Merton Council

Cabinet Agenda

Membership

Councillors:

Stephen Alambritis (Chair)
Mark Allison
Kelly Braund
Mike Brunt
Tobin Byers
Caroline Cooper-Marbiah
Nick Draper
Edith Macauley MBE
Martin Whelton

Date: **Monday 30 July 2018**

Time: **7.15 pm**

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

This is a public meeting and attendance by the public is encouraged and welcomed. For more information about the agenda please contact democratic.services@merton.gov.uk or telephone 020 8545 3616.

All Press contacts: press@merton.gov.uk, 020 8545 3181

Cabinet Agenda

30 July 2018

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6	Annual Public Health Report 2018: Tackling health inequalities - progress in closing the gap within Merton	21 - 124
7	Financial Report 2018/19 – May 2018	125 - 174
8	Exclusion of the public To RESOLVE that the public are excluded from the meeting during consideration of the following report on the grounds that it is exempt from disclosure for the reasons stated in the report.	
9	Cricket Green School expansion construction contract award - Exempt Appendix	To follow

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.

CABINET
25 JUNE 2018

(7.15 pm - 7.50 pm)

PRESENT: Councillors Stephen Alambritis (in the Chair), Mark Allison, Kelly Braund, Mike Brunt, Tobin Byers, Caroline Cooper-Marbiah, Nick Draper, Edith Macauley MBE and Martin Whelton

ALSO PRESENT: Councillor Edward Gretton, Joan Henry, Daniel Holden and Peter Southgate

Hannah Doody (Director of Community and Housing), Chris Lee (Director of Environment and Regeneration), Rachael Wardell (Director, Children, Schools & Families Department), Paul Evans (Assistant Director of Corporate Governance), David Keppler (Head of Revenues and Benefits) and Roger Kershaw (Assistant Director of Resources)

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies were received from the Chief Executive and the Director of Corporate Services.

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 23 May 2018 are agreed as an accurate record.

4 PREVENT TASK GROUP REPORT (Agenda Item 4)

Councillor Kelly Braund, Cabinet Member for Children's Services, introduced the report, thanking all officers and teachers of the schools involved in the Task Group and welcomed how they had embedded the values of Prevent into the heart of their curriculum, and this was echoed by the Director of Children, Schools and Families who expressed her pride in the way Merton's schools had taken on their Prevent duty.

At the invitation of the Chair, Councillor Joan Henry, Chair of the Task Group presented the report thanking all those involved, particularly the contributions of the schools.

Councillor Edith Macauley, Cabinet Member for Cabinet Member for Community Safety, Engagement and Equalities advised that the Joint Consultative Committee

with for Ethnic Minority Organisations had also contributed to the Task Group and had welcomed the recommendations and positive contributions of those involved.

Councillor Caroline Cooper-Marbiah, Cabinet Member for Education welcomed the recommendations, stressing that there was a collective responsibility to protect Merton's young people from becoming radicalised, and thanked all those involved.

The Chair thanked the Scrutiny Task Group for their valuable work and welcomed the report.

RESOLVED:

1. That the report and recommendations (attached in Appendix 1 to the Cabinet report) arising from the scrutiny review of the implementation of the *Prevent* duty in Merton's schools undertaken by the Children and Young People Overview and Scrutiny Panel be noted.
2. That the implementation of the recommendations through an action plan being drawn up by officers in consultation with the lead Cabinet Member be agreed.
3. That this action plan be submitted to the Children and Young People Overview and Scrutiny Panel for consideration.

5 SCRUTINY REVIEW OF RECRUITMENT AND RETENTION OF TEACHERS (Agenda Item 5)

Councillor Caroline Cooper-Marbiah, Cabinet Member for Education, introduced the report, thanking the Scrutiny Task Group for their efforts.

The Director of Children, Schools and Families added that the review had been initiated at the request of teachers in the Borough, and who had asked it to be recorded that a factor affecting their retention was their workloads, which the Council did not have the ability to influence, however there were some bold recommendations contained in the report and this was welcomed.

Councillor Peter Southgate, Chair of the Scrutiny Task Group, presented the report, thanking all those involved and outlining the recommendations. Whilst the review had been at the request of teachers in the borough, it was recognised that there were many other groups whose work and contribution to the borough was vital who had similar housing needs.

Councillor Martin Whelton, Cabinet Member for Regeneration, Housing and Transport thanked the Task Group for their work. He stressed the challenges which the Council faced in retention of key workers and the cost of living in the borough. There were no easy solutions, however with approximately 9000 people on the waiting list for housing, the Council had a duty to address the most acute housing need first and had to take care not to discriminate against other groups and address a number of needs across the borough.

Councillor Edith Macauley, Cabinet Member for Community Safety, Engagement and Equalities advised that school governors discuss the issue regularly when setting budgets for the year; and was grateful for the work which has been carried out.

Councillor Mark Allison, Cabinet Member for Finance advised that the issue of teachers' workloads should be recognised as one of the biggest factors in teacher retention. Cost of housing is important in a wide range of jobs and it was difficult to determine what a key worker is, as without many essential workers London would grind to a halt. The significant problems with the UK housing market was a national issue and one which needed to be addressed by central Government.

The Chair highlighted that the report did flag up the other sectors which were also in need of housing. He thanked Councillor Southgate and all those involved in the Scrutiny Review.

RESOLVED

1. That the report and recommendations (attached in Appendix 1 to the Cabinet report) arising from the scrutiny review of the recruitment and retention of teachers in Merton undertaken by the Overview and Scrutiny Commission be noted;
2. That the recommendations of the task group be responded to through an action plan to be drawn up by officers in consultation with the lead Cabinet Member.
3. That this action plan prior be submitted to the Overview and Scrutiny Commission for consideration.

6 WILLOW LANE BID RENEWAL BALLOT (Agenda Item 6)

Councillor Martin Whelton, Cabinet Member for Regeneration, Housing and Transport presented the report, highlighting the timetable and the proposals for allocating the monies which would be received.

In response to Members, officers clarified that the occupants of Connect House in Willow Lane would not be liable for business rates due to the building being converted to residential use.

The Chair welcomed the report and noted that Merton was one of the few local authorities in London which had Business Improvement Districts in industrial estates.

RESOLVED

1. That the Willow Lane Business Improvement District (BID) proposal for the renewal of the BID ballot be supported and that any future decision on the BID renewal be delegated to the Director of Environment and Regeneration after consultation with the Cabinet Member for Regeneration, Housing and Transport.
2. That the Council will charge the Willow Lane BID Board for the costs of business rates staff in collecting and administrating the levy.

3. That the Council will recover the cost of the BID renewal ballot from the proposers if the renewal ballot is unsuccessful.
4. That the Council will vote in support of the BID renewal for its own rated properties in the BID area and the voter will be the Director of Environment and Regeneration.

7 SUSTAINABLE DRAINAGE (SUDS) DESIGN AND EVALUATION SUPPLEMENTARY PLANNING DOCUMENT (SPD) (Agenda Item 7)

The Cabinet Member for Regeneration, Housing and Transport presented the report and highlighted the proposed public consultation period.

The Chair welcomed the report and the importance of the proposed Supplementary Planning Document.

RESOLVED

That a six week consultation on the Sustainable Drainage Design and Evaluation Supplementary Planning Document (SPD) be approved.

8 RENEWAL OF SHARED SERVICE ENFORCEMENT AGENT (BAILIFF) CONTRACT (Agenda Item 8)

Councillor Mark Allison, Cabinet Member for Finance presented the report, which was an example of the Council working with other boroughs in a collaborative way.

The Chair advised that the Council had reduced the use of bailiffs, but still do need to ensure that people pay their debts when appropriate.

RESOLVED

1. That the renewal of the shared Enforcement Agent (bailiff) service with Sutton council from August 2018 be agreed.
2. That authority be delegated to the Director of Corporate Services to approve and negotiate any new contract and surplus allocation for additional parking debt income collected.

9 BUDGET OUTTURN 2017/18 (Agenda Item 9)

Councillor Mark Allison, the Cabinet Member for Finance presented the report which provided a good example of the work of the Council. There was a need to recognise the pressures the Council was under from central government, however locally the Council had done a good job which had resulted in a modest overall underspend of approximately 1%.

The Assistant Director of Resources advised that pressures were increasing on front line services and officers would update Members on a quarterly basis.

The Chair thanked officers for guiding the Council through difficult times with cuts of up to 40%, and stressed that Members would continue to protect the most vulnerable in society.

RESOLVED

1. That the provisional revenue outturn for 2017/18 be noted.
2. That the outturn position on capital be noted and the slippage into 2018/19 and other adjustments detailed in Appendix 3C and section 7 of the Cabinet report be agreed.
3. That the £60,000 S106 funding for the Beddington Lane Cycle Route be approved.

10 EXCLUSION OF THE PUBLIC (Agenda Item 10)

Cabinet noted that the content of the exempt appendix contained in Item 11 would not be discussed and therefore the meeting remained in public session.

11 RENEWAL OF SHARED SERVICE ENFORCEMENT AGENT (BAILIFF) CONTRACT - EXEMPT APPENDIX (Agenda Item 11)

The Cabinet noted that the content of the exempt appendix would not be discussed; and the decision is set out under Item 8.

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Exempt or confidential report

The following paragraph of Part 4b Section 10 of the constitution applies in respect of information given in **Appendix 1** of this report and it is therefore exempt from publication. Members and officers are advised not to disclose the contents of this report:

Information relating to the financial or business affairs of any particular person (including the Authority holding that information)

Committee: Cabinet

Date: 30 July 2018

Agenda item:

Wards: Cricket Green School is located in Cricket Green Ward but serves a wider area

Subject: Expansion of Cricket Green School – contract award for construction works

Lead officer: Rachael Wardell - Director of Children, Schools and Families

Lead member: Cllr Caroline Cooper-Marbiah – Cabinet Member for Education

Contact Officer: Tom Procter – Head of Contracts and School Organisation

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Recommendations:

A. The council award the contract for the school expansion construction works for Cricket Green School as outlined in the confidential appendix 1, subject to planning permission being granted by Planning Applications Committee.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Cricket Green School is a special school for children with additional complex and varied needs. The purpose of this report is for Cabinet to approve the contract award following a competitive tender process that will allow the expansion of the school as approved by Key Decision on 20 June 2018.

2 DETAILS

2.1 Cricket Green School is an 'Outstanding' special school for children with additional complex and varied needs.

2.2 The London Borough of Merton has a legal obligation to provide sufficient school places for its area and there is a significant increase in demand for special school places and a need to assess nursery children with SEND (Special Educational Needs and Disabilities) early to ensure appropriate school pathways.

2.3 Cricket Green School provides value for money compared with non-maintained or independent special school provision and so meets the objective to provide suitable, high quality places to meet the growing number of SEND children.

2.4 The council has undertaken the statutory process of expanding the school, and the physical extension to the school is required to enable this through a new two storey building to the rear of the site and other changes to ensure the school is fit for purpose with the following objectives:

- Additional 61 places, mostly for secondary but also including providing an assessment nursery and ensuring one extra class in primary
- Replacing a life expired mobile unit currently housing 3 classrooms
- A design that externally links the flow of buildings, makes best use of external space, and allows children to move safely around the site.
- Sufficient ancillary space including enlarged hall and office space to reflect the school will have doubled in size from 130 to 260 pupils over the past 10 years

2.5 With regard to procurement strategy, the originally agreed approach was to utilise the LCP (London Construction Programme) Framework. This was on the basis that it was quicker and there is a reasonable selection of companies on the framework. However, in the mini competition only 3 of the 9 contractors returned a reasonable intention bid.

2.6 On 15 March 2018 it was therefore agreed by the officer Procurement Board to revert to an OJEU restricted tender process, with five firms to be short-listed following a Standard Selection Questionnaire (SQ) on the basis of quality, and then appointment is made in the ITT stage on the basis of price, based on itemised pricing schedules.

2.7 The process was undertaken through the ProContract London tenders portal E-tendering system. 16 responses were received and in addition to compliance questions, contractors were scored on a number of questions as follows:

- Where sub-contract healthy supply chains with your sub-contractor(s)
- Company's experience of working in a school environment.
- Company's experience and approach to working in occupied school sties with nearby residents in close proximity.
- Company's H&S management approach
- Managing the Clients financial risk, and to managing contract cost variations.
- Environmental management
- Accurate contract programming.
- Quality on site
- Value Engineering
- Environmental management policy

2.8 This enabled a short list of five suitably experienced construction companies to be selected to be invited to tender on the basis of compliance and price.

2.9 The tender documents were issued to five companies on 25 May 2018 for return on 28 June 2018. While it was considered that four weeks was sufficient time to submit a tender, the detail of representation from a number of the

companies selected led officers to decide that to receive the most financially advantageous tenders it was necessary to extend the return date to 12 July 2018.

2.10 The confidential appendix details the tender returns.

3 ALTERNATIVE OPTIONS

3.1 The alternative options of procurement by framework or OJEU is detailed in the section above.

3.2 The issues on expanding the school and alternative options were considered in the school expansion Key Decision report agreed by the Director of Children, Schools and Families on 20 June 2018.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.4 The expansion of the school was subject to a statutory consultation as outlined in the Key Decision report (see section 12 “Background Papers” of this report for a link to that report).

5 TIMETABLE

5.1 The works will commence shortly after this approval (subject to planning permission). A phased approach is required to ensure the school can continue to operate during the construction works but the main phase is planned to be completed for September 2019 to enable the school to provide for the additional pupils.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Finance

6.1 The capital budget implications are contained in the confidential appendix.

6.2 With regard to revenue funding for school placements, if this scheme does not proceed the council would still have a statutory obligation to provide a school place for the children and, without any places in its special schools, it would need to be Independent special school provision. The average cost per place for an Independent day-provision is over £45k when the cost for Cricket Green is £13k to 21k. There is therefore a significant financial incentive to provide sufficient in-house provision, in addition to the need to provide continuity for the children. Costs are currently charged to the Dedicated Schools Grant (DSG) which is a fixed government grant.

6.3 The council’s General Fund needs to meet the cost of home to transport for children. Officers have demonstrated that this cost is considerably less expensive when transporting to a LB Merton state funded special school compared to an independent or out borough school. This expansion will therefore reduce the impact on home to school transport costs from additional SEN children.

Property

6.4 Since 2010 Cricket Green has expanded incrementally from 130 pupils to the agreed new capacity for September 2019 of 260 places. Its previous expansion has been enabled by the purchase of a former Doctor's Surgery and utilising the council building Chapel Orchard. This expansion will continue to permanently utilise these buildings and a small segment (675m²) of Worsfold House land. Before proceeding with the design of the school options were considered and this option was considered best value for money while providing a design that provided sufficient space for the school pupils.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1 This report details a procurement that appears to be compliant with the advertising and tendering requirements of the Public Contracts Regulations 2015.

7.2 Provided that the award is made in manner that is compliant with valid award criteria and that the relevant notifications are made to the relevant parties including the unsuccessful tenderers and contract award notice the award should meet all lawful requirements for procurement.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1 Additional school places at Cricket Green School will contribute to the Authority providing access to secondary school places for all its residents, including children with special educational needs (SEN).

9 CRIME AND DISORDER IMPLICATIONS

9.1 There are no specific crime and disorder implications

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1 The scheme does not currently have planning permission. Due to workload pressures Development Control officers were not able to take it to the July Planning Applications Committee as expected but have undertaken that it will go to 23 August committee. Due to the call-in period for Cabinet reports and the Alcatel period for OJEU contracts this will only delay of the contract award by a few days, should planning permission be granted.

10.2 All capital schemes have a financial risk but the scheme is recommended to be awarded with a contingency.

10.3 Health and safety is being considered carefully to ensure there will be a clear separation between pupils, teachers and parents and construction works, especially in the context of a working school.

10.4 The project is being managed under project management methodology and a risk log is held and reviewed at project board meetings.

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

11.1 Appendix 1 (exempt – to follow)

12. LINKED DOCUMENTS

12.1 Key Decision report for Prescribed alteration of the Cricket Green School:

https://merton.moderngov.co.uk/ieDecisionDetails.aspx?id=595&LLL=0

13 BACKGROUND PAPERS

13.1 None

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Committee: Cabinet

Date: 30th July 2018

Agenda item:

Wards: Borough wide

Subject: Local Implementation Plan 3

Lead officer: James McGinlay

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

Contact officer: Chris Chowns chris.chowns@merton.gov.uk

Recommendations:

A. Note the approval process for LIP3 as outlined in the report.

B. Note the overarching MTS outcomes, draft borough trajectories and overall approach for developing LIP3

C. Note the delivery timescales set by TfL for delivering LIP3

D. That the Director of Environment and Regeneration is given delegated authority to finalise the Council's LIP after consultation with the Cabinet Member.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out the primary objectives of the Mayor's Transport Strategy (MTS) that the council is legally required to deliver as part of its next Local Implementation Plan (LIP3), together with a broad outline of key milestones and approval process. It is also the principal funding mechanism for transport and public realm related interventions across the borough.

1.2 Members are invited to note and comment on the contents of the report, more specifically on the broad approach to delivering LIP3. In order to support Healthy Streets (TfL's new concept), it is anticipated that borough priorities will continue to place cycling and pedestrian movement at the centre of Merton's next delivery plan.

1.3 Members are also asked to give the Director of Environment and Regeneration delegated authority in consultation with the Cabinet Member to finalise the Plan after consideration of public consultation comments.

2. DETAILS

2.1 Effective from April 2019 the LIP must contain:-

- A list of potential schemes to 2041;
- Delivery Plan including a costed and funded indicative programme for the 3-year period 2019/20 to 2021/22 with commentary and risks;
- A borough assessment of the impact of initiatives contained in TfL business Plan;
- Funding sources for all LIP initiatives e.g. borough capital, s106, CIL;
- Targets against mode share, MTS & local outcome indicators;

- Borough commitment to monitor delivery indicators;
- Strategic Environmental Assessment (SEA).

2.2 TfL will monitor progress in delivering the MTS through a new Annual Borough Report combining TfL and borough metrics and data. It will also summarise total investment across borough and TfL programmes. The report will form part of a delivery and outcome "health check".

2.3 The previous LIP set the Council's delivery programme for the 5-year period 2013/14 to 2018/19. Over the period it received the following funding from TfL. Allocations are generally formula based in accordance with an agreed set of attributes and metrics:

Year	Corridors (000)	Maintenance (000)	Major Scheme Funding (000)	Local Transport funding (000)	Total (000)
2014/2015	1,511	573	0	100	2,184
2015/2016	1,500	637	2,000	100	4,237
2016/2017	1,511	570	1,100	100	3,321
2017/2018	1,551	455	1,300	100	3,406
2018/2019	1,550.1	0	150	100	1,800.1
Total					14,948.1

Note - In addition to the annual LIP allocation the council is also able to bid for addition funding allocated to specific programmes set by the Mayor or Department for Transport

2.4 Following the loss of government grants from 2018/19, TfL funding for principal road maintenance is currently suspended. Likewise Corridor funding for 2018/19 has only been reinstated to the previous year's level following extensive borough lobbying. Funding will therefore be dependent on future TfL budget savings. TfL has inferred that Merton's LIP allocation for the 2-year period 2019-2021is likely to be reduced. Looking ahead this represents a significant delivery risk.

Mayors Transport Strategy

2.5 The MTS maps out the strategic direction for transport in London. It was adopted on 13th March 2018 and sets out three priority areas for delivery; these are:-

- Heathy Streets and heathy people (including traffic reduction strategy);
- A good public transport experience;
- New Homes and Jobs;

2.6 It also sets an overarching aim that 80 per cent of all trips in London will be made on foot, by cycle or using public transport by 2041. This compares to a London average of 63 per cent and 58 percent average in Merton. To achieve this goal will require a sweeping change in our approach as to how we manage the highway network and overall policy approach to encourage the necessary shift to sustainable modes.

2.7 Outer London Boroughs typically have a poorer access by public transport therefore the Mayor's expectation in achieving this aim may be lower. Indeed the attached draft outputs and trajectories state a 73% figure (see Appendix 1).

However, this still represents a considerable challenge when set against a growing trend in travel demand and population growth.

2.8 Another core theme running through the MTS is Healthy Streets and Healthy people. This seeks to create streets and street networks that encourage walking, cycling and public transport. Furthermore it seeks to reduce car dependency and associated health and road safety problems.

2.9 The Healthy Streets approach takes a public health look at the street environment and sets out 10 high level indicators that help to make a street work better. These centre around the experience of what it feels like to be on a street. They include things to see and do; places to stop; shade and shelter; clean air; pedestrians from all walks of life; easy to cross; people choosing to walk and cycle; quiet; feeling safe and relaxed.

2.10 When linked with reducing the dominance of motor traffic and targeting the sources of road danger, these themes will help delivery the Mayor's Vision Zero objective that "no one to be killed in or by a London bus by 2030 and for deaths and serious injuries from all road collisions to be eliminated from the streets by 2041".

2.11 The nine core outcomes of the MTS are listed below:

Heathy Streets and healthy people (including traffic reduction strategy)

- 1- London's streets will be healthy and more Londoners will travel actively
- 2- London's streets will be safer and more secure.
- 3- London's streets will be used more efficiently and have less traffic on them.
- 4- London's streets will be clean and green.

A good public transport experience

- 5- The public transport network will meet the needs of a growing London.
- 6- Public transport will be safe, affordable and accessible to all
- 7-Journeys by public transport will be pleasant, fast and reliable.

New Homes and Jobs

- 8- Active, efficient and sustainable travel will be the best option;
- 9-Transport investment will unlock the delivery of new homes and jobs

2.12 In recognising the resource and funding constraints, the Council's approach is to develop a programme that focuses on cycling and walking infrastructure, whilst exploring complimentary approaches to create the right environment to nudge people towards making more sustainable travel choices. More assertive approaches could include:-

- Develop demand management measures via a car parking reduction strategy.
- Supporting multi-operator/model car clubs and other emerging on-demand services, such as on demand mini buses.
- Facilitating the trial and roll out of dock-less cycle hire schemes (multi-operator).
- Re-designing streets to shift priority to active modes and public transport

- Re-allocating road space from parking to other uses;
- Support for bus priority measures
- To develop a Liveable neighbourhood scheme (formally Major schemes) submission, e.g. Pollards Hill or Eastfields areas.
- School start and finish time road closures close to primary schools to support a healthier and safer environment for children.
- Explore wider demand management measures e.g. Workplace parking levy (WPL).

2.13 The consideration of WPL could provide an alternative borough funding boost to support an accelerated LIP investment programme, including contributions toward major infrastructure projects, such as a rapid transport system and dedicated infrastructure.

2.14 It is clear that to reduce car use will require a radical change in thinking, especially winning over residents and businesses to new concepts. It is therefore essential to communicate ideas and potential benefits effectively and in a positive way, possibly through a number of schemes showcasing what could be achieved.

3. Delivery Time Table

3.1 Transport for London delivery milestones are set out below:-

- Draft LIP to TfL and other consultees 2 November 2018
- TfL response to LIP December 2018
- Final Draft to TfL 16th February 2019
- Mayoral Approval March 2019.

4. Approval Process

4.1 In order to meet the above milestones it is recommended that the council follows the approval process outlined below:

4.2 Based on the nine core MTS outcomes and draft 3-year delivery programme, it is intended to seek delegated authority for the Director of Environment & Regeneration in consultation with the Cabinet Member to make any necessary changes and sign off the draft/final LIP.

- Sustainable Communities Overview & Scrutiny Panel 9th January 2019

4.3 The LIP represents the boroughs' principal funding stream for delivering transport lead improvements in the borough. There are a number of delivery risks both in terms of future funding allocations from TfL and indirect impacts on staff resources. Real term reductions in funding allocations should be planned for over the period up to 2020.

5. LEGAL AND STATUTORY IMPLICATIONS

5.1 The Greater London Authority Act 1999 (GLA Act) requires each borough to prepare a LIP containing its proposals for the implementation of the Mayor's Transport Strategy.

6. Public Consultation and Communication

6.1 The council is required to undertake a public consultation with statutory Consultee and other stakeholders as the London Mayor considers appropriate. These include TfL, Police, appropriate mobility organisations and neighbouring London boroughs.

6.2 For local engagement it is anticipated that a comprehensive list of stakeholders would be prepared based on the Estates Plan consultees or as advised by the councils' communications team.

6.3 This will be undertaken at the draft LIP submission stage in early November 2018. This will utilise various social media and internet platforms.

7. Staff resources

7.1 Previous LIPs have been staff resource intensive. The new guidance for LIP3 has been comprehensively revised to reduce this burden. However, it still represents a significant undertaking within limited resources.

7.2 TfL has stated they are not willing to let key milestones slip, despite many boroughs expressing concerns.

8. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

8.1 No support funding has been provided by TfL so delivery is dependent on limited internal resources.

9. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

9.1 The delivery and approval milestones have set a demanding timetable. Any referrals beyond that already envisaged or change in policy at a late stage could result in the final sign-off by TfL/Mayor being delayed.

9.2 Competing projects across the Future Merton team are vying for the same staff resource. Any departure in meeting project milestones will require an alternative delivery approach to be agreed with TfL. As a last resort, TfL could take over preparation of the LIP, which may not be in alignment with the Borough's priority.

10. Alternative options

10.1 In the event the council fails to deliver an acceptable Local Implementation Plan, TfL have powers to intervene, which may not prove beneficial for the Borough.

11. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

11.1 None for the purpose of this report

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

- Appendix 1 – Draft Merton delivery Output and trajectories.

BACKGROUND PAPERS

None for the purpose of this report

Appendix 1

Draft Merton Mayor's Transport Strategy Outcome Indicators			Metric	Observed	2021 trajectory	2041 trajectory
Overall aim: 80% walking, cycling and public transport		Overall aim: Londoners' trips to be on foot, by cycle or by public transport	2014/15 to 2016/17	58%	60%	73%
Healthy Streets and Healthy People	Outcome 1: London's streets will be healthy and more Londoners will travel actively	Outcome 1a: Londoners to do at least the 20 minutes of active travel they need to stay healthy each day	2014/15 to 2016/17	36%	43%	70%
		Outcome 1b: Londoners have access to a safe and pleasant cycle network	2014/15 to 2016/17	3%	29%	50%
	Outcome 2: London's streets will be safe and secure	Outcome 2: Vision Zero - Deaths and serious injuries from all road collisions to be eliminated from our streets	KSI (Killed & Seriously Injured) 2016	44	26	0
	Outcome 3: London's streets will be used more efficiently and have less traffic on them	Outcome 3a: Reduce the volume of traffic in London	2016 Annual Vehicle Km (millions)2016	578	5% drop 570 10% drop 570	542 513
		Outcome 3b: Reduce the number of freight trips in the central London morning peak	NA	NA	NA	NA
		Outcome 3c: Reduce car ownership in London	2016	78,497	73,800	72,500
	Outcome 4: London's streets will be clean and green	Outcome 4a: Reduced CO2 emissions	2013	131,100	117,200	29,900
		Outcome 4b: Reduced NOx emissions	2013	480	190	20
		Outcome 4c: Reduced particulate emissions (PM10)	2013	48	39	21
		Outcome 4d: Reduced particulate emissions (PM2.5)	2013	27	19	11
A Good Public Transport Experience	Outcome 5: The public transport network will meet the needs of a growing London	Outcome 5: Increase public transport use	PT trips 2014/15 to 2016/17	130 (000)	147 (000)	212 (000)
	Outcome 6: Public transport will be safe, affordable and accessible to all	Outcome 6: Everyone will be able to travel spontaneously and independently	2015 time difference between full network & Step free network	10	tbc	3
	Outcome 7: Journeys by public transport will be pleasant, fast and reliable	Outcome 7: Bus journeys will be quick and reliable, an attractive alternative to the car	2015 bus speed (mph)	10	10.4	11.5
New Homes and Jobs	Outcome 8: Active, efficient and sustainable travel will be the best option in new developments	There are no outcome indicators for this outcome				
	Outcome 9: Transport investment will unlock the delivery of new homes and jobs	There are no outcome indicators for this outcome				

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Committee: Cabinet

Date: 30 July 2018

Agenda item:

Wards: All

Subject: Annual Public Health Report 2018: Tackling health inequalities – progress in closing the gap within Merton

Lead officer: Dagmar Zeuner, Director of Public Health

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

Contact officer: Samina Sheikh (Principal Public Health Intelligence Specialist) samina.sheikh@merton.gov.uk, Clarissa Larsen (Health and Wellbeing Board Partnership Manager) clarissa.larsen@merton.gov.uk

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Recommendations:

Cabinet is asked to:

A. Receive the attached Annual Public Health Report (APHR) 2018 on Health Inequalities and endorse it for publication.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

There is a statutory duty for the Director of Public Health to produce an independent Annual Public Health Report (APHR) which forms part of the wider Joint Strategic Needs Assessment (JSNA). The purpose of this paper is to share with Cabinet the final draft of the APHR 2018: *Tackling health inequalities - progress in closing the gap within Merton.*

The report aimed to measure progress in closing the gap of inequalities in Merton. Analysis of the available data showed this was not straight forward; this report therefore seeks to clarify meaning, definitions and measures of health inequalities. It provides analyses of trends over time, proposes measures to monitor future progress and summarises evidence of what works to reduce inequalities, as a resource for Councillors, officers and partners.

DETAILS

2. The topic was selected for a number of reasons:

- It is a longstanding aim of the Merton Council and its partners to 'bridge the gap' between the east and west of the borough, addressing the disadvantage that some communities face.
- Closing the gap in health inequalities was the overarching aim of the Health and Wellbeing Strategy (HWBS) 2015-2018; and this analysis is central to impact monitoring, and to informing the refresh of the Health and Wellbeing Strategy 2019-2024.
- Analysis and recommendations from this APHR will also inform other strategic work underway in health and social care, including the development of the Local

Health and Care Plan, the developing Merton Prevention Framework, and the development and evaluation of the East Merton model of health and wellbeing centred on the Wilson site.

- There is synergy with the continued focus on health inequalities in London, including the new draft refresh of the Mayor's Health Inequality Strategy.

3. The APHR 2018 aims to provide a reference for officers, partners and residents to understand what we mean by inequalities, specifically health inequalities, but also the underlying drivers of differences in health outcomes between different groups – inequalities in the social determinants of health such as poverty, education and employment.

   The purpose of the APHR 2018 is to inform a shared understanding of where we are now, how far we have come in 'bridging the gap' between the most and least deprived, and how we might best approach and monitor health inequalities in future.

4. The APHR 2018 is split into the following sections:

   Part 1: an overview of what we mean by inequalities, specifically health inequalities; how we measure them; and what we know works to tackle them.

   Part 2: what we know about health inequalities in Merton over time (using a selection of health-specific indicators and others that represent the social determinants of health), and description of the methodology used to analyse the inequality gap.

   Part 3: a summary of what we can learn from this piece of work to take forward into the HWBS refresh and other strategic work.

5. The APHR 2018 is complemented by a Supplementary Data Report with additional graphs and analysis which is also attached to this report.

Key Issues in the Annual Public Health Report

6. We know that there are inequalities between the east and the west of the borough, but this is the first time that we have looked systematically at the scale and trend in inequalities in Merton. This process has shown that it is more complex to monitor health inequalities than it first appears, and has helped identify an approach to more effectively track inequalities going forward.

7. APHR analysis shows that inequalities are evident in every indicator we studied, the vast majority of which show a worse picture in the most deprived areas, as we would expect. Recent supplementary analysis from Public Health England (PHE) reveals that the top three health indicators most strongly associated with deprivation in Merton are emergency hospital admissions; childhood obesity; and hospital stays for alcohol-related harm.

8. These cumulative inequalities – which are evident throughout different life stages and in the environment within which our residents live – contribute to the overarching inequalities in health outcomes that we see in the significant differences in life expectancy of 6.2 years for men and 3.4 years[1] for women

[1] These figures are from the national 'Slope Index of Inequality' indicator which looks at inequalities in life expectancy at birth between the 10% most and 10% least deprived areas in a borough. Governing Body may be aware that these are different

between the most and least deprived areas. Inequalities in healthy life expectancy are even starker, with a difference of 9 years of healthy life between most and least deprived areas.

9. In terms of trend in inequalities in Merton, the picture is mixed. There are some success stories, for instance the reducing gap between the most and least deprived areas in life expectancy for women, in school readiness, and in the proportion of the economically active population claiming Jobseeker's Allowance, and the apparent reduction in the Child Poverty gap. However, the majority of indicators either show the inequality gap to be stable over time, to be increasing, or to be reducing for the 'wrong' reasons (for instance because the situation for those in more affluent areas appears to be worsening whilst that for those in the more deprived areas remains stable, narrowing the gap). It is evident from this analysis that inequalities in Merton are intransigent, and we need to keep them under review over a longer time frame.

Recommendations

10. The analysis confirms that health inequalities are persistent, complex and difficult to shift. In order to make progress, we have to actively and systematically target them through a long-term, multi-sectoral approach, across all partners. If we take our eye off the ball, health inequalities are likely to increase. Therefore we need to continuously monitor progress and review our approach over time.

Recommendations for tackling health inequalities in Merton:

11. In order to reduce the steepness of the social gradient in health outcomes, a 'proportionate universalism' approach should be adopted, meaning that population-wide action is vital, but that universal interventions should be undertaken with a scale and intensity that is proportionate to the level of disadvantage. Action needs to be taken across the whole life course so that all Merton residents can start well, live well and age well.

12. Whilst recognising the role of personal prevention approaches to improve health (e.g. support for individuals to stop smoking), the evidence shows that we need to rebalance our efforts towards population level prevention. This recognises both the increased cost-effectiveness of interventions at population level compared to personal level interventions, and the evidence of increased impact on health inequalities.

13. Approaches must be underpinned by participatory decision-making and co-design, empowering individuals and communities.

Recommendations for monitoring health inequalities in Merton:

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figures for the gap in life expectancy than previously reported, for instance through the JSNA 2013/14 which gave a figure of 9 years for men and 13 years for women. The APHR (Box 3, Chapter 1) gives a detailed explanation of the changes to the data, trend and methodology behind the figures, and why we recommend the use of this Slope Index going forward, as the headline life expectancy indicator.

14. A standardised methodology should be used across Merton to be able to effectively monitor inequalities and progress. We recommend that the methodology set out in the attached APHR Part 2.2 is adopted across the Merton Partnership.

15. We need to be realistic about timescales in which we can expect changes to the inequality gaps in Merton. Different types of interventions will take different amounts of time to demonstrate impact. When setting targets, we need to be explicit about the timescales within which we expect to see changes in metrics, and that these timeframes are likely to differ from local and national political cycles, requiring coordinated action over time. This is discussed in more detail in the APHR Part 1.

16. Because some of the longer term health outcomes will take time to address, when developing a set of indicators to monitor progress through strategies such as the HWBS or the NHS's Local Health and Care Plan (covering 3-5 year time periods), it will be important to consider an underpinning logic model or theory of change. This can include shorter term 'proxy' measures that can help to suggest if change is occurring in the right direction. This is discussed in more detail in the APHR, Part 3.

17. The summary indicator table in APHR Part 5 highlights some of the indicators we think would be most useful. This includes measures of inequalities in life expectancy, deprivation, education, employment (taking into account the changes to benefits with the introduction of Universal Credit by 2020), and a selection of key healthy lifestyle and disease indicators for children and adults.

18. Merton Public Health will feed back to PHE about the availability of sub-borough indicator data in easy to use formats, to inform their ongoing support to public health teams. We will also respond to the Government's consultation on Universal Credit metrics, to ensure data supports monitoring of inequalities over time.

19. ALTERNATIVE OPTIONS

None

20. CONSULTATION UNDERTAKEN OR PROPOSED

APHR will be professionally designed, and published as part of the Merton JSNA website, and disseminated widely through officers, members and partners.

21. TIMETABLE

The APHR was taken to Health and Wellbeing Board and MCCG Governing Body as set out in the timetable below. Following Cabinet, it will be professionally designed, and published in August 2018 as part of the Merton JSNA website.

We also plan to produce a single page of highlights from the Annual Public Health Report in infographic, easy read format and share this widely.

Action	**Date**
HWBB –received and endorsed publication	26 June 2018
MCCG Governing Body – received and endorsed publication	04 July 2018
Cabinet – to be received and endorsed for publication	30 July 2018

Design and typesetting (TA2 design agency)	July/August 2018
Print / launch / disseminate report and supporting materials	August/Sept 2018
Produce and design a page of highlights in infographic form and disseminate widely	August/Sept 2018

22. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report. Implementation of the recommendations of the APHR is based on delivery within existing resources by changing ways of working of the Council and partners rather than new investment.

23. LEGAL AND STATUTORY IMPLICATIONS

Producing an independent APHR is a statutory duty of the Director of Public Health under section 12 of the Health and Social Care Act 2012 looking at the health of the Borough engaging the community and health professionals with key issues affecting the local area. The duties are explained in the House of Commons report, "Local authorities' public health responsibilities (England)" dated 13 March 2014 and the Department of Health's "Directors of Public Health in Local Government – roles, responsibilities and context" dated 2012. General statutory responsibilities of local authorities are also imposed by Sections 1-7 of the Care Act 2014 including individual wellbeing, preventing needs for care and support, and the integration of care and support with health services.

24. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The APHR focuses on health inequalities – with analysis of the current picture of inequalities in Merton, and recommendations on how to monitor them and how to address them in Merton.

It aims to support LBM to deliver its Public Sector Equality Duty obligations under the Equality Act 2010, which means that we need to pay due regard to equality and inclusion issues in all of our decision making.

25. CRIME AND DISORDER IMPLICATIONS

None

26. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

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

APHR 2018: Tackling health inequalities – progress in closing the gap within Merton

APHR 2018: Supplementary Data Report

BACKGROUND PAPERS

None

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Annual Public Health Report 2018: *Tackling health inequalities - progress in closing the gap within Merton*

Contents

Foreword

Dr Dagmar Zeuner, Director of Public Health

I am delighted to present my independent annual report on the health of the population of Merton, in fulfilment of my statutory duty as Director of Public Health.

This report addresses one of the central public health issues – tackling health inequalities, and specifically, progress in closing the gap within Merton.

The aim was to measure progress in closing the gap of inequalities in Merton but analysis of the available data showed this was not straight forward. This report therefore seeks to clarify meaning, definitions and measures of health inequalities. It provides analyses of trends over time, proposes measures to monitor future progress and summarises evidence of what works to reduce inequalities, as a resource for Councillors, officers and partners.

The findings confirm that inequalities in Merton are persistent, complex and difficult to shift and we need to actively and systematically target them, working with all our partners to make an impact. The data provides a clear basis of our new Health and Wellbeing Strategy and can provide a wider reference and resource to support our joint efforts to tackle inequalities helping us to measure our continuing efforts in closing the gap

I am grateful to my team and many colleagues from the Council, Merton Clinical Commissioning Group and other organisations for their support and contributions. These efforts are much appreciated – on top of everybody's busy daily work – and result in a more informed and collaborative output. We are keen to make our annual report as useful for partners as possible. Please email public.health@merton.gov.uk with any feedback you might have.

Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health & Chair of Merton Health and Wellbeing Board

As the Cabinet Member responsible for public health I commend this annual report of our Director of Public Health.

Tackling inequalities, 'bridging the gap' between the east and west of Merton, is at the heart of what we do as a Council and addressing health inequalities is a major part of this and a core aim of Merton Health and Wellbeing Board.

As resources tighten it is especially important to understand where health inequalities exist, to measure progress in narrowing the 'gap' and identifying what works in trying to tackle inequalities. Some progress is evident and this report is helpful in highlighting the issues involved in effectively measuring change. However, the continuing gap in life expectancy between the most and least deprived areas of 6.2 years for men and a gap for healthy life expectancy of 9 year demonstrate that inequalities in Merton remain intransigent. Action needs to be taken across the whole life course so that all Merton residents can start well, live well and age well.

Merton Health and Wellbeing Strategy, which we are refreshing from 2019, will form a core part of our work to reduce health inequalities. This report provides a sound evidence base for the strategy. The data will help inform, not only our policies, but also the type of indicators we use to measure how effective our work is in future.

The solutions are multiple and wide-ranging and the only way to face the challenge of health inequalities head on, is for us to work in partnership for, and with, the communities and residents of Merton.

Dr Andrew Murray, Chair of Merton Clinical Commissioning Group

As the Chair of Merton Clinical Commissioning Group and a local GP, I see first hand the consequences of health inequalities and know that we need to work together to address the discrepancy between some of our communities in Merton.

The NHS has an important role to play and we must work collaboratively with communities and partners across Merton to co-create sustainable preventative solutions. Our work to develop a new model of health and wellbeing in the east of the borough around the Wilson is a key focus of this and we hope this will have a direct impact on health inequalities across Merton.

I commend the publication of this annual public health report. It is a useful resource and provides a strong focus on the role we can all play in tackling this challenge.

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May 2018

EXECUTIVE SUMMARY

Context

This Annual Public Health Report (APHR) looks at health inequalities in Merton – the current picture and progress in closing the gap. This topic was selected for a number of reasons:

- It is a longstanding aim of the Merton Partnership to 'bridge the gap' between the east and west of the borough, addressing the disadvantage that some communities face;
- Our Public Sector Equality Duty obligations under the Equality Act 2010 mean that we need to pay due regard to equality and inclusion issues in all our decision making. Analysis in this report aims to support the Council and partners to meet this duty;
- Closing the gap in health inequalities was the overarching aim of the Health and Wellbeing Strategy (HWBS) 2015-2018; and this analysis is therefore central to impact monitoring, and to informing the refresh of the HWBS 2019-2024;
- Analysis and recommendations from this APHR will also inform other strategic work underway in health and social care, including the development of the Local Health and Care Plan, the developing Merton Prevention Framework, and the development and evaluation of the East Merton model of health and wellbeing centred on the Wilson site;
- There is synergy with the continued focus on health inequalities in London, including the refresh of the Mayor's Health Inequality Strategy.

Purpose

The APHR 2018 aims to provide a reference for officers, partners and residents to understand what we mean by inequalities, specifically health inequalities but also the underlying drivers of differences in health outcomes between different groups – inequalities in the social determinants of health such as poverty, education and employment.

The purpose of the APHR 2018 is to inform a shared understanding of where we are now, how far we have come in bridging the gap between the most and least deprived using some key indicators, and how we might best approach and monitor health inequalities in future.

The APHR 2018 is split into the following sections:

- Part 1 gives an overview of what we mean by inequalities, specifically health inequalities; how we measure them; and what we know works to tackle them;
- Part 2 outlines what we know about health inequalities in Merton over time (using a selection of health-specific indicators and others that represent the social determinants of health), and describes the methodology used to analyse the inequality gap.
- Part 3 concludes with a summary of what we can learn from this piece of work to take forward into the HWBS refresh and other strategic work.

The APHR 2018 is complemented by a *Supplementary Data Report* with additional analysis.

Summary of key findings

This APHR on Health Inequalities has investigated some of the key inequality gaps between the most and least deprived communities in Merton that impact on health outcomes. It casts new light and produces clear evidence to show a sustained gap in health and wellbeing across communities in Merton and provides robust data, on which our plans and policies can build, to address these inequalities.

- We know that there are inequalities between the east and the west of the borough, but this is the first time that we have looked systematically at the scale and trend in inequalities in Merton over time. This process has shown that it is more complex to monitor health inequalities than it first appears, and has been very useful to identify an approach that will help us to effectively track inequalities going forward.

- APHR analysis shows that inequalities are evident in every indicator we studied, the vast majority of which show a worse picture in the most deprived areas, as we would expect. Recent supplementary analysis from Public Health England (PHE)[1] reveals that the top three health indicators most strongly associated with deprivation locally are emergency hospital admissions; childhood obesity; and hospital stays for alcohol-related harm.
- These cumulative inequalities – which are evident throughout different life stages and in the environment within which our residents live – contribute to the overarching inequalities in health outcomes that we see in the significant differences in life expectancy of around 6.2 years for men and 3.4 years for women between the most and least deprived areas.[2] Inequalities in *healthy* life expectancy are even starker, with a difference of more than 9 years of healthy life between most and least deprived areas.
- In terms of trend in inequalities in Merton, the picture is mixed. There are some success stories, for instance the reducing gap between the most and least deprived areas in life expectancy for women, in School Readiness, and in the proportion of the economically active population claiming jobseeker's allowance (JSA), and the apparent reduction in the Child Poverty gap. However, the majority of indicators either show the inequality gap to be stable over time, to be increasing, or to be reducing for the 'wrong' reasons (for instance because the situation for those in more affluent areas appears to be worsening whilst that for those in the more deprived areas remains stable, narrowing the gap). It is evident from this analysis that inequalities in Merton are intransigent, and we need to keep them under review over a longer time frame.

The data gathered and analysis undertaken here will help inform the Merton HWBS which is being refreshed for 2019. This work represents the opportunity to act to address the identified inequalities by focusing on early intervention and a Health in All Policies approach.

As the analysis confirms that health inequalities are persistent, complex and difficult to shift, in order to make any progress, we have to actively and systematically target them through a long-term multi-sectoral approach across all partners; if we take our eye off the ball, health inequalities are likely to increase. Therefore we need to continuously monitor progress and review our approach over time

Recommendations for tackling health inequalities in Merton

A. Recommendations for tackling health inequalities in Merton

- We have Public Sector Equality Duty obligations under the Equality Act 2010, which means that we need to pay due regard to equality and inclusion issues in all of our decision making. The analysis in this APHR suggests that in order to make progress on closing the inequality gap in Merton, we need to actively and systematically target inequalities through a long-term multi-sectoral approach across all partners. This action should be based on detailed understanding of our population need, as set out in the Joint Strategic Needs Assessment (JSNA), and grounded in evidence of what works (discussed in more detail in Part 1).
- Whilst recognising the role of personal prevention approaches to improve health (e.g. support for individuals to stop smoking), the evidence shows that we need to rebalance our efforts towards population level prevention, recognising both the increased cost-effectiveness of interventions at population level compared to personal level interventions, and the evidence of increased impact on health inequalities.

[1] PHE Health Inequalities Briefing for Merton, March 2018 (relevant findings included in this APHR)

[2] These figures are from the national 'Slope Index of Inequality' indicator which looks at inequalities in life expectancy at birth between the 10% most and 10% least deprived areas in a borough. Readers may be aware that these are different figures for the gap in life expectancy than previously reported, for instance through the JSNA 2013/14 which gave a figure of 9 years for men and 13 years for women. See Box 3 in Chapter 1 of this report for an explanation of the changes to the data, trend and methodology behind the figures, and why we recommend the use of this Slope Index going forward, as the headline life expectancy indicator.

- In order to reduce the steepness of the social gradient in health outcomes, the evidence shows that a 'proportionate universalism' approach should be adopted, meaning that population-wide action is vital, but that universal interventions should be undertaken with a scale and intensity that is proportionate to the level of disadvantage. Action needs to be taken across the whole life course so that all Merton residents can start well, live well and age well.
- In order to be effective, the evidence shows that approaches must be underpinned by participatory decision-making and co-design, empowering individuals and communities.
- The Health and Wellbeing Strategy to be refreshed from 2019 will form a core strand of Merton's strategy to reduce inequalities, and will seek to address the health inequalities issues identified in this report through the approaches outlined above.

B. Recommendations for monitoring health inequalities in Merton

- The detailed analysis in this APHR will inform the suite of indicators for the HWBS from 2019. We want these indicators to be challenging, but also realistic and robust so that they give the Health and Wellbeing Board (HWBB) and partners a clear picture of how effectively we are working to tackle health inequalities. This will involve identifying indicators that can be scrutinised at sub-borough level to look at inequalities within Merton, and which enable tracking of change over time. The summary indicator table (Section 5) highlights some of the indicators we think would be most useful, including measures of inequalities in life expectancy, deprivation, education, employment (taking into account the changes to benefits with the introduction of Universal Credit by 2020), and a selection of key healthy lifestyle and disease indicators for children and adults.
- We need to be realistic about timescales in which we can expect changes to the inequality gaps in Merton to occur: different types of interventions will take different amounts of time to demonstrate impact. When setting targets, we therefore need to be explicit about the timescales within which we would expect to see changes to different metrics, and that these timeframes are likely to sit outside any local and national political cycles, requiring coordinated action over time. This is discussed in more detail in Part 1.
- Because some of the longer term health outcomes will take time to address, when developing a set of indicators to monitor progress through strategies such as the HWBS or the NHS's Local Health and Care Plan (covering 3-5 year time periods), it will be important to consider an underpinning logic model or theory of change, in order to choose shorter term 'proxy' measures that can help to suggest if change is occurring in the right direction. This is discussed in more detail in Part 3.
- A standardised methodology should be used across Merton to be able to effectively monitor inequalities and progress towards closing the gap, and we recommend that the methodology set out in this report (Section 2.2) is adopted across the Merton Partnership.
- Although this APHR has focused on place-based deprivation-linked inequality (using most/least deprived wards, or East/West gap), this is not the only way in which data should be broken down to look at inequalities: where possible it is important to look at inequalities by age, sex, ethnicity and other protected characteristics.
- It is important to measure inequalities in a standardised way, but this report highlights some important limitations in the data available which make measurement of inequalities challenging. In particular, many nationally available health and wellbeing indicators are only available at borough not ward level which does not enable analysis of sub-borough health inequalities, do not have timely data available, or lack historic data which means that we cannot analyse the trend in inequalities over time. Given this, Merton Public Health will feed back to PHE about the availability of sub-borough indicator data in easy to use formats, to inform their ongoing support to local authority public health teams. We will also respond to the government's consultation on Universal Credit metrics, to ensure data supports monitoring of inequalities over time.

INTRODUCTION AND CONTEXT

The first priority of the Merton Partnership Community Plan is working to bridge the gap between the east and west of the borough and between different communities.

This Annual Public Health Report (APHR) aims to provide a reference for officers, partners and residents to understand what we mean by inequalities, specifically health inequalities but also the underlying drivers of differences in health outcomes between different groups – inequalities in the social determinants of health such as poverty, education and employment.

It aims to inform a shared understanding of where we are now, how far we have come in bridging the gap between the most and the least deprived areas in Merton for some key indicators, and how we might best approach and monitor health inequalities going forward.

It is a statutory duty for the Health and Wellbeing Board to produce a joint Health and Wellbeing Strategy (HWBS), based on the Joint Strategic Needs Assessment. The current Merton Health and Wellbeing Strategy 2015-2018 is coming to an end, and one aim of this APHR is explicitly to help inform the choice of indicators for the development of the Health and Wellbeing Strategy refresh from 2019.

This report is split into the following sections:

PART 1	Gives an overview of what we mean by inequalities, how we measure them, and what we know works to tackle them.
PART 2	Looks at what we know about health inequalities in Merton now and over time, and describing the methodology used to conduct inequality gap analysis, and using some key indicators to give an indication of the complex picture.
PART 3	Discusses what we can learn from this piece of work to take forward into the HWBS refresh and other strategic work such as the Local Health and Care Plan.

1. PART 1: WHAT DO WE KNOW ABOUT HEALTH INEQUALITIES?

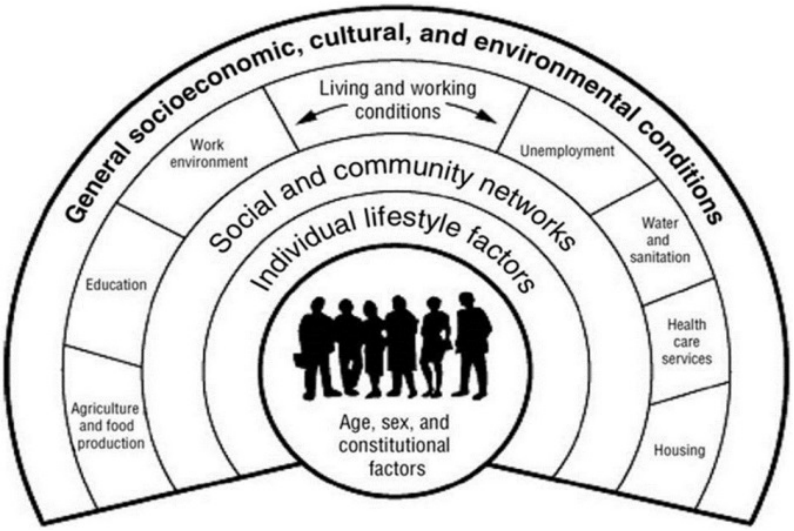
1.1. What do we mean by 'health inequalities'?

Health inequalities are unfair and avoidable differences in health status or the distribution of health determinants between different groups of people or communities.[3][4] Inequalities in health are driven by inequalities in society – "the conditions in which people are born, grow, live, work, and age."[5]

Therefore this report looks at both health inequalities themselves (such as differences in life expectancy between the most and least deprived areas in Merton), as well as at inequalities in these broader determinants of health, such as poverty, education and employment.

There are many aspects of inequality that could be analysed, for instance by age, sex, ethnicity or other protected characteristics, but in this report, we focus on comparing geographic inequalities (between the East and the West of the borough) and/or socioeconomic inequalities (between the most and least deprived areas). In Merton, there is significant correlation between socioeconomic inequalities and geography, with the east of the borough being more deprived than the more affluent west.

Figure 1: Dahlgren & Whitehead diagram: determinants of health and wellbeing



In 2008, Professor Sir Michael Marmot chaired an independent national review to propose the most **effective evidence-based strategies for reducing health inequalities** in England. The resulting report, 'Fair Society Healthy Lives' (2010) concluded that:

- **Health inequalities result from social inequalities** – the 'causes of the causes' or social determinants such as education, employment and living conditions. The result is a clear social gradient in health across society.
- This was demonstrated nationally by the **significant inequalities in life expectancy**, with those living in the poorest areas in England dying on average 7 years earlier than those in the richest areas at the time of the report.
- The more shocking finding was that **people in poorer areas not only die earlier but live more of their shorter lives in poor health** – on average living 17 years more of their lives with a disability than those in richer neighbourhoods (Figure 2).

[3] World Health Organisation glossary http://www.who.int/hia/about/glos/en/index1.html
[4] PHE (2017) Reducing health inequalities: system, scale and sustainability
[5] Marmot Review (2010) Fair Society Healthy Lives

- However, the good news is that **health inequalities are not inevitable or immutable** – they *can* be prevented and rolled back, through coordinated action across all the social determinants of health, and across all sectors of society not just the most disadvantaged. This approach is called '**proportionate universalism'** – taking action **across the whole population** at sufficient scale and intensity to be universal but at the same time with effort **proportionately targeted** to particular groups in order to reduce the steepness of the social gradient in health inequalities over time (Figure 3).

Figure 2 – Life expectancy and disability free life expectancy at birth, persons by neighbourhood income level, England 1999-2003 (Source: Fair Society, Healthy Lives, 2010)

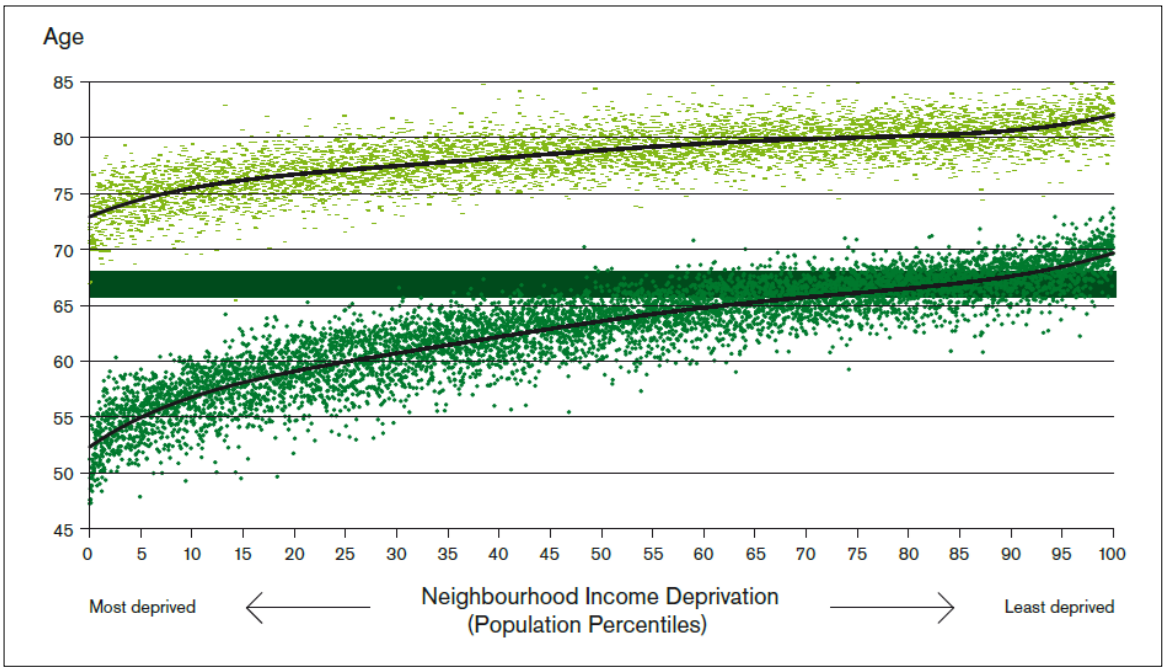
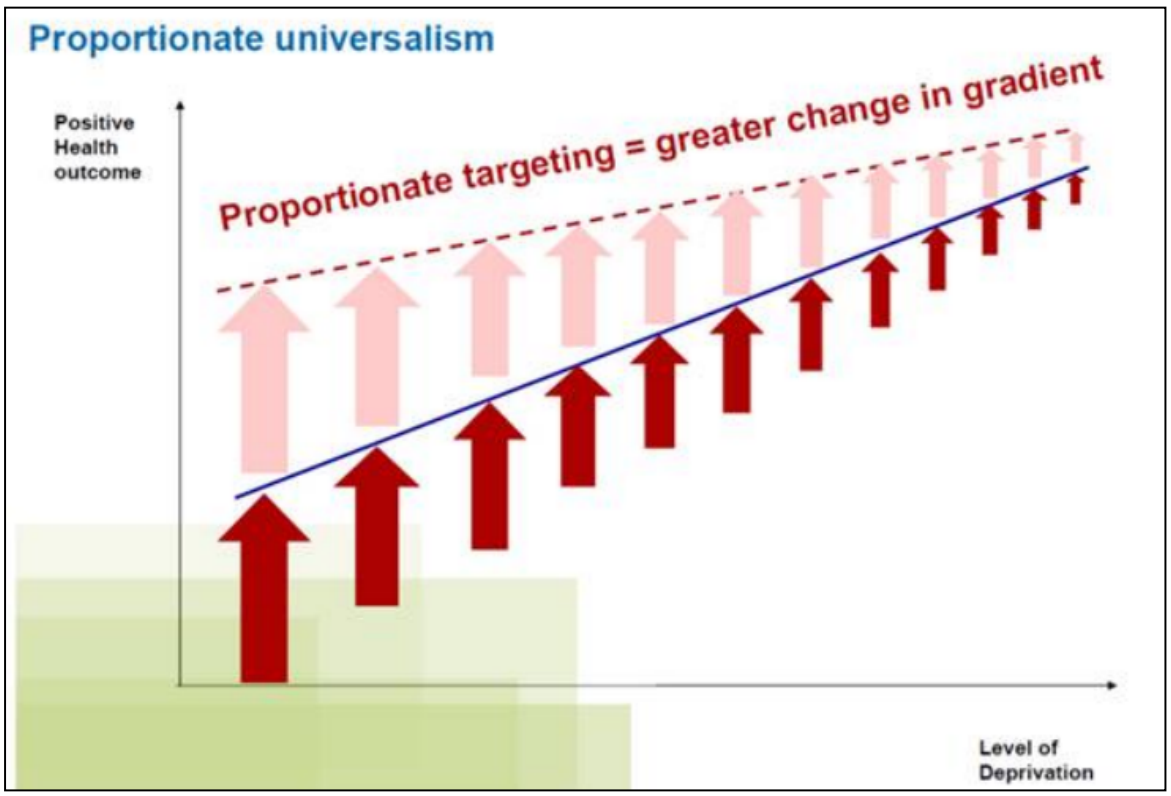
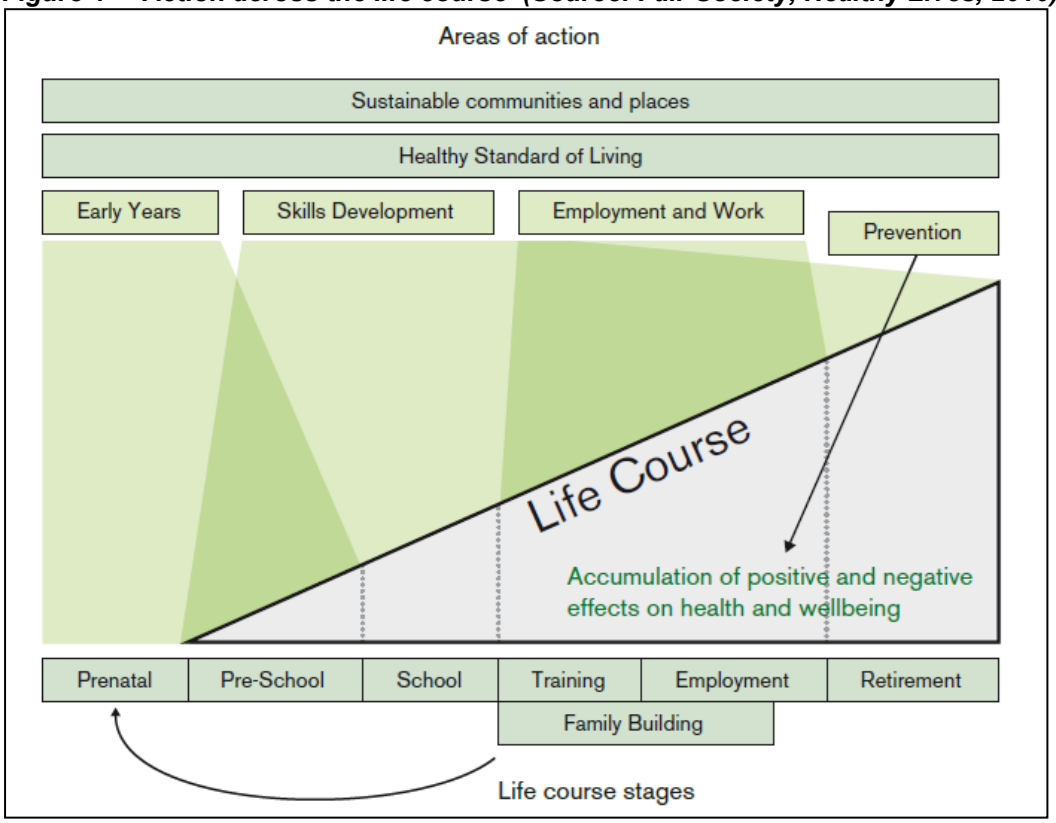


Figure 3 – Proportionate universalism: acting across the social spectrum to change the health outcomes and reduce inequalities (Source: UCL Institute of Health Equity)



- The evidence set out in the Marmot Review also suggests that in order to shift health inequalities, **action needs to be taken across the life course**, even starting pre-conception, taking into account the accumulation of positive and negative effects on health and wellbeing throughout an individual's life (Figure 4). Marmot's six priority areas for action are given in Appendix 3.
- Marmot concluded that **reducing health inequalities is vital to a productive economy**, and that there is significant cost of inaction. Specifically, the Marmot Review estimated that inequality in illness can lead to productivity losses of between £31-33 billion per year, as well as the cost of lost taxes and higher welfare payments.

Figure 4 – 'Action across the life course' (Source: Fair Society, Healthy Lives, 2010)



The most recent national data from Public Health England shows that over the past 15 years, **both life expectancy and healthy life expectancy in England have increased**, with the general population on average living longer and spending more years in good health. However, life expectancy has increased by more years than healthy life expectancy and so the average number of years lived in poor health has also increased.[6] The data also shows that despite the long term trend of improvement in life expectancy and other headline indicators, stark inequalities remain. There has been **little change in inequalities** in male life expectancy, male and female healthy life expectancy and premature cancer mortality between the most and least deprived tenth of areas. For female life expectancy, there has been a small widening of the gap between the most and least deprived areas.[7]

However, there is some evidence that a targeted and coordinated cross-government and NHS approach in some deprived areas **may be showing some impact** on inequalities.[8]

[6] PHE (2017) Health Profile for England https://www.gov.uk/government/publications/health-profile-for-england
[7] PHE (2017) Health Profile for England: Chapter 5 – inequality in health https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health#trends-in-health-inequality
[8] BMJ (2017) Investigating the impact of the English health inequalities strategy: time trend analysis http://www.bmj.com/content/358/bmj.j3310

1.2. How we measure and interpret inequalities

Absolute versus Relative inequality

We can measure either absolute or relative inequalities. Relative inequality looks at ratios, or *proportional* differences between groups (an example is the internationally used Gini co-efficient which looks at income inequality); absolute inequality reflects the *magnitude* of differences between groups. Both are useful measures, but when thinking about tracking health inequalities in Merton in this report, we have concentrated on looking at the absolute rather than the relative gap as it is easier to interpret.

In this report, we look at the absolute gap between the most and least deprived communities in Merton. The specific methodology used, and how the use of most/least deprived communities aligns with East/West Merton, is set out in Section 2.2.

Box 1 – Absolute vs. Relative inequality: an example

Consider someone in East Merton with an income of £10,000 compared to a West Merton resident with an income of £100,000. The *relative inequality* is 1:10, and does not change if these incomes both rise to £20,000 and £200,000 respectively (i.e. the ratio remains the same, 1:10). However, the *absolute* gain to the resident in West Merton of a doubling in salary is much larger than the gain to the resident in East Merton - £100,000 compared to £10,000, shown by the increase in the absolute inequality gap, from £90,000 to £180,000.

Interpreting changes in inequalities

We have to be careful when interpreting headline statistics, as an overall 'reduction' in inequality (for example, a narrowing of the absolute gap) may not be due to improved circumstances or outcomes for the most disadvantaged, but actually due to worsening or flat-lining outcomes in more affluent groups. This is demonstrated by a recent report from the Institute for Fiscal Studies on living standards which shows that the gap between the UK's richest and poorest households has narrowed since the 2007-08 recession, but that some of this narrowing has been driven by falls in the incomes of middle and top earning households, many of whom are employed in hardest hit financial and insurance sectors.[9] This apparent 'reduction in the inequality gap' is not a positive outcome, and would not be a good news story for Merton residents.

Inequalities may also appear to shift if there are significant population changes over time in an area. For instance, inward migration of more affluent groups with better health status into an area over time, e.g. as a result of new developments, or outward migration of more deprived groups with worse health status e.g. due to lack of affordable housing may *appear* to improve data on inequalities, but will not actually represent a real terms benefit for local residents. An understanding of the local population demographics and how they are changing over time is vital when interpreting changes to inequalities data.

It is also important to note that inequalities are often entrenched and will take time to shift, so we need to be planning for coordinated action beyond local and national political cycles.

What we want is for *everyone's* health and wellbeing to improve but that of the poorest to improve *fastest*. As the evidence set out by Marmot shows, the best way to do this is through a 'proportionate universalism' approach. This approach is supported by the National Institute for Health and Care Excellence (NICE): "*Tackling the social gradient in health requires a combination of both universal (population-wide) and targeted interventions that reflect the level of disadvantage and hence, the level of need.*"[10]

[9] IFS (2017) Living standards, poverty & inequality in the UK https://www.ifs.org.uk/publications/9539
[10] NICE 2012 Health Inequalities and Population Health https://www.nice.org.uk/advice/lgb4/chapter/Introduction

1.3. What we know works to tackle health inequalities

So, to make sufficient progress at a population level on inequalities in health outcomes, such as inequalities in life expectancy and healthy life expectancy, the evidence tells us that sustainable and systematic action must be delivered at scale in the following ways:[11]

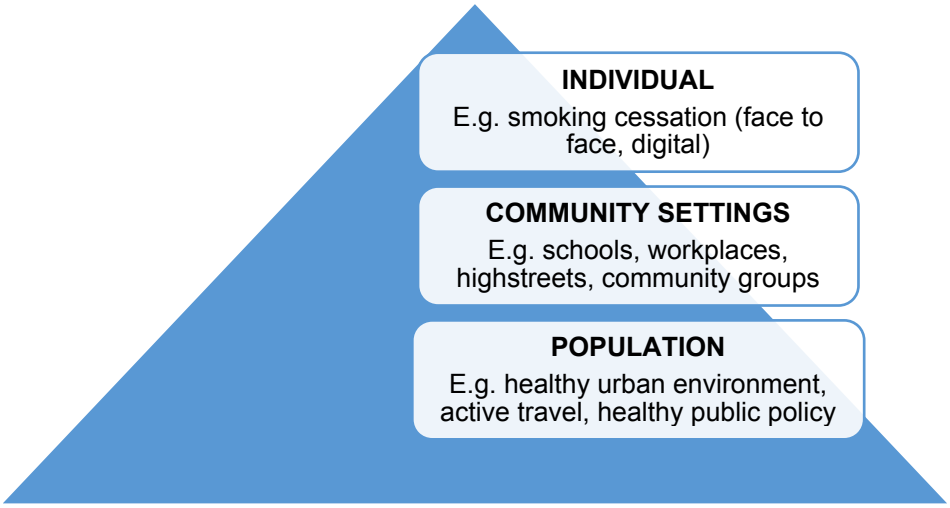
A. Intervening for population level impact

We know that in order to have an impact at population level, we need to take action at individual, community and population levels – separately, these are all important, but a combination of actions across these different levels will lead to greater impact. For example:

- *Individual level*: smoking cessation services delivered through primary care;
- *Community settings:* Health Champions and other peer support for healthy behaviours within community groups; health promoting environments and policies within schools, workplaces, high streets;
- *Population*: adopting a Health in All Policies approach across partners to influence the structural obstacles to good health, for example though healthy public policy (legislation, taxation, welfare etc) and a healthy urban environment.

This tiered approach in Merton underpins our developing 'Prevention Framework' (Figure 7).

Figure 7 - Merton Prevention Framework (Source: Merton Public Health)



At an individual level, there is evidence of the importance of the role that health and care services can play, in particular **primary care and community services**, in reducing inequalities, especially as people grow older with multiple morbidities..[12]

The evidence also shows that, whilst recognising the role of individual level approaches to improve health, it is important to **rebalance our efforts towards population level prevention** and efforts to address the social determinants of health, recognising both the increased cost-effectiveness of interventions at population level compared to personal level interventions, and the evidence of increased impact on health inequalities.[13]

[11] PHE (2017) Reducing health inequalities: system, scale and sustainability
[12] NHS Reducing health inequalities resources: https://www.england.nhs.uk/about/equality/equality-hub/resources/evidence/
[13] McDaid, D, Sassi, F & Merkur, S (2015) Promoting Health, Preventing Disease: The Economic Case. World Health Organisation: http://www.euro.who.int/__data/assets/pdf_file/0006/283695/Promoting-Health-Preventing-Disease-Economic-Case.pdf?ua=1

We also know that we need to take a strategic and coordinated approach, with **interventions that are evidence-based, outcomes orientated, systematically applied, scaled up appropriately, appropriately resourced, and sustainable**.

In order to be effective, approaches must also be underpinned by effective participatory decision-making and co-design of interventions at local level, through **empowering individuals and local communities.**[14]

B. Intervening at different levels of risk

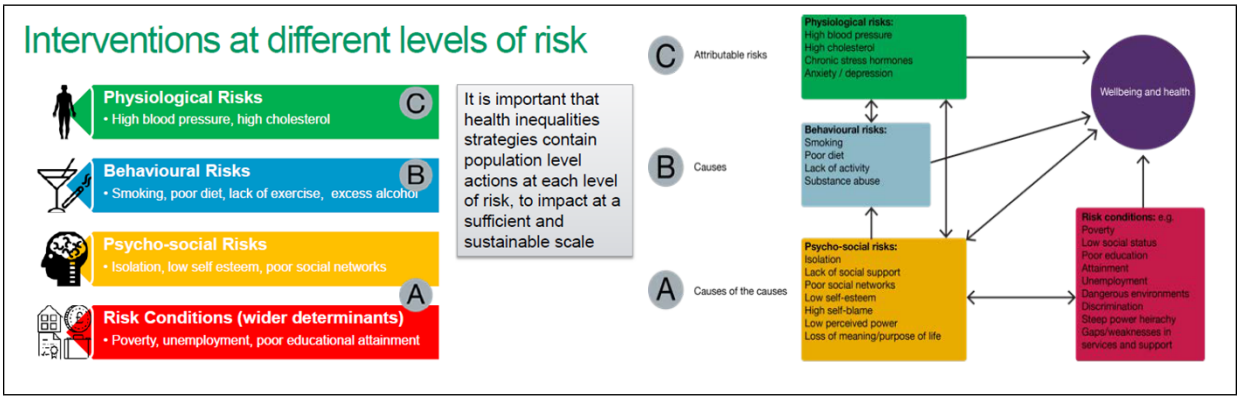
We know that there are different types of risk factors that drive poor health:

- Physiological risks e.g. high blood pressure, high cholesterol, chronic stress, depression;
- Behavioural risks e.g. smoking, poor diet, low physical activity, excess alcohol;
- Psychosocial risks e.g. loneliness, poor self-esteem, poor social networks;
- These risks are all influenced by wider risk conditions, or determinants of health, e.g. poverty, unemployment, poor educational attainment.

These four levels of risk are all interconnected. Therefore the evidence suggests that is important that **strategies to tackle health inequalities contain population-level actions across each of these levels of risk**, rather than solely individual level approaches, in order to create impact at a sufficient and sustainable scale.

Figure 5: Intervening at different levels of risk affecting health and wellbeing (Source: adapted from PHE (2017) Reducing health inequalities: system, scale and sustainability, p11)

[FINAL REPORT TO INCLUDE MERTON-ISED FIGURE INCORPORATING BOTH BELOW]



C. Intervening for impact over time

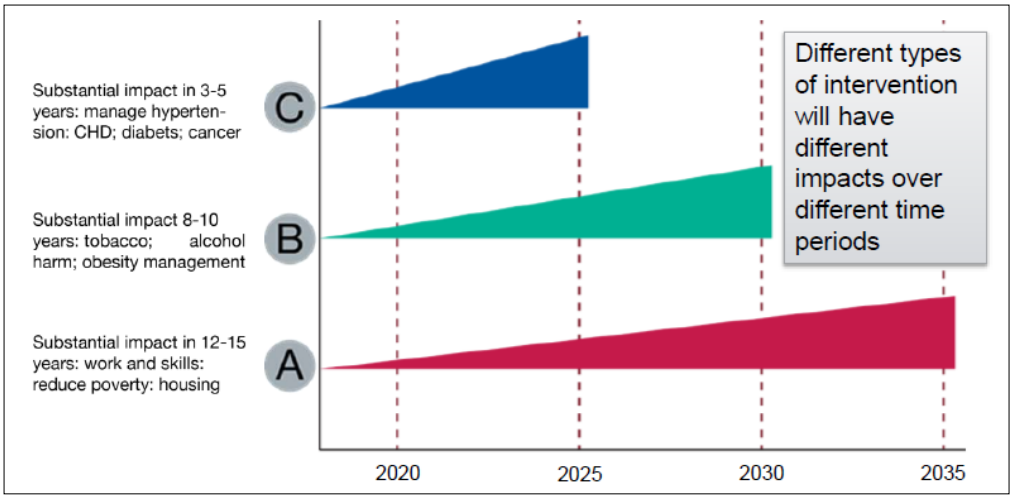
We know that different types of interventions will take different amounts of time to demonstrate impact. For example, stopping smoking is likely to show impact over a short time period in terms of improved health and wellbeing for an individual (in addition to the longer term improvements to life expectancy and healthy life expectancy across a lifetime), where as interventions to improve community green and built infrastructure – encouraging more people to walk and get active – are likely to take a decade or more for any impact on health to begin to become apparent. See Figure 6 for indicative timescales for different types of interventions.

Therefore **we need to be realistic about when we are likely to see any changes to different health outcome metrics,** depending on the type of intervention.

[14] Marmot Review (2010) Fair Society Healthy Lives

Figure 6: Time needed to deliver outcomes from different intervention types (Source: adapted from PHE (2017) Reducing health inequalities: system, scale and sustainability, p11)

[FINAL REPORT WILL INCLUDE MERTON-ISED FIGURE – could consider using same colour scheme in Column 5 of the table in Section 5?]



D. Intervening across the life course

We know that reducing health inequalities is most effective when we purposefully **tackle the wider determinants of health throughout the life course**, starting early in life (even before birth), ensuring every child has the best start in life, that children, young people and adults are able to maximise their capabilities and have control over their lives, and have access to fair employment and good work, within healthy and sustainable places and communities, all the way through to older age.[15] Marmot's six priority areas for action across the life course are set out in Appendix 3.

In summary, what we know about health inequalities and how to tackle them:[16]

- Health inequalities are persistent, complex and difficult to shift.
- In order to make any progress, we have to actively and systematically target inequalities through a long-term multi-sectoral approach across all partners – including the NHS, Council, voluntary sector and the community – working at individual, community and population levels.
- We need to base our approach on evidence of what works to shift inequalities:
    - Intervening for population level impact, particularly given the increased cost-effectiveness of population level interventions compared to personal level interventions, and increased impact on health inequalities
    - Intervening at different levels of risk, including the importance of the role that NHS primary care and community services play in reducing inequalities;
    - Intervening for impact over time;
    - Intervening across the life course;
    - The importance of community empowerment.
- If we take our eye off the ball, health inequalities are likely to increase. Therefore we need to continuously monitor progress and review our approach over time.

See Appendix 1 for further reading and other useful tools for tackling health inequalities.

[15] Marmot Review - Fair Society Healthy Lives 2010
[16] Adapted from Kings Fund (2017) https://www.kingsfund.org.uk/blog/2017/08/reducing-inequalities-health-towards-brave-old-world

2. PART 2: ANALYSIS OF HEALTH INEQUALITIES IN MERTON

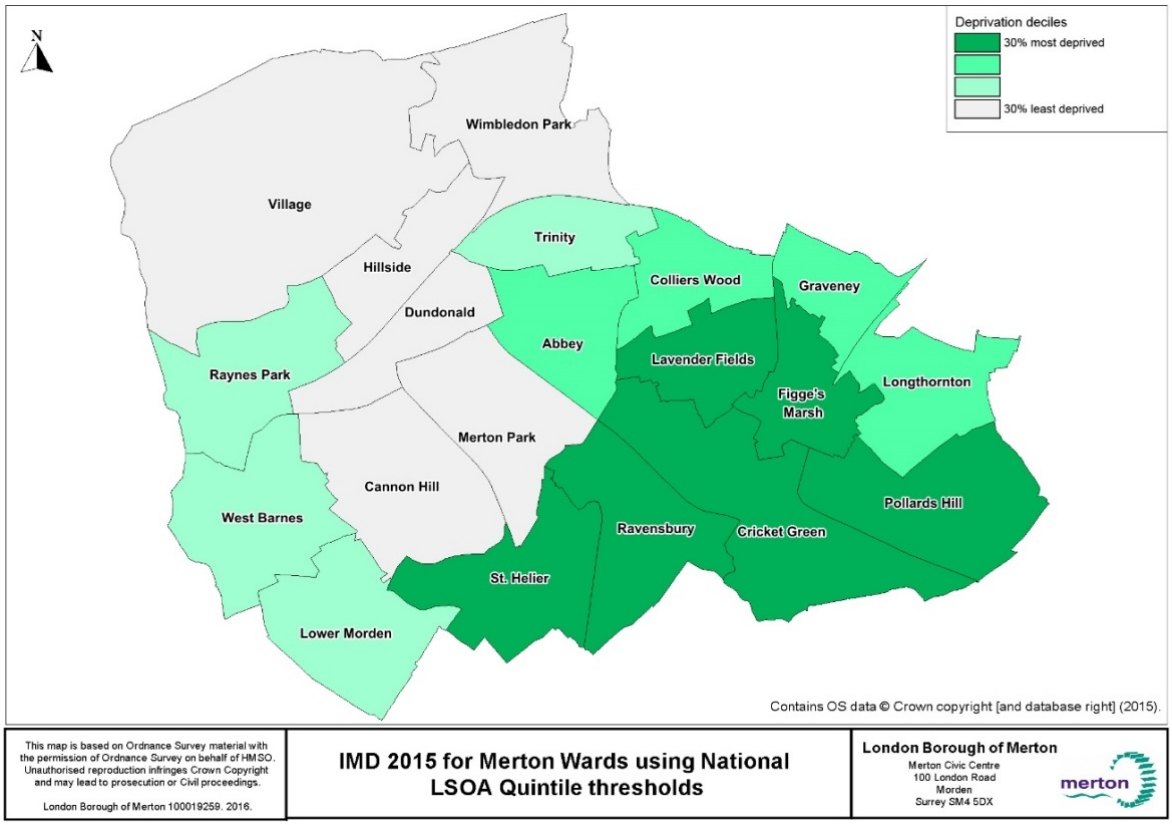
2.1. The Merton Story: overview of Merton as a place

Overall Merton is healthy, safe and has strong public and community assets. The health of people in Merton is generally better than the London and England average: life expectancy is higher than average and rates of death considered preventable are low. This is largely linked to the lower than average levels of deprivation in Merton. We have a range of public and community assets that are important to health; there are many green spaces, vibrant libraries, educational attainment is high, we have a wealth of small businesses and a strong Chamber of Commerce, as well as an active Voluntary and Community Sector and high levels of volunteering. We have good transport hubs, and a significant proportion of people who live in Merton also work in the borough.

However, despite this positive picture, there are areas of concern. Significant social inequalities exist within the borough, and these are important drivers of poor health and wellbeing outcomes.

The Index of Multiple Deprivation (IMD) map (Figure 8) illustrates the contrast between the east and west of Merton: the darker the shading, the higher the level of deprivation. This shows that the most deprived areas are concentrated in the East of the borough, and the least deprived in the West.

Figure 8: Index of Multiple Deprivation (IMD) 2015 for Merton Wards



The Merton Story 2018 is a summary of the Joint Strategic Needs Assessment, and gives more detail of the distribution of risk and resilience factors for health and wellbeing in Merton, as well as the patterns of mortality and morbidity from disease.[17]

[17] See the Merton Story 2018: https://www2.merton.gov.uk/health-social-care/publichealth/jsna.htm

2.2. Methodology for inequality 'gap analysis' used in this report

Inequality gap analysis: comparison of most and least deprived wards ('30/30')

This APHR on Health Inequalities uses a simple deprivation gap analysis to look at inequalities in Merton for a number of key indicators. Inequalities in health and the wider social determinants of health are often considered in terms of the gap between the most and least deprived groups of the population. Therefore, where possible in this report, the gap analysis carried out presents the difference between the averages of the 30% most and 30% least deprived wards in Merton based on the 2015 Index of Multiple Deprivation (IMD) deciles. Figure 9 below shows which wards fall into which category.

There are 20 wards in Merton, none of which fall into the IMD classification decile 1 or decile 2 (the most deprived). The 30% most deprived wards are classified in deciles 3 and 4, and the 30% least deprived wards are classified in deciles 9 and 10. The wards that are classified in deciles 3 and 4 are located in the east of the borough; similarly Merton wards in deciles 9 and 10 align with west Merton.

Gap analysis is useful in that it is a relatively easy concept to understand, and can be calculated easily without the need for statistical modelling. However, it is limited in that it only reflects the difference between the highest and lowest socioeconomic or deprived groups and can be potentially affected by extreme values within each of these groups.

This methodology was checked and agreed as valid by the Marmot team at the Institute of Health Equity at University College London.[18]

Figure 9: Wards in Merton split by deprivation decile, based on the 2015 IMD deciles

Decile	Ward name	Locality	
1	-	-	
2	-	-	
3	Cricket Green	East	30% Most Deprived
4	Figge's Marsh	East	
	Lavender Fields	East	
	Pollards Hill	East	
	Ravensbury	East	
	St Helier	East	
5	Longthornton	East	
6	Colliers Wood	East	
	Graveney	East	
7	Abbey	East	
8	Lower Morden	West	
	Raynes Park	West	
	Trinity	West	
	West Barnes	West	
9	Cannon Hill	West	30% Least Deprived
	Dundonald	West	
	Hillside	West	
	Merton Park	West	
	Wimbledon Park	West	
10	Village	West	

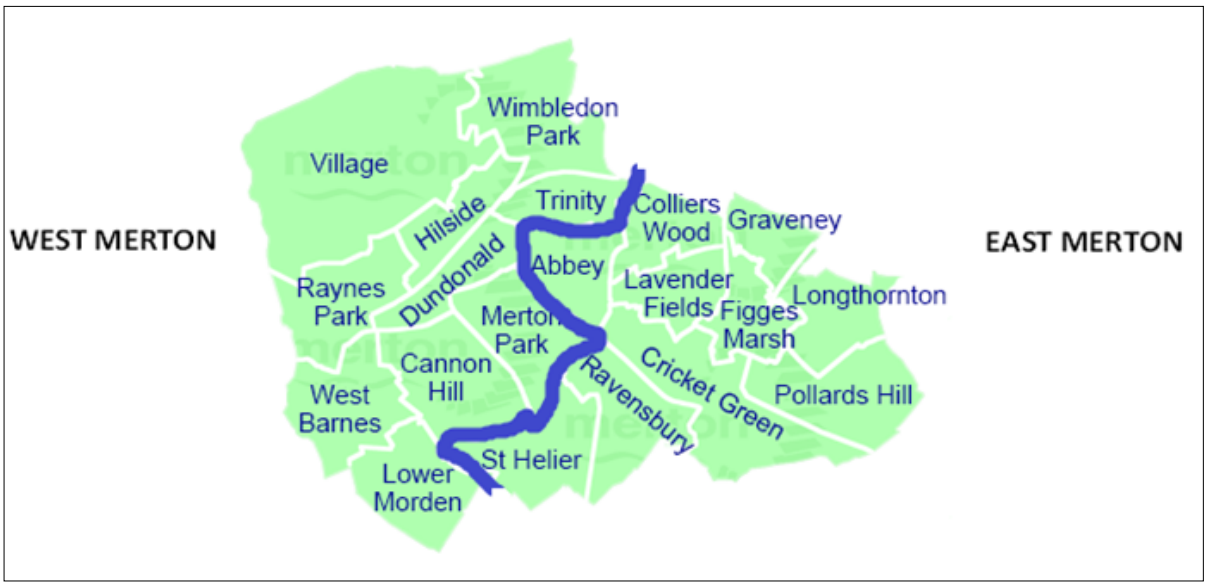
[18] Institute of Health Equity: http://www.instituteofhealthequity.org

Inequality gap analysis: comparison of East/West wards ('E/W')

We were only able to calculate the gap between the most/least deprived for indicators where data was available by ward. For some indicators – particularly health related behaviours such as smoking, and morbidity data such as diabetes prevalence – local level data (and/or trend data) was only available by GP practice as it was based on GP-recorded interactions. In these cases, we have presented the results by East/West rather than most/least deprived. We make it clear for each indicator which analysis has been done, and why. See column 6 of the Summary Table of APHR Indicators in Section 5.

The two methodologies do correlate relatively well, as a comparison of the map in Figure 8 with the map below (Figure 10) shows that the 6 wards in the east of the borough are in the 30% most deprived in England, in contrast with the west of the borough which had 6 wards in the 30% least deprived. The E/W methodology is likely to underestimate the size of the gap, as it includes GP-registered data aligned with *all* wards in East compared to all GP-registered data aligned with *all* wards in West Merton, not just those in the 30% most and 30% least deprived wards. As any East/West inequality gap is based on GP-registered data rather than the 'Merton resident' ward based data used for the most/least deprived calculations, we cannot directly compare figures derived from the two different methodologies.

Figure 10: Merton's East/West split used for gap analysis where only GP level data is available



Other statistical calculations and comparisons

Where possible, we also calculated **Confidence Intervals** (see Appendix 4 - Glossary for definitions), in order to gain some indication of whether the inequality gap was likely to be a statistically significant difference, or was within the range of normal variation.

In some instances, where we had some trend data but no very recent data, **Regression Analysis** was conducted, using the current trend data to project more recent missing data points. This enabled us to estimate the inequality gap should current trends continue. This is something that we can do more of, for the chosen indicators, to help us to determine targets for the HWBS.

As the purpose of this report was to look at inequalities within Merton, we have purposefully *not* compared the Merton inequality gap to the gaps found either in statistical comparator boroughs, neighbouring boroughs, London or England, in order to keep the analysis focused on Merton and understanding our local picture as a first step to coordinated action on inequalities. The only exception is the Slope Index of Inequality, as a single overarching statistical measure of inequality calculated centrally by Public Health England (PHE).

Challenges in data analysis

We faced a significant number of limitations and challenges with the data available, which has restricted the choice of indicators that we were able to analyse to look at inequality within Merton, particularly over time:

- **Lack of ward level data.** For some indicators which would have provided useful insight into health inequalities, there was no ward level data available, only borough level, so we could not look at the inequality gap within the borough. In some instances, where data was available by GP practice we were able to look at the East/West gap rather than the gap between the most/least deprived, as described above. GP practice data aligned to East/West is useful proxy where ward level data is not available, but there are several caveats that need to be considered when interpreting this data, discussed in Box 2.

Box 2: Caveats when interpreting GP data (patients registered with a Merton GP)

GP Profile and/or Quality Outcomes Framework (QOF) data looks at the population of 'people registered with a Merton GP' rather than Merton residents per se. There will be a proportion of people registered with a GP (and therefore included in the data for that GP practice) who do not live near the GP practice, or even within the borough, for instance those registered with a GP near their work rather than home, or those who live near borough boundaries.

Additionally, compared to data collected in a standardised way across whole populations (e.g. the Census), GP recorded data relies firstly on an individual attending their GP, and then on GP diagnosis and recording of behaviours or conditions. It can therefore be difficult to know how closely the GP diagnosed prevalence correlates with the underlying true prevalence. For instance, if over time GPs get better at asking patients about their smoking status and recording it on the patient record system, then prevalence will appear to increase over the same time period, when in fact the data is just becoming more representative of the true prevalence in the population. In addition, patients in more affluent areas may be more proactive in registering with a GP and/or following up symptoms with their GP, and so diagnosis rates and prevalence may appear higher than in more deprived areas where access may be lower.

Therefore GP data (as with all data) needs to be interpreted carefully, with an understanding of the biases inherent in the collection methods.

- **Limited trend data.** To calculate an accurate trend analysis requires at least 3 points of historic data (i.e. 2014/15, 2015/16, 2016/17), and ideally more. The more historic data points available, the more robust the analysis. For a significant number of indicators, where sub-borough data *was* available, it was *only* available for a single recent time point rather than for a number of points over time, and so trend analysis could not be undertaken. For a few other indicators, due to sample size (small numbers), the data at ward level had to be 'pooled' or grouped over a number of year periods in order to allow meaningful comparison at ward level. This then limited the number of time points that were available for trend analysis. For instance, data on alcohol-related harm was only available for two time points: 2010/11-2014/15 and 2011/12-2015/16, and so trend could not be accurately analysed.
- **Changes to indicator definitions.** Changes to indicator definitions over time restricted the ability to conduct trend analysis, as we would not be comparing 'like with like' and so trend over time could not be accurately analysed. This is the case with indicators such as the Index of Multiple Deprivation (IMD). Changes to indicators in the future may hamper trend analysis going forward, so we need to be up to date with any changes, and aware of the most appropriate indicators to use, for instance with the shift by 2020 from recording claimants of Job Seekers Allowance and other benefits to those claiming Universal Credit.

2.3. Summary of indicators included in this report

The main focus of this report was to test out a methodology for calculating sub-borough health inequalities in Merton, and for tracking progress over time. Therefore the indicators included in this report are not meant to be comprehensive, but rather intended to provide a general picture of health inequalities in Merton, using a standard methodology that can be applied to other indicators, and by other partners not just health.

This report looks at both health inequalities specifically, but also at some of the social inequalities such as poverty, education and employment that drive health inequalities. The focus is on geographic and socioeconomic inequalities, although there are many other aspects of inequality that could be measured in future, for instance by age, sex, ethnicity or other protected characteristics.

Approach to choosing indicators for analysis

The starting point for the indicators chosen for review in this APHR were the two Public Health England (PHE) collections of indicators reported in the Public Health Outcomes Framework (PHOF):[19]

- PHE Marmot indicators (15 indicators), giving an overview of the key social determinants of health covered in the Marmot Review 2010;
- PHE Health Equity indicators (18 indicators, 5 of which overlap with Marmot indicators), covering core health indicators, PHE priority areas, and social determinants of health.

This gave us a total of 28 indicators to review. We looked to see what data was available for each of these indicators at ward level, in order to be able to compare the most and least deprived wards. Only a third (11/28) had any ward level data available to be able to calculate the latest sub-borough inequality gap, and of these, only one (life expectancy) had readily available ward trend data to be able to look at changes in the gap over time. See Appendix 2 for the full list of indicators in these PHE indicator sets.

However, we wanted to include a sample of indicators in this report that represented the key themes found in the Marmot Review on health inequalities, and that gave a picture of the situation in Merton with regards to:

- Risk and resilience factors for health and wellbeing at a personal level (Physiological risks e.g. hypertension; Behavioural risks e.g. smoking; Psychosocial risks e.g. loneliness);
- Wider risk and resilience conditions at a population level (e.g. wider determinants such as poverty, education, employment, housing);
- Some measures of morbidity e.g. diabetes prevalence;
- Some measures of mortality e.g. life expectancy, premature mortality.

Given the substantial limitations in the PHE Marmot and Health Equity indicator data readily available through PHOF to be able to look at sub-borough inequality gaps, let alone the trend in the gap, we therefore supplemented these data sets with other routinely available data sets, particularly those available through the PHE Local Health portal (which provides data at a ward level and allows comparison at a regional and national level), in order to give a picture of the current inequality gap across a range of indicators, but also to look at trend data and whether the situation is improving or worsening.

We focused on national data sources for this report, rather than locally collected Merton data such as the Residents Survey, on the basis that standardised national indicators are more likely to continue to be collected and reported on, and to be available on an ongoing basis. However, this does not mean that it would not be useful to apply this methodology to locally collected data sets in future.

[19] PHE PHOF: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Structure of health inequalities data included in this report

The report is structured into the following Chapters, which are informed by the Marmot strategic priority areas for tackling heath inequalities, and which correlate with the Themes of the current Health & Wellbeing Strategy 2015-2018:

1. Key overarching indicators of inequality
2. Giving every child the best start in life
3. Prevention of poor physical and mental ill health
4. Creating the conditions for fair employment and good work for all
5. Ensuring a healthy standard of living for all
6. Creating and developing healthy and sustainable places and communities

Appendix 3 shows how the APHR Chapters map to the Marmot strategic priorities for action, and to the HWBS 2015-18 Themes.

Table 1 below summarises the indicators that we considered in detail for this report, by Chapter. Section 5 of this report gives the full list of indicators in table form, with a visual Red/Amber/Green ('RAG') rated summary of whether local level data and/or trend data is available, whether it is likely to be available in future, and whether each indicator would be worth considering for the HWBS refresh 2019+.

Table 1: Summary of indicators included in this APHR on Health Inequalities, by Chapter

Overarching indicators	Best start in life	Prevention of poor health	Fair employment	Healthy living standards	Healthy places and communities
• Life expectancy • Slope Index Inequality (inequality in life expectancy) • Healthy life expectancy • Premature mortality	• Child Poverty / Income Deprivation Affecting Children (IDACI) • School readiness (child development at age 5), all, and those with Free School Meal status • Child excess weight (Reception) • Child excess weight (Y6)	• Smoking prevalence • Alcohol related harm • Hypertension prevalence • Diabetes prevalence • Tuberculosis (TB) incidence • Mental health prevalence • Depression prevalence • Self reported wellbeing	• Economically active population claiming Job seekers allowance (JSA) • Benefit claimants - employment & support allowance (ESA)	• Deprivation IMD 2015 (ward) • Deprivation IMD 2015 (GP) • Deprivation affecting Older People IMD 2015 (by GP) • Overcrowded households • Fuel poverty	• Burglary • Theft • Criminal damage • Antisocial behaviour • Violence against the person • Older people (65+) living alone

Only a few graphs showing overarching indicators are included in the main body of the report – others are given in the *Supplementary Data Report* that sits alongside this APHR.

2.4. CHAPTER 1: Key overarching indicators summarising the inequality gap

Life expectancy

The strategic overarching indicator in the Health and Wellbeing Strategy 2015-2018, used to measure and monitor differences in health and wellbeing between different communities in the borough, is life expectancy.

Data from PHE Local Health[20] shows that in Merton as a whole over the last few years life expectancy has increased, from 79.7 (2005-9) to 80.4 (2011-15) in men and from 83.3 to 84.2 in women over the same time period.

However, the trend in inequalities between the most and least deprived wards has been mixed. Most recent data shows that the current gap is **4.1 years** for men and **2.7 years** for women, between the 30% most and 30% least deprived wards (2011-15 data). Our analysis shows that the trend for women is positive - the difference in female life expectancy between the most deprived and least deprived wards **reduced** over the period 2005 to 2015, from 4.5 years to 2.7 years. In contrast, the difference in male life expectancy between the most deprived and least deprived wards remained **stable** over this time, at 4.1 years. Comparable data for gap analysis is not available for London or England.

See graphs in the *Supplementary Data Report* for more detail.

We are likely to be able to continue to access LE data from PHE Local Health that will enable us to calculate the inequality gap in future years, and so monitor trend. However, the Slope Index of Inequality indicator discussed below may be a better more consistent indicator to use as it is a measure of inequality in life expectancy that is produced nationally and can be compared in a standardised way to other London boroughs.

Slope Index of Inequality (SII) – inequalities in life expectancy at birth

The slope index of inequality is a single score which represents the absolute gap in life expectancy at birth between the 10% most deprived and 10% least deprived areas. It is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation The larger the SII score (in years), the greater the disparity in life expectancy.[21]

In 2014-16, the SII showed that the gap in life expectancy between people living in the most and least deprived tenths of areas in Merton was **6.2 years** for males and **3.4 years** for females. The England figures are 9.3 years (males) and 7.3 years (females), and London, 7.4 years (males) and 4.8 years (females). We have been advised by PHE that the SII figures for Merton are not directly comparable to these regional and national figures, due to the statistical methods for calculating SII; however, we *can* compare directly to our statistical comparator boroughs, which shows that the SII for both men and women is lower than Barnet (M: 6.3, F: 5.0), Enfield (M: 6.7, F: 4.7), and Redbridge (M: 7.8, F: 4.3), but higher than Ealing (M: 3.4, F: 2.8).

[INCLUDE INFOGRAPHIC OF LIFE EXPECTANCY GAP HERE IN FINAL REPORT]

SII data over time appears to show an **increasing and then reducing** inequality gap for men so it is similar now to what it was a decade ago (6.3 in 2005-07 compared to 6.2 in 2014-16), and potentially a **slight decrease** in the inequality gap in women (from 5.2 in 2005-07 to 3.4), but the overlapping confidence intervals suggest that this does not yet appear to be a statistically significant reduction. See Figures 11 and 12 over the page. This is an important indicator to keep tracking, to look at overarching inequalities over time.

[20] PHE Local Health http://www.localhealth.org.uk/

[21] SII is calculated by comparing the 10% most deprived deprivation deciles in an area with the 10% least deprived, so is a useful measure of inequality but is a different methodology from that used in the rest of this report (where we are comparing 30% most deprived wards with the 30% least deprived, or comparing East Merton wards with West wards).

Figure 11: Life expectancy and Slope Index of Inequality (males) from 2005-07 to 2014-16

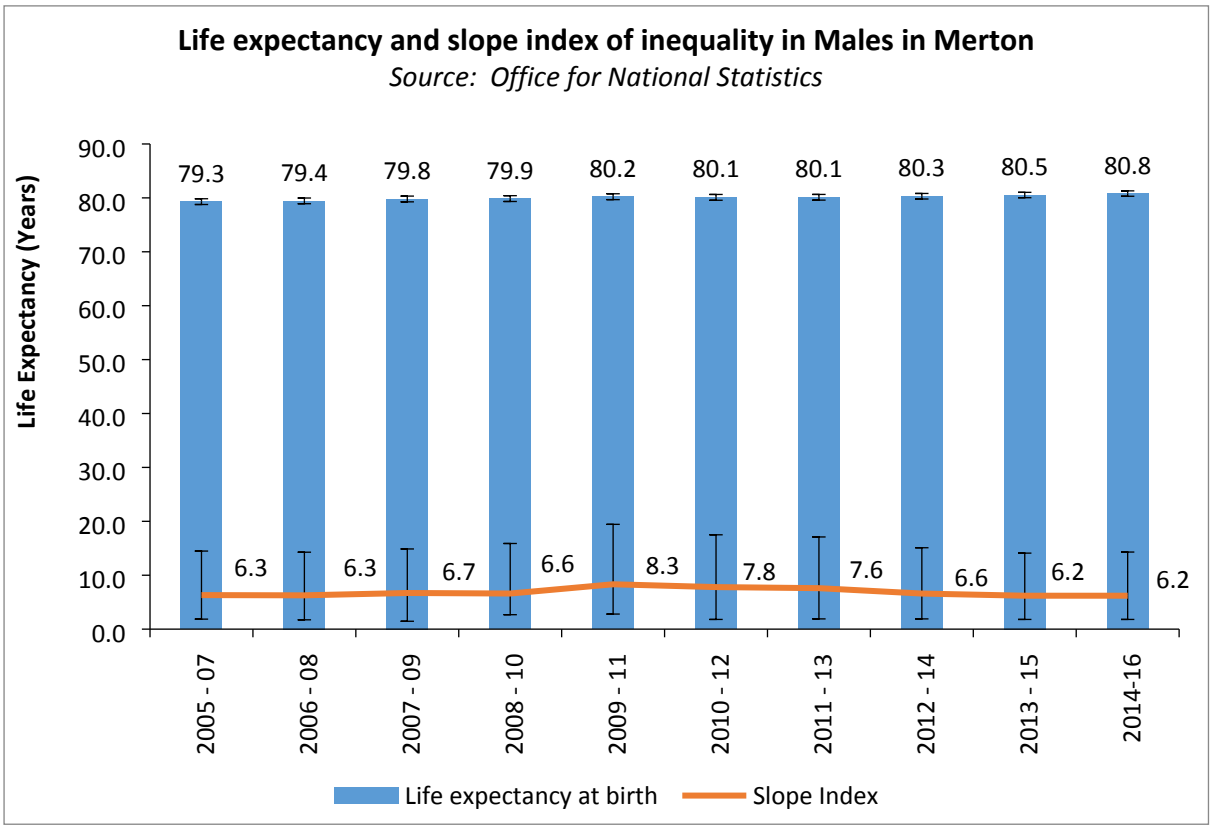
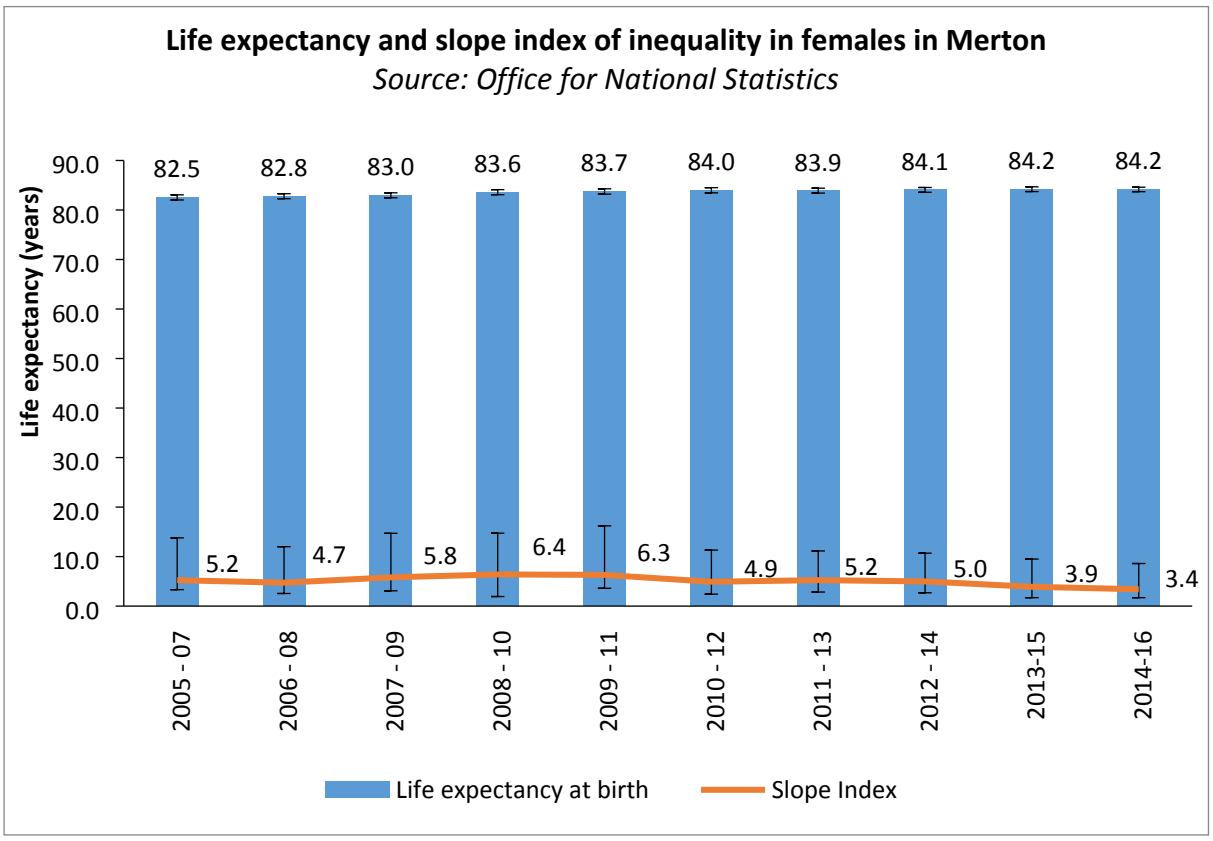


Figure 12: Life expectancy and Slope Index of Inequality (females) from 2005-07 to 2014-16



Box 3: Changes to the reporting of the inequality gap in Merton over time

In the *2013/14 Joint Strategic Needs Assessment*, the life expectancy gap between the most and least deprived areas within the borough was reported as **9 years** for men and **13 years** for women (2006-10 data). This was based on the difference between the outliers – the most deprived ward compared to the least deprived ward.

The *Health and Wellbeing Strategy 2015-2018* uses an 'inequalities in life expectancy' figure of **7.9 years** for men and **5.2 years** for women. This was based on Slope Index of Inequality data from 2011-13, looking at the most and least deprived 10% of areas within the borough.

In this *APHR 2018*, we report the following:

- Life expectancy at birth: **4.1 years** (men), **2.7 years** (women)
- Slope Index of Inequality: **6.2 years** (men), **3.4 years** (women)

The difference is due in part to the use of more recent data, but more importantly, to the different methodology for calculating the inequality gap (see Table 2 below). Some of the reduction in the life expectancy figure for women is also due to the positive trend for the gap in life expectancy for women, discussed above in 2.4.1.

We recommend that going forward, the Slope Index of Inequality is used as the overarching measure of the life expectancy inequality gap, as it is produced nationally and can be compared to statistical comparator boroughs.

Table 2: How methodology, data source and trend over time have impacted on reporting of inequalities in life expectancy in Merton

Report	Indicator	Date	Inequality gap		Comment
			Male	Female	
JSNA 2013/14	*Life expectancy at birth*	*2006-10*	*9*	*13*	*Calculated by comparing the most deprived ward with the least deprived ward (e.g. the 2006-10 data shows life expectancy for men ranged from 76.1 in Ravensbury to 84.8 in Wimbledon Park, a gap of nearly 9 years).*
	Life expectancy at birth	*2006-10*	*2.8*	*3*	*Calculated by comparing the average for West Merton with the average for East Merton.*
HWBS 2015-2018	*Slope Index of Inequality*	*2011-13*	*7.9*	*5.2*	*Calculated by comparing the 10% most deprived deprivation deciles in an area with the 10% least deprived. (N.B. the figures reported here do not match with those shown in Figures 11 and 12 for the relevant years, because changes were made to the indicator definition in 2017 which retrospectively changed all the data since 2010-12).*
APHR 2018 (this report)	**Life expectancy at birth**	**2011-15**	**4.1**	**2.7**	**Calculated by comparing the 30% most and 30% least deprived wards (e.g. 2011-15 data shows an average life expectancy for men of 78.6 in the 30% most deprived wards compared to 82.7 in the 30% least deprived wards, a gap of just over 4 years).**
	Slope Index of Inequality	**2014-16**	**6.2**	**3.4**	**Calculated by comparing the 10% most deprived deprivation deciles in an area with the 10% least deprived.**

Healthy life expectancy

The gap in *healthy* life expectancy (HLE) is greater than the gap in life expectancy. The latest data (2009-2013) shows that the average healthy life expectancy at birth in Merton was 65.4 years for males and 66.3 years for females.

We cannot compare data on healthy life expectancy directly with that on life expectancy as the most recent data for each are from different data sources and time periods.[22] However, a general comparison shows that a significant amount of Merton residents' lives (c.15-18 years on average) are spent in ill health.

In addition, the gap between people living in the 30% most and 30% least deprived areas was **9.4 years** for males and **9.3 years** for females (see Table 3), so someone living in a deprived ward in the east of the borough is likely to spend more than 9 years more of their life in poor health than someone in a more affluent part of the borough, from around the age of 61 or 62 compared to 70 or 71, which will impact on the last years of working life, on family life and on a healthy and fulfilling retirement.

Table 3: Comparison of Healthy Life Expectancy from birth for the 30% most deprived wards and the 30% least deprived wards, for men and for women, in Merton (Source: ONS, 2009-2013)

HLE from birth (2009-2013)	Least deprived	Most deprived	Merton average	Inequality gap
Males	70.5	61.1	65.4	**9.4**
Females	71.2	61.9	66.3	**9.3**

Unfortunately, this data is now a few years old, we are **not able to calculate historic trend** for the inequality gap in HLE as the data is not available from ONS by ward for single years (due to small sample sizes), and it is unclear whether data on this indicator will be available in future years in a format that will enable us to look at future trend in inequalities.[23]

As well as Healthy Life Expectancy at birth, we also have inequalities data from ONS for 2009-2013 on the following metrics:

- Disability Free Life Expectancy (DFLE) at birth (male and female)
- Disability Free Life Expectancy at age 65 (male and female)
- Proportion living without a disability at birth (male and female)
- Proportion living without a disability at age 65 (male and female)
- Proportion of life spent in good health at birth (male and female)
- Proportion of life spent in good health at age 65 (male and female)

These are all different ways of looking at the same issue of how much of someone's life they can expect to spend in good health (see the Glossary in Appendix 4 for the difference in definition between HLE and DFLE; Section 5: Summary Indicator Table for a summary of the gap for each of these indicators; and the *Supplementary Data Report* for the current data).

For all of these, we can see that there is a significant gap between the most and least deprived areas in Merton. However, as with HLE, these are now quite out of date, we are not able to calculate historic trend, and are unlikely to be able to calculate trend in the future for the reasons given above.

[22] Life Expectancy: Local Health, 2011-15; Healthy Life Expectancy: ONS, 2009-13)

[23] ONS report that trend data on HLE at ward level is only possible decennially currently and as wards change so often in boundaries, trend data will always be difficult. In addition, due to sample size, the data at ward level needs to be 'pooled' or grouped over 5 year periods in order to allow meaningful comparison at ward level.

Premature mortality

Figure 13 below demonstrates the correlation between income deprivation and premature mortality (deaths in those under the age of 75) within Merton. Figure 14 shows the percentage of premature mortality by the 30% most and 30% least deprived wards in Merton, out of all deaths in the respective wards. The key message is that there is a social gradient to premature mortality, with a **12.5 percentage point gap** between the 30% most and 30% least deprived wards. More people are dying prematurely in the most deprived areas – 38.5% (2 in 5) of all deaths are premature compared to 27% (1 in 4) in least deprived areas. What's more, this **gap has widened**. This is because premature mortality in the most deprived has remained more or less static over the last 3 year rolling averages since 2011-15, but premature mortality in the least deprived has declined slightly, causing the gap to increase. However, there are only 3 data points so the trend in the gap will need to be monitored over a longer time period to see if it is significant.

Figure 13: Premature mortality for Merton wards by percentage income deprived: deaths for all causes, under 75 years (2011-2015) (Source: PHE Health Inequalities Briefing Merton, 2018)

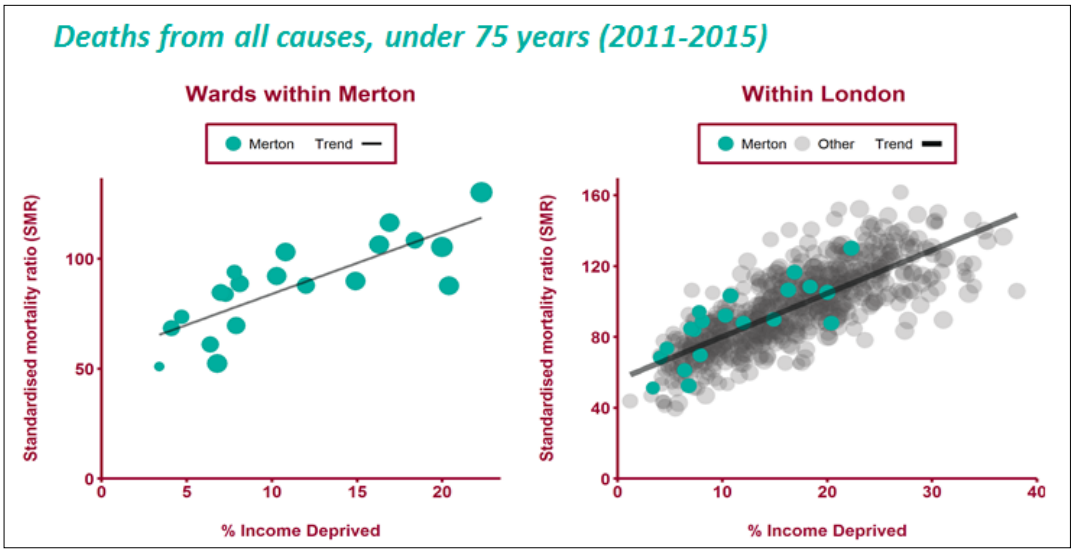
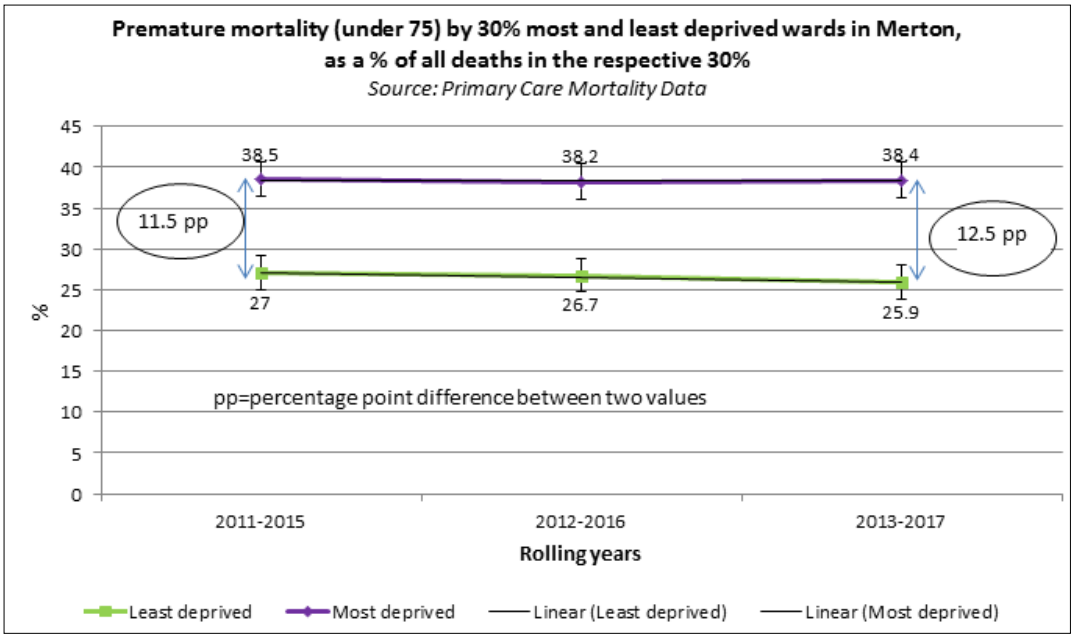


Figure 14: Premature mortality (under 75 years) as a percentage of all deaths, comparing the 30% most deprived wards in Merton with the 30% least deprived, from 2011-15 to 2013-17



2.5. CHAPTER 2: Give every child the best start in life

Why is this important? *The early years are vital to future inequalities in health and wellbeing. The Marmot Report states that "giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status…Later interventions, although important, are considerably less effective where good early foundations are lacking."*

Child Poverty – children living in low income families

This 'Child Poverty' measure shows the proportion of children living in families in receipt of out-of-work benefits or in receipt of tax credits where their reported income is less than 60 per cent of UK median income. The indicator definition is "proportion of children aged 0–15 years living in income deprived households as a proportion of all children aged 0–15 years." It is also known as 'income deprivation affecting children' (IDACI).

Merton data shows that the gap is significant but appears to be reducing, but that the underlying picture is less positive. The gap between the most and least deprived areas in 2015 was **21 percentage points** (27% of children living in low income households in the most deprived 30% of wards compared to 6% of children in the least deprived 30%). Extrapolating the data statistically using regression analysis suggests that the current 2018 gap is likely to be significantly smaller than this, at 6 percentage points (19% of children in the most deprived areas v 13% in the least deprived areas). However, **although the gap appears to have reduced, the underlying picture is mixed** – the trend in child poverty in the most deprived areas is downwards (28% in 2010 to an estimated 19% in 2018) which is positive, but child poverty in the least deprived areas appears to be increasing over the same time period (from 7% to an estimated 13% in 2018), and it is this increase which partially drives the narrowing inequality gap. If published data confirms this anticipated trend, we need to understand what is driving this apparent increase in the least deprived areas.

We will be able to continue to monitor this indicator in the future, therefore it is important that this is an indicator that is included in the refreshed HWBS, and that we continue to explore trend as more recent data is published to compare to our extrapolated trend data.

Child development

Child development at age 5 (a measure of 'school readiness') is an important indicator to look at 'best start in life' for Merton's children. We have access to ward level data for 2013/14 from PHE Local Health so can calculate an inequality gap of **15.9 percentage points** (53.3% of children in the 30% most deprived wards reach a good level of development compared to 69.2% in the 30% least deprived wards).

However, this is relatively old data, and due to a lack of readily available recent ward level data, and/or ward level data over time, we were unable to calculate the *trend* in inequalities gap in the standardised way that we have approached measurement of health inequalities elsewhere in this report. In order to give us a proxy measure of the trend in inequalities, we looked at 'children with Free School Meal' (FSM) status (for which data is available at borough not ward level) as a proxy for 'most deprived' as we know that there is a correlation.[24] This data shows that 73.9% of all children achieve a good level of development in 2016/17, where as only 63.9% of children with FSM status achieve a good level of development in the same time period, a gap of **10.0 percentage points**. This difference is statistically significant. There has been an increase in 'school readiness' in Merton over time,

[24] To note: in this analysis we are comparing data for a subset of the population with data for the whole population, rather than comparing two subsets of the population (most and least deprived), as for other indicators, so the methodology is not comparable to that used for other indicators.

including for those with FSM status, and it appears that the inequality gap as calculated this way has **reduced** slightly (from 13.1 percentage points in 2012/13 to 10.0 in 2016/17).

It will be important to keep an eye on this indicator in case more recent ward level data becomes available, but in the absence of any other way to measure sub-borough inequalities in child development, it may be worth continuing to look at the gap between children with FSM status and all children, as a measure of inequality.

Child excess weight (overweight and obese)

Childhood obesity is a significant problem in Merton, with around 4,500 children (age 4 - 11 years) overweight or obese and nearly a third of children leaving primary school overweight or obese. In addition, the problem is significantly worse in the most deprived areas, with the most recent 2014/15-2016/17 data showing a gap of **9.6 percentage points in excess weight at reception** (24.3% of children are overweight or obese in the 30% most deprived wards compared to 14.7% in the 30% least deprived) and **14.5 percentage points by Year 6** (40.2% in the 30% most deprived wards are overweight or obese compared to 25.7% in the 30% least deprived. For this reason, the gap in excess weight is a key indicator in the HWBS 2015-2018, and Merton HWBB has made tackling childhood obesity a priority.

In terms of trend, for reception age children, levels appear to be relatively stable in the most deprived areas but reducing slightly in the least deprived areas (although the reduction is not statistically significant), leading to a **slight increase** in the gap over time. Trend over time for Year 6 children (10-11 year olds) show levels of excess weight are reducing in the least deprived areas of the borough and increasing in the most deprived (although neither reduction not increase are yet statistically significant) and hence the **gap is increasing**.

There are some signs from the most recent data that the overall trend in excess weight at borough level for Merton may be beginning to stabilise or decrease in the last available year's data (from 2014/15 to 2016/17). How the trend in the sub-borough inequalities gap looks over time will need to continue to be carefully monitored, and action taken through a whole systems preventative approach targeted in the most deprived areas, as set out in the last APHR on Childhood Obesity, and the related child healthy weight action plan.

Other 'best start in life' indicators:

We would have liked to have looked at the Merton inequality gap for the following PHE Marmot/Health Equity indicators, but data was either not available at ward level or not available for sufficient years to be able to calculate trend:

- Infant mortality (Health Equity)
- Low birthweight of term babies (Health Equity)
- Proportion of 5 year old children with/without dental decay (Health Equity)
- 19-24 year olds not in education, employment or training (Marmot)
- GCSE achievement (% young people achieving 5A*-C including English & Maths) (Marmot). The most recent data for this indicator shows a gap of **15.4 percentage points** between the most and least deprived wards (2013/14). This data is relatively old, and trend data is not available due to a recent change in indicator definition, but future trend may be possible to track. There is also an indicator which looks at 'GCSE achievement with FSM status' so in a similar way to School Readiness, we could look at the gap between the whole population and the FSM sub-group as a proxy for inequalities by most/least deprived. However, unlike for school readiness, comparative data is currently only available at one time point (2014/15), and so no trend can be produced.
- Other indicators that may be worth investigating to look at the inequality gap over time include the rate of rate of hospital admissions between the most and least deprived areas for a number of key health conditions in children and young people, such as asthma, or injury.

2.6. CHAPTER 3: Prevention of poor physical and mental ill health

Why is this important? *The main causes of ill health and premature deaths in Merton are cancer and circulatory disease (including coronary heart disease and stroke). Known risk factors (unhealthy diet, smoking, lack of physical activity, and alcohol) account for around 40% of total ill health, and despite the fact that Merton generally ranks positively against London and England, the numbers of people in Merton with unhealthy behaviours are substantial. Consequently, changing patterns of unhealthy behaviour needs to be an important focus for prevention efforts. Furthermore, most risk factors are inversely associated with socio-economic conditions, and there is marked variation in patterns of healthy behaviours, and health outcomes, within Merton.*

Robust ward level data on the four behavioural lifestyle factors which impact most on preventable ill health is challenging to find, for both current inequality gap analysis as well as to look at trend in the gap.

As discussed in Section 1.3 looking at the different types of risk factors that drive poor health, in addition to the behavioural factors, there are also physiological risks such as hypertension (discussed below), and psychosocial risks such as loneliness (discussed in Chapter 6 – healthy and sustainable places). A few marker indicators for disease morbidity are also given below, to give a flavour of the inequality gaps seen in both physical and mental health in Merton, but these are not comprehensive, rather indicative of the issues.

Behavioural risk factor - Smoking

We do not have access to ward level trend data on smoking, so cannot look at the inequality gap between the 30% most and least deprived areas, but we can use GP data to look at the prevalence of smoking between east and west Merton, as recorded by GP Quality Outcome Framework (QOF) registers. This shows that the difference in recorded levels of smoking between east and west Merton is **6.2 percentage points** in 2015/16 (19.36% prevalence in east Merton compared to 13.12%% in west Merton), 2015/16 data. Due to the methodology for calculating this gap (by amalgamating data for individual GP practices), it is not possible to calculate accurate confidence intervals to be able to say whether this difference is statistically significant, but it is quite large.

The gap between east and west appears to have **increased** substantially, from 1.95% in 2012/13 to 6.23% in 2015/16, due to a general increase in smoking prevalence in east Merton and a general decreasing trend in west Merton. It is difficult to know if smoking prevalence is really increasing in east Merton (for instance, it may be that recording of smoking status is improving, rather than any change to underlying levels of smoking, as discussed in Box 2 in Section 2.2), but regardless, there is still a significant inequality gap, and smoking is one of the biggest preventable causes of ill health.

Physiological risk factor – hypertension

The difference in recorded levels of hypertension between east and west Merton is **1.5 percentage points** in 2016/17 (11.59% prevalence in east Merton compared to 10.06% in west Merton). This difference is statistically significant. There has been a slight **increase** in the gap between East and West (from 1.3 percentage points in 2011/12 to 1.5 in 2016/17), although the difference is unlikely to be statistically significant.

Morbidity – Diabetes prevalence

We have chosen diabetes prevalence as an example 'morbidity' indicator to look at the inequalities gap, as diabetes is a priority of the HWBB. The difference in recorded levels of diabetes between east and west is **3.1 percentage points** in 2016/17 (8.0% prevalence in east Merton compared to 4.85% in west Merton). This difference is statistically significant. There has been an **increase** in the gap between East and West (from 2.5 percentage points in 2011/12 to 3.1 in 2016/17), and this increase appears statistically significant.

Morbidity - Tuberculosis (TB)

The rate of TB in Merton overall is decreasing steadily. There is a significant difference in the rate of TB between the most and the least deprived areas of **25.6 per 100,000** (35.03 per 1000 population in the 30% most deprived wards compared to 9.37 rate per 100,000 in the 30% least deprived). Since 2011-13, there appears to have been a slightly faster rate of decline in the 30% least deprived areas, resulting of a **slight widening** in the gap from 23.4 per 100,000 rate difference in 2011-13 to 25.6 percentage points in 2014-16. However, the numbers are relatively small so it is unlikely to be a statistically significant increase.

Morbidity – prevalence of mental health conditions

Mental health is an important indicator as health and wellbeing is not just about physical health but also mental health and wellbeing. We do not have access to ward level data on mental health, so cannot look at the inequality gap between the 30% most and least deprived areas, but we can use GP data to look at the prevalence of mental health between east and west Merton, as recorded by GP QOF data.

This shows that for recorded mental health prevalence, the difference between east and west Merton is **0.24 percentage points** (1.01% prevalence in east Merton compared to 0.77% in west Merton), using 2016/17 data. Although a relatively small recorded prevalence, this difference is statistically significant, as shown by the confidence intervals. The prevalence of mental health conditions recorded by GPs in Merton has increased slightly in both the east and the west, but appears to have increased at a faster rate in west Merton. This means that the **inequality gap appears to have decreased** slightly from 0.30 percentage points in 2012/13 to the current 0.24 percentage point gap. As highlighted earlier, GP prevalence data can be complex to interpret, as this increased gap could be as a result of a real increase in prevalence of poor mental health, or, which is more likely, be a consequence of improved recognition and diagnosis of mental health conditions in primary care. If the latter is true, then this trend data may suggest that diagnosis rates are better in west Merton than east Merton, rather than that there has been an underlying increase in disease, and demonstrates the importance of primary and community care in tackling health inequalities, as discussed in Part 1. This data probably does not therefore tell a positive story of reducing inequality, rather points to poorer diagnosis for more deprived residents relative to their less deprived neighbours.

Morbidity – prevalence of depression

Again, we do not have ward level data for depression, but can use GP records of depression diagnosis to look at the inequality gap between east and west Merton. This shows that the difference in recorded depression is **0.45 percentage points** (7.14% in east Merton compared to 6.69% in west Merton, 2016/17 data). The difference in prevalence between the east and the west in 2016/17 is statistically significant. Between 2011/12 and 2016/17 the **inequality gap appears to have flipped**, from higher rates of depression in west Merton (difference of -1.81 percentage points) to higher rates in east Merton in 2016/17 (difference of 0.45 percentage points). **This is one of the only indicators we looked at where the rate of a disease or risk factor was higher in less deprived areas than more deprived areas at any point in the historical trend data** (the other indicators being rates of theft, and burglary, both higher in the least deprived areas).

As we know that major risk factors for poor mental health and wellbeing are those associated with deprivation (e.g. poor education, unemployment, social exclusion, and poor standards of living), this again points to an interpretation of historical better diagnosis of depression in west Merton compared to east Merton (rather than a true larger prevalence of disease), and therefore hidden inequalities in diagnosis/under-diagnosis of mental health conditions. However, the latest data suggests that this pattern may be in the process of being reversed. We need to continue to monitor this trend to better understand the picture of inequalities in mental health in Merton.

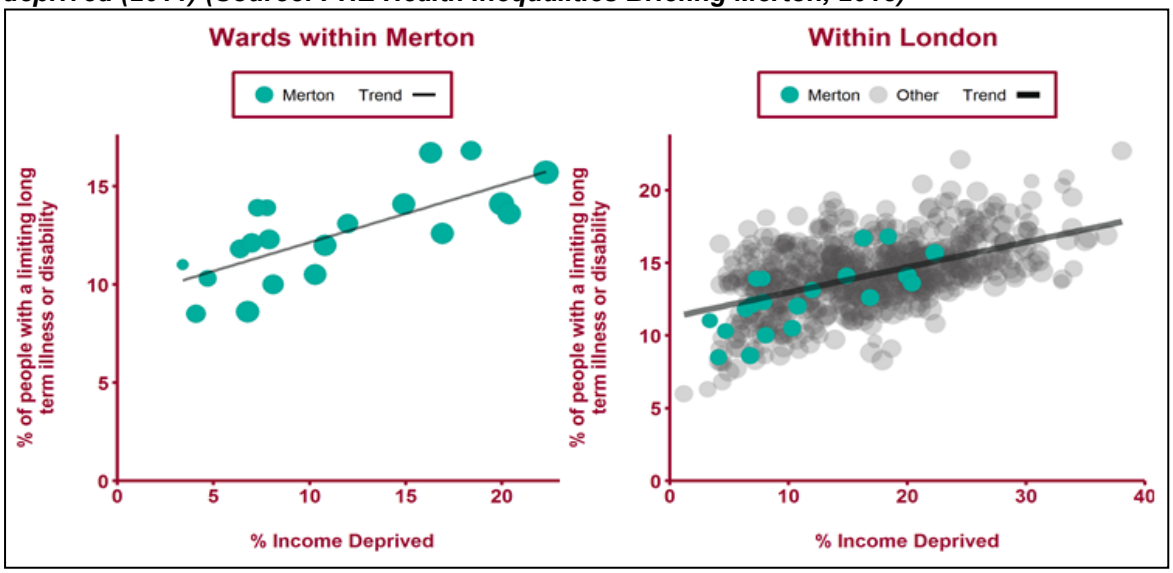
Self-reported wellbeing

The GLA has data on self-reported wellbeing at ward level. This presents a combined measure of well-being indicators based on 12 different measures, with scores over zero indicating a higher probability that the population on average experiences positive well-being. 2013 data, which is the most recent available, shows that the wellbeing score for the 30% most deprived wards was -2.3, suggesting poor wellbeing, compared to a score of 9.4 for the 30% least deprived areas, a gap of **11.7 points**. This supports our hypothesis above that the lower prevalence of depression seen previously in East Merton is likely to be an artefact of lower diagnosis rates rather than better mental health. Between 2009 and 2013, the difference between the most and least deprived wards **reduced slightly**, (from 12.3 to 11.7). However, again this is not really a positive outcome, as wellbeing scores worsened in both the most and least deprived areas, but at a faster rate in the least deprived areas.

Limiting long term illness or disability

'Limiting long term illness or disability' data is based on a Census 2011 question, so we do not have recent or trend data on this indicator, but PHE's recent Health Inequalities Briefing, based on the Global Burden of Disease study, highlights the social gradient in Merton:

Figure 15: Limiting long term illness or disability for Merton wards by percentage income deprived (2011) (Source: PHE Health Inequalities Briefing Merton, 2018)



Other 'prevention of poor health' indicators

Premature mortality is included in Chapter 1 as an overarching indicator of health inequality. There are a range of other indicators that we could consider for the HWBS refresh, or the Local Health and Care Plan which will look specifically at health and care services, in order to track health inequalities, for example:

- Risk factors/morbidity: Hospital admissions for alcohol related harm. We would have liked to have analysed this in more detail, given the importance of alcohol as a public health issue and the strong associated with income deprivation (and that this is a PHE Health Equity indicator), but although we can see there is an inequality gap between the most and least deprived wards (see *Supplementary Data Report*, and summary indicator table in Section 5), there is a lack of robust trend data at ward level.
- Morbidity: disease incidence (e.g. cancer); or all-cause, or disease-specific, hospital admissions (e.g. for Coronary Heart Disease, Stroke, Chronic Obstructive Pulmonary Disease). See the *Supplementary Data Report* for single time point data on emergency hospital admissions related to income deprivation for which there is a strong relationship.
- Premature Mortality: Cardiovascular / Cancer mortality under 75 (both Health Equity)
- Mortality: Suicide (Health Equity)

2.7. CHAPTER 4: Creating the conditions for fair employment and good work for all

Why is this important? *The availability and nature of employment is a key determinant of health inequalities. Good quality work and working environment is a key contributing influence on an individual's health and wellbeing, and that of their family and community. Employment is important because being unemployed or having a poor quality job is bad for health, and good quality appropriately paid employment is a protective factor for health (moving from unemployment into work can substantially reduce the risk of premature mortality) and can contribute to reduced health inequalities. Increasing the quality and quantity of work can help reduce health inequalities.*

Economically active population claiming Job Seekers Allowance (JSA)

Data on claimants of Job Seekers Allowance (JSA) is an important measure of those out of work but who are deemed fit for work. According to ONS NOMIS, JSA 'is not an official measure of unemployment, but is the only indicative statistic available for areas smaller than Local Authorities.' The latest available data from ONS on the percentage of the economically active population claiming JSA shows that there is a **2.5 percentage point gap** in Merton in 2015 (3.3% in the 30% most deprived compared to 0.8% in 30% least deprived wards). This difference appears to be statistically significant.

However, there appears to be a substantial **reduction in the inequality gap over time**, decreasing from a 4.7 percentage point gap in 2011 to a 2.5 point gap in 2015, driven by general decrease across the borough but also a faster decrease in the most deprived wards. This appears positive, although it is difficult to say whether this decrease represents a real reduction in inequality, or changes to the way that benefits are claimed (although the data presented here and in the *Supplementary Data Report* is up to 2015, prior to the introduction of Universal Credit (UC)). Anecdotally, the Mitcham Job Centre do report that they are seeing more people in sustained work than previously, and that those who are left claiming employment related benefits over the long term have much more complex needs, including poor mental health as a significant issue.

As the most recent data is only available to 2015, regression analysis (using the current trend data to project missing data points) has been undertaken, which appears to show that inequality gap in 2018 is likely to narrow further, to just under 1 percentage point difference between the 30% most deprived wards compared to the 30% least deprived. However, the picture will be further complicated by the introduction of Universal Credit in the meantime (introduced into the SM4 Morden area in around 2016, and the CR4 Mitcham area from the end of 2017 – any change of circumstances for claimants, for example a change of address, will trigger a move from JSA to UC). The west of the borough will start the move to UC at the end of June 2018, and the move over to UC is not due to be completed until 2020 – so the data will need to be interpreted carefully going forward.

The data reported here is 'all economically active population claiming JSA'; perhaps a more useful indicator to look at in more detail going forward would be *long term* claimants (for example those claiming employment related benefits for more than a year) – this is a Marmot indicator, but data is not currently readily available at ward level.

Benefit claimants - employment and support allowance (ESA)

Data on claimants of Employment and Support Allowance (ESA) is an important measure of those with a short or long term health condition or disability that impacts on their ability to work; eligibility is dependent on sickness certification. The latest available data from ONS on the percentage of the working age population claiming ESA shows that there is a **3.4 percentage point gap in Merton in 2017** (5.04% in the 30% most deprived compared to 1.64% in 30% least deprived wards). This difference is statistically significant. The inequality

gap appears to be **relatively stable over time** (3.2 percentage points difference in 2014 compared to the current 3.4 point gap).

As with JSA, ESA claimants will gradually be moved over to UC by 2020, with those in the east of the borough moving over sooner than those in the west, which will have implications for how the data available for the years between 2016 to 2020 is interpreted.

Other 'fair employment, good work' indicators

Other employment related data that we considered included 'Benefits claimants – income support' and 'Benefits claimants - Incapacity Benefit/Severe Disablement allowance' but the numbers were too small to be able to make meaningful conclusions at ward level.

At present NOMIS is still the only source of unemployment data, and 'Claiming UC' at borough level is all that is currently available for Universal Credit. In the future, it is likely that the data will be able to be split by reason for claiming UC, and by sub-borough geographies, and we will need to review in order to choose the most appropriate indicators for tracking progress related to fair employment and good work. The Government has recently launched a consultation on how to assess the number of people claiming unemployment-related benefits, and so there is opportunity to shape the way that the data is collected and reported to enable us to better monitor inequalities in the future as Universal Credit is rolled out.[25]

We would have liked to have looked at the Merton inequality gap for the following PHE Marmot/Health Equity indicators, but data was not readily available at ward level:

- Unemployment (Marmot)
- Long term claimants of Jobseekers Allowance (Marmot)
- Work related illness (Marmot)
- Employment gap for those with a long-term condition (Health Equity)

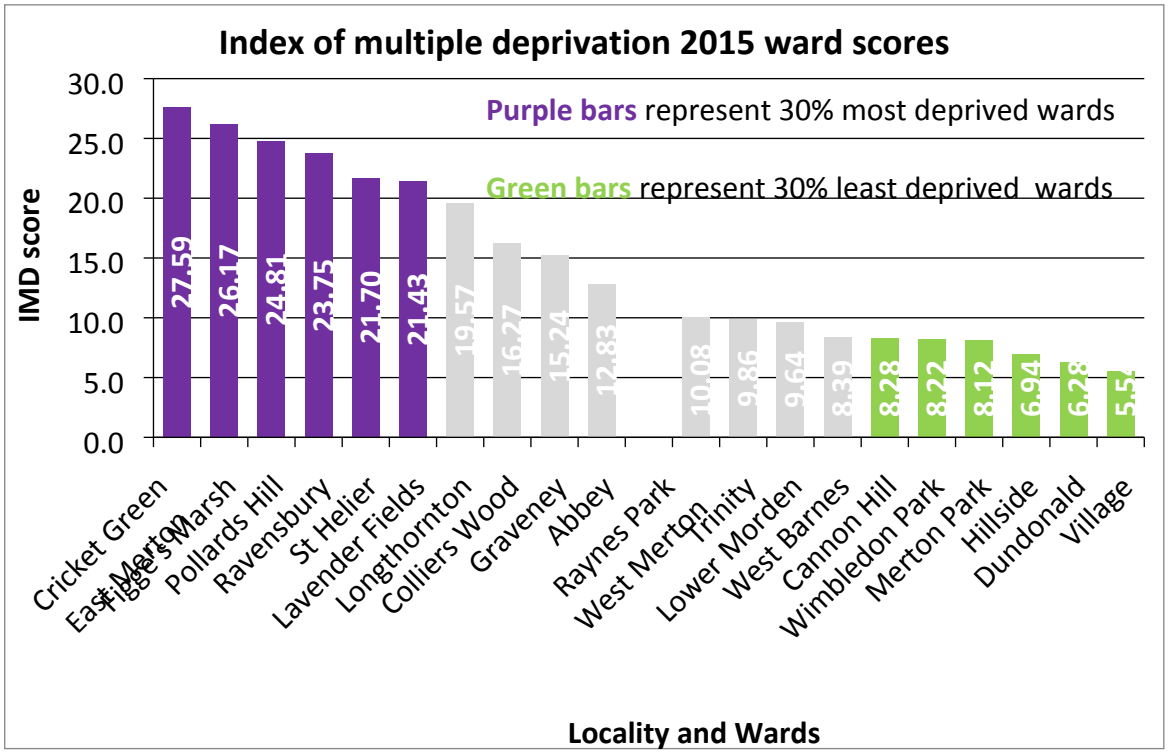
[25] Consultation: Proposals for a new statistical series to count unemployed claimants https://www.gov.uk/government/consultations/proposals-for-a-new-statistical-series-to-count-unemployed-claimants

2.8. CHAPTER 5: Ensure healthy standard of living for all

Why is this important? *As the Marmot review sets out, "having insufficient money to lead a healthy life is a highly significant cause of health inequalities." An insufficient income can cause poor health as "it is more difficult to avoid stress and feel in control; access…material resources; adopt and maintain healthy behaviours; and feel supported by a financial safety net."*[26]*Additionally, those living with health problems are more susceptible to unemployment, lower earnings, and lower household income, and poorer standard of living, so poor health can then lead to deprivation, in a vicious cycle for poor health outcomes.*

Deprivation by ward

The overall ward scores for the IMD (2015) deprivation index shows that there is a difference in score between the 30% most deprived and the 30% least deprived wards of **17.01 points** (score of 24.24 in the most deprived compared to a score of 7.23 in the least deprived). The higher the score the more deprived the area.[27] No benchmarking or confidence intervals are available for this data, and **trend data is not available** for IMD either – although IMD is updated every few years, it is not recommended to compare scores year on year as the underlying indicators change over time.



Deprivation by GP

Similarly, IMD 2015 data split by GP Practice IMD scores shows that there is a substantial difference between the average score of GP practices in east Merton and those in west Merton of **11.74 points** (score of 20.01 in the east compared to a score of 11.28 in the west). As before, the higher the score the more deprived the area.

[26] Health Foundation (2018) What makes us healthy? An introduction to the social determinants of health https://www.health.org.uk/sites/health/files/What-makes-us-healthy-quick-guide.pdf

[27] PHE Fingertips definitions: "The Indices of Deprivation 2015 are relative measures of deprivation. This means it can tell you if one area is more deprived than another, but not by how much. The IMD 2015 is not a measure of affluence; all of the indicators used in the index are designed to identify aspects of deprivation, not affluence. Therefore the area ranked as the least deprived is not necessarily the most affluent"

IMD 2015 data by GP practice is also available looking specifically at deprivation affecting children, and affecting older people:

- Income deprivation affecting children index (IDACI):[28] there is a difference between the average IDACI proportion of GP practices in east and those in west Merton of **13.33 percentage points** (25.24% compared to 11.91%).
- Income deprivation affecting older people index (IDAOPI):[29] there is a difference between the average IDAOPI proportion of GP practices in east and those in west Merton of **8.63 percentage points** (23.38% compared to 14.75%).

Both of these look at the income aspect of IMD for younger and older people. However, any direct comparison between IDACI and IDAOPI is not appropriate as the measures are calculated in different ways.

As with IMD by ward, although previous data for IMD by GP practice is available for the years 2004, 2007, 2010, 2015, this data is not comparable as the weighting of indicators has been changed over time. Therefore **trend data is not available**.

Overcrowding

We only had access to data on household overcrowding at ward level from the 2011 Census. The borough average is 16.1% of households in Merton that are overcrowded, with an inequality gap of **10.2 percentage points** between the most and least deprived areas (21.2% of households are overcrowded in the 30% most deprived wards compared to 11.0% in the least deprived – twice as many). **No trend data** is available on household overcrowding.

Fuel Poverty

Fuel poverty is influenced both by housing typology, including the age and size of housing, as well as the ability of those living there to pay for utilities. We have data from 2015 on fuel poverty (the percentage of households that experience fuel poverty, based on the 'low income high cost' methodology) for wards in Merton which shows that the inequality gap is **1.4 percentage points** between the 30% most and least deprived areas (10.5% in the most deprived areas compared to 9.1% in the least deprived). This difference appears to be statistically significant.

This is a new indicator on the PHE Local Health portal, and so whilst **historic trend at ward level is not available** which means that we cannot look at the trend in the inequality gap to date, we may be able to monitor trend in the future.

Other 'healthy standard of living' indicators

We would have liked to have looked at the Merton inequality gap for the following PHE Marmot/Health Equity indicators, but data was not readily available at ward level:

- Households not reaching minimum income standard (Marmot)
- Homelessness (Health Equity)

[28] Based on the same indicator as Child Poverty. LSOA level deprivation data are applied proportionally to GP practice populations.

[29] Based on the percentage of the population aged 60 and over who receive income support, income based job seekers allowance, pension credit or child tax credit claimants aged 60 and over and their partners (if also aged 60 or over). LSOA level deprivation data are applied proportionally to GP practice populations.

2.9. CHAPTER 6: Develop healthy, sustainable places and communities

Why is this important? *The places in which people live influence the health and wellbeing of individuals, families and communities. This includes the nature of the physical environment, the access to green spaces, and how safe, connected and represented people feel within their neighbourhoods and wider community.*

Reported Crime

Metropolitan Police Data for 2017 gives a picture of reported crime in the borough. Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.

- Burglary Difference in ward scores is **-3.4 per 1000 population rate difference** (5.3 per 1000 in the 30% most deprived compared to 8.7 per 1000 in the 30% least deprived wards).
- Theft: Difference in ward scores is **-8.5 per 1000 population rate difference** (18.0 per 1000 in the 30% most deprived compared to 26.5 per 1000 in the 30% least deprived wards).
- Criminal damage: Difference in ward scores is **4.2 per 1000 population rate difference** (8.5 per 100,000 in the 30% most deprived compared to 4.3 per 1000 in the 30% least deprived wards).
- Antisocial behaviour: Difference in ward scores is **7.0 per 1000 population rate difference** (19.5 per 1000 in the 30% most deprived compared to 12.5 per 1000 in the 30% least deprived wards).
- Violence against the person: Difference in ward scores is **14.5 per 1000 population rate difference** (28.9 per 1000 in the 30% most deprived compared to 14.5 per 1000 in the 30% least deprived wards).

The gap for burglary and theft are both in favour of the most deprived areas (i.e. there is less reported burglary and theft in the more deprived areas); however, this is to be expected as it is probable that the more expensive assets are likely to be found in the more affluent areas, and therefore be a target for theft. There may also be increased reporting of crime in the least deprived areas.

Social isolation

Social isolation is a psychosocial risk factor for poor health and wellbeing. We have some Census 2011 data at ward level on the number of people aged 65 and over living alone (as a percentage of the total number of people aged 65 and over), which shows a gap of **0.5 percentage points** between the 30% most deprived (34.2%) and the 30% least deprived (33.7%). However this metric doesn't tell us how many of those actually *feel* socially isolated, and there is **no trend data** available as the next Census is in 2021.

Other 'healthy and sustainable places' indicators

There is relatively little easily accessible and up-to-date ward level data for the social determinants of 'place' to be able to look at inequalities. This is an area we will need to think carefully about how to monitor in the forthcoming HWBS 2019+.

- We would have liked to have looked at the Merton inequality gap in 'Utilisation of outdoor space for exercise/health reasons' (PHE Marmot indicator), but data was not available at ward level.
- Other indicators that it may be worth investigating include measures of air quality, levels of volunteering, or the percentage of the population who vote.

3. PART 3: LESSONS FOR ADDRESSING HEALTH INEQUALITIES IN MERTON

This APHR on Health Inequalities has investigated some of the key inequality gaps between the most and least deprived communities in Merton that impact on health outcomes. It casts new light and produces clear evidence to show a sustained gap in health and wellbeing across communities in Merton and provides robust data, on which our plans and policies can build, to address these inequalities.

In particular, the findings from this piece of work can directly be used to inform the refresh of the Health and Wellbeing Strategy 2019+, as well as other data analysis and reporting such as the Joint Strategic Needs Assessment, other statutory assessments such the Community Safety Partnership strategic assessment, and the development of indicators and reporting for other strategic work such as the NHS's Local Health and Care Plan.

3.1. Conclusions

Measurement of inequalities

It is important to measure inequalities in a standardised way, but the process of analysing indicators for this report has shown that it is challenging given the limitations in the data available. In particular:

- Many nationally available indicators are only available at borough not ward level which does not enable analysis of sub-borough inequalities. For instance, most PHE Marmot indicators and PHE Health Equity indicators are not available at sub-borough level. This is surprising, and something that we will be feeding back to the data and intelligence team at Public Health England, as in order to track progress on health inequality and to effectively target interventions, sub-borough analysis is vital;
- Some indicators only had data available from a number of years ago, for instance the most recent Healthy Life Expectancy data was from 2009-2013, ward level data for School Readiness was only available for 2013/14, and the most recent data on 'Limiting long term illness or disability' and on 'Household Overcrowding' are from 2011 (as these are from Census data, only collected every 10 years). This means that making relevant conclusions from this data is difficult;
- Where sub-borough data was not available, in some cases there were other ways to look at the likely inequality gap, for example by comparing borough level Child Development data with data for a sub-set of the population with Free School Meal status;
- Where sub-borough data is available for nationally available indicators, often only single data points are readily available through data portals such as PHOF or PHE Local Health. This lack of historic data means that no trend can be calculated. Even where trend data is available, it is often only available for limited time points, which makes trend analysis less accurate. For example, Premature Mortality data was only available for three points, where as Slope Index of Inequality data was available for ten. We can be more confident to make conclusions about trend from more data points;
- Because of the different methodologies used for calculating the inequality gap (30/30 versus East/West), it is not possible to directly compare the magnitude of the gaps between the different methods;
- Using the data available, it is often difficult to calculate if the current gap is significantly different from a statistical perspective, and/or whether the trend is statistically significant.

We have only looked at two related aspects of inequality: geographic and socioeconomic inequalities. It would be worth looking at other measures of inequality, for instance age, sex, ethnicity or other protected characteristics. Where nationally available data cannot be broken down by these characteristics, we may need to look at locally collected data.

Inequalities in Merton

Despite the challenges, the analysis undertaken in this APHR shows that there is much that we can say about inequalities in Merton:

- **Inequalities are evident in every indicator** studied. The vast majority of indicators demonstrated a substantially worse picture in the most deprived areas. For example, we found a 14.5 percentage point difference in proportion of children who are overweight or obese in primary school (Year 6), between the most and least deprived wards in Merton.

  PHE's recent Health Inequalities Briefing for Merton (2018), based on the Global Burden of Disease study, states that the top three indicators **most strongly associated with deprivation locally** are: emergency hospital admissions for all causes, childhood obesity (Year 6), and hospital stays for alcohol-related harm.

  The only indicators that appeared to be in favour of the most deprived wards, or where there was an unclear picture were:

  i. Depression – between 2011/12 and 2016/17 the inequality gap appears to have flipped, from higher rates of depression in West Merton to higher rates in East Merton. The previous higher rates seen in the West of the borough are likely to be a measure of under-diagnosis in the East rather than less mental health need/better mental health.

  ii. Theft and burglary – the rates of these reported crimes are higher in west of the borough, which is not surprising given the socioeconomic picture, as this is where more expensive assets are likely to be, as well as potentially increased rates of reporting by residents.

- **The magnitude of the inequality gap varied**, and the relevance of the size of the gap to residents' health and wellbeing outcomes varies from indicator to indicator. For instance, the difference in percentage of overweight or obese children in Year 6 between the most/least deprived is 14.5 percentage points, which equates to 735 children (2014/15-2016/17) where as the difference in percentage of residents claiming ESA between the most/least deprived is smaller at 3.4 percentage points, but equates to 1,605 residents;

- **In terms of trend in inequalities in Merton, the picture is mixed**. The general message is that inequalities in Merton are intransigent, but that we need to keep them under review over a longer time frame.

  i. There are some success stories, for instance the reducing gap in life expectancy at birth for women in Merton (although the reduction is not yet statistically significant), the apparent reduction in the Child Poverty gap (although the main trend is based on extrapolated data due to lack of very recent published data); the reducing gap in School Readiness (comparing child development at age 5 for all children with that of children with free school meal status), and the reductions in the gap in the economically active population claiming jobseeker's allowance (JSA) between the most and least deprived areas;

  ii. There are a number of areas where the inequality gap appears to be stable (e.g. male life expectancy at birth, ESA claimants), or where picture is complex (e.g. recorded depression prevalence);

  iii. In some cases, the gap appears to be reducing for the 'wrong' reasons, for instance because the situation for those in more affluent areas appears to be worsening whilst that for those in the more deprived areas remains stable or worsening at a slower rate, or improving, all of which have the effect of narrowing the gap. This is the case for Child Poverty, mental health prevalence, and self-reported wellbeing;

  iv. Unfortunately, analysis also shows that there are a substantial number of indicators where inequalities appear to be increasing, including child excess weight, prevalence of smoking, diabetes and hypertension, and premature mortality.

- **Cumulative inequalities throughout life and the environments within which our residents live contribute to overarching inequalities in health outcomes.** We can see these most clearly in the significant differences in life expectancy between the most and least deprived parts of our borough, of around 6.2 years for men and 3.4 years for women borough (Slope Index of Inequality). Inequalities in *healthy* life expectancy are even starker, with a difference of more than 9 years of healthy life..

3.2. Recommendations

A. Recommendations for tackling health inequalities in Merton

The Public Sector Equality Duty obligations under the Equality Act 2010 mean that we need to pay due regard to equality and inclusion issues in all our decision making.

We know that health inequalities are persistent, complex and difficult to shift. **We therefore need to take consistent and intelligent action on health inequalities** in Merton, actively and systematically targeting inequalities through a long-term multi-sectoral approach across all partners – including the NHS, Council, voluntary sector and the community – in order to be able to make any progress.

This action should be:

- Based on evidence of need, driven by data – for example, detailed understanding of which groups have worst health outcomes and why;
- Grounded in evidence of what works and is cost-effective, for example using evidence-driven interventions such as those set out in NICE guidance;
- Grounded in evidence of what works to shift inequalities in particular, using the evidence-based approach of proportionate universalism, with both carefully considered universal approaches (even in times of austerity) and carefully targeted approaches to those who are most at risk of poor health and wellbeing. This includes:
    i. Intervening for population level impact, recognising the increased cost-effectiveness of population level interventions compared to personal level interventions, and increased impact on health inequalities
    ii. Intervening at different levels of risk, including the importance of the role that NHS primary care and community services play in reducing inequalities;
    iii. Intervening across the whole life course, giving all residents the best start in life, so they can start well, live well and age well;

To be effective, approaches must be underpinned by participatory decision-making and co-design, and driven through individual and community empowerment.

If we take our eye off the ball, health inequalities are likely to increase. Therefore we need to intervene for impact over time, and to continuously monitor progress.

B. Recommendations for monitoring health inequalities in Merton

1. The analysis set out in this report will inform the choice of a suite of indicators for the HWBS 2019+

The analysis within this report, particularly around which indicators *can* be tracked at sub-borough level to look at inequalities within Merton, and at changes to the inequality gap over time, should inform the indicators chosen to support the monitoring of the HWBS from 2019. The strategy is likely to cover a period of 5 years, from 2019-2024, and will form the core of Merton's strategy to reduce inequalities.

The table in Section 5 is the most accessible summary of the findings, set out by indicator. The last column indicates whether the indicator may be a good choice for the HWBS 2019+.

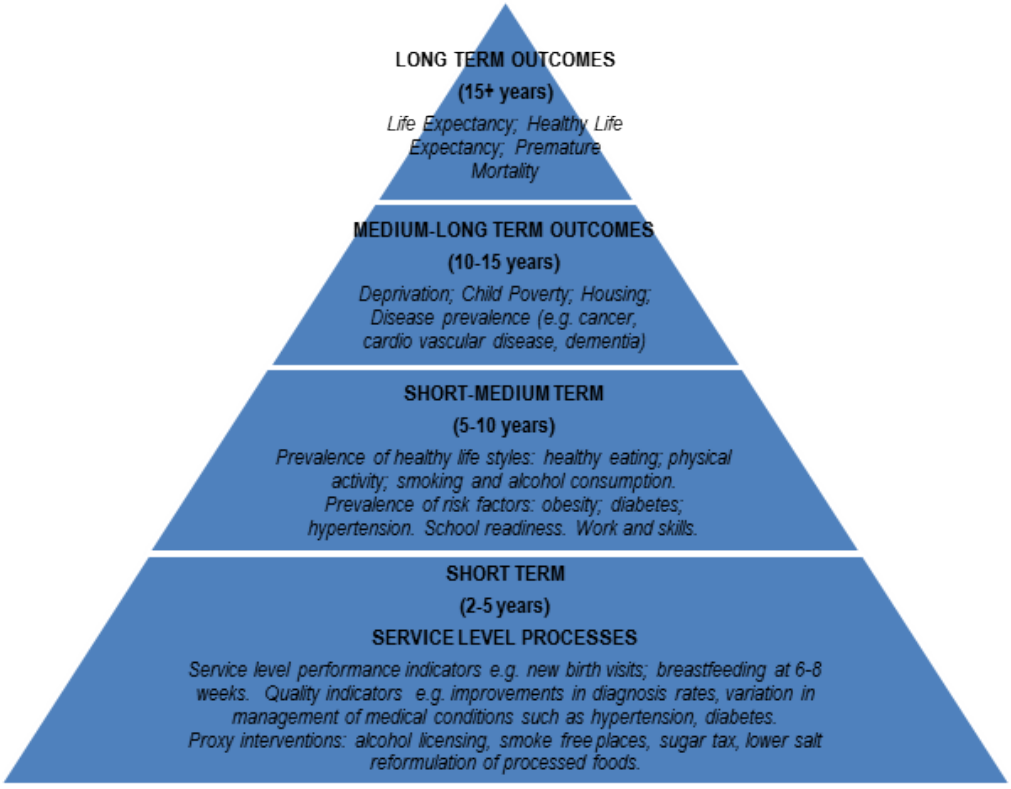
In terms of overall inequalities in life expectancy in Merton, we recommend that the Slope Index of Inequality is used as the overarching measure of the life expectancy inequality gap, as it is produced nationally and can be compared to statistical comparator boroughs.

Some borough level indicators will be important to monitor, but it is also important that some key indicators are also monitored at a sub-borough level to look at the inequality gap. Where no sub-borough and/or trend data is available (historic and/or future) in order to be able to calculate an inequality gap, we may need to think about how we keep eye on progress in closing the gap in other ways, for example using the methodology that we have used for Child Development by comparing borough level data for all children with borough level data for those with Free School Meal status.

When developing a set of indicators, it is important to think about an underpinning logic model or theory of change, in order to develop a hierarchy of indicators, with a clear logical progression and explicit assumptions on the relationships between each tier. See Figure 16 for an example of this tiered approach to developing a suite of indicators for monitoring.

Although this APHR has focused on place-based deprivation-linked inequality (using most/least deprived wards, or E/W gap), this is not the only way in which data should be broken down to look at inequalities. Although as this report has highlighted, there is a lack of data available at sub-borough level even broken down to ward level, but where possible it is important to look at inequalities by age, sex, ethnicity and other protected characteristics.

Figure 16: Example for a tiered approach to monitoring Health & Wellbeing outcomes and proxies over relevant time periods



2. We need to be realistic about timescales in which we can expect to see changes to the inequalities gap in Merton

Part 1 (Section 1.3) of this report reminds us that different types of interventions will take different amounts of time to demonstrate impact. When setting targets, we therefore need to be explicit about the timescales within which we would expect to see changes to different

metrics, and that these are likely to sit outside any local and national political cycles, requiring coordinated action over time.

Regression analysis for chosen indicators will help to set realistic but ambitious targets – recognising that sometimes these targets will be to *halt the rise* in the inequality gap, or to *hold the gap stable*, rather than to actually to be able to reduce the gap within the time frames of most strategies (3-5 years), especially given the recent context of financial austerity.

When choosing targets, it is also important to benchmark ourselves against our statistical comparator boroughs, neighbouring boroughs, as well as the London and England figures.

3. A standardised methodology should be used across Merton to be able to effectively monitor inequalities and progress towards closing the gap

We recommend that the methodology used for gap analysis and trend analysis in this report is adopted by the council and partners for calculating and reporting the gap in inequalities between the East and the West of the borough, to meet the 'bridging the gap' priority of the Merton Partnership.

This has implications for the choice of indicators for forthcoming strategic work such as the NHS's Local Health and Care Plan, and how we look at reporting inequalities as part of statutory assessments (for example the Community Safety Partnership Strategic Assessment), as well as for analysis of other locally collected data, particularly that which is done on a regular basis using relatively standard indicators, such as the council's Residents Survey.

Other partners may also be interested in thinking about taking a 'logic model' approach to developing a suite of indicators to monitor outcomes over defined time periods, with some that focus on short term change as a proxy for longer term progress.

We recommend that where possible, and where granularity of data is sufficient, that indicators from nationally available datasets are used for monitoring trend over time. Where data is collected locally, for instance through the Residents Survey, or in ad hoc surveys for regular reports such as the Strategic Assessment, it is really important to carefully consider how indicators are chosen and worded, to enable consistency of trend analysis over time.

C. Recommendations for monitoring health inequalities nationally

Given that data in many of the easily accessible national PHE data sets is only available at borough not ward level (therefore limiting analysis of sub-borough inequalities), Public Health Merton will feedback to PHE's data and intelligence team about the availability of sub-borough indicator data in easy to use formats, for instance through the online Local Health portal, and particularly for the PHE Marmot and PHE Health Equity indicator sets, to inform their ongoing support to local authority public health teams.

We will also respond to the government's consultation on Universal Credit metrics, as discussed in Chapter 4, to ensure that we are able to access ward level data on appropriate indicators to continue to measure trend in inequalities in the domain of fair employment and good work.

4. Appendices

Appendix 1: Resources for understanding and tackling health inequalities

- **Department of Health** (2008) Systematically Addressing Health Inequalities http://webarchive.nationalarchives.gov.uk/20130124043456/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086573.pdf
- **Department of Health** (2011) Health Inequalities National Support Team - A Generic Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Interventions https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215615/dh_126331.pdf
- **Institute of Health Equity:** http://www.instituteofhealthequity.org/
- **Kings Fund** (2010): Tackling inequalities in General Practice https://www.kingsfund.org.uk/sites/default/files/Health%20Inequalities.pdf
- **Kings Fund** (2013) Improving the public's health: A resource for local authorities https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf
- **Kings Fund** (2013) Improving the public's health: https://www.kingsfund.org.uk/projects/improving-publics-health
- **Kings Fund** (2017) https://www.kingsfund.org.uk/blog/2017/08/reducing-inequalities-health-towards-brave-old-world
- **LGA** Feb 2018 'A matter of justice: Local government's role in tackling health inequalities' https://local.gov.uk/matter-justice-local-governments-role-tackling-health-inequalities
- **LGA:** Health in all policies: A manual for local government https://local.gov.uk/health-all-policies-manual-local-government
- **Health Foundation:** healthy lives infographics series https://www.health.org.uk/collection/healthy-lives-infographics
- **Health Foundation:** healthy lives quick guide https://www.health.org.uk/sites/health/files/What-makes-us-healthy-quick-guide.pdf
- **Marmot** (2010): Fair Society Healthy Lives http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf
- **NHS** Reducing health inequalities resources: https://www.england.nhs.uk/about/equality/equality-hub/resources/evidence/
- **PHE Local Health**: http://www.localhealth.org.uk/
- **PHE Public Health Outcomes Framework (PHOF):** https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
- **PHE Public Health Profiles**: https://fingertips.phe.org.uk/
- **PHE** (2017) Reducing health inequalities: system, scale and sustainability https://www.gov.uk/government/publications/reducing-health-inequalities-in-local-areas
- **WHO** (2015): McDaid, D, Sassi, F & Merkur, S (2015) Promoting Health, Preventing Disease: The Economic Case. World Health Organisation. http://www.euro.who.int/__data/assets/pdf_file/0006/283695/Promoting-Health-Preventing-Disease-Economic-Case.pdf?ua=1

Appendix 2: PHE Indicators sets (Marmot; Health Equity)

Marmot indicators
Life expectancy at birth – males and females
Healthy life expectancy at birth – males and females
Inequality in life expectancy at birth – males and females
People reporting low life satisfaction
Good level of development at age 5
Good level of development at age 5 with free school meal status
GCSE achieved (5A*-C including English & Maths)
GCSE achieved (5A*-C including English & Maths) with free school meal status
19-24 year olds who are not in employment, education or training
Unemployment % (ONS model-based method)
Long-term claimants of Jobseeker's Allowance
Work-related illness
Households not reaching Minimum Income Standard
Fuel poverty for high fuel cost households
Utilisation of outdoor space for exercise/health reasons

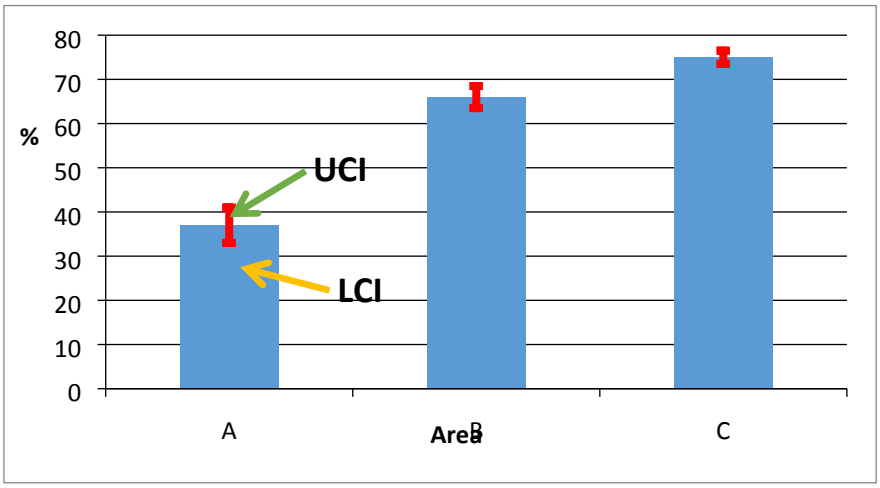
Health Equity Indicators
Life expectancy at birth
Healthy life expectancy at birth
Cardiovascular disease mortality under 75 years
Cancer mortality under 75 years
Infant mortality
Low birthweight of term babies
Proportion of five year old children with dental decay
Child excess weight in 4-5 and 10-11 year olds
Alcohol related hospital admissions
Prevalence of smoking among persons aged 18 years and over
Incidence of tuberculosis
Suicide
Self-reported wellbeing - low life satisfaction
Children in low income families (all dependent children under 20)
Readiness for school
Young people not in employment, education or training
Employment gap for those with a long-term condition
Homelessness

In **bold** – same or similar indicators between the two indicator sets

Appendix 3: Marmot priorities mapped to HWBS 2015-18 and APHR 2018

Marmot strategic priority areas for tackling heath inequalities	**HWBS 2015 – 2018 Themes**	**APHR 2018 Chapters and indicators**
-	-	Chapter 1: Overarching indicators
1. Giving every child the best start in life	Theme 1: Best start in life	Chapter 2: best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives	Theme 1: Best start in life Theme 3: Life skills, lifelong learning and good work	Chapter 2: best start in life
3. Creating the conditions for fair employment and good work for all	Theme 3: Life skills, lifelong learning and good work	Chapter 4: creating the conditions for fair employment and good work
4. Ensuring a healthy standard of living for all	Theme 5: A good natural and built environment	Chapter 5: Ensuring a healthy standard of living for all
5. Creating and developing healthy and sustainable places and communities	Theme 4: Community participation and feeling safe Theme 5: A good natural and built environment	Chapter 6: develop healthy and sustainable places and communities
6. Strengthening the role and impact of ill-health prevention.	Theme 2: Good health	Chapter 3: prevention of poor physical and mental ill health

Appendix 4: Glossary

Term	Definition
Confidence Intervals	Confidence intervals are an indicator of how accurate a set of data values is likely to be. Generally, the more values there are in a dataset, the more accurate the data is likely to be. Confidence intervals of 95% are routinely used. This indicates that 95% of the time, the values would be expected to fall within the range of the upper and lower confidence interval values, around the mean (average) value. It is possible to tell whether a value is statistically significantly higher or lower using confidence intervals. In the following chart, the red markers are the confidence interval levels and in area A, the arrows point to the upper (UCI) and lower (LCI) confidence intervals. An value is considered statistically significantly higher or lower than another value if there is a gap in values, for example, below the UCI in Area A is lower than the LCI in areas B and C, therefore Area A is significantly lower than areas A and B. 
Decile	A decile is method of splitting up a set of ranked data into 10 equally sized subsections.
Directly Standardised Rate	Direct standardisation involves applying the rates of disease observed in the study group of people to a 'standard' population. The choice of the standard population depends on available data, and the purpose of the analysis.
Health Inequality	"Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs." -NHS England
Healthy life expectancy vs. Disability Free life expectancy	From the 2011 Census, one question was asked for each of the two indicators – healthy life expectancy (HLE) and disability free life expectancy (DFLE). Healthy life expectancy is a very general question about overall health and the DFLE question asked about longer term health problems or disabilities that would be expected to last for more than a year. These two questions are related in that they are enquiring about peoples' perceptions

	of their own health, however the responses would not necessarily be linked, for example, it is possible to be limited by a disability but still feel in good health. Census questions: • *Healthy life expectancy question: "How is your health in general?" Very Good/Good/Fair/Bad/Very bad.* • *Disability free life expectancy question: "Do you have any health problems or disabilities that you expect will last for more than a year?" Yes/No. If the answer was yes, a further question was asked; "Do these health problems or disabilities, when taken singly or together, substantially limit your ability to carry out normal day to day activities? If you are receiving medication or treatment, please consider what the situation would be without the medication or treatment" Yes/No.*
IMD	The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small areas in England (Lower Super Output Areas (LSOA)). It is a combined measure of deprivation based on a total of 37 separate indicators that have been grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area. The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area).
IDACI	The Income Deprivation Affecting Children Index (IDACI) is a specific subset of the Income Deprivation Domain relating to child poverty factors. The index is calculated by the Office of the Deputy Prime Minister and measures in a local area the proportion of children under the age of 16 that live in income deprived households. Income deprived families are defined as families that receive: • Income Support; or • income-based Jobseekers Allowance; or • income-based Employment and Support Allowance; or • Pension Credit (Guarantee); or • Working Tax Credit or Child Tax Credit with an equalised income (excluding housing benefit) below 60 per cent of the national median before housing costs
IDAOPI	The Income Deprivation Affecting Older People Index (IDAOPI) is another subset of the Income Deprivation Domain. This is based on the percentage of the population aged 60 and over who receive income support, income based job seekers allowance, pension credit or child tax credit claimants aged 60 and over and their partners (if also aged 60 or over).
Inequity	Inequity is an instance of injustice or unfairness. Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair. "Inequity and inequality: these terms are sometimes confused, but are not interchangeable, inequity refers to unfair, avoidable differences arising from poor governance, corruption or cultural exclusion while inequality simply refers to the uneven distribution of health or health resources as a result of genetic or other factors or the lack of resources." -Global Health Europe
Inequality	"Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger

	populations or differences in mortality rates between people from different social classes." -World Health Organisation Absolute Inequality reflects the magnitude of difference in health between two subgroups. Relative Inequality measures show proportionate differences in health among subgroups.
Life expectancy at birth	Life expectancy at birth can be defined as the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a new born baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life. Figures reflect mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live, both because the mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives. This indicator is an extremely important measure of mortality and morbidity.
Proportionate universalism	To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.
Slope index of inequality (years)	This is a single score representing the gap between the best-off and worst-off within a district for a chosen indicator. The slope index score represents the gap in years of life expectancy at birth between the most deprived and least deprived communities within a local authority area. The larger the index score (in years), the greater the disparity in life expectancy.
Social gradient in health	The social gradient in heath refers to the fact that inequalities in population health status are related to inequalities in social status; people who are relatively disadvantaged have progressively worse health outcomes than those who are more advantaged.
Standardised Admission Ratio (SAR)	The Standardised Admission Ratio (SAR) is a summary estimate of admission rates relative to the national pattern of admissions and takes into account differences in a population's age, sex and socioeconomic deprivation.
Wider determinants of health (also known as the social and economic determinants)	The wider determinants of health are a diverse range of social, economic and environmental factors which impact on people's health. These factors can be largely outside of an individual's direct control, and are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. Examples of wider determinants of health include: • Socioeconomic status • Education • Income • Smoking status • Employment • Alcohol use

	• Social networks

5. SUMMARY TABLE OF APHR 2018 INDICATORS

Chapter	Type of indicator	Indicator Green: analysis included in this report ***Black***: not covered in this report in detail	Most recent data source (year)	Timescale for change[i]	Merton inequality gap[ii] *Method of calculating gap*			Trend in Merton inequality gap[iii] (+/–; stable; mixed; Not Available)	PHE Marmot indicator (Y/N)	PHE Health Equity Indicator (Y/N)	Current Merton indicator? [iv]	Geography level for data availability [v]	Inequality trend to date?[vi] (Y/N) *i.e. can we measure historic trend in inequalities using gap analysis?*	Inequality trend in future?[vii] (Y/N/Maybe) *i.e. will we be able to measure future gap trend?*	Consider as a HWBS 2019-2024 indicator? (Y/N/Maybe)
					30/30	East/West	Other								
CHAPTER 1: Overarching indicators of inequality in health and wellbeing	Determinant	**Life Expectancy at birth (Males)**	Local Health (2011-15)	Long term	M: 4.1 years			Stable	Y	Y	HWBS	Ward; Borough	Y	Y	Y (SII may be more robust)
	Determinant	**Life Expectancy at birth (Females)**	Local Health (2011-15)	Long term	F: 2.7 years			Reducing (unclear if statistically significant)	Y	Y	HWBS	Ward; Borough	Y	Y	Y (SII may be more robust)
	Determinant	**Inequality in life expectancy at birth [Slope Index of Inequality] (Males)**	PHOF (2014-16)	Long term	M: 6.2 years			Stable	Y	N	-	Sub-borough[viii] (10/10 analysis)	Y	Y	Y
	Determinant	**Inequality in life expectancy at birth [Slope Index of Inequality] (Females)**	PHOF (2014-16)	Long term	F: 3.4 years			Reducing (but not yet statistically significant)	Y	N	-	Sub-borough (as above)	Y	Y	Y
	Determinant	**Healthy life Expectancy at birth (male)**	ONS (2009-13)	Long term	9.4 years			N/A	Y	Y	MP	Ward; Borough	N	N	Y (borough not gap)
	Determinant	**Healthy life Expectancy at birth (female)**	ONS (2009-13)	Long term	9.3 years			N/A	Y	Y	MP	Ward; Borough	N	N	Y (borough not gap)
	Determinant	*Disability free life expectancy from birth (male and female)*	ONS (2009-13)	Long term	M: 7.8 years F: 7.1 years			NA	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Disability free life expectancy at age 65 (male and female)*	ONS (2009-13)	Long term	M: 3.1 years F: 2.7 years			NA	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Proportion living without disability at birth (male and female)*	ONS (2009-13)	Long term	M: 4.7 % points F: 4.5 % points			N/A	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Proportion living without disability at age 65 (male and female)*	ONS (2009-13)	Long term	M: 8.7 % points F: 7.0 % points			N/A	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Proportion of life spent in good health at birth (male and female)*	ONS (2009-13)	Long term	M: 6.7 % points F: 7.2 % points			N/A	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Proportion of life spent in good health at age 65 (male and female)*	ONS (2009-13)	Long term	M: 13.4 % points F: 11.8 % points			N/A	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Mortality	**Premature mortality (deaths in those under the age of 75)**	Primary Care Mortality (PCMD) (2013-17)	Long term	12.5 % points			Increasing (unlikely to be statistically significant)	N	N	-	Ward; Borough	Y	Y	Y

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap			Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
					30/30	E/W	Other								
CHAPTER 2: Gaps and trends	Determinant	**Child Poverty - children living in low income families**	HMRC and GLA (2015)	Medium to long term	21 % points (2015); 6 % points (2018 extrapolation)			Reducing (mixed underlying picture)	N	Y	-	Ward; Borough	Y	Y	Y
	Mortality	*Infant mortality*	PHOF	Medium to long term					N	Y	-	Borough	N	N	N
	Determinant / Morbidity	*Low birthweight of term babies*	PHE Local Health (2011-2015)	Medium to long term	0.8 % points			N/A	N	Y	-	Ward; Borough	N	Maybe via Local Health in future – to monitor	M
	Determinant	**School readiness - child development at age 5 (end of reception)**	Dep't for Education via PHE Local Health (2013/14)	Medium to long term	15.9 % points			N/A at ward level, only borough	Y	Y	-	Ward; Borough	N	N	M (borough not gap); lack of recent data
	Determinant	**School readiness - child development at age 5 (end of reception) with free school meal (FSM) status**	PHE Local Health (2016/17)	Medium to long term	10.0 % points (all children vs. those with FSM status: at borough not ward level)			Gap between all children and those with FSM reducing	Y	Y	HWBS (pupil premium not FSM)	Borough	Y but using different gap methodology	Y but using different gap methodology	Y (but gap analysis using different methodology)
	Determinant	GCSE achieved (5A*-C incl. English & Maths)	PHE Local Health (2013/14)	Medium to long term	15.4 % points			N/A – only two time points	Y	N	-	Ward; Borough	N – not robust as only two time points	Maybe via Local Health in future – to monitor	M if sufficient trend data available in future
	Determinant	*GCSE achieved (5A*-C incl. English & Maths) with FSM status*	PHOF (2015)	Medium to long term					Y	N	HWBS (pupil premium not FSM)	Borough	N	N	M (borough, not gap)
	Determinant	*19-24 year olds / young people not in employment, education or training*	GLA (2015)	Medium to long term					Y (19-24 year olds)	Y (16-18 year olds)	MP (16-17 year olds NEET)	Borough	N	N	M (borough, not gap)
	Morbidity	*Proportion of 5 year olds with dental decay*	PHOF	Short to medium term					N	Y		Borough	N	N	M (borough, not gap)
	Morbidity	**Child Excess weight (Reception)**	*National Obesity Observatory/ PHE (14/15-16/17)*	Short to medium term	9.6% points			Increasing	N	Y	-	Ward; Borough	Y	Y	Y – HWBB priority
	Morbidity	**Child Excess weight (Year 6)**	*NOO / PHE (14/15-16/17)*	Short to medium term	14.5% points			Increasing	N	Y	SP, MP, HWBS	Ward; Borough	Y	Y	Y – HWBB priority

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap			Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
					30/30	E/W	Other								
CHAPTER 2: Prevention of ill health	Lifestyle / behavioural risk factor	**Smoking prevalence (as recorded in GP Profiles)**	GP QOF (2015/16)	Short to medium term	6.2 % points			Increasing	N	N but similar (see indicator below)	-	GP; Borough	Y	Y	Y, in lieu of ward data for Health Equity indicator
	Lifestyle / behavioural risk factor	*Prevalence of smoking in those aged 18+*	PHOF	Short to medium term					N	Y	HWBS	Borough	N	N	N – use similar indicator
	Lifestyle / Morbidity	**Hospital stays due to alcohol related harm (Standardised Admission Ratio, SAR)**	PHE Local Health HES (2011/12 - 2015/16)	Short to medium term	38.2 difference in Standardised Admission Ratio			N/A – only two time points	N	N but similar indicator[30]	HWBS	Ward; Borough	N – not robust (only 2 time points)	Maybe via Local Health in future – to monitor	Y if sufficient trend data available in future
	Physiological risk factor / Morbidity	**Hypertension prevalence (GP profiles)**	GP QOF (2016/17)	Short to medium term	1.5 % points			Increasing (not yet statistically significant)	N	N	-	GP; Borough	Y	Y	Y
	Morbidity	**Diabetes prevalence (GP profiles)**	GP QOF (2016/17)	Short to medium term	3.1 % points			Increasing (Statistically significant)	N	N	-	GP; Borough	Y	Y	Y – HWBB priority
	Morbidity	**Incidence Rate of tuberculosis (TB)**	PHE (2014-2016)	Short to medium term	25.6 per 100,000 rate difference			Increasing (unlikely to be statistically significant: small no.s)	N	Y	-	Ward; Borough	Y	Y	Y
	Morbidity	**Mental Health (GP profiles)**	GP QOF (2016/17)	Short to medium term	0.24 % points			Decreasing (but complex picture)	N	N	-	GP; Borough	Y	Y	Y – parity of esteem
	Morbidity	**Depression (GP profiles)**	GP QOF (2016/17)	Short to medium term	0.45 % points			Unclear trend (complex picture)	N	N	-	GP, Borough	Y	Y	Y – MCCG investment
	Morbidity	**Self reported wellbeing – low life satisfaction**	GLA (2013)	Medium to long term	11.7 point gap (2013)			Decreasing (but complex picture)	Y	Y		Borough	Y	M – monitor to see if more recent data	M (borough not gap); lack recent data
	Mortality	*Suicide*	PHOF	Medium to long term					N	Y		Borough	N	N	N
	Mortality	*Cardiovascular disease mortality under 75 years*	PHOF	Long term					N	Y		Borough	N	N	N – use premature mortality
	Mortality	*Cancer mortality under 75 years*	PHE Local Health (2010-14)	Long term	Not calculated but available at ward level			N/A – only two time points	N	Y	-	Ward; Borough	N – not robust as only two time points	Maybe via Local Health in future – to monitor	M if sufficient trend data available in future

[30] PHE Marmot indicator is Directly Standardised Rate (Merton: 495 per 100,000 in 2016/17); however, this is only available at borough, whereas PHE Local Health shows Standardised Admission Ratios by ward.

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap			Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
					30/30	E/W	Other								
CHAPTER 4: Employment, good work	Determinant	*Unemployment % (ONS model-based method)*	PHOF	Medium to long term					Y	N	-	Borough	N	N	Await new Universal Credit (UC) metrics
	Determinant	*Long term claimants of job seekers allowance*	PHOF	Medium to long term					Y	N	-	Borough	N	N	Await new UC metrics
	Determinant	*Work related illness*	PHOF	Medium to long term					Y	N	-	London, England	N	N	N – limited borough data available
	Determinant	*Households not reaching Minimum Income Standard*	PHOF	Medium to long term					Y	N	-	London, England	N	N	N – limited borough data available
	Determinant	*Employment gap for those with a long term condition*	PHOF	Medium to long term					N	Y	-	Borough, London, England	Limited	N	M (borough not gap); await new UC metrics)
	Determinant	**Economically active population claiming jobseeker's allowance (JSA)**[31]	ONS NOMIS (2015)	Medium to long term	2.5 % points			Reducing	N but similar (see above indicators)	N	HWBS	Ward; Borough	Y	Y but depends on new UC metrics	Y (in lieu of ward data for Marmot/ Equity indicators); await new UC metrics
	Determinant	**Employment & Support Allowance (ESA)**	ONS NOMIS (2017)	Medium to long term	3.4 % points			Stable	N	N	--	Ward; Borough	Y	Y but depends on new UC metrics	Y (as above); but await new UC metrics
	Determinant	*Incapacity benefit*	NOMIS (2017)	Medium to long term	Not calculated as numbers too small			Numbers too small to make robust conclusions	N	N	HWBS	Ward; Borough	Y but numbers too small for robust trend	Y but numbers too small for robust trend	Await new UC metrics
	Determinant	*Severe disablement allowance*	NOMIS (2017)	Medium to long term	Not calculated as numbers too small			Numbers too small to make robust conclusions	N	N	-	Ward; Borough	Y but numbers too small to make robust conclusions	Y but numbers too small to make robust conclusions	Await new UC metrics

[31] According to NOMIS: JSA "is not an official measure of unemployment, but is the only indicative statistic available for areas smaller than Local Authorities."

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap			Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
					30/30	E/W	Other								
Chapter 5: Healthy standard of living	Determinant	**Deprivation IMD 2015**	IMD (2015)	Long term	17.01 point difference in average score			N/A	N	N	-	LSOA; Ward	N	N	Y (trend not available, but can look at relative change over time)
	Determinant	**Deprivation IMD 2015**	IMD GP Profiles (2015) DCLG	Long term	11.74 point difference in score			N/A	N	N	-	GP; Borough	N	N	N (use IMD 2015 by ward as above)
	Determinant	**Deprivation IMD 2015- IDACI - Children (GP profiles)**	IMD GP Profiles (2015) DCLG	Long term	13.33 % point difference in score			N/A	N	N	-	GP; Borough	N	N	N – difficult to interpret, direct trend not available, Child Poverty is a better indicator
	Determinant	**Deprivation IMD 2015- Deprivation in Older People**	IMD GP Profiles (2015) DCLG	Long term	8.63 % point difference in score			N/A	N	N	-	GP; Borough	N	N	N – difficult to interpret, direct trend not available
	Determinant	**Household overcrowding**	ONS Census (2011)	Medium to long term	10.2 % points			N/A	N	N	-	Ward; Borough	N	N	N (lack of both recent data and trend until next Census in 2021)
	Determinant	**Fuel poverty for high cost fuel households**	PHE Local Health (ONS 2015)	Medium to long term	1.4 % points			N/A	Y	N	-	Ward; Borough	N	Maybe via Local Health in future – to monitor	M if sufficient trend data available in future
	Determinant	*Homelessness*	PHOF	Medium to long term					N	Y	-	Borough	N	N	Y (borough, not E/W or 30/30 gap), as a good measure of equity in itself)

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap			Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
					30/30	E/W	Other								
CHAPTER 3: Healthy, sustainable communities	Determinant	Burglary	*Metropolitan Police Data* (2017)	Medium to long term	-3.4 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	N
	Determinant	Theft	*Metropolitan Police Data* (2017)	Medium to long term	-8.5 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	N
	Determinant	Criminal damage	*Metropolitan Police Data* (2017)	Medium to long term	4.2 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	N
	Determinant	Antisocial behaviour	*Metropolitan Police Data* (2017)	Medium to long term	7.0 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	Y
	Determinant	Violence against the person	*Metropolitan Police Data* (2017)	Medium to long term	14.5 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	M
	Determinant (Psychosocial risk factor)	Older people (65+) living alone	ONS Census (2011)	Medium to long term	0.5 % points			N/A	N	N	-	Ward, Borough	N	N	N as not a measure of social isolation in itself, and lack of timely trend data (Census)
	Determinant	Utilisation of outdoor space for exercise/health reasons	PHOF	Short to medium term					Y	N	HWBS	Borough	N	N	Y (borough not gap)

[i] These represent the following approximate timescales: Short term: 3-5 years; Short to medium term: 8-10 years; Medium to long term: 12-15 years; Long term: 15+ years
[ii] 30/30 = absolute gap between the 30% most and least deprived wards in Merton; E/W = absolute gap between the average of the East Merton wards compared to the West Merton wards
[iii] Up (red), down (green), stable or mixed picture (orange), NA (not available) - grey
[iv] Indicators that are currently reported on. MP = Merton Partnership, SP = Public Health Service Plan, HWBS = Health and Wellbeing Strategy 2015-2018 indicator
[v] Geographic level that data is available at. LSOA = Lower Super Output Area; GP = GP practice
[vi] Is sufficient historic data available for this indicator so that trend can be calculated? Need at least 3 points of data in order to be able to accurately assess trend, and more is preferable.
[vii] Will this indicator be in use in the future? Will we be able to measure trend going forward?
[viii] Sub-borough gap analysis inherent in the data presented at borough level, comparing 10% most deprived with 10% least deprived areas

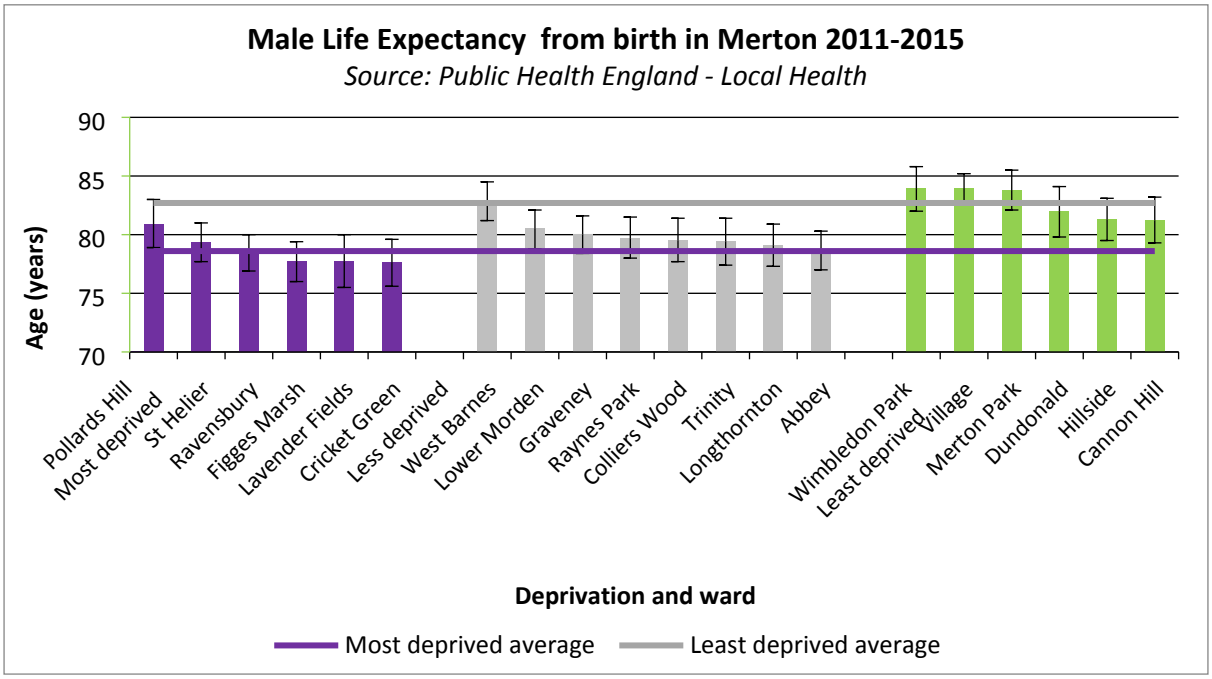
Annual Public Health Report 2018: Health inequalities in Merton
SUPPLEMENTARY DATA REPORT

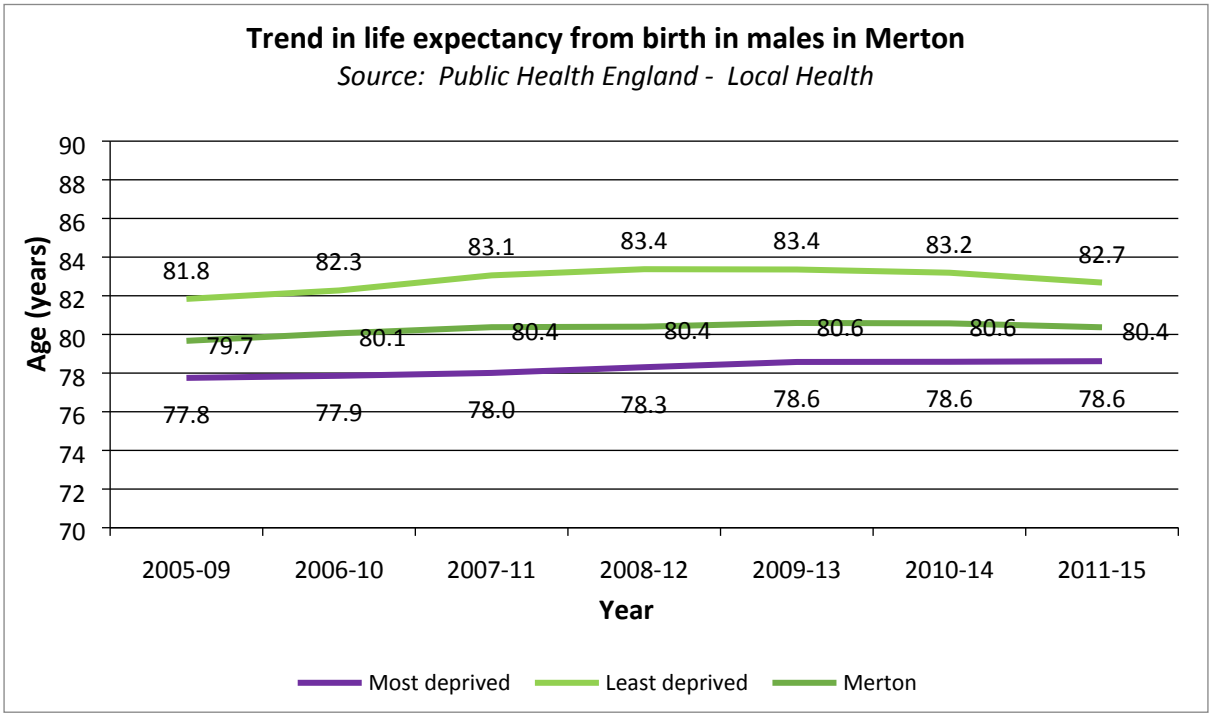
Contents

Supplementary data: graphs to support text

1. CHAPTER 1: Overarching indicators

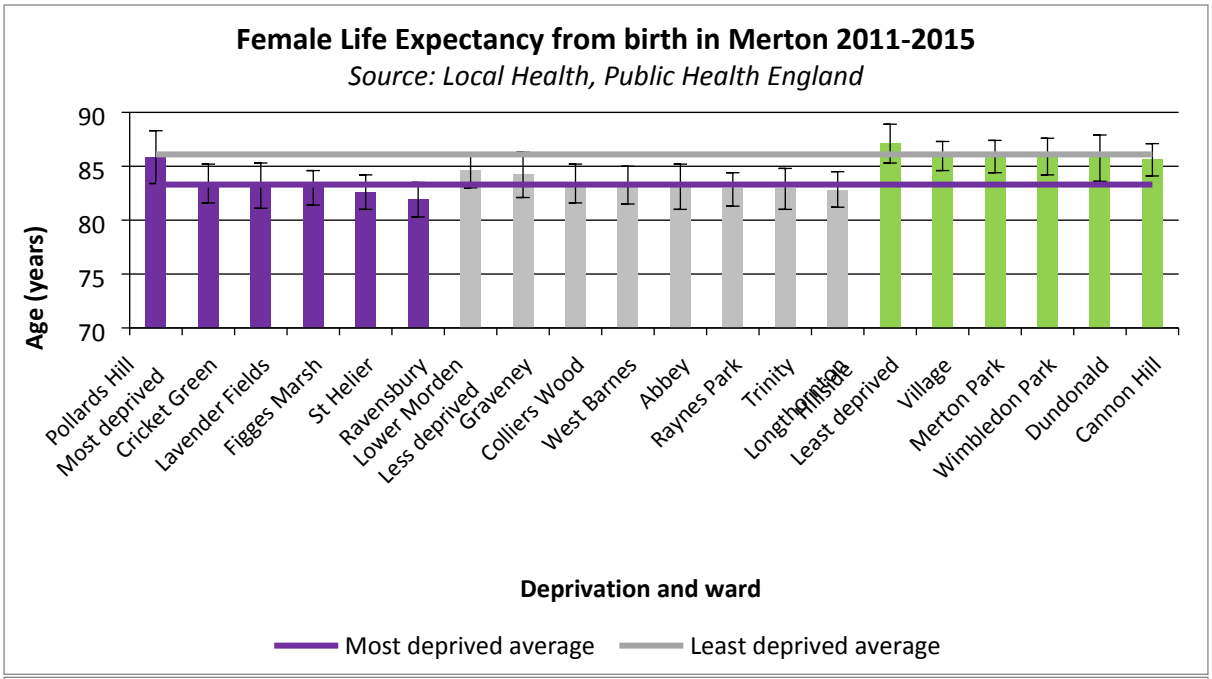
1.1.1.Life expectancy from birth in males, 2005 to 2015

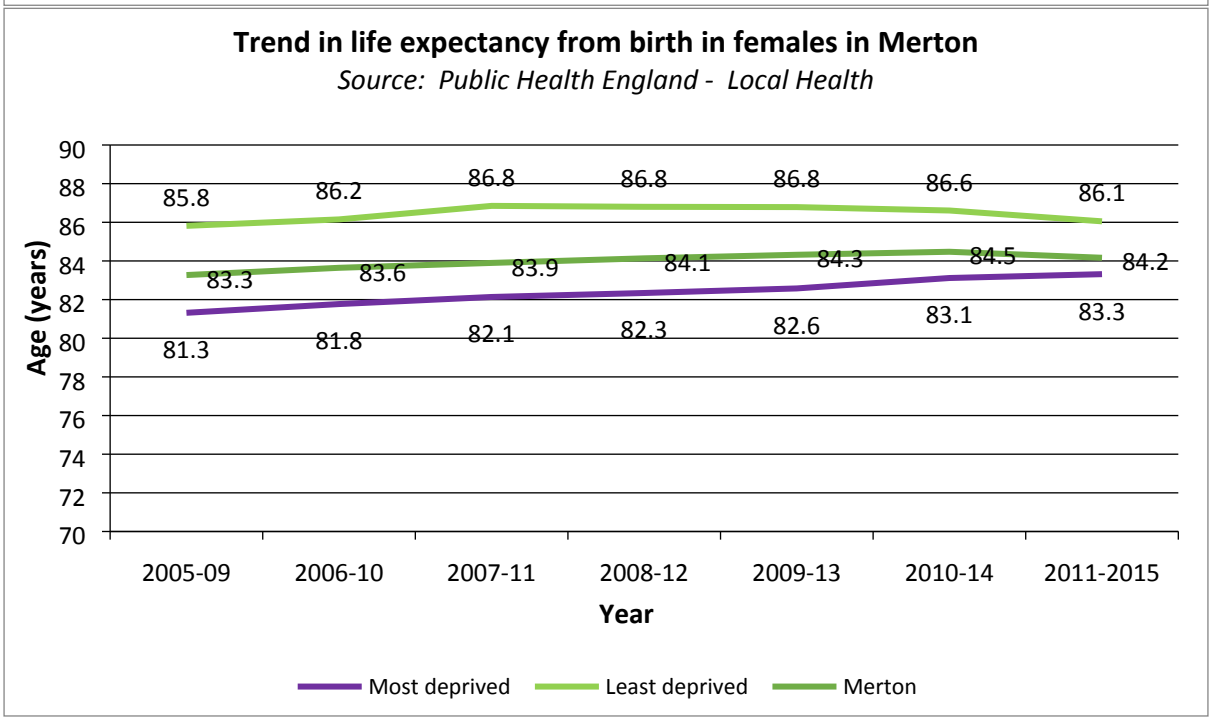




INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 4.1 years (2011-2015 data)
TREND IN INEQUALITY GAP	Between 2005 and 2015, the difference in male life expectancy between the most and least deprived wards remained the same

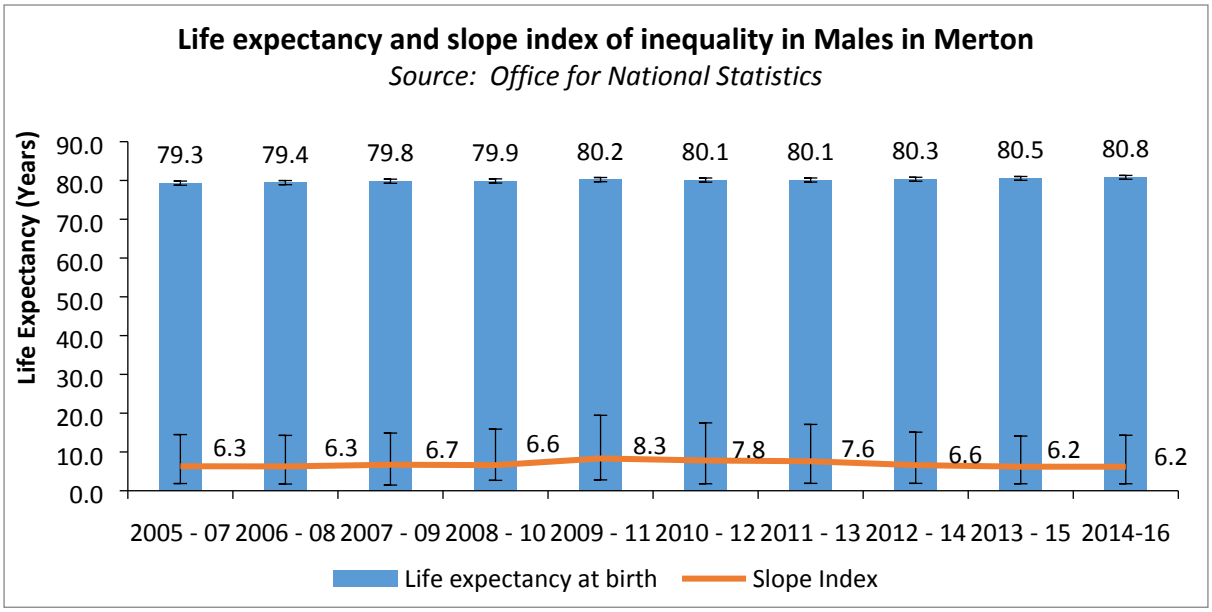
1.1.2. Life expectancy from birth in females, 2005 to 2015





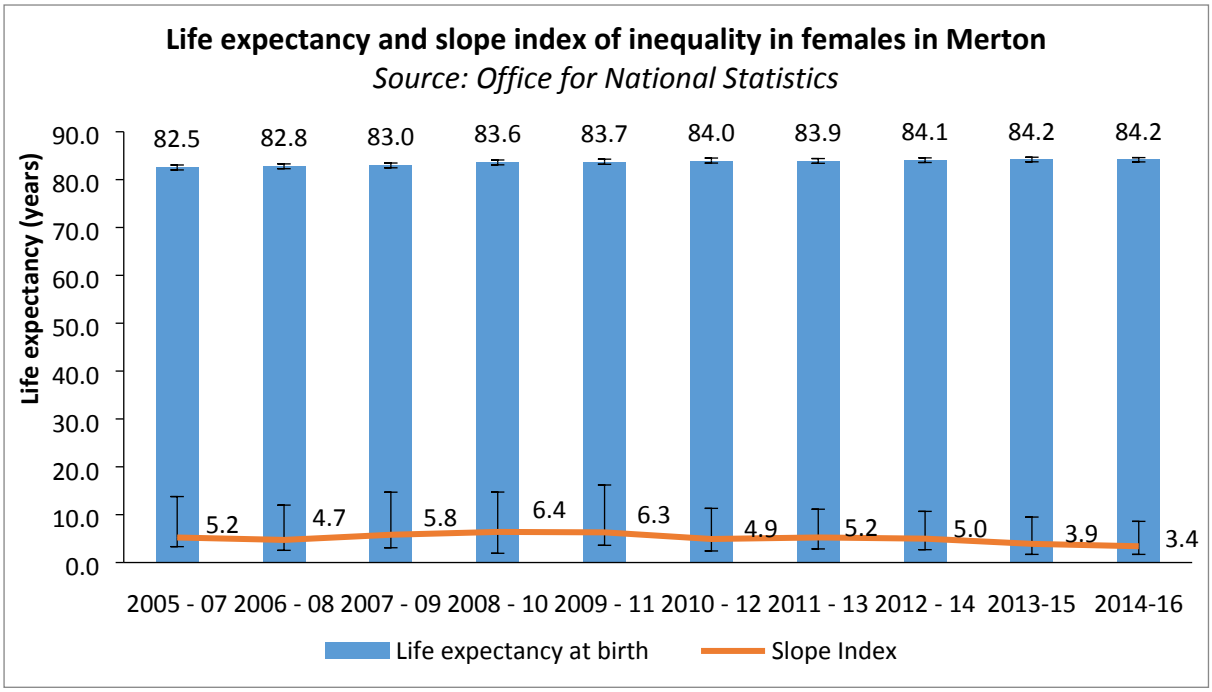
INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 2.7 years (2011-2015 data)
TREND IN INEQUALITY GAP	Between 2005 and 2015, the difference in female life expectancy between the most deprived and least deprived wards reduced (from 4.5 to 2.7).

1.1.3. Slope index of inequality in males, 2005-07 to 2014-16



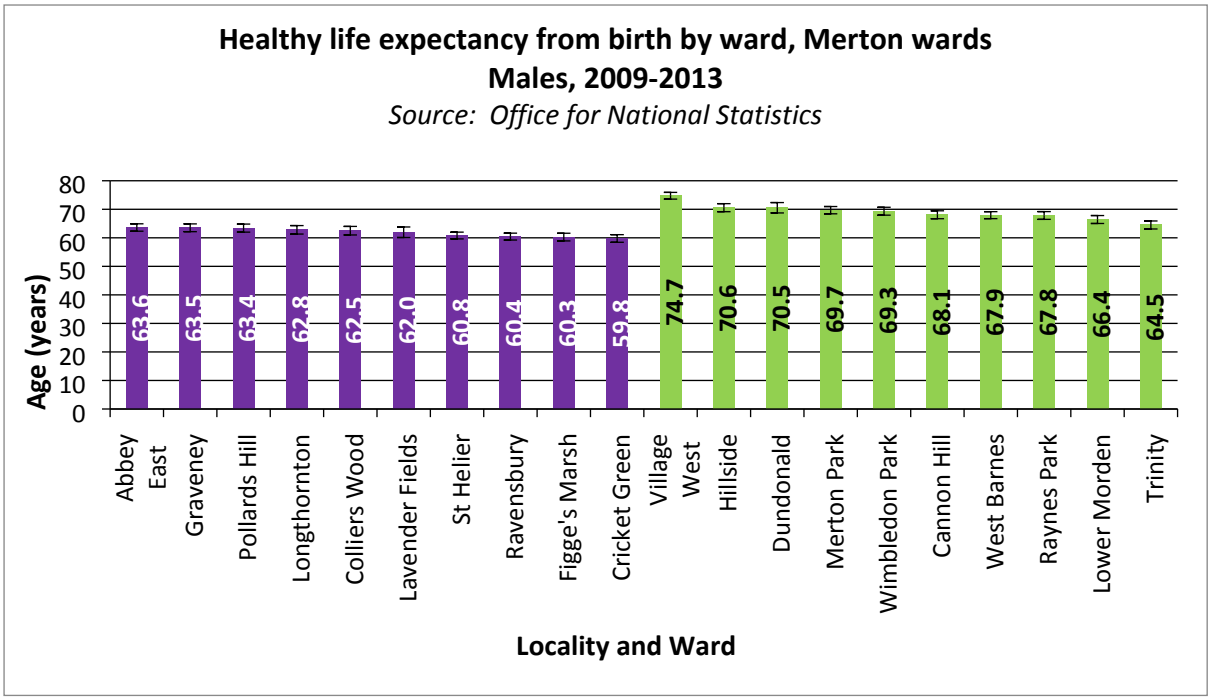
INEQUALITY GAP	Current gap between 10% most and 10% least deprived: 6.2 years (2014-16 data)
TREND IN INEQUALITY GAP	Between 2005-07 and 2014-16, the difference in male life expectancy between the most and least deprived wards remained the same

1.1.4. Slope Index of inequality in females, 2005-07 to 2014-16



INEQUALITY GAP	Current gap between 10% most and 10% least deprived: 3.4 years (2014-16 data)
TREND IN INEQUALITY GAP	Between 2005-07 and 2014-16, the difference in female life expectancy between the most deprived and least deprived wards reduced (from 5.2 to 3.4). However, it is not yet a statistically significant reduction.

1.1.5.Healthy Life Expectancy (males), 2009-2013

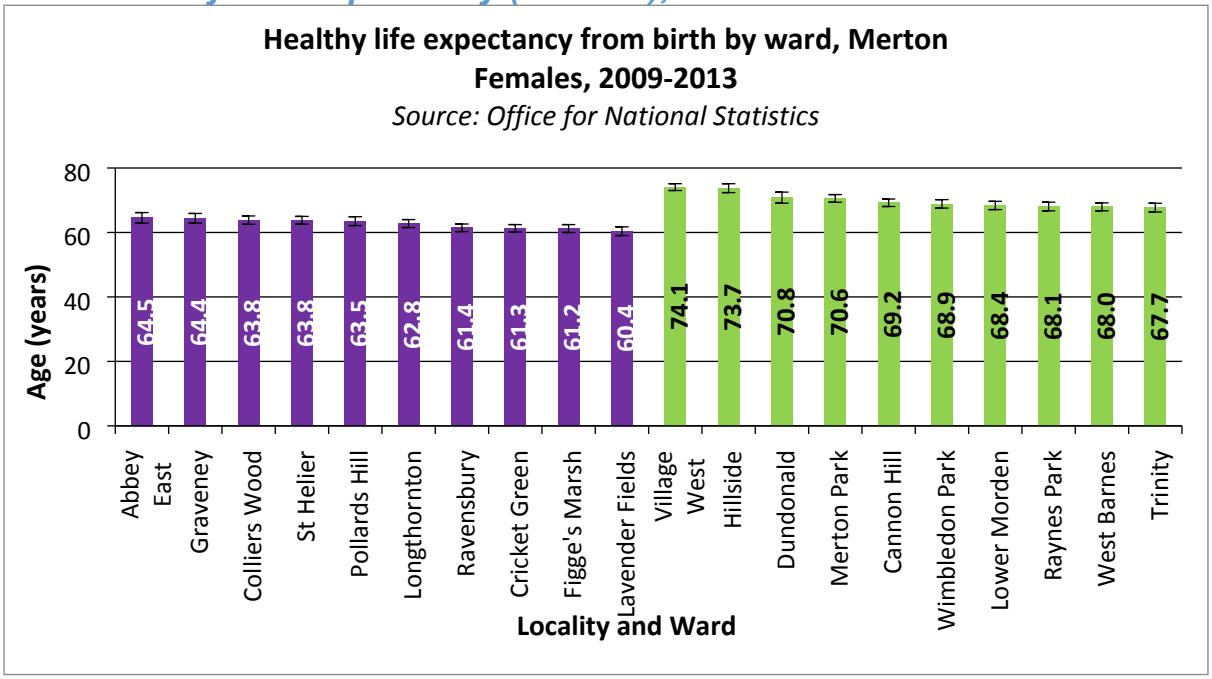


Males Healthy LE from birth 2009-2013	Years
Average for East of borough	61.9
Average for West of borough	69
Merton	65.3

Males Healthy LE from birth 2009-2013	Years
Least deprived	70.5
Most deprived	61.1
Merton	65.4

INEQUALITY GAP	Difference in healthy life expectancy between the 30% most and least deprived is 9.4 years (61.1 years in the 30% most deprived compared to 70.5 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.6.Healthy Life Expectancy (females), 2009-2013

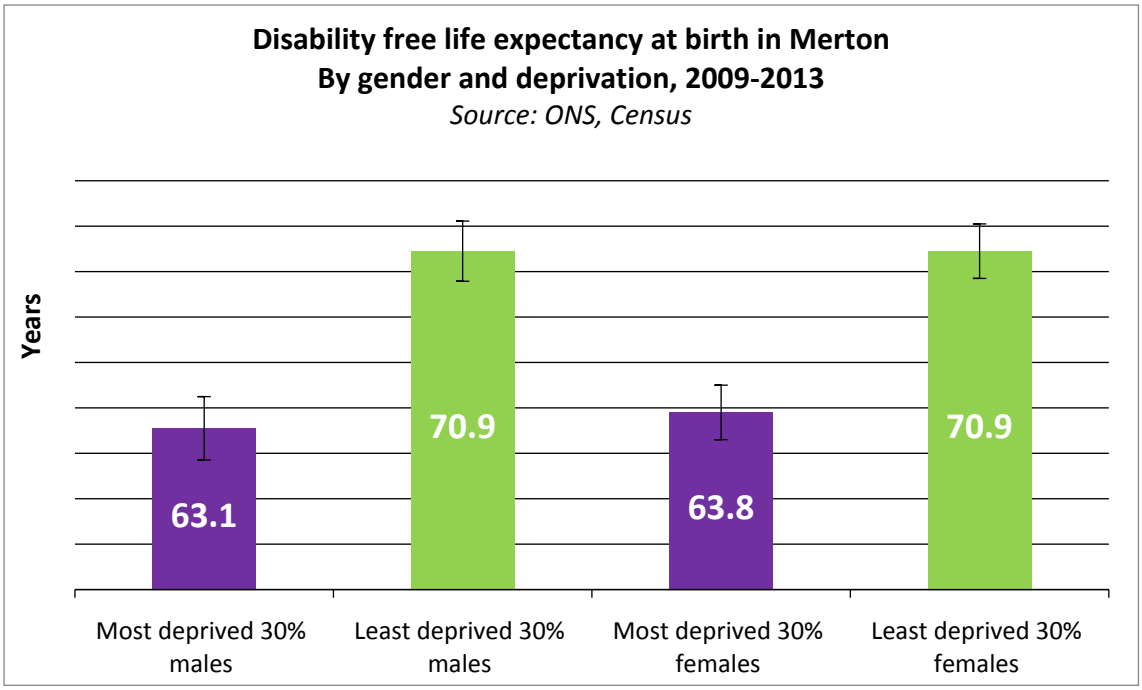


Females Healthy LE from birth 2009-2013	Years
Average for East of borough	62.7
Average for West of borough	69.9
Merton	66.3

Females Healthy LE from birth 2009-2013	Years
Least deprived	71.2
Most deprived	61.9
Merton	66.3

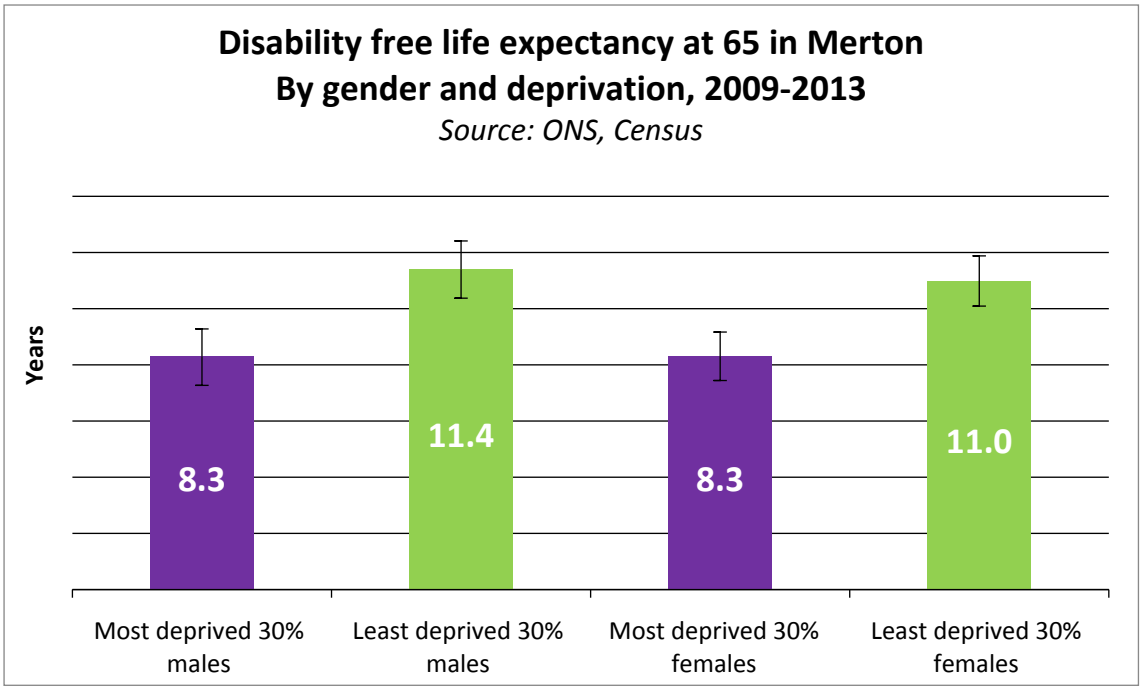
INEQUALITY GAP	Difference in healthy life expectancy (females) between the 30% most and least deprived is 9.3 years (61.9 years in the 30% most deprived compared to 71.2 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.7.Disability Free Life Expectancy at birth, 2009-2013



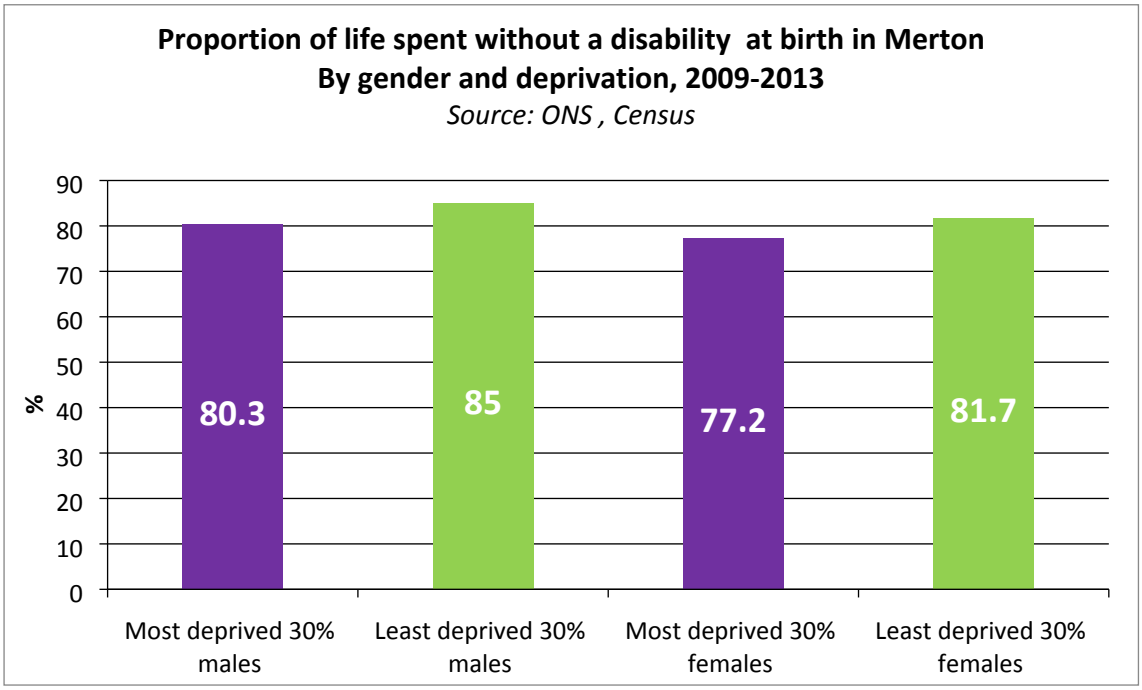
INEQUALITY GAP	Difference in disability free life expectancy at birth between the 30% most and least deprived is 7.8 years in males and 7.1 years in females (2009-2013 data). Confidence intervals show that these differences are statistically significant.
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.8. Disability Free Life Expectancy at age 65, 2009-2013



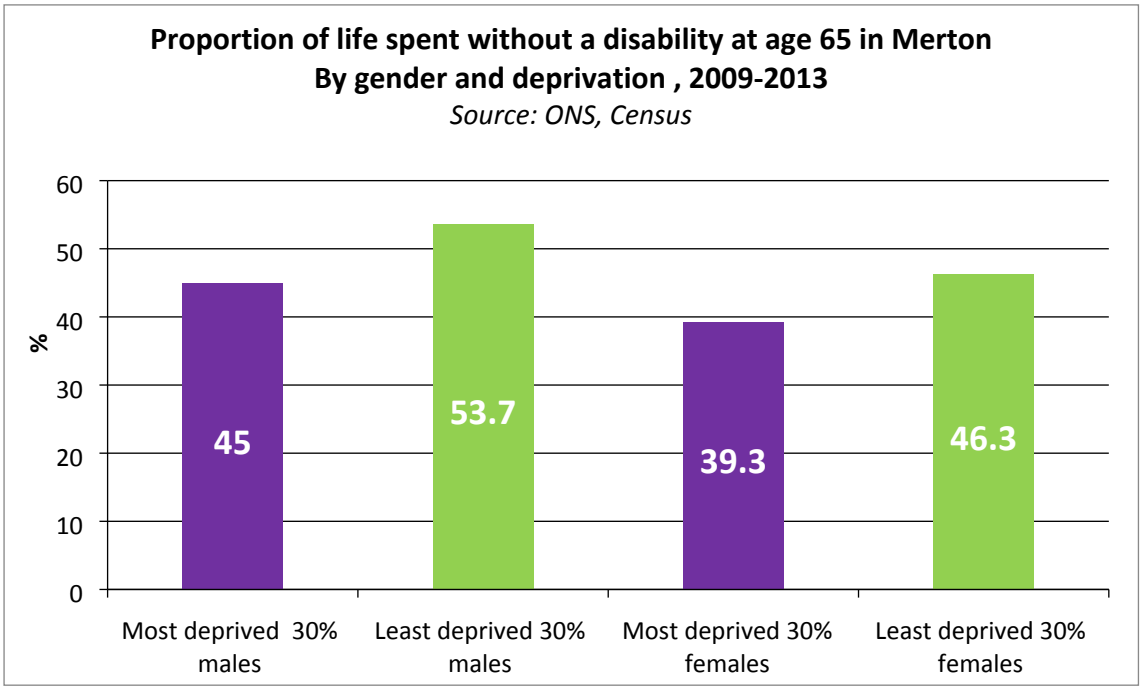
INEQUALITY GAP	Difference in disability free life expectancy at age 65 between the 30% most and least deprived is 3.1 years in males and 2.7 years in females (2009-2013 data). Confidence intervals show that these differences are statistically significant.
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.9.Proportion of life spent without a disability at birth, 2009-2013



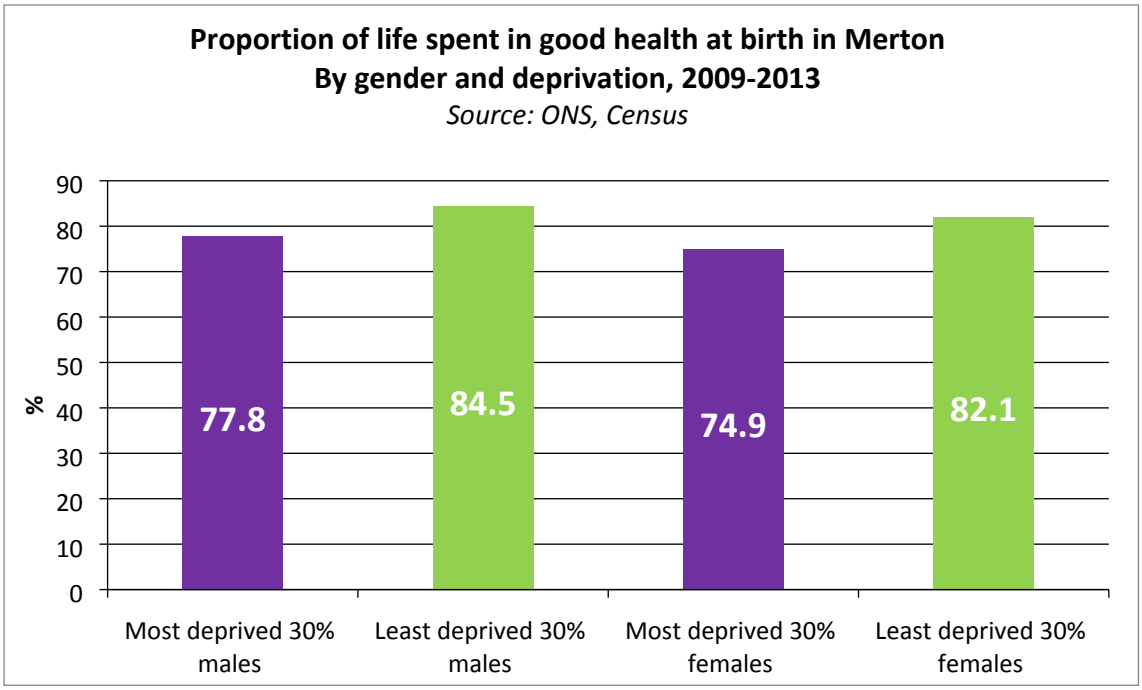
INEQUALITY GAP	Difference in proportion of life spent without a disability at birth between the 30% most and least deprived is 4.7 percentage points in males and 4.5 percentage points in females (2009-2013 data). Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.10. Proportion of life spent without a disability at age 65, 2009-2013



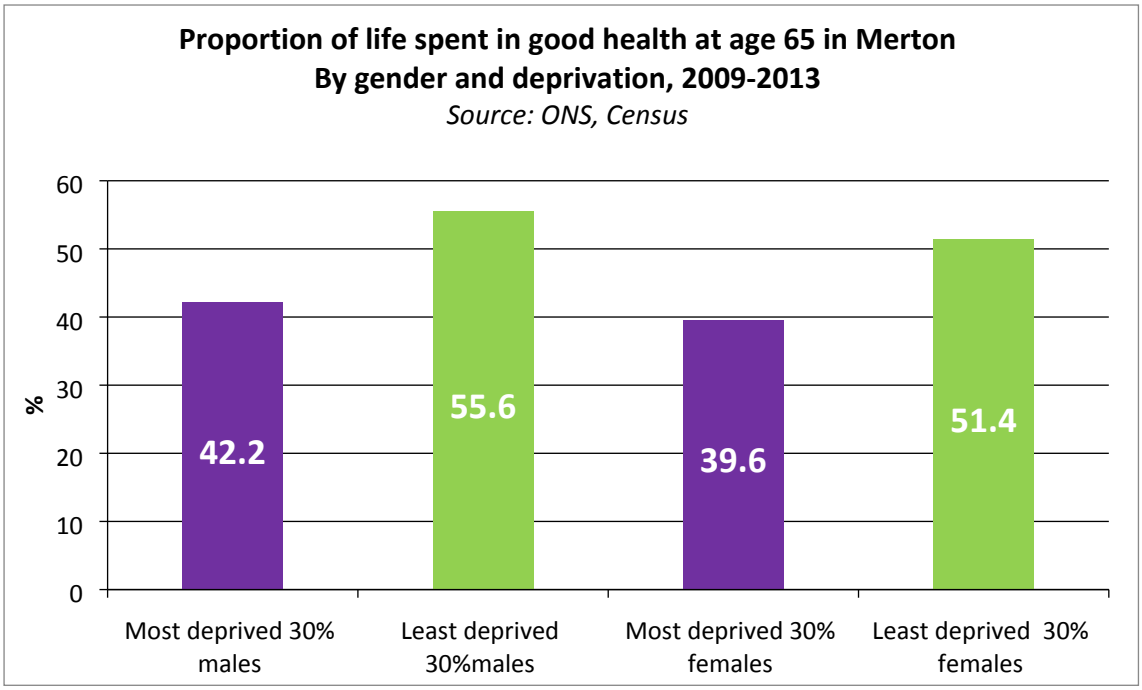
INEQUALITY GAP	Difference in proportion of life spent without a disability at age 65 between the 30% most and least deprived is 8.7 percentage points in males and 7.0 percentage points in females (2009-2013 data). *Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)*
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.11. *Proportion of life spent in good health at birth, 2009-2013*



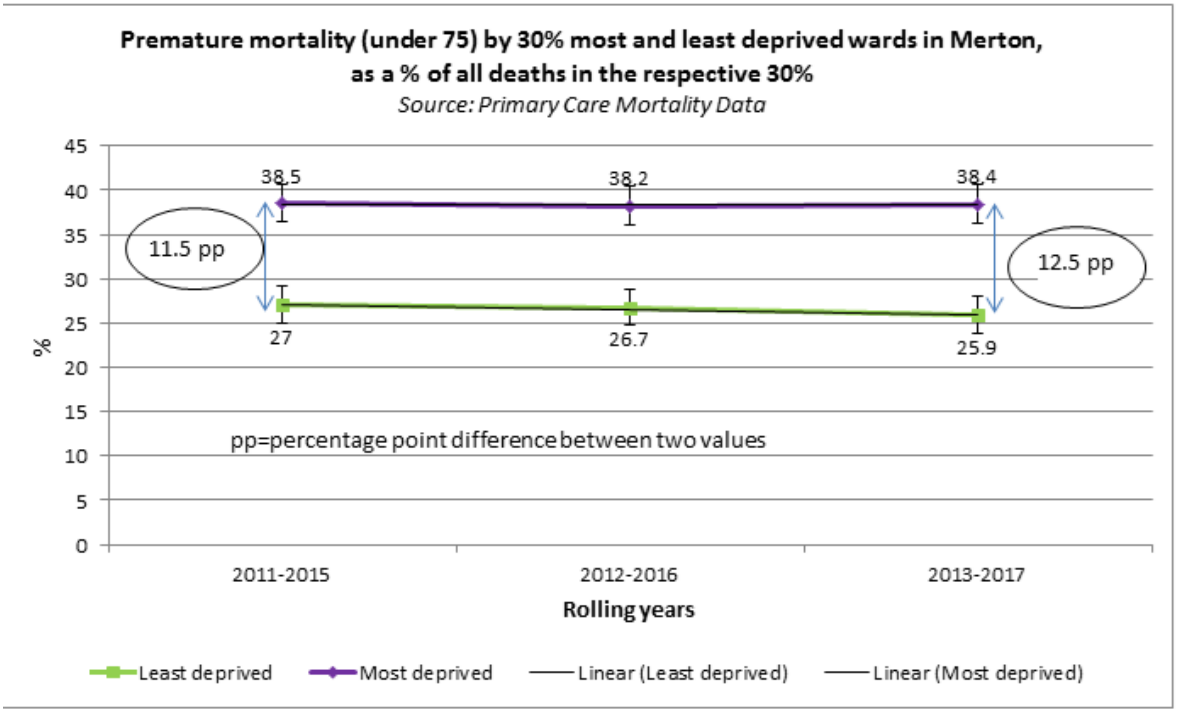
INEQUALITY GAP	Difference in proportion of life spent in good health between the 30% most and least deprived is 6.7 percentage points in males and 7.2 percentage points in females (2009-2013 data). *Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)*
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.12. Proportion of life spent in good health at age 65, 2009-2013



INEQUALITY GAP	Difference in proportion of life spent in good health at age 65 between the 30% most and least deprived is 13.4 percentage points in males and 11.8 percentage points in females (2009-2013 data). *Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)*
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.13. Premature mortality (under 75), 2011-2015 to 2013-2017

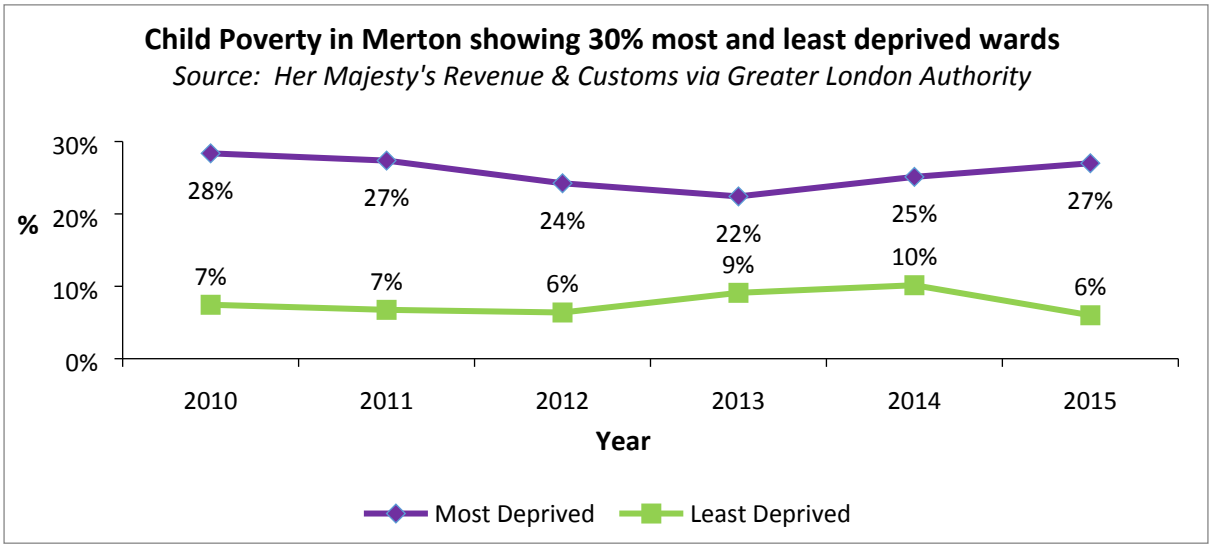


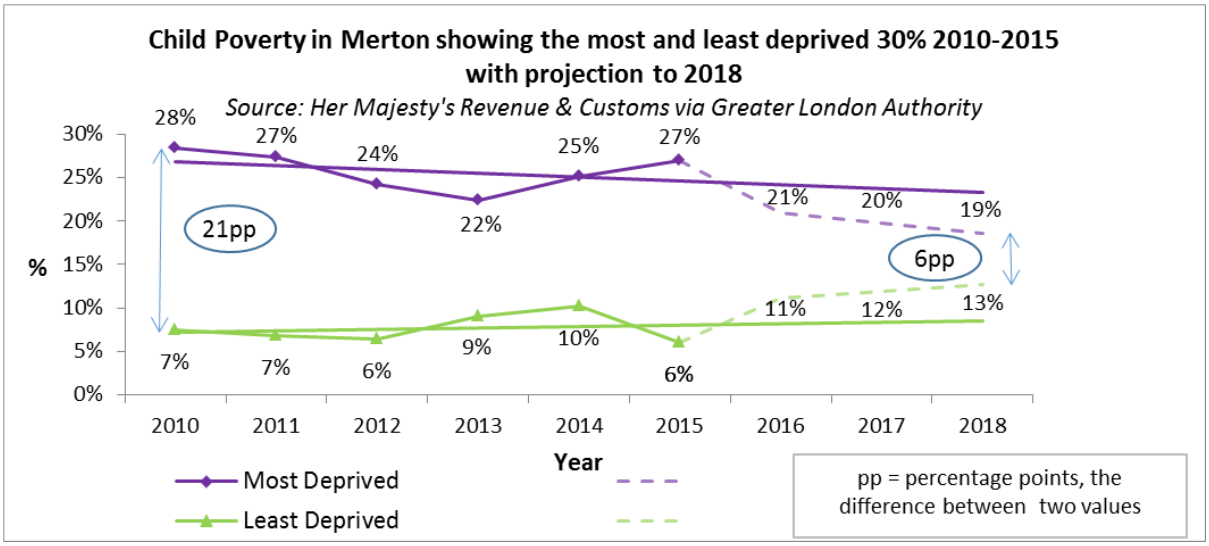
INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 12.5 percentage points (2013-17 data)
TREND IN INEQUALITY GAP	There appears to be is a widening gap between the most and least deprived 30% in Merton, increasing from 11.5 percentage points in the 2011-2015 data to 12.5 percentage points in the 2013-2017 data. The percentage of premature deaths in the most deprived 30% have remained relatively stable, however premature deaths in the least deprived 30% show a drop in percentages from 27% in 2011-2015 to 25.9% in 2013-2017. However, there are only 3 data points, and it is unlikely that this is statistically significant.

2. CHAPTER 2: Best start in life

2.1.1. Child poverty, 2010 to 2015

Child Poverty indicator definition: “Proportion of children aged 0–15 years living in income deprived households as a proportion of all children aged 0–15 years”

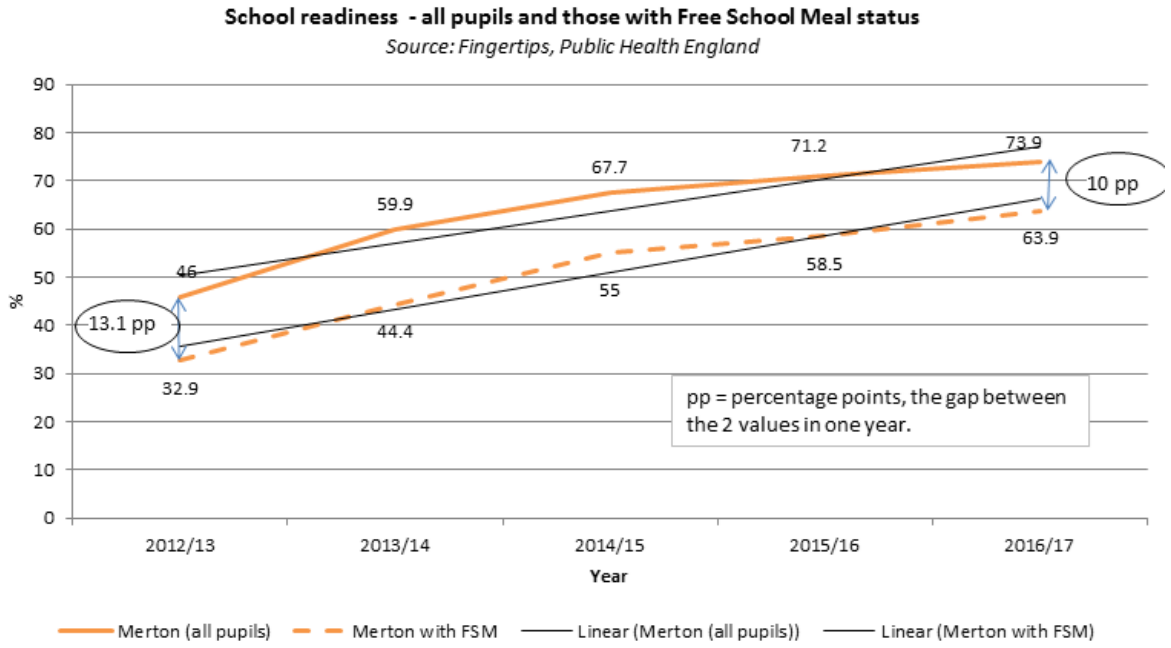




INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 21 percentage points (27% of children living in low income households in the most deprived 30% of wards compared to 6% of children in the least deprived, 2015 data) Statistically extrapolated data suggests that the current 2018 gap is likely to be smaller than this, at 6 percentage points (19% v 13%).
TREND IN INEQUALITY GAP	Although most recent 2015 data appears to show that gap has remained the same as 2010, extrapolated regression analysis suggests the gap is reducing, from 21 % points in 2010 to 6 % points in 2018.However, the underlying picture is mixed: the trend in child poverty in the most deprived areas appears to be downwards (27% in 2015 to an estimated 19% in 2018) which is positive, where as child poverty in least deprived areas appears to be increasing (from 6% to an estimated 13% in 2018) which is worrying, and accounts for some of the narrowing inequality gap. This needs to be monitored over time.

2.1.2. Child development at age 5: school readiness, 2012/13 to 2016/17

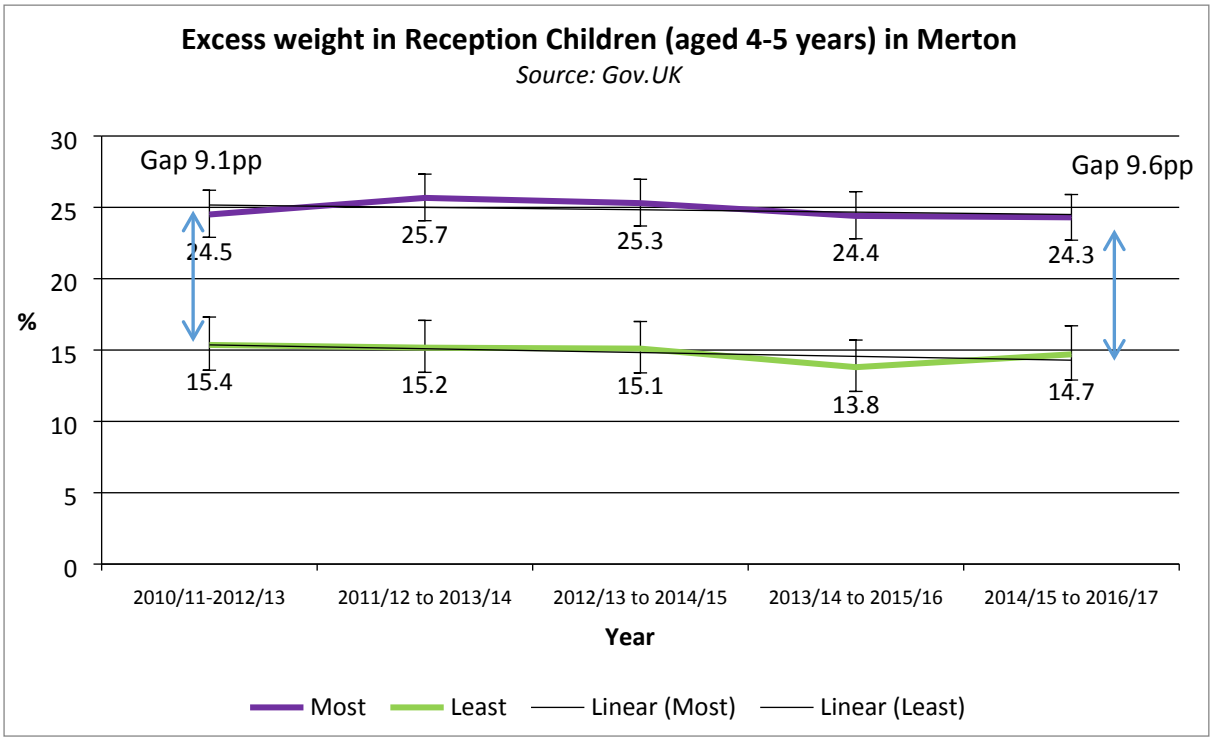
There is a lack of ward level data over a number of years that would enable us to show trend, but we can make some comparisons between the total data set, and the subset of those who have Free School Meal status.



The gap between all children and those with free school meal status for school readiness in **London** between 2012/13 and 2016/17 **rises from 9.7 pp to 10.3 pp** whereas Merton values reduce from 13.1 pp to 10 pp.

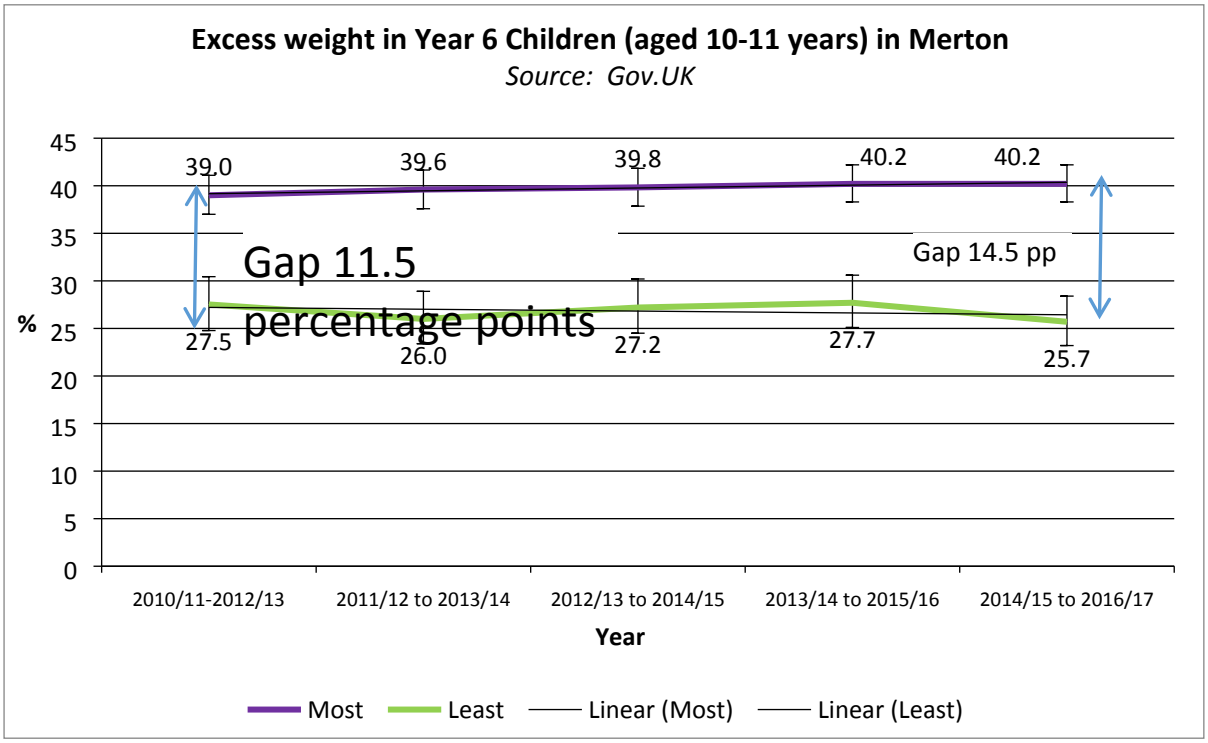
INEQUALITY GAP	Current gap between all children and those with FSM status: 10.0 percentage points (73.9% of all children in Merton achieve a good level of development, where as only 63.9% of children with FSM status achieve a good level of development) (2016/17 data)
TREND IN INEQUALITY GAP	Between 2012/13 and 2016/17, the difference in school readiness between all children and those with FSM status reduced (from 13.1 percentage points to 10.0 percentage points).

2.1.3. Child excess weight: Reception age, 2010/11-2012/13 to 2014/15-2016/17



INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 9.6 percentage points (24.3% compared to 14.7%), 14/15 – 16/17 data. The difference is statistically significant.
TREND IN INEQUALITY GAP	Between 10/11-12/13 and 14/15-16/17, the difference between the most deprived and least deprived wards increased (from 9.1 to 9.6 percentage points).

2.1.4. Child excess weight: Year 6 (age 10-11), 2010/11-2012/13 to 2014/15-2016/17

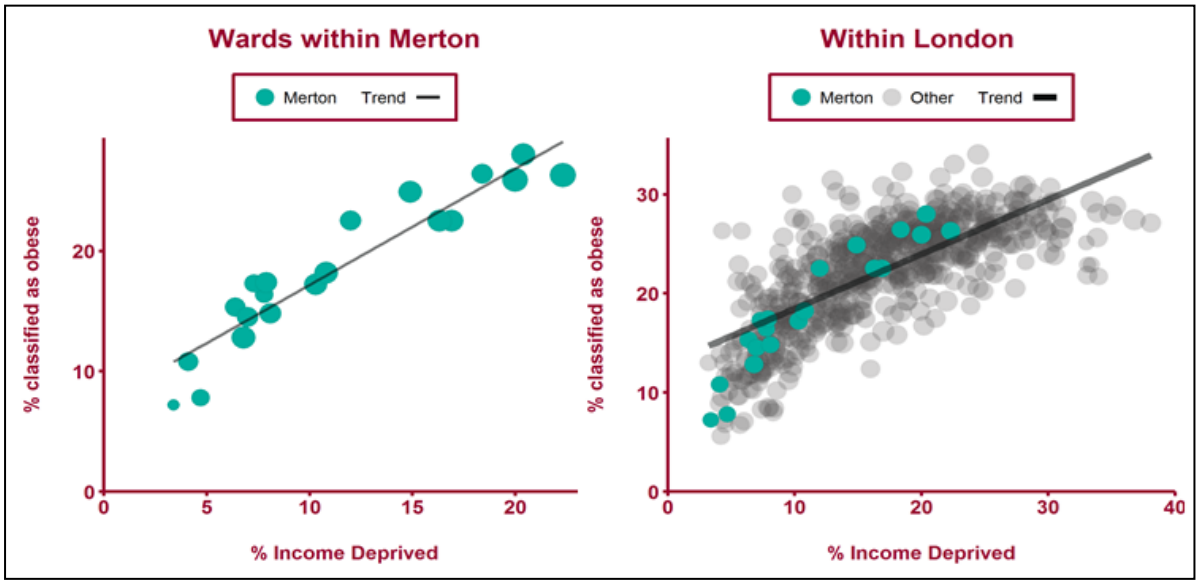


INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 14.5 percentage points (40.2% compared to 25.7%), 14/15 – 16/17 data. The difference is statistically significant.
TREND IN INEQUALITY GAP	Between 10/11-12/13and 14/15-16/17, the difference between the most deprived and least deprived wards increased (from 11.5 to 14.5 percentage points).

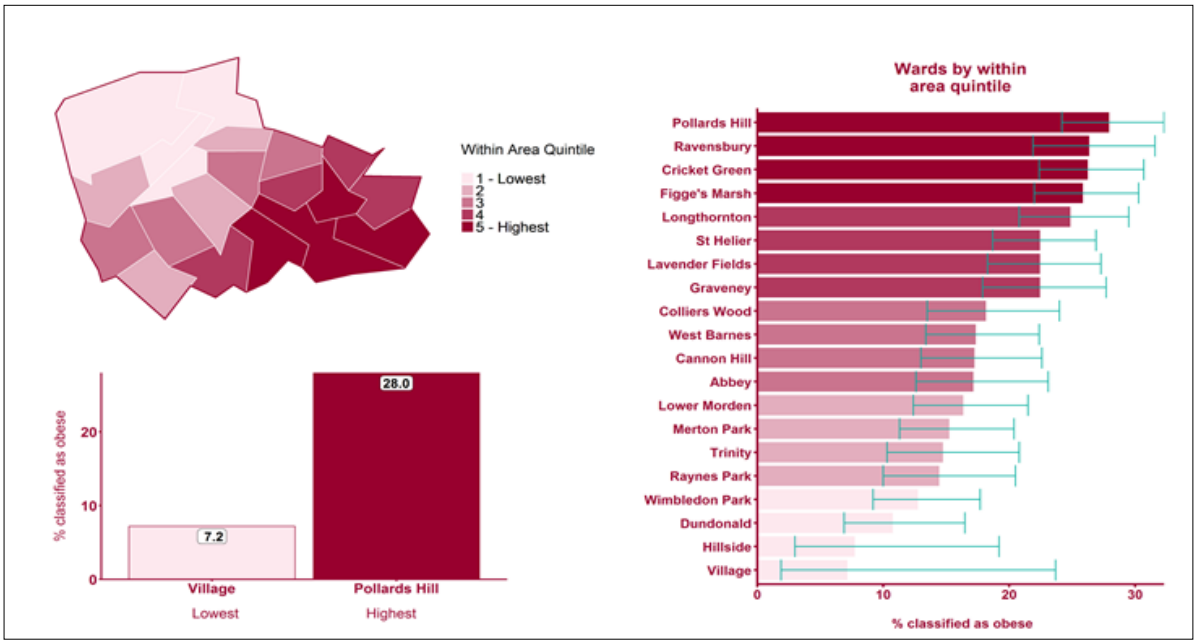
2.1.5. Childhood obesity, 2013/14 – 2015/16

PHE's recent Health Inequalities Briefing, based on the Global Burden of Disease study, highlights the social gradient in childhood obesity in Merton (N.B. this shows obese children, not those with excess weight (='overweight + obese') as the previous graphs):

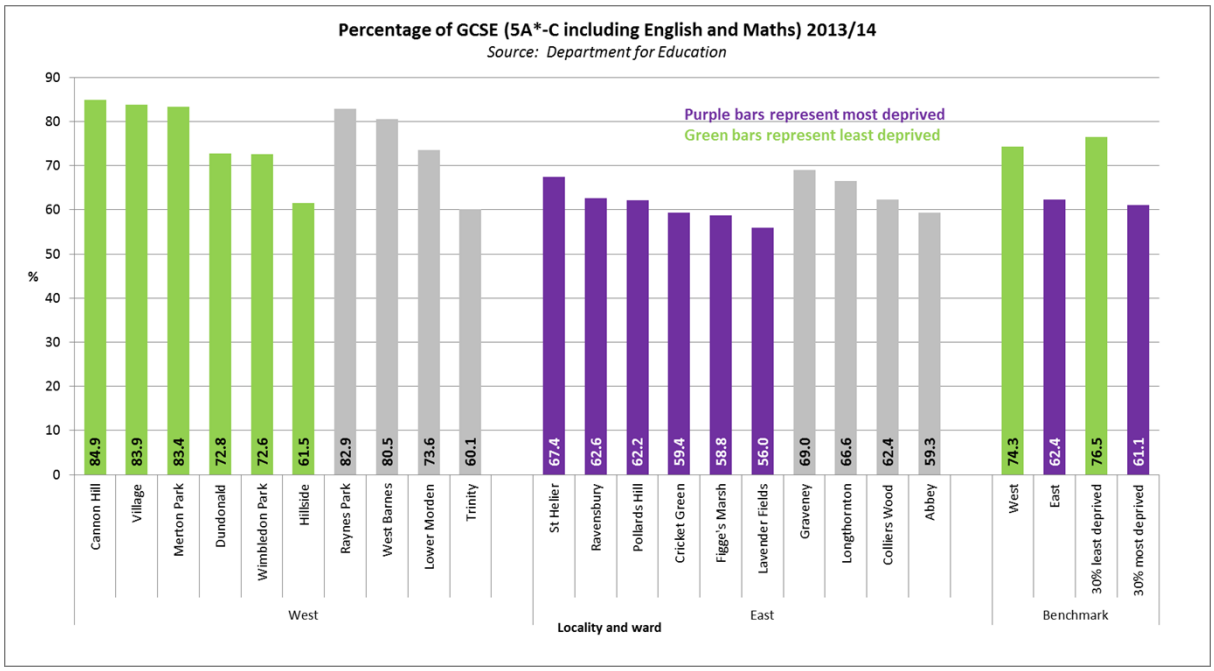
Percentage of children classified as obese (Year 6) for Merton wards by percentage income deprived (2013/14 – 2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)



Percentage of children classified as obese (Year 6) for Merton (2013/14 – 2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)



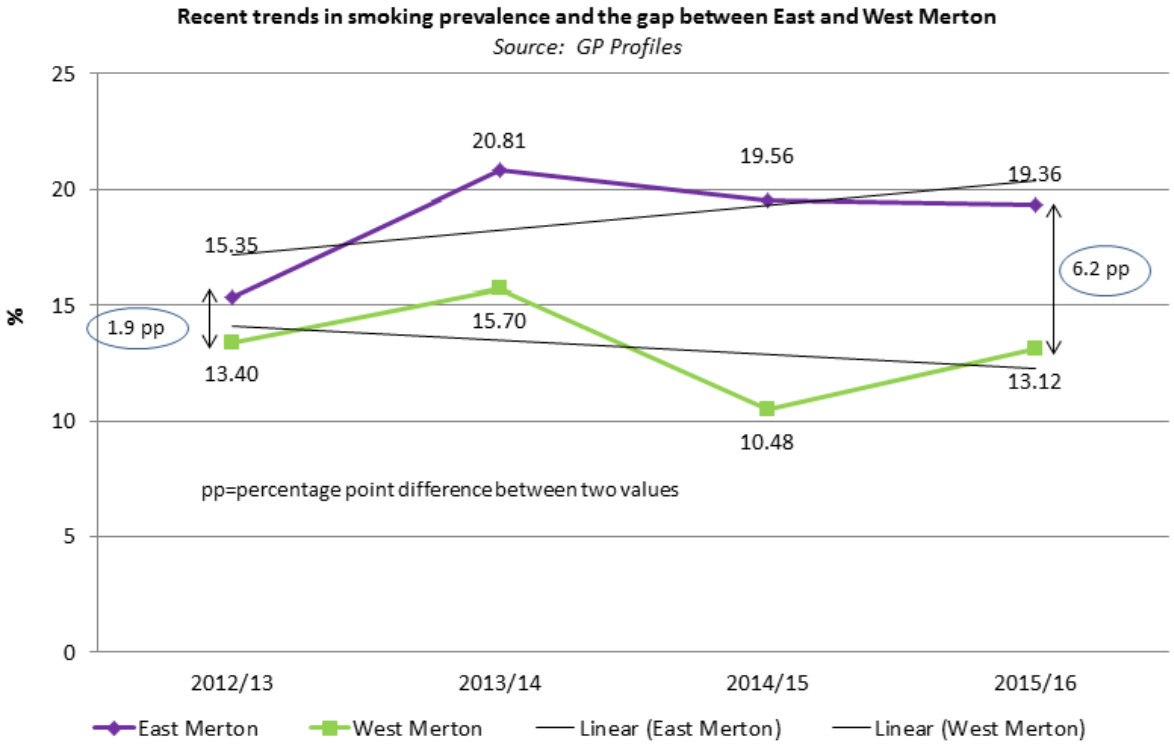
2.1.6. GCSE attainment, 2013/14



INEQUALITY GAP	Difference in GCSE attainment (% young people achieving 5A*-C including English & Maths) between the 30% most and least deprived is 15.4 percentage points (2013/14 data). 30% most deprived wards: 61.1%; 30% least deprived wards: 76.5%. *Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)*
TREND IN INEQUALITY GAP	Trend data not available due to change in indicator definition, but future trend should be possible to track.

3. CHAPTER 3: Prevention of ill health

*3.1.1. Smoking prevalence from GP QOF, 2012/13 to 2015-16**

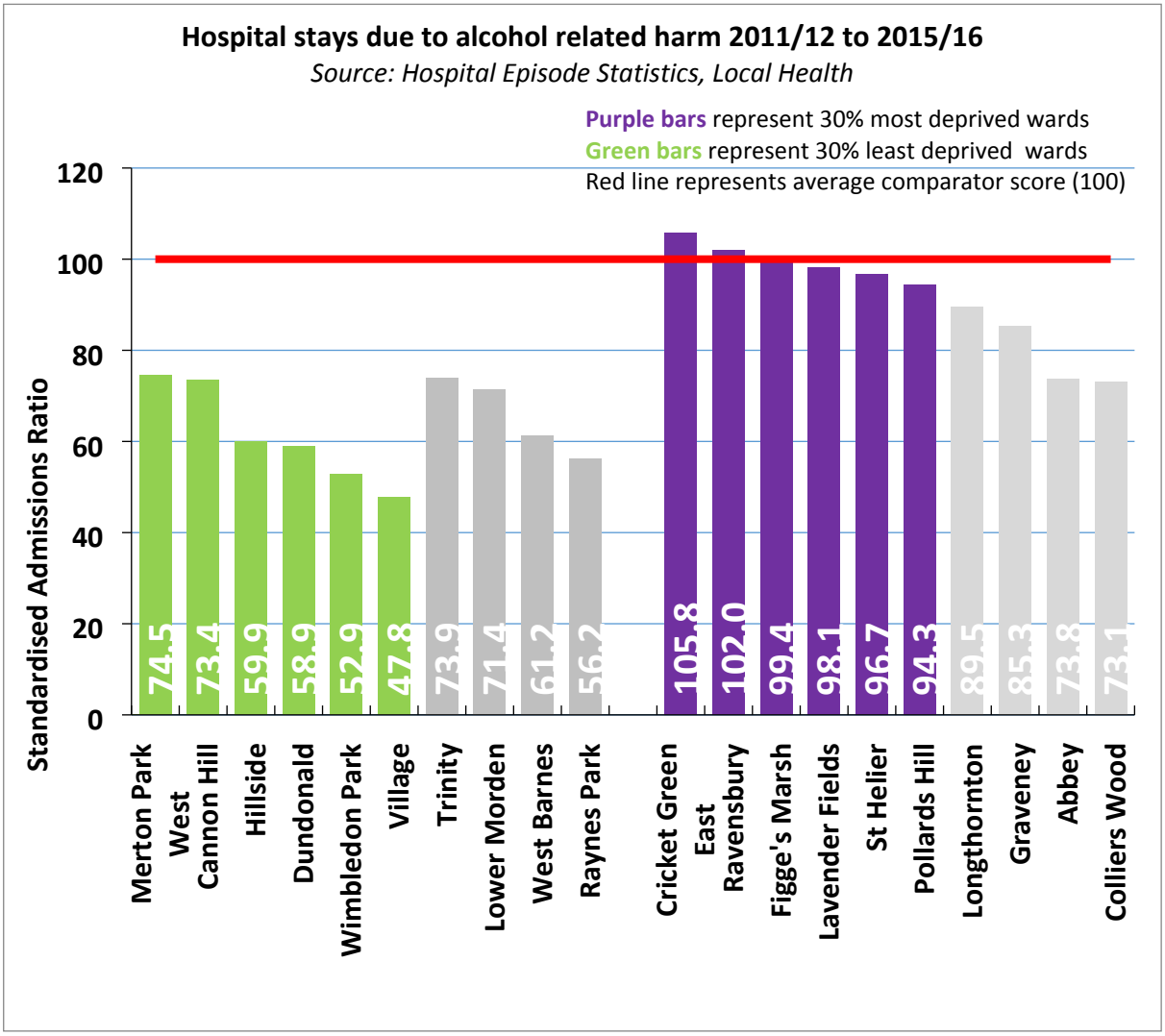


INEQUALITY GAP	Current gap between East Merton and West Merton: 6.2 percentage points (2015/16 data).
TREND IN INEQUALITY GAP	Between 2012/13 and 2015/16, the difference between the most deprived and least deprived wards increased (from 1.9 percentage points to 6.2 percentage points).

** GP practices have been split into east and west localities. However, as GP practice lists provided by the CCG have altered during the writing of this report there are some variations as to which practices are in the east and west localities.*

3.1.2. Alcohol-related harm (hospital admissions), 2011/12-2015/16

The PHE Marmot indicator for alcohol related harm is directly standardised rate per 100,000 (e.g. the 2016/17 figure for Merton is 495); however, this is only available at borough level whereas PHE Local Health shows standardised admission ratios at ward level, enabling us to look at the difference between the 30% most and 30% least deprived wards.

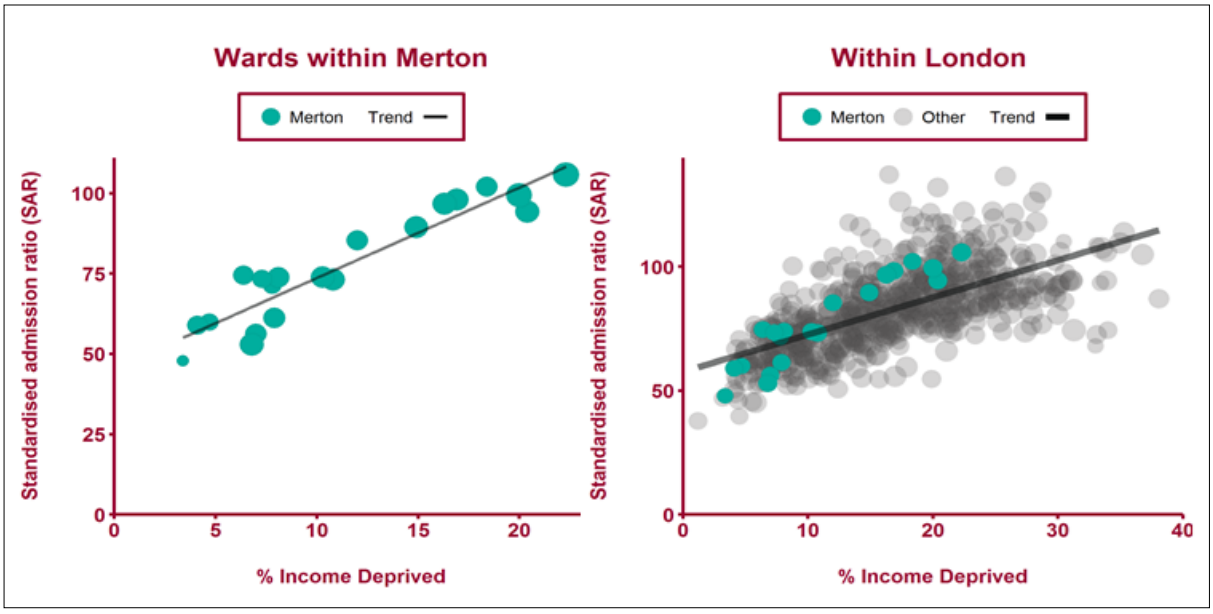


N.B. These are standardised admission ratios SAR and cannot be compared to each other, only the comparator, in this case England. Therefore benchmark data not included in the chart.

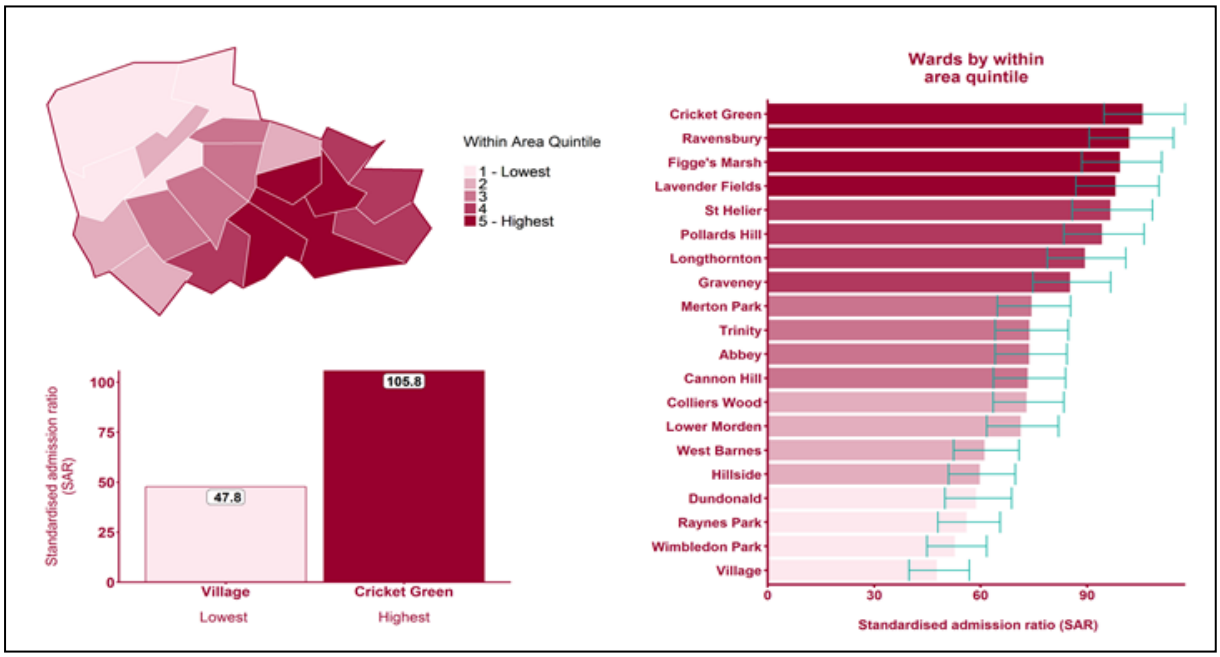
INEQUALITY GAP	Difference in ward scores for Standardised Admission Ratios (SAR) between the 30% most and least deprived is 38.2 SAR points (2011/12 to 2015/16) – 99.4 SAR in the 30% most deprived and 61.2 SAR in the 30% least deprived). An SAR of 100 is the average for England (the comparator).
TREND IN INEQUALITY GAP	*TREND DATA NOT ROBUST (For indicators such as this, PHE Local Health amalgamate years together to provide robust figures when data is at ward level, therefore no yearly trend data available, only two data points: 2010/11-2014/15 and 2011/12-2015/16)*

PHE's recent Health Inequalities Briefing, based on the Global Burden of Disease study, demonstrates this social gradient in alcohol related harm in Merton further:

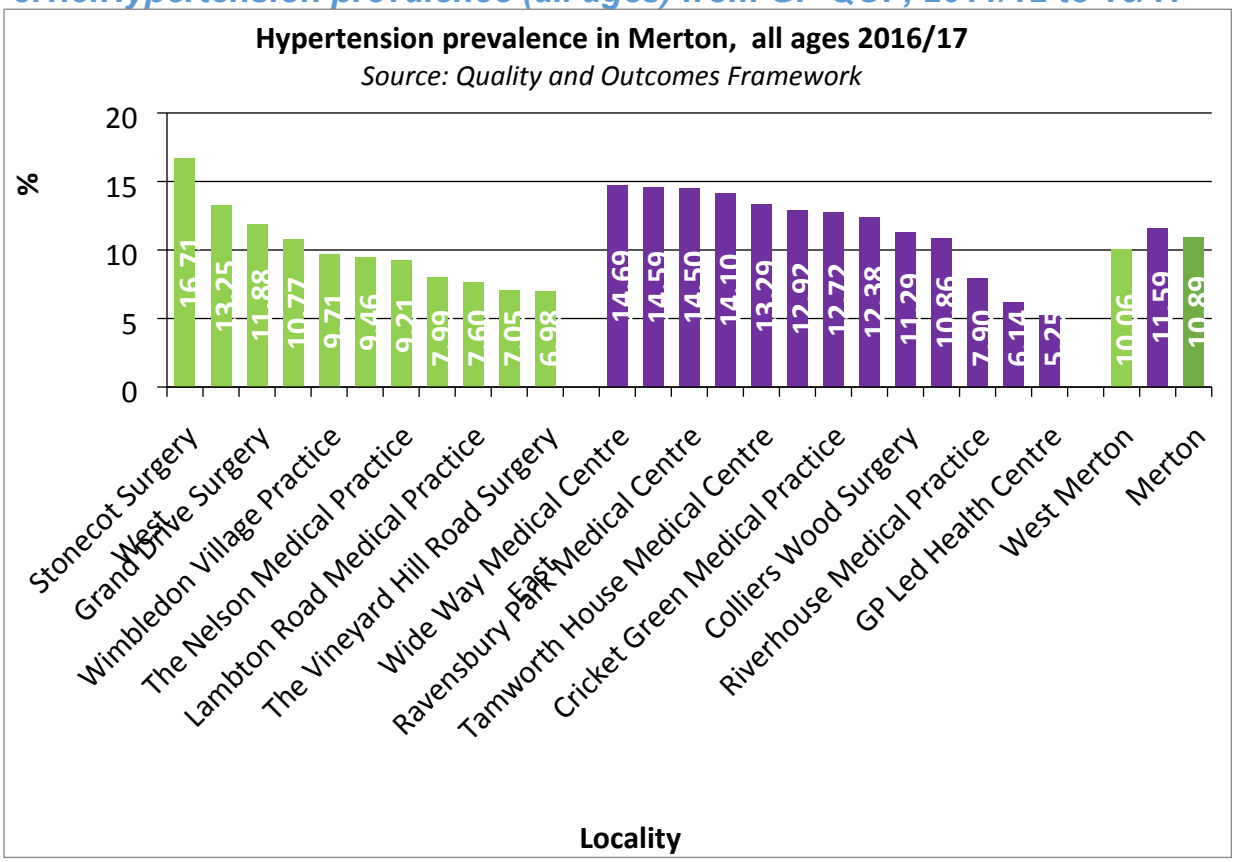
Hospital stays for alcohol related harm for Merton wards by percentage income deprived (2011/12-2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)

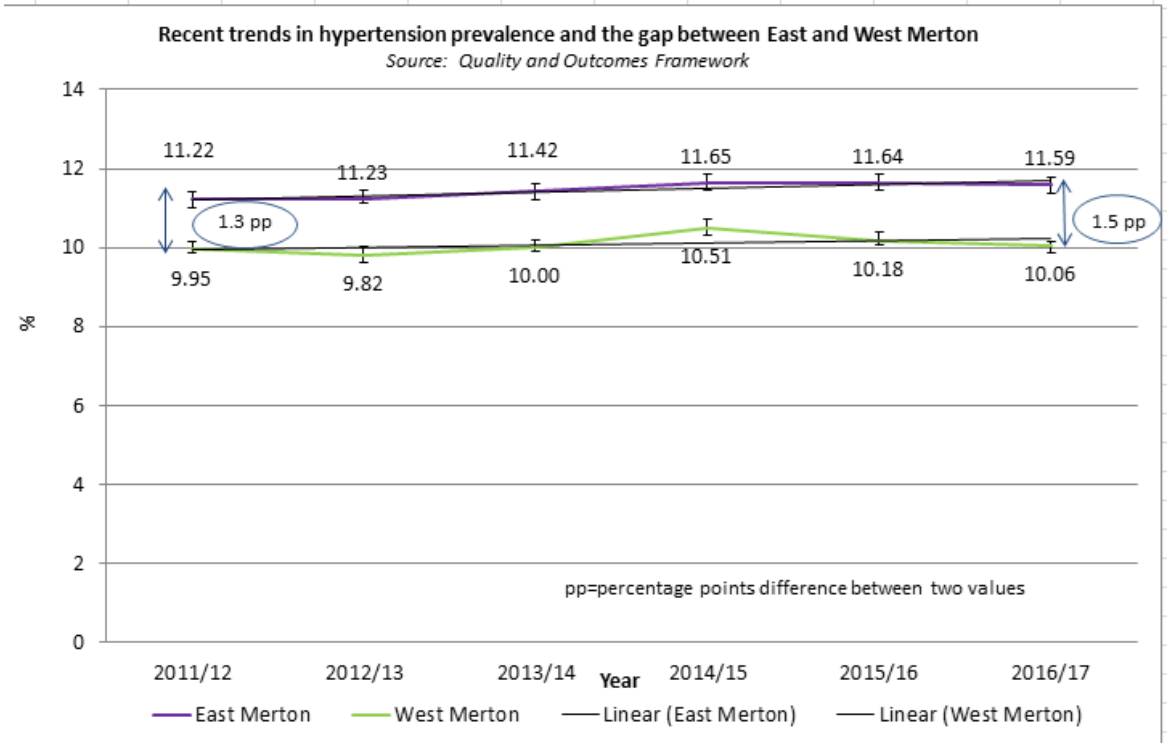


Hospital stays for alcohol related harm for Merton wards (2011/12-2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)



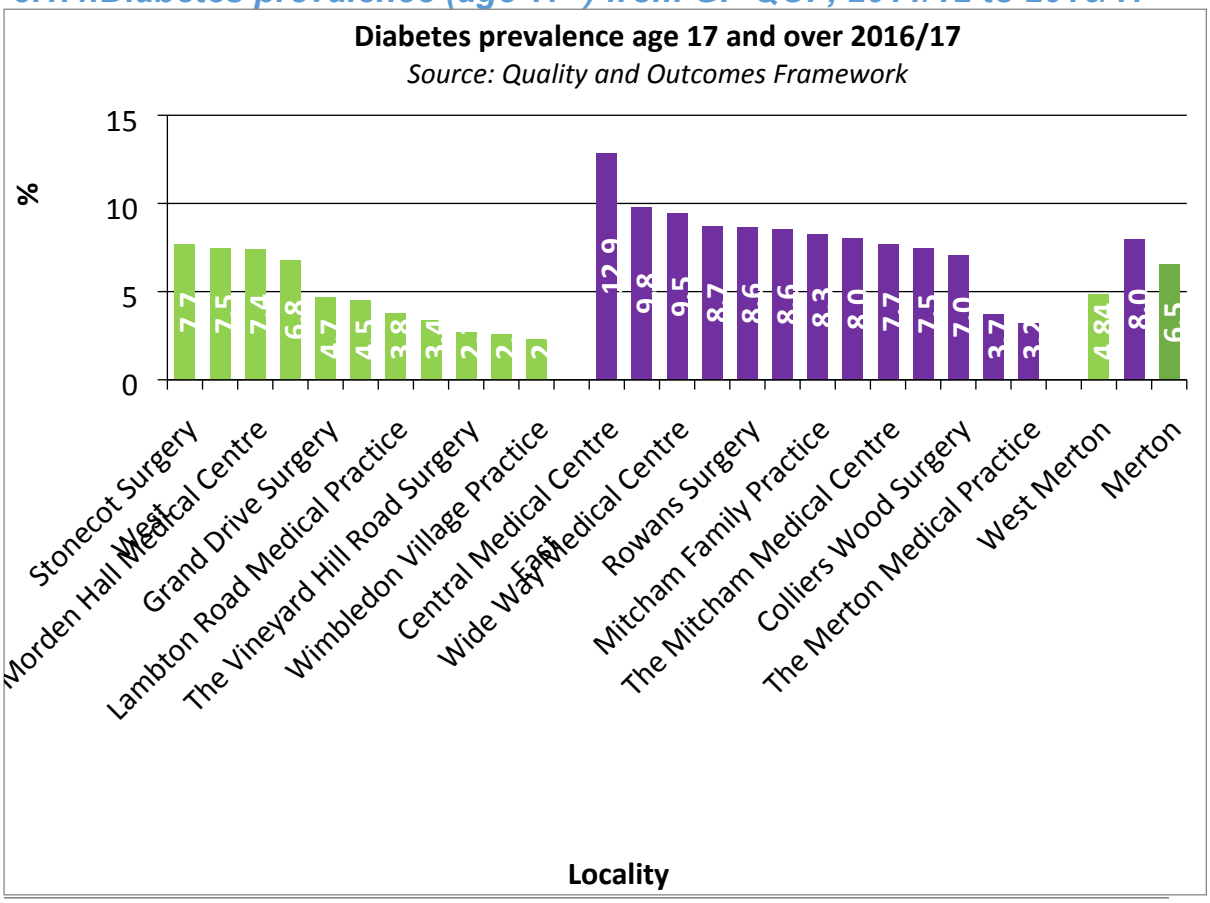
3.1.3.Hypertension prevalence (all ages) from GP QOF, 2011/12 to 16/17*

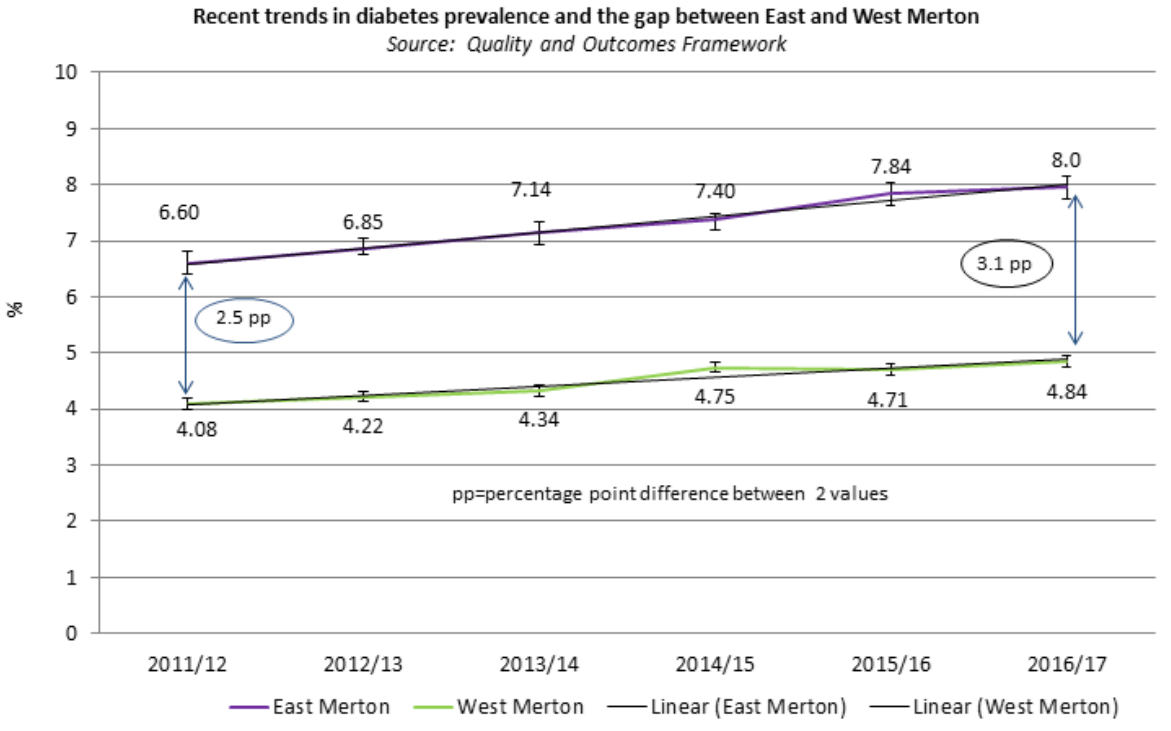




INEQUALITY GAP	Current gap between East and West: 1.5 percentage points (11.59 compared to 10.06) in 2016/17. This difference appears statistically significant.
TREND IN INEQUALITY GAP	Between 2011/12 and 2016/17 there was a slight increase in the gap (1.3 to 1.5). However, the increase is not likely to be statistically significant.

3.1.4.Diabetes prevalence (age 17+) from GP QOF, 2011/12 to 2016/17*





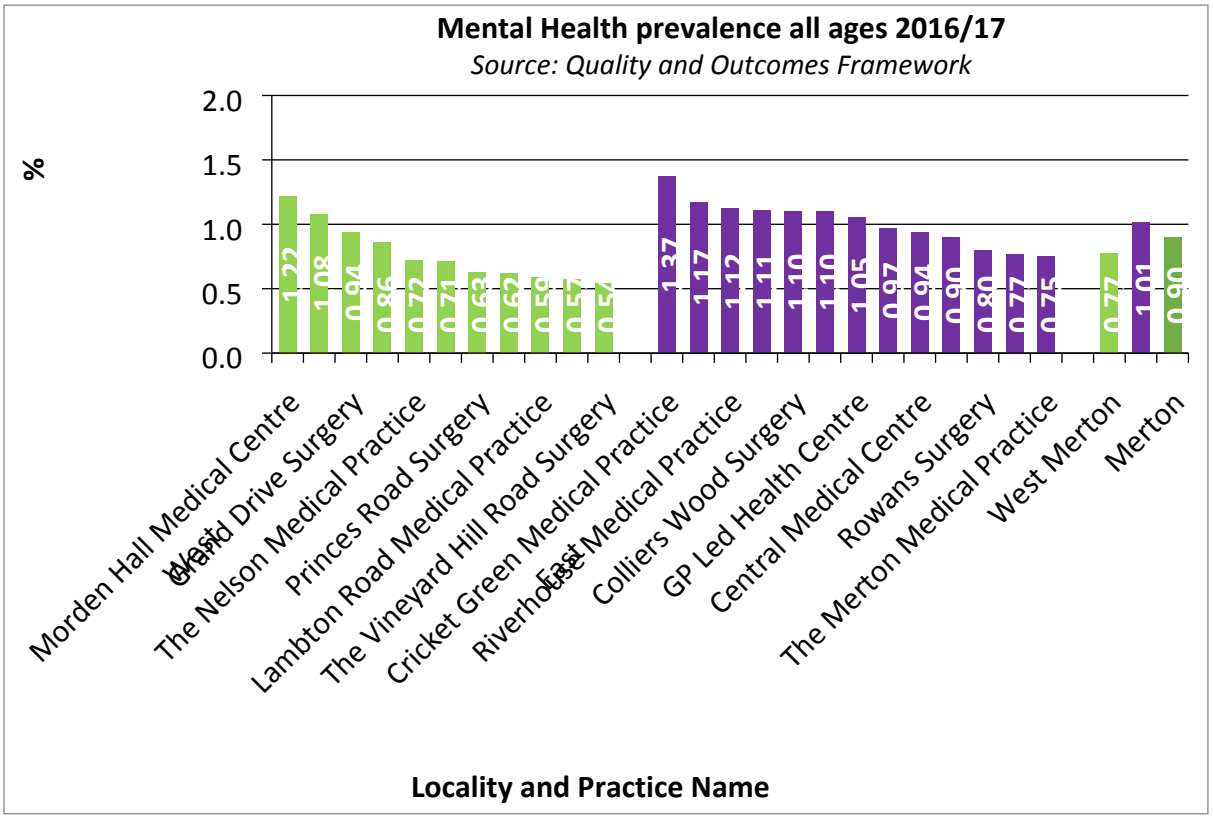
INEQUALITY GAP	Current gap between East and West: 3.1 percentage points (8.0 compared to 4.85) in 2016/17. This difference is statistically significant.
TREND IN INEQUALITY GAP	Between 2011/12 and 2016/17, the difference between East and West increased (from 2.5 to 3.1); this increase appears statistically significant.

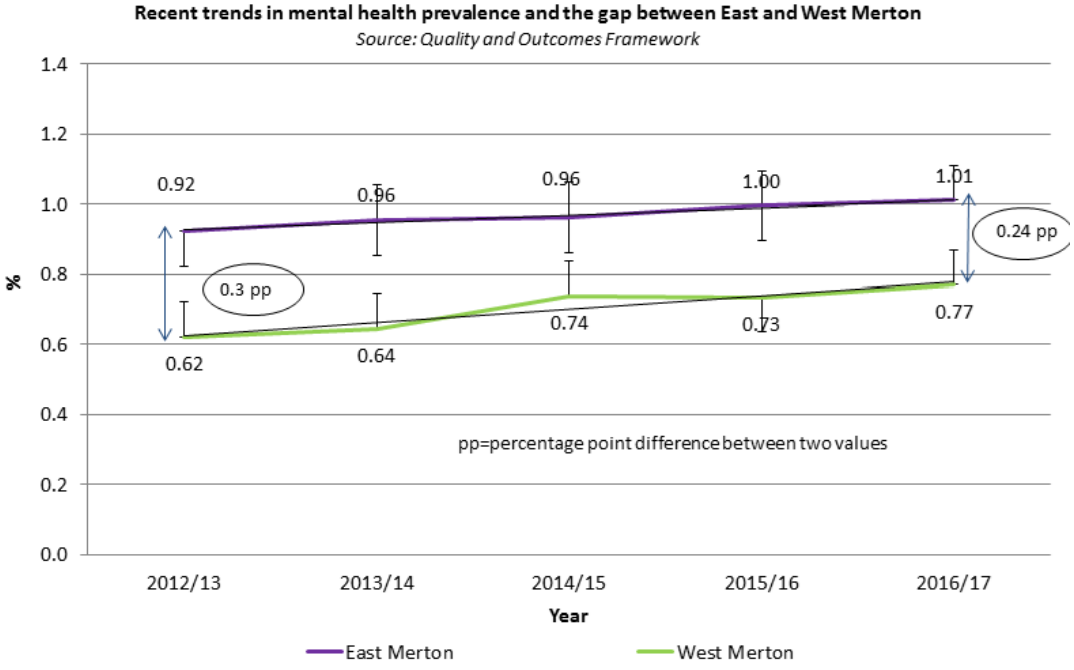
3.1.5. Tuberculosis (TB) incidence, 2011-13 to 2014/16

Gap = 25.6

INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 25.6 (35.0 per 100,000 in the 30% most deprived compared to 9.4 per 100,000 in the 30% least deprived) (2014-16 data)
TREND IN INEQUALITY GAP	Between 2011-13 and 2014-16, the difference between the most deprived and least deprived wards increased (from 23.7 to 25.6). This is unlikely to be a statistically significant increase at this point as numbers are small and confidence intervals are wide.

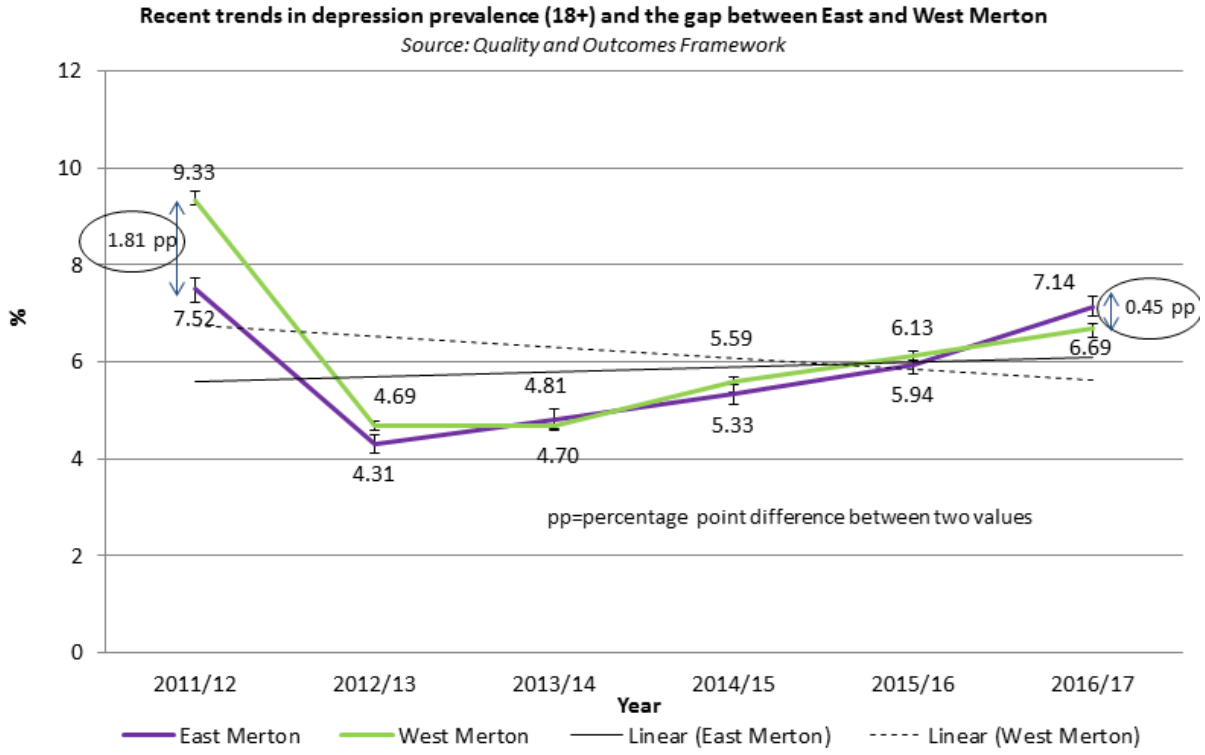
3.1.6. Mental health prevalence (all ages) from GP QOF, 2012/13 to 2016/17*





INEQUALITY GAP	Current gap between East and West: 0.24 percentage points (1.01% compared to 0.77%) in 2016/7). This difference is statistically significant.
TREND IN INEQUALITY GAP	Between 2012/13 and 2016/17 there was a slight decrease in the gap (from 0.30 to 0.24), driven by a faster increasing prevalence in west Merton compared to east).

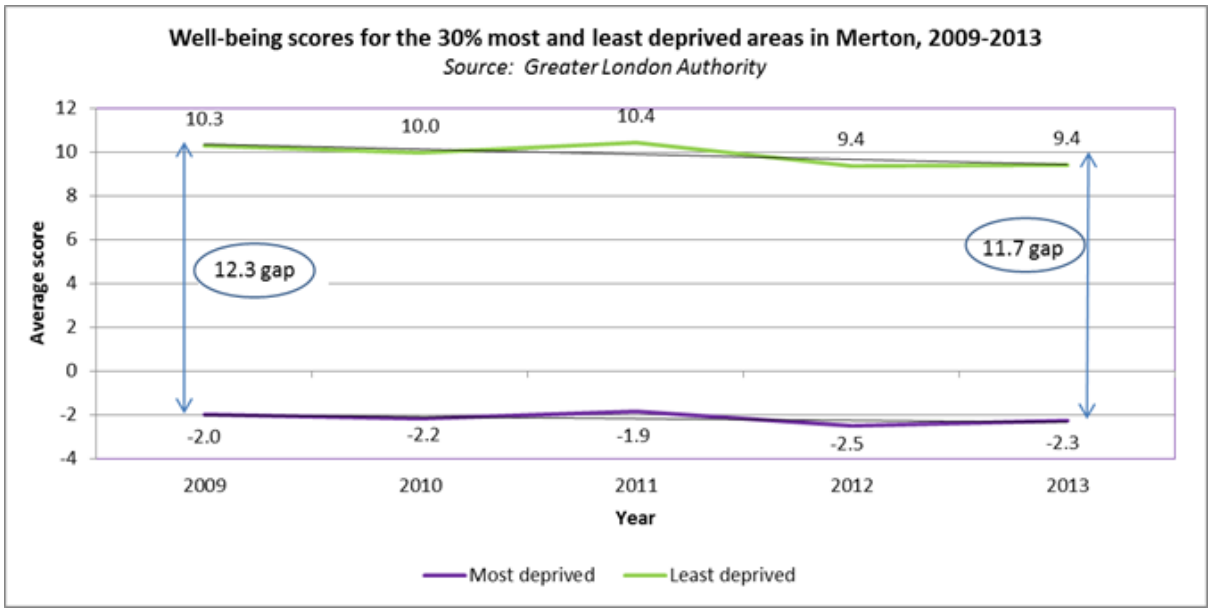
3.1.7. Depression prevalence (age 18+), from GP QOF, 2011/12 to 2016/17*



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Gap between east and west localities	-1.81	-0.38	0.12	-0.25	-0.19	0.45

INEQUALITY GAP	Current gap between East and West Merton: 0.45 percentage points (7.14 in East Merton compared to 6.69 in West Merton, 2016/17 data). The difference is statistically significant.
TREND IN INEQUALITY GAP	Between 2011/12 and 2016/17 the inequality gap appears to have flipped, from higher rates of depression in West Merton (difference of -1.81 percentage points) to higher rates in East Merton in 2016/17 (0.45 percentage points). This is one of the only indicators we looked at where the rate of a disease or risk factor was higher in less deprived areas than more deprived areas at any point in the historical trend data.

3.1.8. Self reported wellbeing scores (low life satisfaction), 2009 to 2013



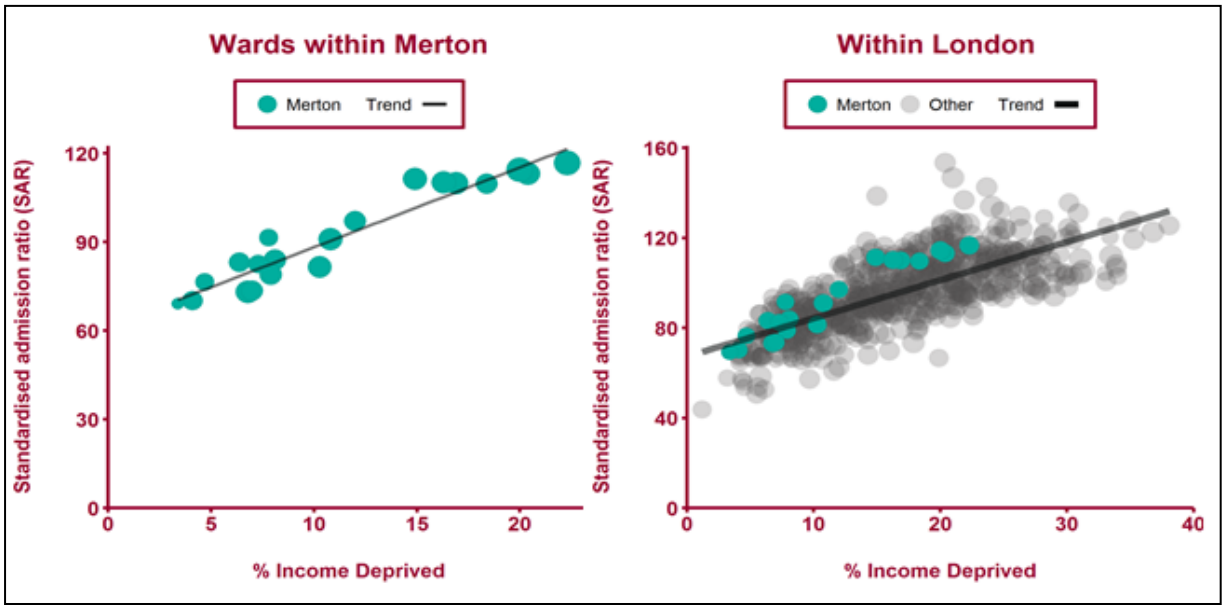
These ward level well-being scores present a combined measure of well-being indicators based on 12 different measures. Where possible each indicator score is compared with the England and Wales average, which is zero. Scores over 0 indicate a higher probability that the population on average experiences positive well-being according to these measures.

INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 11.7 points (a score of -2.3 in the 30% most deprived wards compared to a score of 9.4 in the 30% least deprived), 2013 data
TREND IN INEQUALITY GAP	Between 2009 and 2013, the difference between the most deprived and least deprived wards reduced (from 12.3 to 11.7). However, the wellbeing scores got worse in both the most and least deprived areas, but with a steeper gradient in the least deprived areas, so this does not represent a positive direction of travel.

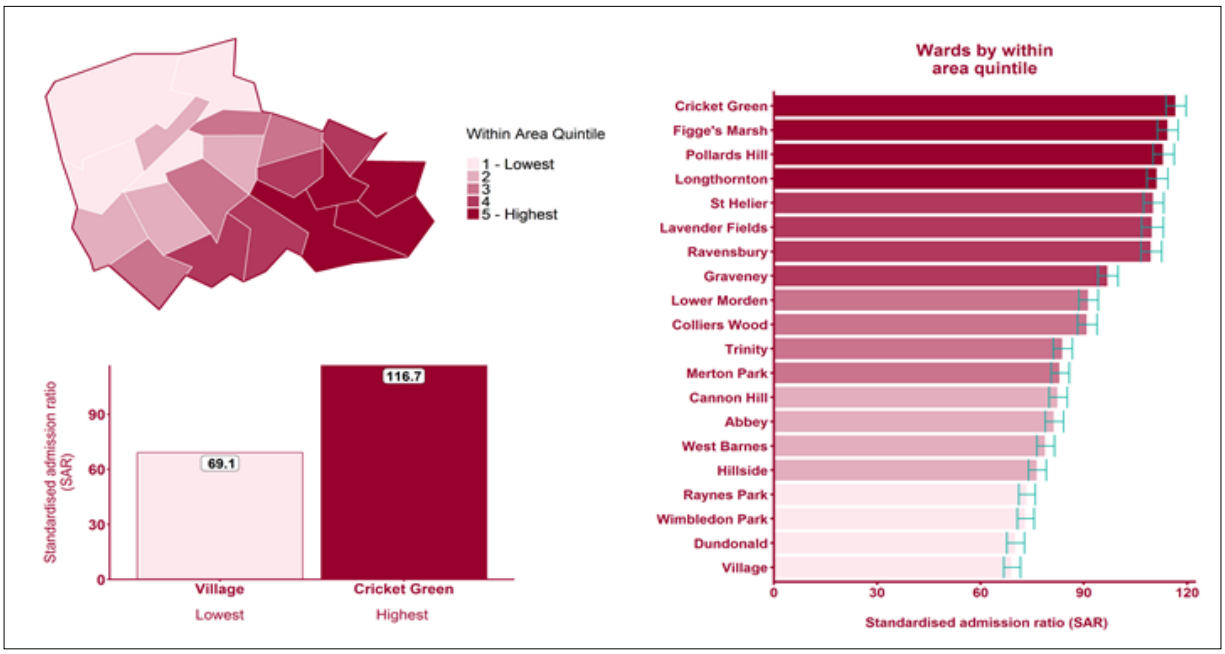
3.1.9.Emergency hospital admissions, 2011/12-2015/16

PHE's recent Health Inequalities Briefing, based on the Global Burden of Disease study, highlights the social gradient in emergency hospital admissions in Merton:

Emergency hospital admissions for all causes for Merton wards by percentage income deprived (2011/12-2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)

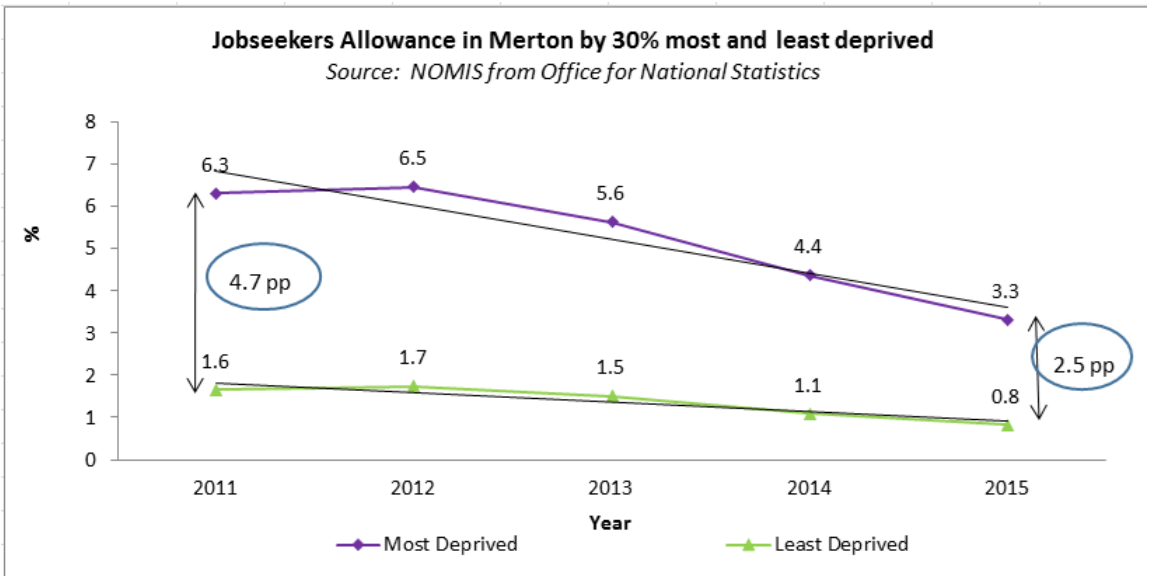


Emergency hospital admissions for all causes for Merton wards (2011/12-2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)



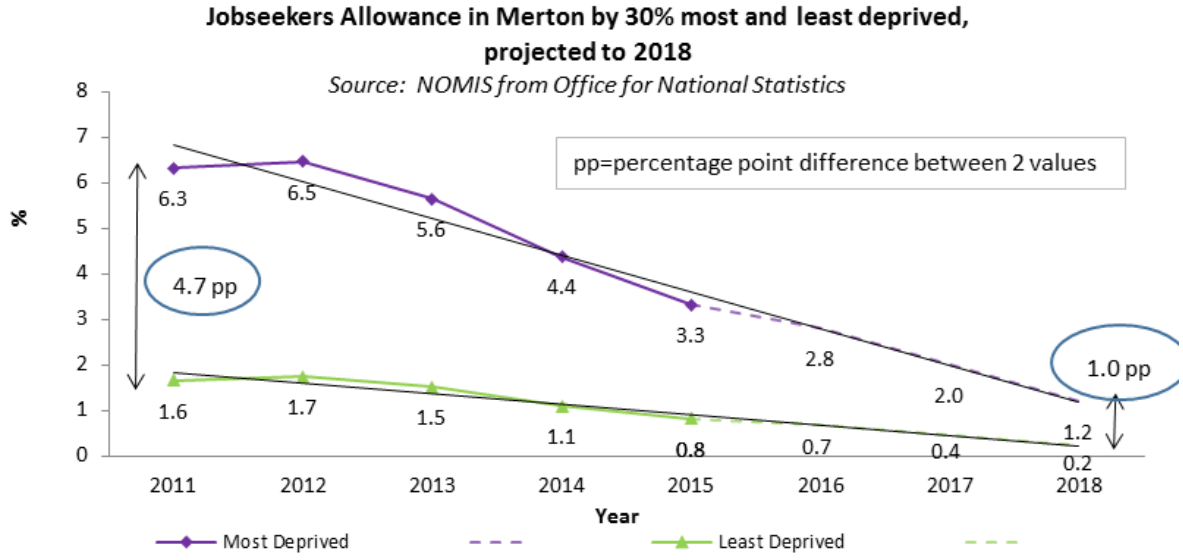
4. CHAPTER 4: Fair employment, good work

4.1.1.Economically active population claiming Job Seekers Allowance, 2011 to 2015

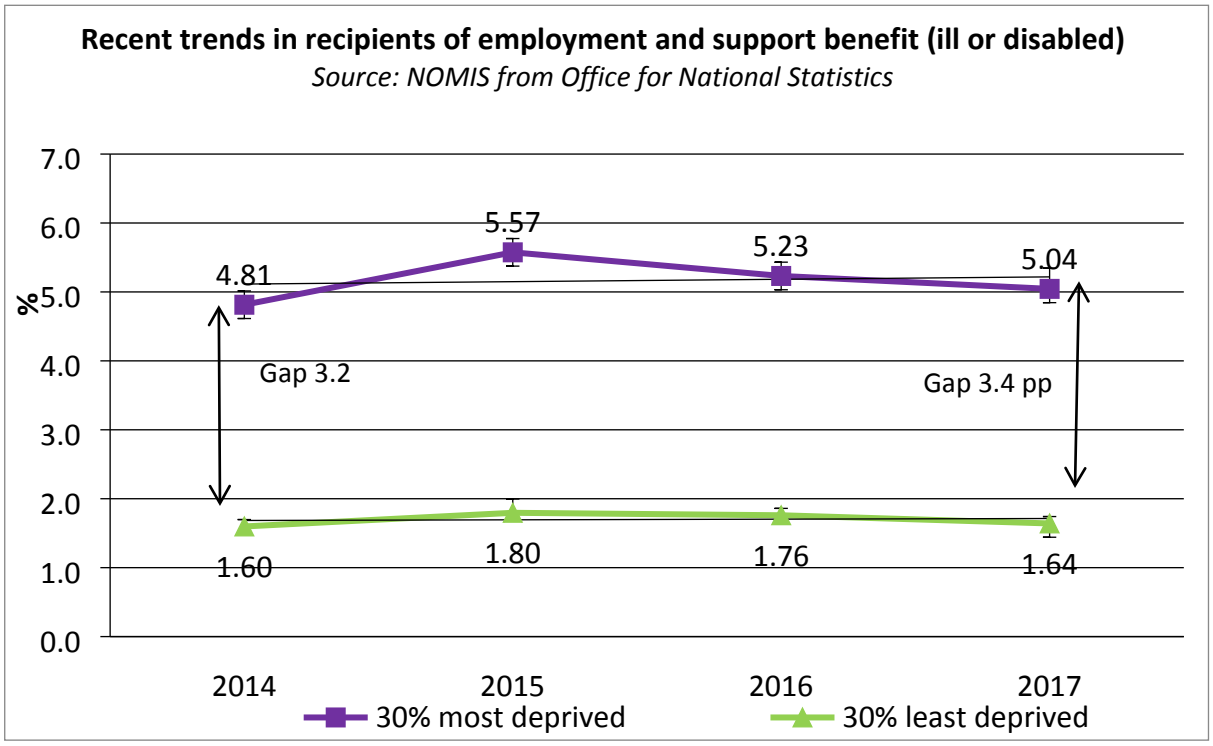


INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 2.5 percentage points (2015 data)
TREND IN INEQUALITY GAP	Between 2011 and 2015, the difference in those claiming JSA between the most deprived and least deprived wards reduced (from 4.7 to 2.5), driven by general decrease across the borough and faster decrease in the most deprived wards

Regression analysis appears to show that gap in 2018 likely to be just under 1 percentage point difference between the most deprived wards (1.2%) compared to the least deprived (0.2%):



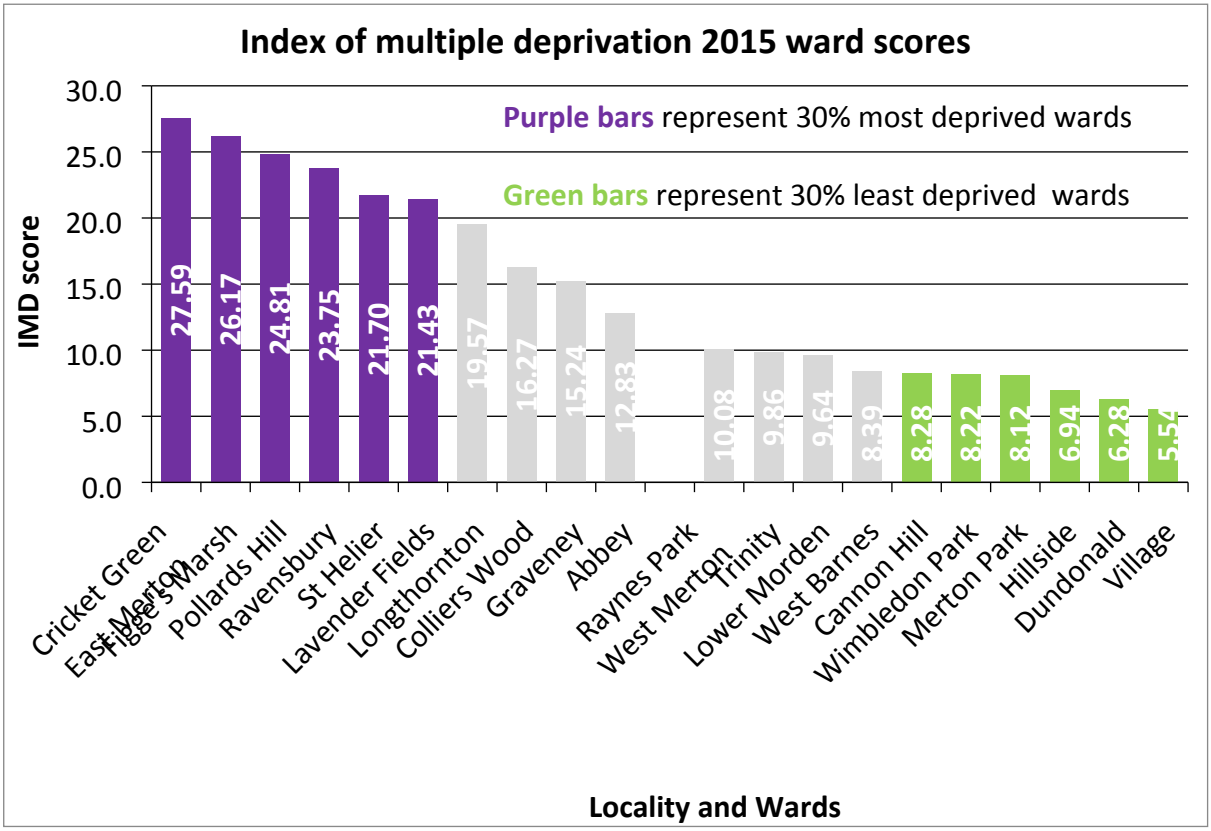
4.1.2. *Benefit claimants - employment and support allowance (ESA), 2014 to 2017*



INEQUALITY GAP	Current gap between 30% most and 30% least deprived:3.4 percentage points (2017). This gap is statistically significant.
TREND IN INEQUALITY GAP	Between 2014 and 2017, the difference in ESA claimants between the most and least deprived wards remained similar.

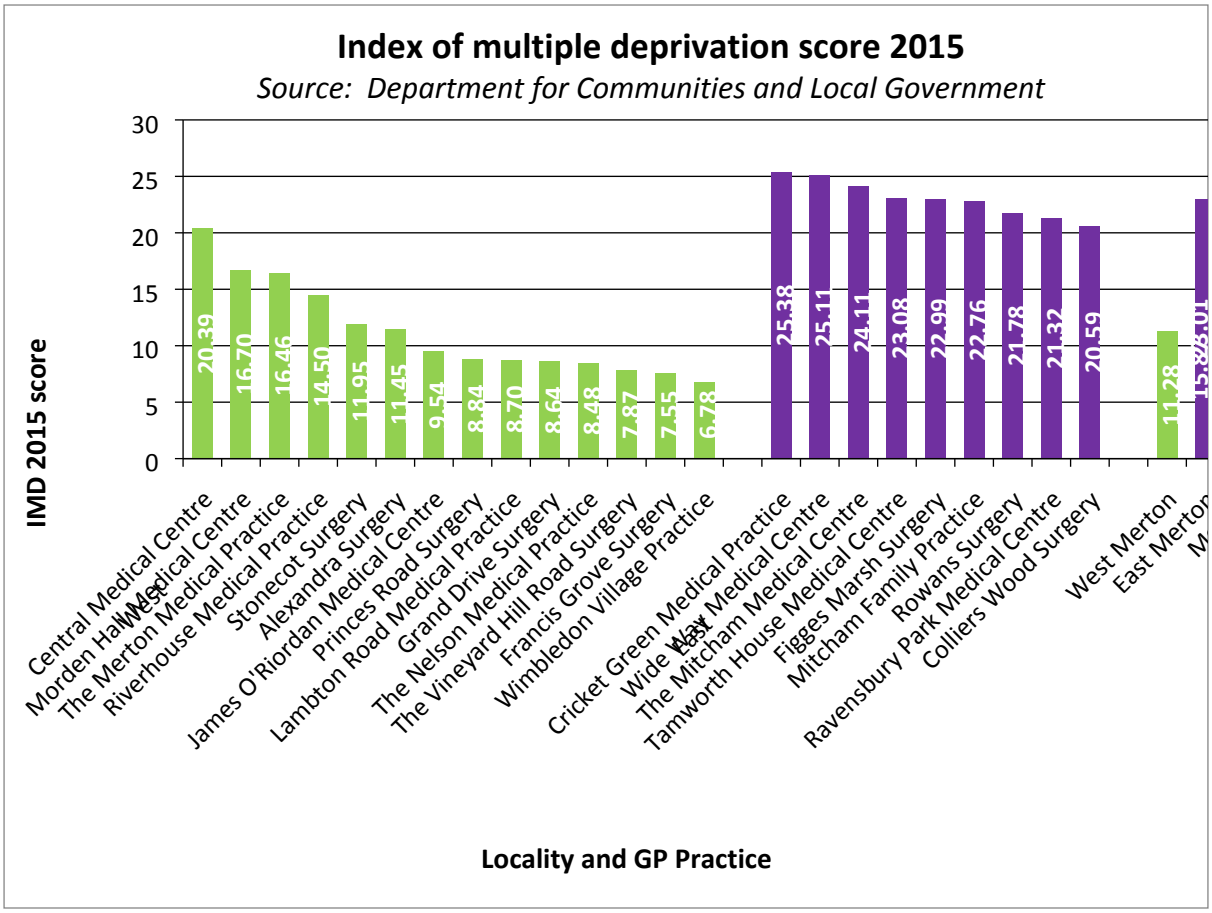
5. CHAPTER 5: Ensure healthy standard of living for all

5.1.1. Index of Deprivation 2015: ward scores



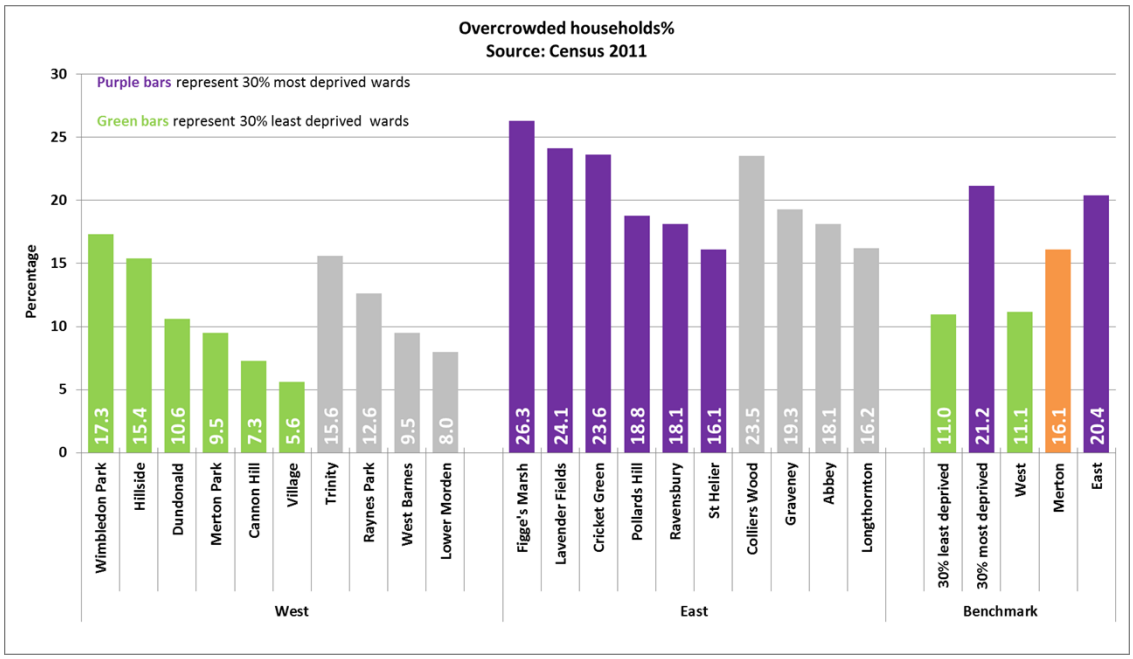
INEQUALITY GAP	Difference in ward scores between the 30% most and least deprived is 17.01 (24.24 in the 30% most deprived compared to 7.23 in the 30% least deprived wards). The higher the score the more deprived the area
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE (Year on year comparisons not possible as the weighting of indicators has been changed over time)*

5.1.2. Index of Deprivation 2015: GP practice scores



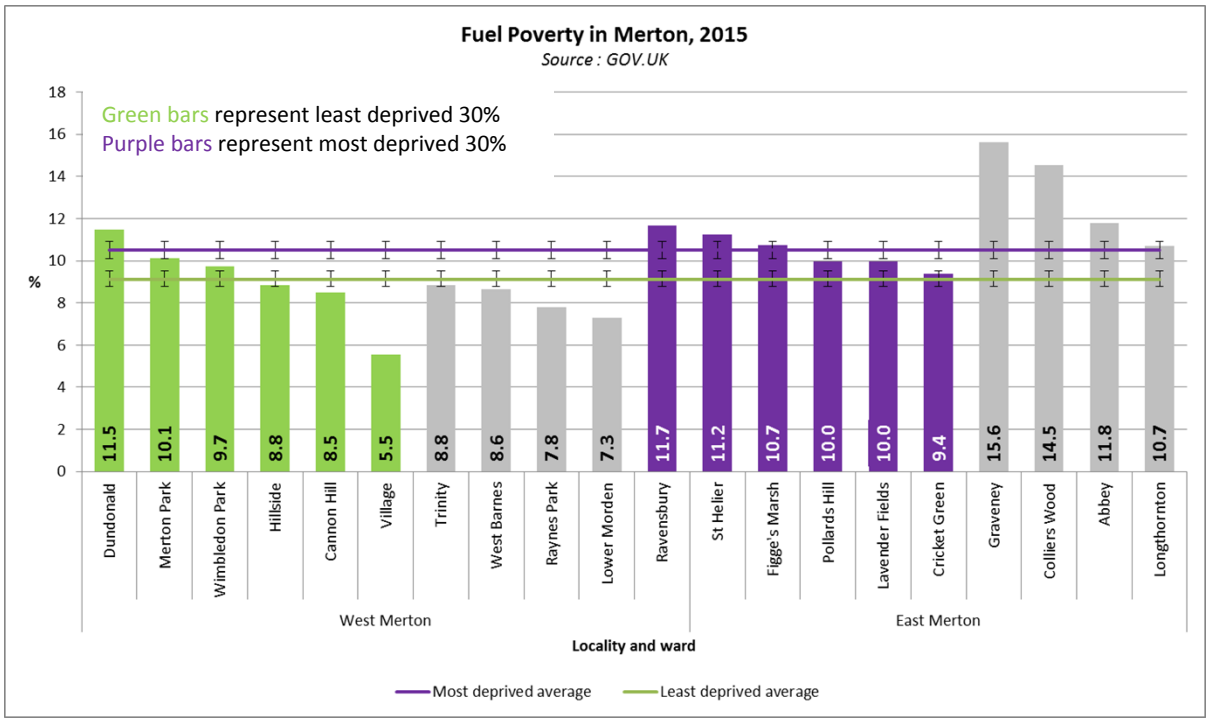
INEQUALITY GAP	Difference between the average score of GP practices in east and those in west Merton is11.74 (23.01 compared to 11.28). The higher the score the more deprived the area.
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE (Year on year comparisons not possible as the weighting of indicators has been changed over time)*

5.1.3. Overcrowded households, 2011



INEQUALITY GAP	Current gap in proportion of overcrowded households between 30% most and 30% least deprived: 10.2 percentage points (21.2% compared to 11.0%, with a borough average of 16.1%)
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE (Census data)*

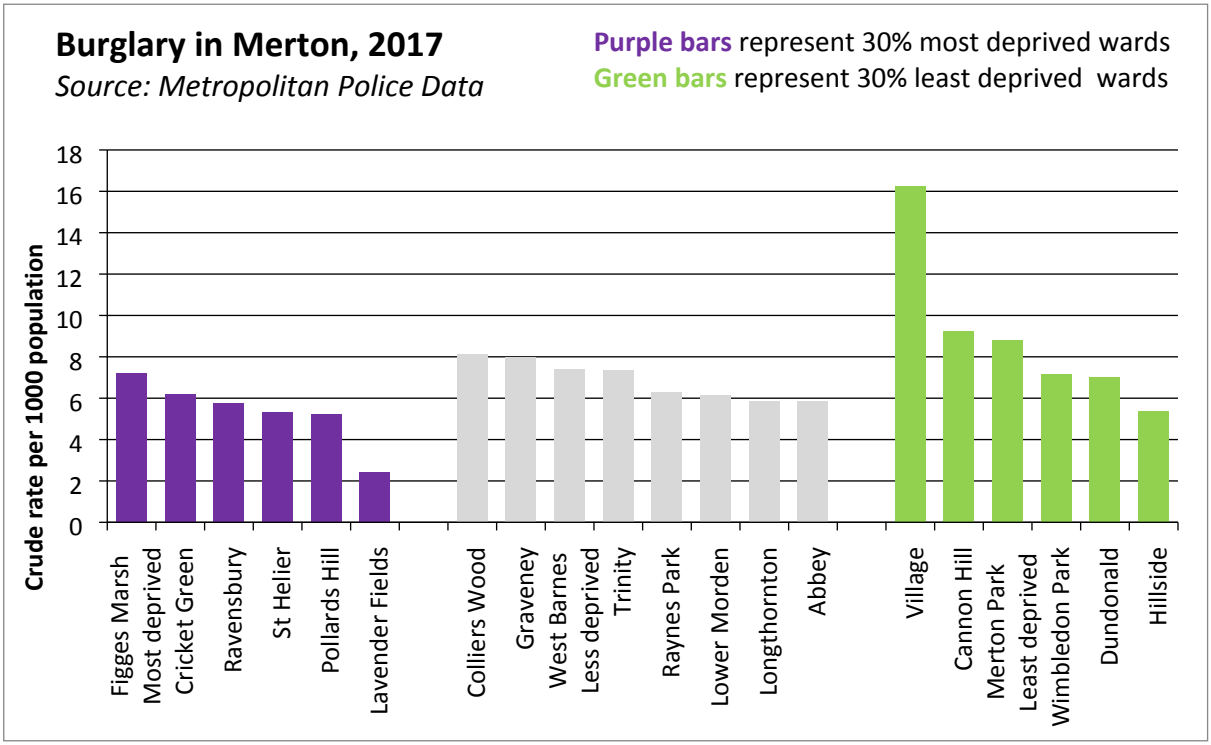
5.1.4.Fuel poverty, 2015



INEQUALITY GAP	Difference between the 30% most deprived and 30% least deprived wards is 1.4 percentage points (10.5% compared to 9.1%). This difference appears to be statistically significant
TREND IN INEQUALITY GAP	HISTORIC TREND DATA NOT AVAILABLE AT WARD LEVEL. This is a new indicator on PHE Local Health, and trend data may be available going forward in future years.

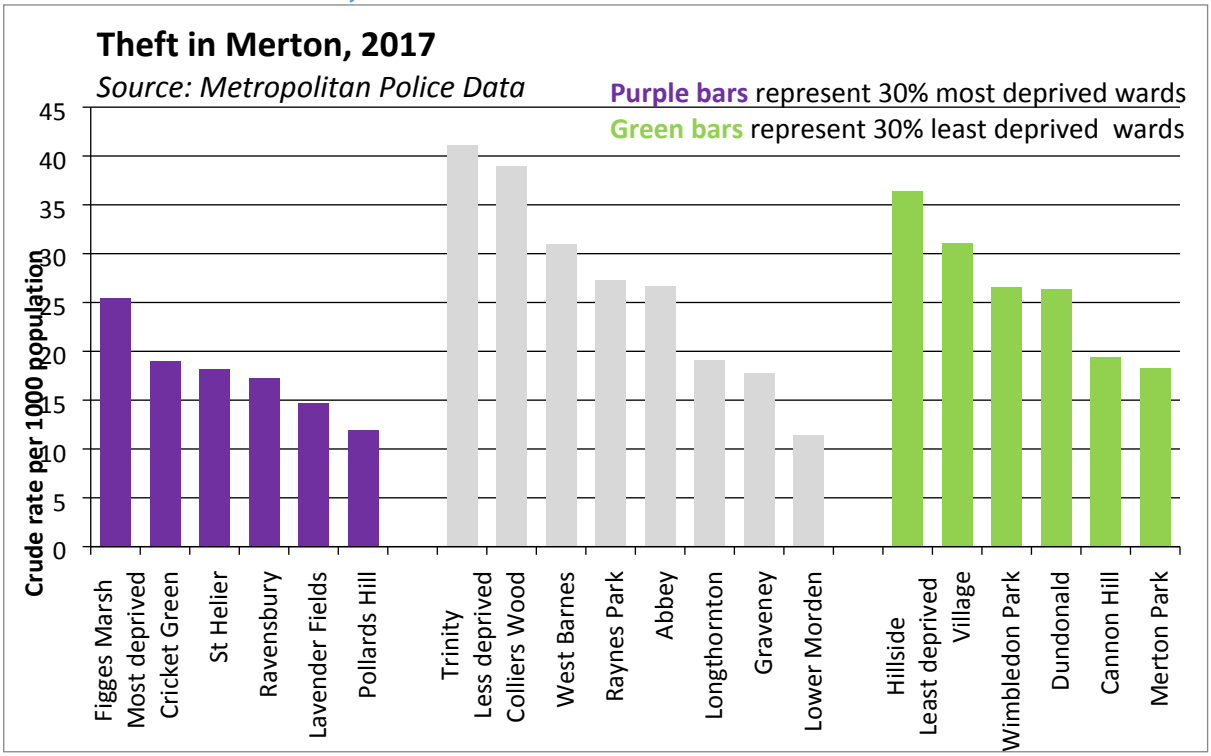
6. CHAPTER 6: Healthy, sustainable communities

6.1.1.Burglary in Merton, 2017



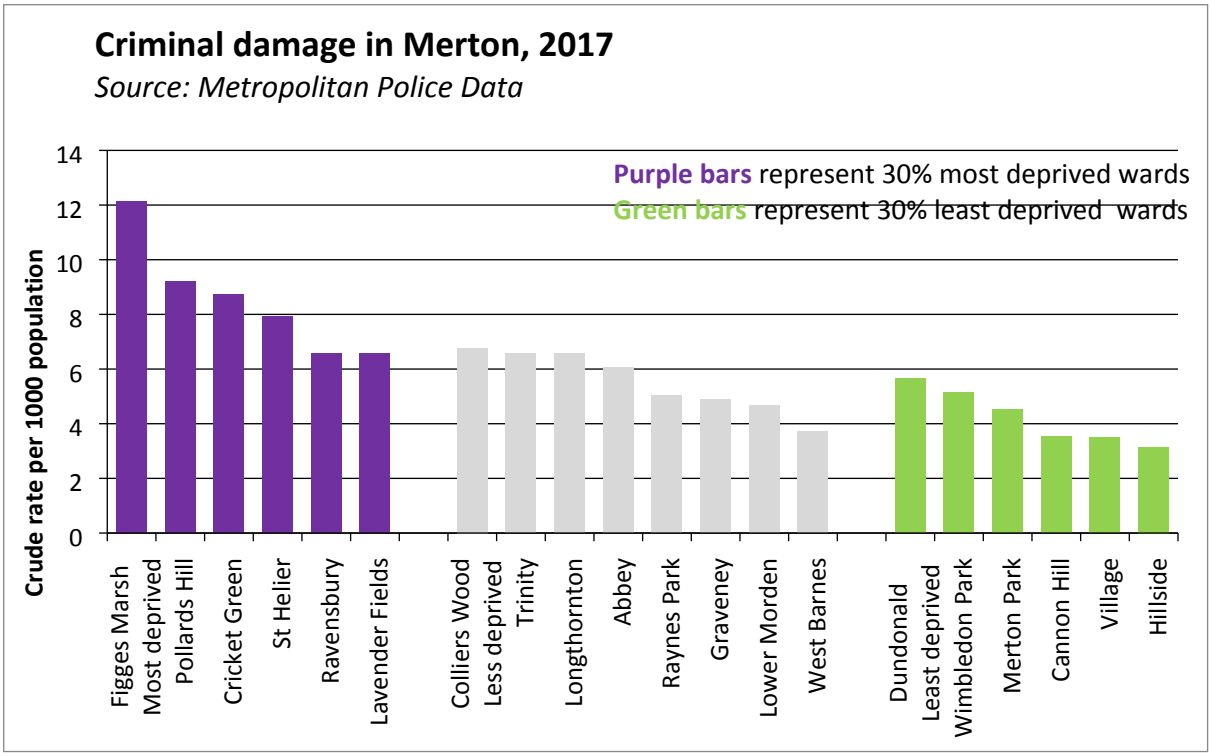
INEQUALITY GAP	Difference in ward scores for burglary between the 30% most and least deprived is -3.4 per 1000 population rate difference (5.3 per 1000 in the 30% most deprived compared to 8.7 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.2. *Theft in Merton, 2017*



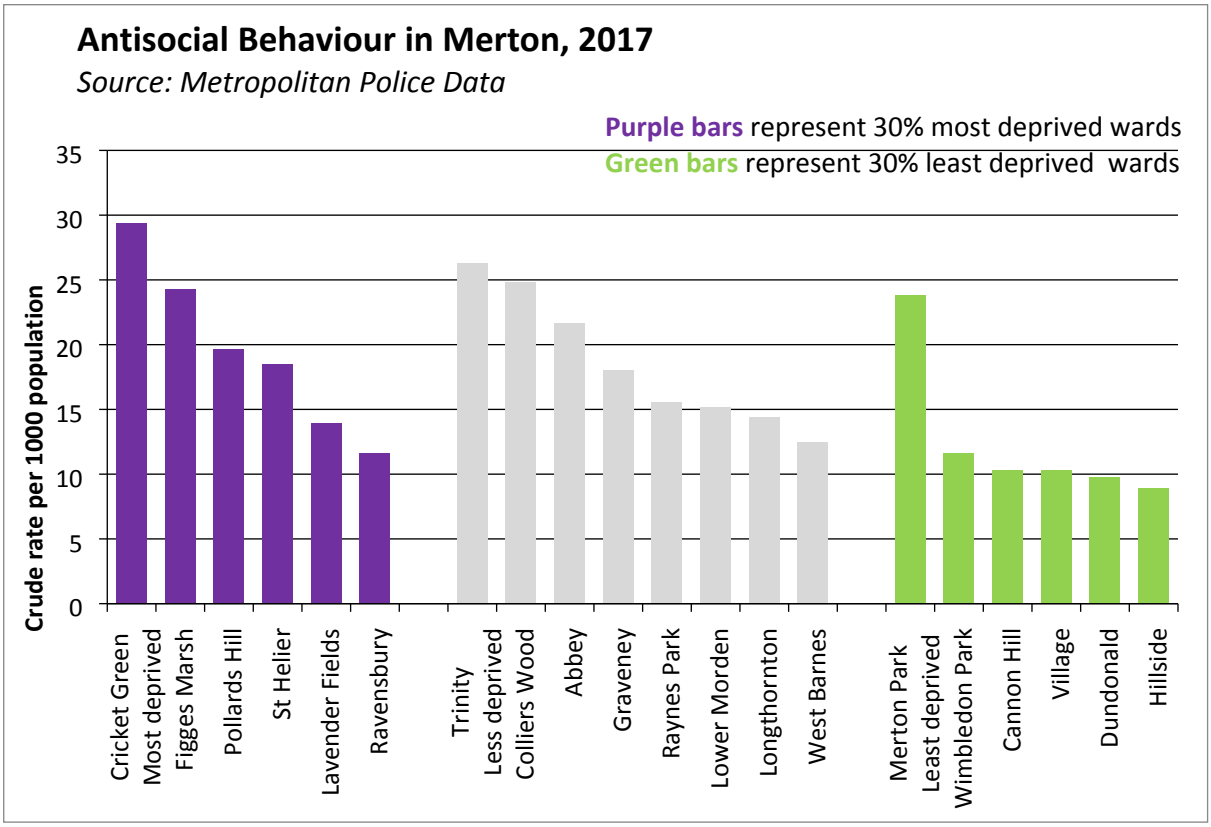
INEQUALITY GAP	Difference in ward scores for theft between the 30% most and least deprived is -8.5 per 1000 population rate difference (18.0 per 100,000 in the 30% most deprived compared to 26.5 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.3. *Criminal damage in Merton, 2017*



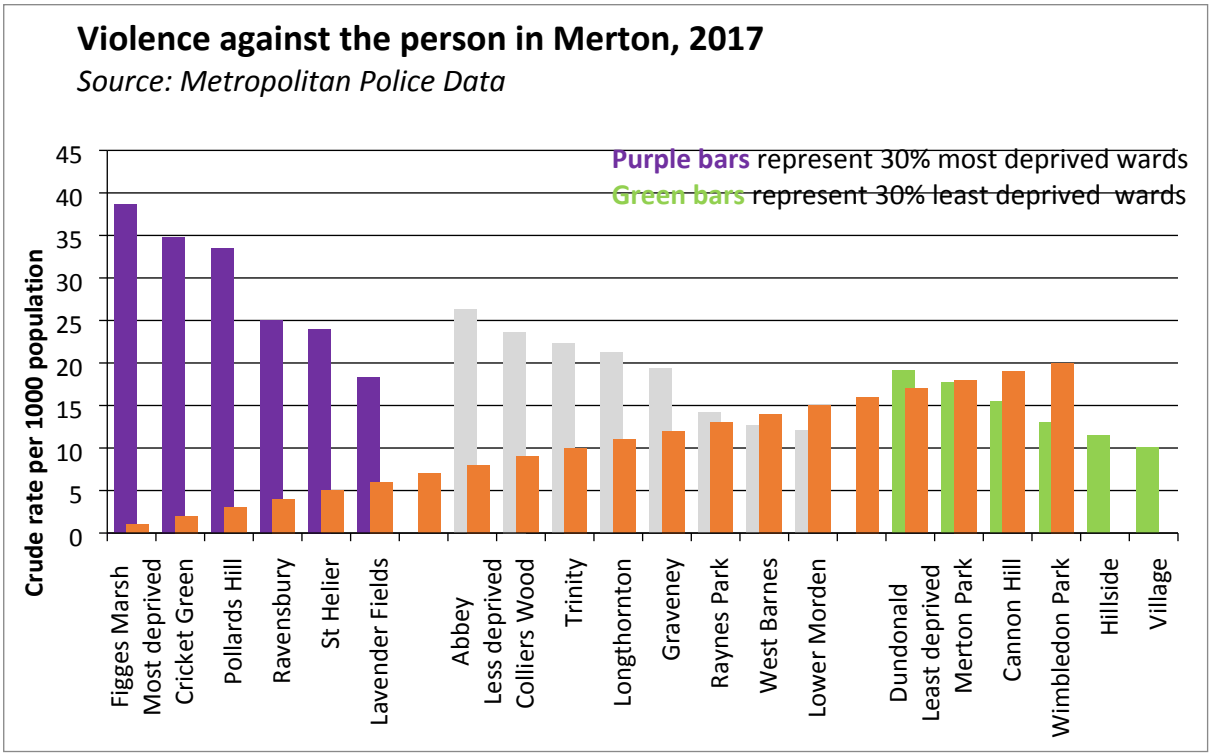
INEQUALITY GAP	Difference in ward scores for criminal damage between the 30% most and least deprived is 4.2 per 1000 population rate difference (8.5 per 100,000 in the 30% most deprived compared to 4.3 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.4.Antisocial behaviour in Merton, 2017



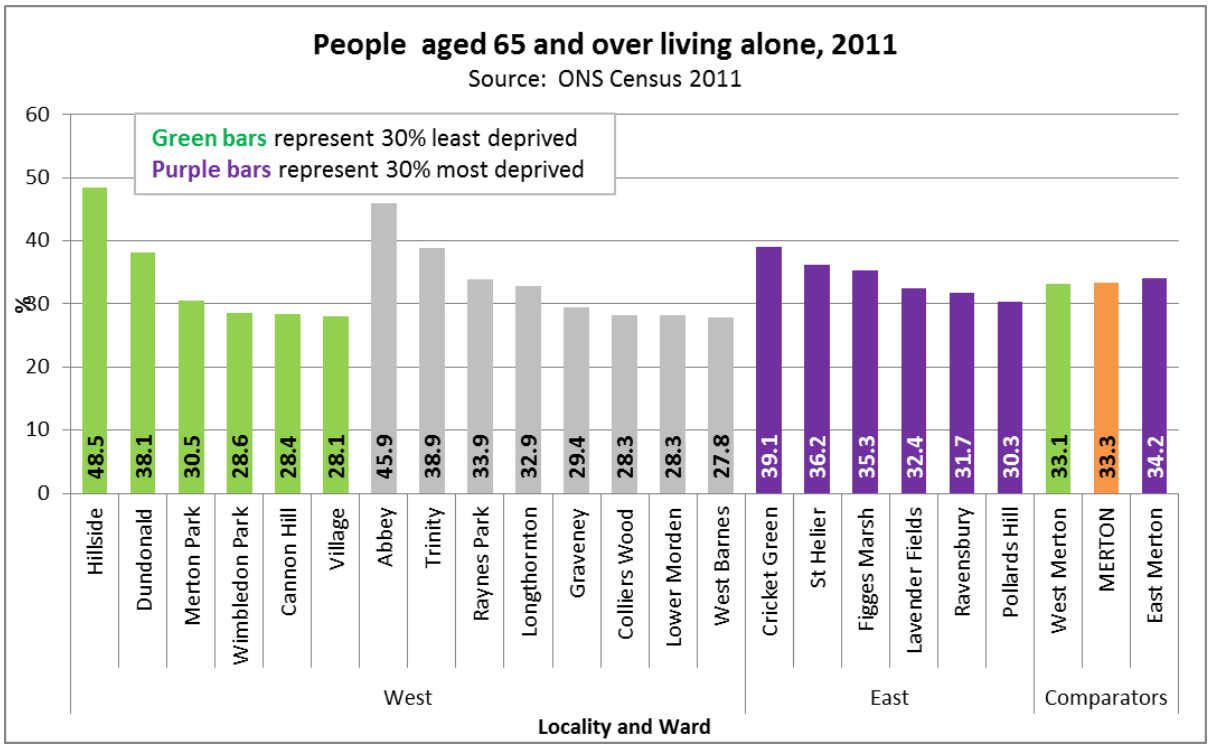
INEQUALITY GAP	Difference in ward scores for antisocial behaviour between the 30% most and least deprived is 7.0 per 1000 population rate difference (19.5 per 100,000 in the 30% most deprived compared to 12.5 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.5. Violence against the person in Merton, 2017



INEQUALITY GAP	Difference in ward scores for violence against the person between the 30% most and least deprived is 14.5 per 1000 population rate difference (28.9 per 100,000 in the 30% most deprived compared to 14.5 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.6. Older people (65+) living alone, 2011



INEQUALITY GAP	Current gap in proportion of older people living alone, between 30% most and 30% least deprived: 0.5 percentage points (34.2% compared to 33.7%
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE (Census data)*

Overview of PHE Marmot indicators for Merton

NB these are at borough level not looking at inequality gap.

Compared to England

Indicator	Period	Merton			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Healthy life expectancy at birth (Female)	2014 - 16	–	-	66.7	64.4	63.9	54.6		71.1
Healthy life expectancy at birth (Male)	2014 - 16	–	-	63.2	63.5	63.3	54.3		69.9
Life expectancy at birth (Female)	2014 - 16	–	-	84.2	84.2	83.1	79.4		86.8
Life expectancy at birth (Male)	2014 - 16	–	-	80.8	80.4	79.5	74.2		83.7
Inequality in life expectancy at birth (Female)	2014 - 16	–	-	3.4	-	-	-	-	-
Inequality in life expectancy at birth (Male)	2014 - 16	–	-	6.2	-	-	-	-	-
People reporting low life satisfaction	2016/17	–	-	*	4.3%	4.5%	-	*Insufficient number of values for a spine chart*	-
School readiness: Good level of development at age 5	2016/17	↑	1,883	73.9%	73.0%	70.7%	60.9%		78.9%
School readiness: Good level of development at age 5 with free school meal status	2016/17	↑	207	63.9%	63.6%	56.0%	43.9%		70.7%
GCSE achieved 5A*-C including English & Maths	2015/16	–	1,169	69.2%	61.3%	57.8%	44.8%		74.6%
GCSE achieved 5A*-C including English & Maths with free school meal status	2014/15	–	120	43.8%	45.8%	33.3%	20.5%		60.0%
19-24 year olds not in education, employment or training	2017	–	-	-	12.7%	13.2%	-	*Insufficient number of values for a spine chart*	-
Unemployment	2016	–	5,400	4.7%	5.7%	4.8%	9.0%		2.3%
Long term claimants of Jobseeker's Allowance	2016	↓	488	3.6*	4.1*	3.7*	13.8		0.7
Individuals not reaching the Minimum Income Standard	2013/14 - 15/16	–	-	-	35.6%	30.3%	-	*Insufficient number of values for a spine chart*	-
Work-related illness	2014/15 - 16/17	–	-	-	3590	3980	-	*Insufficient number of values for a spine chart*	-
Fuel poverty	2015	→	8,151	10.2%	10.1%	11.0%	18.2%		6.7%
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	–	-	16.5%*	18.0%	17.9%	5.1%		36.9%

Compared to London

Indicator	Period	Merton			Region	England	London region		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Healthy life expectancy at birth (Female)	2014 - 16	–	-	66.7	64.4	63.9	55.6		70.0
Healthy life expectancy at birth (Male)	2014 - 16	–	-	63.2	63.5	63.3	58.2		69.9
Life expectancy at birth (Female)	2014 - 16	–	-	84.2	84.2	83.1	81.9		86.8
Life expectancy at birth (Male)	2014 - 16	–	-	80.8	80.4	79.5	77.5		83.7
Inequality in life expectancy at birth (Female)	2014 - 16	–	-	3.4	-	-	-	-	-
Inequality in life expectancy at birth (Male)	2014 - 16	–	-	6.2	-	-	-	-	-
People reporting low life satisfaction	2016/17	–	-	*	4.3%	4.5%	-	*Insufficient number of values for a spine chart*	-
School readiness: Good level of development at age 5	2016/17	↑	1,883	73.9%	73.0%	70.7%	66.4%		78.9%
School readiness: Good level of development at age 5 with free school meal status	2016/17	↑	207	63.9%	63.6%	56.0%	53.7%		70.7%
GCSE achieved 5A*-C including English & Maths	2015/16	–	1,169	69.2%	61.3%	57.8%	54.8%		74.6%
GCSE achieved 5A*-C including English & Maths with free school meal status	2014/15	–	120	43.8%	45.8%	33.3%	34.7%		60.0%
19-24 year olds not in education, employment or training	2017	–	-	-	12.7%	13.2%	-	*Insufficient number of values for a spine chart*	-
Unemployment	2016	–	5,400	4.7%	5.7%	4.8%	7.9%		3.8%
Long term claimants of Jobseeker's Allowance	2016	↓	488	3.6*	4.1*	3.7*	6.8		1.7
Individuals not reaching the Minimum Income Standard	2013/14 - 15/16	–	-	-	35.6%	30.3%	-	*Insufficient number of values for a spine chart*	-
Work-related illness	2014/15 - 16/17	–	-	-	3590	3980	-	*Insufficient number of values for a spine chart*	-
Fuel poverty	2015	→	8,151	10.2%	10.1%	11.0%	15.7%		6.9%
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	–	-	16.5%*	18.0%	17.9%	9.8%		27.5%

Cabinet

Date: 30 July 2018

Subject: Financial Report 2018/19 – May 2018

Lead officer: Roger Kershaw

Lead member: Mark Allison

Recommendations:

A. That Cabinet note the financial reporting data relating to revenue budgetary control, showing a forecast net overspend at year end of £2 million.

B. That Cabinet note the adjustments to the Capital Programme contained in Appendix 5b and approve the following adjustments to the Capital Programme :

Scheme		2018/19 Budget	2019/20 Budget	2020/21 Budget	2021/22 Budget	Funding/Re-profiling
Corporate Services						
Aligned Assets		(75,000)	75,000	0	0	Re-profiling
Revenue and Benefits	(1)	(400,000)	400,000	0	0	Re-profiling
Capita Housing	(1)	(100,000)	100,000	0	0	Re-profiling
Planning&Public Protection Sys	(1)	(130,000)	130,000	0	0	Re-profiling
Spectrum Spatial Analyst Repla		(42,000)	42,000	0	0	Re-profiling
Replacement SC System	(1)	(400,000)	400,000	0	0	Re-profiling
Acquisitions Budget	(1)	(7,101,680)			7,101,680	Re-profiling
Capital Bidding Fund	(1)	(1,186,400)			1,186,400	Re-profiling
Children, Schools and Families						
Schools Maintenance		85,000	0	0	0	School Contributuions
Perseid Expansion	(1)	260,000	0	0	0	Virement
Harris Merton Expansion	(1)	(260,000)	0	0	0	Virement
Harris Wimbledon Expansion	(1)	(572,570)	**572,570**	0	0	Re-profiling
Devolved Formula Capital	(1)	353,390				Specific Government Grant
Cricket Green Expansion	(1)	(1,000,000)	**1,000,000**	0	0	Re-profiling
Environment and Regeneration						
Street Lighting Replacement Pr	(1)	(200,000)	**0**	0	0	Virement
Borough Roads Maintenance	(1)	200,000	**0**	0	0	Virement
Transportation Enhancements	(1)	0	**(500,000)**	(1,000,000)	1,500,000	Re-profiling
Wandle Project	(1)	59,770	**0**	0	0	Section 106 Funding
Shop Front Improvements	(1)	264,000				CIL Neighbourhood Funding
Polka Theatre (Section 106)	(1)	149,950				Section 106 Funding
S106 Ravensbury Park Open Space	(1)	87,000	**0**	0	0	New S106 Scheme
Total		**(10,008,540)**	**2,219,570**	**(1,000,000)**	**9,788,080**	

*items marked with (1) only for Cabinet

C. That Cabinet approve the £149,950 Section 106 funding for the Polka Theatre, £87,000 Section 106 funding for Ravensbury Park Open Space and £59,770 Section 106 funding for the Wandle Project.

D. Cabinet are requested to approve a virement between the Environment & Regeneration and Corporate Services departments as part of the ongoing process of centralising the authority's software licences to the Business Improvement division. The virement amount is £10,360 which relates to the Transport Services route optimisation and planning software.

E. Cabinet are requested to approve a virement of £350k from Corporate items to Corporate Services to fund the recent local elections.

F. Cabinet are requested to approve a virement of £1.5m to gross up the Housing Benefits subsidy received on overpayments to align income and expenditure budgets within Corporate Services.

G. Cabinet are requested to approve a release from reserve of £370k relating to the One Public Estate Programme for Wilson Hospital redevelopment (£110k), and Morden Town Centre (£260k).

H. Cabinet approve a virement of £25k from Corporate Services to E&R for the Christmas lights budget which is managed within sustainable communities.

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This is the financial monitoring report for period 2, 31st May 2018 presented in line with the financial reporting timetable.
This financial monitoring report provides:-

- The income and expenditure at period 2 and a full year forecast projection.
- An update on the capital programme and detailed monitoring information;
- An update on Corporate Items in the budget 2018/19;
- Progress on the delivery of the 2018/19 revenue savings

2. THE FINANCIAL REPORTING PROCESS

2.1 The budget monitoring process in 2018/19 will continue to focus on adult social care and children's social care as these areas overspent in 2017/18 and continue to have budget pressures.

2.2 Chief Officers, together with budget managers and Service Financial Advisers are responsible for keeping budgets under close scrutiny and ensuring that expenditure within budgets which are overspending is being actively and vigorously controlled and where budgets are underspent, these underspends are retained until year end. Any final overall overspend on the General Fund will result in a call on balances, however this action is not sustainable longer term.

2.3 2018/19 FORECAST OUTTURN BASED UPON LATEST AVAILABLE DATA

Executive summary – At period 2 to 31st May 2018, the year end forecast is a net £2m overspend compared to the current budget.

Summary Position as at 31st May 2018

	Current Budget 2018/19 £000s	Full Year Forecast (May) £000s	Forecast Variance at year end (May) £000s	Outturn variance 2017/18 £000s
Department				
3A.Corporate Services	9,742	8,637	(1,105)	(812)
3B.Children, Schools and Families	56,145	59,781	3,637	2,249
3C.Community and Housing	63,754	64,178	425	922
3D.Public Health	0	200	200	0
3E.Environment & Regeneration	17,951	16,824	(1,127)	(1,211)
Overheads	0	0	0	0
NET SERVICE EXPENDITURE	**147,590**	**149,620**	**2,030**	**1,148**
3E.Corporate Items				
Impact of Capital on revenue budget	8,403	8,403	0	(103)
Other Central budgets	(12,599)	(12,599)	0	(823)
Levies	938	938	0	0
TOTAL CORPORATE PROVISIONS	**(3,257)**	**(3,257)**	**0**	**(926)**
TOTAL GENERAL FUND	**144,333**	**146,363**	**2,030**	**222**
FUNDING				
Revenue Support Grant	0	0	0	1
Business Rates	(45,636)	(45,636)	0	182
Other Grants	(11,258)	(11,258)	0	(670)
Council Tax and Collection Fund	(87,439)	(87,439)	0	0
FUNDING	**(144,333)**	**(144,333)**	**0**	**(487)**
NET	**(0)**	**2,030**	**2,030**	**(265)**

The current level of GF balances is £12.778m and the minimum level reported to Council for this is £12.09m. This means that another reserve or further savings will need to be found to offset the remaining £1.34m overspend.

3. DEPARTMENTAL SUMMARY OF CURRENT POSITION

Corporate Services

Division	2018/19 Current Budget £000	2018/19 Full year Forecast (May) £000	2018/19 Forecast Variance (May) £000	2017/18 Outturn Variance £000
Customers, Policy & Improvement	3,245	3,351	106	46
Infrastructure & Technology	10,689	10,515	-174	71
Corporate Governance	2,404	2,400	-4	-229
Resources	5,785	5,719	-66	-515
Human Resources	1,775	1,772	-3	-207
Corporate Other	1,032	68	-964	22
Total (Controllable)	**24,930**	**23,825**	**-1,105**	**-812**

Overview

At the end of period 2 (May) the Corporate Services (CS) department is forecasting an underspend of £1,105k at year end. The table above reflects the new structure within Corporate Services in 2018/19. The 2017/18 outturn variance has been adjusted to reflect the new structure in order to provide a meaningful comparison with the period 2 position.

Customers, Policy and Improvement - £106k over

The Communications Service is under-achieving on the advertising income target which is partly offset by underspends elsewhere in the service.

Infrastructure & Technology - £174k under

There are forecast underspends within printing and post services that are partly offset by a lower than expected income from the professional development centre (Chaucer Centre) where the number of bookings is expected to be below the budgeted level.

Corporate Governance - £4k under

There are no significant variations from budget at this stage.

The South London legal partnership (SLLp) is forecasting to overspend by £33k on expenditure budgets but this will be fully covered by hard charging to the other boroughs.

Resources - £66k under

The Merton Bailiff Service is forecasting to over-achieve income by £385k but this is offset by a forecast £44k under-achievement of income in the Shared Bailiff Service. There is a forecast underspend of £105k within Benefits Administration principally due to additional one-off unbudgeted income from DWP for a number of schemes.

There is a forecast overspend with Local Taxation Services and Local Welfare Support of £210k principally due to additional IT licence and postage costs.

Human Resources – £3k under

There are a number of vacant posts within the division that are offset by a number of budget pressures including lower than budgeted income from schools as part of the buyback scheme.

Corporate Items - £964k under

The Housing Benefit budget shows a forecast surplus of £1.2m on the account due to the subsidy received on overpayments. The total surplus in 2017/18 was £1.5m.

This is partly offset by a forecast overspend on Merton's share of the coroners' court due to unbudgeted costs of the Westminster Bridge inquiry.

Environment & Regeneration

Environment & Regeneration	2018/19 Current Budget £000	Full year Forecast (May) £000	Forecast Variance at year end (May) £000	2017/18 Outturn Variance £000
Public Protection	(11,070)	(11,873)	(803)	(1,602)
Public Space	15,072	14,469	(603)	632
Senior Management	952	1,041	89	3
Sustainable Communities	7,643	7,860	190	(244)
Total (Controllable)	**12,597**	**11,498**	**(1,127)**	**(1,211)**

Description	2018/19 Current Budget £000	Forecast Variance at year end (May) £000	2017/18 Variance at year end £000
Overspend within Regulatory Services	550	146	78
Underspend within Parking & CCTV Services	(12,072)	(906)	(1,633)
Underspend within Safer Merton	452	(43)	(47)
Total for Public Protection	**(11,070)**	**(803)**	**(1,602)**
Underspend within Waste Services	13,857	(639)	97
Breakeven within Leisure & Culture	728	0	(166)
Overspend within Greenspaces	1,393	37	754
Underspend within Transport Services	(906)	(1)	(53)
Total for Public Space	**15,072**	**(603)**	**632**
Overspend within Senior Management & Support	952	89	3
Total for Senior Management	**952**	**89**	**3**
Overspend within Property Management	(2,907)	48	(422)
Underspend within Building & Development Control	(63)	(22)	397
Overspend within Future Merton	10,613	164	(219)
Total for Sustainable Communities	**7,643**	**190**	**(244)**
Total Excluding Overheads	**12,597**	**(1,127)**	**(1,211)**

Overview

The department is currently forecasting an underspend of £1,127k at year end. The main areas of variance are Regulatory Services, Parking Services, Waste Services and Future Merton.

Public Protection

Regulatory Services overspend of £146k

The forecast overspend is as a result of a few factors. Firstly, a 2017/18 saving (E&R14) of £100k relating to further expansion of the Regulatory Services Partnership to include the London Borough of Wandsworth, will only be achieved in

part this year. Secondly, a 2018/19 saving (ENV08) of £40k is forecast not to be achieved this year. Thirdly, an underachievement of Licensing income of £50k is forecast, which is associated with a 2016/17 saving (E&R13) of £50k and a 2018/19 saving (ENV09) of £12.5k.

Parking & CCTV Services underspend of £906k
The underspend is mainly as a result of the implementation of the ANPR system across the borough (£936k). The positive effects of this fully functional system are beginning to be realised e.g. improved traffic flow. An over-achievement in Ringo parking fees is also forecasted (£211k).

Included within this forecast is employee related overspend of c£91k due to a combination of savings not yet implemented and increased demand. Due to the implementation of the diesel surcharge and the delay in fully implementing ANPR the section has been forced to delay implementing certain savings, whilst needing to recruit additional agency staff to manage PCN and permit demands. This pressure is being offset by an over-recovery in permit revenue (£265k). Further costs of £129k are forecasted to contribute to the overspend for P&D machines and CCTV equipment maintenance.

Public Space

Waste Services underspend of £638k
The forecast underspend is largely as a result of an in-year underspend on disposal costs of £913k, which can be attributed to two main factors. Firstly, the section has experienced a c11% reduction in waste being landfilled this financial year – this is fairly consistent with the c8% reduction in total waste tonnages being generated across all of the authority's waste streams. Secondly, Viridor our disposal contractor, is scheduled to begin testing the new ERF facility. During this commissioning phase, currently three months, the authority will benefit from reduced disposal costs leading to an estimated cost reduction of c£500k this financial year. This is a one off saving.

This forecast underspend is being partially offset by a forecast overspend relating to the Phase C contract (£164k), and mobilisation costs relating to the October 2018 service change (£250k).

Sustainable Communities

Future Merton
The section is forecasting an overspend of £164k. This is mainly due to £100k in staffing for CPZ, £20k in advertising, and £50k underachievement of income in Footpath crossings and Skip licensing charges.

Virement for Cabinet Approval
Cabinet are requested to approve a virement between the Environment & Regeneration and Corporate Services departments as part of the ongoing process of centralising the authority's software licences to the Business Improvement division. The virement amount is £10,360 which relates to the Transport Services route optimisation and planning software.

Children Schools and Families

Children, Schools and Families	2017/18 Current Budget £000	Full year Forecast (May) £000	Forecast Variance at year end (May) £000	2017/18 Variance at year end £000
Education	18,018	18,708	690	(703)
Social Care and Youth Inclusion	21,251	24,573	3,322	3,596
Cross Department budgets	1,577	1,532	(45)	(95)
PFI	8,159	7,829	(330)	(342)
Redundancy costs	2,124	2,124	0	(207)
Total (controllable)	**51,129**	**54,766**	**3,637**	**2,249**

Overview

At the end of May, Children Schools and Families had a forecast overspend of £3.637m on local authority funded services. Due to the volatile nature of placement and SEN transport budgets and the current volume of CSC activity and EHCP requests we are exercising appropriate demand management balancing our education and social care statutory duties with careful and considered oversight of spend.

The department received £500k growth for the current financial year that was mainly used to fund the additional eight social workers funded through contingency for three years and was part of the departmental overspend last year. There were pressures over and above the growth allocated to the department some of which were offset by planned underspends and management action in year. Whilst some planned underspends continued, many of the underspend used to offset cost pressures last year were either non-recurrent management action or one-off windfalls which are not guaranteed or expected in the current financial year.

Local Authority Funded Services

Significant cost pressures and underspends identified to date are detailed in the table below:

Description	Budget £000	May £000	2017/18 £000
Procurement & School organisation	608	(236)	(319)
SEN transport	4,183	939	566
Other small over and underspends	12,716	(13)	(738)
Subtotal Education	**18,018**	**690**	**(703)**
Fostering and residential placements (ART)	5,302	429	813
Supported lodgings/housing	1,792	125	156
Un-accompanied asylum seeking children (UASC)	542	1,150	693
Community Placement	0	956	750
No Recourse to Public Funds (NRPF)	21	339	353
MASH & First Response staffing	1,559	180	403
Other small over and underspends	11,995	143	288
Subtotal Children's Social Care and Youth Inclusion	**21,251**	**3,322**	**3,596**

Education Division

Procurement and school organisation budgets are forecast to underspend by £236k because of lower spend on revenuisation budgets. This budget relates to construction projects that cannot be classified as capital. The majority of this is required for temporary classrooms due to rising pupil demand when it is not viable to provide permanent buildings.

The SEN transport budget is forecasting to overspend by £939k at the end of the financial year, which includes £821k taxi cost and £118k direct payments. The forecast outturn for taxis is £3.2m, circa £428k more than last year. The forecast increase reflects the 35 extra taxi service agreements (21% increase) compared to this time last year. Due to the increase in EHCPs requiring a specialist placement, the number of children needing to be transported is expected to continue to go up through the financial year and particularly from September. Strategies are in place to alleviate this further pressure, including maximising any further opportunities for placing more children on the buses, re-tendering routes and considering any consolidation possible. The service is planning to go through the individual routes spend more forensically to ensure the accuracy of the forecast. This is difficult due to the dynamic nature of these costs. Unless this review changes the forecast, the position is unlikely to be much clearer until the October 2018 budget return when the outcome of summer tendering and 2018/19 academic year placements will be better known.

There are various other small over and underspends forecast across the division netting to a £13k underspend. These combine with the items described above to arrive at the total reported divisional overspend of £690k.

Children's Social Care and Youth Inclusion Division

While the numbers of Looked after Children (LAC) remain relatively stable, and indeed Merton maintains relatively low levels of children in care, the complexity of a significant proportion of cases is causing cost pressures as detailed below. Placement costs are reviewed on a monthly basis to ensure that projections of spend are as accurate as possible.

Service	Budget £000	Forecast spend £000	Variance May £000	Placements May Nr
Residential Placements	2,271	2,060	(211)	14
Independent Agency Fostering	1,816	2,233	417	47
In-house Fostering	978	1,438	460	62
Secure accommodation	136	0	(136)	0
Mother and baby unit	101	0	(101)	0
Total	**5,302**	**5,731**	**429**	**123**

The ART service seeks to make placements with in-house foster carers wherever possible and in line with presenting needs, however, the needs of some looked after children mean that placements with residential care providers or independent fostering agencies are required. Some specific provision is mandated by the courts.

- The residential placement expenditure is forecast to underspend by £211k. This is due to three young people predicted to be moving soon to SIA placements and three young people predicted to be moving into school placements in September and therefore paying for 14 weeks from this budget.

- The agency fostering placement expenditure is expected to overspend by £417k. This increase is due to 6 mother and baby placements ordered through the Courts. This covers costs for12 placements

- The in-house foster carer expenditure is forecast to overspend by £460k. This is an increase in payments of 1.5% (agreed by DMT). This year we have budgeted for 62 placements compared to 50 in May last year.

- We have had no young people in secure accommodation for this year yet and are therefore forecasting no expected spend at this stage.

- We have had no mother and baby unit placements for this year yet and are therefore forecasting no expected spend at this stage.

The budget for semi-independent and supported lodgings/housing placements are estimated to overspend by £125k. These are for young people who require semi-independent provision and for Care Leavers through to independence or, in some cases, through to the age of 21 (older in exceptional circumstances), as part of our statutory duties. There were 58 semi-independent placements for young people at the end of May 2018.

The UASC placements are expected to overspend by £1.150m this year.

Service	Budget £000	Forecast spend £000	Variance May £000	Placements May Nr
Independent Agency Fostering	375	404	29	9
In-house Fostering	0	538	538	20
Supported lodgings/housing	167	750	583	28
Total	**542**	**1,692**	**1,150**	**57**

At the end of May we had 29 UASC placements and 28 young people aged 18+ with no recourse to public funds in semi-independent accommodation.

We are forecasting a £956k overspend on a community placement. This provision relates to a complex case currently under discussion between the CCG and the local authority. The figure is our best estimate at this stage but is subject to change. A review is underway to change the current provision that will, when agreed, be phased in later the year with the aim to limit disruption to the child. This should reduce the cost to Merton, but we are not able to quantify this until the CCG progress this further.

The NRPF budget is forecast to overspend by £339k in the current financial year. The NRPF worker is working closely with housing colleagues to manage cases as they arise and is also reviewing historic cases to identify ones where claimant circumstances has changed and can therefore be stepped down from services. We

continue to use the Connect system to progress cases and continue to review open cases with the aim to limit the cost pressure on the council.
Strong gate keeping has resulted in a reduction of overall numbers from a peak of about 30 to a current caseload of 15.

The MASH and First Response team's staffing costs are expected to overspend by £180k. This is due to the team having to cover vacancies with agency staff due to difficulty in recruiting permanent members of staff.

There are various other small over and underspends forecast across the division netting to a £187k overspend. These combine with the items described above to arrive at the total reported divisional overspend of £2,366k.

Dedicated Schools Grant
DSG funded services is forecast to overspend by £3.870m. At the current estimate, the DSG reserve will be going into an overspend position during the current financial year.

The main reasons for the forecast relates to an estimated overspend of £1.930m on Independent Day School provision, £652k on EHCP allocations to Merton maintained primary and secondary schools, £612k on EHCP allocations to out of borough maintained primary, secondary and special schools, and £717k on one-to-one support, OT/SLT and other therapies as well as alternative education.

There are various other smaller over and underspends forecast across the DSG netting to a £41k underspend which, combined with the items above, equates to the net overspend of £3.870m.

We continue to keep abreast of proposed changes to the National Funding Formula, especially in relation to risks associated with services currently funded by de-delegated elements of the DSG.

Management Action

<u>New burdens</u>
There are a number of duties placed on the Local Authority that have not been fully funded or not funded at all through additional burdens funding from Central Government. Excluding the cost of these duties would leave a net departmental overspend of £2.023m, however that figure masks substantial once off windfalls and non-recurrent and recurrent management action. The table below highlights the continued estimated overspends relating to these unfunded duties:

Description	Budget £000	May overspend forecast £000	2017/18 overspend £000
Supported lodgings/housing	1,792	125	156
Un-accompanied asylum seeking children (UASC)	542	1,150	693
No Recourse to Public Funds (NRPF)	21	339	353
Total	**2,355**	**1,614**	**1,202**

Following changes introduced through the Children & Social Work Act, local authorities will take on new responsibilities in relation to children in care and care leavers. Local authorities will be required to offer support from a Personal Adviser to all care leavers to age 25. New burdens funding will be provided to support implementation of this change.

Further new burdens are expected for 2018/19 including:

- Social Care Act requirement for new assessment process for all social workers
- SEND tribunals will cover elements of children care packages and therefore cost
- New requirement of social work visits to children in residential schools and other provision.

Staffing

Agency cost continues to be a cost pressure for the department as permanent social worker recruitment continues to be challenging in certain services. We are operating, however at our lowest level of agency staff in 3 years. The continued recruitment drive including recruitment of NQSWs, temporary to permanent initiatives and retention payments will all have a positive impact on the current financial year and we will continue to take action to bring down anticipated overspends on agency/staffing costs.

Placements

Our strong management oversight enables us to ensure that an appropriate entry to care threshold is well-maintained. The impact of increased numbers of UASC is in particular affecting our LAC and care leaver numbers and we remain in the lowest rate of care range in London.

We are continuing to work with colleagues in the CCG in order to lever in appropriate health contribution to children with complex needs and our ART service is driving down placement costs through negotiations with providers

Our ART Fostering Recruitment and Assessment team is continuing to recruit new foster carers who will offer locally based placements. This continues to reduce the increase in more expensive agency foster placements, but there is a time lag.

Our ART Placement service is working with providers to establish more local provision and offer better value placements to the Council. There is now an established agreed cost framework for semi- independent providers and this has resulted in more appropriately priced placements for Care Leavers and older LAC.

We have contracted with a provider to block purchase five independent units for care leavers aged 18+. This will act as a step down into permanent independent living. For the total 5 placements in the provision, this cost is £1,800 per week including support costs. This is a significantly better financial deal than using the semi-independent market for our care leavers. We have 5 young people living there.

We have updated our Staying Put policy for young people aged 18+ to enable them to remain with their foster carers as recommended following our Ofsted inspection. We currently have 6 young people remaining with in house foster carers and a

further 4 with IFAs. Financially this is a more cost effective offer than semi-independent provision. However, the increased use of Staying Put for young people aged 18+ impacts on available placements for younger teenagers and therefore there is a likelihood of an increase in the use further IFA placements in the near future. We continue to focus our foster carer recruitment on carers for teenagers to mitigate these potential additional costs.

All semi-independent placements are being reviewed over the coming weeks and all residential placements are regularly reviewed. The fostering recruitment strategy is being refreshed in light of the new Staying Put requirement and the need to focus on recruiting more foster carers for teenagers, mother and baby placements and UASC.

Community & Housing Current Summary Position

Community and Housing is currently forecasting an overspend of £624k as at May 2018

The main areas overspending as at May 2018 are Housing, Public Health and Adult Social Care. The housing forecast overspend is due to the costs of temporary accommodation exceeding the subsidy provided. Public Health are forecasting an overspend on sexual health due to predicted increases in demand and service users attending at other provisions that are more expensive. Adult Services has pressures in direct provision due to staff costs and demands on the placements budget.

Community and Housing	2018/19 Current Budget £000	Forecast (May 18) £000	Forecast Variance (May 18) £000	2017/18 Outturn Variance £000
Access and Assessment	46,166	46,342	176	455
Commissioning	4,266	4,217	(49)	211
Direct Provision	4,309	4,393	84	(195)
Directorate	943	1,007	64	181
Adult Social Care	**55,684**	**55,959**	**275**	**652**
Libraries and Heritage	1,984	1,981	(3)	20
Merton Adult Learning	(14)	(14)	0	(6)
Housing General Fund	1,829	1,981	152	256
Sub-total	**59,483**	**59,907**	**424**	**922**
Public Health	**(143)**	**57**	**200**	**0**
Grand Total	**59,340**	**59,964**	**624**	**922**

Access & Assessment - £176k overspend

This section is forecasting an over spend of £176k which made up of under and overspends as set out in the table below. Part of the pressure relates to unachieved savings in housing support contracts from 2017/18.

The table below shows areas of significant expenditure

Access & Assessment	Forecast Variances May 18 £000	Outturn Variances March 18 £000
Underspend on Concessionary Fares	(15)	(100)
Overspend on Better Care Fund Risk Share	0	425
Other	(315)	(307)
Placements	1,093	1,671
Income	(587)	(1,234)
Total	**176**	**455**

Work continues to manage demand, whilst we plan for the future. Savings are currently on track, although proposed savings on transport and mental health staffing will take more time than anticipated to deliver. Underspends elsewhere on the budget are expected to compensate for these shortfalls.

The table below sets on the movement in the number of service users in each care group between months. It shows a net decrease since April. This is for a range of reasons including client death, moves to other boroughs and care no longer needed.

Total Number of Clients with an external care package

Placements	No. of clients May 2018	No of clients April 2018	Net increase/(decrease)
Older People	1,157	1,167	-10
Physical /Sensory	215	219	-4
Learning Disabilities	353	356	-3
LD Housing Support	2	2	0
Mental Health Placements	126	125	1
MH Housing Support	11	11	0
Substance Misuse	2	1	1
Grand Total	**1,866**	**1,881**	**-15**

Commissioning - £49k underspend

This section has an underspend of £49k across a number of contracts.

Direct Provision - £84k over spend

Direct Provision service is currently forecasting an overspend at Riverside Drive which is an internal 8 bed residential home for people with learning disabilities. Staffing costs have also been high due to sickness in night cover posts; which are expensive shifts to cover but are necessary to meet CQC requirements. Two residents have complex personal care needs requiring a minimum of two staff to carry out personal care. A temporary delay in processing bank time sheets led to a large number being paid in April and May. A grading claim by a group of staff is in the process of being settled; this could add between £6 and £12k to the staffing costs.

Management actions by Head of Service are:-

- Trialling different rotas to contain staff costs – check weekly
- Resolving the staffing grade change
- Head of Service scrutiny of rostering and timesheets
- Checking staffing usage on a weekly basis.

Adult Social Care: other management action 2018/19

Adult Social Care will continue its senior management scrutiny of budgets and spend and the action plan to manage budget pressures.

Key elements of the current financial year action plan:-

- Transitions from Children's to Adult Services
- Detailed monitoring of placements activity and spend
- Ensuring that Direct Payments are used for the designated purposes
- Riverside Drive staffing/salary rota
- Ensuring an efficient and effective financial assessment service, so that service users are assessed for their contribution as soon as possible so they know what they need to pay.

C&H - Other Services

Libraries - £3.2k underspend

This service is currently forecasting a £3.2k underspend as at May 2018. This is attributable to an improved income outlook.

Merton Adult Education – Breakeven

The Merton Adult Learning service is expected to breakeven in 2018/19. The service relies solely on funding from the Education and Skills Funding Agency (ESFA).

Housing - £152k overspend

Housing is forecasting an overspend of £199k which is due to a shortfall in housing benefit subsidy in temporary accommodation and an underspend of £47k in rent sanctuary payments. It is however very early in the financial year and it is expected that as a result of the new burdens from April 2018 that this service will be placed with an increased demand for its service. Although we expect to receive funding to meet increased burdens it is expected that demand will exceed the grant allocation.

The Housing Need budgets remain under considerable pressure as it faces rising homelessness and supply side volatility. Homelessness applications have increased by 48% from the same time last year following the enactment of the Homeless Reduction Act 2017. Whilst these cases have not necessarily translated into a demand for temporary accommodation the position remains fragile. These cases require more proactive work than previously required to prevent homelessness including the legal requirement to provide all customers with a written personalised housing plan.
In recent years the net cost of temporary accommodation has exceeded budget provision, mainly due to pressures arising from temporary accommodation subsidy, and early forecasts suggest that this position will be repeated this year However, despite the continued increases in acute housing need and demand and the tightening of the housing supply base, the service continues to prevent homelessness and maintains its position of having the lowest numbers of households in temporary accommodation in London.

Analysis of Housing Temporary Accommodation Expenditure

Housing	Budget 2018/19 £000	Forecast Variances (May 18) £000	Outturn Variances (Mar 18) £000
Temporary Accommodation-Expenditure	2,330	0	909
Temporary Accommodation-Client Contribution	(140)	0	(595)
Temporary Accommodation-Housing Benefit Income	(2,000)	0	(160)
Temporary Accommodation-Subsidy Shortfall	322	199	517
Temporary Accommodation- Grant	-	-	(406)
Total Temporary Accommodation	512	199	259
Housing Other Budgets- Over(under)spend	1,317	(47)	(3)
Total	1,829	152	256

Temporary Accommodation Movements to date

Temporary Accommodation	Numbers IN	Numbers OUT	Total for the Month
March 2018	**16**	**16**	**165**
April 2018	**22**	**17**	**170**
May 2018	**21**	**16**	**175**

Public Health - £200k overspend

The local authority has a mandatory responsibility to ensure the provision of open access to sexual health services, including access to contraceptive services, treatment of sexually transmitted infections and prevention. In 2017 Merton jointly re-commissioned their sexual health services with LB Wandsworth and LB Richmond. The services commenced on 1st October 2017.

A financial pressure of £200k has been identified from the total budget for sexual health services of £2.4m, out of the total public health budget of £10.4m.

Preliminary analysis indicates that this pressure is due to a combination of an increase in activity at some South West London providers; and higher tariff prices in Sutton & Croydon services, which have not yet been recommissioned in line with the London framework. It was forecast that over half (51-60%) of Merton residents would use the new local services under the CLCH contract, however recent data indicates that more people than forecast are still using services outside the local integrated service. Recent data also indicates that sexual health demand is increasing, particularly in relation to gonorrhea and syphilis which indicates that there will be continued need for open access to GUM services.

Mitigating actions to contain pressures on sexual health services include:

- In-depth work/review of the key drivers and activity trends behind these financial pressures, which will ensure we better understand the need/demand and people accessing services.
- Close collaborative work with partners in South West London, including discussion with Sutton and Croydon about recommissioning of services from 2019 in line with the London tariff.
- Close collaboration with pan-London Sexual health programme, including continued commitment to preventative work.
- Working with partners to explore negotiation of a cap across wider services, in order to have more control and predictability.
- Work with local services in order to repatriate service users to the Merton integrated services.
- Introduction of an e-service which will provide testing services for asymptomatic patients over 16 years old.
- Identify potential underspends across the public health budget which can offset this pressure.

Corporate Items

The details comparing actual expenditure up to 31 May 2018 against budget are contained in Appendix 2. There are no areas of significant variance as at 31 May 2018:-

Corporate Items	Current Budget 2018/19 £000s	Full Year Forecast (May) £000s	Forecast Variance at year end May.) £000s	Forecast Variance at year end (Apr.) £000s	2016/17 Year end Variance £000s
Impact of Capital on revenue budget	**8,403**	**8,403**	**0**	**0**	**(103)**
Investment Income	(759)	(759)	0	0	408
Pension Fund	3,346	3,346	0	0	(389)
Pay and Price Inflation	2,486	2,486	0	0	(736)
Contingencies and provisions	4,291	4,291	0	0	(2,447)
Income Items	(1,367)	(1,367)	0	0	(104)
Appropriations/Transfers	(1,548)	(1,548)	0	0	2,445
Central Items	**6,449**	**6,449**	**0**	**0**	**(823)**
Levies	938	938	0	0	0
Depreciation and Impairment	(19,008)	(19,008)	0	0	0
TOTAL CORPORATE PROVISIONS	**(3,217)**	**(3,217)**	**0**	**0**	**(926)**

4 Capital Programme 2018-22

4.1 The Table below shows the movement in the 2018/22 corporate capital programme since the last meeting of Cabinet:

Depts	Current Budget 18/19	Variance	Revised Budget 18/19	Current Budget 19/20	Variance	Revised Budget 19/20	Current Budget 20/21	Variance	Revised Budget 20/21	Revised Budget 21/22	Variance	Revised Budget 21/22
CS	19,497	(9,435)	10,062	24,855	1,147	26,002	3,945	0	3,945	3,862	8,288	12,150
C&H	937		937	480	0	480	630	0	630	280	0	280
CSF	12,631	(1,133)	11,498	12,053	1,573	13,626	3,202	0	3,202	650	0	650
E&R	22,811	561	23,372	7,060	(500)	6,560	7,017	(1,000)	6,017	5,052	1,500	6,552
TOTAL	**55,876**	**(10,008)**	**45,869**	**44,448**	**2,220**	**46,668**	**14,794**	**(1,000)**	**13,794**	**9,844**	**9,788**	**19,632**

4.2 The table below summarises the position in respect of the 2018/19 Capital Programme as at May 2018. The detail is shown in Appendix 5a

Capital Budget Monitoring May 2018

Department	Actual to May £	Year to Date Budget £	Variance £	Revised Annual Budget £	May Year End Forecast £	Forecast Full Year Variance £
Corporate Services	168,809	822,500	(653,691)	10,061,540	9,986,290	(75,250)
Community and Housing	105,110	61,360	43,750	937,310	935,490	(1,820)
Children Schools & Families	264,340	(158,370)	422,710	11,496,600	10,323,597	(1,173,003)
Environment and Regeneration	806,974	591,725	215,249	23,372,100	23,334,526	(37,575)
Total	**1,345,233**	**1,317,215**	**28,018**	**45,867,550**	**44,579,902**	**(1,287,648)**

a) Corporate Services –There are currently two projected underspends, the Customer Contact (49k) and IT Systems Projects (£26k). IT Projects totalling £747k and Replacing Social Care System £400k have been re-profiled from 2018-19 to 2019-20. The Acquisitions Budget £7,101 and Bidding Fund £1,186k have been re-profiled from 2018-19 to 2021-22, the last year of the approved programme, these schemes will be moved forward as items of expenditure are identified and approved.

b) Community and Housing – Officers are projecting a small underspend on the ASC IT Equipment budget (£2k).

c) Children, Schools and Families – The Devolved Formula Capital Grant of £353k has been announced and added to the Capital programme. The majority of the schools maintenance budget has been allocated and the virement includes £85k additional schools contributions to the scheme. Harris Wimbledon (573k) and Cricket Green (£1,000) have been re-profiled from 2018-19 to 2019-20. Officers are currently finishing the tender evaluation for Cricket Green, a virement required from the projected underspend on the Harris Wimbledon Budget will be finalised in that report elsewhere on the agenda. The finalised figure will be detailed within the June 2018 Monitoring Report.

d) Environment and Regeneration –

a) Three section 106 schemes have been added to the programme for Polka Theatre (£150k), Ravensbury Park Open Space (£87k) and the Wandle Project (£60k).
b) One neighbourhood CIL budget is being added to the programme of £264 for Shop Front Improvements, this is in addition to the £79k added as part of adjustments at the June Cabinet, the additional sum is being funded from CIL receipts in the first quarter.
c) Officers are currently projecting one underspend of £49k in Parks. In addition, officers are projecting a £12k overspend on fleet vehicles.
d) The Transportation budget is being re-profiled within the approved programme.
e) One virement of £200k is proposed from Street Lighting to Borough Roads Maintenance the additional budget is required for the resurfacing programme within Borough Roads Maintenance due to the effects of a very severe winter (this is reflected in the latest condition surveys which show a deterioration of our roads) and for the suspension of funding (£455k) nominally allocated from TfL for our principal road maintenance. The net impact is that borough funding for non-principal road and un-classified roads will have to be stretched further and the number of the roads that are currently resurfaced/reconstructed per year will decrease. This will inevitably result in increased reactive repair costs in future years. Officers are able work with a £200k reduction in the Street Lighting budget due the availability of funding from the FM Invest to Save budget for LED lantern upgrades.

4.3 Appendix 5b details the adjustments being made to the Capital Programme this month. The items marked with (1) require Cabinet approval:

Scheme		2018/19 Budget	2019/20 Budget	2020/21 Budget	2021/22 Budget	Funding/Re-profiling
Corporate Services						
Aligned Assets		(75,000)	75,000	0	0	Re-profiling
Revenue and Benefits	(1)	(400,000)	400,000	0	0	Re-profiling
Capita Housing	(1)	(100,000)	100,000	0	0	Re-profiling
Planning&Public Protection Sys	(1)	(130,000)	130,000	0	0	Re-profiling
Spectrum Spatial Analyst Repla		(42,000)	42,000	0	0	Re-profiling
Replacement SC System	(1)	(400,000)	400,000	0	0	Re-profiling
Acquisitions Budget	(1)	(7,101,680)			7,101,680	Re-profiling
Capital Bidding Fund	(1)	(1,186,400)			1,186,400	Re-profiling
Children, Schools and Families						
Schools Maintenance		85,000	0	0	0	School Contributuions
Perseid Expansion	(1)	260,000	0	0	0	Virement
Harris Merton Expansion	(1)	(260,000)	0	0	0	Virement
Harris Wimbledon Expansion	(1)	(572,570)	**572,570**	0	0	Re-profiling
Devolved Formula Capital	(1)	353,390				Specific Government Grant
Cricket Green Expansion	(1)	(1,000,000)	**1,000,000**	0	0	Re-profiling
Environment and Regeneration						
Street Lighting Replacement Pr	(1)	(200,000)	**0**	0	0	Virement
Borough Roads Maintenance	(1)	200,000	**0**	0	0	Virement
Transportation Enhancements	(1)	0	**(500,000)**	(1,000,000)	1,500,000	Re-profiling
Wandle Project	(1)	59,770	**0**	0	0	Section 106 Funding
Shop Front Improvements	(1)	264,000				CIL Neighbourhood Funding
Polka Theatre (Section 106)	(1)	149,950				Section 106 Funding
S106 Ravensbury Park Open Space	(1)	87,000	**0**	0	0	New S106 Scheme
Total		**(10,008,540)**	**2,219,570**	**(1,000,000)**	**9,788,080**	

4.4 Cabinet are being asked to approve the three Section 106 bids for the Polka Theatre (£149,950), Wandle Project (Merton Priory Chapter House) (£59,770) and Ravensbury Park Open Space (£87,000).

4.5 Appendix 5c details the impact all the adjustments to the Capital Programme have on the funding of the programme in 2018/22. The table below summarises the movement in 2018/19 funding since its approval in February 2018:

Depts.	Original Budget 18/19	Net Slippage 2018/19	Adjustments	New External Funding	New Internal Funding	Re-profiling	Revised Budget 18/19
Corporate Services	23,482	5,051				(18,472)	**10,062**
Community & Housing	773	165				0	**937**
Children Schools & Families	15,158	924		933		(5,518)	**11,497**
Environment and Regeneration	21,853	919		1,600		(1,000)	**23,372**
Total	**61,266**	**7,059**	**0**	**2,533**	**0**	**(24,990)**	**45,868**

4.6 The table below compares capital expenditure (£000s) to May 2018 to that achieved over the last few years:

Depts.	Spend To May 2015	Spend To May 2016	Spend To May 2017	Spend to May 2018	Variance 2015 to 2018	Variance 2016 to 2018	Variance 2017 to 2018
CS	(122)	131	79	169	291	38	90
C&H	(127)	(13)	(26)	105	232	118	131
CSF	2,805	1,869	699	264	(2,541)	(1,605)	(435)
E&R	798	376	1,051	807	9	431	(244)
Total Capital	**3,354**	**2,363**	**1,803**	**1,345**	**(2,299)**	**(1,056)**	**(548)**
Outturn £000s	29,327	30,626	32,230				
Budget £000s				45,869			
Projected Spend May 2018 £000s				44,580			
Percentage Spend to Budget				2.93%			
% Spend to Outturn/Projection	11.44%	7.72%	5.59%	3.02%			
Monthly Spend to Achieve Projected Outturn £000s				4,323			

4.7 During May 2018 departments have spent a total of £1.685 million. It is apparent from the annual spend over the past few years and the average monthly spend required to achieve outturn that the current budget for 2018/19 is approximately £12 million above that likely to be achieved. Finance officers will continue to work with budget managers to reduce 2018/19 budget to a more realistic level.

5. DELIVERY OF SAVINGS FOR 2018/19

Department	Target Savings 2018/19	Projected Savings 2018/19	Period 2 Forecast Shortfall	Period Forecast Shortfall (P2)	2019/20 Expected Shortfall
	£000	£000	£000	%	£000
Corporate Services	2,024	1,549	475	23.5%	375
Children Schools and Families	489	489	0	0.0%	0
Community and Housing	2,198	1,113	1,085	49.4%	200
Environment and Regeneration	2,317	1,831	486	21.0%	212
Total	**7,028**	**4,982**	**2,046**	**29.1%**	**787**

Appendix 6 details the progress on savings for 2018/19 by department.

Progress on savings 2017/18

Department	Target Savings 2017/18	2017/18 Shortfall	2018/19 Projected shortfall	2019/20 Projected shortfall
	£000	£000	£000	£000
Corporate Services	2,316	196	0	0
Children Schools and Families	2,191	0	0	0
Community and Housing	2,673	201	200	200
Environment and Regeneration	4,771	1,935	443	0
Total	**11,951**	**2,332**	**643**	**200**

Appendix 7 details the progress on savings for 2017/18 by department and the impact on the current year.

6. CONSULTATION UNDERTAKEN OR PROPOSED

6.1 All relevant bodies have been consulted.

7. TIMETABLE

7.1 In accordance with current financial reporting timetables.

8. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

8.1 All relevant implications have been addressed in the report.

9. LEGAL AND STATUTORY IMPLICATIONS

9.1 All relevant implications have been addressed in the report.

10. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

10.1 Not applicable

11. CRIME AND DISORDER IMPLICATIONS

11.1 Not applicable

12. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

12.1 The emphasis placed on the delivery of revenue savings within the financial monitoring report will be enhanced during 2016/17, the risk of part non-delivery of savings is already contained on the key strategic risk register and will be kept under review.

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

Appendix 1-	Detailed position table
Appendix 2 –	Detailed Corporate Items table
Appendix 3 –	Pay and Price Inflation
Appendix 4 –	Treasury Management: Outlook
Appendix 5a –	Current Capital Programme 2018/19
Appendix 5b -	Detail of Virements
Appendix 5c -	Summary of Capital Programme Funding
Appendix 6 –	Progress on savings 2018/19
Appendix 7 –	Progress on savings 2017/18

14. BACKGROUND PAPERS

14.1 Budgetary Control files held in the Corporate Services department.

15. REPORT AUTHOR

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APPENDIX 1

Summary Position as at 31st May 2018

	Original Budget 2018/19 £000s	Current Budget 2018/19 £000s	Year to Date Budget (May) £000s	Year to Date Actual (May) £000s	Full Year Forecast (May) £000s	Forecast Variance at year end (May) £000s	Outturn variance 2017/18 £000
Department	-	-	-	-	-	-	-
3A.Corporate Services	9,495	9,742	4,766	3,928	8,637	(1,105)	(812)
3B.Children, Schools and Families	56,145	56,145	3,508	(137)	59,781	3,637	2,249
3C.Community and Housing	-	-	-	-	-		-
Adult Social Care	58,778	58,953	11,020	7,609	59,229	276	646
Libraries & Adult Education	2,771	2,678	621	326	2,675	(3)	20
Housing General Fund	2,207	2,122	305	326	2,275	152	256
3D.Public Health	(0)	(0)	(802)	(3,133)	200	200	0
3E.Environment & Regeneration	17,951	17,951	2,249	(5,180)	16,824	(1,127)	-1,211
Overheads	0	0	0	0	0	0	0
NET SERVICE EXPENDITURE	**147,345**	**147,590**	**21,667**	**3,739**	**149,620**	**2,030**	**1,148**
3E.Corporate Items	-	-	-	-	-	-	-
Impact of Capital on revenue budget	8,403	8,403	1,053	1,177	8,403	0	(103)
Other Central items	(12,353)	(12,599)	(5,350)	(127)	(12,599)	0	(823)
Levies	938	938	190	190	938	0	0
TOTAL CORPORATE PROVISIONS	**(3,012)**	**(3,257)**	**(4,107)**	**1,240**	**(3,257)**	**-**	**(926)**
TOTAL GENERAL FUND	**144,333**	**144,333**	**17,560**	**4,979**	**146,363**	**2,030**	**222**
-	-	-	-	-	-	-	-
Funding							
- Business Rates	(45,636)	(45,636)	32	32	(45,636)	0	182
- RSG	0	0	0	0	0	0	1
- Section 31 Grant	(1,975)	(1,975)	(743)	(743)	(1,975)	0	(672)
- New Homes Bonus	(2,371)	(2,371)	(593)	(593)	(2,371)	0	2
- PFI Grant	(4,797)	(4,797)	0	0	(4,797)	0	0
- Adult Social Care Grant 2017/18	(2,115)	(2,115)	0	0	(2,115)	0	0
Grants	**(56,894)**	**(56,894)**	**(1,304)**	**(1,304)**	**(56,894)**	**0**	**(487)**
Collection Fund - Council Tax Surplus(-)/Deficit	(1,653)	(1,653)	0	0	(1,653)	0	0
Collection Fund - Business Rates Surplus(-)/Deficit	1,223	1,223	0	0	1,223	0	0
Council Tax						0	
- General	(86,678)	(86,678)	0	0	(86,678)	0	0
- WPCC	(331)	(331)	0	0	(331)	0	0
Council Tax and Collection Fund	**(87,439)**	**(87,439)**	**0**	**0**	**(87,439)**	**0**	**-**
FUNDING	**(144,333)**	**(144,333)**	**(1,304)**	**(1,304)**	**(144,333)**	**0**	**(487)**
NET	**(0)**	**(0)**	**16,256**	**3,675**	**2,030**	**2,030**	**(265)**

Appendix 2

3E.Corporate Items	Council 2018/19 £000s	Original Budget 2018/19 £000s	Current Budget 2018/19 £000s	Year to Date Budget (May) £000s	Year to Date Actual (May) £000s	Full Year Forecast (May) £000s	Forecast Variance at year end (May) £000s	Outturn Variance 2017/18 £000s
Cost of Borrowing	8,403	8,403	8,403	1,053	1,177	8,403	0	(103)
Use for Capital Programme							0	0
Impact of Capital on revenue budget	**8,403**	**8,403**	**8,403**	**1,053**	**1,177**	**8,403**	**0**	**(103)**
Investment Income	**(759)**	**(759)**	**(759)**	**(4,175)**	**(141)**	**(759)**	**0**	**408**
Pension Fund	**3,346**	**3,346**	**3,346**	**0**	**0**	**3,346**	**0**	**(389)**
Corporate Provision for Pay Award	2,108	2,108	2,108		0	2,108	0	0
Provision for excess inflation	378	378	378		0	378	0	(436)
Pay and Price Inflation	**2,486**	**2,486**	**2,486**	**0**	**0**	**2,486**	**0**	**(736)**
Contingency	1,500	1,500	1,500		0	1,500	0	(1,500)
Single Status/Equal Pay	100	100	100		5	100	0	(96)
Bad Debt Provision	500	500	500		0	500	0	395
Loss of income arising from P3/P4	200	200	200		0	200	0	(400)
Loss of HB Admin grant	179	179	179		0	179	0	(179)
Reduction in Education Services Grant	0	0	0		0	0	0	0
Apprenticeship Levy	450	450	450	413	(30)	450	0	(235)
Revenuisation and miscellaneous	1,361	1,361	1,361		(3)	1,361	0	(432)
Contingencies and provisions	**4,291**	**4,291**	**4,291**	**413**	**(29)**	**4,291**	**0**	**(2,447)**
Other income	0	0	0	0	0	0	0	(56)
CHAS IP/Dividend	(1,367)	(1,367)	(1,367)		0	(1,367)	0	(48)
Income items	**(1,367)**	**(1,367)**	**(1,367)**	**0**	**0**	**(1,367)**	**0**	**(104)**
Appropriations: CS Reserves	0	0	(246)	(246)	0	(246)	0	0
Appropriations: E&R Reserves	4	4	4	4	43	4	0	2
Appropriations: CSF Reserves	49	49	49	49	0	49	0	0
Appropriations: C&H Reserves	(104)	(104)	(104)	(104)	0	(104)	0	(600)
Appropriations:Public Health Reserves	(1,200)	(1,200)	(1,200)	(1,200)	0	(1,200)		600
Appropriations:Corporate Reserves	(91)	(91)	(91)	(91)	0	(91)	0	2,443
Appropriations/Transfers	**(1,342)**	**(1,342)**	**(1,588)**	**(1,588)**	**43**	**(1,588)**	**0**	**2,445**
Depreciation and Impairment	**(19,008)**	**(19,008)**	**(19,008)**	**0**	**0**	**(19,008)**	**0**	**0**
Other Central Items	**(12,353)**	**(12,353)**	**(12,599)**	**(5,350)**	**(127)**	**(12,599)**	**0**	**(926)**
Levies	**938**	**938**	**938**	**190**	**190**	**938**	**0**	**0**
TOTAL CORPORATE PROVISIONS	**(3,012)**	**(3,012)**	**(3,257)**	**(4,107)**	**1,240**	**(3,257)**	**0**	**(926)**

Appendix 3

Pay and Price Inflation as at May 2018

In 2018/19, the budget includes 2.7% for increases in pay and 1.5% for increases in general prices, with an additional amount, currently £0.378m which is held to assist services that may experience price increases greatly in excess of the inflation allowance provided when setting the budget. With CPI inflation currently at 2.4% and RPI at 3.4% this budget will only be released when it is certain that it will not be required

Pay:

The local government pay award for 2018/19 was agreed in April 2018 covering 2018/19 and 2019/20. For the lowest paid (those on spinal points 6-19) this agreed a pay rise of between 2.9% and 9.2%. Those on spinal points 20-52 received 2%.

Prices:

The Consumer Prices Index (CPI) 12-month rate was 2.4% in May 2018, unchanged from April 2018. The Consumer Prices Index including owner occupiers' housing costs (CPIH) 12-month inflation rate was 2.3% in May 2018, up from 2.2% in April 2018. The rate has fallen back from a recent high of 2.8% during autumn 2017.

Rising motor fuel prices produced the largest upward contribution to the change in the rate between April and May 2018. There were also large upward effects from air and sea fares, which rose between April and May this year but fell between the same two months a year ago, influenced by the timing of Easter. Partially offsetting downward effects came from price changes for games, domestic electricity, food and non-alcoholic beverages, and furniture and furnishings.

The RPI 12-month rate for May 2018 stood at 3.3%, down from 3.4% in April 2018.

Outlook for inflation:

The Bank of England's Monetary Policy Committee (MPC) sets monetary policy to meet the 2% inflation target and in a way that helps to sustain growth and employment. At its meeting ending on 20 June 2018, the MPC voted by a majority of 6-3 to maintain Bank Rate at 0.5%. The Committee voted unanimously to maintain the stock of sterling non-financial investment-grade corporate bond purchases, financed by the issuance of central bank reserves, at £10 billion. The Committee also voted unanimously to maintain the stock of UK government bond purchases, financed by the issuance of central bank reserves, at £435 billion.

The latest Inflation Report was published on the 10 May 2018.

In the May 2018 Inflation Report, the MPC noted that "Labour demand growth remains robust and a very limited degree of slack is left in the economy. Productivity growth is projected to rise from its recent weak pace, but to remain well below pre-crisis rates. As a result, the pace at which output can grow without generating inflationary pressures is likely to be modest."

In the minutes to its June 2018 meeting the MPC noted that "CPI inflation was 2.4% in May, unchanged from April. Inflation is expected to pick up by slightly more than projected in May in the near term, reflecting higher dollar oil prices and a weaker

sterling exchange rate. Most indicators of pay growth have picked up over the past year and the labour market remains tight, suggesting that domestic cost pressures will continue to firm gradually, as expected.

The Committee's best collective judgement remains that, were the economy to develop broadly in line with the May Inflation Report projections, an ongoing tightening of monetary policy over the forecast period would be appropriate to return inflation sustainably to its target at a conventional horizon. All members agree that any future increases in Bank Rate are likely to be at a gradual pace and to a limited extent."

The latest inflation and unemployment forecasts for the UK economy, based on a summary of independent forecasts are set out in the following table:-

Table 11: Forecasts for the UK Economy

Source: HM Treasury - Forecasts for the UK Economy (May 2018)			
2018 (Quarter 4)	Lowest %	Highest %	Average %
CPI	1.8	3.0	2.3
RPI	2.4	4.0	3.2
LFS Unemployment Rate	3.9	4.6	4.3
2019 (Quarter 4)	Lowest %	Highest %	Average %
CPI	1.5	3.5	2.1
RPI	2.3	4.2	3.0
LFS Unemployment Rate	3.7	5.2	4.4

Clearly where the level of inflation during the year exceeds the amount provided for in the budget, this will put pressure on services to stay within budget and will require effective monitoring and control.

Independent medium-term projections for the calendar years 2018 to 2022 are summarised in the following table:-

Source: HM Treasury - Forecasts for the UK Economy (May 2018)					
	2018	2019	2020	2021	2022
	%	%	%	%	%
CPI	2.5	2.0	2.0	2.1	2.1
RPI	3.4	3.0	3.0	3.2	3.2
LFS Unemployment Rate	4.2	4.3	4.4	4.4	4.5

Treasury Management: Outlook

At its meeting ending on 20 June 2018, the MPC voted by a majority of 6-3 to maintain Bank Rate at 0.5%. The Committee voted unanimously to maintain the stock of sterling non-financial investment-grade corporate bond purchases, financed by the issuance of central bank reserves, at £10 billion. The Committee also voted unanimously to maintain the stock of UK government bond purchases, financed by the issuance of central bank reserves, at £435 billion.

In the May 2018 Inflation Report, the MPC discussed potential increases in Bank Base Rate. Over the period of the next MTFS, it was stated that "The MPC continues to judge, however, that a very limited degree of slack remains in the economy. As in February, based on a conditioning path for Bank Rate that embodies three 25 basis point rises over the next three years, a small margin of excess demand is likely to emerge by early 2020, raising domestic inflationary pressures such that inflation settles at the 2% inflation target."

The MPC's forecasts of Bank Base Rate in recent Quarterly Inflation Reports which were made pre-Brexit up to May 2016 are summarised in the following table:-

	End Q.2 2018	End Q.3 2018	End Q.4 2018	End Q.1 2019	End Q.2 2019	End Q.3 2019	End Q.4 2019	End Q.1 2020	End Q.2 2020	End Q,3 2020	End Q.4 2020	End Q.1 2021	End Q.2 2021
May '18	0.6	0.7	0.7	0.8	0.9	1.0	1.0	1.1	1.1	1.2	1.2	1.2	1.2
Feb.'18	0.5	0.6	0.7	0.8	0.9	0.9	1.0	1.0	1.1	1.1	1.1	1.2	
Nov.'17	0.6	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9	1.0	1.0		
Aug.'17	0.4	0.5	0.5	0.5	0.6	0.6	0.7	0.7	0.7	0.8			
May '17	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5				
Feb'17	0.4	0.4	0.4	0.5	0.5	0.6	0.6	0.7					
Nov.'16	0.2	0.3	0.3	0.3	0.3	0.4	0.4						
Aug.'16	0.1	0.1	0.2	0.2	0.2	0.2							
May '16	0.6	0.6	0.7	0.7	0.8								
Feb. '16	0.9	1.0	1.0	1.1									
Nov '15	1.1	1.2	1.3										
Aug.'15	1.7	1.7											
May '15	1.4												

Source: Bank of England Inflation Reports

In order to maintain price stability, the Government has set the Bank's Monetary Policy Committee (MPC) a target for the annual inflation rate of the Consumer Prices Index of 2%. Subject to that, the MPC is also required to support the Government's economic policy, including its objectives for growth and employment.

The MPC's projections are underpinned by four key judgements :-

1. global growth remains robust
2. investment and net trade support UK demand, while consumption growth remains subdued
3. very little slack remains and the pace of potential supply growth is modest
4. with demand outstripping potential supply, domestic inflationary pressures continue to build while the contribution from energy and import prices dissipates further.

Merton Capital Programme May 2018 Monitoring

Narrative	Actual to May	Year to Date Budget	Variance	Revised Annual Budget	May Year End Forecast	Forecast Full Year Variance
Capital	**1,345,233**	**1,317,215**	**28,018**	**45,867,550**	**44,579,902**	**(1,287,648)**
Corporate Services	**168,809**	**822,500**	**(653,691)**	**10,061,540**	**9,986,290**	**(75,250)**
Business Improvement	**48,000**	**10,000**	**38,000**	**2,412,980**	**2,337,730**	**(75,250)**
Customer Contact Programme			0	1,899,010	1,850,000	(49,010)
IT Systems Projects		10,000	(10,000)	363,970	337,730	(26,240)
Social Care IT System	48,000		48,000	150,000	150,000	0
Facilities Management Total	**33,262**	**342,500**	**(309,238)**	**3,301,220**	**3,301,220**	**0**
Works to other buildings	(26,491)	20,000	(46,491)	695,040	695,040	0
Civic Centre	16,411		16,411	568,430	568,430	0
Invest to Save schemes	46,517	322,500	(275,983)	2,037,750	2,037,750	0
Asbestos Safety Works	(3,175)		(3,175)			0
Infrastructure & Transactions	**22,547**	**470,000**	**(447,453)**	**2,255,290**	**2,255,290**	**0**
Disaster recovery site		70,000	(70,000)	394,290	394,290	0
Planned Replacement Programme	22,547	400,000	(377,453)	1,861,000	1,861,000	0
Resources			**0**	**132,050**	**132,050**	**0**
ePayments System			0	91,050	91,050	0
Invoice Scanning SCIS/FIS			0	41,000	41,000	0
Corporate Items	**65,000**		**65,000**	**1,960,000**	**1,960,000**	**0**
Acquisitions Budget	65,000		65,000	0	0	0
Capital Bidding Fund			0	0	0	0
Transformation Budgets			0	1,500,000	1,500,000	0
Multi Functioning Device (MFD)			0			0
Westminster Ccl Coroners Court			0	460,000	460,000	0
Community and Housing	**105,110**	**61,360**	**43,750**	**937,310**	**935,490**	**(1,820)**
Adult Social Care	**5,160**	**4,360**	**800**	**49,070**	**47,250**	**(1,820)**
ASC IT Equipment	5,160	4,360	800	5,320	3,500	(1,820)
Telehealth			0	43,750	43,750	0
Housing	**96,668**	**57,000**	**39,668**	**771,500**	**771,500**	**0**
Disabled Facilities Grant	96,668	57,000	39,668	771,500	771,500	0
Libraries	**3,282**		**3,282**	**116,740**	**116,740**	**0**
Library Enhancement Works	2,807		2,807	16,740	16,740	0
Major Library Projects	475		475			0
Libraries IT			0	100,000	100,000	0

Appendix 5a

Merton Capital Programme May 2018 Monitoring

Narrative	Actual to May	Year to Date Budget	Variance	Revised Annual Budget	May Year End Forecast	Forecast Full Year Variance
Children Schools & Families	**264,340**	**(158,370)**	**422,710**	**11,496,600**	**10,323,597**	**(1,173,003)**
Primary Schools	**(37,873)**	**50,980**	**(88,853)**	**796,200**	**796,200**	**0**
Hatfeild			0	50,000	50,000	0
Joseph Hood	0		0	2,900	2,900	0
Dundonald	(22,695)	50,980	(73,675)	50,980	50,980	0
Poplar	(8,569)		(8,569)	40,000	40,000	0
Wimbledon Chase	(1,337)		(1,337)			0
Wimbledon Park			0	23,500	23,500	0
Abbotsbury	(628)		(628)			0
Morden	(3,954)		(3,954)	74,380	74,380	0
Cranmer			0	72,000	72,000	0
Gorringe Park			0	60,000	60,000	0
Haslemere			0	50,000	50,000	0
Liberty			0	70,000	70,000	0
Links	(690)		(690)			0
Singlegate			0	11,000	11,000	0
St Marks			0	99,240	99,240	0
Lonesome			0	55,000	55,000	0
Stanford			0	132,330	132,330	0
Unlocated Primary School Proj			0	4,870	4,870	0
Secondary School	**121,424**		**121,424**	**6,655,650**	**5,482,650**	**(1,173,000)**
Harris Academy Morden			0	143,560	143,560	0
Harris Academy Merton	(2,213)		(2,213)	444,090	444,090	0
St Mark's Academy			0	200,000	200,000	0
Rutlish			0	495,000	495,000	0
Harris Academy Wimbledon	123,637		123,637	5,373,000	4,200,000	(1,173,000)
SEN	**122,263**		**122,263**	**3,524,150**	**3,524,150**	**0**
Perseid	97,954		97,954	935,960	935,960	0
Cricket Green			0	2,110,170	2,110,170	0
Secondary School Autism Unit			0	160,000	160,000	0
Unlocated SEN	24,310		24,310	288,020	288,020	0
Melbury College - Smart Centre				30,000	30,000	0
CSF Schemes	**58,526**	**(209,350)**	**267,876**	**520,600**	**520,597**	**(3)**
CSF - IT Schemes			0	58,310	58,310	0
School Equipment Loans		(209,350)	209,350	108,900	108,900	0
Devolved Formula Capital	58,526		58,526	353,390	353,387	(3)

Appendix 5a

Merton Capital Programme May 2018 Monitoring

Narrative	Actual to May	Year to Date Budget	Variance	Revised Annual Budget	May Year End Forecast	Forecast Full Year Variance
Environment and Regeneration	**806,974**	**591,725**	**215,249**	**23,372,100**	**23,334,526**	**(37,575)**
Public Protection and Developm	**(12,796)**		**(12,796)**	**39,490**	**39,329**	**(161)**
Off Street Parking - P&D			0			0
CCTV Investment	(12,796)		(12,796)	39,490	39,329	(161)
Public Protection and Developm			0			0
Street Scene & Waste	**1,490**	**10,000**	**(8,510)**	**6,008,630**	**6,021,063**	**12,433**
Fleet Vehicles			0	562,900	575,333	12,433
Alley Gating Scheme	1,490	10,000	(8,510)	40,000	40,000	0
Smart Bin Leases - Street Scen			0	5,500	5,500	0
Waste SLWP			0	5,400,230	5,400,230	0
Sustainable Communities	**818,281**	**581,725**	**236,556**	**17,323,980**	**17,274,134**	**(49,847)**
Street Trees			0	60,000	60,000	0
Highways & Footways	35,659	192,620	(156,961)	4,478,880	4,478,880	0
Cycle Route Improvements	26,689	(27,710)	54,399	480,830	480,830	0
Mitcham Transport Improvements	1,248		1,248	563,680	563,680	0
Unallocated Tfl			0			0
Tackling Traffic Congestion	(16,743)		(16,743)		(1)	(1)
Mitcham Area Regeneration	1,524	40,000	(38,477)	2,719,380	2,719,380	0
Morden Area Regeneration			0			0
Borough Regeneration	96,654	111,820	(15,166)	560,590	560,590	0
Morden Leisure Centre	630,983		630,983	6,203,360	6,203,360	0
Sports Facilities	(6,642)		(6,642)	446,960	446,960	0
Parks	48,910	264,995	(216,085)	1,756,410	1,706,564	(49,846)
Mortuary Provision			0	53,890	53,890	0

Virement, Re-profiling and New Funding - May 2018

Appendix 5b

		2018/19 Budget	Virements	Adjusted & New Funding	Reprofiling	Revised 2018/19 Budget	2019/20 Budget	Reprofiling	Revised 2018/19 Budget	Narrative
		£	£	£	£	£	£		£	
Corporate Services										
Aligned Assets		75,000			(75,000)	0	0	75,000	75,000	Re-profiled in line with anticipated spend
Revenue and Benefits	(1)	400,000			(400,000)	0	0	400,000	400,000	Re-profiled in line with anticipated spend
Capita Housing	(1)	100,000			(100,000)	0	0	100,000	100,000	Re-profiled in line with anticipated spend
Planning&Public Protection Sys	(1)	467,730			(130,000)	337,730		130,000	130,000	Re-profiled in line with anticipated spend
Spectrum Spatial Analyst Repla		42,000			(42,000)	0	0	42,000	42,000	Re-profiled in line with anticipated spend
Replacement SC System	(1)	550,000			(400,000)	150,000	0	400,000	400,000	Re-profiled in line with anticipated spend
Acquisitions Budget	(1)	7,101,680			(7,101,680)	0			0	Re-profiled to last year of the approved programme
Capital Bidding Fund	(1)	1,186,400			(1,186,400)	0			0	Re-profiled to last year of the approved programme
Children, Schools and Families										
Cranmer roof replacement		0	62,000	10,000		72,000	0	0	0	School Contribution
Gorringe Park roof replacement		0	50,000	10,000		60,000	0	0	0	School Contribution
Haslemere boiler replacment		0	40,000	10,000		50,000	0	0	0	School Contribution
Hatfeild floor & veranda floor replacement		0	40,000	10,000		50,000	0	0	0	School Contribution
Liberty lighting & roof replacement & external brickwork		0	60,000	10,000		70,000	0	0	0	School Contribution
Lonesome heating pipework		0	45,000	10,000		55,000	0	0	0	School Contribution
Melbury College (Smart Centre) roof replacement		0	20,000	10,000		30,000	0	0	0	School Contribution
Morden boiler & heating system		16,380	53,000	5,000		74,380	0	0	0	School Contribution
Poplar boiler		0	30,000	10,000		40,000	0	0	0	School Contribution
Stanford refurbishment works prior to academy transfer		0	100,000	0		100,000	0	0	0	
St Mark's Primary boiler replacement		9,240	80,000	10,000		99,240	0	0	0	School Contribution
Wimbledon Park roof replacement		0	23,500	0		23,500	0	0	0	
Joseph Hood		0	2,900	0		2,900	0	0	0	
Unalocated Schools Maintenance Budget		621,270	(606,400)	(10,000)		4,870	650,000	0	650,000	Allocation to invidual schools
Perseid Expansion	(1)	675,960	260,000			935,960	0	0	0	Virement to offset projected overspend
Harris Merton Expansion	(1)	704,090	(260,000)			444,090	0	0	0	Virement to offset projected overspend
Harris Wimbledon Expansion	(1)	5,945,570			(572,570)	5,373,000	1600000	572,570	2,172,570	Re-profiled in line with anticipated spend
Devolved Formula capital	(1)	0		353,390		353,390	0		0	Department of Education Grant
Cricket Green Expansion	(1)	3,110,170			(1,000,000)	2,110,170	2,046,000	1,000,000	3,046,000	Re-profiled in line with anticipated spend
Environment and Regeneration										
Street Lighting Replacement Pr	(1)	498,280	(200,000)			298,280	290,000		290,000	Virement to provide short term response to TfL Reduction
Borough Roads Maintenance	(1)	1,500,000	200,000			1,700,000	1,200,000		1,200,000	Virement to provide short term response to TfL Reduction
Transportation Enhancements	(1)	0				0	1,000,000	(500,000)	500,000	Re-profiled in line with anticipated spend
Wandle Project	(1)			59,770		59,770	0		0	Section 106 Funding
Shop Front Improvements	(1)	79,000		264,000		343,000	0		0	CIL Neighbourhood Funding received Q1 2018/19
Polka Theatre (S106)	(1)	0		149,950		149,950	0		0	New S106 Scheme
S106 Ravensbury Park Open Space	(1)	0		87,000		87,000	0	0	0	New S106 Scheme
Total		23,082,770	0	999,110	(11,007,650)	13,074,230	6,786,000	2,219,570	9,005,570	

1) Requires Cabinet Approval

Virement, Re-profiling and New Funding - May 2018

Appendix 5b

		2020/21 Budget	Reprofiling	Revised 2020/21 Budget	2021/22 Budget	Reprofiling	Revised 2021/22 Budget	Narrative
		£	£	£	£	£	£	
Corporate Services								
Acquisitions Budget	(1)	0		0	0	7,101,680	7,101,680	Re-profiled to last year of the approved programme from 2018/19
Capital Bidding Fund	(1)	0		0	0	1,186,400	1,186,400	Re-profiled to last year of the approved programme from 2018/19
Environment & Regeneration								
Transportation Enhancements	(1)	3,000,000	(1,000,000)	2,000,000	1,000,000	1,500,000	2,500,000	Re-profiled in line with anticipated spend
Total		3,000,000	(1,000,000)	2,000,000	1,000,000	9,788,080	10,788,080	

Capital Programme Funding Summary 2018/19

	Funded from Merton's Resources	Funded by Grant & Capital Contributions	Total
	£000s	£000s	£000s
Approved Prog. June 2018 Cabinet	**40,546**	**15,330**	**55,876**
Corporate Services			
Aligned Assets	**(75)**	**0**	**(75)**
Revenue and Benefits	**(400)**	**0**	**(400)**
Capita Housing	**(100)**	**0**	**(100)**
Planning&Public Protection Sys	**(130)**	**0**	**(130)**
Spectrum Spatial Analyst Repla	**(42)**	**0**	**(42)**
Replacement SC System	**(400)**	**0**	**(400)**
Acquisitions Budget	**(7,102)**	**0**	**(7,102)**
Capital Bidding Fund	**(1,186)**	**0**	**(1,186)**
Children, Schools and Families			
Schools Maintenance Budget	**0**	**85**	**85**
Harris Wimbledon Expansion	**(573)**	**0**	**(573)**
Devolved Formula Capital	**0**	**353**	**353**
Cricket Green Expansion	**(1,000)**	**0**	**(1,000)**
Environment and Regeneration			
Wandle Project	**60**	**0**	**60**
Shop Front Improvements	**264**	**0**	**264**
Polka Theatre	**150**	**0**	**150**
S106 Ravensbury Park Open Space	**87**	**0**	**87**
Proposed Capital Programme	**30,099**	**15,768**	**45,868**

Capital Programme Funding Summary 2019/20

	Funded from Merton's Resources	Funded by Grant & Capital Contributions	Total
	£000s	£000s	£000s
Approved Programme June Cabinet	**41,326**	**3,123**	**44,448**
Corporate Services			
Aligned Assets	**75**	**0**	**75**
Revenue and Benefits	**400**	**0**	**400**
Capita Housing	**100**	**0**	**100**
Planning&Public Protection Sys	**130**	**0**	**130**
Spectrum Spatial Analyst Repla	**42**	**0**	**42**
Replacement SC System	**400**	**0**	**400**
Children, Schools and Families			
Harris Wimbledon Expansion	**573**	**0**	**573**
Cricket Green Expansion	**1,000**	**0**	**1,000**
Environment and Regeneration			
Transportation Enhancements	**(500)**	**0**	**(500)**
Revised Funding	**43,545**	**3,123**	**46,668**

Capital Programme Funding Summary 2020/21

	Funded from Merton's Resources	Funded by Grant & Capital Contributions	Total
	£000s	£000s	£000s
Approved Programme June Cabinet	12,614	2,180	14,794
Environment and Regeneration			
Transportation Enhancements	(1,000)	0	(1,000)
Revised Funding	11,614	2,180	13,794

Capital Programme Funding Summary 2021/22

	Funded from Merton's Resources	Funded by Grant & Capital Contributions	Total
	£000s	£000s	£000s
Approved Capital Programme	8,194	650	8,844
-			
Other	1,000	0	1,000
Adjustment	(280)	280	0
Approved Programme June Cabinet	8,914	930	9,844
Corporate Services			
Acquisitions Budget	7,102	0	7,102
Capital Bidding Fund	1,186	0	1,186
Environment and Regeneration			
Transportation Enhancements	1,500	0	1,500
Revised Funding	18,702	930	19,632

APPENDIX 6

Department	Target Savings 2018/19	Projected Savings 2018/19	Period 2 Forecast Shortfall	Period Forecast Shortfall (P2)	2019/20 Expected Shortfall
	£000	£000	£000	%	£000
Corporate Services	2,024	1,549	475	23.5%	375
Children Schools and Families	489	489	0	0.0%	0
Community and Housing	2,198	1,113	1,085	49.4%	200
Environment and Regeneration	2,317	1,831	486	21.0%	212
Total	**7,028**	**4,982**	**2,046**	**29.1%**	**787**

DEPARTMENT: COMMUNITY & HOUSING SAVINGS PROGRESS 2018/19

Ref	Description of Saving	2018/19 Savings Required £000	Shortfall £000	RAG	2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments	R /A Included in Forecast Over/Underspend ? Y/N
	Adult Social Care								
CH55	**Less 3rd party payments** through "Promoting Independence" throughout the assessment, support planning and review process and across all client groups. Aim to reduce Res Care by £650k and Dom Care by £337k.	987	512	G	0	G	**Richard Ellis**	£475k was achieved in May 18. A further review of April reductions is in progress, which will increase this figure	**Y**
CH73	A review of management and staffing levels of the AMH team in line with the reductions carried out in the rest of ASC.	100	52	G	0	G	**Richard Ellis**	On track due to reduced use of agency staff	**Y**
CH36	Single homeless contracts (YMCA, Spear, Grenfell) - Reduce funding for contracts within the Supporting People area which support single homeless people - Reduced support available for single homeless people - both in terms of the numbers we could support and the range of support we could provide. In turn this would reduce their housing options. (CH36)	38	38	A	(38)	G	**Richard Ellis**	Project lead recruitment in progress. Plan & timetable in place	**Y**
CH71	Transport: moving commissioned taxis to direct payments. Service users can purchase taxi journeys more cheaply than the council.	50	50	A	0	G	**Richard Ellis**	Analysis done. Project resource to be allocated	**Y**
CH72	Reviewing transport arrangements for in-house units, linking transport more directly to the provision and removing from the transport pool.	100	100	R	(100)	R	**Richard Ellis**	Not achievable in 1819	**Y**
CH74	The implementation of the MOSAIC social care system has identified the scope to improve the identification of service users who should contribute to the costs of their care and assess them sooner, thus increasing client income. Assessed as a 3% improvement less cost of additional staffing	231	131	G	0	G	**Richard Ellis**	Additional income as at 6/5/18	**Y**
	Subtotal Adult Social Care	**1,506**	**883**		**(138)**				
	Library & Heritage Service								
CH56	Introduce a coffee shop franchise across 6 libraries	30	0	G	0	G	**Anthony Hopkins**		**Y**
	Housing Needs & Enabling								
CH42	Further Staff reductions. This will represent a reduction in staff from any areas of the HNES & EHH :	62	62	R	(62)	R	**Steve Langley**	Restructure to commence shortly	**Y**

APPENDIX 6

DEPARTMENT: CHILDREN, SCHOOLS AND FAMILIES - PROGRESS ON SAVINGS 18-19

Ref	Description of Saving	2018/19 Savings Required £000	Shortfall	18/19 RAG		2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments	R /A Included in Forecast Over/Underspend? Y/N
	Schools									
CSF2015-03	Increased income from schools and/or reduced LA service offer to schools	**200**	**0**	**G**		**0**	**G**	Jane McSherry		**N**
	Commissioning, Strategy and Performance									
CSF2015-04	Commissioning rationalisation	**90**	**0**	**G**		**0**	**G**	Leanne Wallder		**N**
	Cross cutting									
CSF2017-01	Review of non-staffing budgets across the department	**76**	**0**	**G**		**0**	**G**	Jane McSherry		**N**
CSF2017-02	Reduction in business support unit staff	**33**	**0**	**G**		**0**	**G**	Jane McSherry		**N**
	Children Social Care									
CSF2017-03	Delivery of preventative services through the Social Impact Bond	**45**	**0**	**G**		**0**	**G**	Jane McSherry		**N**
CSF2017-04	South London Family Drug and Alcohol Court commissioning	**45**	**0**	**G**		**0**	**G**	Jane McSherry		**N**
	Total Children, Schools and Families Department Savings for 2017/18	**489**	**0**			**0**				

APPENDIX 6

DEPARTMENT: ENVIRONMENT & REGENERATION SAVINGS PROGRESS: 2018-19

Ref	Description of Saving	2018/19 Savings Required £000	2018/19 Savings Expected £000	Shortfall	18/19 RAG		2019/20 Savings Expected £000	2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments	R /A Included in Forecast Over/Unders pend? Y/N
	SUSTAINABLE COMMUNITIES											
E&R6	Property Management: Reduced costs incurred as a result of sub-leasing Stouthall until 2024.	18	18	0	G		18	0	G	James McGinlay		N
ENV14	Property Management: Increase in income from rent reviews of c60 properties.	100	100	0	G		100	0	G	James McGinlay	Performance dependent on implementation of commercial property review.	N
ENV16	Traffic & Highways: Further reductions in the highways maintenance contract costs following reprocurement	65	65	0	G		65	0	G	James McGinlay	For both 2018-19 and 2019-20 these savings are covered by Growth	N
ENV17	Traffic & Highways: Reduction in reactive works budget	35	35	0	G		35	0	G	James McGinlay	For both 2018-19 and 2019-20 these savings are covered by Growth	N
ENV20	D&BC: Increased income from building control services.	35	0	35	R		35	0	A	James McGinlay	This has not been possible due to severe staff shortages and very difficult to fill posts	Y
ENV34	Property Management: Increased income from the non-operational portfolio.	40	40	0	G		40	0	G	James McGinlay		N
ENR8	Property Management: Increased income from rent reviews	150	150	0	G		150	0	G	James McGinlay	Performance dependent on implementation of commercial property review.	N
D&BC7	D&BC: Shared service collaboration with Kingston/Sutton	50	50	0	G		50	0	G	James McGinlay	A replacement saving was agreed by Cabinet in November 2017.	N
D&BC8	D&BC: Review of service through shared service discussions	274	274	0	G		274	0	G	James McGinlay	A replacement saving was agreed by Cabinet in November 2017.	N
	PUBLIC PROTECTION											
E&R7	Parking: Due to additional requests from residents, the budget will be adjusted to reflect the demand for and ongoing expansion of Controlled Parking Zone coverage in the borough.	163	163	0	G		163	0	G	Cathryn James		N
ENV07	Parking: Reduction in supplies & services/third party payment budgets.	60	13	47	R		13	47	R	Cathryn James	£13k saving will be made in CCTV but equipmet savings of £47K will not be achieved in Parking due to continued necessary expenditure on P&D maintenance / technical team operations.	Y
ENV08	Regulatory Services: Funding of EH FTE by public health subsidy. As agreed between DPH and Head of PP .	40	0	40	R		0	40	R	Cathryn James	Alternative saving required	Y
ENV09	Regulatory Services: Investigate potential commercial opportunities to generate income	50	0	50	A		0	50	A	Cathryn James	Commercial income generating team to be established as part of the proposed restructure of regulatory services. Currently investigating charging for food hygiene rating rescores.	Y
ENR2	Parking & CCTV: Pay & Display Bays (On and off street)	44	22	22	R		44	0	G	Cathryn James	Implementation of saving delayed due to possible change of administration at May 18 election. Proposal now needs to urgently be put to new Cabinet member for approval. Previous cabinet member requested that the number of available disabled bays off-street be increased before implementation and so, if required, re-lining will then need to be carried out as will a major communications drive to advise the public of the withdrawal of a long-standing concession in Merton. As a result, it is unlikely that any revenue effect be will be seen before Oct 18. The shortfall will be mitigated by over-achievement in other revenue streams.	Y
ENR3	Parking & CCTV: Increase the cost of existing Town Centre Season Tickets in Morden, Mitcham and Wimbledon.	17	0	17	R		17	0	G	Cathryn James	In May 2017, we were advised that members wanted options to review/increase permit prices for all Parking activities. These options have now been collated for presentation to the new Cabinet member following the May 18 election. Any increase in season tickets will form part of this as extensive work will be needed to change relevant TMOs / statutory notices etc. Once decided, it is unlikely that any price increases will be implemented before April 19. Shortfall will be mitigated by over-achievement in other revenue streams	Y
ALT1	Parking: The further development of the emissions based charging policy by way of increased charges applicable to resident/business permits as a means of continuing to tackle the significant and ongoing issue of poor air quality in the borough.	440	440	0	G		440	0	G	Cathryn James		N

APPENDIX 6

DEPARTMENT: ENVIRONMENT & REGENERATION SAVINGS PROGRESS: 2018-19

Ref	Description of Saving	2018/19 Savings Required £000	2018/19 Savings Expected £000	Shortfall	18/19 RAG		2019/20 Savings Expected £000	2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments	R /A Included in Forecast Over/Underspend? Y/N
	SENIOR MANAGEMENT											
ENV01	Reduce the level of PA support to Heads of Service by 0.6fte.	19	19	0	G		19	0	G	Chris Lee		**N**
	PUBLIC SPACE											
E&R1	Leisure Services: Arts Development - further reduce Polka Theatre core grant	4	4	0	G		4	0	G	Anita Cacchioli		**N**
E&R2	Leisure Services: Water sports Centre - Additional income from new business - Marine College & educational activities.	5	5	0	G		5	0	G	Anita Cacchioli		**N**
E&R4	Leisure Services: Morden Leisure Centre	100	100	0	G		100	0	G	Anita Cacchioli		**N**
E&R20	Waste: To contribute to a cleaner borough, enforcement of litter dropping under EPA/ ASB legislation with FPN fines for contraventions.	-2	-2	0	G		-2	0	G	Anita Cacchioli	The level of income from the successful issuing and processing of FPN has remained constant. High payment rates are being achieved supported by the prosecution of non payment with full cost being award	**N**
ENV18	Greenspaces: Increased income from events in parks	100	100	0	A		100	0	A	Anita Cacchioli	Works on going to secure additional income from events.	**N**
ENV31	Waste: Commencing charging schools for recyclable waste (17/18) and food waste (18/19) collection	9	9	0	G		9	0	G	Anita Cacchioli	garanteed income being achieved. Risk is now manged by our collections contractor.	**N**
ENV32	Transport: Review of Business Support requirements	30	0	30	R		0	30	R	Anita Cacchioli	This can no longer be delivered as the service has transferred to the CSF commissioning team.	**Y**
ENV35	Waste: Efficiency measures to reduce domestic residual waste rounds by 1 crew following analysis of waste volumes and spread across week	150	150	0	G		150	0	G	Anita Cacchioli	This has been achieved as part of the Phase C savings	**N**
ENV37	Transport workshop: develop business opportunities to market Tacho Centre to external third parties	35	0	35	R		0	35	R	Anita Cacchioli	This can no longer be delivered as the facility is now under the operational mangement of our waste contractor.	**Y**
ENR5	Transport Services: Delete 1 Senior Management post	76	76	0	G		76	0	G	Anita Cacchioli	Completed - establishment and budget has been amended to reflect the reduction of post.	**Y**
ENR6	Waste: Wider Department restructure in Waste Services	200	0	200	R		200	0	A	Anita Cacchioli	This will not be delivered in 2018. Review and restructure still outstanding	**Y**
ENR7	Transport Services: Shared Fleet services function with LB Sutton	10	0	10	R		0	10	R	Anita Cacchioli	This can no longer be delivered as LB Sutton no longer require this service.	**Y**
	Total Environment and Regeneration Savings 2017/18	**2,317**	**1,831**	**486**			**2,105**	**212**				

APPENDIX 6

DEPARTMENT: CORPORATE SERVICES - PROGRESS ON SAVINGS 18-19

Ref	Description of Saving	2018/19 Savings Required £000	Shortfall	18/19 RAG	2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments	R /A Included in Forecast Over/Underspen
	Customers, Policy & Improvement								
CSD19	Staff reductions - Delete 1 FTE	**49**	**0**	**G**	**0**	**G**	Sophie Poole		Y
CS2015-11	Reduction in corporate grants budget	**19**	**0**	**G**	**0**	**G**	John Dimmer		Y
CSREP 2018-19 (7)	Translation - increase in income	**10**	**0**	**A**	**0**	**A**	Sean Cunniffe	The decision of existing customers to refer work elsewhere, within other organisations i.e. LB Sutton using RBK translation Services.	N
CSREP 2018-19 (16)	Operating cost reduction	**11**	**0**	**G**	**0**	**G**	Sophie Ellis		Y
	Infrastructure & Technology								
CS71	Delete two in house trainers posts	**43**	**0**	**G**	**0**	**G**	Richard Warren		Y
CSD2	Energy Savings (Subject to agreed investment of £1.5m)	**150**	**0**	**G**	**0**	**G**	Richard Neal		Y
CS2015-09	Restructure of Safety Services & Emergency Planning team	**30**	**0**	**G**	**0**	**G**	Adam Vicarri		Y
CS2015-10	FM - Energy invest to save	**465**	**465**	**R**	**365**	**A**	Richard Neal	The capital spend to achieve this was slipped and hence the saving will be delayed with £100k expected in 19/20 and the balance in 20/21. Shortfall to be funded by Corporate Services reserve	Y
CSREP 2018-19 (1)	Renegotiation of income generated through the corporate catering contract	**20**	**0**	**G**	**0**	**G**	Edwin O Donnell		Y
CSREP 2018-19 (2)	Review the specification on the corporate cleaning contract and reduce frequency of visits	**15**	**0**	**G**	**0**	**G**	Edwin O Donnell		Y
CS2015-01	Reduction in IT support / maintenance contracts	**3**	**0**	**G**	**0**	**G**	Clive Cooke		Y
CS2015-02	Expiration of salary protection	**16**	**0**	**G**	**0**	**G**	Clive Cooke		Y
CSREP 2018-19 (13)	Business Improvement - Business Systems maintenance and supp	**10**	**0**	**A**	**0**	**G**	Clive Cooke	At risk due to APR increases by some suppliers.	Y
CSREP 2018-19 (14)	M3 support to Richmond/Wandsworth	**20**	**0**	**A**	**0**	**G**	Clive Cooke	This is dependent on agreement with RSSP, may be at risk if they don't migrate to M3 system	Y
CSREP 2018-19 (15)	Street Naming and Numbering Fees/Charges Review	**15**	**0**	**G**	**0**	**G**	Clive Cooke		Y
	Corporate Governance								
CSD43	Share FOI and information governance policy with another Council	**10**	**10**	**R**	**10**	**R**	Karin Iane		Y
CS2015-06	Delete auditor post and fees	**50**	**0**	**G**	**0**	**G**	Margaret Culleton		Y
CS2015-12	Savings in running expenses due to further expansion of SLLP	**41**	**0**	**G**	**0**	**G**	Fiona Thomsen		Y
CSREP 2018-19 (9)	Corp Gov -Reduction in running costs budgets	**11**	**0**	**G**	**0**	**G**	Julia Regan		Y
CSREP 2018-19 (10)	SLLp - Increase in legal income	**25**	**0**	**G**	**0**	**G**	Fiona Thomsen		Y
CSREP 2018-19 (11)	Audit and investigations	**50**	**0**	**G**	**0**	**G**	Margaret Culleton		Y
	Resources								

CSD20	Increased income	**16**	**0**	**G**	**0**	**G**	Nemashe Sivayogan		Y
CSD27	Further restructuring (2 to 4 posts)	**100**	**0**	**G**	**0**	**G**	Roger Kershaw		Y
CS2015-05	Staffing costs and income budgets	**75**	**0**	**G**	**0**	**G**	Roger Kershaw		Y
CSREP 2018-19 (6)	Reduction in running costs budgets	**9**	**0**	**G**	**0**	**G**	David Keppler		Y
CSREP 2018-19 (3)	Miscellaneous budgets within Resources	**13**	**0**	**G**	**0**	**G**	Roger Kershaw		Y
CSREP 2018-19 (4)	Recharges to pension fund	**128**	**0**	**G**	**0**	**G**	Nemashe Sivayogan		Y
	Human Resources								
CSREP 2018-19 (12)	Reduction in posts across the department	**185**	**0**	**G**	**0**	**G**	Kim Brown		Y
	Corporate								
CSREP 2018-19 (5)	Council tax and business rates credits	**220**	**0**	**G**	**0**	**G**	Roger Kershaw		Y
CSREP 2018-19 (8)	Dividend from CHAS 2013 Limited	**215**	**0**	**G**	**0**	**G**	Ian McKinnon		Y
	Total Corporate Services Department Savings for 2018/19	**2,024**	**475**		**375**				

APPENDIX 7

Department	Target Savings 2017/18	2017/18 Shortfall	2018/19 Projected shortfall	2019/20 Projected shortfall
	£000	£000	£000	£000
Corporate Services	2,316	196	0	0
Children Schools and Families	2,191	0	0	0
Community and Housing	2,673	201	200	200
Environment and Regeneration	4,771	1,935	443	0
Total	**11,951**	**2,332**	**643**	**200**

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DEPARTMENT: CHILDREN, SCHOOLS AND FAMILIES - PROGRESS ON SAVINGS 17-18

Ref	Description of Saving	2017/18 Savings Required £000	2017/18 Expected Shortfall £000	17/18 RAG	2018/19 Expected Shortfall £000	18/19 RAG	2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments	R /A Included in Forecast Over/Underspend? Y/N
	Children Social Care										
CSF2012-07	Family and Adolescent Services Stream - Transforming Families (TF), Youth Offending Team (YOT) and in Education, Training and Employment (ETE). 2016/17 savings will be achieved by the closure of Insight and deletion of YJ management post.	**100**	**0**	**R**	**0**	**G**	**0**	**G**	Paul Angeli	This saving was delivered from July 2017 and the short for the first quarter covered through reduced grant-funding for targeted intervention services.	**N**
	Total Children, Schools and Families Department Savings for 2017/18		**0**				**0**				

DEPARTMENT: CORPORATE SERVICES - PROGRESS ON SAVINGS 17-18

Ref	Description of Saving	2017/18 Savings Required £000	2017/18 Shortfall	17/18 RAG	2018/19 Expected Shortfall £000	18/19 RAG	2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments
	Business improvement									
CSD42	Restructure functions, delete 1 AD and other elements of management	**170**	**70**	**R**					Sophie Ellis	Replacement saving identified and approved for 18/19 - CSREP 2018-19 (1-16)
CS2015-	Staffing support savings	**13**	**13**	**R**					Sophie Ellis	Replacement saving identified and approved for 18/19 - CSREP 2018-19 (1-16)
	Infrastructure & transactions									
CS70	Apply a £3 administration charge to customers requesting a hard copy paper invoice for services administered by Transactional Services team	**35**	**35**	**R**					Pam Lamb	Replacement saving identified and approved for 18/19 - CSREP 2018-19 (1-16)
	Resources									
CSD26	Delete 1 Business Partner	**78**	**78**	**R**	**0**	**G**		**G**	Caroline Holland	Due to delays in projects this saving was not achieved until 18/19
	Total Corporate Services Department Savings for 2017/18		**196**		**0**		**0**			

APPENDIX 7

DEPARTMENT: ENVIRONMENT & REGENERATION SAVINGS PROGRESS: 2017-18

Ref	Description of Saving	2017/18 Savings Required £000	2017/18 Savings Achieved £000	Shortfall	17/18 RAG		2018/19 Expected Shortfall £000	18/19 RAG		2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments	R /A Included in Forecast Over/Underspend? Y/N
	SUSTAINABLE COMMUNITIES													
ER23b	Restructure of team to provide more focus on property management and resilience within the team.	18	0	18	R		18	R		0	A	James McGinlay	Business Case for restructure in progress, but due to the delay it's unlikely to be fully achieved this financial year. Saving being achieved through rents (reported through monthly budget return).	Y
D&BC1	Fast track of householder planning applications	55	0	55	R							James McGinlay	A replacement saving (ALT1) implemented in 2018/19, was agreed by Cabinet in November 2017.	N
D&BC2	Growth in PPA and Pre-app income	50	0	50	R							James McGinlay	A replacement saving (ALT1) implemented in 2018/19, was agreed by Cabinet in November 2017.	N
D&BC3	Commercialisation of building control	50	0	50	R							James McGinlay	A replacement saving (ALT1) implemented in 2018/19, was agreed by Cabinet in November 2017.	N
D&BC4	Deletion of 1 FTE (manager or deputy) within D&BC	45	0	45	R		45	R		0	A	James McGinlay		Y
D&BC5	Eliminate the Planning Duty service (both face to face and dedicated phone line) within D&BC	35	0	35	R							James McGinlay	A replacement saving (ALT1) implemented in 2018/19, was agreed by Cabinet in November 2017.	N
D&BC6	Stop sending consultation letters on applications and erect site notices only	10	0	10	R							James McGinlay	A replacement saving (ALT1) implemented in 2018/19, was agreed by Cabinet in November 2017.	N
ENV15	Reduction in street lighting energy and maintenance costs. Would require Capital investment of c£400k, which forms part of the current capital programme - Investment in LED lights in lamp Colum stock most capable of delivering savings	148	100	48	R		0	G		0	G	James McGinlay		N
ENV20	Increased income from building control services.	35	0	35	R							James McGinlay	A replacement saving (ALT1) implemented in 2018/19, was agreed by Cabinet in November 2017.	N
	PUBLIC PROTECTION													
E&R14	Further expansion of the Regulatory shared service.	100	0	100	R		50	R		0	A	Cathryn James	Wandsworth staff transferred under TUPE to Merton on 1st November with the new expanded service expected to go live in August./September 2018.	Y
ENV02	Review the current CEO structure, shift patterns and hours of operation with the intention of moving toward a two shift arrangement based on 5 days on/2 days off.	190	0	190	R		190	R		0	A	Cathryn James	This saving is not currently being achieved as the there has been slippage in the timetable for the restructure. Mitigation could come from increased revenue.	Y
ENV03	Reduction number of CEO team leader posts from 4 to 3	45	0	45	R		45	R		0	A	Cathryn James	This saving is not currently being achieved for the same reasons as those given in respect of ENV02 .	Y
ENV05	Review the back office structure based upon the anticipated tailing off of ANPR activity and the movement of CCTV into parking services.	70	0	70	R		70	R		0	A	Cathryn James		Y
ENV06	Reduction in transport related budgets	46	0	46	R							Cathryn James	A replacement saving (ALT1) implemented in 2018/19, was agreed by Cabinet in November 2017.	N
ENV09	Investigate potential commercial opportunities to generate income	50	25	25	R		25	R		0	A	Cathryn James		Y
	PUBLIC SPACE													
E&R16	joint procurement of waste, street cleansing, winter maintenance and fleet maintenance services (Phase C)	1,500	1,100	400	R		0	G		0	G	Anita Cacchioli	Full savings not achieved in Year 1 of contract. Actual savings delivered are being monitored closely	N
E&R25	Joint procurement of greenspace services as part 2 of the Phase C SLWP procurement contract with LB Sutton	160	44	116	R		0	G		0	G	Anita Cacchioli		N
ENV12	Loss of head of section/amalgamated with head of Greenspaces	70	0	70	R		0	A		0	A	Anita Cacchioli		N
ENV13	Staff savings through the reorganisation of the back office through channel shift from phone and face to face contact.	70	0	70	R		0	A		0	A	Anita Cacchioli		N
ENV18	Increased income from events in parks	100	0	100	R							Anita Cacchioli	A replacement saving (ALT1) implemented in 2018/19, was agreed by Cabinet in November 2017.	N
ENV21	Reduction in the grant to Wandle Valley Parks Trust	6	0	6	R		0	G		0	G	Anita Cacchioli		N
ENV23	Further savings from the phase C procurement of Lot 2.	160	0	160	R		0	A		0	A	Anita Cacchioli	Saving forms part of Phase C, but may not be achieved this financial year.	N
ENV25	Department restructure of the waste section	191	0	191	R		0	G		0	G	Anita Cacchioli	Saving achieved as part of Phase C procurement and outsourcing of service. Budget reduced in line with savings target	N
	Total Environment and Regeneration Savings 2017/18		**1,269**	**1,935**			**443**			**0**				

DEPARTMENT: COMMUNITY & HOUSING SAVINGS PROGRESS 2017/18

Ref	Description of Saving	2017/18 Savings Required £000	Shortfall £000	17/18 RAG		2018/19 Expected Shortfall £000	18/19 RAG	2019/20 Expected Shortfall £000	19/20 RAG	Responsible Officer	Comments	Budget Manager Comments	R /A Included in Forecast Over/Underspend ? Y/N
	Adult Social Care												
CH57	**Staff savings:** transfer of savings from housing	50	19	R		0	G	0	G	**Richard Ellis**	To be met fro HRA grant proposals		**Y**
CH35, CH36, CH52	**Supporting People**: re-commissioning of former Supporting People contracts. Savings can be achieved by removing funding from community alarms and reducing the capacity for housing support (including single homeless, mental health and young people at risk)	100	100	R		100	R	100	G	**Richard Ellis**	Deferred to 201819. Work on re-commissioning in progress		**Y**
	Library & Heritage Service												
CH7	Introduce self-serve libraries at off peak times: Smaller libraries to be self-service and supported only by a security guard during off peak times (nb. Saving would be reduced to £45k if Donald Hope and West Barnes libraries are closed). 3.5FTE at risk	90	33	R		0	G	0	G	**Anthony Hopkins**		**Full saving to be achieved**	**Y**
	Housing Needs & Enabling												
CH43	Further Staff reductions. This will represent a reduction in staff from any areas of the HNES & EHH :	100	49	R		100	A	100	G	**Steve Langley**		**Full saving to be achieved**	**Y**
	Total C & H Savings for 2017/18		**201**			**200**		**200**			**The department has looked at ways to mitigate unachieved savings in 18/19 by securing further under spends across C&H**		

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