and governance structure, and commit representatives from their organisations to participate.

---

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of this report is to set out the approach to the development of a whole system approach to tackling diabetes. The aim is to take an innovative approach and to develop a supporting strategic framework to underpin our whole system approach, as we learn by exploring this complex issue.

1.2. This approach will build upon the excellent work already undertaken in Merton, for example on clinical management of diabetes and on a whole system approach to childhood obesity.

1.3. It will provide significant opportunity for the HWB to further refine system leadership skills, enable them to gain insight into what it is like to have diabetes and deepen the connection of the HWB to local communities, helping to shift balance of power and decision making in tackling diabetes.

2 BACKGROUND

2.1. In June 2017, the Health and Wellbeing Board agreed diabetes as a priority for 2017/18 and to adopt a whole system approach (WSA) across the life course. Rather than a focus on diabetes as a specific disease, the aim of this approach is to use it as an exemplar for a whole system preventative

approach because it lends itself to clinical, non-clinical and prevention approaches.

2.2. Diabetes is a 'complex' problem

Diabetes is an area where the traditional 'medical model' centred on specialist and hospital based care has been unable to curb the rise in diabetes cases, serious complications and spiralling costs, and despite evidence-based guidelines there remains considerable variation in hospital, primary and community services, and patient outcomes.

Where standard 'complicated' problems require expert analysis and a logical choice of solutions, truly 'complex' problems, such as tackling diabetes at scale across a population, need more experimental approaches. See Appendix 1 for a visual example of tackling a *complicated* problem (treating diabetes in an individual) compared to a *complex* problem (understanding and tackling obesity or diabetes at a system level).

Leadership theory suggests that for complex problems, new approaches need to be tried out to see how systems react, with the opportunity to safely probe, sense, respond and repeat, using learning from the results that occur to feed back into the next iteration.[1]

2.3. This approach suggests that solutions to diabetes as a complex problem will need to emerge from the HWB and the community itself rather than trying to impose them. As such, we are framing diabetes as a systems leadership challenge for the HWB, and one which requires the iterative development of a strategic framework rather than a more straightforward clinical strategy.

2.4. As part of this, we propose that the approach to developing a strategic framework will include listening to people experiencing diabetes, trying new ways of working and then learning from these, iteratively. Although solutions to complex problems cannot always be easily replicated at scale, as they often need to be bespoke, the aim of building a relationship with people experiencing diabetes is that over time we can build a movement and voice in Merton to support behaviour change at scale, with learning for the wider health economy about how best to do this.

3 DETAILS

3.1. Strategic Framework: A Whole System Approach to Diabetes

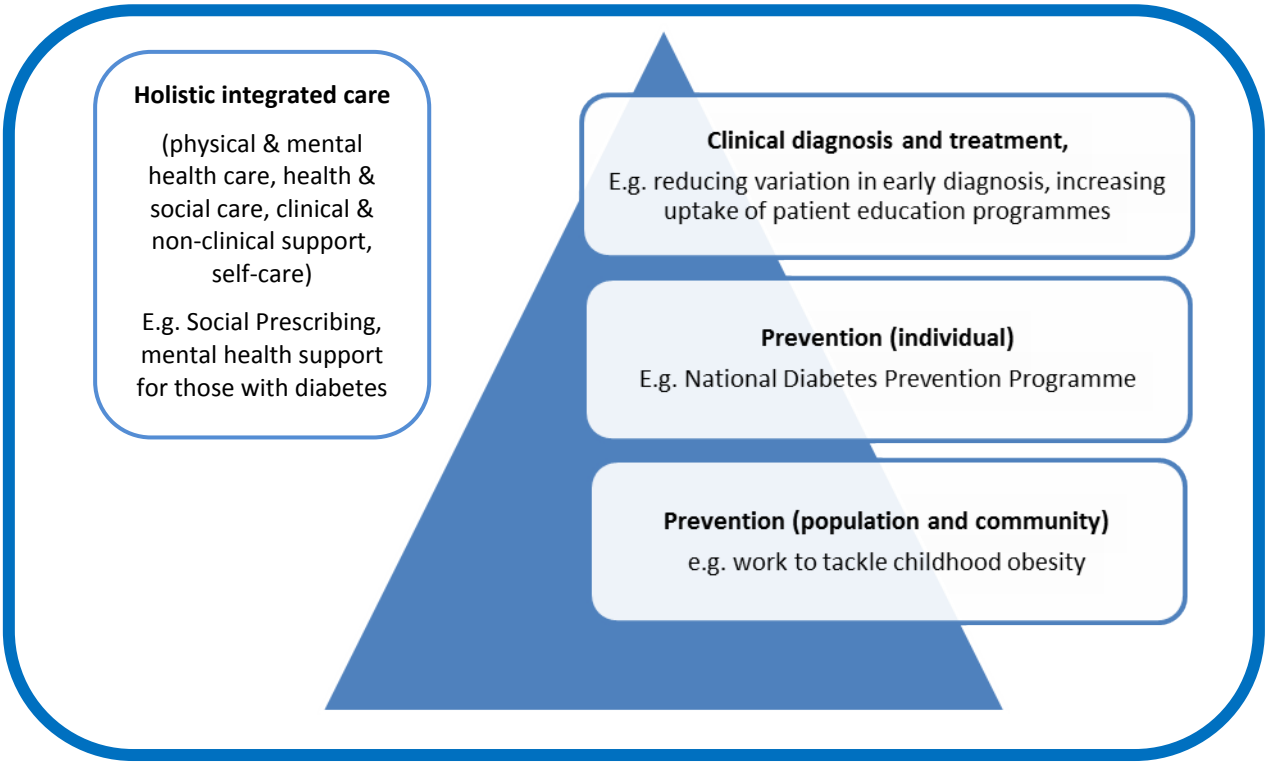
The Diabetes Strategic Framework will build on the work already undertaken in Merton to tackle diabetes. Building on the HWB work on childhood obesity and social prescribing in 2016/17, the framework will take a life course approach, span the whole health and care system, and focus on prevention and tackling health inequalities including those linked with poverty and ethnicity. It will aim to deliver behaviour change at scale, as well as improve early diagnosis and holistic integrated health and care in the community.

The strategic framework will look at where we are now, and where we want to be in terms of outcomes that matter to individuals at risk of or already with diabetes, to their families, and to the health and care system (from clinical

[1] Snowdon, DJ and Boone, ME (2007) A Leader's Framework for Decision Making. Harvard Business Review, Nov; 85 (11): 68-76, 149. https://hbr.org/2007/11/a-leaders-framework-for-decision-making

measures such as HbA1c and reduced inequalities in uptake of services, through to outcomes that the community itself defines as success measures), and how we can get there. The diagram below (Figure 1) gives a suggested outline of the different facets of a whole system approach to diabetes, but will be developed and refined over time, with the first input being the learning from the proposed leadership work of the HWB to hear from community members with diabetes, set out in this paper (Section 3.2.1).

Figure 1: Example facets of a whole system approach to diabetes



3.2. <u>Proposed approach to developing the Strategic Framework</u>

The process for the development of the framework will be an intervention in its own right, making explicit use of the different skills, experiences and roles of the member of the board as clinicians, community representatives, council officers and politicians, as well as a broader range of officers, clinicians and place shapers in the local area.

Currently, there are three main programmes of proposed work that will feed into the development of the strategic framework, and learning about 'what works', particularly thinking at scale:

- Work with HWB and individuals on a 'diabetes truth' programme: 'buddying up' with individuals with diabetes
- Work with diabetes community connectors in the South Asian community
- Work with clinicians to encourage new ways of thinking about a whole system approach to prevention, using diabetes as an exemplar

These are discussed in more detail below. Over time, as we build the learning from these pieces of work into the development of the framework, we may develop other work areas.

3.2.1 *Part one - Diabetes Truth Programme.*

The idea of a 'diabetes truth' programme is to develop the HWB's behaviour as systems leaders in addressing a complex problem, using diabetes as an example. Through insight into what it is like to experience diabetes (and what influences the behaviour that will prevent or improve conditions for people with diabetes) board members will be able to understand the true costs to those people living with diabetes, and the trade offs that they are willing to make for improved diabetes outcomes.

Funding for the programme has been secured from the Leadership Centre Local Vision to provide expert facilitation to the HWBB (by Mari Davis with whom the Board is familiar). The initial thinking is that each Board member consider 'buddying up' with a named individual, who is living with diabetes or at risk of diabetes, with the potential to form a longer-term relationship and connection with people, initially over a year. The intention is that this learning is then fed into the emerging diabetes framework and governance process.

This will help the HWB members to get a deeper understanding of the lived experience of diabetes and therefore the vulnerabilities that others might feel, the link to poverty and also how HWB and senior professionals might work with people and communities differently. What it might mean to be community led around the prevention and treatment of diabetes and how the HWB, through its organisations and teams, might mobilise people with diabetes to take action around their own health.

3.2.2 *Part two – diabetes community connectors in the South Asian community*

A further funding application has been submitted to the NHS In Place Leadership Innovation Fund. The outcome of this bid is imminent and, if successful, this work aims to broaden the connection specifically to the South Asian community to develop movement building skills to tackle diabetes (further details in supporting documents – *In Place Leadership Innovation Fund EoI - MERTON*).

3.2.3 *Part three – development workshop for clinicians*

It is also proposed, if possible within funding available, to plan development sessions with clinicians to encourage new ways of thinking about diabetes prevention, learning from the success of the LGA Prevention matters workshop in September 2017 with local Councillors and GPs.

3.2.4 There may be opportunities through this work to work with the local Academy of Public Health[2] to develop an approach (e.g. a manual or toolkit) to operationalise complex leadership challenges at work at scale.

3.3. Proposed governance for Diabetes Strategic Framework/WSA

The governance for complex problems such as a Whole System Approach to diabetes is not straightforward. Rather than introducing new governance

[2] Health Education England (HEE) Academy of Public Health for London and the South East: https://www.hee.nhs.uk/hee-your-area/north-central-east-london/our-work/working-together-across-london-south-east/academy-public-health-london-south-east

arrangements, we want to make best use of existing knowledge and structures across Merton, the LDU, SWL and pan-London. We want to make sure that there is accountability and oversight of the approach, but that there is also freedom to experiment. We propose a small steering group and inclusive reference group with HWB oversight, but appreciate the support of HWB to help us to think this through.

3.4. See Section 6 for a proposed timeframe

4 ALTERNATIVE OPTIONS

Not to develop a strategic framework to tackle diabetes.

Not to work with HWB and communities to better understand diabetes.

5 CONSULTATION UNDERTAKEN OR PROPOSED

Proposals are being developed with partners and are planned to involve partners and the community (Section 3.2).

6 TIMETABLE

Table 1: Proposed for development of Strategic Framework for WSA to Diabetes

Activity	Date
Discussion of approach at HWB	28 November 2017
HWB Focal topic – WSA Diabetes	January 2018
Launch of Whole System Approach - workshop	January 2018
Part 1: Diabetes Truth programme (Leadership Centre Local Vision)	Dec 2017 to Dec 2018
Part 2: Diabetes Community Connectors ('In Place' NHS Leadership Innovation Fund bid)	Dec 2017 to Mar 2018
Part 3: Diabetes Whole System Approach development workshop with clinicians	Early 2018
Draft Strategic Framework for Diabetes	April 2018
Implementation of a Whole System Approach	Iterative and ongoing

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Leadership Centre funding secured is specifically for HWB facilitation support

8 LEGAL AND STATUTORY IMPLICATIONS

None

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Strategic Framework is specifically aimed at tackling health inequalities.

10 CRIME AND DISORDER IMPLICATIONS

None

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

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

12.1. APPENDIX 1: Examples of complicated and complex problems

12.2. APPENDIX 2: Current work underway on diabetes

12.3. APPENDIX 3: HWB paper (20 June 2017) Proposal for diabetes to be adopted as a HWB priority 2017/18

13 BACKGROUND PAPERS

13.1. In Place Leadership Innovation Fund Expression of Interest - MERTON

13.2. Snowdon, DJ and Boone, ME (2007) A Leader's Framework for Decision Making. Harvard Business Review, Nov; 85 (11): 68-76, 149. https://hbr.org/2007/11/a-leaders-framework-for-decision-making

APPENDIX 1: Complicated vs. Complex problems[3]

'Complicated' problems require probing, analysing, and then responding with an appropriate expert solution, compared to 'complex' problems which tend to need more experimental approaches and iterative feedback loops. Complex problems tend to have the following characteristics: large number of interacting elements, interactions are non-linear, the system is dynamic, and solutions are not effective if imposed rather than emerging from the circumstances. We propose that a whole systems approach to diabetes is a *complex* rather than a complicated problem.

Figure 2: Example 'complicated' problem – a linear NICE Pathway requiring expert analysis and appropriate intervention

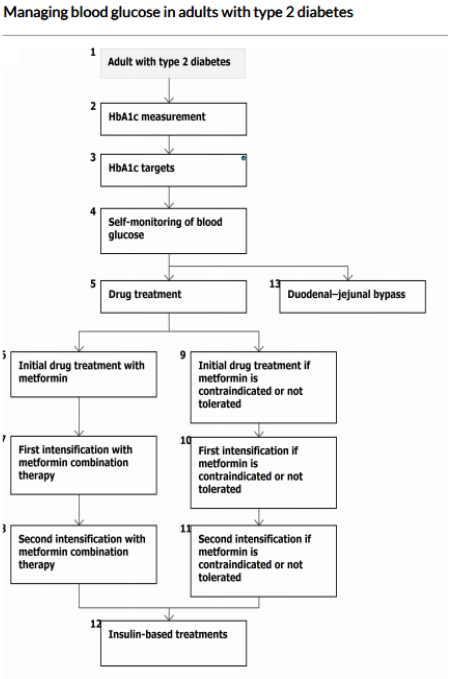
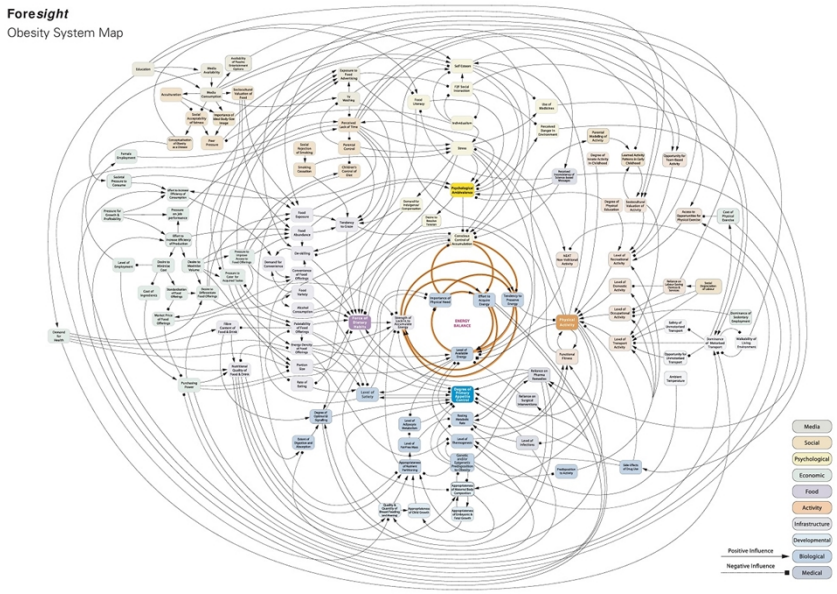


Figure 3: Example 'complex' problem – Foresight Report on Obesity 2007 (a similar picture could be drawn for a Whole System Approach to Diabetes) – making systematic change to a complex problem requires iterative experimental approaches and learning at different points across a system



[3] Snowdon, DJ and Boone, ME (2007) A Leader's Framework for Decision Making. Harvard Business Review, Nov; 85 (11): 68-76, 149. https://hbr.org/2007/11/a-leaders-framework-for-decision-making

APPENDIX 2: Current work underway on diabetes

Currently there is work underway on multiple levels, from the individual GP practice or group of GP practices, Merton Primary care level, Merton and Wandsworth Primary Care Level, and on a full SW London level. There is also work ongoing between the CCG and individual hospital trusts, so this summary is a small flavour.

Prevention (population and community)

Merton and Wandsworth Local Delivery Unit (LDU) are working in partnership with St Georges Hospital to develop a pre-diabetes pathway for patients who have been identified as a risk with 'borderline' diabetes. The pathway aims to support clinicians with giving patients good advice and directing them on to support services to try and prevent them progressing to diabetes, and also to encourage patients to engage with NHS health checks and be proactive about their health.

The work from the childhood obesity strategy that looks at encouraging people to make healthier choices is very much aligned with what is needed to prevent diabetes.

Patients who are diagnosed as being 'borderline' are then entered into a recall system to ensure they are checked annually to see whether they have progressed to diabetes. Studies show that engagement with lifestyle services such as those provided by the NDPP can prevent patients from developing diabetes, and it is important that this 'borderline' stage is not thought of as an inevitable precursor; progression to diabetes and all the resulting complications and life impact can be prevented.

Prevention (individual).

Type 2 diabetes is a leading cause of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack and stroke.

Those patients who are found to have 'borderline' diabetes can be referred into the national Healthier You: the National Diabetes Prevention Programme (NDPP) which goes live in Merton in December, and offers a combination of education about preventing diabetes and information to help reduce their risk of diabetes that will include signposting to lifestyle services e.g. weight management, exercise classes, counselling etc.

If patients cannot engage with the full NDPP there are the other public health offerings around weight management, exercise and smoking cessation (via the One You Merton service).

To ensure hard to reach diabetic patients have access to education Merton CCG is piloting a new approach to diabetes structured education (evidence is that patients who have education around their condition are much better able to manage their condition). It combines education, supported behaviour change, and self-directed learning to empower people with type 2 diabetes (T2DM) to improve their health and develop self-management skills as per any standard course but this ois offered as a series of online modules that patients can complete at a time that is convenient to them. Identified patients will have access to a Diabetes Specialist Dietician and a range of self-study learning resources.

Clinical diagnosis and treatment.

Merton CCG is focussed on improving the care of Merton diabetic patients, using the NICE guideline 9 separate care processes that each person with diabetes should have review of as a marker for quality of care.

There are clear guidelines about levels to aim for in terms of treatment targets and Primary Care reports on these and the CCG has oversight.

Where patients are more complex and need specialist intervention Merton has commissioned Central London Community Healthcare to deliver a community based diabetes service. GPs have through this service access to rapid specialist advice and review from Diabetic Consultants and Specialist Diabetic Nurses to ensure their patients receive the most appropriate treatment to manage their condition.

A certain group of particularly complex patients require hospital based care and this is provided at the three local hospitals of St George's, St Helier and Kingston depending on patient choice.

The CCG has received additional funding from NHSE to improve access to patient self management structured education (usually delivered when people are first diagnosed, but now available at any point and for top up), foot health and in-patient care. The funding has enabled St Georges and St Helier Hospitals to recruit additional diabetic nurse capacity and provide training and mentorship in partnership with London South Bank University. This additional resource will improve treatment for diabetic patients admitted to these hospitals and on discharge to their GP**.**

There is also a SWL funding bid to improve access to specialist foot care for diabetes patients. The funding has meant an increase in the number of specialist podiatrists in the area as well as the establishment of a pathfinder podiatrist to be able to help care navigate for patients and a plan in the coming year to develop a 7 day service for diabetes foot care

Merton CCG is involved with Primary Care education, both that is commissioned on a South West London basis with local provision, and with specific local design facilitated by the local CEPN. The education supports GPs and Practice Nurses to identify and support their diabetic patients well, and also aims to give strategies and options specifically for their hard to reach diabetic patients.

There is now agreed clinical management pathways around diabetes that are easily available to Primary Care and education sessions have already been run in Wandsworth and are planned for Merton early next year.

Part of the aim of the developed pathways are to support patients to self-manage their diabetes, and with education to ensure that all members of the Primary Care and Community care teams are confident and able to deliver a good standard of care. This will help to significantly reduce diabetes as a hospital outpatient specialty, as well as have an impact on the complication rates from diabetes that result from poor control.

Merton CCG reports Primary Care outcomes via the GP 'Quality Outcomes Framework' (QOF) attainment, and although there is variation amongst practices overall the area does well compared to similar other areas of London.

Standard Primary Care diabetes care involves an annual check of feet, eyes, blood pressure, cholesterol, blood sugar reading and this happens more frequently if a patient's results are not within the guideline range.

Across SWL there is work under way to try and generally improve London diabetes care and there is further education and pathway work happening at this level.

Practices are also being encouraged to engage with the National Diabetes Audit, and looking at software options that enables GPs to identify their diabetic patients that do not receive all 9 diabetic care processes.

This page is intentionally left blank

APPENDIX 3

Health and Wellbeing Board Discussion

20 June 2017

Proposal for diabetes to be adopted as a HWB Priority for 2017/18

Lead Officers: Andrew Murray, Chair, MCCG / Dagmar Zeuner, Director of Public Health, LBM

Lead member: Cllr Tobin Byers

Contact officer(s): Anjan Ghosh, Public Health Consultant, LBM

---

1 Summary

This report sets out the current status and challenges relating to diabetes in Merton, the areas that the Merton CCG and Public Health are proposing to address in 2017/18, and the opportunity to use this key disease area as an exemplar to develop a whole systems approach in Merton and potentially wider across SW London.

The report makes the case for the HWBB to adopt diabetes as a priority for 2017/18.

2 Background

A Merton Snapshot of diabetes and further information is presented in Appendices 1, 2, 3 and 4

2.1 Diabetes rates are increasing in the UK with a large cost to the NHS. In the UK around 700 people a day are diagnosed with diabetes. That's the equivalent of one person every two minutes[i]. There are an estimated 4.5 million people in the UK with diabetes[ii] of which an estimated 1.1 million are undiagnosed[iii]. It is also estimated that there are currently a further 4-5 million people in England (10.7% of the population) at high risk of developing type 2 diabetes[iv].

2.2 Type 2 diabetes usually appears in middle-aged or older people, although more frequently it is being diagnosed in younger overweight people, and it is known to affect people from BAME backgrounds at a younger age[v]. People with diabetes in the family are two to six times more likely to have diabetes than people without diabetes in the family[vi]. People from South Asian and Black communities are two to four times more likely to develop Type 2 diabetes than those from Caucasian backgrounds[vii]. Obesity is the most potent risk factor for Type 2 diabetes. It accounts for 80–85 per cent of the overall risk of developing Type 2 diabetes and underlies the current global spread of the condition[viii]. The risk of developing Type 2 diabetes can be reduced by changes in lifestyle.

2.3 In part, because of the types of risk factors described above for diabetes, it is a disease of inequalities. Lack of awareness and access to services further compound these inequalities.

2.4 People with diabetes experience disproportionately high rates of mental health problems such as depression, anxiety and eating disorders[ix].

3. DETAILS

Why is Diabetes important to the HWBB?

3.1 Diabetes is an area where the 'traditional' medical model centred on hospital based care has been unable to curb the rise in diabetes cases, complications and costs, over the last five years.

3.2 There are a number of challenges faced by the system:

- It currently cannot cope with patient numbers (and the trend is upwards)
- Not enough is being done to halt the trend
- There are increasing numbers of complex patients
- People are not empowered to manage their own condition
- There is considerable variation in process and outcomes for patients, particularly in Primary Care, but also in community and hospital care.
- Patients, who suffer from serious complications of diabetes like sight impairment / loss, amputations etc., have an impact not just on health care but also social care and carers.

3.3 Therefore the approach needs to shift to a whole system life-course approach with the added focus on prevention and tackling stark inequalities linked with poverty and ethnicity. This approach widens the scope of diabetes work to include childhood obesity, behaviour change and early diagnosis, and holistic integrated health and care in the community (spanning health and social care, physical and mental health).

3.4 Diabetes as a priority fully chimes with HWBB ethos and the HWB Strategy. In 2016/17 childhood obesity and social prescribing were priority areas for the HWBB. Both are linked very strongly with diabetes. Addressing childhood obesity is a key factor in the early years, in preventing or delaying the onset of type 2 diabetes later in life and can significantly reduce the burden of disease in the future.

3.5 Tackling diabetes offers a unique opportunity to bring together and amplify existing priorities including childhood obesity, social prescribing, East Merton Model of Health and Wellbeing (including the Wilson), health and care integration, and HIAP (including Think Family).

3.6 In 2016/17 a task group of the Healthier Communities and Older People Overview and Scrutiny Panel completed a report on 'Preventing Diabetes in the South Asian Community'. The recommendations from this report formed the basis of an action plan to improve awareness, prevention, access, early diagnosis and better management among Merton residents of South Asian

origin.
https://democracy.merton.gov.uk/mgIssueHistoryHome.aspx?IId=9112&Opt=0

3.7 Tackling diabetes also builds on the numerous strands of existing on-going work including the implementation of the childhood healthy weight action plan, scaling up the social prescribing pilot, developing the Wilson health and wellbeing offer, implementation of the national diabetes prevention programme, new provider and service model for healthy lifestyle service and health check programme, action plan for diabetes prevention in South Asian community, and planned care programme.

3.8 There is a request from the SWL Clinical Board to all HWBBs in SW London to adopt diabetes as a priority, and this will offer synergies across the region.

3.9 Diabetes fits well in the prevention framework developed in Merton, which looks across the whole system from place level solutions, to community level and individual level solutions. It is about prevention investment across the life-course and impact at scale (see appendix 5).

3.10 Diabetes is also being addressed in the SW London STP as a system exemplar for prevention because it lends itself so well to clinical, non-clinical and prevention approaches. The planned focus is 'embedding the prevention framework in policies and practice'- using local borough/CCG examples to demonstrate what this could look like. Diabetes is an example that lends itself to demonstrating impact across the whole system.

3.11 There is potential for ongoing joint work with vision leadership centre – and diabetes could be used as an exemplar.

3.12 It is recognised that the suggestion for the HWBB to adopt diabetes as a priority, is an opportunistic one rather than a systematic exercise but hoped that members will see the potential for the HWBB to make a real difference to this important issue.

4. Questions for the HWBB to consider

4.1 Does the rationale (as set out above) for diabetes as a 2017/18 priority for the HWBB make sense?

4.2 Have you any early ideas how the HWBB / partner organisations can help deliver this priority?

4.3 Do you agree diabetes as a 2017/18 priority for the HWBB?

5 Next steps

If agreed by the next step would be to develop an action plan with clarification of the roles of all partners and timelines to be reported to the HWBB.

APPENDICES

Appendix 1: Diabetes – Essential Facts

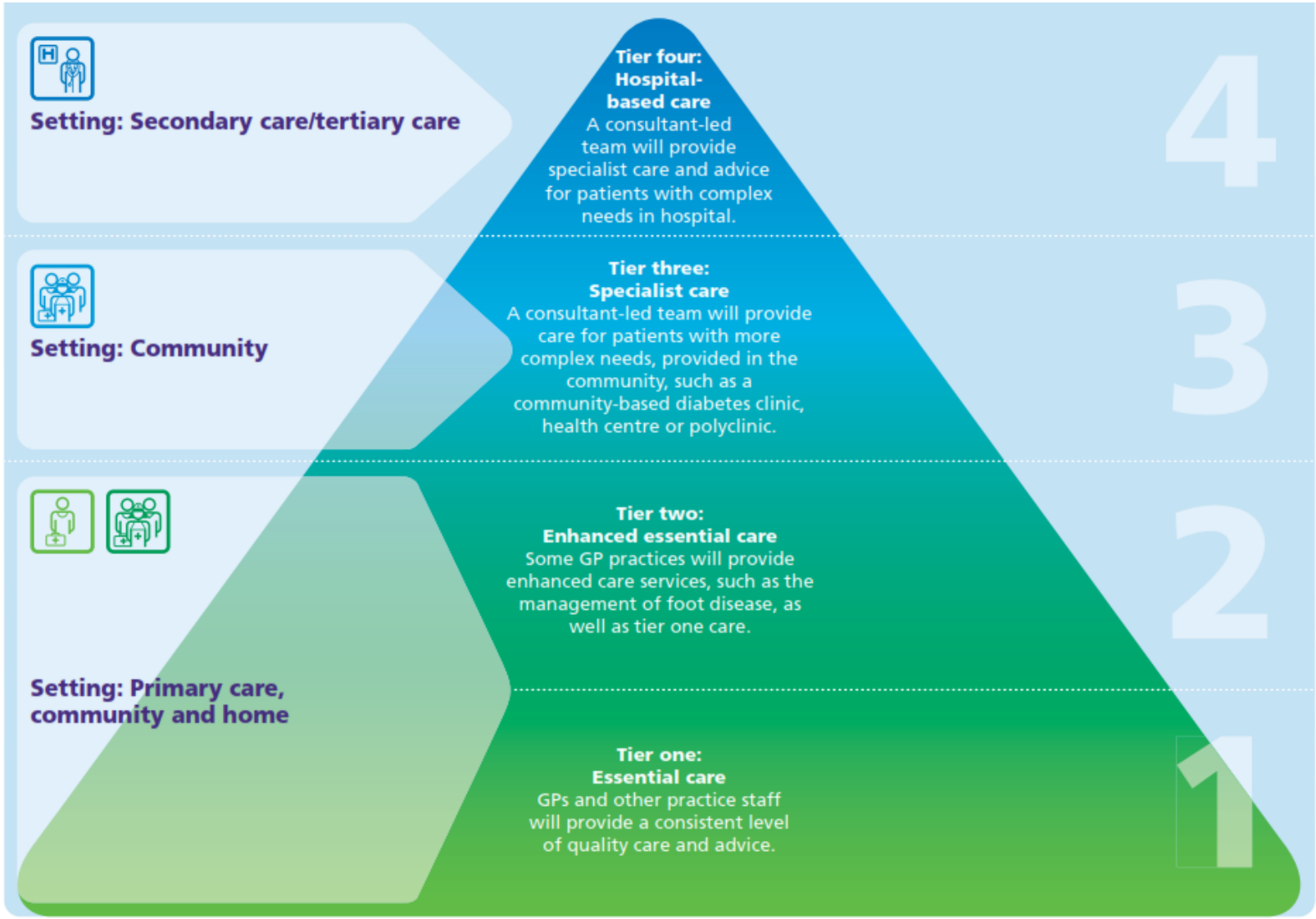
1. It is estimated that 10% of all adults and children with diabetes have Type 1 diabetes and 90% have Type 2 diabetes[x].
2. Good diabetes management has been shown to reduce the risk of complications. But when diabetes is not well managed, it is associated with serious complications including heart disease, stroke, blindness, kidney disease and amputations leading to disability and premature mortality. There is also a substantial financial cost to diabetes care as well as costs to the lives of people with diabetes.
3. It is currently estimated that about £10 billion is spent by the NHS on diabetes, which is 10 per cent of the NHS budget. This is only taking into account the NHS healthcare costs. When the total cost (direct care and indirect costs) associated with diabetes are taken into account, diabetes in the UK currently costs an estimated £23.7 billion and is predicted to rise to £39.8 billion by 2035/6[xi].
4. There is a strong evidence base for the effectiveness of diabetes prevention programmes delaying the onset of disease. The NHS Diabetes Prevention Programme (NDPP) was announced in the NHS Five Year Forward View, published in October 2014, which set out the ambition to become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to NHS Health Checks. Under the brand “Healthier You” the NDPP is a joint initiative with NHS England, Public Health England (“PHE”) and Diabetes UK which aims to deliver at a large scale services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention to reduce their weight and increase physical activity.
5. All 12 South London boroughs, encompassing all the CCGs and Local Authorities in South London (including NHS Merton CCG and London Borough of Merton) with NHS Southwark CCG as the lead organisation, entered into an MOU with NHS England to provide the NDPP across South London.
6. Once diagnosed with diabetes, all patients aged 12 years and over should receive all of the nine NICE recommended care processes. These are: the annual checks for the effectiveness of diabetes treatment (HbA1c), cardiovascular risk factors (blood pressure (BP), serum cholesterol, body mass index (BMI), smoking) and emergence of early complications (eye screening, foot surveillance and urine albumin/serum creatinine (kidney surveillance)).
7. Every year a national diabetes audit (NDA) is carried out to assess the quality of diabetes care, including the nine care processes mentioned in point 6 above, and is reported for each borough. This is predicated on the participation of, and the timely return of data from, GP Practices – in order to obtain a truly representative local picture. Merton GP Practices have been particularly poor in their participation in the NDA (see below in Merton Snapshot).
8. The diabetes model of care is based on four tiers of care provided in three settings: primary care, the community and in hospital. According to their individual needs, a

person with diabetes may receive care in all of these settings. The majority of diabetes care is currently provided in primary care and community settings; and around 80% of care will be provided in these settings in future. The four tiers of care are depicted in appendix 3.

Appendix 2: Merton Snapshot

1. 6% of adults in Merton (approximately 10,700 individuals aged 17+years) were diagnosed with diabetes in 2015/16. Current estimates indicate that around 14,300 adults have diabetes, and therefore an estimated 3,700 adults remain undiagnosed (although diagnosis rates have improved over the last 3 years).
2. The level of diabetes is projected to rise significantly locally - to 15,300 adults with diabetes in 2020 (8.3% of the adult population). The increase is due to the rise of obesity and lack of understanding of unhealthy levels of sugar consumption.
3. Although Merton has lower prevalence of adult obesity than nationally, 60% of adults in Merton are overweight or obese are at risk of developing diabetes and dying prematurely.
4. Merton has a poor ranking in meeting standards of management and control of diabetes risk factors - blood sugar levels, cholesterol and hypertension. In 2015/16, 56.7% of Merton patients were recorded as having good control of their blood sugar levels compared to 58.2% regionally and 60.1% nationally.
5. Only five out of twenty-four GP practices in Merton participated in the National Diabetes Audit (NDA) in the 2014-15 and 2015-16 rounds. In 2015-16 this was a participation rate of 20.8% compared with an England average of 81.4%.
6. The NHS Diabetes Prevention Programme (NDPP), under the brand “Healthier You”, aims to deliver at a large scale services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention to reduce their weight and increase physical activity.
7. Modelling data from Public Health England’s Health Survey estimates that there are 18,450 people living in Merton with non-diabetic hyperglycaemia, giving a prevalence of 11.0%. There are an estimated 4000 patients on GP Practice registers in Merton who have documented non-diabetic hyperglycaemia and are eligible for the NDPP.

Appendix 3: Four tiers of diabetes care (HealthCare for London)

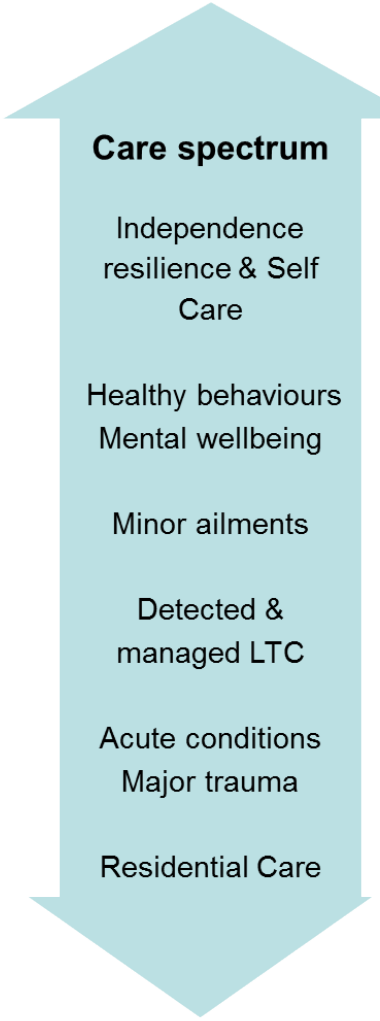


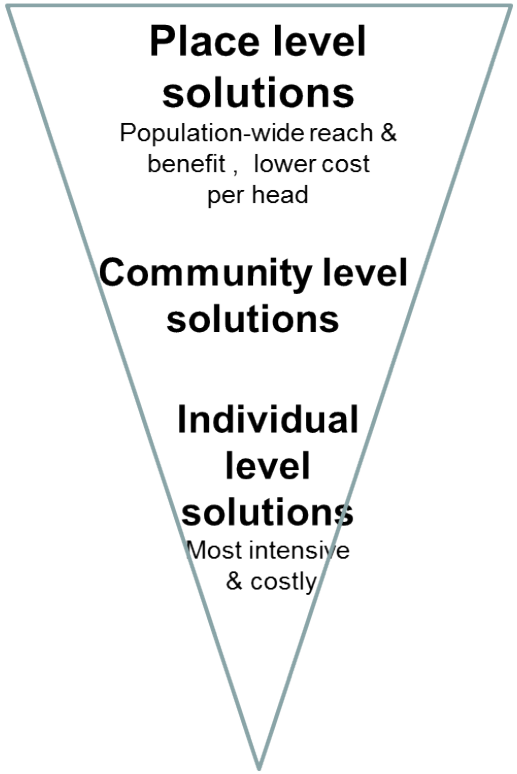
Appendix 4: Summary of existing work

1. With the development of the SW London CCG alliance and the Wandsworth-Merton LDU (Local Delivery Unit), the work on diabetes is increasingly in partnership with Wandsworth spanning across the LDU.
2. Wandsworth CCG has recently commissioned a Multispecialty Community Provider (MCP) model of delivery for their community health services, and this includes community diabetes services. This is following a number of years of project work developing the model for diabetes based on local knowledge and experience and evidence of best practice elsewhere.
3. Merton CCG has in place an established community diabetes services (since April 2016) and the priority areas for Merton are:
    a. increasing the utilisation of this service
    b. agreeing and implementing criteria for specialist input from secondary care
    c. addressing variation in primary care
    d. increasing the currently poor participation in the National Diabetes Audit
4. The different models operated in the two CCGs (including services funded for delivery in primary care) presents a challenge as there is potential for variation in quality across the two. It also offers the opportunity of sharing learning, however, to ensure the best standard of care for patients across the two CCGs.
5. In Merton, the NDPP is due to commence from June 2017 and will run a full 12 months, with the aim of referring 1200 eligible patients with non-diabetic hyperglycaemia to the commissioned nine-month lifestyle intervention service provided by Reed Momenta. This will be implemented through Merton GP Practices.
6. NHS Merton CCG and Public Health Merton are jointly addressing the recommendations ensuing from the Healthier Communities and Older People Overview and Scrutiny Panel report on ‘Preventing Diabetes in the South Asian Community’, through an action plan approved by the Panel.
7. Public Health Merton has recently recommissioned the Merton Lifestyle and Stop Smoking Services as well as the NHS Health Checks programme- with a population focussed approach to prevention and early detection. Both tie closely with the prevention and early detection of diabetes, while addressing health inequalities and equity issues through a targeted model aimed at marginalised and high priority groups.

Appendix 5: Prevention Framework (next page)

A whole systems approach to prevention





Adapted from Richmond & Kingston

Approach

Promoting healthy daily choices through environmental / social changes
e.g. Planning, active travel, community safety, licensing

Community led and owned support
e.g. healthy setting such as work place, school, high street

Social marketing

E-solutions for self-care and self-management

Individual-focused interventions
e.g. Smoking cessation, weight management, alcohol brief intervention

Appendix 6

Proposed next steps if agreed as HWBB priority

At HWB level, this is to develop an action plan with clarification of the roles of all HWB partners and timelines.

Among commissioners approach is to focus on a realistic number of defined areas over 2017/18 and deliver within the resources available, making use of a whole systems approach to amplify the impact of the work.

In 2017/18 NHS Merton CCG in partnership with other stakeholders including Public Health Merton intend to address the following areas:

i. Primary care variation in diabetes diagnosis and management, and increasing participation in the NDA

ii. Strengthening the delivery of the four tiers of diabetes care, ensuring that patients are seen at the most appropriate and least cost level of care for their need.

iii. Increasing the uptake of structured education programmes

iv. Implementing the NDPP in Merton

v. Implementing the action plan for the Healthier Communities and Older People Overview and Scrutiny Panel report on ‘Preventing Diabetes in the South Asian Community’

The intention would be to re-establish a multi-agency diabetes steering group (there was one before) hosted by the CCG and understanding the gaps between what is currently provided, and the outcomes and aims of the services in accordance with the four tiers of care. This will help to identify what is required to change over the longer term to ensure equity of service and a high standard of service provision. This programme of work requires scoping and the project work is in its initial stages.

References

---

[i] Figure based on newly diagnosed figures from the 2011/12 and 2012/13 National Diabetes Audit, extrapolated up to the whole population with diabetes indicated by the QoF data for the equivalent years and divided by two to give an annual average

[ii] Quality and Outcomes Framework (2014/15), Diabetes Prevalence Model 2016 (Public Health England) and 2012 APHO Diabetes Prevalence Model.

[iii] This figure was worked out using the diagnosed figure from the 2014/15 Quality and Outcomes Framework, the 2016 Diabetes Prevalence Model and the 2012 AHPO diabetes prevalence model.

[iv] Public Health England (2015) NHS Diabetes Prevention Programme (NHS DPP) Non-diabetic hyperglycaemia. Produced by: National Cardiovascular Intelligence Network (NCVIN)

[v] Tuomilehto J, Lindström J, Eriksson JG et al (2001). Prevention of Type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. N Engl J Med 344 (18); 1343–1350

[vi] Vaxillaire M and Froguel, P (2010). The genetics of Type 2 diabetes: from candidate gene biology to genome-wide studies, in Holt RIG, Cockram CS, Flyvbjerg A et al (ed.) Textbook of diabetes, 4th edition. Oxford: Wiley-Blackwell

[vii] Health and Social Care Information Centre (2006). Health Survey for England 2004, Health of Ethnic Minorities

Ntuk, U.E., Gill, J.M.R., Mackay, D.F., Sattar N. & Pell, J.P. (2014). Ethnic-Specific Obesity Cufoffs for Diabetes Risk: Cross-sectional Study of 490,288 UK Biobank Participants. Diabetes Care 37(9), 2500-7

Tillin, T., Hughes, A.D., Godsland, I.F., Whincup, P., Forouhi, N.G., Welsh, P., Sattar, N., McKeigue, P.M. & Chaturvedi, N. (2012). Insulin Resistance and Truncal Obesity as Important Determinants of the Greater Incidence of Diabetes in Indian Asians and African Caribbeans Compared With Europeans. The Southall and Brent Revisited (SABRE) cohort. Diabetes Care 36(2), 383-93.

[viii] Hauner H (2010). Obesity and diabetes, in Holt RIG, Cockram CS, Flyvbjerg A et al (ed.) Textbook of diabetes, 4th edition. Oxford: Wiley-Blackwell

[ix] https://www.diabetes.org.uk/Professionals/Resources/shared-practice/Psychological-care/

[x] HSCIC: National Diabetes Audit 2012/13: Report 1: Care Processes and Treatment Targets, and Scottish Diabetes Survey 2012: http://www.diabetesinscotland.org.uk/Publications/SDS2013.pdf

[xi] Hex, N., et al (2012) Estimating the current and future costs of Type 1 and Type 2 diabetes in the United Kingdom, including direct health costs and indirect societal and productivity costs. Diabetic Medicine. 29 (7) 855-862