Merton Council
Health and Wellbeing Board

Date: **27 November 2018**

Time: **6.15 pm**

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

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

1	Apologies for absence	
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9	Merton Health and Care Plan & Commissioning Intentions 2019/20 NOTE:THIS ITEM HAS BEEN REPLACED BY ITEMS 12 AND 13 IN THE SUPPLEMENTARY AGENDA	
10	Health Protection Protocol	151 - 192
11	Future Dates of HWBB and Dementia Friends Training Verbal Item	

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

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

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

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

Note on declarations of interest

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

Health and Wellbeing Board Membership

Merton Councillors

- Tobin Byers (Chair)
- Kelly Braund
- Janice Howard

Council Officers (non-voting)

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

Statutory representatives

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

Non statutory representatives

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

Quorum

Any 3 of the whole number.

Voting

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

HEALTH AND WELLBEING BOARD
26 JUNE 2018

(6.15 pm - 8.21 pm)

PRESENT Councillor Tobin Byers - Chair
Dr Andrew Murray - Vice Chair and Chair of Merton CCG
Councillor Janice Howard,
Councillor Kelly Braund - Cabinet Member for Children's Services
Hannah Doody - Director of Community and Housing
Rachael Wardell – Director of Children, Schools and Families
Dr Dagmar Zeuner - Director of Public Health
Dr Doug Hing – Merton CCG
Dr Karen Worthington – Merton CCG
Josh Potter – Director Commissioning of Merton CCG
Khadiru Mahdi - Chief Executive Merton Voluntary Service
Lyla Adwan-Kamara -Community Engagement Network
Brian Dillon – Merton Healthwatch

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for Absence were received from:
Chris Lee – Director of Environment and Regeneration
James Blythe – Chief Executive of Merton And Wandsworth CCG
Dave Curtis – Merton HealthWatch

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 27 March 2018 are agreed as an accurate record.

4 INTRODUCTIONS TO MEMBERS OF HEALTH AND WELLBEING BOARD (Agenda Item 4)

The Chair opened the meeting by thanking the former Councillors Katy Neep and Gilli Lewis-Lavender for all their work and contributions to the Health and Wellbeing Board over the previous few years.

The Chair said it was an exciting time for the Health and Wellbeing Board to be systems leaders for health and wellbeing and asked all members of the Board to introduce themselves and talk briefly about an aspect of their passion for health and wellbeing.

5 DIABETES STRATEGIC FRAMEWORK (Agenda Item 5)

The Director of Public Health presented her report on Tackling Diabetes that gave a full write up of the findings of the recent Diabetes Truth conversations. She outlined the learning and insight that Health and Wellbeing members have gained through the work. She explained that the work will now feed into the Diabetes Plan and that this will involve continuing to listen to the community through 'mini conversations', with clinicians taking forward the clinical approach through the planned Diabetes Summits.

The Director of Public Health was asked what would practical support for tackling diabetes look like, for example how long would a person have to wait to see a nutritionist? The Director replied that often people are overwhelmed by their initial diagnosis and the most important factor is that they know what help is available to them so that they can then engage with it.

The Vice Chair commented that it was superb report, and suggested that it might be best to pick on a few things that could be done to make a difference. The Director of Public Health agreed with this and explained that a Whole Systems Approach is needed.

The Board acknowledged that it was important for this work to widely involve residents and communities within Merton. The proposed 'mini conversations Diabetes Champions, peer networks and conversations with those who manage diabetes in different communities would assist with this process. Councillor Howard commented on the role of pharmacists in reaching communities.

The Chair thanked Dagmar Zeuner and Mahri Davis and the team who delivered the Diabetes Truth Programme, and especially the expert witnesses who gave up their time to attend.

RESOLVED

The Health and Wellbeing Board agreed to:

A. Discuss and endorse the findings of the Diabetes Truth programme.

B. Consider the proposed approach to tackling diabetes, including the continued engagement of communities and the development of a Diabetes Strategic Framework.

C. Consider and agree (in principle) to support the launch of the Merton Mile, as part of the promotion of healthy living and as a celebration of community assets in Merton.

6 ANNUAL PUBLIC HEALTH REPORT (Agenda Item 6)

The Director of Public Health presented the Annual Public Health Report (APHR). The aim of this report 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 clarified meaning, definition and measures of health inequalities, analysing

trends over time, proposing measures to monitor future progress and summarising evidence of what works to reduce health inequalities.

The Vice Chair asked about life expectancy and the impact of accumulated life experiences. It was agreed that a definition of how life expectancy is calculated be added to the Glossary.

The Board discussed the indicators used and it was asked if indicators related to financial resilience could be considered. Indicators relating to people living with a disability were raised as was a desire for more Merton specific data. The Director of Public Health answered that other indicators could be considered in future years, but it was important to achieve a balance in the amount of data presented. She explained that there was also a balance between local and regional indicators, confidence levels in the statistics needed to be high enough to enable conclusion to be drawn.

The Director of Children, School and Families asked the Board to consider how the information in the APHR could be used to inform future reports and strategy. She suggested that it should be referred to more regularly, made live in discussions, and used to reposition baseline information and shaped according to need.

RESOLVED

The Health and Wellbeing Board agree to:
A. To receive and endorse for publication the attached Annual Public Health Report (APHR) 2018 on Health Inequalities.
B. To consider the recommendations of the APHR, how partners can work to tackle and monitor health inequalities and use existing infrastructure to take this forward.

7 AUTISM STRATEGY (Agenda Item 7)

Julia Groom, Consultant in Public Health presented the report on the Merton Autism Strategy 2018-2023 and Action Plan, highlighted the collaborative work involved in developing this and asked Health and Wellbeing Board members to champion Merton as an autism friendly borough

There was agreement that the involvement of people experiencing autism and their carers in the engagement was really good practice. The timescale for training was raised and Julia Groom agreed to look at this.

The Board noted that of the Strategy had helped recognise that mental health pathways are complex so working with St George's SWL MH Trust and others and avoiding labels to improve access if vital.

RESOLVED

The Health and Wellbeing Board Agree:
A. To approve the Autism Strategy 2018-2023.

B. To endorse the Strategy Action Plan.

C. To champion the ambition to make Merton an autism-friendly borough, and in particular to support the objective to improve autism awareness in the wider population which was highlighted as a priority in engagement on the Autism Strategy.

D. The proposed governance arrangements for the Strategy.

8 HEALTH AND WELLBEING STRATEGY (Agenda Item 8)

The Director of Public Health presented her report on the plans for developing the Health and Wellbeing Strategy 2019-2024. She emphasised that she wants to translate learning and current knowledge into the new HWB Strategy, and is keen to involve the Board in the process. It will be important to consider the outcomes and indicators of this strategy carefully (using the APHR and JSNA), that will focus on the four themes of 'Start Well', 'Live Well', 'Age Well' and '….in a healthy place'

It was agreed this work should link to that of the Strategic Collaborative Working Group with the voluntary sector. She commented that the Merton Story has now incorporated comments from the HWBB and that work was ongoing on a more in depth chapter on disability for the JSNA.

The Director of Children, Schools and Families said that she wanted to ensure that Children and Young People were involved in the engagement process and she would lead on this piece of work.

The Director of Public Health said that she would like a Board Member to chair each of the session and would let them know about workshop dates

RESOLVED

The Health and Wellbeing Board Agree:

A. To review and clear the proposed plans for developing the Health and Wellbeing Strategy (HWS) 2019-2024

B. To provide feedback on the proposed task and finish workshops; the proposed themes: proposed agenda: and to discuss whom from the HWBB would like to attend the workshops

C. To note the synergies between the Health and Wellbeing Strategy and the Merton Local Health and Care Plan

9 MERTON HEALTH AND CARE TOGETHER UPDATE & LOCAL HEALTH AND CARE PLAN (Agenda Item 9)

Josh Potter, Director of Commissioning at Merton CCG, delivered his presentation on Merton Health and Care Together programme and the Merton Health and Care Plan. The Plan marks a new relationship between providers and commissioners setting out the priority areas of 'Start Well, Live Well, Age Well' for joint work where we can best add value.

The Board noted that it was currently planned to finalise the Merton Health and Care Plan in Autumn 2018, depending on the timing of the release of the NHS 10 year plan and Government Green Paper on Health and Social Care.

The Chair asked whether the Merton Health and Care Together reports through the Health and Wellbeing Board and Josh Potter confirmed it did.

The Director of Communities and Housing explained that this work on integration has been taken back locally from South West London and now needed to be delivered. It was agreed that clinicians should be involved early on. The Board noted that the programme needed to ensure a person centred approach, and a continuous improvement system that made listening to service users central.

The Board noted that the plan would come back to them in the Autumn and agreed the recommendations in the report.

RESOLVED

The Health and Wellbeing Board

A. Noted the background to, and development of, the Merton Health and Care Together programme, and the Merton Local Health and Care Plan
B. Approved the priorities contained within the Health and Care Plan

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Committee: Health and Wellbeing Board
Date: 27 NOVEMBER 2018

Subject: iThrive

Lead officer: Paul Angeli

Contact officer: Leanne Wallder

Recommendations:

1. That the HWBB agree with adopting the THRIVE Framework and implementing iTHRIVE in Merton
2. That members of the HWBB Champion this model going forward

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

2. DETAILS

2.1 In recent years, the most frequently recognised attempt to conceptualise CAMHS has been through a model that divides service provision into four Tiers, where:

- Tier 1 refers to non- specialist, unilateral early work such as that undertaken by Health Visitors or School Nurses, including sleep or feeding difficulties.
- Tier 2 refers to Primary Mental Health workers, providing interventions in areas such as bereavement and loss, parenting etc.
- Tier 3 refers to Specialist multi-disciplinary (CAMH) teams, usually based in a community clinic, dealing with emerging mental illness such as depression and early onset psychosis
- Tier 4 refers to specialised day and in-patient facilities for Children and Young People with severe mental health problems.

2.2 Although generally agreed to be very useful at the time of development and introduced and widely used in Merton as in the majority of the country, it is now increasingly felt that the model has led to the unhelpful development of concrete divisions between tiers and service delivery.

2.3 THRIVE was originally co- developed in 2014, by a collaboration from the Anna Freud Centre and the Tavistock and Portman NHS Foundation Trust and was cited in the Government report 'Future in Mind' which outlined the Government's intentions for developing and improving the mental health

and well being of children, based on the findings of a cross-party taskforce, stating:

> " …. has the potential to move away from an inflexible and restrictive system, towards one which enables agencies to commission and deliver support to allow children and young people to move more easily between services and to make collaborative choices about what would work best for them at given pints in time.

The model is currently being rolled out across 70 locations in England.

2.4 CAMHs is inevitably a smaller part of a bigger system whether representing the child part of mental health or the mental health of child services and historically there has been a tendency for CAMHS to be an afterthought to wider policy and funding initiatives.

2.5 Community initiatives that support mental wellness, emotional wellbeing and resilience of the whole population are areas of mental health support that some consider have been neglected in the past, but are where the potential impact could be great.

2.6 Thrive LDN is a citywide movement to improve the mental health and wellbeing of all Londoners**.** It is supported by the Mayor of London and led by the London Health Board partners and is an attempt to address some of these whole population issues.

2.7 Their early engagement work and a number of community conversations held during 2017 have been focused on 6 aspirations for Londoners:

- A city free from mental health stigma and discrimination
- A city where individuals and communities are in the lead
- A city that maximises the potential of children and young people
- A city with a happy, healthy and productive workforce
- A city with services when and where needed
- A zero suicide city

2.8 There is synergy between the THRIVE Framework and the aspirations and work of Thrive LDN and we must not underestimate their potential combined effect, especially on the 'thriving' group (see below).

2.9 A tangible example of a benefit to young people in Merton is that through a Thrive LDN initiative every school in London will have access to a Youth Mental Health First Aider (MHFAider) by 2021. Youth MHFAiders are trained individuals who can recognise the crucial warning signs and symptoms of poor mental health in young people and can guide a young person to the appropriate support.

2.10 This paper focuses on the THRIVE Framework, which provides an integrated; person centred and needs led approach to delivering **mental health services** to children, young people and their families.

2.11 The THRIVE Framework replaces the tiers with a whole system approach which is based on the identified needs of Children and Young People and their families; advocates the effective use of data to inform delivery to meet needs; identifies groups of Children ad Young People and the range

of support they may benefit from and ensures Children and Young People and their families are active decision makers.

2.12 There are four key principles that underpin the THRIVE Framework:

- Shared decision making at the heart of choice
- Acknowledgement of limitations to treatment
- Distinction between treatment and support
- Greater emphasis on how to help children and young people and communities build on their strengths

2.13 THRIVE endorses multi-agency definitions of mental health promoting practices, encourages shared multi-agency responsibility for promoting 'thriving', promotes multi-agency proactive advice and help and supports multi-agency clarity on endings as well as beginnings.

2.14 The THRIVE needs based groups are:

- Thriving – prevention and promotion
- Getting Advice and Signposting
- Getting Help – goal focused, evidence based interventions
- Getting more help – extensive evidence based treatment
- Getting risk support – risk management and crisis support

2.15 The CAMH Partnership Board have been considering the adoption of the THRIVE Framework and as part of this consideration had a presentation from the iTHRIVE Clinical Lead and Information Lead.

2.16 Following this a smaller group of key stakeholders met to explore in-depth the work that would be required to cascade understanding of the Framework, prior to the implementation of an iTHRIVE model in Merton

2.17 There is a helpful iTHRIVE implementation self-assessment toolkit available on the website, which provides a way of assessing how 'THRIVE-like' our current services are. This tool would be used as an assessment to support the development of our implementations and provide a baseline for subsequent measurement of improvements in our CAMH transformation journey.

2.18 The CAMH Partnership have identified key benefits of implementing the iTHRIVE model now as:

- Timely in relation to the need to revise the current CAMH Strategy (2015-18)
- Strategic fit in terms of work to destigmatise mental health issues and making mental health everybody's business
- Timely in terms of the recent Green Paper: Transforming children and young people's mental health provision: a green paper (Dec 2017).
- Provides one system that underpins and supports the organisation and monitoring of all CAMH services.

2.19 It is likely to take *at least* 18 months to fully implement the model and implementation will require project planning and resources (specifically staff time).

2.20 There is considerable on-line iTHRIVE Programme Support available, including the self assessment toolkit, an iTHRIVE community of practice,

case studies and an iTHRIVE Academy. Some of this is open access, but some support, such as the academy modules would require funding.

2.21 It would be appropriate for small amounts of the CAMH Transformation budget to be used to support the implementation of iTHRIVE, but project success would be predominantly reliant on multi-agency support and 'buy-in' in terms of staff time and commitment.

3. ALTERNATIVE OPTIONS

3.1 We could continue to use the current tiered model, but as explained in 2.2 this provides artificial silos and does not fit with current thinking or CAMH direction of travel.

3.2 There are a small number of areas such as Leeds and Liverpool that have been working to move away from the tiered structure. They have achieved this by tailored design of new local models which create a seamless pathway of care and support and which address the need for the diversity of circumstances and issues with which families and young people approach mental health services in their area. Because of the localisation of these models, it does not seem logical to try to replicate any in Merton.

3.3 Specialist CAMH services are commissioned jointly across South West London sector. We know that other partners within the sector are either already implementing or considering the implementation of iTHRIVE and it would make sense that all five boroughs used the same conceptual model.

4. CONSULTATION UNDERTAKEN OR PROPOSED

4.4 As highlighted in 2.9 consultation has taken place with members of the CAMH Partnership Board to date.

4.5 Consultation and stakeholder engagement will be key to the implementation of this conceptual framework and a consultation and engagement plan a key element of the project documentation going forward.

4.6 Consultation with young people themselves will be of paramount importance.

5. TIMETABLE

5.1 To be confirmed once HWBB endorse this model going forward.

6. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1 As highlighted in 2.15

7. LEGAL AND STATUTORY IMPLICATIONS

7.1 None

8. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1 Equalities impact would be part of the implementation project plan. Implementation of the model will help in our identification of specific groups of children and young people, their levels of vulnerability and how the emotional and mental health needs can be best met.

9. CRIME AND DISORDER IMPLICATIONS

9.1 Representation from the Youth Justice Service are on the CAMH Partnership Board and would be a key stakeholder in the implementation of the new model. The model would encompass all vulnerable groups including those young people known to Youth Justice

10. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1 A key part of the framework is the management of risk with individuals, especially when in crisis and how this is jointly managed across agencies.

11. APPENDICES – the following documents are to be published with this report and form part of the report

None

12. BACKGROUND PAPERS

Short Power Point Presentation

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The Thrive Conceptual Framework

An Introduction

The Thrive Conceptual Framework

THRIVE was originally authored by professionals involved in mental health support for children and young people, all of whom came from a health background.

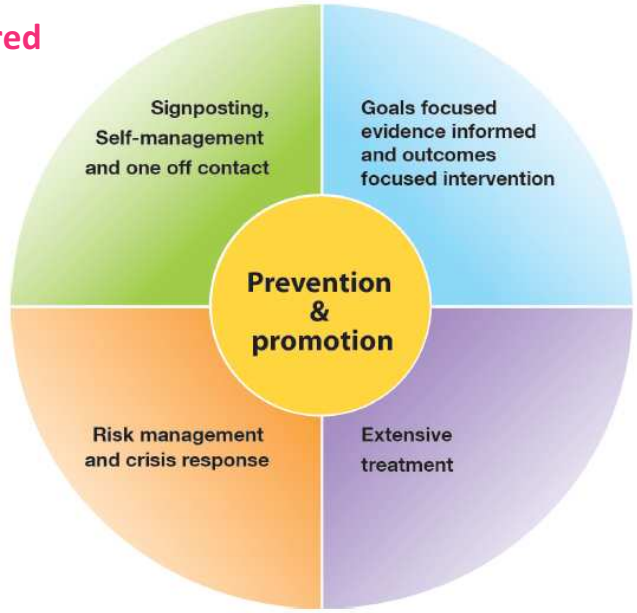
THRIVE Elaborated (Second Edition) now has co-authors from the world of education and social care, and have drawn on views from head teacher panels, CCG leads and local authority directors.

Four key ways in which the THRIVE framework is inherently multi-agency are:

1. THRIVE endorses multi-agency definitions of mental health promoting practices
2. THRIVE encourages shared multi-agency responsibility for promoting “thriving”
3. THRIVE promotes multi-agency proactive “advice” and “help”
4. THRIVE supports multi-agency clarity on endings as well as beginnings

The THRIVE Conceptual Framework

Input offered



Description of the THRIVE-groups

- Distinction between advice/support and evidence based 'treatment'
- The five needs based groups are distinct in terms of the:
  - needs and/or choices of the individuals within each group
  - skill mix of professionals required to meet these needs
  - resources required to meet the needs and/or choices of people in that group

THRIVE Elaborated, Second Edition (Wolpert et al., 2016)

IRIVE Key Principles

- Shared decision making at heart of choice
- Acknowledgment of limitation of treatment
- Acknowledgment of limitations of resources
- Distinction between treatment and risk support
- Greater emphasis on how to help young people and communities build on their own strengths

THRIVE Elaborated, Second Edition (Wolpert et al., 2016)

Difference between Getting More Help and Risk Support

Getting More Help

- **evidence**-based, carefully **designed** and tested for **fidelity**
- aim of **recovery**, or goal of **improvement** expected to enhance **wellbeing**
- participants **committed** to achieving **change**
- focused activity with **predetermined timeframes**
- **structured** with a **theoretical** rationale **based on understanding** of the disorder
- **modification** to the treatment protocol is indicated **by session by session** treatment **response**

Risk Support

- **individually tailored support** based on **collaborative** shared **plan** for each family
- aim of **reducing** the **risk** of harm, **catastrophic outcomes** (death, injury) and decreasing the chance of **deterioration** as well as **increasing self-management**, resilience and **agency**
- participants **committed** to **improving** their **reactions to crises**
- **ongoing** process **dependent on** the young person's **needs**
- **pragmatically driven**; **family** to influence **structure** and **content** of the intervention within **legal** constraints
- **modification** to the agreed protocol is a **regular** occurrence in **response** to the **safety outcomes** achieved

The THRIVE Conceptual Framework: Summary

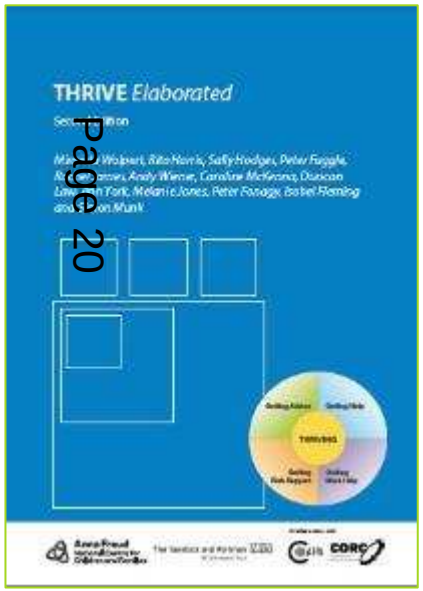
The THRIVE framework:

- replaces tiers with a whole system approach
- is based on the identified needs of children, young people and their families
- advocates the effective use of data to inform delivery and meet needs
- identifies groups of children and young people and the sorts of support they need
- draws a clearer distinction between treatment and support
- builds on individual and community strengths wherever possible
- ensures children, young people and their families are active decision makers

Implementing the conceptual framework in Merton

Our iThrive Model

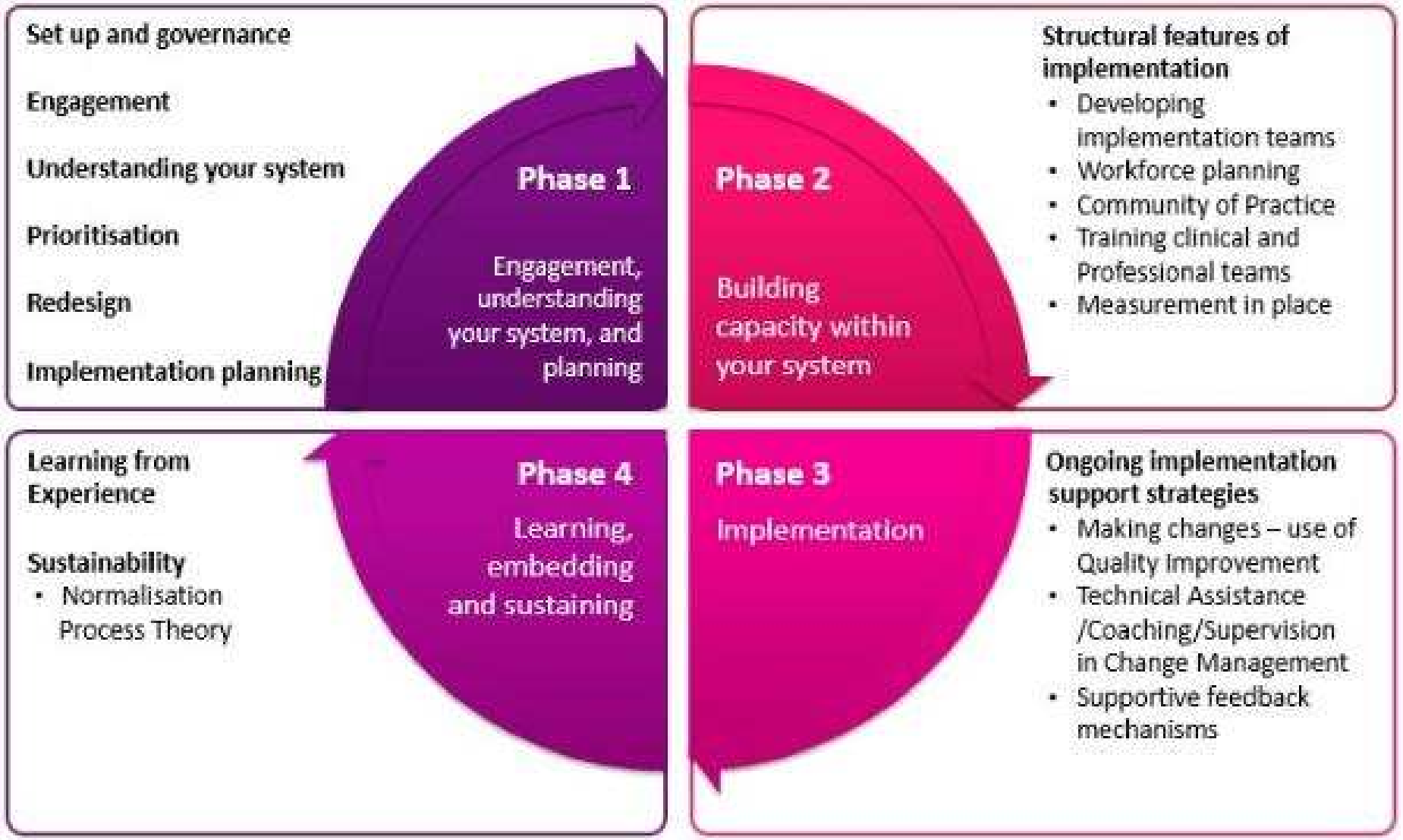
The iTHRIVE Programme



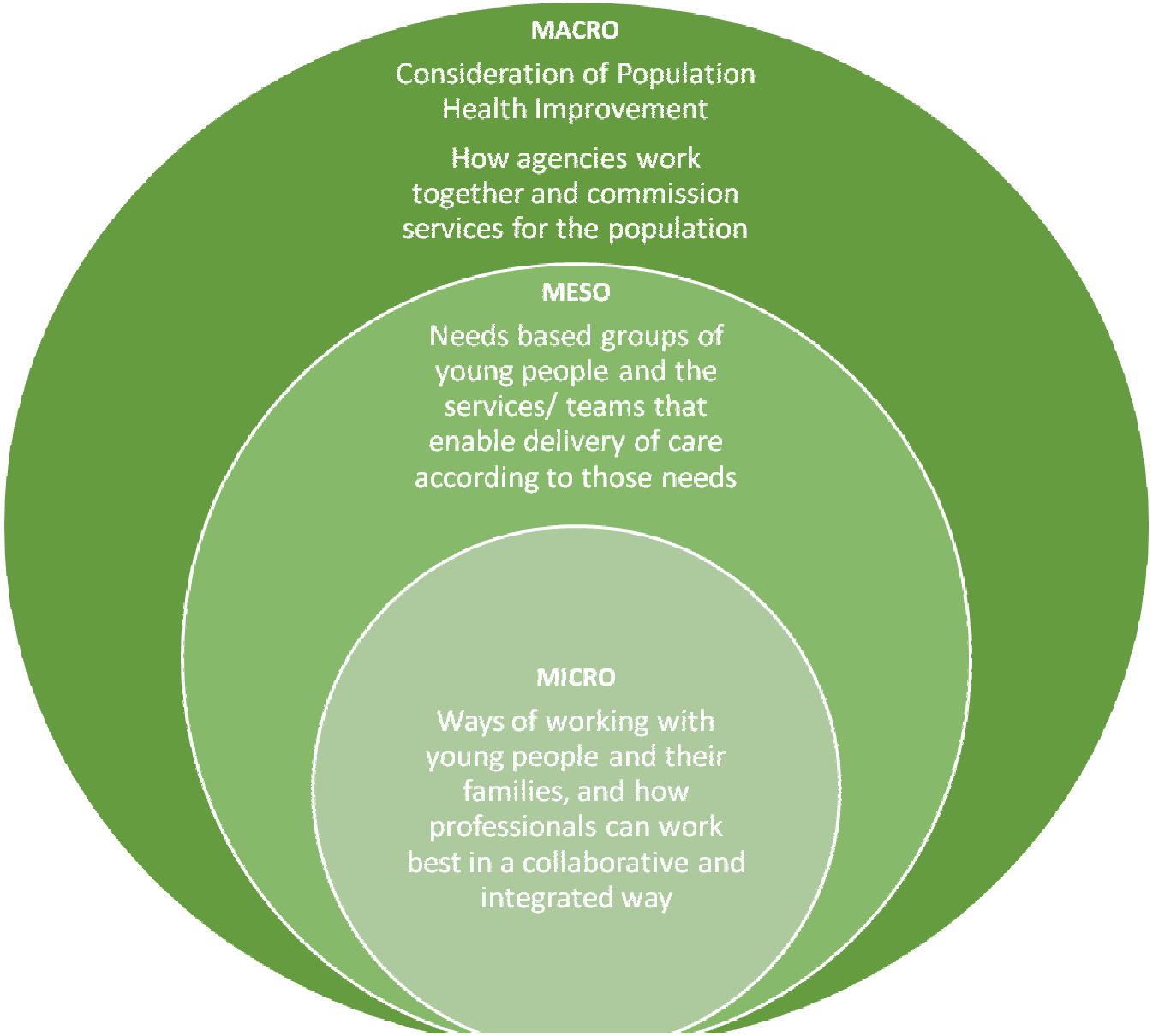
i-THRIVE

i-THRIVE is the implementation programme that supports sites to translate the THRIVE conceptual framework into a model of care that fits local context.

i-THRIVE Approach to Implementation



i-THRIVE Approach to Implementation: whole system change



For more information: i-THRIVE

www.implementingTHRIVE.org

Thrive London – Where does this fit?

Thrive Framework & Model

- Conceptual framework to underpin *service delivery* based on identified needs of individual children and families
- Focus specifically on Merton

Thrive London

- A movement to improve the mental health and wellbeing of a population (Londoners).
- Pan London

Collectively aiming to maximise the potential of our children and young people

Committee: Health and Wellbeing Board

Date: 27 November 2018

Subject: Safeguarding Children Board (MSCB) Annual Report 2017/18

Lead officer: Rachael Wardell, Director of Children's Schools & Families

Lead member: Cllr Kelly Braund, Cabinet Member for Children's Services

Contact officer: Paul Bailey MSCB Safeguarding Development & Policy Manager

Recommendations:

A. To note the MSCB annual report 2017/18.

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

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

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

2 DETAILS

2.1 The MSCB annual report 2017/18 is produced on behalf of the safeguarding partnership involving all key agencies and supports the council and the Chair of the MSCB in assuring local arrangements.

2.2 The questions that the Board is continuously seeking to answer are:

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

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

- The MSCB was judged as Outstanding with no recommendations for improvement by Ofsted in 2017
- The MSCB is a mature partnership that is open to learning and challenge
- Senior representation and engagement from agencies
- A relentless focus on working together to keep children safe
- A strong performance focus including the annual QA process
- Annual conference and comprehensive training programme

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

2.4 Our agreed areas of focus during 2017-2018 included:

i. A successful transition from LSCBs to Safeguard Partnerships
ii. Think Family -
iii. Supporting Vulnerable Adolescents
iv. Early Help

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

2.5 The Annual Report was approved by the MSCB on 18th September 2018

3 ALTERNATIVE OPTIONS

3.1 None

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1 All key agencies contributed.

5 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

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

6 LEGAL AND STATUTORY IMPLICATIONS

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

7 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

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

8 CRIME AND DISORDER IMPLICATIONS

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

9 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

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

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

Appendix 1: MSCB Annual Report 2017/18

https://www2.merton.gov.uk/MSCBAnnualReport2018.pdf

Merton
Safeguarding
Children Board

Annual report of the

Merton Safeguarding Children Board 2017/18

Contents

1.0
Chair's Introduction

2017-2018 has been a year of progress and transition. In June and July 2017 Merton Safeguarding Children Board (MSCB) was inspected by the Office for Standards in Education, Children's Services and Skills (Ofsted). As you may be aware, the Single Inspection Framework is the most rigorous and forensic examination of children's services and the work of Local Safeguarding Children Boards. Over a period of 4 weeks in June and July 2017, a team of 7 Ofsted inspectors, 2 Data Analysts and 1 Quality Assurance Manager inspected the work of the Children's Social Care and the Merton Safeguarding Children Board. The team:

- Interviewed 206 staff and partners
- Tracked and audited 162 cases
- Requested and reviewed 429 documents
- Observed or led a range of meetings and focus groups.

Inspectors found that:

Merton's Local Safeguarding Children Board (MSCB) is outstanding. It is highly effective in holding agencies to account for their individual safeguarding arrangements in the welfare and protection of children.

Inspectors noted that:

There is a sustained commitment to and focus on the delivery of the board's safeguarding priorities, including families in which adult mental health, neglect, alcohol, drugs and domestic violence feature in children's lives. The safeguarding needs of children pervade the board's work and business and subgroup plans.

In March 2018, after almost 10 years of dedicated service to Merton's Children, Schools and Families, our Director, Yvette Stanley, was recruited to serve as the National Director of Children's Social Care for Ofsted. Yvette has many achievements to celebrate, most notably Merton's Children's services being rated good with outstanding features at its recent Ofsted inspection and being the highest in the country for progress in secondary schools. Yvette will be missed but she can be proud of the legacy of a Children's Schools and Families Department, partners and stakeholders, who place vulnerable children and their families at the very centre of all we do.

We are grateful to Paul Angeli, Assistant Director for Children's Social Care and Youth Inclusion and Jane McSherry, Assistant Director of Education who both served as the acting Director of Children's Schools and Families until May 2018, when we were joined by Rachael Wardell. Rachael comes from West Berkshire where she served as the Corporate Director for Communities for West Berkshire Council, Rachael brings a great deal of invaluable experience to Merton. Her career to date includes eight years in local government starting as assistant director in Wokingham Borough Council children's services and early intervention. Prior to that she spent seven years at Ofsted, where she was responsible for children's policy projects in early years and social care and an earlier seven years at the Legal Aid Board.

The Children and Social Work Act 2017 received Royal Assent in April 2017. The Children and Social Work Act 2017 (the Act) replaces Local Safeguarding Children Boards (LSCBs) with new local safeguarding arrangements, led by three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups). It also places a duty on child death review partners (local authorities and clinical commissioning groups) to review the deaths of children normally resident in the local area – or if they consider it appropriate, for those not normally resident in the area. The Board is working with partners to determine the future constitution and structure of the safeguarding partnership. A proposal will come to the Board in September 2018 and will go out to wider consultation, with a view to seeking approval for the new arrangements in January 2019. The plan will be for the LSCB to be dissolved on 31st March 2019 and the new safeguarding partnership to be established on 1st April 2019.

We are pleased to say that the Board remains on a journey of continuous improvement that seeks to place children, the families and the

practitioners who support them at the very heart of what we do. The vision of the MSCB is that the Board works to ensure that *everyone in Merton does everything they can to ensure that every child is safe, supported and successful*. This annual report is an evaluation of our progress towards achieving this vision as well as an assessment of the overall impact of the Board especially with regards to our four key priorities.

In November 2017 a seven year old Merton child was tragically murdered by her father. The Board took the decision to commission a Learning and Improvement Review (LiR) of the circumstances surrounding this event. This case did not meet the statutory threshold for a SCR; however, the Board considered that there may be some significant learning for the multi-agency safeguarding system.

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

The Board's strengths are identified as:

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

Our agreed areas of focus during 2017-2018 included:

1. Managing the arrangements for the transition from Merton Local Safeguarding Children Board to the Merton Safeguarding Children Partnership

In 2019 the Board will see the dissolution of LSCBs and the establishment of Safeguarding Partnerships. In addition to reviewing the progress that the Board has made to date, we will need to develop clear plans about the future shape and direction of the Board.

The MSCB is Outstanding with no recommendations regarding improvements. Building from this secure base, the Board has agreed not to radically change its constitution but to use the Children and Social Care Act 2017 as an opportunity to strengthen our partnership to ensure that safeguarding children remains a priority for all partners in our safeguarding system and to ensure the most effective representation from statutory and other key partners in the work of safeguarding Merton's children and families and promoting their welfare.

At the Board's Away Day it was agreed that a task and finish group would be established to propose the arrangements for the establishment of Safeguarding Partnership. A task and finish group has been appointed by the Board to explore options for the new Partnership and make recommendations.

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

A great deal of work has been undertaken to embed Think Family as an approach to interventions with children and families across both adults and children's services. We are making good progress in ensuring that our partnerships enable the most vulnerable families to be supported; that vulnerable parents are enabled to care for their children and children receive the care they need to thrive and achieve their potential. Evidence from local and national research tells us that our most vulnerable parents/families are those who:

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

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

Building on this work, the Board is seeking to drive improvements in our practice with vulnerable families so that stigma is reduced and families with poor mental health and substance misuse issues will feel confident in seeking help and support. We are also able to assure ourselves that practitioners are supported with the skills and confident to engage with all families including:

- Families who are difficult to engage
- Families who are challenging (for a variety of reasons including social class – evidence from practice and SCRs show that affluent families can pose distinct challenges to multi-agency safeguarding systems resulting in harm to children; families who present as 'powerful' etc.).

The Board is also seeking to further highlight the important role of schools, educational and early years' establishments, as a critical safeguarding partner.

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

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

- Child Sexual Exploitation (CSE)
- Children who go missing from home/ school/care
- Children and young people who are at risk radicalisation and violent extremism
- Children at risk of serious youth violence and gangs
- Children at risk of criminal and other forms of exploitation including county lines, peer on peer abuse and harmful sexual behaviour
- Self-harm and poor mental health para-suicide.

The Board is seeking to develop a strategic response to Contextual Safeguarding. In particular, we are seeking to develop a coordinated response to overlapping forms of adolescent risk/harm which occurs outside of the family home in spaces such as the neighbourhood, school, community centres and housing estates.

The Board would also like to be more systematic regarding its work in listening to children and allowing them to shape the services that are provided to them. The Merton User Voice Strategy outlines the variety of ways in which the views and opinions of children and young people are considered. The Board would like this to be more coordinated so that these views and opinions can more strongly influence the ways we support families and keeps children safe, so impact of our work with children, young people and their families can be measured more effectively.

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

Merton has reviewed its Children Young People and Families Well-Being Model. We are now reviewing our Early Help (EH) and Preventative work; in particular, we are exploring models for coordinating preventative and early help across the well-being model. As part of our review we will:

- Consider the interface between our MASH and EH arrangements
- Review our service offer at all levels of the Merton Well Being Model and Engage partners in discussion on thresholds, clarify Step-Up-Step-Down processes and the tools to support early help assessments including the Common And Shared Assessment tool and intervention (Signs of Safety/Signs of Well-Being)
- Review the arrangements for the quality assurance of EH and Preventative work.

Addressing the incidence and impact of neglect is a cross-cutting theme that runs across the work of the Board and each of our priorities.

The questions that the Board is continuously seeking to answer are:

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

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

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

Keith Makin
MSCB Chair
July 2018

2.0
Progress of MSCB Business Plan 2016–17

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

2.1 Think Family –Supporting families with particular vulnerabilities

2.1 a. Embedding the 'Think Family' Approach across the multi-agency partnership

I. The appointment of the Think Family Coordinator and the establishment of a Think Family Strategic Group

In order to ensure that the 'Think Family' approach becomes the normal way in which we work with children and families, a Think Family Coordinator has been appointed. The role of the Think Family Coordinator is to work with both the children's and adults' workforce to facilitate joint understanding and effective joint working.

The Think Family Coordinator attends the Merton Safeguarding Children Board meetings and sits on the Policy Sub-Group.

We are beginning to see evidence of a shared understanding of roles and responsibilities; we are also seeing more effective joint working between adults and children's services. We want to see this embedded across the system.

II. The Mental Health Protocol

The Board has reviewed and revised a *Multi-Agency Mental Health Protocol*. This document was drafted jointly by Merton Safeguarding Children Board and Merton Safeguarding Adults Board, which includes the Clinical Commissioning Group, South West London St Georges Mental Health Trust. The protocol sets out:

- Key questions that all practitioners working with adults who have mental health problems must ask in their work, where their patients or service users are parents or are in contact with children
- Clear guidance about the pathway to obtaining additional support for the children or young people who need early help or safeguarding
- Guidance for the children's workforce about when to access additional support for the adults who are experiencing mental health problems.

The multi-agency Protocol to meet the needs of children and unborn children whose parents or carers have mental health problems was launched at the joint Merton Safeguarding Children Board, Children's Schools and Families and Adult Social Care conference' in March 2018. The protocol is supported by an implementation plan which is monitored by the Policy Sub-Group.

III. Domestic Abuse Guidance

The Board has also approved multi-agency guidance to address domestic violence and abuse. The aims of the guidance are:

1. To protect the child/ren
2. To support the victims/survivors to assist them to protect themselves and their child/ren; and
3. To hold the abusive partner accountable for the violence and provide them with appropriate support and opportunities to change.

The guidance is for use by all professionals (the term includes qualified and unqualified managers, staff and volunteers) who have contact with children and with adults who are parents / carers, and who therefore have responsibilities for safeguarding and promoting the welfare of children.

The guidance includes violence/abuse between adults (in both heterosexual and same-sex relationships), child to parent violence/abuse and teenage relationship abuse. The guidance also includes coercive control as a form of domestic abuse.

It is expected that protocols for supporting parents engaged in substance misuse and parents with disabilities will be approved by 31st March 2019. This will complete our Think Family suite of protocols.

2.2 Supporting Vulnerable Adolescents

2.2 a. CSE

Merton Safeguarding Children's Board's *Child Sexual Exploitation (CSE) Strategy* was launched in 2013, refreshed in 2015 and again in 2017. These reviews were supported by intelligence from our Joint Strategic Needs Assessment and 2014 peer review on CSE and were prompted by changes in the definition of CSE and the appointment of a CSE Lead in 2017.

Our strategy provides clear and practical guidance for social workers and other practitioners dealing with cases where there is suspected and confirmed child sexual exploitation.

The MSCB Sub-Group 'Promote and Protect Young People' has received papers outlining the rise in criminal exploitation and this is identified as being related to the low numbers of boys referred for CSE. Therefore, a proposal is being drafted for a broader 'Exploitation Strategy' and process.

Over the past 3 years we have had an average of 33 referrals to our Multi Agency Sexual Exploitation Panel. Notably the last year (2017/18) has seen a significant decrease in referrals. Coupled with an increase of cases closed (placed on 'ICE') the number of CSE open cases at the end of March 2018 was only 13 children.

2.2 b. Self-harm and Adolescent well-being

In 2016 the MSCB approved a multi-agency *Self-Harm Protocol* for professionals working with children and young people who harm themselves. The Board will be refreshing this protocol in 2018-2019. This will be set within the framework of a strategy focused on supporting adolescent well-being and preventing suicide. The MSCB will work with the Child and Adolescent Mental Health Service's (CAMHs) Transformation Board to develop a multi-agency strategic response to promoting adolescent mental health and well-being as well as developing a suicide prevention strategy.

2.2. c. High risk Adolescents

We are continuing our focus on supporting high risk adolescents. High risk adolescents are children and young people who have had a range of adverse childhood experiences including neglect, physical and emotional abuse; this includes being exposed to domestic violence and abuse, living with a parent with poor mental health or living with a parent with significant substance misuse. High risk adolescents include:

- Young people who regularly go missing from home, school or care
- Young people who are at risk of criminal exploitation from gangs
- Young people who are at risk of sexual exploitation
- Young people who are known to the Youth Justice System
- Young people who misuse substances such as alcohol or drugs.

The Board has strengthened the arrangements for interviewing children and young people who return home after a period of going missing. We have reviewed our *CSE Protocol* and refreshed our *CSE Strategy*. In addition, we have approved a *Harmful Sexual Behaviour Protocol* and approved an *Online Safety Strategy*. These strategies, protocols and guidance documents support multi-agency practitioners with the knowledge and understanding of these issues and outline a clear procedure for responding to young people who are exposed to these risks. Managers and practitioners are also supported with materials which can be used to brief staff so that the guidance is understood and consistently implemented.

The MSCB Training Programme provides briefings on CSE, *harmful sexual behaviour*, working with young people at risk of being involved in gangs and young people who are at risk of criminal and other forms of exploitation. The programme includes the following training:

- The impact of domestic abuse on children and young people
- The impact of parental mental illness on children and young people
- Working with children and families affected by substance misuse
- Merton gangs (girls and boys) and child sexual exploitation
- Substance misuse and young people
- Sexual Health and Relationships Education
- Talking to young people about drugs, alcohol and sexual health, early identification of risk and building resilience by earlier interventions.

2.2. d. Contextual Safeguarding

Throughout 2017-2018, the MSCB commissioned a Contextual Safeguarding audit. The first phase of this audit process was a paper audit to:

- review all relevant strategic documents, operating protocols, assessment tools and guidance documents currently used to respond to peer-on-peer abuse in Merton
- Observe relevant multi-agency strategic and operational meetings
- Meet with practitioners and young people.

There is a contextual safeguarding Project Plan in place which outlines how Merton will establish

clear governance and strategic oversight of this work. The plan sets out how practice will be observed and how practitioners and young people will be engaged in shaping our response. The findings of this work will then be disseminated. The MSCB and partners will then determine how our response to contextual safeguarding will be developed and applied across the safeguarding partnership.

2.3 Early Help

The MSCB is committed to ensuring the provision of high quality early help and preventative services. The Ofsted inspection of services for children in need of help and protection, children looked after and care leavers and review of the effectiveness of the Local Safeguarding Children Board found that:

> *Children are protected through an outstanding early help offer.*[1]

Inspectors also noted that:

> *High-quality early help assessments help to identify needs, leading to children and families benefiting from a range of integrated early help support services.*[2]

Inspectors reported that:

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

> *The training and engagement with early help partners contribute to very strong early help assessments, which are undertaken by a wide range of partners. This ensures timely identification of need, with decision-making and work overseen by a social work qualified team manager. Effective intervention at an early stage is having a positive impact on reducing the number of children who require a more specialist service. Families benefit from prompt support from a range of innovative, high-quality early help services, such as a*

[1] The Office for Standards in Education, Children's Services and Skills (Ofsted) (2017) *Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board.*

[2] Ibid.

dedicated victim support service for children, and mental health practitioners in schools. Parents spoke very highly of the early help services available and the positive difference that they are making for children.

If risks to children change, they experience a relatively seamless transition between early help and statutory services. Step-up and step-down processes are well considered and purposeful, with the vast majority evidencing a clear rationale and decision-making. This ensures that children and their families are receiving the right service at the right level of intervention to meet their needs.[3]

Although Merton's early help offer is judged as outstanding, we are not complacent and we believe that our early help and preventative services would be strengthened by greater coordination and further developing quality assurance processes; we would also like to ensure that there is an early help adaptation of the Merton Social Work Practice model which would include developing an early help version of the Signs of Safety approach to working with children and their families. In order to achieve these aims, an Early Help Task and Finish group has been formed to explore models of coordinated early help. The task and finish groups include senior leaders across health, education, children's social care, the police and the voluntary sector.

2.4 The MSCB's Work on Neglect

Neglect remains one of our cross-cutting priorities. There is evidence from the numbers of referrals that we are getting better at recognising incidents of neglect. However, we want to ensure that as a safeguarding system we:

- **a.** Have a shared understanding of neglect in all its forms
- **b.** Are able to recognise and intervene in cases of neglect
- **c.** Are able to raise community awareness and understanding
- **d.** Keep a clear focus on adolescent neglect

[3] The Office for Standards in Education, Children's Services and Skills (Ofsted) (2017) *Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board.*

2.4.1 Neglect Audit

In 2017, the Quality Assurance Sub-Group conducted a multi-agency audit of 3 cases. The audit was arranged around the journey of the child through the child protection system and included:

- a Child in Need Case
- a case where the child was subject to a Child Protection Plan and
- a case of a Looked After Child.

The audit found aspects of good practice including:

- good child centred work
- good recording of actions and decisions
- evidence of a good understanding of the types of neglect
- good multi-agency communication and information sharing.

The audit also identified some areas for further development:

- There is a need for more effective multi-agency communication especially with Early Years settings
- In complex cases, where parents have multiple needs and vulnerabilities, there is a need for practitioners to focus on the safeguarding of children whilst working with others to support the needs of parents
- We need to get better at engaging with fathers in child protection, especially in cases where the behaviour of the father places children at risk
- Effective early intervention in cases of neglect to prevent neglected younger children becoming neglected adolescents and subject to a wider range of adolescent risks and vulnerability.

2.4.2 Neglect Toolkit

The MSCB's Training Officer is an internationally recognised expert on the issue of neglect and has worked with the Learning and Development and Policy Sub-Groups in order to develop a Neglect Toolkit. The Toolkit is aimed at supporting practitioners in the early identification and assessment of neglect and in recognising the impact of the cumulative harm caused by neglectful experiences on children and young people.

The following three principles should guide the use of the Toolkit:

1. Focus on the lived experiences of children and young people
2. Adopt a holistic approach based on the domains of the Assessment Framework
3. Multi-agency approach to promote timely, evidence-based information sharing amongst practitioners and volunteers.

The Toolkit has been designed to consider different aspects of neglect experienced by children and young people, and includes a section on the parents and family history and functioning. It is intended to be used for children and young people at all stages of the journey of the child, from pre-birth assessments, pre-school and school ages to adolescents aged 18 years.

The Toolkit is to be used by all practitioners and volunteers working with children and their families in statutory and voluntary organisations. It is intended to offer practitioners the opportunity to evidence base and rate their concerns to help make a judgement as part of an early help or statutory assessment approach.

The Toolkit was piloted between March 2018 and July 2018. An evaluation report will come to the Board in September 2018.

3.0
Local context and need of the childhood population for Merton[4]

3.1 Merton the place

Merton has a total population of 209,400 including 48,200 children and young people aged 0-18 (Census 2011) between 2012 and 2016 the 0-18 population increased by 4%. This growth is predicted to increase by between 4% and 6% by 2020, based respectively on the GLA population projections for its Strategic Housing Land Availability Assessment and its alternative trend forecasts, which take additional factors into account. Within the whole child and young people's population increase, there are variations for different age groups. Between 2011 and 2020 we can estimate the population (based on SHLAA 2015) increases as follows:

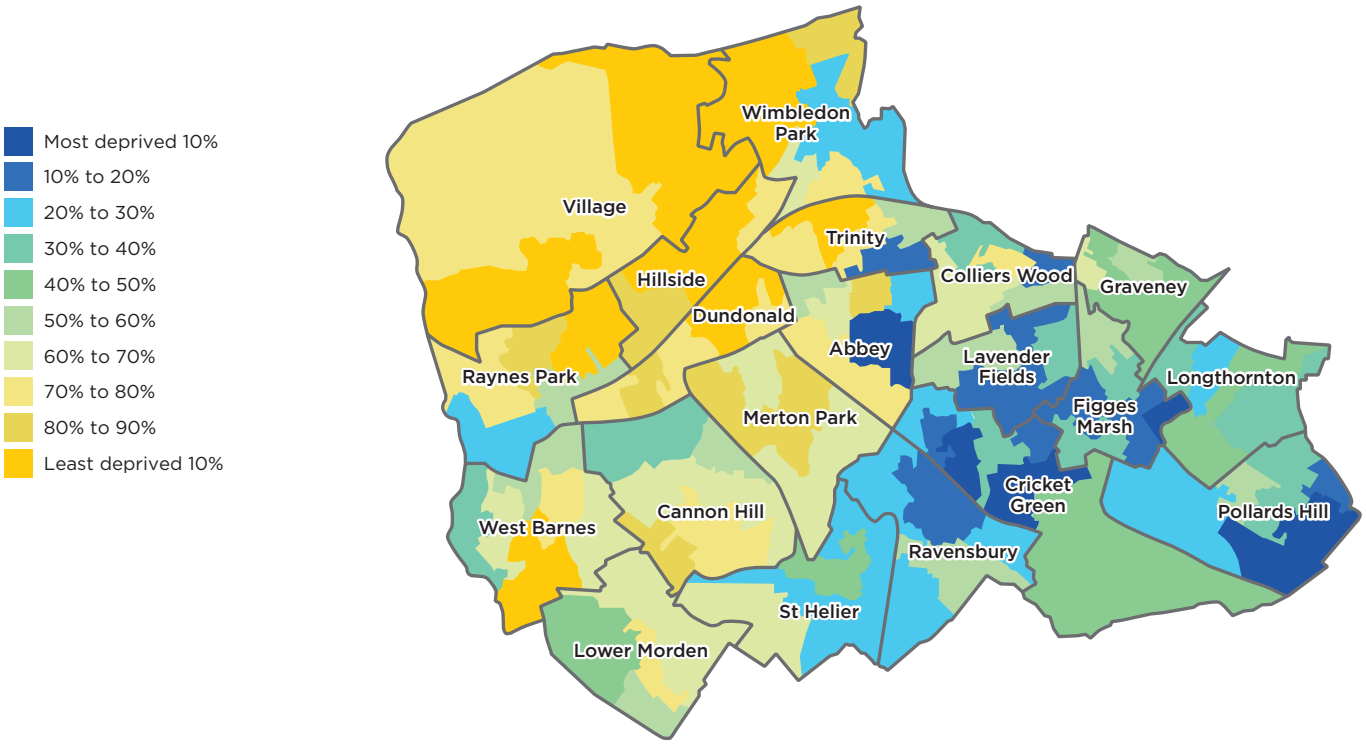
- Primary school children aged between 5 and 10 will have increased by 20%
- Secondary school aged children aged 11 to 15 will have increased by 13%.

Historically there was a 40% net increase in births per year from 2,535 in 2002 to a peak of 3,507 in 2012 and is approximated at 3,178 by 2020. This increase in births, together with other demographic factors such as migration of families into the borough, has already created the need for more school places, put pressure on early years and pre-school services, children's social care and early intervention.

East Merton currently has almost 17,800 5-17 year olds compared to 15,000 in west Merton. Both east and west Merton are predicted to show an increase in this age group by 2025 to 18,500 in the east and 15,600 in the west.

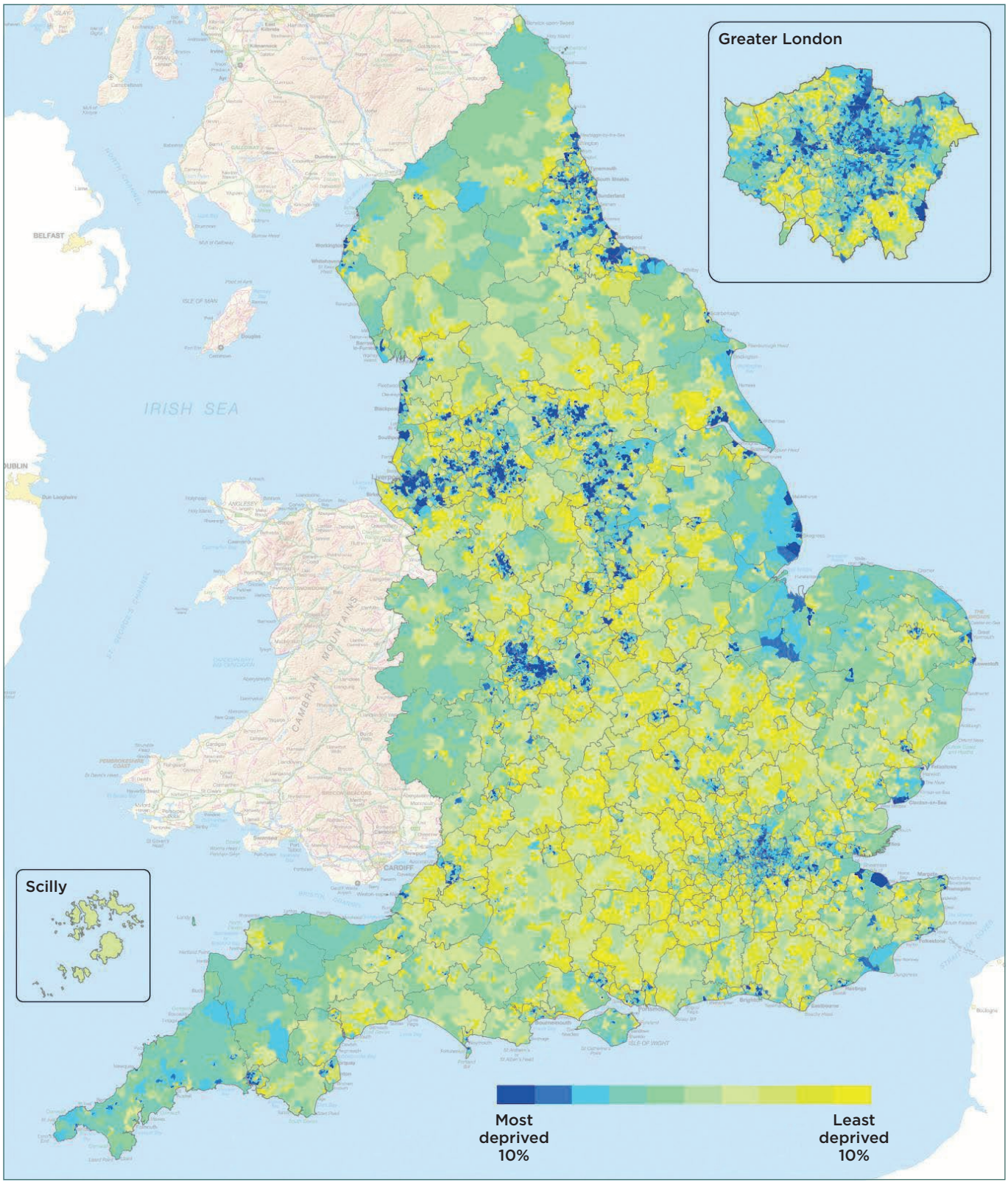
Predominantly suburban in character, Merton is divided into 20 wards and has three main town centres; Wimbledon, Mitcham and Morden. There are a number of pockets of deprivation within the borough mainly in the eastern wards and some smaller pockets in the central wards

Merton Income Deprivation Affecting Children Index 2015



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

UK Indices of Deprivation



(Mitcham and Morden towns). These wards have multiple deprivations, with high scores on income deprivation, unemployment and limited educational attainment. Five of Merton's 20 wards are amongst the 30% most deprived areas across England for children. This means 37% of Merton school pupils are living in an area of deprivation (30% most deprived, IDACI 2015). Since 2010 we have seen an increase of 32% of children who are eligible for free school meals (2010, 2881 FSM children, 2016, 3817 FSM children).

35% of Merton's total population is Black, Asian or Minority ethnic (BAME), this is expected to increase further to 39% by 2017. Pupils in Merton schools are more diverse still, with 67% from BAME communities, 44% with a first language which is not English, speaking over 120 languages (2016). The most prominent first languages for primary pupils apart from English are Tamil 7%, Polish 7% and Urdu 6%.

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

4.0
Merton's Children in Need, Children with a Protection Plan and those Looked After

4.1.1 Children in Need

Merton's Child in Need (CIN) rate per 10,000 (2016-2017) is lower than the London average of 308.1 and is also lower than the National average of 330.4. We are also lower than our statistical neighbours (SN) who are at 311.9. See table 1 below.

Table 1: Increases in CIN rate between 2011 and 2017

Year	2012-13	2013-14	2014-15	2015-16	2016-17	SN 2016-17	London 2016-17	National 2016-17
CIN Rate	336	355	338	411	287	311	308	330

4.1.2 Children Subject to a Child Protection Plan

Rates of Children subject to a Child Protection Plan in Merton in 2016-2017 remain lower than the London rate at 36.72; the Merton rate is 27.2. Merton is also lower than our statistical neighbours who are at 45.4. Please see table 2 below.

Table 2: Children Subject to a Child Protection Plan

Year	2012-13	2013-14	2014-15	2015-16	2016-17	SN 2016-17	London 2016-17	National 2016-17
Rate per 10,000	37.9	40.3	38.8	29.9	27.2	45.4	36.72	43.3

Source: LAIT

Nationally 3% of children were subject to a Child Protection Plan lasting for 2 years or more. The number of Merton children subject to a Child Protection Plan lasting 2 years or more is in line with the national averages.

4.2.1 Looked After Children

At 31 March 2017, the looked after children rate per 10,000 of the population, aged under 18 was 33.00. This is a slight decrease in rate from 35 in 2016. Merton had 161 looked after young people. Similarly both London and national averages held a steady course at 51.0 and 60.0 respectively. Overall, Merton's rate is lower than both national and London averages.

Table 3: Looked after children by 10,000 population

	2012-13	2013-14	2014-15	2015-16	2016-17
Merton	**31**	**34**	**34**	**35**	**33**
London	54	54	52	51	45
National	60	60	60	60	62

Table 4: Ethnic Group of Looked After Children

Ethnic Group	Number LAC during 2016-17	Percentage LAC during 2016-17	Number LAC on 31st March	Percentage LAC on 31st March	Number of Care Leavers (S24)	Percentage of Care Leavers (S24)
Asian or Asian British	17	7%	10	6%	18	10%
Black or Black British	48	20%	33	21%	44	25%
Mixed Heritage	34	14%	22	14%	19	11%
White or White British (includes White Other and White Irish Traveller)	106	45%	70	45%	65	37%
Chinese	0	0%	0	0%	0	0%
Any Other Ethnic Group	29	12%	19	12%	32	18%
Not Obtained	1	0%	0	0%	0	0%
Refused	0	0%	0	0%	0	0%

Looked After Children with Stability in their placement

As at 31st March 2017, 71% of Children who had been looked after continuously for at least 2.5 years, were living in the same placement for at least 2 years. This is an improvement on the 68% outturn in 2016 and places Merton slightly above national averages.

Table 5: Percentage of Looked After Children with Stability in their placement

	2012-13 (31st March)	**2013-14** (31st March)	**2014-15** (31st March)	**2015-16** (31st March)	**2016-17** (31st March)
Merton	**64%**	**55%**	**54%**	**68%**	**71%**
National	67%	67%	67%	68%	70%

Source: SSDA 903

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

Table 6: Care Leavers in Touch

	2015-16		**2016-17**	
Merton	**Number**	**%**	**Number**	**%**
Yes	132	89%	154	87%
No	3	2%	7	4%
Service No Longer Required	3	2%	14	8%
Young Person Refuses Contact	7	5%	2	1%
Young Person Returned Home	3	5	1	1%

Source: SSDA 903

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

Key Information: Care Leavers 2016-17

There were 161 Care Leavers aged 18 to 21 years old during 2016-17:

- 87% of Care Leavers aged 18 to 21 were in-touch with Merton CSF (140 out of 161 Care Leavers)
- 54% of in-touch Care Leavers aged 18 to 21 are using semi-independent provision (75 out of 140)
- 95% of in-touch Care Leavers aged 18 to 21 were residing in suitable accommodation at the point of contact (133 out of 140 in-touch Care Leavers)
- Majority of in-touch 18 and 19 year old care leavers residing in 16+ Semi-Independent provision at point of contact.

Table 7: Percentage of Care Leavers in Education, Employment or Training

	2013 (31st March)	**2014** (31st March)	**2015** (31st March)	**2016** (31st March)	**2017** (31st March)
Merton	**60.0%**	**47.0%**	**45%**	**66%**	**71%**
SN	67.8%	55.15%	52.2%	50.10%	
National	58%	45%	48%	49%	

Source: SSDA 903

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

71% of our care leavers are in education, employment or training (2015/16) this is a significant improvement on 2014/15, 45% and can be attributed to actions delivered against our Care Leavers Strategy. 95% of care leavers (aged 19, 20, 21) were living in 'suitable accommodation' in 2016/17.

4.3 Children at Risk of Sexual Exploitation

Over the past 3 years we have had an average of 33 referrals to our Multi-Agency Sexual Exploitation (MASE) Panel. Notably the last year (2017/18) has seen a significant decrease in referrals. Coupled with an increase of cases closed (placed on 'ICE') the number of CSE Open cases at the end of March 2018 was only 13 children.

Numbers of referrals to MASE:

- In 2015/16 referrals totalled 38 – total iced 30, re-referrals 0
- In 2016/17 referrals totalled 41 – total iced 44, re-referrals 4
- In 2017/18 referrals totalled 21 – total iced 35, re-referrals 4.

The majority of referrals are girls with an average age of 14 years.

- 2015/16 average age 14 years, ranging from 8 years to 17 years. 3 male
- 2016/17 average age 14 years, ranging from 9 years to 17 years, 2 male
- 2017/18 average age 14 years, ranging from 12 years to 17 years, 0 male
- 46% of the children referred are White British (63 of 136)
- 27% are Black British, Black African or Black Caribbean
- 24% are Mixed or 'other'.

The most recent 'Dashboard' in regard to CSE was completed 30th September 2017. This outlines all those referred to MASE during 2017/18 and of those referred (32 young people), Social Care's involvement is outlined as follows:

- 18.7% (n6) were Looked After
- 18.7% (n6) were on a Child Protection Plan
- 21.8% (n7) were on a Child in Need Plan
- 0.31% (n1) was a Care Leaver.

Current open cases are tracked each month at the MASE meeting.

Summary of CSE Activity in 2017-2018

- A piece of joint work was specifically undertaken with a cohort of young people attending a local library where CSE concerns were raised among a number of other behavioural concerns. This involved collaboration with Participation Services, Catch 22, Mayor's Office for Policing And Crime (MOPAC), VWAG Worker and the Library staff. This created a safe space for young people to develop trusting relationships with workers that could signpost them to relevant services.
- Awareness raising and collaborative initiatives are undertaken on a regular basis. These include the Annual CSE Awareness Day that offers short sessions of training focusing on particular areas of vulnerability linked to CSE. Each term there is a CSE Champions meeting that shares intelligence and knowledge to support early identification.
- A Young Women and Girls (YWAG) worker is supervised by the Lead within the Adolescent Service but based in the MASH team one morning a week and attends weekly missing meetings, Cross Borough Meetings and CSE strategy meetings.
- The MSCB launched a refreshed CSE Strategy and Protocol in 2017 to align with the new definition of CSE and clarify referral processes.
- A number of schools in Merton use PHSE lessons as the forum for promoting and raising awareness of CSE with pupils.
- Merton implemented CSE Champions' Meetings where staff from some of Merton's secondary and primary schools, who are designated leads on CSE, meet. Other attendees and champions come from health, voluntary sector and alternative education.
- Training on gangs and CSE is delivered by the CSE Lead and MOPAC workers at least twice a year.

- Catch 22 CSE service was commissioned in 2017 to receive referrals for young people in Merton at high risk of CSE. The CSE team delivers targeted initiatives and 1:1 work with identified young people at risk of and/or experiencing CSE.
- There has also been a number of young people referred who are on the periphery/associating with other vulnerable young people known to be at risk of either CSE or being groomed/exploited for sex, gang, criminal and/or drug related activity. The Catch22 CSE service also provide workshops and presentations to raise awareness.
- Catch22 has had a high rate of engagement from referrals. In the year to date (April to December 2017) there were 26 Referrals and 23 Engaged. The number of referrals decreased when the newly appointed Young Women And Girls (YWAG) worker started in post. A process for managing the referrals to either Catch22 CSE or the YWAG was established between the LBM CSE Lead and the Catch22 Service Manager.
- The WISH Centre are an organisation who specialise in providing support for young people at risk of self-harm and also have started to provide services for young people in Merton who are also at risk of sexual violence.
- Cross borough working around CSE and missing children is managed primarily by the Police. We recognized that this was an area that required further development and we utilized our current partnerships to develop this further. The CSE lead makes contact with boroughs that place young people with CSE risks within Merton to ensure safety plans are in place.

4.3.1 CSE and Looked After Children

There continues to be a strong grip on the issue of looked after children and CSE. The Promote and Protect Young People Strategic Sub-Group (PPYPS) has strategic oversight of CSE and looked after children and reviews multi-agency performance of this issue at each meeting. In addition to this looked after children who are at risk of CSE are reviewed at each MASE meeting. In 2017-2018, Merton had two looked after young people who were identified as being at risk of CSE.

4.3.2 CSE and Out of Borough LAC Cases

Whilst the desire is normally to keep young people in the local area, in some cases we have placed young people away from the borough because of our concerns about the individual. For some young people placements away from their home community is a key part of the care plan as a result of their vulnerability to exploitation in this borough or neighbouring boroughs. For some the needs of the young people are such that they require specialist placements which are not available in Merton or surrounding boroughs. For all children being placed outside of the borough the DCS is required to sign off agreement for the placement. Care plans for these children and young people are reviewed to ensure that where possible they are supported to return to their home community at the earliest opportunity. These cases are all held open to the CSE Operational Lead and monitored for a period of time while the placement settles and the CSE is deemed to no longer be a risk. If CSE is felt to still to be a risk whilst the young person is in placement they will remain open and monitored with a plan in place ensuring support for the young person.

4.4 Children Missing from Home and School

Children Missing Education(CME)

CME Panel 2015-16	CME (Off Roll)	Vulnerable to CME (On Roll)
Number of cases discussed	128 CME (Off Roll) cases discussed at CME Panel during 2015-16 Academic Year (26 cases open at end of AY; 102 cases closed during AY) 18% reduction	123 Vulnerable to CME (On Roll) cases discussed at CME Panel during 2015-16 AY (36 cases open at end of AY; 87 cases closed during AY)
Panel timeliness	96% CME (Off Roll) cases actioned and closed by CME Panel during 2015-16 Academic Year within three months of case start date (up by 15 percentage points compared to 2014-15)	57% Vulnerable to CME (On Roll) cases actioned and closed by CME Panel during 2015-16 Academic Year within three months of case start date (in line with 2014-15 academic year)

CME Panel 2016-17	CME (Off Roll)	Vulnerable to CME (On Roll)
Number of cases discussed	129 CME (Off Roll) cases discussed at CME Panel during 2016-17 Academic Year (25 cases open at end of AY: 104 cases closed during AY) 19% remaining open	131 Vulnerable to CME (On Roll) cases discussed at CME Panel during 2016-17 AY (61 cases open at end of AY: 70 cases closed during AY)
Panel timeliness	89% CME (Off Roll) cases actioned and closed by CME Panel during 2016-17 Academic Year within three months of case start date	52% Vulnerable to CME (On Roll) cases actioned and closed by CME Panel during 2016-17 Academic Year within three months of case start date

On average 130 to 150 Off Roll children and young people are discussed at the CME Panel each academic year. 89% of all CME Off roll cases during 2015/16 were actioned and closed by the panel within three months with a target of 90%.

The DFE guidance for all schools (Maintained, Academy and Independent) on referring all off roll and on roll children via the LA has significantly increased the workload of Education Welfare Service (EWS). The Council has increased resources to the team and the team have stopped other functions to comply with the guidance. We predict that this will be over 1,500 children by September 2018 within the school year. Of these approximately 30% require case intervention by EWS.

The patterns emerging from this data are:

- International families in the UK to work (Non-EU and EU) – usually in Wimbledon.
- Evictions from the private rented sector – more commonly in Mitcham.
- Some pupils will withdrawn due to the parental view of the quality of the school, issues in school or needs of the child.

All cases are tracked and over 95% resolved with the year. Some will transfer to Elective Home Education (EHE). There is a robust system in place to ensure that children who receive EHE are safe. This is managed by the EWS.

CME policies and procedures, comply with the revised Statutory Guidance and *Keeping Children Safe In Education 2018*. Merton's EWS promotes and enforces regular and punctual school attendance. EWS support schools, parents and students to ensure that a child of compulsory school age has access to education and attends school regularly and punctually or receives a suitable education other than at school as well as ensuring that risks are well understood and minimised. Merton's school attendance is very good, above national, London and outer London in primary, secondary, special and PRU.

CME Multi-Agency Panel reviews all children who are missing education and tracks actions to return them to full time education. This panel meets monthly.

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

We are vigilant on illegal schools and have worked closely with neighbouring boroughs on Merton residents that have attended out of borough illegal schools this year.

We work pan-London on quality assuring Alternative Education Provision to ensure safety and quality.

Actions to Address Children Missing From Home and Care

- Ongoing strengthening of 'Multi Agency Missing from Care and Home Panel' supported by a 'Missing dataset' which identifies other vulnerabilities including CSE and CME.
- 'Weekly Missing Meeting' established in April 2016 and embedded in response to a need to strengthen multi agency operational working to ensure that children receive timely support from appropriate services including a return home interview.
- Policies and procedures are in place to deliver a well-coordinated response to children who are reported as missing from home or care (reviewed and refreshed to be presented to the Board in September 2018).
- Ongoing utility of Police Missing Person Co-ordinators analysis of repeat locations and individuals for missing persons meetings.
- Independent organisation (Catch22) commissioned to work as part of a wider interagency team to provide practical and emotional support and prevent/reduce episodes of going missing. Catch22 also provide 'return home interviews'.
- With regards to children/young people known to Children's Social Care, case management of CIN/CP CYP missing from home is improving and recording and case management of Looked after Children missing or absent has improved over the last 12 to 18 months.
- All in-house foster carers have received 'missing and absent' procedure training.
- 'Children Missing' policies and procedures are checked as part of the placement commissioning process. Agency foster carers and residential placements are required to report missing episodes in a timely way to the Council and Police and are required to support the Council to implement safety plans.

Action Taken To Address Children Missing from School

- A strong partnership approach of the multi-disciplinary Hard to Place and CME Panels.
- Maintained our strong performance with low levels of NEET and achieved significant reduction of numbers of young people in the "Not Known" category.
- CME/PA protocols between Education and Social Care services strengthened with regular reporting to CSF Continuous Improvement Board.
- Briefings provided to Primary and Secondary School head teachers on safeguarding risks associated with absence from school and reinforced as appropriate in termly designated teachers' events.
- Specific guidance provided to schools on forced marriage, female genital mutilation, child trafficking and Prevent.
- Continued to improve school attendance and maintained our strong focus on preventing permanent exclusions.
- Developed schools and early year's' settings safeguarding audit tool and guidance.
- Adopted a vigilant approach to the quality of alternative education provision in the borough and the identification and notification of unregistered schools.
- Strengthened Education Welfare Service focus on the home education process where families opt to educate children other than at school (EOTAS). Action is taken by the authority in relation to unregistered schools, we are activity monitoring and liaising with Ofsted where necessary.
- Ongoing commitment to Schools Police Officers with a proactive prevention programme and key link role.
- Rolled out changes in relation to Pupil Registration Regulations 2016 regarding on and off rolling.
- Further developed the CME panel dataset and intelligence analysis.
- Consolidated school partnerships and further developed the Merton Education Partnership, used forums to highlight Safeguarding. Developed schools and early years Safeguarding audit tool and guidance (In early years all funded support and targeted support settings).

4.5 Prevent

The Board's Promote and Protect Young People Strategic Sub-Group works with Safer Merton to ensure that there is strong grip and clear oversight of all prevent cases involving young people. The MSCB has worked hard, along with Safer and Stronger, to achieve strong engagement with the 'Prevent' agenda involving key partners including police, schools, early year's settings and with faith, voluntary sector and wider communities. Merton has not been identified as a Prevent Borough.

There is comprehensive Prevent Guidance available to staff via the MSCB and a programme of training for staff and external stakeholders in the borough.

CSF supports schools to deliver the Prevent Duty which is evident by:

- The provision of Governor training;
- Annually every school trains all staff;
- The use of Head Teachers meetings to discuss Prevent matters;
- Schools undertake IT monitoring and the London Grid for Learning is in place in all schools;
- Schools are teaching British values and there are a range of curriculum projects to support this; and
- The borough operates a strong Standing Advisory Committee on Religious Education (SACRE) with involvement from Prevent and Counter Terrorism Police.

Prevent referrals are all managed through the MASH. This ensures safeguarding measures to be put in place from the start of a referral. The Channel Panel has representation from the MASH and enables appropriate case discussion to implement appropriate safeguarding measures.

The local delivery of Prevent was scrutinised as part of the OFSTED inspection that took place in June 2017 and rated as 'Good'. One of the

inspectors led a focus group discussion with the partners that support local delivery. The borough was able to demonstrate that through strong partnership working; effective safeguarding plans were in place to support Merton's young people.

An area for development is ensuring that Prevent concerns about cases discussed at other panels, such as MAPPA or Offender Management, are shared with the Channel chair (either informally or via a referral). In 2017-2018 there were 11 referrals relating to Prevent; of these referrals 7 were Merton children (1 becoming a Channel Case).

4.6 Female Genital Mutilation

The Board refreshed its multi-agency guidance on Female Genital Mutilation (FGM) in 2017-2018 and provided a range of briefings and multi-agency training sessions on FGM. The Board provides multi-agency training on FGM, which is well attended. The Board also provides 'red alert' briefings to Merton schools around Easter and Summer holidays, which have been identified as key risk periods for FGM due to the length of the holiday period. There were 10 women identified with FGM in Merton.

5.0
Statutory and Legislative Context

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Children and Social Work Act 2017, received Royal Ascent on 27th April 2017. The Act will abolish LSCBs, replacing them with Safeguarding Partnerships. Working Together to Safeguard Children 2018 was published in July 2018.

Section 16 of The Children and Social Work Act 2017 amends the Section 16D of the Children Act 2004 Act. The Act provides that

(1) The safeguarding partners for a local authority area in England must make arrangements for:

(a) the safeguarding partners, and

(b) any relevant agencies that they consider appropriate, to work together in exercising their functions, so far as the functions are exercised for the purpose of safeguarding and promoting the welfare of children in the area.

(2) The arrangements must include arrangements for the safeguarding partners to work together to identify and respond to the needs of children in the area.

(3) In this section:

"relevant agency", in relation to a local authority area in England, means a person who:

(a) is specified in regulations made by the Secretary of State;

and

(b) exercises functions in that area in relation to children.

"Safeguarding partner", in relation to a local authority area in England, means:

(a) the local authority;

(b) a clinical commissioning group for an area any part of which falls within the local authority area;

(c) the chief officer of police for a police area any part of which falls within the local authority area.

These duties are further clarified in the statutory guidance: *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2018, Chapter 3* (WT 2018)

LSCB duties are specified in WT 2018, Chapters 3, 4 and 5, with a responsibility to have oversight of single agency and multi-agency safeguarding and promotion of children's welfare (under Children Act 2004, section 11,) as set out in WT chapters 1 and 2.

6.0
MSCB Inter-relationships and Influence with other Key Partners

The Board has a rolling 24-month Business Plan, to be refreshed each March for the business year starting each April. The update of the MSCB Business Plan for 2017-2019, agreed by the Board in June 2016, is attached as Appendix 1. The Business Plan outlines the Board's priorities for 2017-2019 and was agreed by the Board at its annual Away Day in March 2017. Priority items can be added within the year.

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

The current membership[5] of the Board includes the following statutory partners:

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

Membership of the Board also includes:

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

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

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

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

7.0 MSCB Sub-Groups

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

7.1 Quality Assurance Sub-Group

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

The QA Sub-Group undertook the following activities between March 2017-2018:

- Conducting a multi-agency audit on the theme of Children with Disabilities in May 2017
- Conducted a multi-agency audit on the theme of neglect.

The Sub-Group also monitored the following action plans to ensure effective implementation:

- Monitored the implementation of the Child B Serious Case Review (SCR) Action Plan
- Monitored the implementation of the Baby C Learning and Improvement Review (LiR) and a multi-agency quality assurance framework to ensure that the learning from this is cascaded across all agencies
- Conducted a range of briefings regarding the learning from Multi-Agency audits and local LiRs and SCRs
- Maintained oversight of escalations to the MSCB.

The QA Sub-Group is overseeing the review of the MSCB Performance Dataset. A Task and Finish Group has been established and will meet during the autumn term to make proposals regarding performance to the Board.

7.2 Promote and Protect Young People Sub-Group

The Promote and Protect Young People (PPYP) Sub-Group met 8 times in 2017-2018. The purpose of the PPYP is to take overall lead responsibility on behalf of the MSCB to ensure that there are effective and up-to-date multi-agency policies, protocols and procedures to ensure children and young people are safeguarded and protected and their welfare is promoted; *concentrating on* ***extra-familial*** *abuse where there is risk of abuse outside the family.* PPYP is responsible for policies relating to issues like CSE, children missing from home, care or education, child on child abuse, other forms of exploitation (such as radicalization), e-safety, trafficking, abuse by those in a position of trust or in institutions – including faith organisations and community organisations; and policies and procedures in relation to allegations against those in a position of trust (Local Authority Designated Officer (LADO) referrals).

During 2017-2018, the PPYPS Sub-Group:

- Reviewed and refreshed the MSCB CSE Strategy to include the new DfE definition of CSE
- Reviewed and refreshed the MSCB CSE Protocol clarifying processes for referring and managing CSE cases
- Monitored the implementation of the CSE Action Plan
- Oversaw the work of the MASE Panel
- Review the work of commissioned services including parenting support, the work of Catch-22, Barnardos, Metro support for boys and young men, and the work with young people at risk from gangs, work with girls who are vulnerable to CSE and exploitation from gangs, the CSE Coordinator, parenting support work etc.
- Developing the work in relation to contextual safeguarding.

7.3 Learning and Development Sub-Group

7.3.1 MSCB Joint Conference with Children's Schools and Families Department and the Safeguarding Adults Board

The Merton Safeguarding Children Board (MSCB), Merton Safeguarding Adult Board and Merton Children's Social Care Joint Conference was held on 21st March at Epsom Jockey Club Conference Centre. The Conference theme was *Think Family: No Wrong Door a spotlight on parental mental health*.

The Conference was attended by almost 200 professionals from a wide variety of disciplines across adult and children's services and included strong representation from the private and voluntary sector. This year we were honoured to have in attendance a group of parents who were service-users; their contribution to the conference was invaluable.

The Conference featured presentations from Hannah Doody (Director of Community & Housing) and Paul Angeli (Assistant Director Children, Schools & Families). The MSCB's Training Coordinator, Carla Thomas gave a powerful presentation entitled, *The children are watching – the possible impact of parental difficulties on children and young people.* This was one of the most highly rated presentations of the Conference.

Our keynote address was delivered by Dr Crispin Day, from South London and Maudsley, NHS Foundation Trust, King's College, London, Institute of Psychiatry. The focus of Dr Day's presentation was on Transformational Parenting and helping us think through the services that are behind each 'door' or access point.

7.3.2 MSCB Training

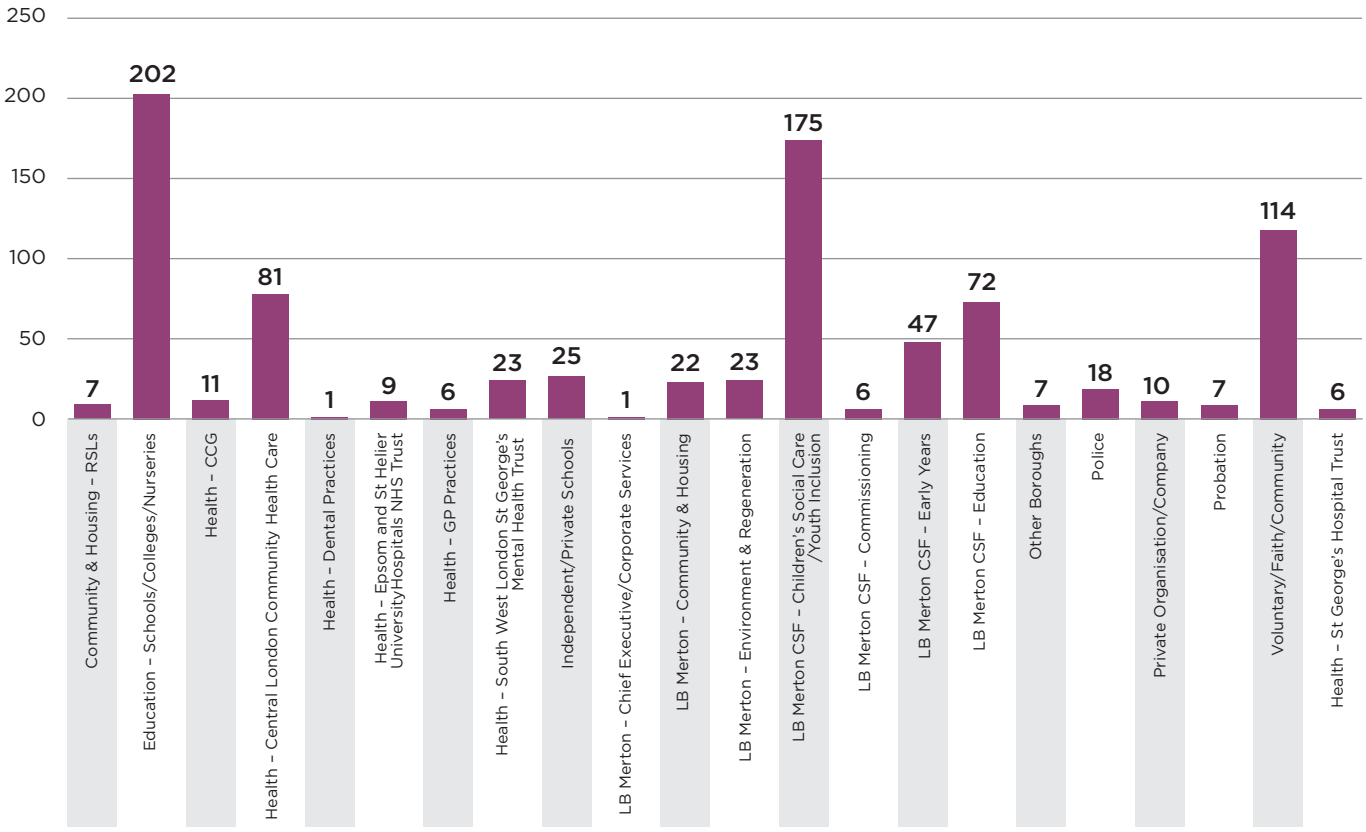
The table below gives a quick overview of the number of planned and run training events from April 2017 to March 2018.

The table overleaf indicates attendance per course and per agency.

MSCB Training 2017/2018

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Planned events	4	9	7	6	0	9	5	7	1	3	5	8	64
Added events			1			1		5	1	2	2		12
Cancelled events	1	2	4	2		1		4	1		1	2	18
Actual events	3	7	4	4		9	5	8	1	5	6	6	58
Booked	28	126	39	68		125	81	142	8	79	83	267	1046
Cancellations	1	9	1	10		8	12	7		4	4	8	64
DNAs	7	21	4	7		22	15	20	2	18	15	33	164
Extras	3	22	1	5		8	6	20		10	6	6	87
Number attended	**23**	**118**	**38**	**53**	**0**	**96**	**57**	**110**	**6**	**66**	**68**	**221**	**856**

MSCB training attendance per agency April 2017 – March 2018



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

The MSCB's Learning and Development Strategy was reviewed in June 2017. The strategy outlines the MSCB's approach to Multi-Agency Learning and Professional Development.

The provision of learning and development will be based on:

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

The MSCB's programme remains one of the most comprehensive multi-agency safeguarding training programmes in London, offering a wide range of training opportunities for multi-agency safeguarding practitioners. The training programme includes events booked until March 2019. We have recently added to the programme a series of briefings including:

- A briefing on Harmful Sexual Behaviour Protocol
- A briefing on the multi-agency working protocol for children living with parents with mental health problems
- A briefing delivered by Kingston LSCB on Learning lessons from a Kingston LIR which related to a family who were resident in Merton and known to Merton services.

The MSCB training programme is aligned to the Board's key priorities and reflects the learning coming out of our SCR and LiR as well as learning emerging from analysis of SCRs nationally.

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

7.3.3 E-Learning

As part of our on-going review of the MSCB's training offer, we have reviewed the E-Learning Programme. Unfortunately, there is limited takeup and completion of E-Learning Courses across the multi-agency safeguarding system; as a result, the Learning and Development Sub-Group confirmed the decision not to renew the MSCB's E-Learning License. This means that from 31st July 2018, the MSCB will no longer offer an E-Learning package.

7.4. Policy Sub-Group

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

7.5 Merton Child Death Overview Panel (CDOP)

The Merton Child Death Overview Panel has local arrangements to respond to and review child deaths in Merton in accordance with the Working Together to Safeguard Children (2018) guidelines. These include:

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

For the period 1st April 2017 to 31st March 2018 eight child deaths were reported to the Merton CDOP. Four of the eight child deaths were 'unexpected' and so subject to a rapid response meeting and one death was referred to the MSCB for consideration of a learning review, however the MSCB decision was the case did not meet the required threshold for a review. In all four unexpected deaths where a rapid response meeting was held the national timeframe of 5 days was met. One of the eight deaths reported occurred outside of the borough of Merton.

There were three CDOP meetings convened in 2017/18 and ten child deaths reviewed. The timeframe for the review of child deaths at CDOP is six months[6]. Merton CDOP reviewed 70% of child deaths within six months of the death which compares favourably with the national performance indicator of 24%[7].

The ten deaths reviewed were classified by CDOP as 'expected' and considered to have 'no modifiable factors'. Two of the child deaths reviewed concerned children who had life limiting conditions. Three of the child deaths reviewed were neonatal deaths (extreme prematurity) and no modifiable factors were identified. There were no cases reviewed that were classified as sudden unexpected death in an infant (SUDI).

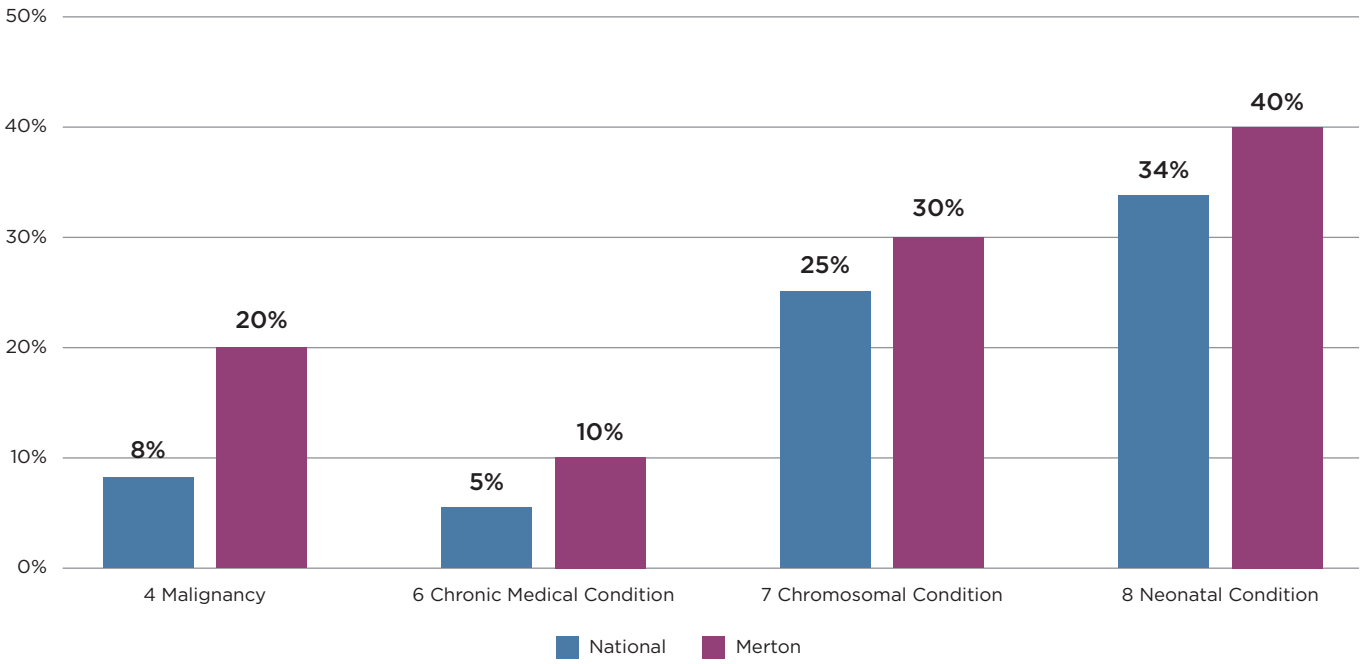
The categories of death for the ten Merton cases reviewed by Panel in 2017-18 were:

- Category 4: Malignancy (2)
- Category 6: Chronic medical condition (1)
- Category 7: Chromosomal condition (3)
- Category 8: Perinatal/neonatal event (4)

[6] National statistics from https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2017

[7] Ibid. as per (1) above.

Table 7: National and London Borough of Merton Categories of Child Death (%) 2017/18



National data (table 7) demonstrates Merton having higher than national percentage of child deaths relating to all the above conditions. In 2017-18 Merton has more than twice the amount of child deaths from malignancy-related conditions than national averages. In all other categories Merton is nominally more than national average, however the local numbers proportionately are small and should be interpreted with caution.

The Children and Social Work Act 2017 supported by national guidance will impact on how CDOPs function in the future; the sponsor for CDOP will shift to the Department of Health and each CDOP will be expected to review 60 deaths annually. The rationale for these changes being the vast majority of child deaths have a medical or public health causation and the increasing the number of deaths reviewed will enable meaningful analysis of data.

7.6 Youth Crime Executive Board (YCEB)

The Youth Crime and Prevention Executive Board (YCPEB) is chaired by the Director of Children's, Schools and Families. Membership includes senior representatives from Police, Children's Social Care (CSC), Education Inclusion, Probation, Housing, Public Health and the Clinical Commissioning Group (CCG). The YCPEB is the governance structure for Merton in relation to the work of the Youth Justice Team (the local Youth Offending Team), including production of the Annual Youth Justice Plan, performance management and quality assurance. It also oversees the partnership response to serious youth violence, gangs and the "Troubled Families" programme (known locally as Transforming Families) (TF). The YCPEB reports to the MSCB and the Safer and Stronger Partnership, which has wider oversight of crime issues in the borough.

The YCPEB's key priorities over the past year have involved maintaining and monitoring the team's performance against the Youth Justice Board's three key performance indicators of reducing first time entrants to the Youth Justice system, sustaining low numbers of young people

who are sentenced to custody and reducing the number and rate of young people who reoffend. The YCPEB priorities have also been in regard to delivering the TF programme and reducing the serious youth violence and gang activity in the borough. Therefore the YCPEB contributes to all three of the MSCB priorities in regard to Think Family, Early Help and Vulnerable Adolescents.

Following a restructure in April 2018, the Youth Justice Team, Transforming Families Teams and newly established Tackling Exploitation Team (managed by the CSE Lead) have been placed into a new service, which the staff renamed as the Adolescent and Family Service. The YJT Manager's post has been deleted and assimilated into the Head of Service post, which sits within the Children's Social Care and Youth Inclusion senior leadership team. The YJT is a multi-agency service with seconded staff from Police, Probation, Education, CAMHS, Catch22, Nursing and Social Care. The YJT undertakes assessments and delivers interventions with young people receiving a formal disposal from either the Police (pre-court outcomes) or the courts (statutory orders) and also has a bespoke specialist offer for parents. The Transforming Families team delivers targeted interventions with families aiming to intervene effectively before problems escalate within a family. This involves working closely with schools, academies, the Police and the Education Welfare Service. The team has a targeted parenting officer who provides group work. The MOPAC funded gangs' worker in TF delivers both group work and individual interventions with young people involved in gangs and/or serious youth violence.

The YCPEB oversees Merton's response to new legislation, the inspection regime, its local crime reduction and prevention initiatives, monitors issues concerning risk and safeguarding and ensure staffing and resourcing levels are in place to maintain performance and effectiveness within the delivery of the youth crime and prevention services.

A partnership development in the last year has been the implementation of a Liaison and Diversion Service within the YJT, commissioned by the CCG and funded by NHS England. The aim is to liaise with Police and other professionals at the earliest opportunity when a young person enters the criminal justice system (usually at the point of arrest) to assess their health and wellbeing needs and consider potential diversion opportunities for these needs to be met outside of the criminal justice system. The funding has allowed for the 0.5fte CAMHS Forensic Psychologist position in the YJT to be extended to full-time, thereby offering a flexible response to cases across the system. The funding has been utilised to also extend the Speech and Language Therapy (SALT) hours to allow a service for pre-court outcomes and to commission a specialist consultant for harmful sexual behaviour training and consultancy (for all services).

The CCG has also identified a gap in regard to young people on the edge of the criminal justice system (often involved with the Transforming Families Team) and will be putting forward a business case for an additional 0.5fte provision to meet this gap and ensure that a health offer is provided across the criminal justice pathway, as per the Transformation Plan and Health in Justice framework.

Merton's Borough Police have recently undergone changes to merge as a Borough Command Unit with Wandsworth, Kingston and Richmond. This has resulted in changes of personnel representing different target areas (safeguarding, neighbourhood safety, investigations). The Superintendent of Neighbourhoods now represents the Police at the YCPEB. The change has positively impacted the YJT and seen an increase in staffing from the Police with a second seconded Police Officer (0.8fte) joining the YJT in September 2018. This will allow for more capacity to undertake joint work and contact victims of youth court outcomes in compliance with both GDPR and the Victim Code.

The YCPEB monitors performance through quarterly 'dashboard' reports, summaries of the highest risk young people monitored at the Youth Offender Management and Gang Multi-Agency Panel, receiving notifications from partners and the Youth Justice Board in regard to national changes and developments and through audit reports.

The YCPEB is preparing for a new inspection framework from HMIP, which includes a casework audit but has been extended to include an assessment of the governance and leadership of youth justice and the pre-court work carried out by both Police and the YJT. The Board members have attended a 'visioning event' with the YJT staff to understand the work undertaken by all the team members, which was presented through a roleplay and 'interesting facts' handout. This was followed by roundtable discussions to allow both board members and YJT staff to discuss examples of good practice and any barriers to achieving positive outcomes. The event was seen as a success and is likely to be repeated in future, including with representatives from children's social care and schools. The YCPEB has also supported the process of a peer review between Merton YJT and their neighbouring YOT in Sutton, which will focus on the elements of governance and leadership. The YJT will also have an external audit, which should provide a benchmark for further actions since the last external audit was completed in November 2016.

Due to the small cohort currently entering the system and receiving statutory orders the changes in performance can be dramatic and last year saw a rise in both custody and re-offending rates, which has been analysed in more detail within the Youth Justice Plan.

The YCPEB commissioned the IT team to create profile reports from the YJT case management system (Careworks). This has enabled a more robust analysis within the Youth Justice Plan and a detailed summary of the needs and barriers to desistance presented by the majority of cases. These have been particularly striking in regard to mental health, social, learning and communication needs, substance misuse and relationship difficulties. This therefore allows for a focused and targeted response to those most at risk of re-offending or causing harm and supports the continued provision of a multi-disciplinary team to work with the most entrenched cases on statutory orders.

A rising concern is that of criminal exploitation, in particular 'county lines' drug dealing. The Youth Justice Team was successful in gaining grant funding from the Home Office to deliver a pilot project aimed at preventing young people's involvement in serious and organised crime. Merton was one of three areas in England and Wales to be granted the funding. The project prioritised cases with Class A drug supply, particularly those in county locations, as a response to the Local Assessment Process undertaken by the Community Safety Institute in February 2017. The pilot worked with eight young people and another 15 cases were identified as involved in county-lines. The mapping of these 23 cases has identified a number of trends in regard to education, peer groups and family needs. A presentation was given to the Merton Partnership in February 2018 by the YJT, TF and Safer Merton managers in regard to gangs, serious youth violence and exploitation, highlighting that while the numbers are small the impact has been significant due to the type of violence (sometimes involving samurai swords or machetes) and the link between Merton's young adults and a small number of murders in London during 2017. Further presentations were made to the Children's Trust and MSCB and a joint knife crime plan is being developed in Merton, led by partners but in collaboration with the YJT and TF.

One of the MOPAC funded workers in the Adolescent and Family Service has been supporting victims of serious youth violence and engaging young people on court orders into restorative justice processes. With the rise in county lines and knife possession his role has evolved with most referrals for young people on orders being those at risk of criminal exploitation (in addition to victims of serious youth violence to engage them in restorative approaches). Therefore, his job title has changed from 'reducing reoffending worker' to 'reducing criminal exploitation and violence worker' and he has moved from the YJT into the Tackling Exploitation Team in order to maintain this expanded area of work alongside the child sexual exploitation processes.

In order to maintain joint oversight to reduce the risk, exploitation and harm caused through exploitation and serious youth violence the chairs of the current adolescent panels (Police DCI for Safeguarding and the YJT manager / Head of Service) have developed an integrated multi- agency risk, vulnerability and exploitation (MARVE) panel. The panel will discuss children most at risk or vulnerable to exploitation or harming others and will combine the other adolescent panels previously held within the borough (MASE, Persons of Concern, Young Offender Management Panel, Gangs Multi-Agency Panel and TF). The panel is outlined within the MARVE Protocol, co-written by the CSE Lead, which integrates elements from other protocols (Serious Youth Violence and Criminal Exploitation, Child Sexual Exploitation, Harmful Sexual Behaviour), which all provide workers with clear definitions, responses, pathway routes and actions plans, including responsibilities for children in Merton and/or looked after by Merton.

The focus for the YCPEB in the next year will be to improve performance in regard to re-offending and use of custody, consider avenues for sustainable services in light of the funding for TF ending in 2020 in parallel to reductions in YJB Grant and MOPAC funding, supporting the integrated management of exploitation and harm, ensuring high quality services and staffing are in place for the most high risk and vulnerable adolescents, be 'inspection-ready' and confidently sharing good practice.

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

The MSCB is committed to addressing the violence against women and girls. The strategic aims outline four priority areas in tackling VAWG and domestic abuse, which are:

1. Providing accessible, evidence-based, holistic support to people who have experienced or are at risk of VAWG
2. Implementing effective systems and interventions for working with perpetrators
3. Fostering an integrated and coordinated approach to tackling VAWG
4. In order to deliver the four strategic aims this action plan is split into to four priority themes:

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

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

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

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

Key achievements or highlights for 2017-2018.

The Merton VAWG board oversaw a range of work during 2017-18:

- Merton was the first London Borough to adopt the "Ask Angela" campaign which works to address sexual violence within the night time economy. Based on our work this campaign has now been adopted by the Metropolitan Police who are now rolling this out across the city. Wimbledon has 100% coverage and the rest of the borough has 90% coverage of the scheme.
- Work undertaken through the campaigns resulted in some increases in reports for quarters 1-3 however reporting in quarter 4 reduced. The reduction may coincide with there being no sustained promotion during these months. The seasonal peaks for DV reporting for August and December have changed slightly with August still being a peak month but December reports had lowered and as such we now ensure that services are ready for these profiled seasonal increases.
- The partnership agreed to commence work on a sexual violence profile. This work will be undertaken in the 2018-19 financial year and will drive forward our next 12 months focus on the NO MORE campaign.
- Merton's Police achieve 22.3% successful detection rate (July 2017 – June 2018) for Violence with Injury (Domestic Abuse) the second best in the MPS. There has been a 10% increase in DVA reports in the last 12 months.
- Operation Dauntless is the Metropolitan Police Service's range of responses to the issue of domestic violence; the use of the approach with higher risk suspects is now routine.
- Delivered a full programme of activities for the 16 Days of Activism 2016. This included a learning day, a cake sale, an event at Merton College and a tweet a day via Twitter and Facebook.
- Continued providing training support to the MSCB.

- Recruited a Victim Champions post.
- Looked at the Pan London Housing Reciprocal protocol that has been rolled out across London to determine how Merton can be involved.
- A special meeting to look at JTAI Multi-Agency response to children living with domestic abuse and have briefed agencies in preparation to an inspection.
- The VAWG Strategic Partnership has been involved with developing the Children' Schools and Families DVA Strategy.

As we move forward through 2018-19 we will continue to build on this work by:

- Embedding the Victims' Champion and developing the strategic offer of VAWG sub-group further.
- Completing the Sexual Violence Profile and considering how the outcomes of this will change operational delivery and strategic commissioning.
- Completing an overview profile of all VAWG strands which are less understood within Merton.
- Conduct a light review and update of the DVA profile in advance of the 2019-20 full review.
- Discharging our year two priorities from the VAWG strategy and developing the detail around our year three ambitions.
- Continue to build on our successes of the NO MORE and Ask Angela campaigns to further improve reporting rates within the borough.
- Commission a new DVA service for 2019-2021 to ensure that Merton can meet the needs of our DVA victims moving forward.
- Develop and deliver an improved programme of events during the 16 Days of Activism campaign 2017, deliver a robust programme of events for NO MORE week 2018 and ensure that the VAWG partnership acknowledge all international, national and/or local days around VAWG.

7.8 MASH Strategic Board

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

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

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

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

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

7.9 Structure and Effectiveness of the MSCB

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

The Board has 100% compliance with its section 11 process for statutory agencies. This was supported

by a rigorous Peer Review and Challenge process to which challenged each agency to demonstrate their effectiveness in safeguarding and promoting the welfare of children locally.

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

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

The Board is assured by partner agencies regarding their recruitment and supervision of persons who work with children as part of our Section 11 process. There are arrangements in place for the LADO. The Board also receives the private fostering annual report in January each year.

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

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

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

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

Since 2012 the MSCB has:

- Submitted 7 serious incident notifications to Ofsted
- Completed two SCRs (the Tia Sharpe SCR and the Child B SCR)
- Completed 3 learning and improvement reviews (Child J, Baby PP and Baby C).

As noted in this report, the Board was inspected by Ofsted in June-July 2017. Inspectors found that:

Merton's Local Safeguarding Children Board (MSCB) is outstanding. It is highly effective in holding agencies to account for their individual safeguarding arrangements in the welfare and protection of children.

Inspectors also reported that:

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

7.10 MSCB Budget

The MSCB has an agreed budget to which agencies contribute. Its income for 2017/2018 was £248,470. The MSCB Budget for 2017-2018 is detailed as follows:

Brought forward from 2016-2017	£18,642
Income for 2017-2018	
Agency Contributions	
CAFCASS	£550
London CRC	£1,000
London Probation Service	£1,000
London Borough of Merton	£142,030
Merton CCG	£55,000
Metropolitan Police	£5,000
Sub-total	**£204,580**
London Borough of Merton Baseline supplement[8]	£43,890
Total	**£248,470**
Expenditure	
Staffing	£144,170
Premises	£2000
Supplies and Services	£100,460
Transport	£1,840
Totals	**£248,470**
Brought forward from 2017-2018	£0.00

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

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

8.1 Harmful Sexual Behaviour Task and Finish Group

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

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

The task and finish group also consulted with schools and young people. The Harmful Sexual Behaviour Protocol was developed in accordance with the relevant chapters in the ***London Child Protection Procedures***[9], drawing upon the following local and national guidance:

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

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

The Harmful Sexual Behaviour Protocol was recommended to PPYPS and was approved by the Board in June 2017.

8.2 CSE Protocol and CSE Strategy Task and Finish Group

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

8.2.1 The CSE Strategy

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

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

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

8.3 Mental Health Protocol Task and Finish Group

A task and finish group was formed to develop a multi-agency mental health protocol. The document was drafted jointly by Merton Safeguarding Children Board and Merton Safeguarding Adults Children Board, which includes the Clinical Commissioning Group, South West London St George's Mental Health Trust. There was also consultation with commissioned services, voluntary organisations, young carers and parents who suffer from poor mental health.

This protocol is important for the safeguarding of children and families in Merton. It should be read and implemented when necessary by staff who deliver services to children and young people whose parents or carers have mental health problems, and staff who deliver services to adults who are parents or carers with mental health problems. The protocol applies equally to pregnant women and their partners where there are concerns about their mental health. The protocol also applies to adults with mental health problems who have contact with a child or children, even if they are not a parent or carer; for example, siblings, lodgers, family visitors, babysitters or childminders.

The protocol was approved by the MSCB and SAB in March 2018.

8.4 The Young Carers Strategy Task and Finish Group

The Young Carers Task and Finish Group comprised of colleagues in Children's Social Care, Health, the Mental Health Trust, Adult Social Care, Merton Carer Support and other voluntary organisations. The proposed Young Carers strategy sets out how Merton council, and its partners will bring about improvements in the way services work together to identify, assess and improve outcomes for young people with caring responsibilities. This strategy aims to build on the priorities of the Merton Safeguarding Children's Board, to 'Think Family' in its collective partnership approach to fostering positive outcomes for children and young people. It also forms our collective response to lessons drawn from Serious Case Reviews, including our own local example.

The priorities for change, identified within this strategy, have first and foremost been developed through listening to the voice of our local young carers and are agreed by the range of agencies and professionals that work with children and families across the health, education, social care and voluntary sector. The strategy sets out what actions will be taken to achieve our priorities and identifies the resources needed to meet these. The strategy will be presented to the Board for approval in September 2018.

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

The Section 11 Process for 2016-2017

At the Business Implementation Meeting held on 7th February 2017, it was agreed that the Section 11 process for 2016-2017 would include the full submission of each agency's Section 11 Self-Audit return for 2016-2017.

Merton Schools contribute to a separate safeguarding audit which feeds into the Section 11 Process.

The MSCB Section 11 process is managed in two parts:

Part A is a self-audit based on the pan-London Section 11 Audit Tool. The audit tool allows each agency/organisation to assess the quality of its safeguarding practice against eight agreed safeguarding standards providing supporting evidence where appropriate. These standards are as follows:

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

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

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

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

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

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

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

STANDARD 8 – There is effective Information Sharing

Agency Returns

The MSCB has received completed returns from the following agencies:

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

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

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

Schools were not asked specifically to complete a section 11 audit in this round. A safeguarding systems audit for each school had been undertaken in the autumn term 2017 and reported to the MSCB in January 2018.

Part B is a series of Peer Challenge Meetings. It was agreed that Quality Assurance and Challenge Meetings would be held with each key agency. It was agreed that the Peer Challenge was helpful and that it was valuable to involve a Lay Member, where possible. The involvement of Commissioners was also seen as helpful as it enabled the Chair and the Director of Children, Schools and Families to challenge commissioned services regarding improving the quality of their safeguarding practice.

The purpose of these meetings were as follows:

1. To ensure agency compliance and provide an additional level of scrutiny of the evidence presented by each agency
2. To challenge each agency as 'critical friend'
3. The process is designed to be helpful and developmental for each agency.

Quality Assurance and Peer Challenge meetings were held for each agency organised as follows:

1. Public Protection and the Police: Including National Probation, Police (Borough and CAIT), Safer Merton
2. Community and Housing: including Adult Social Care, Housing Needs and Public Health
3. Health Agencies: including CLCH, Epsom and St Helier NHS Trust, St George's NHS Trust, South West London and St George's Mental Health Services, Merton CCG
4. Children's Services: including Children's Social Care, Youth Justice, Early Years, Early Help and Commissioned Services, Education Inclusion.

These meeting were held between 25th September 2017 and the 17th November 2017.

The agenda for each meeting included the following general pattern and was tailored to each agency.

1. Notes/Actions from previous Annual QA Meeting / Performance Meeting
2. Review of Section 11 Compliance Agencies' self-review of work to safeguard children April 2016 – March 2017
3. Relevant agency data showing impact of safeguarding children from the agency perspective. (Agency to make available how it monitors its safeguarding performance)
4. Agency support to the MSCB and Sub Groups (Membership, Attendance)
5. Learning and Improvement (Agency and Multi-Agency Learning and Development; take up of MSCB Training/Briefings),
   a. Implementing relevant learning from SCRs
      - Child B
      - Baby C
6. Agency Performance Regarding the Safeguarding of Care leavers and Looked After Children
7. Agency Update of Work in Relation to Child Sexual Exploitation

8. Implementing new guidance:
   Revised Working Together 2015
   Revised guidance to schools 2016
   Revised Information Sharing Guidance 2015
   and
   Merton Information Sharing Protocol 2015.

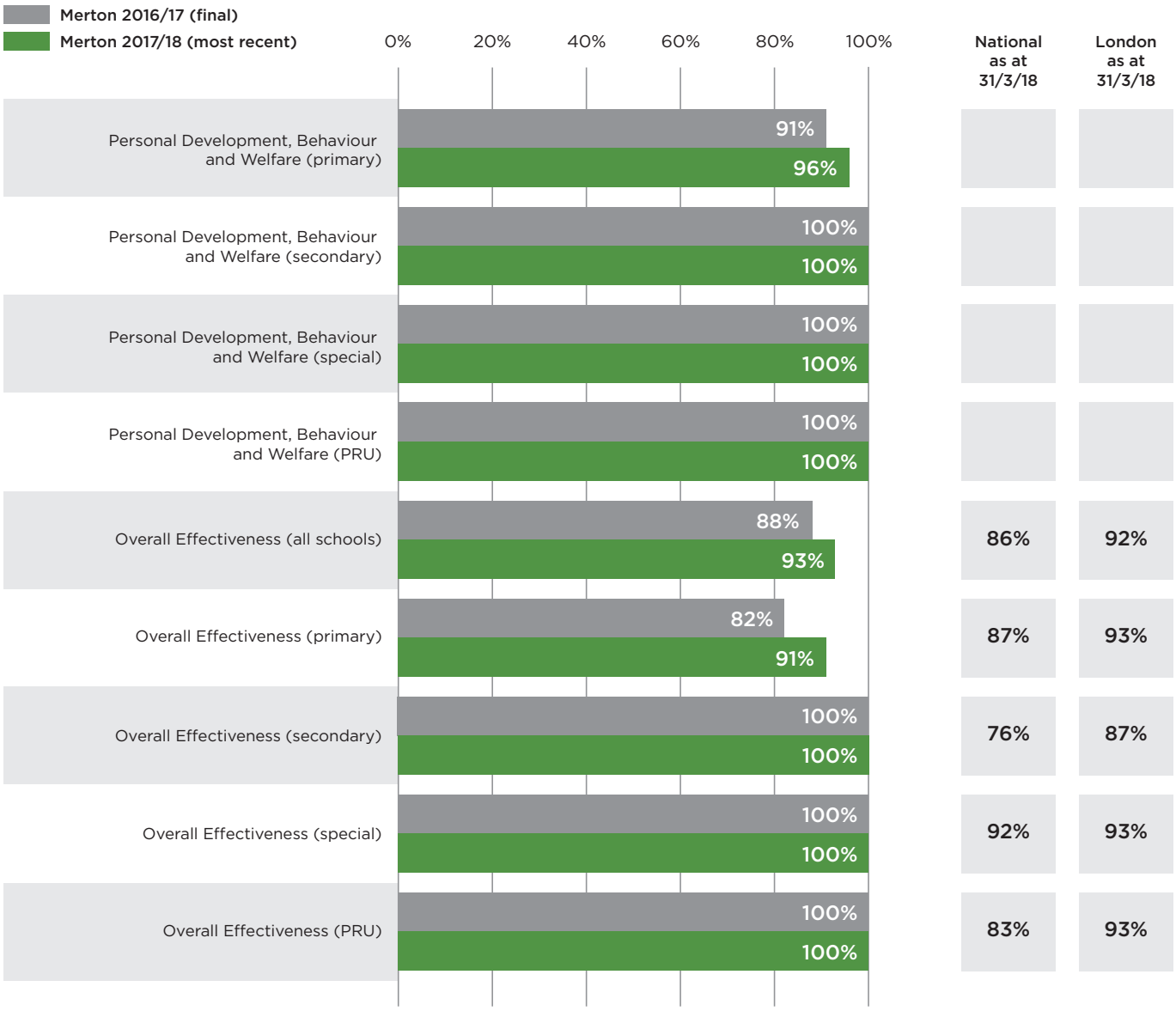
Her Majesty's Inspectors found that:

There is an exceptionally effective section 11 process. The incisive analysis through the annual peer challenge and review meeting process ensures appropriate and respectful challenge of partners' compliance with safeguarding standards and seeks assurance of impact on practice. All senior agency representatives attend these annual challenge sessions. Partners spoken to by inspectors said that they found the process to be rigorous but supportive.[10]

[10] The Office for Standards in Education, Children's Services and Skills (Ofsted) (2017) *Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board.*

9.1.1 Schools

Ofsted inspection outcomes rated good or better



9.2 Children, Schools and Families (CSF) Department

CSF department completed section 11 audits for CSC; Early Years; the Youth Service, Education Inclusion and the FAS (including Youth Justice). The CSF departmental return provided the Board with good assurance regarding the quality of children's safeguarding.

9.3 Acute Trusts

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

9.3.1 SW London & St George's Mental Health Trust

South West London and St George's Mental Health Trust completed Section 11 Self-audit. The Trust was involved in the Section 11 Challenge Meeting.

9.3.2 Epsom and St Helier NHS Trust

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

9.3.3 NHS Merton Clinical Commissioning Group (CCG)

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

9.3.4 St George's Hospital NHS Trust

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

9.3.5 Central London Community Healthcare NHS Trust

The Trust was awarded the community health care contract from the first of April 2016. The trust completed their Section 11 submission to the Board for 2017. The Trust also provided supplementary evidence which gave the Board assurance that the Trust was fulfilling its statutory responsibilities in relation to Section 11 of the Children Act 2004.

9.3.6 Public Health

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

9.4 Community and Housing Dept. – London Borough of Merton

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

9.5 Corporate Service – HR – London Borough of Merton

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

9.6 Metropolitan Police/Probation/Cafcass

Regional Section 11 returns have been completed by all three organisations. The Metropolitan Police have completed returns for the Borough Command and CAIT. The Police have included local information and analysis. The Borough Command and CAIT are strong partners in the work of the Board and its Sub-Groups.

10.0
Views of Children and Young People and the Community

10.1 Merton's Children's Trust User Voice Strategy

This year we have further embedded our commitment to ensure that, through their everyday practice, practitioners and managers put children's and families' wishes and feelings at the centre of decision making and planning about their care. We have formulated and started to embed **'Merton's Practice Model for Social Work'** along with a programme of skills training in methods which facilitate this approach, which aims to deliver services which are ***child and family led*** and responsive to the needs of the people they serve. In addition, we have refreshed our Quality Assurance Framework which aims to evaluate and continuously improve the 'practice model', supporting the development of 'a culture which values learning from frontline practice and the ***lived experiences of children and families***', and involves direct conversations with children and families.

Children and young people have been supported to participate in their **child protection (CP) conference**, and the most common method by which their views have been represented this year has been via the social work report.

We have implemented the **Signs of Safety approach to CP Conferences**, and the majority of parents who have attended conferences this year based on this model (September 2016-February 2017) have told us that after the conference:

- They know what to do to keep their child safe
- They understand what the worries are
- Child's view was an important part of the meeting
- They felt listened to and treated with respect
- They feel involved and that collaborative working is taking place.

In 2017-2018, a high proportion of **Looked After Children have participated in their review this year** – between 97.8 to 100% – and the most common method has been by the young **person attending the meeting and speaking for themselves**. The independent advocacy service has supported 17 young people this year to have their voices heard at their LAC review.

We have piloted the new **'Merton Model' of LAC reviews** based on the 'Sheffield Model' of good practice. The pilot meetings have received very positive feedback from young people who **feel listened to** and **more involved**, and from practitioners who say that the approach **supports the child to express their views in a range of ways**, and creates a **child centred meeting**.

Teams across children's social care have embedded a range of child and family centred practice approaches – Signs of Safety, Motivational Interviewing, Tightrope®, Helping Families Programme – as part of 'Merton's Practice Model for Social Work'. The response to these approaches by both users and practitioners is very positive:

- Children and families are supported to express themselves in a range of ways and report 'feeling listened to'.
- Users are empowered to identify their own needs and strengths, and be their own agents of change.
- Users and practitioners are working in partnership to achieve positive outcomes.

Merton's **SEN Team** takes a 'partnership' approach to working with children and families to produce Education, Health and Care Plans (EHCP) for children with SEN and Disabilities, to ensure that their views are central to the process. Feedback from parents who have been supported by the team this year suggest that parents are **confident that EHCPs are meeting their child's needs and supporting their future achievements and well-being**.

This year's case review and learning (audit) overview reports have identified evidence of good practice including:

- Capturing the child's voice in the assessment and plan.
- Being proactive in building a relationship with a young person.
- Listening to child's wishes and feelings led to a change in care plan.

Merton's **Information and Advice Support Service (IASS) Officer** has continued to provide support to parents and carers of children with SEN and disabilities who are going through the Education Health and Care Plan (EHCP) process. This year feedback from parents has highlighted that the service:

- **Facilitated partnership working** with the family and across agencies to access the right support for the child.
- **Worked closely with the family** to support a move from mainstream to specialist provision.
- **Supported year 7 transitions** to secondary schools within the specialist sector, and within the mainstream sector, managing anxieties and ensuing that all necessary support was accessed.

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

This year, our commitment to providing a range of participation opportunities for all children and young people has been further enhanced by the launch of the new dedicated Young People's Participation and Engagement Service. The service has implemented a new strategy which will modernise our existing 'participation promise', implement a structure to increase the accessibility of participation opportunities, deliver guidance and training to the borough's youth organisations to ensure that they deliver 'ethical and meaningful' participation, and improve evaluation and quality assurance processes to ensure the continuous improvement of participation activity across the borough.

Through a range of young people's forums/ groups, including – Merton Youth Parliament, Young Inspectors, Pollard's Hill Youth Committee,

and school based 'pupil voice' activities – youth led conferences; and 'positive activities' groups including Merton Police Cadets – Merton's young people have influenced a range of issues which affect their lives. Notable participation activity includes:

- Developing the Merton Youth Parliament (MYP) constitution, and the local strategy for the wider **participation of children and young people**.
- Taking part and winning the **mental health** debate competition held at Facebook headquarters.
- Contributing ideas for the development of a new **health and community** campus in Mitcham.
- Delivering the HealthFest conference to promote **health and well-being**.
- Informing the **tendering, commissioning and recruitment** process for Merton's Risk and Resilience Service.
- Feeding back on the **new design** of the 'Getting it on' website which gives information on sexual health and drugs and alcohol services for teenagers in South West London.
- Undertaking training, delivered by **Public Health**, to complete a review of local take away food outlets.
- Leading on **decision making** for Pollard's Hill Youth Centre.
- Delivering a c**onference supporting the emotional health and well-being of LGBT**+ (lesbian, gay, bisexual, transgender, plus) young people.
- Shaping **teaching and learning improvement action plans** for individual schools in the borough.
- Taking part in European Union and United Nations 'parallel' **conferences for pupils**.
- Merton Police Cadets supported Merton's 16 Days against Domestic Violence event, providing "front of house" meet and greet, and welcoming guests.

Through a range of research, consultations and surveys this year young people have told us the following, which will be used to inform a number of key strategic action plans:

- Their top concerns are: **gangs, bullying, online victimisation, sexual exploitation, and physical harm** (Young People's Views on Safeguarding)[11]; and **gangs, crime and littering** (Young Residents' Survey, (YRS).
- Where young people have concerns about their safety they are most likely to seek help from **friends, parents, or other family member** (Young People's Views on Safeguarding)[12]; or **family, teacher or Police** (YRS).
- Young people give the highest satisfaction rating to **libraries, primary schools and public transport** (YRS).
- They are satisfied with the local area as a place to live – 94% (YRS).
- Merton listens to the concerns of young people – 47% (YRS).
- The **top three solutions to supporting children** to lead healthier lives are (Merton Great Weight Debate):
  1. **Less marketing and advertising** of high fat and sugary food and drink.
  2. **Cheaper healthy food and drink**.
  3. Support for families to **cook healthier food**.
- They have a clear vision for the development of the new community health campus in Mitcham (at The Wilson), as a welcoming, accessible place, with a sense of community, which supports the diverse needs of local people. (East Merton Community Conversation).

[11] March 2017, MSCB and London South Bank University.

[12] As before.

11.0
Conclusions and Priorities for 2018–19 Business Years

The Board remains on a journey of continuous improvement; seeking to sharpen our focus and streamline our processes so that we are increasingly able to fulfil our statutory responsibilities in relation to safeguarding children and young people and promoting their welfare. We are pleased with the Outstanding rating by HMI Ofsted; however, we are in no way complacent.

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

At the Board's Annual Away Day in March it was agreed that the Board would focus on effectively managing the transition from statutory Local Safeguarding Children Boards to Safeguarding Partnerships under the Children and Social Work Act 2017. We will continue to focus on fewer priority safeguarding items whilst continuing to deliver on a range of key 'Business as Usual' issues. Members of the Board have agreed the following priorities for the period 2018-2019:

1. Managing the arrangements for the transition from Merton Local Safeguarding Children Board to the Merton Safeguarding Children Partnership

In 2019 the Board will see the dissolution of LSCBs and the establishment of Safeguarding Partnerships. In addition to reviewing the progress that the Board has made to date, we will need to develop clear plans about the future shape and direction of the Board.

The MSCB is Outstanding with no recommendations regarding improvements. Building from this secure base, the Board has agreed not to radically change its constitution but to use the Children and Social Care Act 2017 as an opportunity to strengthen our partnership to ensure that safeguarding children remains a priority for all partners in our safeguarding system and to ensure the most effective representation from statutory and other key partners in the work of safeguarding Merton's children and families and promoting their welfare.

At the Board's Away Day it was agreed that a task and finish group would be established to propose the arrangements for the establishment of Safeguarding Partnership. A task and finish group has been appointed by the Board to explore options for the new Partnership and make recommendations.

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

A great deal of work has been undertaken to embed Think Family as an approach to interventions with children and families across both adults and children's services. We are making good progress in ensuring that our partnerships enable the most vulnerable families to be supported; that vulnerable parents are enabled to care for their children and children are in turn receive the care they need to thrive and achieve their potential. Evidence from local and national research tells us that our most vulnerable parents/families are those who:

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

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

Building on this work, the Board is seeking to drive improvements in our practice with vulnerable families so that stigma is reduced and families with poor mental health and substance misuse issues will feel confident in seeking help and support. We will also assure ourselves that

practitioners are supported with the skills and confident to engage with all families including:

- Families with whom we find it difficult to engage
- Families who we experience as challenging (for a variety of reasons including social class – evidence from practice and SCRs show that affluent families can pose distinct challenges to multi-agency safeguarding systems resulting in harm to children; families who present as 'powerful' etc.).

The Board is also seeking to further highlight the important role of schools, educational and early years' establishments, as a critical safeguarding partner.

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

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

- Child Sexual Exploitation (CSE)
- Going missing from home/school/care
- Radicalisation and violent extremism
- Serious youth violence and gangs
- Criminal and other forms of exploitation including county lines, peer on peer abuse and harmful sexual behaviour
- Self-harm and poor mental health para-suicide.

The Board is seeking to develop a strategic response to contextual safeguarding. In particular we are seeking to develop a coordinated response to adolescent risk/harm which occurs outside of the family home in spaces such as the neighbourhood, school, community centres and housing estates.

The Board would also like to be more systematic regarding its work in listening to children and allowing them to shape the services that are provided to them. The Merton User Voice Strategy outlines the variety of ways in which the views and opinions of children and young people are considered. The Board would like this to be more coordinated so that these views and opinions can more strongly influence the ways we support families and keeps children safe, and so that the impact of our work with children, young people and their families can be measured more effectively.

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

Merton has reviewed it Children Young People and Families Well-Being Model. We are now reviewing our Early Help (EH) and Preventative work; in particular we are exploring models for coordinating preventative and early help across the well-being model. As part of our review we will:

- Consider the interface between our MASH and EH arrangements
- Review our service offer at all levels of the Merton Well Being Model and engage partners in discussion on thresholds, clarify Step-Up Step-Down processes and the tools to support early help assessment CASA and intervention (Signs of Safety/ Signs of Well-Being)
- Review the arrangement for the quality assurance of EH and Preventative work.

Addressing the incidence and impact of neglect is a cross-cutting theme that runs across the work of the Board and each of our priorities.

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

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

Appendix 1
Merton Safeguarding Children Board Business Plan 2017–19

Progress of this Plan will be updated monthly & monitored at each MSCB Meeting. Presented to the Board June 2018.

Objectives		Outcomes	Actions (who and what)		Resources	
					Governance/ oversight	When?
1. For Merton Safeguarding Children Board to Make the Transition to Merton Safeguarding Children Partnerships						
1.1	To establish a task and finish group which will explore options for effective safeguarding partnerships. This group will: (a) draft a constitution/ partnership agreement for the Merton Safeguarding Children Partnership and (b) propose a partnership agreement which will form the legal basis for the partnership	The new partnership to consider the following: • Membership a) Partners b) Relevant agencies • Geographical Footprint • Leadership and governance? • Independent Scrutiny • Quality Assurance • Training and Practice Development • Funding • Dispute Resolution • Listening and responding to children	The Independent Chair Assistant Director of Children's Social Care and Youth Inclusion The Director of Education Senior Representative from the Police Senior Representative from the CCG Senior Representation from Housing MSCB Business Manager	A task and finish group comprised of key partners are to explore options and propose a draft partnership agreement to the Board for sign off	The MSCB partnership and Strategic Boards CCG Rep MPS BCU Rep Education Rep CSC Rep Housing Rep HWBB Rep Lead Member	January 2019; with a view to the Board being dissolved 31st March 2019 and constituted as a safeguarding partnership from 1st April

Objectives		Outcomes	Actions (who and what)	Resources		
				Governance/ oversight	When?	
2. Think Family – looking beyond symptoms and supporting families with particular vulnerabilities (with a focus on neglect as a cross-cutting theme)						
2.1	To embed the Think Family Approach across the multi-agency partnership	We want to make it easier for all types of families to access help and support without stigma or blame. Especially families experiencing DVA, mental health, substance misuse, disability	To approve the DVA Strategy To Implement the Mental Health Protocol To approve and implement a Parental Substance Misuse Protocol To approve Protocol for Supporting Parents with disabilities	The Think Family Strategic Board to further embed multi-agency work across adult and children's services CMc Policy Sub-Group Substance Misuse Commissioned Service Policy Sub-Group to agree key agencies	Policy Sub-Group	January 2019
		We want all our practitioners to be skilled at working with all types of families and are positive at engaging with them	To review our training offer to ensure that practitioners have access to appropriate training To seek assurance from agencies that supervisory arrangements provide support with regard to authoritative practice with families	Learning and Development Sub-Group Section 11 and challenge Process	Learning and Development Sub-Group	January 2019 November – December 2018
		To scope out a framework that supports schools, educational and early years institutions involvement in leading and developing multi-agency safeguarding arrangements and improvements in the quality of practice	To work with schools, educational and early years institutions to ensure that they have the capacity and confidence to lead preventative multi-agency safeguarding	The Think Family Strategic Group	The BIG	January 2019

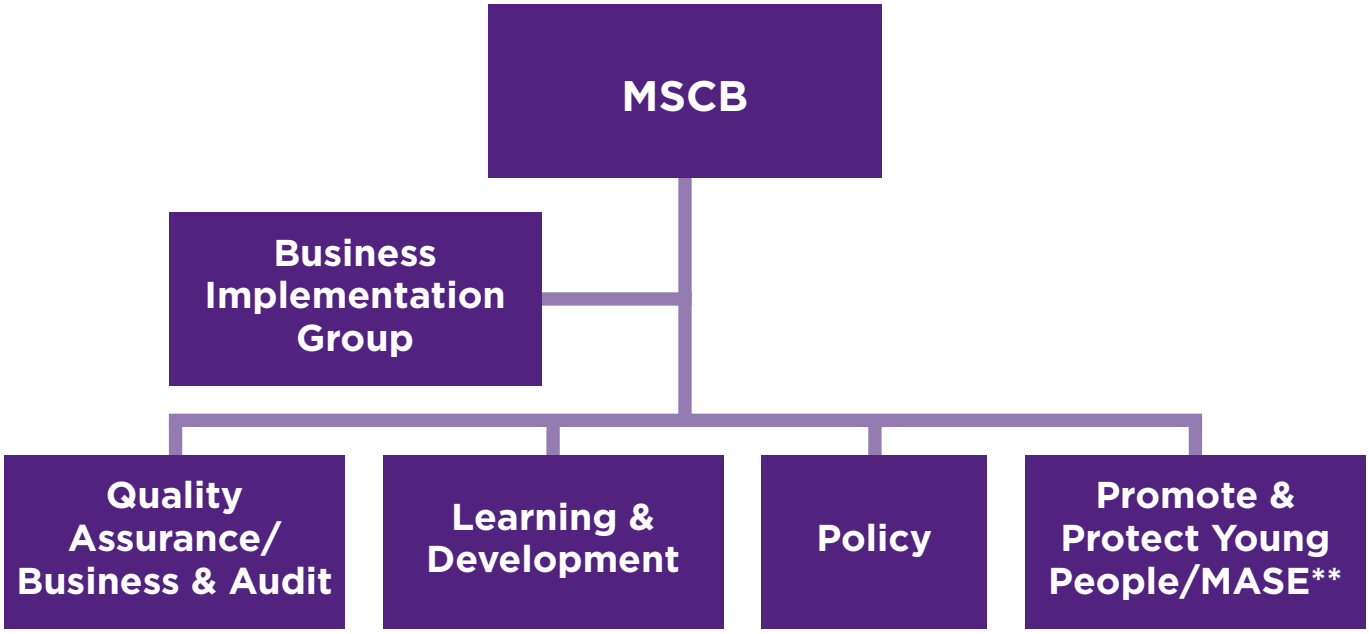
Objectives		Outcomes	Actions (who and what)		Resources	
					Governance/ oversight	When?
2. Think Family – looking beyond symptoms and supporting families with particular vulnerabilities (with a focus on neglect as a cross-cutting theme)						
2.2	To maintain a focus on neglect as a form of harm requiring a skilled, urgent multi-agency response	To feedback key practice lessons from the audit To integrate these lessons into current training and practice development initiatives	**What** QA Sub-Group and MSCB partners to conduct a multi-agency audit of neglect cases To add Neglect to the Section 11 Self-audit	**Who** All relevant MSCB partners including Health (CCG, CLCH, acute trusts, Mental Health Trust), Education, Police, CSC, Voluntary Orgs.	QA Sub-Group and BIG Head CSC &YI QA Chair Paul Angeli	March 2019
		To report to the Board on the outcome of the Neglect Tool Pilot and to make recommendations for the use of this tool in Merton	MSCB to adopt and promote a range of practice tools to address neglect	Carla Thomas CSC Health Police Education Early Years	QA Sub-Group and Learning and Development Sub-Groups MSCB BSU	March 2019
		For the Board to be assured that there is a clear link between the work on neglect including the trigger trio and Think Family	Multi-agency partners to demonstrate an understanding neglect as an effect, with the trigger trio, in many cases, being the cause	MSCB partners including, SAB Health (CCG, CLCH, acute trusts, Mental Health Trust), Public Health Education, Police, CSC, Voluntary Orgs.	Policy and Quality Assurance Sub-Group Chair	March 2019

Objectives		Outcomes	Actions (who and what)		Resources	
					Governance/ oversight	When?
3. Supporting Vulnerable Adolescents						
3.1	Listening and responding to the voices of children and young people	We listen to young people and their lived experience We will identify coordinate the various ways in which we hear from young people and ensure that the Board has oversight. We will also ensure that the voice of the child and the family is heard in the commissioning and delivery of services	The BIG	To review the user voice strategy For the Board to agree on-going ways to secure the of the child in the work of the Board	MSCB	January 2019
3.2	We understand ASD and social communication disorders and provide appropriate support to children and families and practitioners	To ensure that the Board is sighted on the Implementation of the ASD Strategy	CAMHs Transformation Group	To ensure that the risks to children and young people with ASD are managed effectively	PPYPS	January 2019
3.3	Promoting Good Mental Health for Adolescents (12-18 year-olds)	We support good adolescent mental health and emotional well-being – we are clear on the difference between 'normal' adolescent behaviour, inappropriate behaviour needing a parental response and adolescent mental health We want to strengthen the link between commissioned services, schools and families (where appropriate)	All agencies Commissioners and commissioned services Secondary Schools	Promote good mental health to more children and young people across the safeguarding system. Champion the voices of Merton young people and parents to influence mental health policy and practice. To work with commissioners and commissioned services to ensure effective, integrated services	PPYPS Sub-Group	March 2019
3.4	Reducing Incidents of Self-harm and preventing adolescent suicide	To work with the CAMHs strategic group to develop a suicide prevention strategy To review the Self-Harm Protocol	CAMHs PPYPS Acute Trusts Red Thread Policy Sub-Group	To develop a Suicide Prevention Strategy To review the implementation of the Self-harm Protocol	PPYP and Policy Sub-Groups	March 2019

Objectives		Outcomes	Actions (who and what)		Resources	
					Governance/ oversight	When?
3. Supporting Vulnerable Adolescents						
3.5	Developing a Strategic response to Contextual Safeguarding	We have an effective, joined-up contextual safeguarding response to overlapping adolescent risks including: • CSE • gangs and county lines, serious youth violence • peer on peer abuse • harmful sexual behaviour • adolescent substance misuse	PPYPS YJT Transforming Families MPS	To develop a contextual safeguarding strategy To ensure that the strategy is underpinned by a process to manage and review adolescent risk related to peers, space and place	PPYPS	January 2019

Objectives		Outcomes	Actions (who and what)		Resources	
					Governance/ oversight	When?
4. Skilled and coordinated Prevention at all levels of need						
4.1	Skilled and coordinated Prevention at all levels of need	Effective coordination and QA of early help	Early Help Task and Finish Group	To exploring models for coordinating early help, preventative services	MSCB Children's Trust	March 2019
		Ensuring effective preventative services at all levels of the MWBM	Early Help Task and Finish Group	To have clarity regarding Merton's Early Help/ preventative services offer	MSCB Children's Trust	March 2019
		Integrating signs of safety as a part of a preventative response (a shared language and approach for families, professionals and services)	Signs of Safety Steering Group	To provide training to multi-agency managers and lead practitioners	MSCB Signs of Safety Steering Group	March 2019

Appendix 2
MSCB Structure



** MASE Multi-Agency Sexual Exploitation Group

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

The MSCB Chair may commission a Panel to undertake SCRs or LIRs.

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

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

Learning and Development
- twice per year

Policy
- twice per year

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

HR Sub-Group
- once per year

MASH Strategic Board
- meets monthly

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

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

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

Appendix 3
Membership

Membership of MSCB has been agreed as follows:

P **Statutory Partner**

S **Statutory Sector Partner**

C **Co-opted**

V **Voting**

PO **Participant Observer**

SA **Statutory Advisor**

A **Advisor**

B **Board support**

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

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

	MSCB	
	Independent Chair	Casting Vote
P	**Vice Chair to be drawn from the Statutory Members**	
P V	Chief Officer, Merton Clinical Commissioning Group	
P V	NHS England (London)	
P V	Chief Nurse, Central London Community Healthcare Services	
P V	Sutton & Merton Service Director, SW London & St George's MH Trust	
P V	Consultant Child and Adolescent Psychiatrist, SW London & St George's	
P V	St George's Healthcare NHS Trust	
P V	Borough Commander, Met Police	
P V	DCI, Child Abuse Investigation Team, Met Police	
P V	Assistant Chief Officer, London Probation	
P V	Assistant Chief Officer, The London Community Rehabilitation Company Limited	
S V	Lay Members (Two) – 1 vacant	
S V	Voluntary Sector Agency (Two) – vacant	
P V	Director, Children Schools & Families	
P V	Assistant Director for CSC & YI, CSF	
P V	Assistant Director for Education, CSF	
C V	Director of Public Health Merton, Community & Housing	
C V	Safeguarding Adults Manager, Community & Housing	
C V	Housing Needs Manager, Community & Housing	
P V	Senior Service Manager, CAFCASS	
SV	Head Teacher Primary School 'Rep of Governing Body of a Maintained School	
SV	Special School	
SV	Maintained secondary school	
SV	Representative of the proprietor of a city technology college, a city college for technology or the arts, or an Academy – vacant	
SV	Independent Sector School – vacant at Jan 2015	
CV	CP Officer, Merton Priory Homes	
PO	Merton Council Lead Member Children's Services	**Non-voting**
SA	Designated Doctor for Child Protection, Merton CCG	**Non-voting**
SA	Designated Nurse Safeguarding, Merton Clinical Commissioning Group	**Non-voting**
SA	Principal Social Worker	**Non-voting**
P V	Consultant Child and Adolescent Psychiatrist, SW London & St George's	
A	Joint Head of HR Business Partnerships	**Non-voting**
A	Service Manager, Policy, Planning and Performance	**Non-voting**
BS	MSCB Board Development Manager	**Non-voting**
BS	MSCB Administrator/s	**Non-voting**
A	MSCB Training Officer	**Non-voting**

Contact Details

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Merton
Safeguarding
Children Board

Committee: Health and Wellbeing Board

Date: 27th November 2018

Subject: Suicide Prevention Framework

Lead officer: Dr Dagmar Zeuner, Director of Public Health

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

Forward Plan reference number:

Contact officer: Daniel Butler, Senior Principal Public Health and Barry Causer, Head of Strategic Commissioning.

Recommendations:
For members of the Health and Wellbeing Board:

A. To consider and endorse the Suicide Prevention Framework 2018-23 and the first year's action plan.

B. To note involvement of partners to date, including the voluntary sector, CCG and Council, in the Task and Finish Group. To note the role of the Suicide Prevention Forum, the Mental Health Programme Delivery Group and CAMHS Partnership Board which will have oversight of the Suicide Prevention Framework.

C. To consider opportunities for members to champion the Suicide Prevention Framework objectives and actions as system leaders.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To present the Suicide Prevention Framework, set out the relevance of suicide prevention to Health and Wellbeing Board (HWB) partners, receive comments on the draft document and endorse the Framework.

1.2 For HWB Members to agree to actions outlined in the Framework as part of our Health in all Policies (HIAP) approach and to consider the opportunities for championing the strategic objectives and actions as systems leaders.

2 BACKGROUND

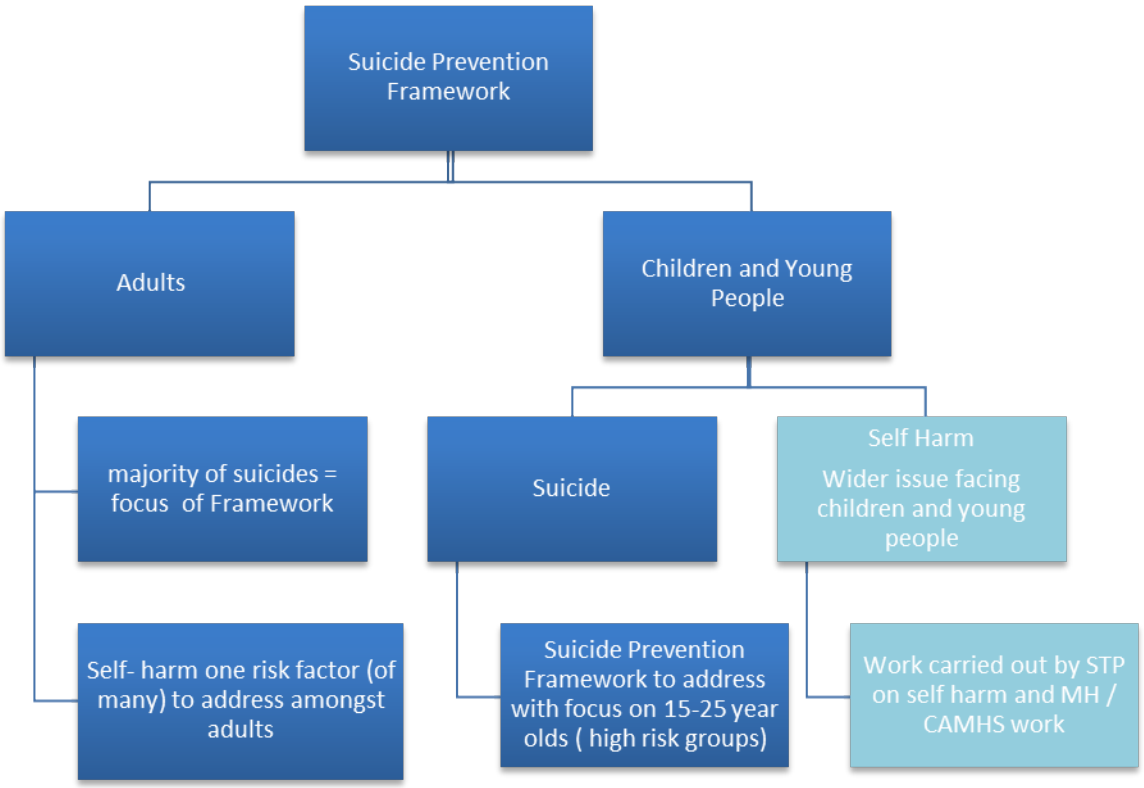
2.1 The National Suicide Prevention Strategy (2012) requires that all local authorities develop a local Suicide Prevention strategy or plan.
Local plans should have two main objectives; to reduce the suicide rate in the general population and to support those bereaved or affected by suicide.

2.2 Our approach has been to develop a 5 year Suicide Prevention Framework outlining what we wish to achieve over the five years and an annual action plan that will be refreshed each year.

2.3 A Task and Finish Group was set up in May 2018 to develop the Framework, which met three times to agree our priorities and comment on the draft

document. The Group has membership from a wide range of stakeholders (outlined at the end of this report). The Task and Finish group has been well attended and there is enthusiasm by the group to continue to work on suicide prevention as part of the development of a wider Suicide Prevention Forum.

2.4 Outside of the scope for the Framework is self-harm affecting children and young people. This is because self- harm is a much wider issue than its role as a risk factor for suicide and this wider work is being covered by the CAMHS and STP work streams. These work streams are however discussed in detail within the Framework.



3 DETAILS

3.1.1 The framework takes a life course approach and has five key priorities

- **Suicide Prevention in high-risk groups**; this priority focuses on how we reduce the risk of suicide in key populations. The framework focuses on middle aged and older men from lower income backgrounds and young people aged 15-19. We know risk does not end at 19 and therefore our aspiration is that our focus on younger people is those aged 15 to 25. There is a particular need to focus on young people who are vulnerable; such as those known to mental health services, youth offending, substance misuse services and those leaving care.

- **Reducing access to the means of suicide**; this theme focuses on interventions that can prevent a suicide from occurring. Our framework considers work being done on the railways, how police and South West

London St George's Mental Health Trust reduce risk in 'controlled environments', work being done in primary care to reduce risks due to medication, support that can be provided to high risk professions and potential work on building design and access.

- **Improving the mental health offer for targeted populations**; this focuses on those using mental health services who are at a much greater risk of suicide and considers how staff working with these groups are trained and how services provide the appropriate support.

- **Suicide prevention awareness and good mental wellbeing for all**; this focuses on prevention and the role that good mental health and wellbeing can have in reducing numbers moving into high risk groups (such as those with mental health conditions). It also focuses on addressing loneliness and isolation and community awareness around suicide and mental health, where people can signpost to services and feel better able to talk about mental health issues.

- **Supporting those bereaved or affected by suicide;** this theme looks at the services that are needed to support those bereaved by suicide and how this can contribute to reducing suicide risk.

3.1.2 We also include two cross cutting themes: ensuring our understanding of suicide locally is informed by evidence; and, that our plans are sustainable and have identifiable leadership.

3.1.3 Each financial year we will prioritise new key actions for the year ahead. The aim is that partners will sign up to these actions and over the life course of the Framework we will achieve the majority of outcomes.

Governance

3.1.4 The proposals for Governance will be annual reporting to the CAMHS Partnership Board (children and young people 15 - 25) and Mental Health Program Delivery Group (adults).

3.1.5 A Suicide Prevention Forum for stakeholders will also be formed. Its purpose will be to monitor progress, help progress actions, share best practice and propose new activity and ideas. Forum members will also comment on and agree the annual action plan. This will meet twice a year and we will develop more detailed Terms of Reference, making clear the ask of Forum members.

Why suicide prevention is relevant to the HWB Partners

3.1.6 HWB partners have a leadership role in promoting suicide prevention both within their organisations and with partners, community groups and residents. Our aim is for residents to feel able to talk about good mental health and be aware of organisations who can provide appropriate support.

3.1.7 Staff at HWB organisations will be engaging with individual's in high risk groups as patients, service users, clients or residents. Or they may commission services that interact with these groups.

3.1.8 HWB Members may be able to take practical steps to reduce access to the means of suicide. For example reviewing tall buildings/sites of high risk, reducing or changing medication to at risk patients and considering high risk professions (such as nurses and primary school teachers) and considering the staff wellbeing and support offer that is available to staff.

3.1.9 Merton CCG and Merton Council commission a number of mental health services relevant to suicide prevention and it is important these services consider risk factors such as the discharge process from secondary mental health services into primary care; services for those who self-harm and support for those in mental health crisis. It is also important that these services meet best practice standards and we welcome the commitment from Merton CCG that over the life course of the Framework re-commissioning of the self-harm pathway meets these standards.

3.1.10 HWB partners have a key role in promoting discussion around mental health and suicide awareness to communities and residents. For example we welcome the commitment from our voluntary sector partners to promote suicide awareness training to our residents. HWB organisations can also promote websites such as 'Good Thinking' to staff and residents, which offers free on-line resources that support mental health.

3.1.11 HWB organisations can play a key role to embed suicide prevention as part of the Health in All Policies (HIAP) approach. For example officers commissioning services could consider the use of the Social Value Act 2012 to include suicide awareness training or mental health first aid training as an additional element of the service.

3.1.12 HWB organisations can play a key role in promoting national postvention support to our patients and residents, with our overall aim that support is widely known about. For example GP's will likely interact with patients who have lost a relative or friend of the patient to suicide and be able to signpost to appropriate information.

3.1.13 HWB organisations can also play a role in identifying an appropriate staff Member to attend the Suicide Prevention Forum.

NEXT STEPS

3.1.14 Following HWB endorsement we will

- Make final amendments to the document including a Councillor / CCG foreword.

- Publish and launch the Framework as part of our wider work on 'Thrive Merton'. This will take place in early 2019, where we implement 'Thrive London' principles and projects for good mental health at a local level.

- Brief Merton and Wandsworth's Clinical Oversight Group on the Framework during January 2019, including discussion on how primary care can contribute to the action planning and Forum.

- Develop a Suicide Prevention Forum that will bring partners together every six months to discuss how we can work in partnership to contribute to the outcomes of the Suicide Prevention Framework.

4 ALTERNATIVE OPTIONS

4.1. N/A

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The Framework document has been developed with advice from an extensive range of stakeholder organisations outlined in Appendix A of the Framework document.

5.2. Engagement has also taken place with the Promote and Protect Young People Group, Safeguarding Board, Mental Health Programme Delivery Board, Local Medical Council and CAMHS partnership.

5.3. The Framework document has been to the Mental Health Forum and sent to the CCG's Clinical Oversight Group for comment (outside of meetings).

5.4. We have also sent the Framework out to all secondary head teachers and asked for comment/feedback.

5.5. The need to produce a Framework document within a relatively short timescale and meet Public Health England requirements (to have a document in place by 2018) has meant there has not been widespread consultation with service users/residents.

5.6. We will look to invite organisations representing service users to the Suicide Prevention Forum, who will be able to help steer our action plan in future years.

6 TIMETABLE

The framework has been developed under the following timescales

Activity	Date
Steering Group Meeting 1 – prioritising issues (1), reviewing evidence.	10th May 2018
Steering Group Meeting 2 – prioritising issues (2), agreeing structure	18th July 2018
Steering Group Meeting 3 – consultation with steering group on 1st draft	3rd October 2018
Consultation with Steering Group Members on final draft	
Community and Housing and Children School and Families DMT for comment/sign off	25th October 2018
Paper to Mental Health Programme Delivery Board	8th November 2018
Paper to Corporate Management Team, Merton Council	13th November 2018
Sign off at Protect and Promote Board (Children and Young People)	13th November 2018
Sign off at Merton's Health and Wellbeing Board (Adults)	27th November 2018
Information (post sign off) at Clinical Oversight Group (LDU)*	January 2019

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. Public Heath has funded Imagine Independence £6.5k for the 2018/19 financial year for a first tranche of Mental Health First Aid and suicide awareness training.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. The National Suicide Prevention Strategy "Preventing suicide in England: a cross-government outcomes strategy to save lives" (2012) requires all local authorities to develop a suicide awareness strategy or plan. Public Health England are monitoring local authorities on their plans. The Prime Minister's latest announcement (9th October 2018) reinforced the requirement for local authorities to have an action plan in place.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. The Framework is likely to have positive impacts in terms of disability (mental health, long term conditions), gender (most suicides are in men although women are more likely to attempt suicide), age (young people, middle aged and older people) and sexual orientation (LGBTQ).

10 CRIME AND DISORDER IMPLICATIONS

10.1. It is important that we differentiate suicide and suicide prevention from crime and disorder. The language around suicide should also refrain from using 'commit' or 'committed' as organisations working on suicide prevention highlight this is linked to the historic criminal offence of suicide, which is stigmatising and hurtful for families who have experienced a family member kill themselves.

10.2. People in the criminal justice system are at greater risk of suicide and joint work with probation services is required on suicide prevention.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. N/A

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

Appendix A – Suicide Prevention Framework

13 BACKGROUND PAPERS

List of Task and Finish Group Members

- Paul Angeli, Children's, Schools and Families, Merton Council
- Andrew Beardall, South Thames College
- Patrice Beveney, Merton CCG
- Harry Biggs-Davidson, Papyrus
- Gemma Blunt, Adult Social Care, Merton Council
- Vere Bowyer, Metropolitan Police
- Jessica Buckpitt, South Western Railway
- Daniel Butler, Public Health, Merton Council
- Elizabeth Campbell, Westminster Drug Project
- Barry Causer, Public Health, Merton Council
- Ayda El-Deweiny, Job Centre Plus
- Beau Fadahunsi, MVSC
- Alessandro Finistrella, South Western Railway
- Charlotte Harrison, South West London and St Georges Mental Health Trust
- David Hobbs, Mental Health Forum
- Joy Horden, Samaritans
- John Horwood, Clarion Housing Association
- Richard Jackman, DWP
- Steve Langley, Housing services, Merton Council
- Barry Milward, Govia Thameslink
- Dr Andrew Otley, Merton CCG Clinical Lead
- Andy Ottaway Searle, Direct Provision, Merton Council
- Ben Rowe, South Thames College
- Rosa Treadwell, Public Health, Merton Council

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Suicide Prevention Framework

2018 - 2023

London Borough of Merton

Councillor Foreword (Adults)

Councillor Foreword (CSF)

Merton (CCG) Foreword

Introduction

1.1 This document provides a working framework for Merton's suicide prevention plans for 2018 to 2023. It outlines key issues and highlights the outcomes we wish to achieve over the duration of the plan.

1.2 This plan has been developed by a Task and Finish Group comprised of a broad range of stakeholders that have been invaluable in providing insight and commitment to Merton's plans. A full list of Task and Finish group members can be found in Appendix A.

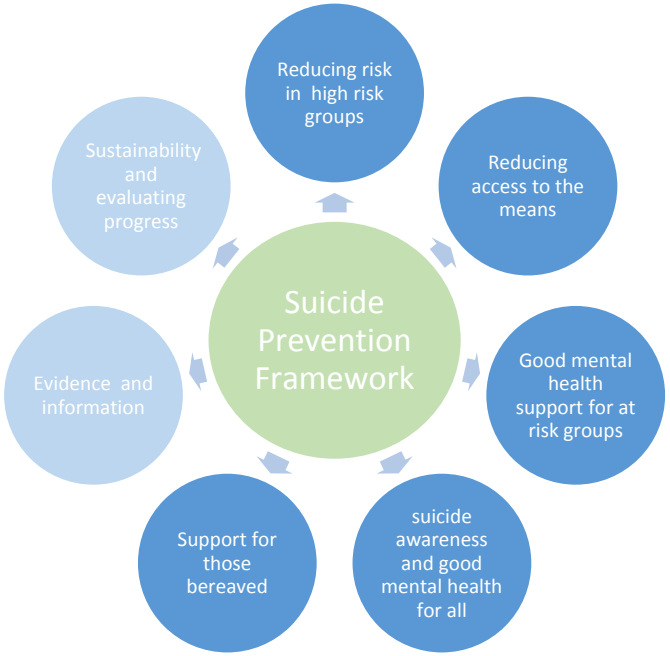
Vision

1.3 Our vision is for a zero suicide Borough where no suicide is inevitable. Through our actions we demonstrate that suicide is preventable and we contribute to the Mayor's aspiration of a zero suicide London. It is a Borough where our residents know where to get help when they need it, where those supporting people at greater risk of suicide are well trained and where our communities encourage people to talk about good mental health.

Overview of Framework's Priorities

1.4 Our Framework has five main priorities outlined below. There are also two cross cutting themes including ensuring our understanding of suicide locally is informed by evidence.

Our Framework's Priorities



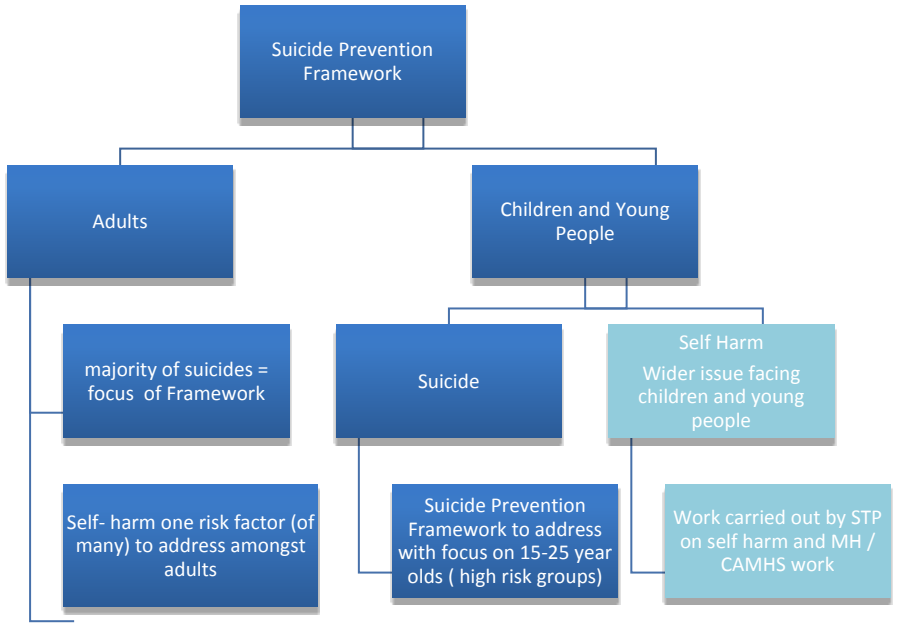
What the Framework covers

1.5 The Framework takes a life-course approach from children and young people to adults and older people.

1.6 With the vast majority of suicides in the UK being amongst the adult population (nationally only 0.1% of suicides are amongst those aged 10-14[i]) the majority of proposed actions will be focused on adults. That said suicide is the leading cause of death for children and young people nationally, with 15.2% of male deaths and 9.6% of female deaths of 5 to 19 year olds during 2016 identifying suicide as

the cause of death[ii]. It is vital therefore that the Framework prioritises young people at greatest risk , these are those aged 15 – 19 and those who are vulnerable such as care leavers, looked after children and young people known to youth offending or mental health services . Risk for young people doesn't end at 19 and therefore our aspiration is that the Framework focuses on reduces risk for young people aged 15 – 25.

Overview of Framework coverage



1.7 Self-harm is a major issue facing children and young people and a history of self-harm is one of the risk factors for suicide. Self-harm amongst children and young people is a significant issue and a broader issue than just suicide prevention. Children, Schools and Families (CSF) are already doing work in this area alongside work carried out by the South West London Sustainability and Transformation Partnership (STP). Therefore self-harm amongst children and young people will be out of scope of the framework although we will reference the linkages with the CSF/STP work-streams.

Strategic Fit

1.8 Taking a life-course approach Merton's Suicide Prevention Framework 2018 – 2023 will be monitored by both the Mental Health Programme Delivery Board (adults) and the Children and Adolescent Mental Health Services (CAMHS) Partnership Board (young people). An annual report on progress will go to the Health and Wellbeing Board.

1.9 The Framework will be championed by our Cabinet Lead for Adult Social Care and Health, Cabinet Lead for Children's services and CCG Clinical Lead for mental health.

Monitoring our plans

1.10 Each financial year (starting 2018/19) a short action plan will be developed outlining five to seven key actions. Our aim is to achieve these actions, which over time will allow us to build up and deliver the Outcomes outlined in this document.

1.11 A Suicide Prevention Stakeholder Forum (meeting twice a year) will also monitor and evaluate progress made in our plans as well as contributing to the delivery of outcomes.

Policy Context

Policy Context

2.1 In 2011 the Government published "*No Health Without Mental Health: A cross-Government mental health outcomes strategy for people of all ages*" which aimed to improve outcomes on mental health, including: a population with better mental health, a focus on recovery, better physical health for people with mental health conditions, good care and support and a reduction in avoidable harm. As part of this the Government committed to developing a national Suicide Prevention strategy.

2.2 The National Suicide Prevention Strategy *"Preventing suicide in England: a cross-government outcomes strategy to save lives"* (2012) included two principal objectives;

- to reduce the suicide rate in the general population
- to support those bereaved or affected by suicide.

Our Framework document will be guided by these two objectives. It also outlined six key areas to take action on which has also influenced our thinking;

- Reduce the risk of suicide in high-risk groups.
- Tailor approaches to improve mental health in specific groups.
- Reduce access to the means of suicide.
- Provide better information and support to those bereaved or affected by suicide.
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
- Support research, data collection and monitoring.

2.3 Public Health England (PHE) guidance *"Local Suicide Prevention Planning"* (2016) recommends that Local Authorities address eight areas of action over the longer term but in the short term should focus efforts on some of the areas outlined in chart 1 on the next page.

2.4 London Councils have also developed a draft guidance document for London Local Authorities, "*A model suicide prevention plan - A London Local Government offer for the prevention of suicide"* (2018). Key elements include;

- Areas of high frequency, reducing access to means and promoting support
- Intervention and support
- Suicide prevention and postvention
- Sustainability and capacity building

- Suicide Prevention, Mental Health and Wellness Promotion & Awareness

It also recommends that local plans consider training, evaluation, a reporting framework to Health and Wellbeing Boards, leadership and Councillor involvement.

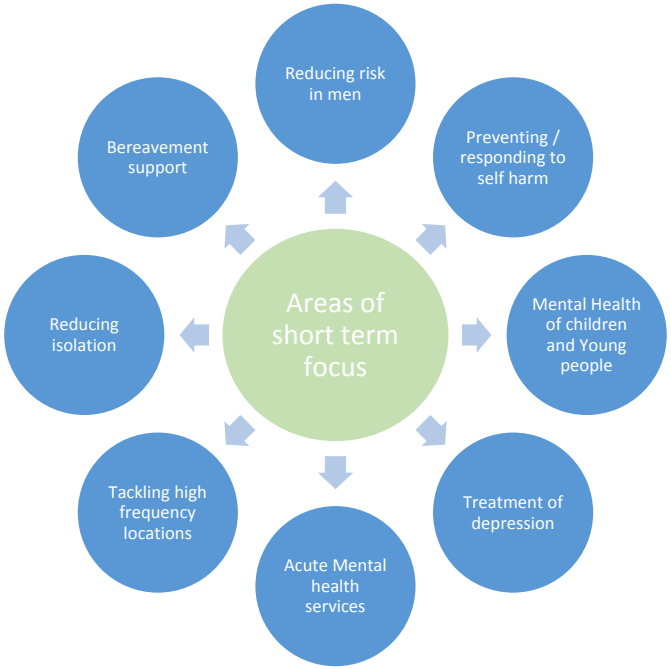


Chart 1 PHE Areas of short term focus (2016)

2.5 The London Health Inequalities Strategy 2018 – 2020 implementation plan contains a number of targets around suicide prevention including achieving the Five Year Forward View national target of reducing suicide by 10% by 2021. It also outlines this as a stepping stone to the ambition that London becomes a zero suicide city.

2.6 More specifically the strategy contains actions to ensure all secondary schools have staff trained in mental health first aid by 2021; action is taken to address mental health stigma and promotion of the 'Good Thinking' digital mental health and wellbeing platform for London.

Merton's Health and Wellbeing Strategy (2015 – 2018 and refresh)

2.7 It is a statutory duty for the Health and Wellbeing Board to produce a joint Health and Wellbeing Strategy. The current Merton Health and Wellbeing Strategy 2015-2018 is coming to an end this year, work has begun on its refresh, including a full engagement programme.

2.8 It is planned that the Health and Wellbeing Strategy 2019 – 2024 will be based around 4 key themes:

- Start Well
- Live well
- Age well
- …in a Healthy Place

2.9 The Strategy will be informed by the Merton Joint Strategic Needs Assessment (JSNA), including analysis from the Annual Public Health Report 2018, the Merton Story, and Merton Data. As such it is envisaged there will be a

significant focus on mental health and alignment with the Suicide Prevention Framework document.

2.10 Much work currently underway will link closely with the Health and Wellbeing Strategy refresh, including:

- Merton Local Health and Care Plan
- 2018 Annual Public Health Report on health inequalities
- Prevention framework refresh
- Health in all Policies Action Plan
- Merton's Local Plan
- Mayor of London's Health Inequalities Strategy

Merton's Crisis Care Concordat

2.11 The Crisis Care Concordat is a national agreement between agencies and services involved in the care and support of people in crisis. It sets out how organisations work together to make sure people gain the support they need during a mental health crisis. There are four main priorities;

- Access to services prior to crisis point
- Urgent and emergency access to care
- Quality of treatment and care during crisis
- Recovery and staying well.

All local areas are required to have a local plan and Merton's is available here. The plan aims to ensure the concordat principles are addressed at a local level and make sure people who need immediate mental health support at a time of crisis get the right services when they need them, and get the help they need to move on and stay well.

Merton's CAMHS Health and Wellbeing Strategy 2015-2018

2.12 Merton's CAMHS Strategy aims to improve the mental health and wellbeing of children and young people in Merton ensuring they receive the right intervention at the appropriate time with the right outcome. The strategy contains a number of priorities relevant to suicide prevention including 'ensuring care for the most vulnerable' and 'promoting resilience, prevention and early help.

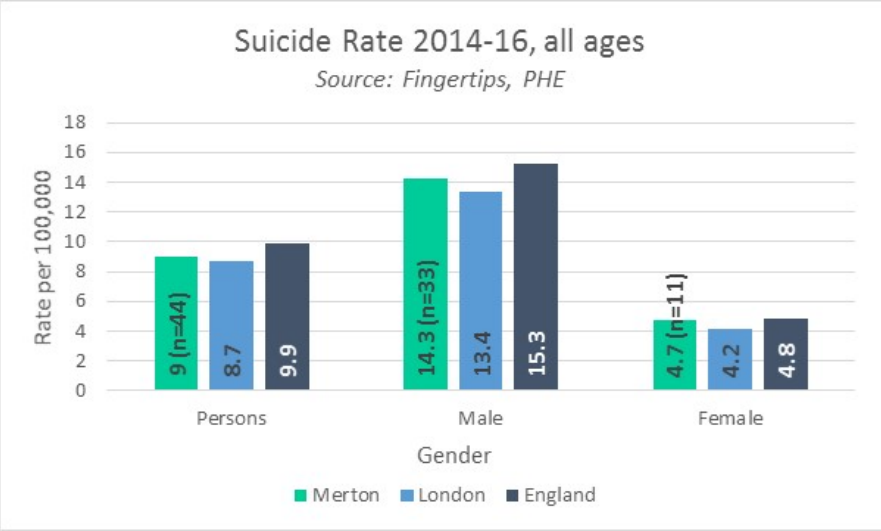
South West London and St George's Mental Health Trust – Suicide Prevention Strategy 2018 -2021

2.13 SWLSG MH Trust has developed a suicide prevention strategy that focuses directly on areas they can influence, with a focus on reducing risk in those known to SWLSG MH Trust services. The strategy has a zero suicide ambition, recognising the many ways that mental health services can improve clinical practice to reduce the risk of suicide amongst service users.

2.14 The strategy broadly implements actions that follow national best practice guidelines. Key activity includes: suicide awareness training for staff and patients, ensuring buildings are safe and reduce access to the means of suicide, considering medication reviews which also reduces access to means and improving the mental health of staff.

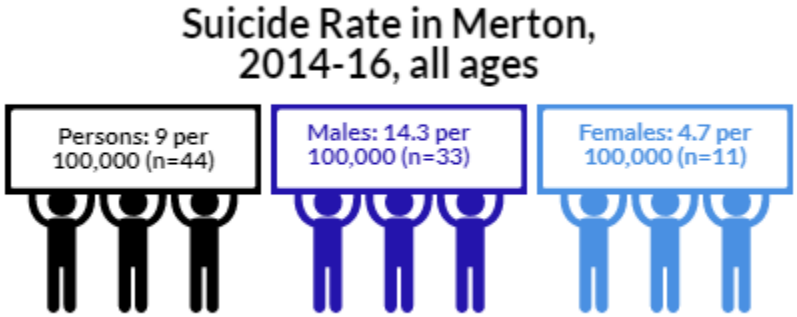
Local Data

3.1 The following infographics provide some key data messages about suicide in Merton using data from our Suicide Prevention Audit (2017) and Public Health Outcome Framework data.



3.2 The suicide rate in Merton at 9.0 per 100,000 population (2014 – 2016) was slightly higher than the London average (8.7) but below the England average (9.9). Rates are however statistically similar.

3.3 The suicide rate in Merton is higher in men than women but it should be noted that national research highlights that women make more suicide attempts than men (but more men die by suicide)[iii].



3.4 Men aged 35-64 still form the largest single group of people who have killed themselves in Merton.

3.5 Merton's suicide rate for older men (65+) is higher than for London and England, although still statistically similar.

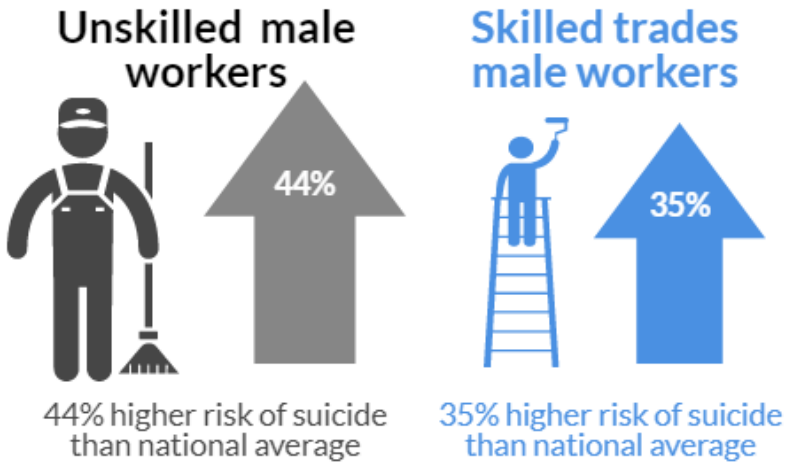
Please note the rates for women are for all London and not just Merton – rates are too low to show by borough.

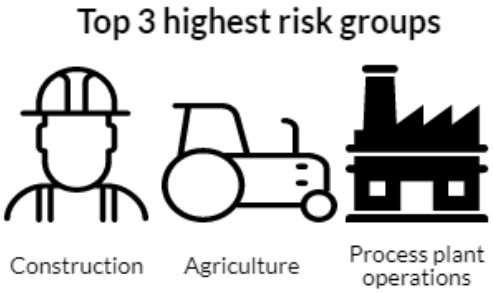
3.6 For women the highest rates of suicide are amongst women aged over 65 followed by women aged 35 to 64. This is a London wide rate.

3.7 Merton's overall suicide rates have generally declined between 2003 and 2013, and have been statistically similar to the London and England average.

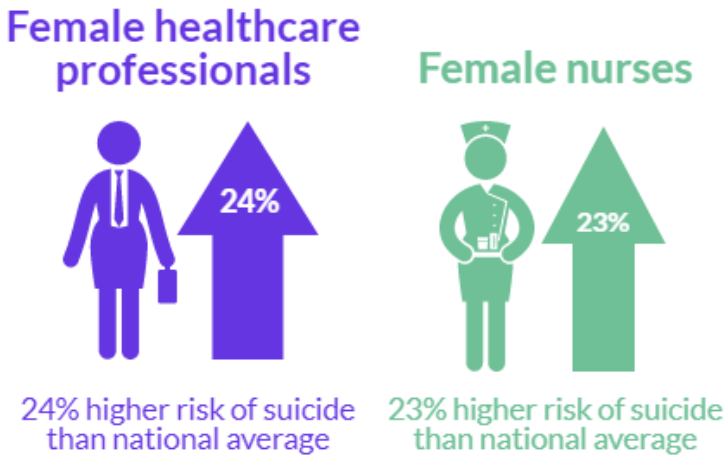
3.8 Nationally men working in unskilled occupations and skilled trades are at greater risk of suicide.

3.9 The three highest risk groups are construction, agriculture and process plant operation.





3.10 In women, healthcare professionals had a 24% higher risk of suicide, which is largely attributed to nurses, who specifically have a higher risk of 23% compared to the national average.



3.11 Local data (collated by PCMD) from 2011-2016, describes most suicides disproportionally occur at home, in both men and women – 62.16% and 57.15 %, respectively. Train stations were the second most common site of suicide in both men and women, 16.21% and 21.4% respectively, followed by hospital.

1. Home
2. Train stations
3. Hospital

3.12 Our annual report to the Suicide Prevention Forum will include key trend data and over the life course of the Framework document we will review the need to refresh our Suicide Prevention Audit.

3.13 We will also work with the South West London STP and our south west London Borough partners in order to work towards gaining access to coroner data.

Priority 1 - Prevention in high risk groups

4.1 A number of population groups face an increased risk of suicide. The first priority of our Framework will be to reduce risk in these groups.

Over the life-course of the Framework what outcomes do we want to see?

- An overall reduction in suicide in Merton and a reduction in suicide from people in high risk groups.

Middle aged and older men from low income backgrounds

4.2 National research highlights that the poorest are ten times at risk of suicide than the most affluent[iv]. Middle aged men from the most deprived backgrounds are a group particularly at risk.

4.3 There are a number of risk factors that make middle aged men at greater risk, these are outlined in Diagram 2. Research has highlighted risk factors which may include: views around discussing emotional issues and concepts of masculinity, not having someone to talk to about personal issues, emotional reliance on a partner and impact of relationship breakdown, being at mid life where options for change in career or relationship may be viewed as limited.

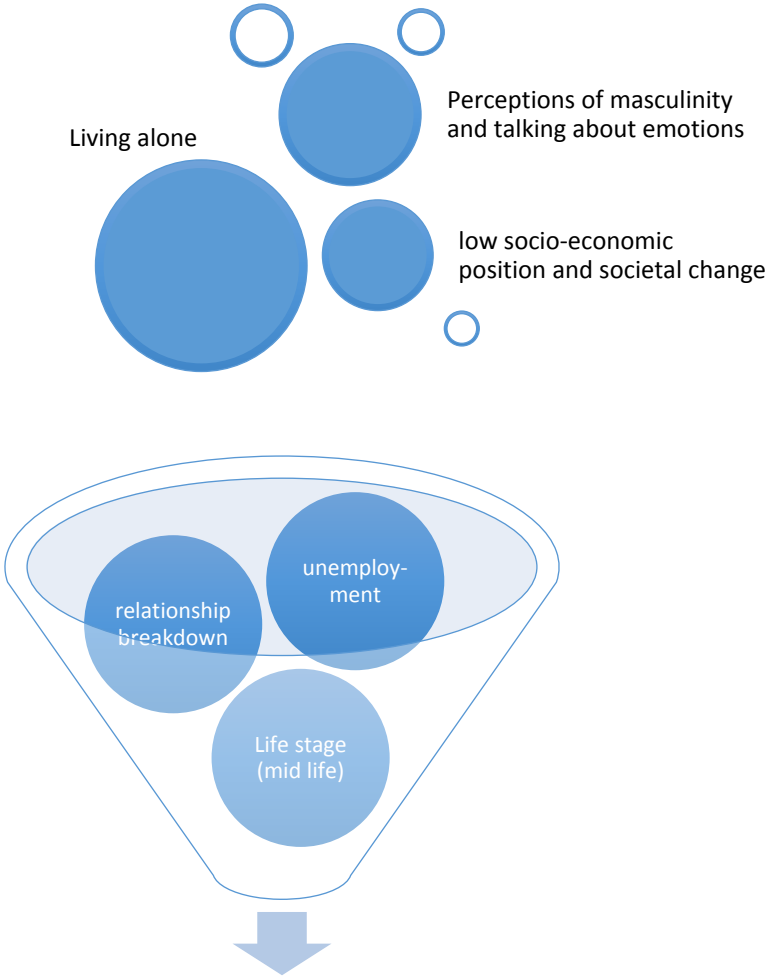


Diagram 2 – Risk factors[v]

Other risk factors may be related to work insecurity, unemployment and money issues.

4.4 Locally in Merton the *rate* of suicide amongst older men aged 65 and over is higher than the London average. Therefore our focus is on middle aged *and* older men.

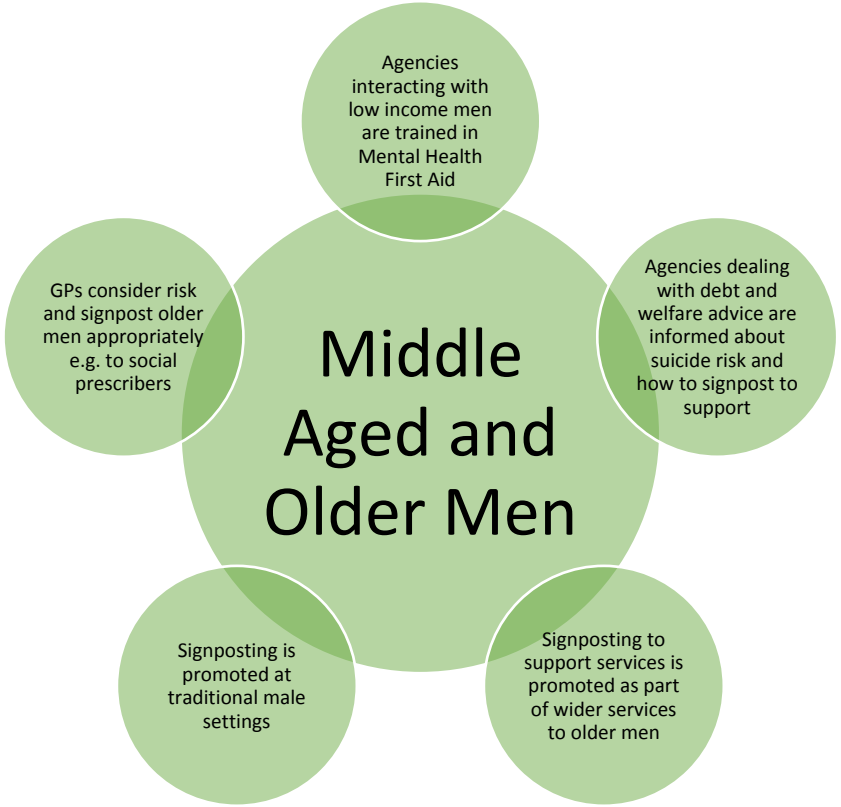
Reducing risk in middle aged and older men

4.5 Public Health England's guidance outlines this group as a priority and also focusing on economic factors, social isolation and substance misuse affecting men.

4.6 PHE recommends a number of activities including

- Suicide awareness training to frontline service providers across education, housing, employment.
- Citizens Advice, housing associations and homelessness services to provide and promote financial and debt counselling support to vulnerable individuals.
- Consider level of training and awareness for GPs and those working in substance misuse and mental health.
- Community outreach activity; suicide awareness messages to be promoted at traditional male settings e.g. football, rugby, public houses and music venues.

Over the life course of the Framework what outcomes do we want to see?



4.7 Merton's Transforming Families Team work with vulnerable families across the Borough. Men in these families are

likely to fit into the risk criteria category and the team, through building relationships over time and giving men the space to talk can support men to be signposted to relevant services.

What action will we take now?

4.8 We will work with the voluntary sector, GP surgeries/primary care(including social prescribers) , housing associations, homelessness and job centre staff to train them in suicide awareness training.

Over the life course of the strategy what will we do?

- We will work to promote suicide awareness messages at traditional male settings.
- We will encourage partners working with low income men to train their staff in mental health first aid.
- We will seek innovative ways to engage isolated lower income older men (65+) such as via our befriending service.
- We will promote suicide awareness training with our social care providers, who visit older and isolated men.
- We will ensure grant funded money advice and welfare benefits services and social prescriber staff in the Borough are aware of the risk facing low income men around suicide.

Young People aged 15 – 25 and vulnerable young people

4.9 Suicide is the leading cause of death for children and young people nationally with 15.2% of male deaths and 9.6% of female deaths of 5 to 19 year olds during 2016 identifying suicide as the cause of death[vi].

4.10 The majority of people who die by suicide are however adults and the Framework document focuses largely on these groups.

4.11 One high risk group that it is important to prioritise is those aged 15-19 who are at greater risk of suicide. Additionally vulnerable young people are at greater risk including care leavers and those involved with the youth offending or mental health services. As risk doesn't end at 19 our aspiration is that the Framework reduces risk in young people aged 15 – 25.

What does policy guidance recommend?

4.12 PHE guidance *"Local Suicide Prevention Planning"* (2016) recommends that Local Authorities prioritise focusing on young people. They outline action to support the mental health of children and young people (with a particular focus on reducing risk amongst 15-19 year olds and those in vulnerable groups).

Self Harm and Young People

4.13 Self harm is a risk factor for suicide and is a key issue facing young people. As an issue it is also a lot broader than suicide prevention and is in itself complex. Our Framework will therefore cross link to the more detailed pieces of work that are underway to reduce the incidences of self harming behaviours and work with young people that have been identified as self-harming. It is important however to highlight recent work to date and the current work-streams that are taking place;

4.14 The Child and Adolescent Mental Health (CAMH) Partnership Board is the interagency group that provides local leadership and oversight in relation to the emotional well-being and psychological and mental health of children and young people in Merton through the development of a local vision, strategy and action plans, known collectively as our Local CAMH Transformation Plan (LTP).

4.15 The LTP, which is refreshed and published annually encompasses preventive, early and specialist services that focus on either specific vulnerable groups such as Looked After Children, Youth Offenders, or specific issues such as Eating Disorders or Self Harm. The refresh is published each year on 31st October and at the same time submitted to NHS England, who assure all plans across the country to ensure they are meeting government requirements. Progress in Merton specifically relevant to this Framework includes:

Relevant work the LTP delivered in 2016/17

- Invest in Eating Disorder service to comply with national standards
- Pilot evidence-based early help interventions
- Develop 'Coping' and 'Getting Help' Provision within schools and train up mental health champions
- Pilot ASD support interventions
- Map, develop and publish CAMHS local offer
- CAMHS Partnership Board monitoring transformation projects and CAMHS data such as SPoA performance.

Relevant work the LTP delivered in 2017/18

- Delivered the Mental Health Investment Standard.
- Delivered the target to increase access to services for children and young people by 30% in 2017-18.
- Increased support for children and young people with special educational needs.
- Increased access to therapeutic counselling services for young people with emotional disorders.

Relevant work the LTP will deliver in 2018/19

- Deliver the target to increase access to services for children and young people in 2018-19 by 32% on the baseline access numbers

- Increase support for parents of children with special educational needs and learning disabilities
- Enhanced delivery of the Liaison and Diversion Service for young people in the youth justice system and on the edge of offending behaviour
- Procurement of an enhanced therapeutic counselling service for young people with emotional disorders
- Support the development of the Merton Autism Strategy and delivery of the Action Plan.

4.16 The Partnership is also currently consulting on a new Emotional Well being and Mental Health Strategy, effective from April 2019 to March 2022.

South West London STP work stream

4.17 Across south west London there is a rising incidence of young people who self-harm. To address this issue the south west London STP held workshops in early 2018, consulted with young people who had self-harmed and developed a programme of work to reduce the incidence of self harm by 20% over the next three years. The work will have a broader emotional well being focus and will have 3 main arms, underpinned by the research evidence of the causes of self harm and the information that our young people provided on the emotions and reasons that lead them to self harm:

- Support for children and young people
- Support for parents
- Whole School approach

4.18 The work will commence with a pilot cluster of schools during 2018-19, with the overarching aim to improve the support available for emotional wellbeing amongst young people. Work will focus on building emotional resilience, providing support materials for teachers, building knowledge and skills to discuss issues/signpost appropriately. Alongside this 'Empowering Parents, Empowering Communities' an evidence based parenting programme that is peer-led by trained and accredited local parents will be piloted. The STP plans will be approved by the CAMH Partnership to ensure synergy with developments in the LTP, including the intention to develop more non-medical solutions to emerging mental health problems, such as mindfulness; already practised in many of Merton Primary Schools and focused support for individuals within vulnerable groups such as those with Autistic Spectrum Disorder or Eating Disorder who may also self-harm.

Communication between organisations to reduce risk

4.19 Engagement with head teachers also highlighted the importance of good communication channels between GP's, schools and CAMHS in reducing the risk of suicide amongst young people.

Risk Factors for suicide amongst young people

4.20 The University of Manchester published "Suicide by Children and Young People" (2017)[vii] reviewing data on suicide nationally over a specific time period. They identified ten common themes linked to the risk of suicide amongst young people. These are outlined on Diagram 3.

4.21 Papyrus is a national charity that aims to reduce the number of young people who take their own lives, reducing stigma around suicide and equip young people and their communities with the skills to recognise and respond to suicidal behaviour. They have started working in some secondary schools in Merton including Kings College and Wimbledon College on the 'Save the Class of 2018' campaign.

4.22 A key message is that awareness needs to be across all secondary school staff not just teachers. For example a lunchtime supervisor may be the first person to identify a young person at risk.

4.23 Locally our steering group identified a number of issues including:

- On-line bullying and the need to respond to the changing nature of on-line platforms or apps.
- Young people exposed to sexual exploitation by electronic means and social media.

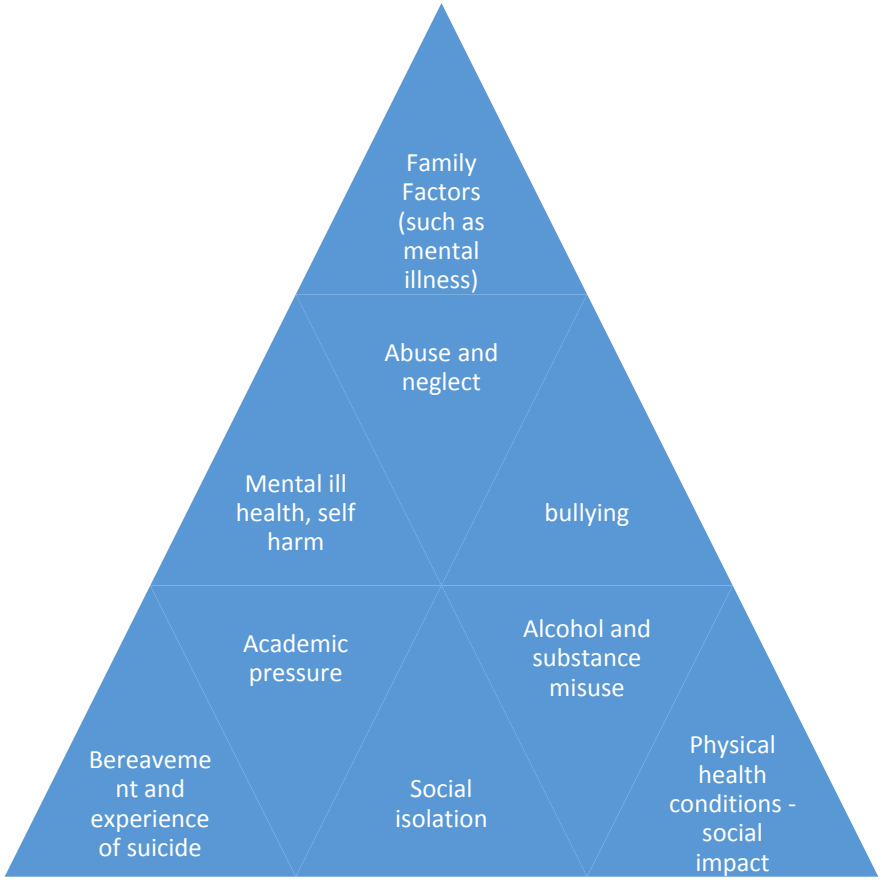


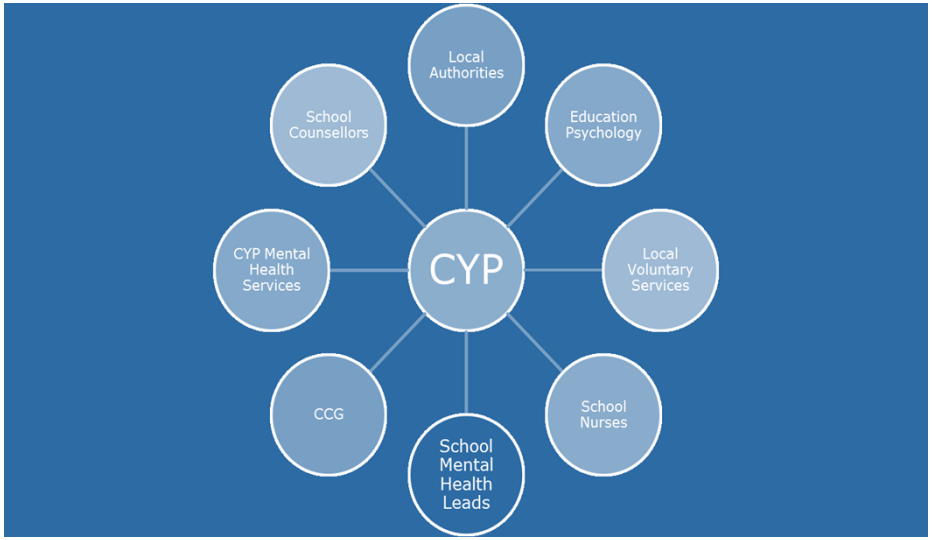
Diagram 3 - University of Manchester published "Suicide by Children and Young People" (2017)[viii] highlighting the following risk factors.

- Exam stress and the need for secondary schools to support young people with building emotional resilience.
- Issues faced by Lesbian Gay Bisexual Transgender and Queer (LGBTQ) young people who are at greater risk of suicide.
- Impact of trauma from bereavement of close family member.
- Disability faced by young people.
- Young people transitioning to adult mental health services and those leaving care.

Anna Freud Work with Schools

4.24 The Mental Health Services and Schools Link Programme is an exciting opportunity to support the mental health and wellbeing of children and young people by improving the way that mental health services and schools and colleges work together. This project, underway in Merton from Sept – Dec 2018 is facilitated by the Anna Freud National Centre for children and funded by central Government. The workshops are attended by schools and mental health professionals from a range of backgrounds that work individually with C&YP, operationally or strategically to improve the mental health of C&YP.

Diagram 4 - Partnerships within the Anna Freud Project



4.25 The purpose of the workshops is to build strong relationships across schools and mental health professionals so that they can begin to make positive changes in the way children and young people with mental health issues are supported. The project is being evaluated as part of a National initiative, with aims to understand how the range of approaches to new ways of working are implemented, how well they work and the lessons that can be learnt from them.

4.26 Each cohort includes 20 schools (including primary, secondary, special, academy, private and college) and 20

mental health professionals that attend two full days. There are three cohorts running across Sept-Nov, in Merton.

Other relevant support services

4.27 Jigsaw is commissioned to provide bereavement support for young people and their families. They also provide specialist support to children and families bereaved by suicide. Further information is provided in 'Support for People bereaved by Suicide'.

4.28 The Transforming Families Team work with some of the most vulnerable families and play a key role in supporting children and young people. This can be via assisting in early intervention or ongoing support work/risk management with families via safety plans.

4.29 Catch22 is commissioned through a partnership between Children School and Families and Public Health to provide a specialist Risk and Resilience service for young people aged 24 and under. The service aims to increase young people's engagement in diversionary activities, reduce the use of substances, promote sexual health and positive health choices through early intervention, prevention and substance misuse treatment for young people aged 24 and under.

Relevant work includes

- Risk/resilience education via targeted workshops in schools and youth provision
- Alcohol/Drugs workshops for young people.
- Early identification and referral to specialist services.
- Brief Interventions around sexual health and substance use, including alcohol.
- Tailored care planned 1:1 support/treatment interventions with a specialist substance misuse practitioner.
- Parenting interventions on a 1:1 basis or via groups and/or workshops.

4.30 The Samaritans run 'Developing emotional awareness and listening (DEAL), a free on-line teaching resource to help raise awareness of emotional health amongst young people aged 14+. The focus is on accessing support, coping strategies and reducing stigma around talking about mental health.

Vulnerable Children and Young People

4.31 Children who are Looked After, in Need and subject to Child Protection Plans suffer from a variety of vulnerabilities which make them particularly vulnerable to self harming, developing mental health problems later in life and going on to attempt suicide. Awareness among social workers and other professionals working with this cohort is of critical importance.

What will we do now?

4.32 Mental health first aid including elements of suicide awareness training will be made available to CAMHS,

leaving care and substance misuse staff working with young people.

4.33 We will work with Papyrus to promote pan London suicide awareness training to all secondary schools in the Borough.

4.34 We will work with Thrive London to develop Mental Health First Aid trainers in secondary schools in Merton.

Over the life course of the Framework we will ensure

4.35 Local secondary schools work to promote emotional resilience, with a focus on risk factors including exam pressure and bullying.

4.36 The mental health support needs of at risk groups such as LGBT young people and those with a disability are considered by services and appropriate support provided.

4.37 Secondary schools provide support for young people facing bullying including safe internet use training for young people.

4.38 Bereavement support that includes support after suicide continues to be available to young people.

4.39 Support is available for children subject to child in need, child protection and child in care plans.

What outcomes do we want to see over the life course of the Framework?

Other High Risk Groups

There are a number of other population groups who are at greater risk of suicide and which our Framework needs to consider.

People with a substance misuse issue

4.40 People who are known to alcohol and substance misuse services are at greater risk of suicide. One study[ix] of 403 people who died by suicide over a two year period found 67% had previously sought help from alcohol services. One in four cases reviewed also tested positive for illegal substances.

4.41 People with a dual diagnosis (who have both a mental health support need) and a substance misuse issue are also at greater risk of suicide.

4.42 WDP Merton offers a free and confidential support service for individuals over the age of 18 and their families and carers affected by drug and alcohol problems. Their specialist team includes substance misuse workers, doctors, nurses, as well as peer mentors. They offer a range of services including: information and advice; medical assessments and access to detoxification; support and advice; 1-2-1 key-working and group work. They work to support people who may be at risk of suicide by ensuring completion of robust risk assessments, discussion within multi disciplinary meetings, partnership working and sign posting to mental health and support services.

People involved with the criminal justice system

4.43 People in the criminal justice system are at higher risk of suicide, with periods of transition providing the highest risk periods. This includes the first 28 days after release from prison. One study from Sweden found that the risk of suicide for ex offenders was 18 times that of the general population and that ex offenders with a history of substance misuse were at higher risk[x].

High risk professions

4.44 National research highlights certain professions have a greater risk of suicide. For both men and women the risk of suicides was higher for those who work in culture, media and sport occupations. The highest risk was amongst performers, musicians and entertainers. For women risk was also high amongst nurses and primary school teachers.

Rough Sleepers

4.45 People who are homeless and rough sleeping are 3.5 times more likely to die by suicide compared to the general population[xi]. People who rough sleep often have other risk factors such as poor mental health and substance misuse.

People who are Lesbian, Gay, Bisexual or Transgender

4.46 A ‘Gay Man’s Health Survey’ of 6800 men (2013) found 3% of gay men had attempted to take their own life compared

to 0.4% of the general population during the same time period[xii]. A similar survey for lesbian and bisexual women in 2008 found that 5% had attempted to take their life[xiii]. People who are transgender have an even higher risk with one study finding that 11% of respondents had considered taking their own life in the last year and 33% had tried to kill themselves at some point in the past[xiv].

People with a long term physical health condition or illness

4.47 Whilst U.K. research has not focused greatly in this area there is some evidence that a long term health condition or illness is a risk factor for suicide. A Canadian study found older people aged over 65 and who had three or more health conditions had a threefold risk of dying by suicide[xv]. Research by Demos reviewing coroner's records in Norwich of 259 people who had died by suicide also found 9.7% had a terminal or chronic illness[xvi].

4.48 Research does demonstrate that long term health conditions can increase the likelihood of mental health conditions (a risk factor for suicide), with 20% of people with a long term condition likely to develop depression[xvii].

People transitioning from young person to adults services

4.49 Young adults who have previously utilised young people's services may find that adult services have different access criteria and as a result of this the support offer changes or is reduced. A key risk of falling through a 'transitions gap' in services is disengagement with services. Looked after children are 4 to 5 times more likely to attempt suicide in adulthood[xviii] and therefore transitions planning need to consider suicide risk in this vulnerable cohort.

What action will we take now?

4.50 We will promote mental health first aid to those working in substance misuse services.

What action will we take over the course of the Framework?

- We will work with commissioners to ensure that mental health first aid and suicide awareness training are considered as part of social value act benefits when commissioning new services.
- We will work with probation services to ensure suicide prevention training forms part of staff training.
- We will raise awareness of the groups at higher risk of suicide so services working with clients can consider how best to support those who may be at higher risk, such as LGBT residents or those with a long term physical health condition.

What outcomes do we want to see over the life course of the Framework?

Priority 2 – Reducing access to the means of suicide

5.1 Suicides often take place during a period of crisis. Reducing access or delaying access to the means of suicide for that crisis moment can thus prevent a suicide from taking place.

5.2 Reducing access can take a number of forms including physical barriers to accessing high risk locations, substitution (such as changing a higher risk medicine for another or the quantity of a medicine available), to monitoring and intervention by staff (such as at a train station).

Pragmatic ways to reduce access to means - Railways

5.3 Railway companies and network rail have over the last few years actively worked to reduce suicide, including fencing off areas, CCTV monitoring, staff training, signage and posters (such as for the Samaritans). They have their own strategies in place to reduce suicide on the railway and carry out intelligence and action plans for high risk locations. In Merton the two main rail companies are Southwestern Railway and Govia Thameslink Railway.

5.4 Govia Thameslink Railway (GTR) operates a Suicide Prevention Plan and through this plan looks to address three principles of suicide management; prevention, intervention and postvention. Prevention measures look at

how to reduce the means to access the railway through physical mitigations and also how to promote help seeking behaviour. Their plan has two objectives relating to physical mitigations and in addition to this work they collaborate with Network Rail to identify areas where they can prevent access, such as by installing platform end gates, mid-platform fencing, lineside fencing and improve the access arrangements for some platforms where access is not required on a regular basis.

5.5 They are also reviewing Samaritans signage they have on display at our stations, with a view to bringing them all in line with industry guidance in order to promote help seeking behaviour without advertising the location as an area/location of high risk. Their intervention work looks into how they provide staff with the skills and confidence to approach a vulnerable person in a time of crisis through training and awareness sessions and also how they report inventions which take place. This allows the company to assess and understand the risks at different locations, ensuring that prevention measures are appropriate to the level of risk before, rather than after an incident.

5.6 Southwestern Trains have implemented a number of changes at stations in the Borough including anti-trespass fencing on platforms including to not stopping trains, barriers at ends of platforms, anti-trespass matting (that prevents access), opaque screens on stairs and walkways – that prevent views onto the track and yellow hatching on platform ends. They have also introduced Samaritan signage at some stations.

5.7 They also run periodic security checks and regular patrols for vulnerable individuals and carry out awareness raising with staff. At certain stations they have trained front line staff in the Managing Suicidal Contacts course, run by the Samaritans.

Pragmatic ways to reduce access to means - buildings

5.8 There are also tower blocks and other locations such as flyovers that may be high risk locations. Owners can take action to ensure physical access is restricted and buildings can be checked to be 'suicide proofed' e.g. no access to roofs. Work can also take place to ensure planners are aware of 'suicide proof' design principles.

Controlled environments

5.9 There are some areas where prevention to the means of suicide is more difficult (such as with hanging) as it may involve materials that are commonly available and takes place in the home. Research on this area[xix] highlights the importance of restricting access in controlled environments, where high risk individuals may be placed such as police stations, hospitals and prisons. It should be stated that nationally only 10% of suicides by hanging occur in controlled environments.

Reporting

5.10 Sensitive reporting by the media is an important element for suicide prevention and research links issues around media reporting with risk of imitative behaviour. Public Health England highlights issues such as describing methods in detail and extended or sensationalist coverage. The Samaritans highlight the issue of media, discussing site location and risks of a site with a high suicide rate becoming known as such. It is therefore important that local media follow appropriate guidance, such as outlined by the Samaritans and articles include details of support available.

Primary Care and Healthcare professionals

5.11 GPs, pharmacies and Mental Health Teams all have a key role to play in reducing access to the means of suicide. For example GPs may consider substitution or lower dosage of medicines of patients at risk of suicide whilst pharmacies have a role in dispensing and monitoring. Where someone has died at home and have been on medication such as morphine (where there is risk of over-dose) the attending physician should ensure the medication is not left that a grieving spouse could use. Consideration should also consider the quantity of prescription drugs such as opioid medication for people with long term pain conditions, who are a group at greater risk of suicide.

5.12 National research highlights healthcare professionals had a 24% higher risk of suicide, which is largely attributed to nurses, who specifically have a higher risk of 23% compared to national average. Research has highlighted easier access to medicine as a key risk factor. There is a need to ensure those working in high risk occupations have access to or can be signposted to mental health and wellbeing support services within their organisation.

Reducing Stress amongst the healthcare workforce

5.13 SWLSG MHT is running Health and Wellbeing Training workshops to Managers/Leaders across the Trust. Work is being planned to support areas reporting high levels of stress. This will help understand the main causes and make available a range of interventions designed to help manage and reduce stress amongst the workforce.

What action will we take now?

5.14 We will ensure every train station in the Borough has clear signage on accessing support in a crisis, such as the Samaritans.

5.15 We will carry out a confirmation checklist with partners such as the Police and South West London and St George's Mental Health Trust that a) plans are in place and b) are regularly reviewed, on reducing access to the means of suicide for those in controlled environments, such as cells or inpatient accommodation.

5.16 Investigate levels of overdosing amongst Merton residents to see if this is an issue to inform framework actions for the following years.

5.17 Support work being carried out by 'Thrive London' on raising awareness of the means of suicide around prescriptions and vulnerable groups.

Over the five year period of the Framework we will

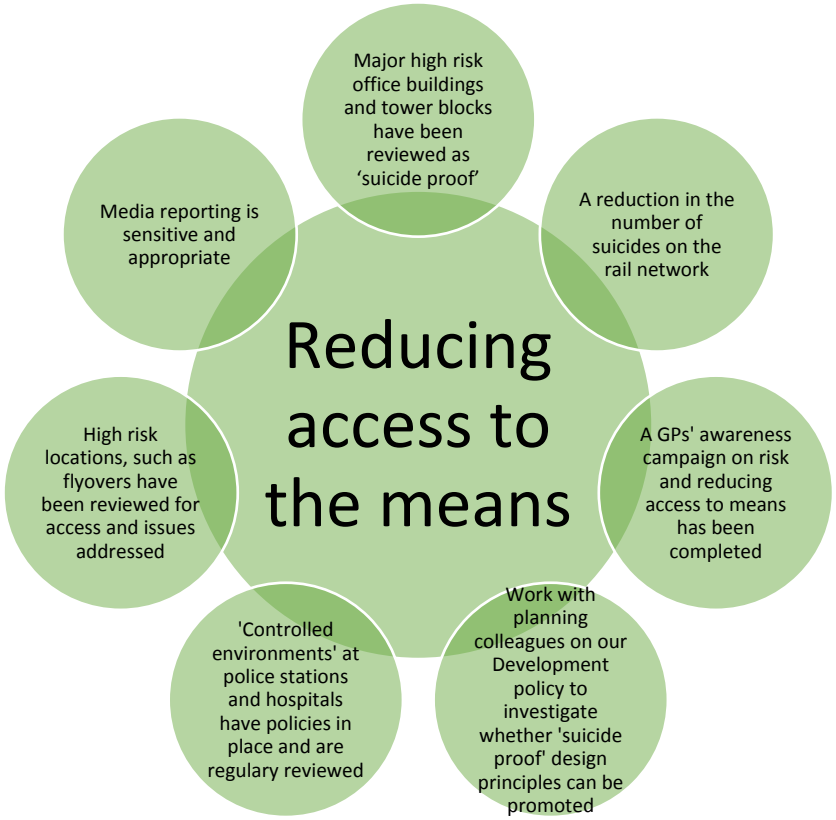
5.18 Work with our planning department to identify and map high risk buildings or structures in the Borough.

5.19 Work with our largest social housing providers to consider safety and access to means within their housing stock.

5.20 We will work with employers of high risk professions and encourage promotion of mental health and wellbeing organisational resources.

5.21 We will work with our communications team to promote the Samaritan's guidance to local press and media and voluntary sector organisations. This work will form part of any South West London STP work-streams.

Over the life course of the Framework, what outcomes do we want to see?



Priority 3 – Good mental health and support services for at risk groups

6.1 People with a diagnosed mental health condition are at greater risk of attempting or completing suicide.

6.2 Evidence shows 27% of people who die by suicide were previously known to mental health services[xx]. It is vital therefore to ensure our mental health services consider suicide awareness and provide appropriate levels of support to patients at risk of suicide.

6.3 Effective pharmacological and psychological treatment of depression is an important element to suicide prevention[xxi].

6.4 For patients who have left secondary mental health services ongoing support within a primary care setting is an important part of keeping people well.

Hospital Discharge

6.5 The time after discharge from hospital for those with a mental health condition is a time of heightened risk of suicide. Whilst someone will not be discharged unless appropriate to do so, it is still important that there is good communication between secondary mental health services and primary care to support vulnerable patients.

6.6 Historically, work carried out reviewing mortality reports by South West London and St George's Mental Health Trust identified two risk issues related to suicide prevention;

- Discharge of patients and appropriate communication with primary care.
- Follow up of patients who have not attended appointments on multiple occasions.

To address this there has been a renewed push within SWLSTG trust to address these issues and to mitigate some the risks mentioned above. SWLSG also has developed a comprehensive Suicide Prevention Strategy (2018-2021).

Young People

6.7 Discussions with a number of stakeholders working with young people highlighted a gap in service provision locally to support vulnerable young people and their families where they have attempted suicide yet are well enough to be discharged from hospital. Mental health support via CAMHS is available but day to day support for those at risk and their families was seen as a gap in service provision. We will work to identify potential funding streams to address this.

6.8 The importance of good communication channels between

schools, CAMHS and GP surgeries was also raised as a wider issue that supports suicide prevention.

Targeting groups at risk of poor mental health

6.9 Certain groups are at higher risk of poor mental health or have less access to support from mental health services. Public Health England highlight these groups including:

- Vulnerable children and young people such as those leaving care
- People with long term conditions
- People who are LGBTQ
- Ex service personnel
- People from BAME communities
- Asylum seekers
- Survivors of abuse
- People who misuse drugs and alcohol
- People who are vulnerable due to social and economic factors

It is important therefore that commissioners of mental health services consider engagement with these key groups.

Self Harm

6.10 Whilst the majority of people who self harm do not die by suicide, a history of self harm is a significant risk factor for suicide[xxii]. Public Health England highlights the importance of NICE (The National Institute for Health and Care Excellence) standards and pathways CG16 and CG133 for patients who self harm. This includes ensuring psychosocial assessments and risk assessment (that consider suicide risk) form part of the service offer. Merton CCG will work over the life course of the Framework to ensure that the re-commissioning of the self-harm pathway meets these standards.

Support for those in crisis

6.11 There are a number of services that provide important support for those in mental health crisis and therefore contribute to supporting people who may be at risk of suicide. A key outcome of the Framework is that these services continue to provide support to at risk groups.

6.12 Providing support at a time of mental health crisis is an important element to the suicide prevention framework and our wider mental health pathway. South West London and St George's Mental Health Trust (SWLSG MHT) provide a psychiatric liaison service out of A&E. Recently Merton CCG funded them to provide a 'Core 24' level of service. This means that the commissioned service provides a 24 hour service where there is appropriate mix of skill levels and staffing to run the service efficiently. The service provides a 1 hour response to A&E referrals and a 24 hour response to urgent referrals from inpatient wards. Similar hospitals including Kingston and Epsom and St Helier provide a similar level of service.

6.13 SWLSG MHT also commission two crisis cafés that supports people who self identify that they are or at risk of moving into a mental health crisis. This provides a non- clinical alternative to A&E or hospital admission. The café's staff also work with clients to develop coping skills to avoid future crisis and build emotional resilience.

6.14 The Metropolitan Police work with mental health practitioners to operate a 'street triage' system. This has operated for the last 18 months. The police and a community psychiatric nurse can attend an emergency call and support someone in a public place, allowing vulnerable people to access care more quickly. The scheme also reduces the number or s136 referrals to a place of safety.

Ongoing Support in Primary Care

6.15 Merton CCG is commissioning a primary mental health care service which will become operational in April 2019. The service will incorporate a Wellbeing element, talking therapies (within an Improving Access to Psychological Therapies (IAPT) service), and a Primary Care Recovery service. Together, these services should provide support to local residents with a wide range of mental health needs, from common mental health problems to severe and enduring mental health problems. Where possible, the Merton Primary Mental Health Care service will support people with a range of mental health problems to stay well, or maintain their recovery from mental illness, without advancing into secondary care, or more intrusive forms of treatment.

Peer Support

6.16 The Council commissions a peer support service for patients who have been using secondary mental health services. Peer support refers to mutual support provided by people with similar life experiences. Peer support services can increase social contact and raise self-esteem[xxiii] and encourage a greater recovery focus[xxiv]. We will work to ensure that mental health peer support is available to support independence and good quality lives for people with serious mental health conditions.

What action will we take now?

6.17 We will explore funding opportunities for support for young people who have attempted suicide who have been discharged from hospital but who still require enhanced support

Over the life course of the Framework we will

6.18 We will check with our hospital and Primary care colleagues that processes are in place that aid communication and support at risk individuals when they are discharged from secondary mental health services.

6.19 Ensure staff from CCG commissioned services for mental health are skilled in suicide awareness and suicide prevention.

6.20 Ensure peer support services are available for those leaving secondary mental health services.

6.21 Ensure our self-harm pathway for adults meets NICE guidelines.

6.22 Develop an e bulletin highlighting the particular risks facing those with mental health issues around suicide, for use by primary care and other organisations.

What outcomes do we want to see around good mental health and support services for at risk groups?

Priority 4 – Suicide awareness and good mental health and wellbeing for all

7.1 The World Health Organisation (WHO) defines mental health as

"a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"[xxv]

7.2 In any given year one in six adults will experience at least one diagnosable mental health problem. Signposting and access to services such as Improving Access to Psychological Therapies (IAPT) and wider wellbeing activities, such as mindfulness can play a role in keeping us well. For those with mental health issues wellbeing activities such as problem solving /coping strategies, encouraging greater connectivity to family, friends and community may also play a role in reducing risk of suicide[xxvi].

7.3 With the relationship between poor mental health and risk of suicide it is important to recognise the role that prevention can play. Work done 'upstream' to promote good mental health, emotional resilience and wellbeing can play a role (by reducing the flow of people into 'at risk' groups) in our plans for suicide prevention.

7.4 NICE Guideline [NG105] includes a number of recommendations around community awareness of suicide including: raising awareness of the impact of suicide, reducing stigma associated with suicide, addressing popular misconceptions, highlighting support available and encouraging help seeking behaviour[xxvii].

Thrive London

7.5 Thrive London is a London wide movement to improve the health and wellbeing of all Londoners. It is supported by the Greater London Authority (GLA) and London Boroughs. It aims to deliver a number of campaigns and a key objective is for London to be a zero suicide city.

Good Thinking

7.6 Good Thinking is a digital mental health and wellbeing offer for Londoners, providing tools and information on issues such as anxiety, sleep problems, stress and low mood. It is currently (as at August 2018) in its beta testing phase, meaning the site is live but still being tested.

Merton CCG commissioned services

7.7 Improving Access to Psychological Therapies (IAPT) is a national programme that aims to improve access to treatment for those with depression and anxiety disorders by offering NICE approved interventions and is evidenced by measuring patient's health outcomes. There is strong

evidence that appropriate and inclusive services and pathways for people with common mental health problems, specifically depression and anxiety, reduce an individual's usage of NHS services and contribute to overall mental wellbeing and economic productivity.

7.8 Merton CCG commission a range of services to treat mental illnesses, such as IAPT. They are currently re-commissioning IAPT and wider wellbeing services aimed at anyone with a mental health need, such as anxiety or depression. The aim is to increase access to IAPT within the Borough.

Thrive Merton

7.9 The Council and CCG will develop a local Thrive partnership, 'Thrive Merton' by June 2019. This partnership will aim to improve the mental health and wellbeing of residents and patients locally including working collaboratively with Thrive London and adopting new initiatives locally.

Role of large scale employers

7.10 Large scale employers in Merton can also play a role in improving residents' health through running mental health first aid and wellbeing programmes for their employees.

Role of secondary schools and colleges

7.11 The role of secondary schools in promoting good mental wellbeing has been highlighted in the 'reducing risk in high risk groups' chapter. Additionally adult education colleges can play a key role in promoting initiatives such as the Mental Health First Aid and suicide awareness training as part of their adult training programme to the community.

Role of Community and Voluntary Sector Partners

7.12 It is important that our residents understand the importance of good mental health and are encouraged to be able to signpost to organisations that can help, from finding activities that contribute to wellbeing to who to turn to in a time of crisis. Community and voluntary organisations can play a key role in promoting this message.

Reducing social isolation and loneliness

7.13 Loneliness and isolation can impact on people's physical and mental health including increased risk of coronary heart disease and are risk factors for cognitive decline, hypertension and depression. Loneliness has also been identified as one of a number of risk factors for suicide[xxviii].

7.14 National research highlights that older men are more likely to be lonely compared to older women[xxix].

7.15 The Council commissions a befriending service for older people and we will ensure this service targets older men as well as women. Library, Adult Education and Heritage staff

will also look to deliver a music and football project for men aged 50+, a key at risk group.

Over the life course of the Framework what outcomes do we want to see regarding good mental health and wellbeing for all?

What action will we take now?

7.16 Hold suicide awareness and mental health first aid training for community and voluntary groups

7.17 Ensure our Befriending service for older people considers how best to target older men who may be socially isolated.

7.18 Library services supported by Public Health will investigate grant funding opportunities to run a music and football activity pilot for men over 50.

Over the life course of the framework what will we do?

7.19 We will work with community organisations to promote mental health first aid, the importance of talking about mental wellbeing throughout the Borough.

7.20 We will support national campaigns around suicide awareness locally such as those by the Samaritans or Public Health England.

7.21 Encourage other large scale employers in the Borough to adopt Health in All Policies approach and run initiatives to support employee wellbeing.

Priority 5 - Support for people bereaved by suicide

8.1 Suicide affects not just an individual but families, friends, colleagues and communities. Families affected by suicide may go through a number of emotions such as profound shock, distress or even guilt. They may search for explanations as to why their loved one took their life. The stigma that is often associated with suicide may also make it more difficult for the bereaved to seek the support they need.

8.2 More widely, people witnessing a suicide may be affected and require support, such as counselling.

People who are bereaved through suicide are at greater risk of suicide and poor mental health

8.3 Evidence suggests that compared with people bereaved through other causes individuals bereaved through suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning[xxx].

8.4 A survey in 2010 found that friends, relatives of people who die through suicide have a 1 in 10 risk of making a suicide attempt after their loss[xxxi].

8.5 Public Heath England 'Local Suicide Prevention Planning' (2016) identifies people who have been bereaved through suicide as one of the priority groups for action. They recommend information and support needs to be provided to those bereaved or affected by suicide.

8.6 Support also needs to be able to respond at a community level such as support for schools or in the event of an emerging suicide cluster. Wider support such as IAPT or counselling services need to also be available to those who have witnessed a suicide or who deal with traumatic events on a regular basis, such as the police.

8.7 Children often come to the attention of Children's social care because of the suicide of a parent or a close relative. Social Workers and others need to be able to assess and provide or identify support for these children and their families.

Support to staff on the railways

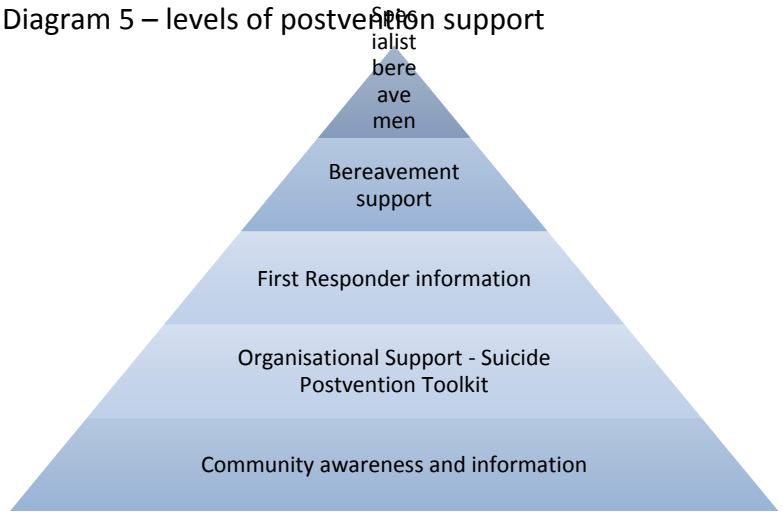
8.8 Govia Thameslink offer a range of postvention measures, looking at what happens to their passengers and staff after a suicide, in order to reduce the harm to these individuals with focus on staff support and in particular support for drivers. As part of this they are implementing a system of peer support, enhancing their post-incident support from managers and also strengthening the relationships stations have with local Samaritans' branches.

Support to Young People

8.9 Jigsaw4U is a charity commissioned to provide bereavement support to young people in Merton. They also provide bereavement support for children, young people and their families around suicide. In 2017/18 they worked with 17 individuals following the death of a loved one by suicide (nearly 2/3 of which were children/young people). This support has been provided through group work, individual work and family work. They also provided telephone advice and consultation to 5 individuals (teachers, social workers and parents).

8.10 Our Task and Finish Group also highlighted the need for clear pathways to access postvention support.

Diagram 5 – levels of postvention support



Support from the Samaritans

8.11 The Samaritans also provide a 'Step by Step' support offer to schools. This provides a team of Samaritan volunteers who can support schools and colleges in response to a suspected suicide. They support the school community to come to terms with what has happened and reduce further risk.

8.12 The Samaritans also provide a presence at railway stations in the Borough following a suspected suicide, providing support to anyone who has been affected.

What action will we take?

8.13 *Help is at Hand* is a support guide for people affected by suicide, providing both practical advice and information about emotional support. We will work with our partners to ensure this guide is promoted to community organisations alongside articles on awareness of the importance of support for people affected by suicide.

8.14 We will work with the Police, Fire and Ambulance services as well as GPs and other front line responders to ensure they have copies of and are aware of 'Help is at Hand' and the Help is at Hand Z card[xxxii].

Merton CCG Commissioned services for trauma

8.15 Merton CCG commissions treatment services for people who have experienced trauma including IAPT and more specialist trauma services. These can support people who have witnessed suicide.

Over the longer term we will

8.16 Encourage large scale employers in the Borough to consider adopting the postvention toolkit for employers.

8.17 Map levels of bereavement support and specialist bereavement support available in Merton, ensuring awareness of local resources and considering potential gaps as part of the Council's and CCGs' commissioning intentions.

8.18 Make schools aware of the 'Step by Step' support offer available from the Samaritans to schools.

8.19 We will ensure our mental health services can react to the impact of suicides (such as in a schools setting) and can respond with rapid referrals to community mental health teams.

Over the life course of the Framework, what outcomes do we want to see around postvention?

Action Plan 2018/19 (partial) and 2019/20

Outcome		Action	Timescale	Lead	
Prevention in High Risk Groups	1	Deliver Phase One of a programme of Mental Health First Aid (MHFA) for Merton including • Supporting Thrive Merton's MHFA secondary school training in Merton. • Delivering MHFA (2 sessions) and MHFA Champions (3 sessions) targeting those working with 'at risk' groups During 2019/20 we will • Work with community and voluntary sector partners to bid for grant funding opportunities (MHFA and suicide awareness). • Explore opportunities to add MHFA to our contracts through the Social Value Act 2012. • Work with Adult Education Services to provide MHFA training within community settings.	April 2019 February 2020	Thrive London Public Health ASC, PH & Corporate. Libraries Service	
	2	Deliver Suicide awareness training to those working with at risk groups including • Delivering 3 initial accredited training sessions • Create suicide prevention articles for E Bulletins • Promote free awareness on-line training • Support Papyrus work on suicide awareness training with secondary schools in Merton During 2019/20 we will • Explore social value act opportunities to run training.	April 2019	Public Health MVSC / Public Health Papyrus Suicide Prevention	

		• Work with the Suicide Prevention Forum to bid for grant funding. • Promote zero suicide alliance on-line training.	March 2020	Forum Public Health and partners	
	3	We will explore funding opportunities for support for young people who have attempted suicide who have been discharged from hospital but who still require enhanced.	November 2019	Children, Schools and Families CAMHS	
Reducing Access to the Means of Suicide	4	We will ensure every train station in the Borough has clear signage on accessing support in a crisis, such as the Samaritans.	December 2019	South Western Govia /Thameslink	
	5	We will complete a confirmation checklist with partners such as the Police and South West London and St George's Mental Health Trust that a) plans are in place and b) are regularly reviewed, on reducing access to the means of suicide for those in controlled environments, such as cells or inpatient accommodation.	October 2019	Public Health SWLSG MHT Metropolitan Police	
Good Mental health and support services for at risk groups	6	In 2018/19 we will • Deliver topic based e-bulletins on mental health risk and suicide to brief those working in primary care (GP surgeries, pharmacies). In 2019/20 we will • Ensure staff from CCG commissioned services for mental health (adults) are skilled in suicide awareness and suicide prevention. • Ensure newly commissioned service that includes a self	January 2019 June 2019	Public Health Merton CCG	

		harm pathway (adults) meets NICE recommended guidelines CG16 and CG133.	November 2019	Merton CCG	
Suicide Awareness and good mental health and wellbeing for all	7	We will set up a Suicide Prevention Stakeholder Forum that will meet every six months We will address isolation issues in the borough through; • Exploring opportunities for funding a music and football project for men over 50. • Ensure befriending service engages older men and consider risk of suicide and support offer	March 2019 March 2019 December 2018	Public Health Libraries Public Health Public Health	
Support for People bereaved by suicide	5	Make sure appropriate literature is available in Merton including • Promote 'Help is at Hand' to community and voluntary sector organisations throughout the Borough as part of wider awareness campaign. • Ensure the emergency services and GPs have 'Help is at Hand' Z cards and use them.	August 2019 August 2019	MVSC Public Health Metropolitan Police LAS London Fire Brigade GPs / CCG	

Appendix A – List of Task and Finish Group Members

We would like to thank Task and Finish Group Members for contributing to the development of the Framework document and action plan.

- Paul Angeli, Children's, Schools and Families, Merton Council
- Andrew Beardall, South Thames College
- Patrice Beveney, Merton CCG
- Harry Biggs-Davidson, Papyrus
- Gemma Blunt, Adult Social Care, Merton Council
- Vere Bowyer, Metropolitan Police
- Jessica Buckpitt, South Western Railway
- Daniel Butler, Public Health, Merton Council
- Elizabeth Campbell, Westminster Drug Project
- Barry Causer, Public Health, Merton Council
- Ayda El-Deweiny, Job Centre Plus
- Beau Fadahunsi, MVSC
- Alessandro Finistrella, South Western Railway
- Charlotte Harrison, South West London and St Georges Mental Health Trust
- David Hobbs, Mental Health Forum
- Joy Horden, Samaritans
- John Horwood, Clarion Housing Association
- Richard Jackman, DWP
- Steve Langley, Housing services, Merton Council
- Barry Milward, Govia Thameslink
- Dr Andrew Otley, Merton CCG Clinical Lead
- Andy Ottaway Searle, Direct Provision, Merton Council
- Ben Rowe, South Thames College
- Rosa Treadwell, Public Health, Merton Council

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Committee: Health and Wellbeing Board

Date: 27th November 2018

Wards: All

Subject: Merton Health and Wellbeing Strategy 2019-24 update on refresh

Lead officer: Dagmar Zeuner, Director of Public Health

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

Contact officers: Clarissa Larsen (Health and Wellbeing Board Partnership Manager) Clarissa.Larsen@merton.gov.uk and Natalie Lovell (Health Places Officer, Healthy Places) Natalie.lovell@merton.gov.uk

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Recommendations:

The Health and Wellbeing Board are asked to:

A. Note the continuing refresh of the Merton Health and Wellbeing Strategy 2019 – 24.

B. Note the links and synergies between the Health and Wellbeing Strategy, the Merton Health and Care Plan and other strategies.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report sets out the refresh work currently underway to help inform the development of the new Health and Wellbeing Strategy which will run from 2019 –24. The report also explains the links and synergies between the Health and Wellbeing Strategy and the Merton Local Health and Care Plan.

2 CONTEXT The Health and Wellbeing Board

2.1. The Health and Wellbeing Board (HWBB) brings together key stakeholders to provide leadership for health. This includes shaping a health promoting environment (healthy place) as well as promoting good health and care services. Its work is influenced by the Joint Strategic Needs Assessment and an ongoing dialogue of what matters to people. It is a statutory duty for the Health and Wellbeing Board to produce a joint Health and Wellbeing Strategy.

Values and ways of working

2.2. Past experience suggests that the Heath and Wellbeing Board is most effective when it focuses efforts on a few select priority areas, rather than

a broader range of issues.[1] Its success partly lies in the commitment of its members to promote shared values including social justice, prevention and a desire to learn and experiment, in their own organisations.

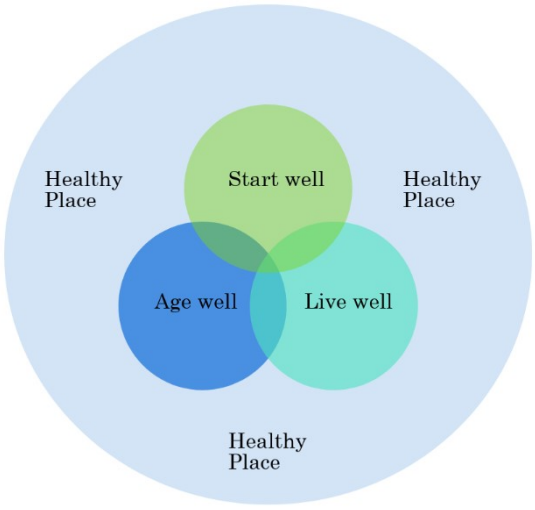
Themes of the Health and Wellbeing Strategy 2019-24

2.3. The Health and Wellbeing Strategy sets out how the HWBB will work in partnership to ensure a fair share of opportunities for Merton residents to live healthy lives, take early action to improve their health and wellbeing, and to reduce health inequalities. The refreshed Strategy will have four key themes:

- Start Well
- Live well
- Age well
- …in a Healthy Place

2.4. The Healthy Place theme is an integral part of the first three themes. See Figure 1.

Figure 1: Themes of the Health and Wellbeing Strategy 2019-24



[1] For example, the Health and Wellbeing Board has previously prioritised childhood obesity, applying a preventative, whole systems approach to tackling this complex issue, and developing a Child Health Weight Action Plan which was complemented by an Annual Public Health Report 16/17 on Childhood Obesity

Synergy with the Local Health and Care Plan

2.5. The first three themes of the Strategy are mirrored in the Local Health and Care Plan which is currently being developed by the NHS together with the Local Authority and other partners to focus on health and care services and integration.

2.6. The Local Health and Care Plan is overseen by the Merton Health and Care Together Board; whilst this Board focuses on health and care services and integration, the Health and Wellbeing Board provides the overall vision, oversight and strategic direction for health and wellbeing in Merton, encompassing the wider determinants of health.

2.7. We are working closely with colleagues to coordinate both of these plans and make sure they complement each other. This includes sharing insight gained through the engagement work currently underway. See Figure 2 for a visual of these two complementary plans.

Figure 2: The complementary plans: Health and Wellbeing Strategy and Local Health and Care Plan

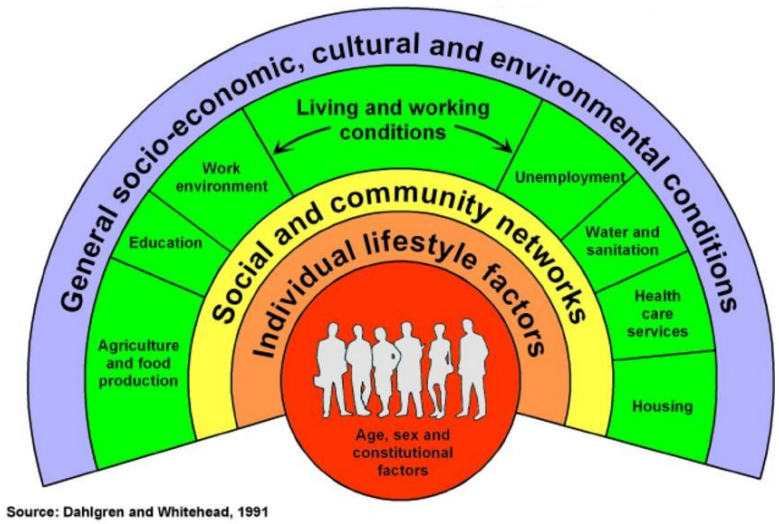
Refresh process

2.8. Although governance of the Health and Wellbeing Strategy sits with the Health and Wellbeing Board, the refresh process will involve all thematic partnerships; Children's Trust Board; Safer and Stronger Partnership; and the Sustainable Communities and Transport Partnership, all of whom influence the wider determinants of health. See Figure 3.

2.9. We are engaging and communicating with local leaders to help shape, take ownership of and achieve the vision of the Health and Wellbeing Strategy refresh. These local leaders and place shapers include: Health and Wellbeing Board members; London Borough of Merton Directors; CCG; GPs; Councillors; local leaders; officers; the voluntary sector; and the people of Merton.

2.10. We are working in synergy with colleagues working on other strategies currently being refreshed including the Local Health and Care Plan as mentioned previously, the Children and Young People's Plan, the Community Plan and the Early Years framework.

Figure 3: The wider determinants of health



Source: Dahlgren and Whitehead, 1991

3 HEALTH AND WELLBEING STRATEGY: BUILDING OWNERSHIP AND LEARNING WHAT MATTERS TO PEOPLE

3.1. The HWBB development seminar on 3 October contributed to the Health and Wellbeing Strategy refresh as members considered achievements to date and how the HWBB can most add value through the future strategy's priorities and actions across each of the themes.

Themed workshop programme

3.2. Four planned themed workshops will allow us to discuss and reflect on what we think are the priorities for Start Well, Live Well, Age Well and Healthy Place for 2019-24. We would like to build on the ongoing work of the Health and Wellbeing Board in these areas, and its commitment to fairness, promoting early action and reducing inequalities. The workshops are a fantastic opportunity to learn from the collective expertise and personal experiences of the people in the room.

Start Well workshop

3.3. On 5 November the first of these themed workshops took place. The Start Well session was led by Rachael Wardell and Cllr Kelly Braund together with Dr Dagmar Zeuner and Dr Subrho Muckherjee. It was a participative session; we discussed and reflected on what we think are the priorities for children and young people's health and wellbeing for 2019 – 24, with a particular focus on what a healthy place would look like to help children and families flourish.

3.4. A key emerging message was that having a good start in life isn't just good for our physical and mental wellbeing in our teenage and adult years; it is an end in itself. All children have a right to play, to learn, to build positive relationships and to flourish in the public spaces and places around them.

3.5. Findings from this workshop are currently being written up and will be shared. Initial thinking revealed tentative priorities to be: Early Years; Think Family; Childhood Obesity; and Mental and Emotional Wellbeing, however the continuing engagement will be used to further shape and develop these priorities.

Workshop timeline

3.6. The timeline for the remaining workshops is set out below and HWBB members have been invited to lead each of the sessions:

Participative Workshop	Date
Live Well	18 December 2018
Age Well	31 January 2019
Healthy Place – bringing all four themes together	12 February 2019

Community engagement

3.7. We are also linking with colleagues in Children, Schools and Families who are working on the refresh of the Children and Young People's Plan to engage with young people. We are in the process of finalising a survey for pupils in Years 7 and 11 in Merton schools including questions on their health and wellbeing. This will help further shape our understanding of what matters to young people in Merton.

3.8. We will share all findings with colleagues working on the Merton Health and Care Plan and will continue to identify opportunities for joint engagement with our colleagues as part of the Live Well, Age Well and Healthy Place themes.

3.9. We are also planning an online survey, making best use of our stakeholders' networks and including questions in the Merton Resident's Survey early 2019.

4 ALTERNATIVE OPTIONS

It is statutory duty for all Health and Wellbeing Boards to produce a Health and Wellbeing Strategy

5 CONSULTATION UNDERTAKEN OR PROPOSED

The consultation programme is as set out in the report.

6 TIMETABLE

The plans for developing the health and wellbeing strategy 2019-2024 are outlined in the timetable below.

Date	Meeting	Purpose
November/December		
18 December	**Live Well Workshop**	2nd engagement workshop
December – February dates tbc	HWS on-line survey	Wider engagement that we and workshop contacts can direct their own contacts to.
2019 January		
29 January	**HWBB**	Report on HWS engagement if needed TBC
31 January	**Age Well Workshop**	3rd engagement workshop
February		
5 February	Merton Partnership Exec Board meeting	Opportunity to take HWS report – engage MP
5 February	Health Scrutiny Panel	HWS report for discussion / input from Scrutiny
12 February TBC	**Final workshop to bring together all themes + in a Healthy Place**	4th and final engagement workshop – returning to all themes in a Healthy Place
February	HWS on-line survey closes	Final analysis of full engagement takes place
March		
26 March	**HWBB**	Draft HWS to be discussed
June		
25 June	**HWBB**	Final HWS for sign off

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report.

8 LEGAL AND STATUTORY IMPLICATIONS

It is a statutory duty for the Health and Wellbeing Board (HWBB) to produce a joint Health and Wellbeing Strategy (HWS), based on the Joint Strategic Needs Assessment (JSNA).

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The HWS is directly concerned with improving health equity.

10 CRIME AND DISORDER IMPLICATIONS – N/A

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS-N/A

12 APPENDICES -none

Committee: Health and Wellbeing Board

Date: 27th November 2018

Subject: Local Plan – HWBB Participation in Consultation

Lead officer: Director for Environment and Regeneration, Chris Lee

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

Contact officer: Strategic policy planner, Ann Maria Clarke

Recommendations: That the Health and Wellbeing Board

A. Participate in the draft Local Plan consultation which will finish on 6th January 2019

www.merton.gov.uk/newlocalplan

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Following on from initial recommendation on the 28th November 2017 and then on the 27th March 2018. This report will update the Health and Wellbeing Board on the new Local Plan, ask for responses to the Stage 2 consultation before 6th January 2019 and request ongoing involvement, particularly on developing policies, site allocations and providing information on new infrastructure requirements in Merton.

2 BACKGROUND

2.1. In the last few years there has been renewed understanding that the places in which we live have a strong influence over our health and wellbeing. Amongst the most significant influence on population health is the built environment, which is intrinsically linked to our opportunities for an active and healthy lifestyle.

2.2. Merton's Health and Wellbeing Strategy (HWS) highlights some of the population health challenges which the planning system can help to tackle, including the following:

- Reducing health inequalities
- Helping people to be more active and live active lives
- Planning for an aging population
- Addressing mental health and isolation
- Protecting the population from hazards

2.3. Merton's new Local Plan with consideration to the highlighted issues in the HWS, seeks to improve the health and wellbeing of residents, encourage and support healthy living; tackle the causes of ill health and health inequalities in Merton, as highlighted for example in the HWS, Joint Strategic Needs Assessment (JSNA) and the Child Health Weigh Action Plan.

2.4. Once adopted the new Local Plan will set out the Council's strategy for development in Merton. The plan contains planning policies against which all planning applications received by the Council will be assessed. The Plan is required to be in line with national planning policies, Mayor's London Plan and its supporting documents such as the Mayor's Health Inequalities Strategy.

2.5. In the process of developing the new Local Plan towards adoption, the approach taken is to have health and wellbeing as its 'golden thread' throughout document for example; in policies on design, housing, open space, public realm, and sustainable transport. In doing so, it will be taking forward the commitment to 'Health in all' Policies which offers a means to optimise the council and partner's statutory duties for population health and wellbeing.

2.6. It seeks to ensure that neighbourhoods and developments are well designed, promote healthier living, improve connectivity to essential services, promote active living, encourage walking and cycling and adopt active living and aging approaches.

2.7. In addition, it has health and wellbeing policies which emphasise the Council's ambition to be a Dementia Friendly Borough and the need to create safe and accessible neighbourhoods that promote social interactions, including places for people to meet, socialise and help combat loneliness. It clearly emphasises that developments in the borough will be need to adopt Healthy Streets approaches, which are beneficial to health and wellbeing.

2.8. In developing the Plan, policy planners have worked closely with Merton Public Health colleagues, who are carrying out a Health Impact Assessment to measure the health impacts of the Local Plan towards its adoption. The policy planners will continue to work with Public Health at each stage of the Plan's development towards adoption.

2.9. Since the last committee report policy planners have met with the CCG to discuss primary health infrastructure capacity to support future housing growth and will continue to have further discussions with the CCG and other appropriate health bodies.

3 DETAILS

3.1. The Stage 1 consultation finished in January 2018 and the comments we received from the public and stakeholders have helped shape the draft Local Plan out for consultation.

3.2. The Local Plan aims to help guide how the borough develops over time and create a vision that enables the council to successfully and responsibly manage growth and create a healthy place to live and work.

3.3. We are recommending that the Health and Wellbeing Board consider the following:

- **To respond to the stage 2 consultation by 6th January 2019.** Responses can be submitted via an online questionnaire www.merton.gov.uk/newlocalplan or by writing to us at future.merton@merton.gov.uk

4 ALTERNATIVE OPTIONS

4.1. None for the purposes of this report.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The current consultation started on 30th October 2018 and will end on the 6th January 2019, although it is expected that engagement on individual issues will continue into spring 2019. Further consultation opportunities are set out in the timetable below.

6 TIMETABLE

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

- **Autumn 2018: consultation on Stage 2 new Local Plan – until the 6th January 2019.**
- Winter 2018/19: council recommendation to submit new Local Plan to the Secretary of State, followed by six weeks publication
- 2019: Examination by an independent planning inspector (usually takes at least six months)
- 2019/2020: Adoption of the new Local Plan

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. Funding to support this work will come from existing resources and officers will seek opportunities for funding bids wherever possible. Once adopted, the new Local Plan will have assessed the infrastructure needed to support new development over the next 15 years, which will be essential to enable planning officers to negotiate with developers to help support this funding (e.g. by providing land or finance towards it)

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. None for the purposes of this report

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

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

9.2. The Local Plan takes into account the health and wellbeing impacts of its policies and seeks encourage physical activity, living well and to reduce health inequalities across the borough, by creating healthy place. As part of the development of the Local Plan a Health Impact Assessment has been carried. In doing so, it will be taking forward the commitment to Health in all

Policies which offers a means to optimise the council and partner's statutory duties for population health and wellbeing.

9.3. The HiAP approach helps to reduce health inequalities because it focuses attention on the underlying social, economic and environmental causes that the council and partners can influence. The Local Plan is a key council strategic document which can effectively deliver Health in all Policies.

10 CRIME AND DISORDER IMPLICATIONS

10.1. None for the purposes of this report.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. None for the purposes of this report.

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

13 BACKGROUND PAPERS

Merton Public Health Team

Health Protection Oversight Function: Overview and Protocols

Sept 2018 -FINAL DRAFT

Contents

Table of Contents

1st version: March 2018
Review Date: March 2020

1. Introduction

1.1 Purpose of the document

1. Since the Health and Social Care Act in 2012, there have been changes in the way in which Health protection is led and managed at both national and local levels. The aim of the current arrangements is for an integrated, streamlined health protection system that delivers effective protection for the population from outbreaks of disease and emergency preparedness through to improving local people's health and access to health services.

2. Nationally, Public Health England has a responsibility to deliver a specialist health protection response through health protection teams. Locally, Local Authorities have a mandated responsibility for providing oversight to ensure that health protection arrangements are robust. Both roles need to be complementary to ensure an effective response.

3. The purpose of this document is to clarify the health protection roles and responsibilities of the Merton Public Health team. It also provides a resource for members of the team and others, setting out an overview of systems, roles and processes, governance and working arrangements and links to relevant guidance and data. It highlights the partnership approach across LBM and with NHS England, Public Health England, Clinical Commissioning Group and community services.

1.2 How to use the document

4. The document outlines the specific protocols in Merton Public Health team with regard to various areas of health protection, for example immunisations, antenatal and newborn screening, cancer screening, healthcare associated infections, infectious disease outbreak management and emergency planning and resilience.

5. When informed about a Health protection query, one should be able to refer to the correct section of the document. In each section a lead officer/protocol should be listed in order to manage or pass the query on.

6. Individuals who are new to the team are also able to refer to this document when presented with an unknown health protection query. It will outline the correct procedure they need to follow in order to allow an appropriate response.

1.3 Background

7. Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation. As well as major programmes such as national immunisation programmes and the provision of health services to diagnose and treat infectious diseases, health protection involves planning, surveillance, screening populations for diseases and response to incidents and outbreaks.

8. Local authorities have a critical role in protecting the health of their local population, both in terms of helping to prevent threats arising and in ensuring appropriate responses when things do go wrong. The Civil Contingencies Act (2004) classifies Local Authorities as Category I responders, with statutory responsibilities for actively planning for, and leading the response

to, health protection incidents and emergencies.[1] It is expected that Local Authorities will work with other key local partners to ensure that threats to health are understood and properly addressed. These partners include other Category 1 responders, such as Public Health England (PHE) and local health protection teams, NHS England (NHSE) and local health providers as well as Category 2 responders, such as Merton Clinical Commissioning Group (MCCG) and voluntary organisations.

9. In addition to the responsibilities of local authorities, Directors of Public Health and local authority Public Health teams have particular roles to play in supporting health protection work, as defined by the Health and Social Care Act (2012).[2] Despite commissioning no health protection services directly, the Act mandated that Directors of Public Health maintain an 'oversight' function to ensure that health protection arrangements are robust for their local population. Directors of Public Health also have a wider health protection role in supporting Public Health England with the management of outbreaks and incidents within their local authority area.[3] These responsibilities can include the following routine activity:

    - Review of health protection surveillance produced by NHS England and Public Health England Health Protection teams.

    - Monitoring of service performance for key health protection services commissioned by partners (i.e. child hood immunisations services commissioned by NHS England).

    - Assurance of local health protection response plans and the co-ordination of test exercises.

    - Reviewing the local response to health protection incidents and outbreaks and ensuring that any learning is shared among local partners and acted upon.

10. The Department of Health's Health and Social Care Act 2012 guidance states that the Director of Public health should:

    - provide strategic challenge to health protection plans/arrangements produced by partner organisations
    - scrutinise and as necessary challenge performance
    - if necessary, escalate any concerns to the local health resilience partnership (LHRP)
    - Receive information on all local health protection incidents and outbreaks and take any necessary action, working in concert with Public Health England and the NHS.
    - contribute to the work of the LHRP, possibly as lead DPH for the area
    - provide the public health input into the local authority emergency plans

[1] The Civil Contingencies Act, 2004 (Available online at: https://www.gov.uk/guidance/preparation-and-planning-for-emergencies-responsibilities-of-responder-agencies-and-others)

[2] The Health and Scoial Care Act 2012 (Available online at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted)

[3] *Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities, Regulations 2013*: (Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf)

2. Local Arrangements and Governance

11. This document sets out the statutory responsibilities of the DPH on behalf of local authority to provide oversight for health protection systems. To support this, we need to have effective internal arrangements and governance.

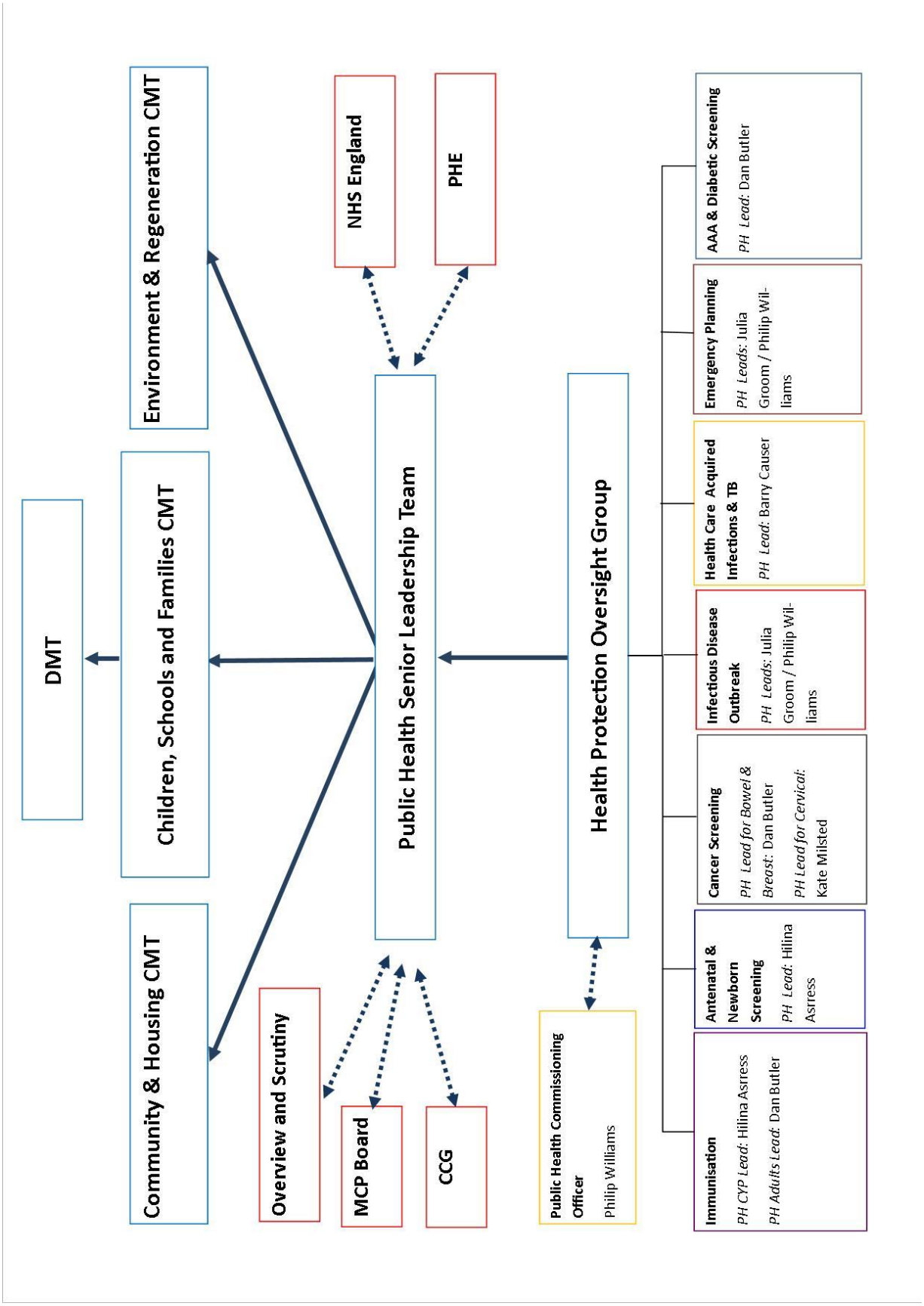
12. A pathway has been designed for Merton Public Health team (*see Figure 1*) in which relevant key officers are assigned to each area of health protection:

    - Relevant key officers within the Merton Public Health team take on lead role for monitoring relevant data and information on health protection areas. Data sources can be found in your specified section in this document
    - An internal Public Health Protection Oversight group has been established, chaired by the lead Consultant in Public Health and co-ordinated by the Public Health Commissioning Officer. This will meet quarterly to review issues and escalate to Public Health Senior Leadership Team (PH SLT) if required. It will also have oversight of any communication activity and help priorities where limited resources are directed. Full Terms of Reference can be seen in Appendix 2.
    - The PH SLT will review escalated matters and any further actions required. The DPH will share with relevant DMTs (C&H, CSF, E&R) and relevant Cabinet Members if deemed necessary. The DPH can also gain information from key stakeholders e.g. NHS England, PHE and Merton CCG as well as relay information to them. If any issues need to be discussed at a sector level, these can be relayed at the 6 weekly SWLDPH meetings that the DPH attends.
    - Overview and Scrutiny will be invited to consider any health protection areas where there are issues impacting on the health and wellbeing of Merton residents.

13. Role of key officers include:
    - Proactively tracking and maintaining data in their area (e.g. using PHE and NHS-E reports) and saving in an easy to access file on the Shared network
    - Ensuring this data is reviewed, providing oversight for their area and identifying issues that require a response (e.g. underperformance, incidents, outbreaks)
    - Ensuring you are aware of protocols and the relevant key contacts listed in your specified area
    - Ensuring urgent queries are dealt with in a timely response and escalating quickly to the Director of Public Health if necessary
    - Attending quarterly meetings to discuss any issues within your specified area
    - Passing on key information to other relevant members in the team should you receive a query not in you area.

14. Role of the Public Health Commissioning Officer
    - Co-ordinate the Health Protection Oversight Group by organising the meetings and agenda of each quarterly meeting. Ensuring minutes/action plans are recorded and distributed to the group
    - Manage the flow of information that is being received by Merton Public Health team – ensure the information is saved on a shared drive that is easily accessible.
    - Ensure information is circulated amongst members and key officers within the group.

Figure 1: Local Arrangements and Governance



3. Health Protection Functions and Protocols

3.1 Immunisation

15. Immunisation provides protection from a range of serious infectious diseases and, after clean water, is one of the most effective public health interventions. The WHO has a target of 95% uptake of immunisations in order to maintain 'herd' (community) immunity.

16. Most immunisations are provided in primary care settings by local General Practices and pharmacists (especially in relation to flu). School age immunisations are provided by community health services teams, for Merton this is Hounslow and Richmond Community Health NHS Trust (HRCH).

17. The national immunisation programmes are commissioned by NHS England. NHSE is responsible for ensuring quality of immunisation services. These include maternal and targeted neonatal vaccinations; childhood immunisations; school age vaccinations and adult vaccinations, seasonal vaccinations including flu preparedness and the pneumonia vaccine. Public Health England works locally regionally and nationally with NHS England and others, providing evidence and surveillance of infectious diseases and immunisation programmes.

18. Merton CCG hosts an Immunisation Steering Group. This group is attended by NHSE, CCGs, Community Health providers and public health. It provides a forum to review the latest data and to co-produce and monitor a shared action plan to improve the uptake across child and adult immunisations. The Immunisation Steering Group reports to NHS England as well as feeding back to MCCG and public health about any incidents that may have occurred, for example, fridge incidents at certain GP practices (see figure 2 for a diagram showing local arrangements).

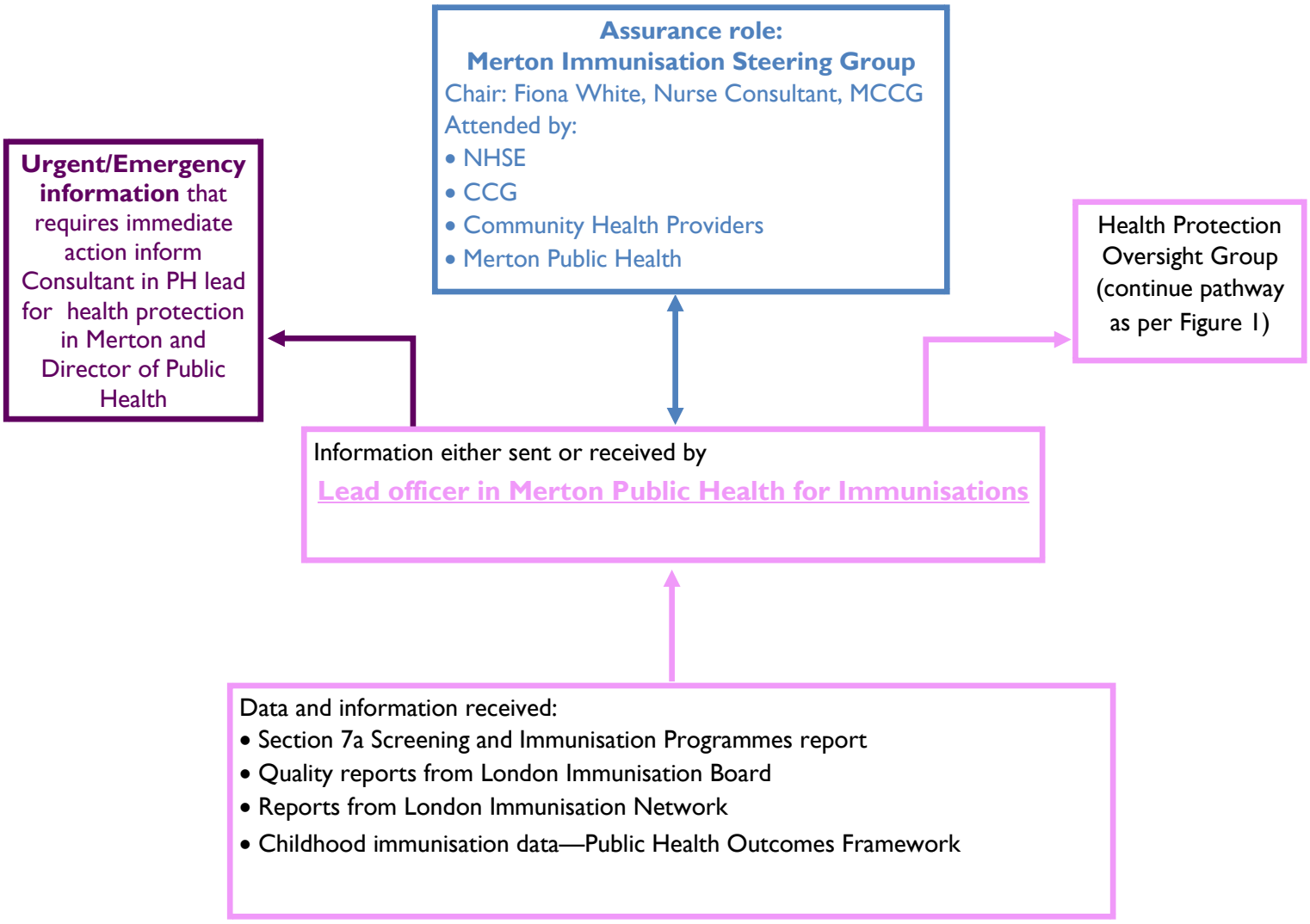
19. Local authority's role in Merton is one of oversight. In accordance with the Local Authority Regulations 2013, as part of the Director of Public Health's oversight function, there is a responsibility to scrutinise and challenge commissioning arrangements to ensure they meet the health protection needs of the local population. The local authority does not have resources to do targeted work on immunisation, except in relation to flu, where clinics are co-ordinated by HR to provide immunisations to frontline staff. The focus is ensuring that we support NHSE and CCG communications by:

    - using appropriate local authority channels, such as My Merton magazine, website, social media, e-newsletters, intranet and staff bulletins and,
    - disseminating electronic information to schools, children's centres and childcare providers, libraries, care homes and CVS organisations.

20. Overview and scrutiny have played an active role in providing oversight of immunisations if necessary, including a scrutiny of childhood immunisation and a follow up review.

Figure 2: Merton Public Health arrangements for Immunisations

NHSE and PHE have lead role in commissioning and improving immunisations
Local Authority Public Health has a role in oversight and scrutinising commissioning arrangements to ensure they meet the health protection needs of the local population



Key Contacts, Guidance and Information/data - Immunisations:	
PH Lead/s	Hilina Asrress, Senior Public Health Principal
Partner contacts	Merton Immunisation Steering Group (Merton CCG) lead by Fiona White (nurse consultant) - Fiona.White@mertonccg.nhs.uk Bernadette Johnson bernadette.johnson@nhs.net - NHS England Immunisations Commissioning Manager Samantha Perkins (PHE) Samantha.perkins@phe.gov.uk – Principal Health Protection Practitioner Mary Maimo (PHE) mary.maimo@phe.gov.uk – Senior Health Protection Practitioner
Guidance & resources	NHSE (London) information, with a link to the Immunisation & Screening National Delivery Framework & Local Operating Model: https://www.england.nhs.uk/london/our-work/immunis-team/ The Green Book (with all immunisation details): https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book Childhood immunisation Schedule (NHS Choices): http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx Department of Health Resources Orderline (to be used for ordering resources in an outbreak): http://www.orderline.dh.gov.uk/ecom_dh/public/home.jsf Vaccine uptake guidance and the latest coverage data nationally is available: https://www.gov.uk/government/collections/vaccine-uptake#pertussis-vaccine-uptake-in-pregnant-women
Information/data (& frequency received)	*NHS England provide:* • Quarterly update on Section 7a Screening and Immunisation Programmes – currently received by DPH • London Immunisations Board send quality reports Which are also sent on to the Association of Directors of Public Health (ADPH) who provide a quarterly report – currently received by DPH • London Immunisation Network led by Fiona White – updates currently sent to Merton CCG and Hilina *Local Data:* • Childhood immunisation data – Public Health Outcomes Framework - http://fingertips.phe.org.uk/profile/health-protection Data is currently saved on the Shared Drive.

3.2 Antenatal and Newborn Screening (ANNB)

22. There are six ANNB screening programmes screening a total of 30 conditions, including infectious diseases, Down's syndrome and physical abnormalities.

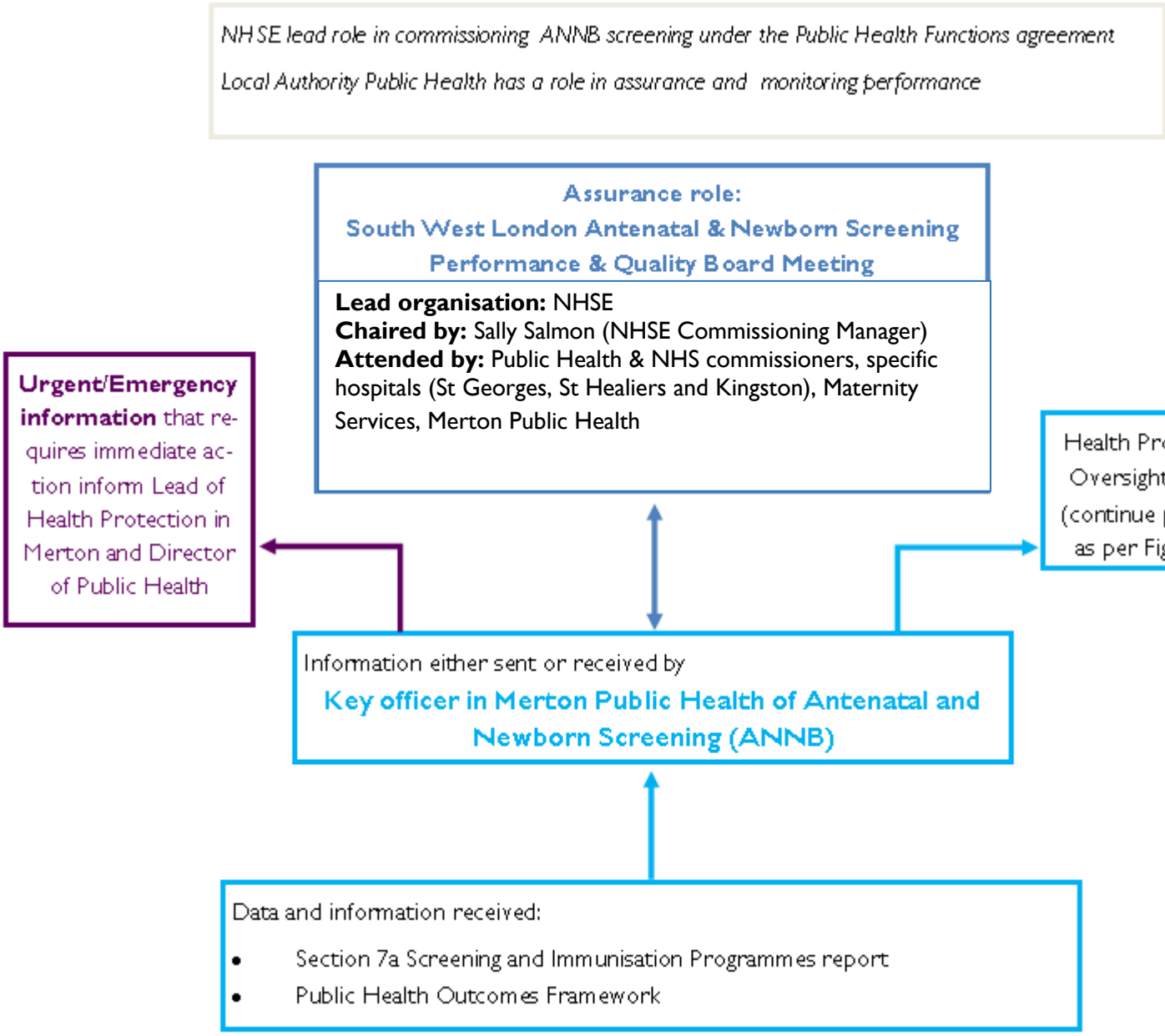
23. The tests are provided by local hospital maternity services and tend to involve ultrasound scanning, blood tests or a combination of both. Tests are used to find women & babies at higher risk of a health problem. Early intervention can reduce mortality, morbidity and economic cost of life long treatment and support from health, education and social services. The tests can help in decision making about care or treatment during pregnancy or after the baby is born.

24. ANNB services are commissioned by NHSE under the Public Health Functions agreement (Section 7a agreement) between the Secretary of State and NHSE. Most elements of ANNB screening programmes are funded wholly or partly within the Maternity Pathway Payment (MPP), and contracts are within CCGs and CSUs contracts with local maternity providers.

25. PHE nationally produces a professional briefing with high level national commentary on the antenatal and newborn screening programmes.

26. Locally, the public health team review performance by participating in the South West London Antenatal & Newborn Screening Performance & Quality Board Meeting who meet on a quarterly basis. At these board meetings members of the commissioning team and of specific hospitals such as St Georges, St Heliers and Kingston Hospital attend and discuss performance status of both antenatal and newborn screening. Members of the maternity services are also present. Any underperformance is followed up with a request to NHSE for a remedial action plan. Aspects discussed and data presented at these meetings is now emailed to local boroughs.

Figure 3: Merton Public Health Team arrangements for ANNB Screening



Key Contacts, Guidance and Information/data:	
PH Lead/s	Hilina Asrress, Senior Health Protection Principal
Other contacts	South West London Antenatal & Newborn Screening Performance & Quality Board Meeting Sally Salmon sallysalmon@nhs.net - ANNB Commissioning Manager – NHS England Alison Fiddler alison.fiddler@nhs.net – Quality Assurance adviser (antenatal and newborn), Screening Quality Assurance Service, London PHE Screening Specific hospital screening coordinators from St Heliers, St Georges and Kingston Hospital Health Visiting Service Lead – Claire Carroll, CLCH
Guidance & resources	Public Health Outcomes Framework: https://fingertips.phe.org.uk/search/screening#page/1/gid/1/pat/6/par/E12000007/ati/102/are/E09000024 National Screening Committee Guidance https://www.gov.uk/search?q=antenatal+and+newborn+screening PHE Screening Blog updates from ADPH www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status
Information/data (& frequency received)	Quarterly update on Section 7a Screening and Immunisation Programmes, NHS England - currently received by DPH. Public Health Outcomes Framework – accessible via: https://fingertips.phe.org.uk/search/screening#page/1/gid/1/pat/6/par/E12000007/ati/102/are/E09000024

3.3 Adult Screening Programmes, including Cancer, Abdominal Aortic Aneurism (AAA), and Diabetic Eye Screening

Cancer Screening

27. Early detection of cancer greatly increases the chances for successful treatment. Recognising possible warning signs of cancer and taking prompt action leads to early diagnosis in individuals who have the disease but do not yet have symptoms. Cancer screening can save thousands of lives each year as well as having a huge financial benefit on the NHS.

28. NHS England (NHSE) is responsible for commissioning NHS screening programmes..

29. Local Authority Public Health maintains an oversight role to review trends and to highlight concerns, in order to ensure adequate delivery of screening services to the local population.

30. Local oversight includes reviewing bowel, breast and cervical cancer screening uptake. Data is now received on a quarterly basis via Section 7a Screening Immunisation Programmes from NHSE. Local data can also be found on Public Health Outcome Framework.

31. In addition, cervical screening falls under the oversight of sexual health services. In 2018 a sexual health strategy/framework is being developed and a sexual health steering group will be established.

32. Merton Public Health review performance through the lead officers and report at the internal Public Health Protection Oversight Group. Inadequate performance is escalated and followed up with a request to NHSE for a remedial action plan.

33. Support for NHS E and CCG communications may include use of appropriate local authority channels, such as My Merton magazine, website, social media, e-newsletters, intranet and staff bulletins. This will need to be built into the Communications plan and negotiated with London Borough of Merton Communications team as required. There is no capacity for targeted improvement work at local authority level.

Abdominal Aortic Aneurism (AAA)

34. Abdominal aortic aneurysm (AAA) screening is a way of checking if there's a bulge or swelling in the aorta, the main blood vessel that runs from the heart down through to the abdomen. This bulge or swelling is called an abdominal aortic aneurysm, or AAA. It can be serious if it's not spotted early on because it could get bigger and eventually burst (rupture). Abdominal Aortic Aneurism (AAA) screening In England is offered to men during the year they turn 65.

35. NHS England (NHSE) is responsible for commissioning the AAA screening programme.

36. Local Authority Public Health maintains an oversight role to review trends and to highlight concerns, in order to ensure adequate delivery of screening services to the local population.

37. Merton Public Health review performance through the lead officers and report at the internal Public Health Protection Oversight Group. Inadequate performance is escalated and followed up with a request to NHSE for a remedial action plan.

Diabetic Eye Screening

38. Diabetic eye screening is a key part of diabetes care. People with diabetes are at risk of damage from diabetic retinopathy, a condition that can lead to sight loss if it's not treated. If retinopathy is detected early enough, treatment can stop it getting worse. Otherwise, by the time symptoms become noticeable, it can be much more difficult to treat. This is why the NHS Diabetic Eye Screening Programme was introduced. Everyone aged 12 and over with diabetes is offered screening once a year. Diabetic retinopathy is extremely unusual in children with diabetes who are under the age of 12.

39. NHS England (NHSE) is responsible for commissioning the Diabetic Eye screening programme.

40. Local Authority Public Health maintains an oversight role to review trends and to highlight concerns, in order to ensure adequate delivery of screening services to the local population.

41. Merton Public Health review performance through the lead officers and report at the internal Public Health Protection Oversight Group. Inadequate performance is escalated and followed up with a request to NHSE for a remedial action plan.

Key Contacts, Guidance and Information/data:	
PH Lead/s	PH lead for Bowel and Breast cancer screening, AAA, Diabetic eye screening – Dan Butler PH lead for Cervical cancer screening– Kate Milsted
Other contacts	Discussed at the regional screening board NHSE commissioner for screening to be updated (Dan Butler)
Guidance & resources	National Screening Committee Public Health Outcomes Framework
Information/data (& frequency received)	Quarterly update on Section 7a Screening and Immunisation Programmes, NHS England – received quarterly by DPH Public Outcomes Framework Local data analysis completed by Merton Public Health through access to GP data platform.

3.4 Infection Control and Health Care Acquire Infections (HCAI)

42. Infection control is an essential though often under recognised part of the infrastructure of healthcare. It involves taking steps to prevent the spread of infectious diseases in both healthcare and community settings. Every year lives are lost because of the spread of infectious diseases. Infection control uses simple procedures such as good handwashing and hygiene practices to prevent the spread of diseases to patients and healthcare workers.

43. Infection control also deals with the management and response to healthcare-associated infections (HCAIs) which can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well known include those caused by meticillin-resistant *Staphylococcus aureus* (MRSA), meticillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium difficile* (*C.diff*) and *Escherichia coli* (*E. coli*).

44. HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can incur significant costs for the NHS and others, and cause significant morbidity and mortality for those infected. As a result, infection prevention and control is a key priority for the NHS, and Public Health England has a responsibility to advise and support the NHS and others in their efforts to prevent HCAIs and any associated risks to health.

45. Most healthcare settings have their own Infection Control teams which enforce and monitor infection control rates within each trust. Merton CCG commissions SLCSU Infection Control team which monitors infection control in hospitals. If there is an outbreak the Director of Public Health should be informed.

46. In Merton, HCAIs in acute Trusts most used by Merton residents are reported through the relevant Clinical Quality Review Groups (St Georges, Epsom St Helier and Kingston), which then report up to Merton CCG Clinical Quality Committee. Quarterly reporting provides assurance to the CCG. Inadequate performance is addressed by the lead CCG and remedial plans monitored by the Contract Review Group and CQRG.

47. Should additional support be required, both healthcare settings and community setings such as schools and nurseries in Merton are able to gain further advice from South London Health Protection Team. The health protection team then liaise with members in Environmental Health if required to ensure infection control matters are being enforced.

48. MCCG should notify Public Health of any significant incidents or concerns. The PH lead officer will report any issues at the internal Public Health Protection Oversight Group and any unresolved issues will be escalated to the Senior Leadership Team and then the Director of Public Health.

Key Contacts, Guidance and Information/data:	
PH Lead/s	Barry Causer
Other contacts	South London Health Protection Team Address: Zone C 3rd floor, Skipton House, 80 London Road, London, SE1 6LH Tel: 03443262052 (and out of hours too) Fax: 03443267255 Email: phe.slpht@nhs.net, slhpt.oncall@phe.gov.uk Merton CCG Julie Hesketh (Director of Quality) – Merton & Wandsworth CCGs Julie.hesketh@nhs.net

	Andrew Bradley (LBM Enviromental Health Manager) Andrew.bradley@merton.gov.uk 0205 453 947 LBM Public Health - Ann Clarke Ann.clarke@merton.gov.uk 020 8545 4845
Guidance & resources	Health Protection in schools, nurseries and families PHE Document: https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities NHS improvement website with a wide range of resources for HCAI: https://improvement.nhs.uk/resources/healthcare-associated-infections/ Infection Prevention and Control Commissioning Toolkit Produced by the Royal College of Nursing and the Infection Prevention Society, this toolkit provides an overarching framework to support commissioning and provider organisations in England to meet the challenge of reducing health care acquired infections https://www.rcn.org.uk/professional-development/publications/pub-005375 Kings Fund: https://www.kingsfund.org.uk/publications/healthcare-associated-infections HCAI Operational Guidance and Standards fro Health Protection Units: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332051/HCAI_Operationalguidancefinalamended_05July2012.pdf
Information/data (& frequency received)	DPH to be notified of any alerts by MCCG

3.5 Emergency Planning & Resilience

49. The Civil Contingencies act (2004) defines an emergency as something that threatens serious damage to either human welfare in the UK, the environment in the UK, or an act of war or terrorism that threatens the security of the UK. In the event or situation where an organisation is unable to perform daily working duties effectively, the Civil Contingencies Act also places a duty on local authorities to prepare business continuity plans for its own services.

50. The regional London Local Health Resilience Partnership provides health-specific strategic planning. At a sector level, there is a South London Local Health Resilience Partnership of which Merton is a member.

51. The role of Public Health in Emergency planning in local authority focuses on overseeing and ensuring protocols are in place to protect the public from outbreaks and health protection incidents, for example extreme weather events (heatwaves and cold weather), pandemic influenza planning, environmental hazards and any other major health incident which could have serious repercussions on the health of a local population. The oversight function includes communication responsibilities and facilitating close working with partners. The Association of Directors of Public Health have prepared summaries of the role of Public Health and Directors of Public Health in overseeing and supporting the response to major incidents, including in cases where mutual aid is required between organisations (attached below). This focuses on Public Health's roles in supporting strategic leadership, communications and data management and helping to co-ordinate the health services response.

Major-Incidents-Checklist-for-Directors-of-Publ

Mutual-Aid-Guidance-for-Directors-of-

52. The Civil Contingencies Act (2004) divides responders into Category 1 and and Category 2. Category 1 responders are required to work together to play a leading role in planning for, and responding to, emergencies. This includes putting in place emergency plans and business continuity arrangements, ensuring lines of communication and co-ordination between partners, and the communication of advice to partners and the public. Category 1 Reponders include the emergency services, local authorities and NHS bodies. Category 2 responders are 'co-operating bodies' and are required to support Category 1 partners in planning for and responding to an incident or emergency, but are not required to lead work locally. Category 2 responders include utility and transport companies and the Health and Safety Executive.

53. In order to discharge their collective duties under the Civil Contingencies Act (2004) Local Authorities and Category 1 and 2 partners regularly meet to discuss, plan and test plans for responding to an emergency within the borough or across London. This is carried out via a three tiered approach, regionally at the London level (London Resilience Forum), sub-regionally and at the borough level (Borough Resilience Forum).

54. Regionally, London Prepared is the website of London Resilience which maintains the London Resilience Forum and contains general information on emergency preparedness and useful

documents such as the London Resilience Partnership Strategy. This is a coalition of over 170 organisations with specific responsibilities for preparing and responding to emergencies

55. At a Borough level, The Borough Resilience Forum is a statutory group formed of local representatives from all Category 1 responders and partners chaired by Merton Council. This forum meets 4 times a year and works in line with London and National planning by following the Pan London frameworks developed by the Local Authorities Panel.

56. The Local authority conducts an annual review of these plans and provides information and updates to the Borough Resilience Forum.

57. In the Borough of Merton plans have been drawn up by the Civil Contingencies Advisor in collaboration with senior directors across council and the Borough Resilience Forum, known as the "Major Incident Plan" (a link to the plan can be seen below) (*see Figure 4*).

58. Merton's "Major Incident Plan" can be activated either by an officer of the emergency services if an incident occurs within the borough, or an officer of the London Borough of Merton if an incident affects a corporate building.

Merton Major Incident Plan

59. If an incident occurs in Merton, across London or nationally, a Gold strategic group will be asked to convene. This will consist of senior managers from agencies required to attend, such as local authorities, emergency services and health.

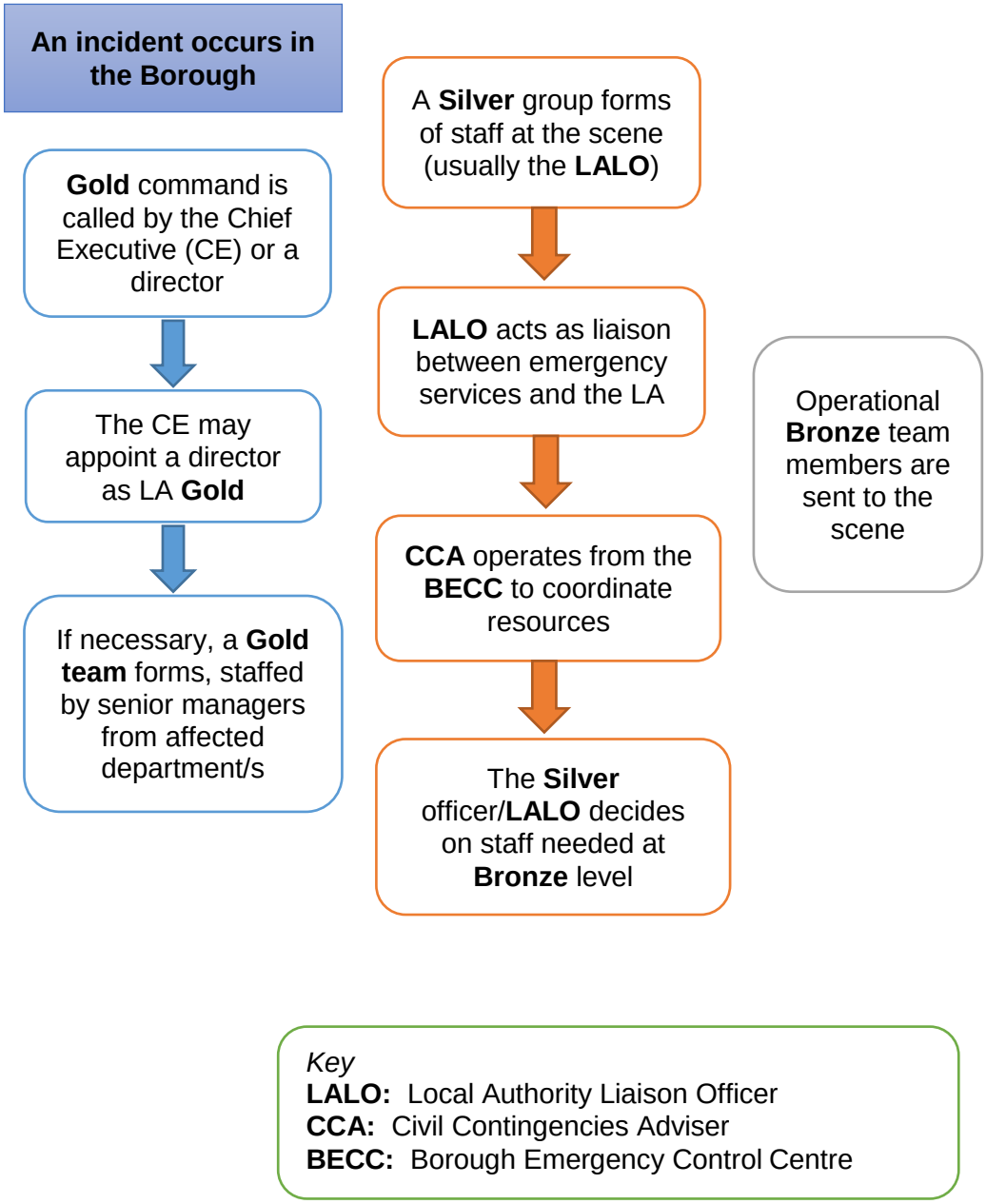
60. Gold refers to the strategic group; Silver refers to the tactical group and Bronze to the operational group. The nature of the incident and decisions made at the Gold Command determine whether Silver or Bronze levels are used.

61. A level 3 incident triggers a gold command which suggests that the meeting can be triggered by any local authority director where response plans can be drawn up and enacted. As a minimum, the Civil Contingencies Advisor and a representative from Communications must be present. At these meetings, roles and directives are defined as well as follow up actions.

62. Another key objective at these meetings is to establish chains of communication across the council and determine what information can be circulated freely and what should be protected. Response statements can also be formulated here to answer queries from council, local media and members of the public. It is important to maintain a consistent message to any matter of health protection in order to ensure effective management of the situation, clear communication across agencies and to protect against reputational risk of poor communication or failed response. Briefing notes generated here can then be sent to those groups that may receive questioning from their front line staff or general stakeholders for example, the same briefing note used by members of the Childrens, Schools and Families team to staff within the school of the incident and community members.

63. If it is likely that the incident may affect more than one borough, the London local authority Gold is activated by the London Resilience protocol (see link below). The London local

authority Gold lead will be an on-call chief executive from a nominated local authority, and will



represent all London local authorities' response to the incident.

Figure 4: Diagrams to complement Merton Major Incident Plan

Emergency Planning Team

Merton council has moved away from **standard operating procedures** and now use **departmental plans** to follow in case of emergency. However, in specific circumstances such as severe weather or pandemic flu, there may be a corporate plan. Merton's emergency planning page holds all of the necessary information.

Please contact the Emergency Planning team if any of the following criteria are met (or if you are unsure whether an emergency response is warranted):

If the situation is an emergency as defined under the **Civil Contingencies Act 2004**

- An event or situation that threatens the *environment* in the UK
- An event or situation that threatens serious damage to *human welfare*
- *War or a terrorist act* which threatens serious damage to the UK

If the situation affects *two* departments or more

If a *corporate building* is affected, the Emergency Planning Team must be contacted **as soon as possible,** so that the corporate or departmental business continuity plan may be activated if necessary.

If there is *major disruption* to a service or services, which may affect the local authority.

Office hours only	Emergency Planning Team	**02085453476**
Out of hours	**MASCOT Telecare** (The Duty Local Authority Liaison Officer – **LALO,** will be alerted)	02082745940

Key Contacts, Guidance and Information/data:	
PH Lead/s	Julia Groom/Philip Williams
Other contacts	Civil Contingencies Advisor – Sarah Chittock Borough Resilience Forum South London Local Health Resilience Partnership Category 1+2 responders
Guidance & resources	Merton Emergency Planning page: **http://www2.merton.gov.uk/council/plansandpolicies/emergencyplan.htm#brf** Merton Major incident plan: **http://www2.merton.gov.uk/major_incident_plan_2016.pdf** Health-specific strategic planning, London Local Health Resilience Partnership: **https://www.england.nhs.uk/ourwork/eprr/lhrp/** London Resilience protocol: **https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/Strategic%20Coordination%20Protocol%20v6.5%20April%202015%20(web).pdf** Pan London Emergency Planning frameworks: **https://www.london.gov.uk/about-us/organisations-we-work/london-prepared/planning-emergencies-capital**
Information/data (& frequency received)	

3.6 Infectious Disease Incident and Outbreaks

64. A notifiable disease is any disease that is required by the *Public Health (Control of Disease) Act 1984* and *Health Protection (Notification) Regulations 2010* to be reported to Public Health England via local health protection teams.

65. Public Health England aims to protect the public's health from infectious diseases and environmental hazards by detecting possible disease outbreaks and epidemics as rapidly as possible. A disease outbreak is the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season. Disease outbreaks are usually caused by an infection, transmitted through person-to-person contact, animal –to-person contact, or from the environment to other media.

66. The majority of infectious disease outbreak responsibility lies in the hands of Public Health England who discharge the management of the situation to local health protection teams. There are currently 31 notifiable diseases(The full list of notifiable diseases is available at the following link: https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report#list-of-notifiable-diseases)

67. Public Health England state that registered medical practitioners have a statutory duty to notify the "proper officer" at their local council to local health protection team of suspected cases of certain infectious diseases. A notification form must be completed immediately on diagnosis of a suspected notifiable disease, laboratory confirmation of a suspected infection or contamination of infection is not needed prior to notification. All laboratories in England performing a primary diagnostic role must notify Public Health England on confirmation of a notifiable organism.

68. Public Health England health protection teams produce regular reports for local authorities, summarising their caseload and significant events that have taken place over the last few weeks or months. These reports can be weekly as well as monthly surveillance updates.

69. The statutory duty of local authority public health teams lies in oversight and communication. The management of the situation is led PHE South London health protection team. Merton Pubic Health has a role in dissemination of information and communicating queries and concerns from involved parties back to PHE (*see Fig. 2 below for specific details*). For effective management of these situations there needs to be a uniform and co-ordinated response, which Merton Public Health can support as needed.

70. This link between local authority and local health protection teams is essential as often infectious disease outbreaks can involve numerous stakeholders within the council, for example a TB incident in a local primary school could involve not only public health but the Children's, Schools and Families team, Communications, Health and Safety as well as the executive of the council.

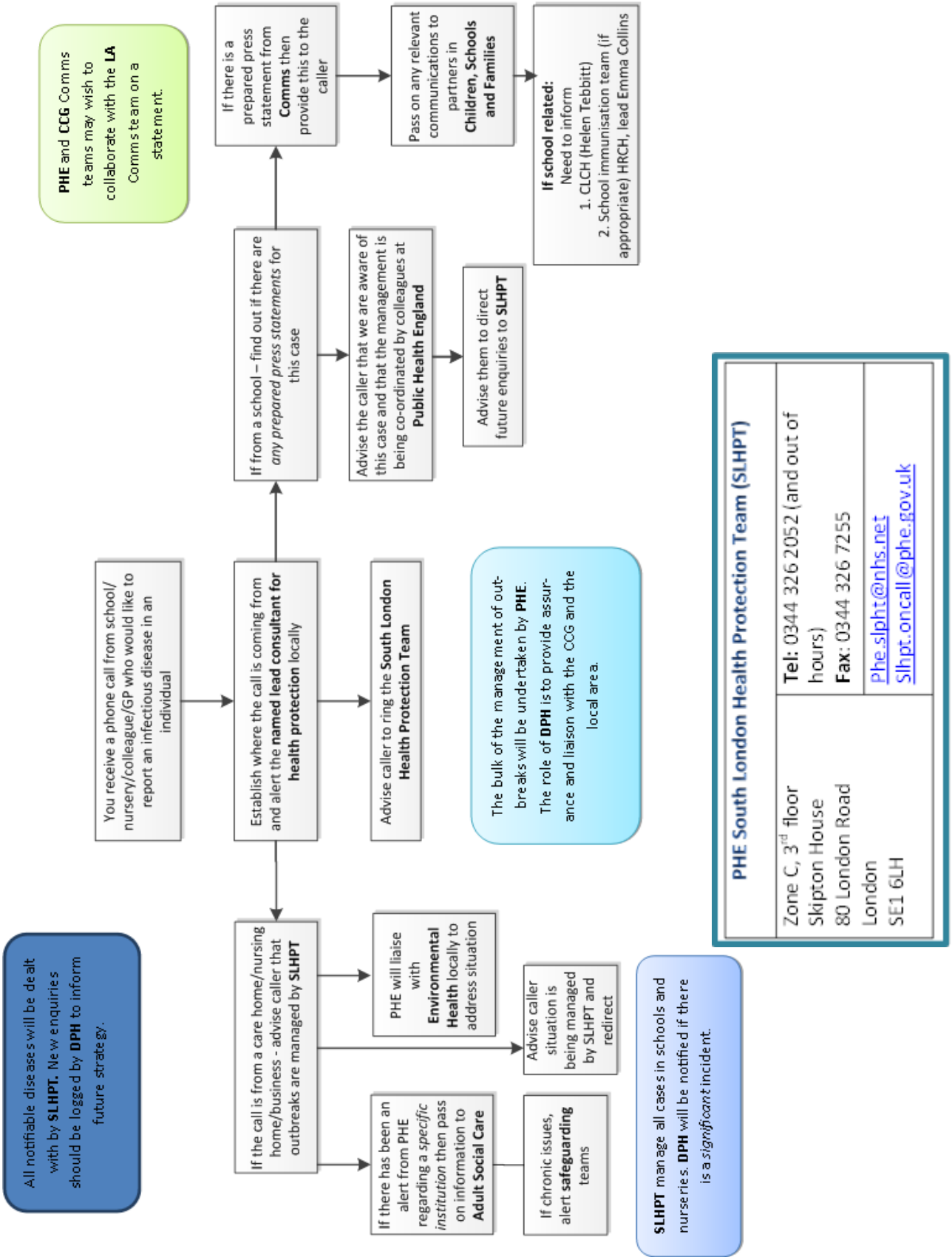
71. If there are any specific concerns or incidents these are sent through separate briefing notes alerting the DPH to any further action that may be required locally. This information can they be disseminated to the relevant departments and colleagues within the council as required.

72. Local health protection teams also coordinate with local Environmental Health departments in tackling food related illnesses and outbreaks.

Key Contacts, Guidance and Information/data:	
PH Lead/s	Julia Groom/Philip Williams
Other contacts	South London Health Protection Team Dr Rachel Hancock Address: Zone C 3rd floor, Skipton House, 80 London Road, London, SE1 6LH Tel: 03443262052 (and out of hours too) Fax: 03443267255 Email: phe.slpht@nhs.net, slhpt.oncall@phe.gov.uk Samantha Perkins (PHE) Samantha.perkins@phe.gov.uk – Principal Health Protection Practitioner Mary Maimo (PHE) mary.maimo@phe.gov.uk – Senior Health Protection Practitioner **Children Schools and Families** Elizabeth Fitzpatrick (Head of School Improvement) Elizabeth.fitzpatrick@merton.gov.uk / 0208545 3806 / 07535 448600 **Adult Social Care** John Morgan (A Director of Adult Social Care) John.morgan@merton.gov.uk / 020 8545 4535 **Environmental Health** Andrew Bradley (LBM Enviromental Health Manager) Andrew.bradley@merton.gov.uk 0205 453 947 **Comms Team** Sophie Poole (Head of Communications) Sophie.poole@merton.gov.uk Director of Public Health meets with SWLDPH meetings 6 weekly and if any health protection issues need to be discussed on a sector level, they can be discussed then.
Guidance & resources	How to report infectious diseases to Health Protection Teams and a list of all notifiable diseases: https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report

Information/data (& frequency received)	Weekly reports and monthly surveillance updates to Director of Public Health from Public Health England and local health protection teams. Also specific separate reports from local health protection teams if there is a significant health protection issue i.e. outbreak in school of infectious disease or repeated outbreaks in school or care home setting.

Figure 2: Proposed plan for communication within Merton Public Health Team with Notifiable Diseases



3.7 3.8 Cold weather planning

73. Cold weather conditions are associated with an increase in illness and injuries. It increases the risk of heart attacks, strokes, lung illness, flu and other diseases. People slip and fall in the snow or ice, sometimes suffering serious injuries. Some groups, such as older people, very young children, pregnant women and people with serious medical conditions are particularly vulnerable to the effects of cold weather.

74. On average, there are around 25,000 excess winter deaths each year in England. There is strong evidence that some of these winter deaths are indeed related to cold temperatures, living in cold homes and as a result of infectious diseases such as influenza. Recently, the rate of winter deaths in England was twice the rate observed in some northern European countries, such as Finland.

75. Simple preventative actions can avoid many of the deaths, illnesses and injuries associated with the cold. Many of these measures need to be planned and undertaken in advance of cold weather.

76. The Department of Health first published a Cold Weather Plan (CWP) for England in November 2011 which composed of a focus on cold weather actions that need to take place, a series of action cards taken from the plan and intended to be used as aide memoirs and long-term strategic planning regarding cold weather why it is essential to health and wellbeing. It aims to prevent avoidable harm to health, by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately. It also aims to reduce pressure on the health and social care system during winter through improved anticipatory actions with vulnerable people. It outlines the key areas where public, independent and voluntary and community sector health and social care organisations should work together to maintain and improve integrated arrangements for planning and response in order to deliver the best outcomes possible during cold weather.

77. This plan is to be used by health and social care services and other public agencies and professionals who interact with those most at risk from health effects of cold weather. It is available in an electronic format only.

78. Local health resilience partnerships (LHRPs) and local resilience forums (LRFs) will have a critical role in preparing for, responding to, and recovering from, server winter weather at a local level, working closely with Health and Wellbeing Boards on longer-term strategic planning.

79. NHS England provides national leadership for improving healthcare outcomes and directly commissions primary care (GP services, dentistry, optometry and pharmacy), some specialist services and oversees CCGs. It is responsible for assuring that the NHS is prepared for cold weather (see Figure 5).

80. CCGs commission planned hospital care, rehabilitative care, urgent and emergency care, most community health services, mental health and learning disability services. They are responsible for assuring that the each of these bodies is prepared for cold weather (see figure 5).

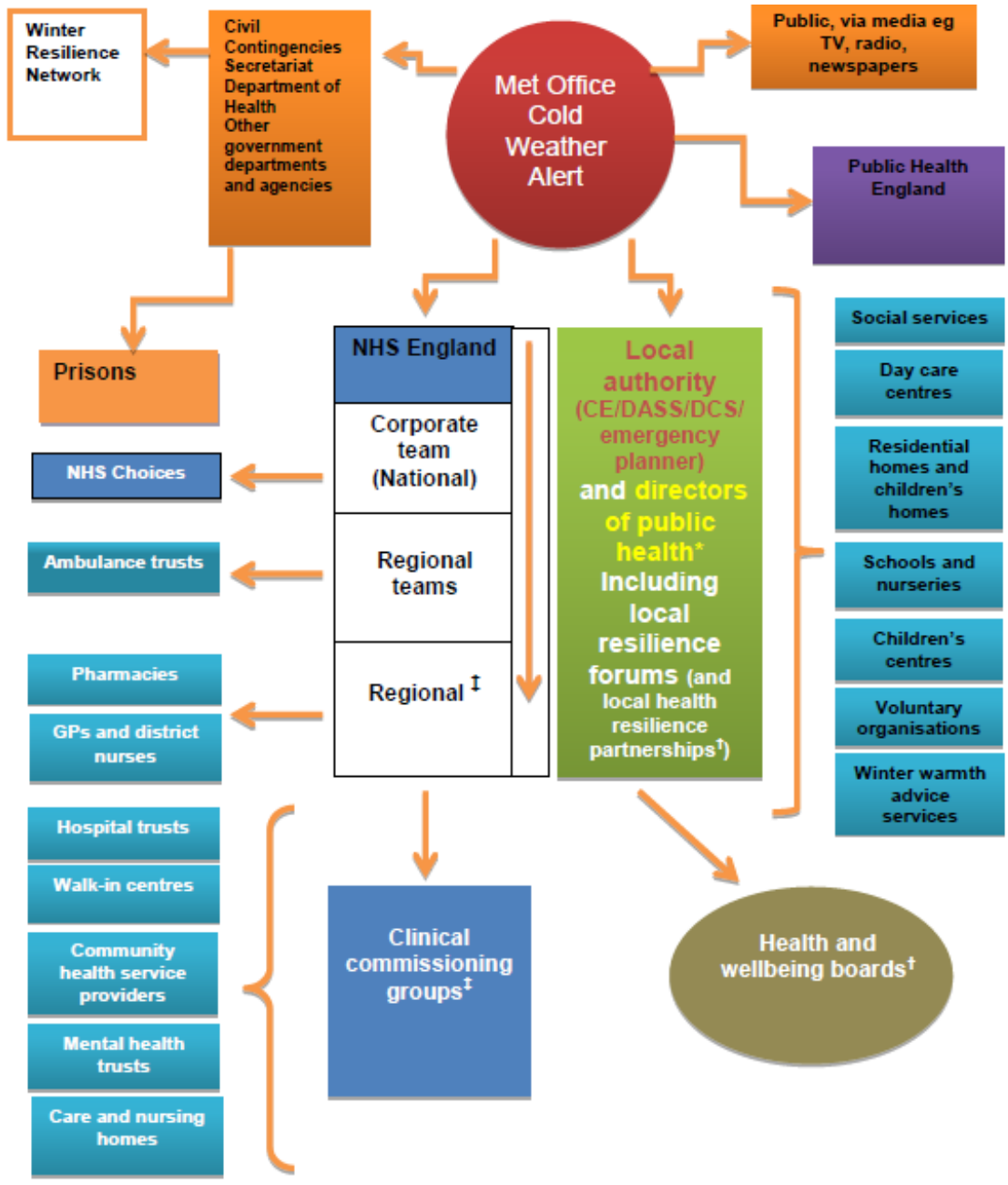
81. PHE provides expert services to support public health and it is the responsibility of PHE to prepare and publish the Cold Weather Plan for England. They will also seek to ensure that it is widely communicated using a variety of channels to ensure maximum publicity. They will make advice available to the public and health and social care professionals across England in preparation for winter, and to regions, where severe cold weather is forecast via NHS Choices and websites of Met Office and PHE.

82. LHRPs should bring together local health organisations to support strategic planning to help ensure that the health sector plays and effective, co-ordinated role in multi-agency planning and response, based around the various agencies and providers responsibilities at a local level

83. In Merton, action cards created by the Cold Weather Plan by PHE are sent out ahead of cold weather season in October to the relevant leads (see figure 6) by our Civil Contingencies Advisor. During 1st November to 31st March each year, Cold Weather Alerts are received directly from the Met Office by our Civil Contingencies Advisor. When these cold weather alerts are received, they should be sent to the relevant leads (see figure 6) in order for them to inform their sector that they need to be addressing all of the actions in association with that particular level.

84. Community and Housing have links with their contractors who are able to disseminate these action cards to their providers and ensure that actions are being met as the levels change. Contact details for the leads in each department are provided in the table later. They also have links with various utility providers who install devices in vulnerable people homes that can measure temperatures and alert community and housing when their home temperature falls below a certain level.

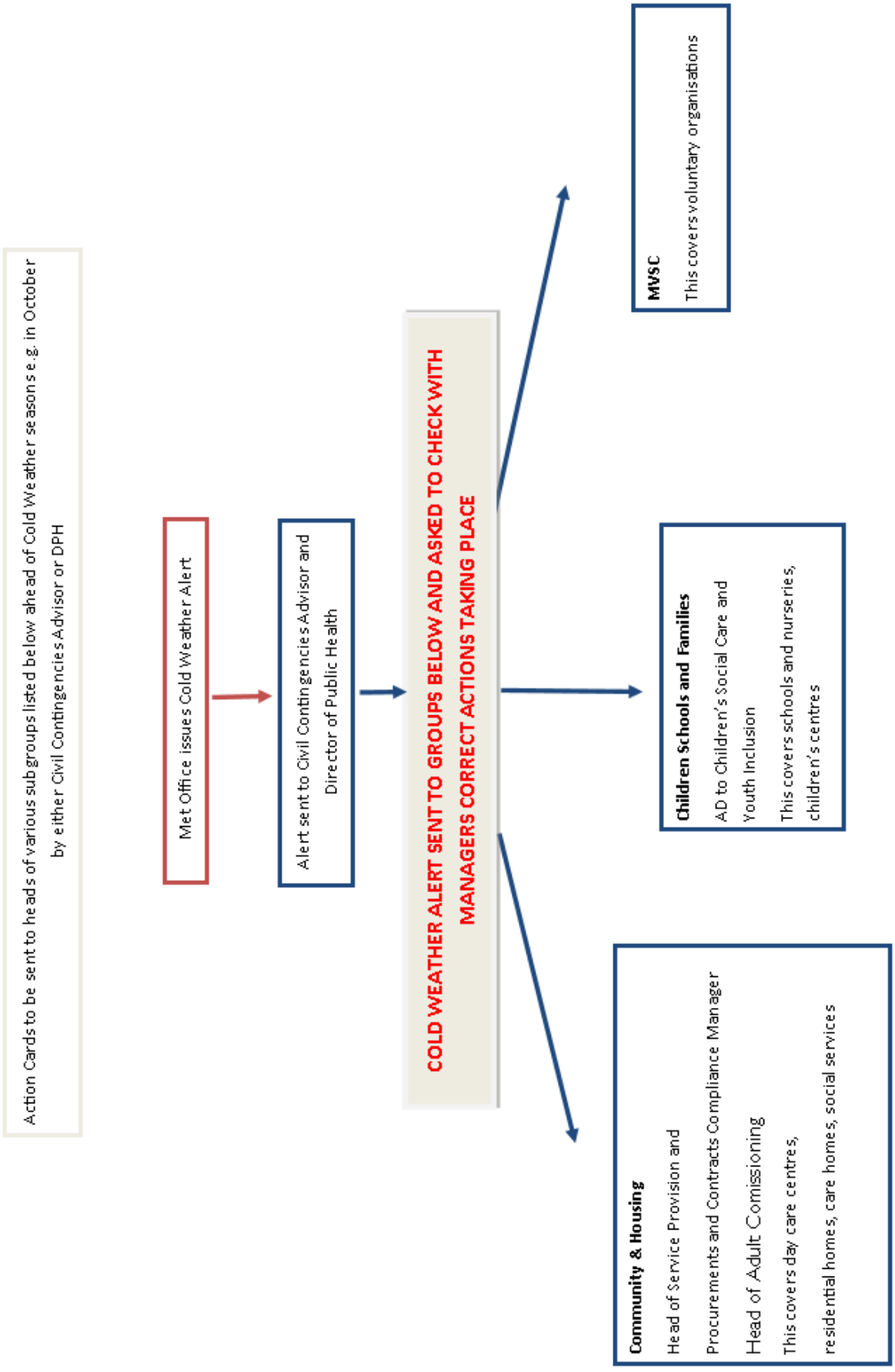
Figure 5: Cold Weather Plan as per PHE guidance



Notes:
†LHRPs and HWBs are strategic and planning bodies, but may wish to be included in local alert cascades.
‡NHS England Regional and CCGs should work collaboratively to ensure that between them they have a cascade mechanism for cold weather alerts to all providers of NHS commissioned care both in business as usual hours and the out of hours period in their area.
*PHE Centres would be expected to liaise with Directors of Public Health to offer support, but formal alerting would be expected through usual Local Authority channels.

Level 0	**Year-round planning** *All year*
Level 1	**Winter preparedness and action programme** *1 November to 31 March*
Level 2	**Severe winter weather is forecast – Alert and readiness** *mean temperature of 2°C or less for a period of at least 48 hours and/or widespread ice and heavy snow are predicted, with 60% confidence*
Level 3	**Response to severe winter weather – Severe weather action** *Severe winter weather is now occurring: mean temperature of 2°C or less and/or widespread ice and heavy snow.*
Level 4	**Major incident – Emergency response** *Central Government will declare a Level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health*

Figure 6: Proposed arrangement in Merton for Cold Weather Plan



Key Contacts, Guidance and Information/data:

PH Lead/s	Julia Groom/Philip Williams
Other contacts	See table below Samantha Perkins (PHE) Samantha.perkins@phe.gov.uk – Principal Health Protection Practitioner Mary Maimo (PHE) mary.maimo@phe.gov.uk – Senior Health Protection Practitioner sarah Chittock – Civil Contingencies Advisor
Guidance & resources	Cold Weather Plan 2017 PHE (including links to cold weather action cards):- https://www.gov.uk/government/collections/cold-weather-plan-for-england

Name	Job Title	Contact details	Department	Information/data (& frequency received)
Andy Ottaway-Searle	Head of Service Provision Regulated services	Ext 4500 Work Mobile: 07956619755 andy.ottaway-searle@merton.gov.uk	Community and Housing, 3rd floor Civic Centre	
David Slark	Procurements and Contracts Compliance Manager	Ext 3043 david.slark@merton.gov.uk	Community and Housing, 4th floor Civic Centre	
Richard Ellis	Head of Adult Comissioning	0208 545 4630 richard.ellis@merton.gov.uk	Community and Housing, Adult Social Care, 4th floor Civic Centre	
Jane McSherry	AD Education	Ext 3376 Jane.mcsherry@merton.gov.uk	Children, Schools and Families, 10th floor Civic Centre	
Elizabeth Fitzpatrick	Head of School Improvement	Elizabeth.fitzpatrick@merton.gov.uk	Children, Schools and Families, 10th floor Civic Centre	
Alison Jones	Head of Early Years	Alison.jones@merton.gov.uk	Children, Schools and Families, 10th floor Civic Centre	

Khadiru Mahdi	Merton Voluntary Services Council	khadiru@mvsc.co.uk	

3.8 Hot weather planning (Heatwave)

85. Although hot weather is looked forward too for many in England, if the temperature gets too high it can become dangerously hot for some individuals. Risks to health in a heatwave are extensive and excessive exposure to high temperatures can kill.

86. In 2003 during the pan-European heatwave, there were over 2000 excess deaths over the 10 days. The first Heatwave Plan for England was published in 2004 in response to that event by Public Health England. There is strong evidence that these summer deaths are the result of heat-related conditions. Unlike cold weather, the rise in mortality as a result of very warm weather follows very sharply – within one or two days of the temperature rising.

87. This means that by the time a heatwave starts, the window of opportunity for effective action is very short and therefore advanced planning and preparedness is essential.

88. The Heatwave Plan for England as set out by PHE sets out what should happen before and during severe heat in England. It spells out what preparations both individuals and organisations can make to reduce health risks and includes specific measures to protect at-risk groups. It explains the responsibilities at a national and local level. The plan is primarily for health and social care services and other public agencies and professionals who interact with those most at risk from excessive heat during heatwaves.

89. At-risk groups include older people, the very young and people with pre-existing medical conditions as well as those whose health, housing or economic circumstance put them at greater risk of harm from very hot weather for example some medications that make the skin more sensitive to sunlight.

90. NHS England provides national leadership for improving healthcare outcomes and directly commissions primary care (GP services, dentistry, optometry and pharmacy), some specialist services and oversees CCGs. It is responsible for assuring that the NHS is prepared for a heatwave (see Figure 7).

91. CCGs commission planned hospital care, rehabilitative care, urgent and emergency care, most community health services, mental health and learning disability services. They are responsible for assuring that the each of these bodies is prepared for a heatwave (see figure 7).

92. PHE provides expert services to support public health and it is the responsibility of PHE to prepare and publish the Heatwave Plan for England. They will also seek to ensure that it is

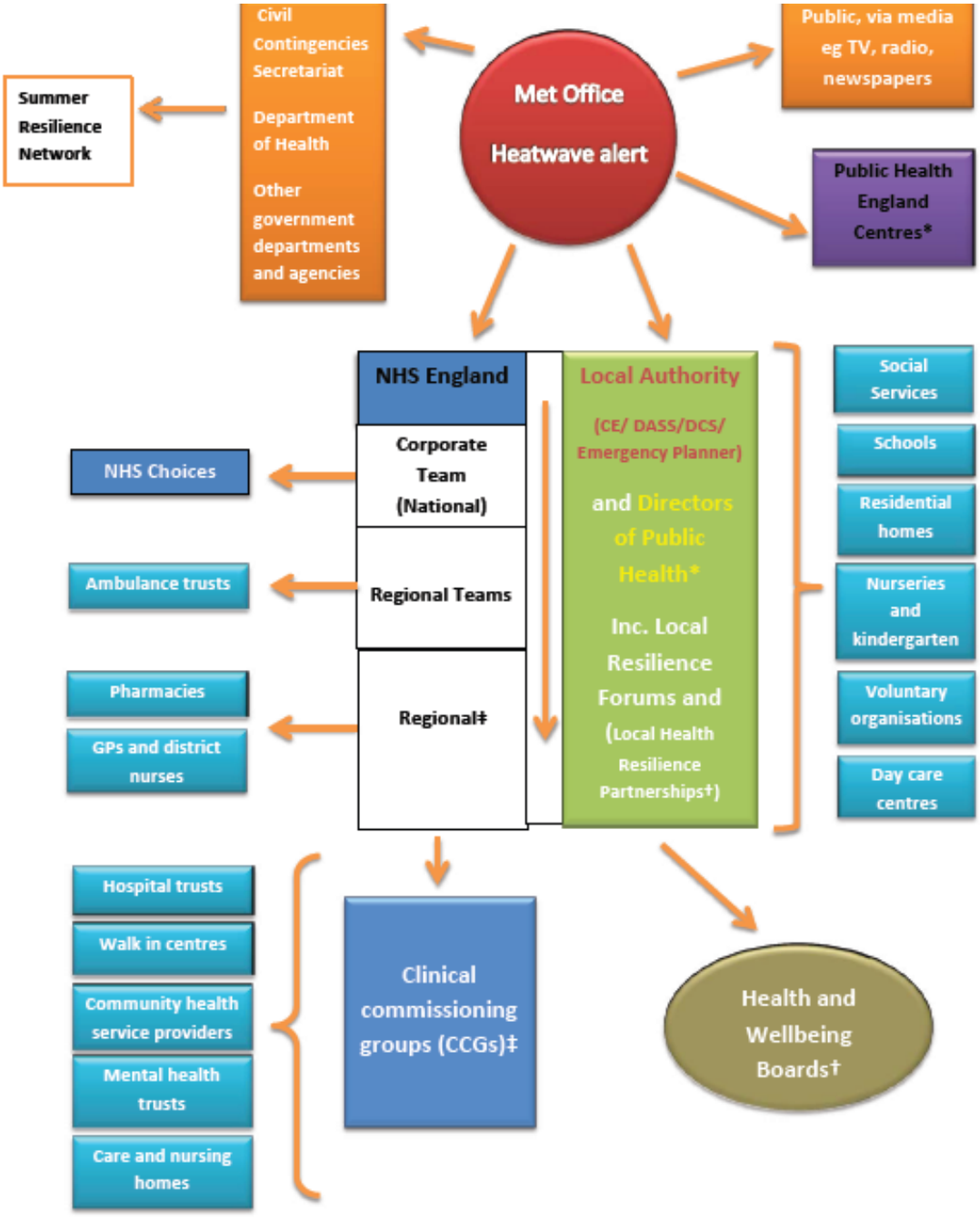
widely communicated using a variety of channels to ensure maximum publicity. They will make advice available to the public and health and social care professionals across England in preparation for summer, and to regions, where severe hot weather is forecast via NHS Choices and websites of Met Office and PHE.

93. The heatwave plan outlines key areas where public, independent and voluntary sector health and social care organisations should work together to maintain and improve integrated arrangements for planning and response in order to deliver the best outcomes possible during a heatwave in the summer.

94. At a local level emergency planning arrangements run by local government and the NHS are brought together in the Local Resilience Forum (LRF). Local Health Resilience Partnerships (LHRPs) have been established to support strategic planning.

95. In Merton, action cards created by the Heatwave Plan by PHE are sent out ahead of hot weather season in March to the relevant leads (see figure 8) by our Civil Contingencies Advisor. During 1st June to 15th September each year, Hot Weather Alerts are received directly from the Met Office by our Civil Contingencies Advisor. When these cold weather alerts are received, they should be sent to the relevant leads (see figure 8) in order for them to inform their sector that they need to be addressing all of the actions in association with that particular level.

96. Community and Housing have links with their contractors who are able to disseminate these action cards to their providers and ensure that actions are being met as the levels change. Contact details for the leads in each department are provided in the table below.



Notes

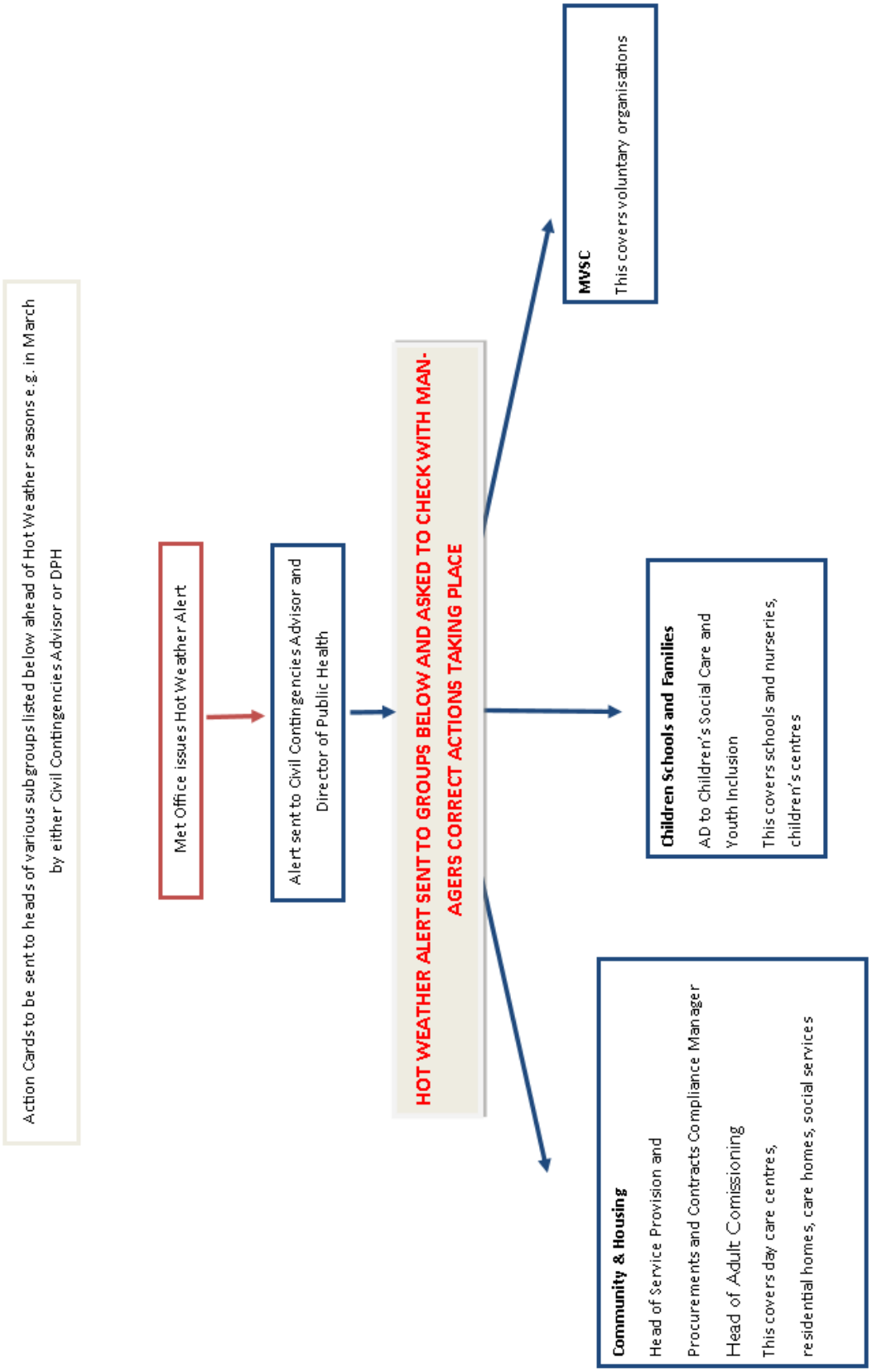
‡NHS England Regional and CCGs should work collaboratively to ensure that between them they have a cascade mechanism for heatwave alerts to all providers of NHS commissioned care both in business as usual hours and the out of hours period in their area.

***PHE Centres would be expected to liaise with Directors of Public Health to offer support, but formal alerting would be expected through usual local authority channels.**

†LHRPs and HWBs are strategic and planning bodies, but may wish to be included in local alert cascades.

Level 0	Long-term planning - All year
Level 1	Heatwave and Summer preparedness programme - 1 June – 15 September
Level 2	Heatwave is forecast – Alert and readiness - 60% risk of heatwave in the next 2 to 3 days
Level 3	Heatwave Action - temperature reached in one or more Met Office National Severe Weather Warning Service regions
Level 4	Major incident – Emergency response - central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health

Figure 7: Proposed arrangement in Merton for Hot Weather Plan (Heatwave)



Key Contacts, Guidance and Information/data:	
PH Lead/s	Julia Groom/Philip Williams
Other contacts	See table below Samantha Perkins (PHE) Samantha.perkins@phe.gov.uk – Principal Health Protection Practitioner Mary Maimo (PHE) mary.maimo@phe.gov.uk – Senior Health Protection Practitioner Sarah Chittock – Civil Contingencies Advisor
Guidance & resources	Heatwave Plan PHE 2015: https://www.gov.uk/government/publications/heatwave-plan-for-england
Information/data (&	

Name	**Job Title**	**Contact details**	**Department**
Andy Ottaway-Searle	Head of Service Provision Regulated services	Ext 4500 Work Mobile: 07956619755 andy.ottaway-searle@merton.gov.uk	Community and Housing, 3rd floor Civic Centre
David Slark	Procurements and Contracts Compliance Manager	Ext 3043 david.slark@merton.gov.uk	Community and Housing, 4th floor Civic Centre
Richard Ellis	Head of Adult Comissioning	0208 545 4630 richard.ellis@merton.gov.uk	Community and Housing, Adult Social Care, 4th floor Civic Centre
Jane McSherry	AD Education	Ext 3376 Jane.mcsherry@merton.gov.uk	Children, Schools and Families, 10th floor Civic Centre
MVSC Khadiru Mahdi			

3.9 Chemical/biological/radiological/nuclear (CBRN) or Hazardous Material (HazMat) Incidents

97. The London Resilience Partnership defines a CBRN(E) incident as one that involves the actual or threatened dispersal of chemical, biological, radiological or nuclear material either on their own or in combination with each other or with explosives.

98. It involves deliberate criminal, malicious or murderous intent which is targeted at a given population, economic or symbolic points. CBRN materials can be passed through number of methods: contact, inhalation, injection and ingestion. CBRN materials can affect people's health directly, and radiological agents can cause additional impacts to the person in the future. HazMat procedures should be followed in an event of a CBRN incident.

99. Public Health England have a lead role in providing technical advice on CBRN and HazMat incidents. Guidance on clinical management and health protection procedures for CBRN incidents are available at the following link, including action cards summarising key response actions for each category of event: https://www.gov.uk/government/publications/chemical-biological-radiological-and-nuclear-incidents-recognise-and-respond

Impacts of a CBRN(E) incident:			
Type	**Description**	**Types of agents**	**Impacts**
Chemical	These fast acting agents can be split into: toxic industrial chemicals and military chemical agents.	• Nerve agents • Blister agents • Choking agents • Incapacitants	**Health:** A number of health impacts, including: • Eye damage • Blisters • Breathing difficulties The higher the exposure the more severe the effects, which can lead to comas and possibly death. **Environment:** • The chemicals can affect groundwater and other water supplies • Damage of the environment **Infrastructure/Technology:** • Building damage which can lead to instability
Biological	A biological release can be passed from person to person or through water sources. These incidents are hard to detect and identify and can be carried out by using different methods such as a mechanical sprayer, contamination of foodstuffs or the environment.	• Bacteria • Viruses • Prions • Viruses • Parasites	**Health/Environmental:** • Can affect the population, animals, water supplies and plants. • Depending on the method of release, the surrounding area ma be contaminated, resulting in the need for decontamination. **Economy:** Due to: • Areas being disused for either short or long periods • Foodstuff being lost due to contamination.
Radiological	Radiation can have and internal and external impact upon a person; these can be direct impacts or can occur in the future. This attack can be carried out by using a Radiological Dispersion Device (IRD), also known as a 'dirty bomb', to disperse the radioactive material.	• Alpha particles • Beta particles • Gamma rays	**Health:** • Can cause health problems, by increasing the chances of cance making the person who is exposed to the radiation feel unwe and with high exposure radiation can cause death. • Dirty bomb detonation can result in the deaths of those nearby and can also damage the surrounding area. **Environment:** • Contamination of topsoil • Contamination of nearby water courses with radioactiv particles. **Infrastructure/Technology:** • Buildings will become contaminated with radiation, and will hav to undergo decontamination to make them safe to inhabit.

Nuclear	These are carried out by using an Improvised Nuclear Device (IND), which causes an explosion.	• Gamma rays • Neutrons	**Health:** • Deaths and radiation poisoning to those with in the affecte area. • Development of health problems in the future and for othe generations. **Environment:** • Fires due to the IND • Radioactive material can impact the surrounding environmer (e.g. water systems, foodstuffs and wildlife). **Infrastructure/Technology:** • Electronics and communications disruptions due t electromagnetic pulse (EMP) from the explosion.

Visual Indicators of a CBRN event:

In the absence of definitive intelligence at the scene, information can potentially be determined by the presenting symptoms from casualties and recognition of key indicators:

- Dead or distressed people and animals
- Multiple individuals showing unexplained signs of skin, eye or airway irritation; nausea; vomiting; twitching; sweating; pin-point pupils; runny nose; disorientation; breathing difficulties; and convulsions
- The presence of hazardous materials or unusual materials/equipment
- Unexplained vapour or mist clouds
- Unexplained oily droplets or films on surfaces or water
- Withered plant life or vegetation

NOTIFICATION

Local Incident	Pan-London Incident
The Council will be contacted by the emergency services if a CBRN event has occurred in the borough, and is expected to invoke the Major Emergency Response Plan (MERP)	In the event of a pan-London incident, LLAG will enac arrangements, leading to the setup of the London Loca Authority Coordination Centre to coordinate all Loca Authority activity.

Merton Council Responsibilities *during* a CBRN event:

- Activation of the Borough Emergency Control Centre (BECC) to coordinate the response to the incident
- Deployment of the Local Authority Liaison Officer (LALO).
- Appointing a Humanitarian Assistance Lead Officer (HALO) to determine the appropriate type of humanitarian assistance response required (Survivor Reception Centre, Rest Centre or Humanitarian Assistance Centre), and facilitate the centre(s).
- Assisting MPS and LFB with the evacuation of cordon area
- Identification of any vulnerable people within the affected area
- Supporting the emergency services and the local community
- Coordinating a response with the voluntary agencies
- Helping with distribution of medicines and providing equipment
- Organising counselling services for survivors
- Setting up temporary medical centres
- Assisting with the transportation of decontaminated people
- Setting up healthcare help-lines and drop-in centres for those who need information and re-assurance.
- Working alongside religious and ethnic community leaders to ensure their custom and beliefs are respected during this time.
- Facilitating the Designated Disaster Mortuary/ any temporary mortuary arrangements (*if needed*).
- Requesting Mutual Aid from other boroughs (*if needed*).

Merton Council Responsibilities *after* a CBRN incident:

• Leading on the long term recovery process, to work towards restoring normality and maintaining normal services.
• Lead on contaminated waste management planning
• Provision of physical and psycho-social care to evacuees
• Provision of specialist staff / contractors for:
  • public protection; • highways; • waste disposal;
  • dangerous structures; • environmental health; • temporary housing, etc
• Co-ordinate multi-agency support for the decontamination process
• As necessary, assessing the structural stability of affected buildings, and if they appear to be dangerous exercise powers under the Building Act 1984 (for England and Wales) and the Building (Scotland) Act 1959.
• Organise and manage the decontamination of the affected area
• Restoring the environment to normal use
• Invoke any existing mutual aid arrangements with neighbouring authorities and contractors as appropriate
• Manage health and safety of workers decontaminating the environment and disposing of the waste.

4. Appendix

4.1 Appendix 1: Terms of Reference Internal Health Protection Oversight Group

Name of group
Public Health - Health Protection Oversight Group

Purpose and role of group

- To provide co-ordinated approach to the public health, health protection oversight function
- To review issues and identify actions
- To escalate issues as required to the Senior Leadership Team
- To provide an overview of Communications issues
- To provide knowledge and input on priority areas and help prioritise where limited resources are directed

Membership

- Key Officers leading in each section of Health Protection in Merton
- Consultant in Public Health with lead for Health Protection
- Public Health Commissioning Officer
- GP trainee working on producing the oversight document

Role and responsibility of key officers

- Proactively tracking and maintaining data in their area (e.g. using PHE and NHS-E reports) and saving in an easy to access file on the Shared network
- Ensuring this data is reviewed, providing oversight for their area and identifying issues that require a response (e.g. underperformance, incidents, outbreaks)
- Ensuring you are aware of protocols and the relevant key contacts listed in your specified area
- Ensuring urgent queries are dealt with in a timely response and escalating quickly to the Director of Public Health if necessary
- Attending quarterly meetings to discuss any issues within your specified area
- Passing on key information to other relevant members in the team should you receive a query not in you area.

Accountability
This is an internal group with accountability to PH Senior Leadership Team and Director of Public Health.

Review and Working Methods
The Health Protection Oversight Group will meet quarterly. It will be chaired by Consultant in Public Health. The meetings will be managed Public Health Commissioning Officer.

4.2 Appendix 3: Roles and Responsibilities of Partner Agencies

Background

The Health and Social Care Act 2012[i] redefined the way public health was practiced in the UK. Public Health England was created to deliver the Secretary of State for Health's duties for health protection and health improvement. Local public health teams were absorbed into local authority function[ii] Between PHE, NHS England (NHSE) and local public health teams' health protection and health improvement functions are being discharged in the UK. Whilst there are some clear statutory functions which have been bestowed upon local public health teams, the scope of their role pertaining to health protection has not been outlined as explicitly[iii]. Through this document we intend to define the mandatory health protection duties of all three organisations and explore in further detail the roles and responsibilities of local authorities in health protection.

Statutory Duties

NHS England (NHSE)

NHS England is the overarching organisation responsible for delivering a 'national health service' in England[ii]. They are responsible for commissioning services to CCG and other local organisations. Beyond this role they also perform some necessary health protection functions, such as screening and immunisations. Their aim is to "achieve positive health outcome for the population and reduce inequalities in health," as per the National Health Service Act 2006.

Their specific functions are detailed in 'Public Health Section 7A Intentions'[ii], and are summarised below:

Immunisations services
Screening programmes
Cancer screening
Child Information Health systems
Public Health service in secure and detained settings
Sexual assault referral centres

Public Health England (PHE)

Public Health England is an executive body in the Department of Health through which the Secretary of State for Health discharges his or her duty to protect the health of and address health inequalities in the population.

PHE works locally, regionally and nationally to execute four critical functions[4][iv]:

- Protecting the public's health from infectious diseases and environmental hazards
- Securing improvement to the public's health by working to combat health inequalities
- Improving population's health by supporting sustainable health and care services such as national prevention strategies and immunisation and screening services commissioned by NHSE
- Ensuring the public health system maintains the capability and capacity to tackle public health challenges

Their health protection roles and responsibilities are summarised below:

Emergency planning, resilience and response
Field epidemiology services
Infectious disease surveillance and control
Public health strategy
Centre for radiation, chemical and environmental hazards

PHE produces regular reports for local authorities, summarising their caseload and significant events that have taken place over the last few weeks or months. If there have been any situations they feel would be pertinent to alert local authorities or other stakeholders about, they will prepare a specific briefing for them, advising on follow up actions. PHE also coordinate with local Environmental Health departments in tackling food related illnesses and outbreaks.

Local Authority Public Health Teams

With the reorganisation of how healthcare is provided locally decreed by the Health and Social Care Act 2012, local public health teams moved from the now defunct PCTs to local authority. Although many of their mandated duties remained the same under this new configuration their role pertaining to health protection has not been explicitly defined. To clarify these details guidance was drafted in 2013 – "Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representative) Regulations 2013"[2].

The intention behind this document was to define the roles and responsibilities local authority public health teams had towards health protection. Directors of Public Health were to be appointed locally to lead this responsibility and teams were encouraged to have open, co-operative relationships with their central government colleagues. Beyond stating the need for a local leadership function and active accommodating role in the sharing of information and support of PHE functions, little else was stated.

As the core health protection function still lies primarily with PHE and NHS England there is little idea for what is expected locally aside from collaboration and co-operation with central government. Through this document we hope to explore and state the specific role and responsibilities for all organisations mentioned with the intention to allow Merton Public Health to maximise its productive capacity.

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[i] **GOV.UK** Health and Social Care Act 2012: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[ii] **GOV.UK** Protecting the health of the local population: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf

[iii] **NHS England** Commissioning Intentions 2017-18: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/09/public-hlth-comms-intent-2017-18.pdf

[iv] **Public Health England** About Us: https://www.gov.uk/government/organisations/public-health-england/about

4.3 Glossary

AAA - Abdominal Aortic Aneurism

ACHOSC – Adult Care and Health Overview Scrutiny Committee

ANNB – Antenatal Newborn Screening

CCG –Clinical Commissioning Group

DPH – Director of Public Health

HCAI – Health Care Associated Infections

HPV - Human Papillomavirus

LHRP – Local Health Resilience Partnership

NHSE – NHS England

PCT – Primary Care Trust

PHE – Public Health England