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Merton Council
Children and Young People Overview and Scrutiny Panel

Date: 21 June 2023
Time: 7.15 pm
Venue: Council chamber - Merton Civic Centre, London Road, Morden SM4 5DX

AGENDA

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Children and Young People Overview and Scrutiny Panel membership

Councillors:
Usaama Kaweesa (Chair)
Chessie Flack (Vice-Chair)
Michael Butcher
Caroline Charles
Jil Hall
Billy Hayes
Andrew Howard
Linda Kirby MBE
Samantha MacArthur
James Williscroft

Co-opted Representatives
Mansoor Ahmad, Parent Governor Representative Secondary and Special Sectors
Roz Cordner, Church of England Diocese
Becky Cruise, Parent Governor Representative
Dr Oona Stannard, Catholic Diocese

Substitute Members:
Max Austin
Sheri-Ann Bhim
Jenifer Gould
Edith Macauley MBE
Robert Page

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. For further advice please speak with the Managing Director, South London Legal Partnership.

What is Overview and Scrutiny?

Overview and Scrutiny describes the way Merton's scrutiny councillors hold the Council's Executive (the Cabinet) to account to make sure that they take the right decisions for the Borough. Scrutiny panels also carry out reviews of Council services or issues to identify ways the Council can improve or develop new policy to meet the needs of local people. From May 2008, the Overview & Scrutiny Commission and Panels have been restructured and the Panels renamed to reflect the Local Area Agreement strategic themes.

Scrutiny's work falls into four broad areas:

⇒ **Call-in**: If three (non-executive) councillors feel that a decision made by the Cabinet is inappropriate they can 'call the decision in' after it has been made to prevent the decision taking immediate effect. They can then interview the Cabinet Member or Council Officers and make recommendations to the decision-maker suggesting improvements.
⇒ **Policy Reviews**: The panels carry out detailed, evidence-based assessments of Council services or issues that affect the lives of local people. At the end of the review the panels issue a report setting out their findings and recommendations for improvement and present it to Cabinet and other partner agencies. During the reviews, panels will gather information, evidence and opinions from Council officers, external bodies and organisations and members of the public to help them understand the key issues relating to the review topic.
⇒ **One-Off Reviews**: Panels often want to have a quick, one-off review of a topic and will ask Council officers to come and speak to them about a particular service or issue before making recommendations to the Cabinet.
⇒ **Scrutiny of Council Documents**: Panels also examine key Council documents, such as the budget, the Business Plan and the Best Value Performance Plan.

Scrutiny panels need the help of local people, partners and community groups to make sure that Merton delivers effective services. If you think there is something that scrutiny should look at, or have views on current reviews being carried out by scrutiny, let us know.

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CHILDREN AND YOUNG PEOPLE OVERVIEW AND SCRUTINY PANEL
13 MARCH 2023

(7.15 pm - 9.55 pm)

PRESENT: Councillors Councillor Usaama Kaweesa (in the Chair), Councillor Chessie Flack, Councillor Michael Butcher, Councillor Caroline Charles, Councillor Jil Hall, Councillor Billy Hayes, Councillor Andrew Howard, Councillor Linda Kirby, Councillor Samantha MacArthur, Councillor James Williscroft, Mansoor Ahmad, Roz Cordner, Becky Cruise and Dr Stannard

ALSO PRESENT: Councillor Sally Kenny (Cabinet Member for Education and Lifelong learning)

Stella Akintan (Scrutiny Officer), Elizabeth Fitzpatrick (Assistant Director for Education and Early Help), Maisie Davies (Head of Performance, Improvement and Partnerships), Jane McSherry (Executive Director of Children, Lifelong Learning and Families) and Keith Shipman (Social Inclusion Manager) Dheeraj Chibber, Assistant Director for Children's Social Care and Youth Inclusion) David Michael (Head of Children in Care and Resources) Rachel Bowerman (Head of School Improvement)

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

There were no apologies for absence.

2 MINUTES OF THE PREVIOUS MEETING (Agenda Item 2)

The minutes of the previous meeting were agreed.

3 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 3)

There were no declarations of pecuniary interests.

4 CORPORATE PARENTING IN MERTON (Agenda Item 4)

A panel member asked how the progress of children in care is measured. It was reported that key performance indicators are used alongside assessments and reviews. Childrens voices are heard through the Bright Spot Survey.

In response to questions, it was reported that:

In semi-independent accommodation there is responsible adult present. Quality assurance checks are undertaken on homes. Over 18s can access independent living when appropriate.

Health assessments, dental checks, eyesight checks are undertaken for looked after children. These take place alongside holistic checks including the emotional wellbeing of the child.

Details on the number of private children's homes in Merton will be provided to the panel.

The children's voice is represented in the Corporate Parenting Strategy.

Young people were listened to, and feedback had been provided on participation and involvement, and increasing time with birth families.
Challenges in recruiting foster carers is reflected across London. The council is working with London Commissioning alliance, using a digital campaign which is working effectively.

The Panel would like an update from the Catch 22 team to look at the number of youth workers and impacts of cuts to the service.

There is a significant shortage of secure children's homes, early work is being undertaken to scope a secure children home for London.
The Panel asked for the number of children placed in secure homes out of borough.

Merton takes its role as a corporate grandparent very seriously and supports young people if they have a child.

It was reported that some specific groups are targeted for foster carers such as the LGBTQI community.

It can be difficult to place larger sibling groups, but the Mockingbird model supports this with regular meet up time.

RESOLVED
The Chair thanked officers for their presentation.

5 CORPORATE PARENTING ANNUAL REPORT (Agenda Item 5)

6 EDUCATION STANDARDS REPORT (Agenda Item 6)

The Head of Education Inclusion and Head of School Improvement gave an overview of the report.

In response to questions, it was reported that:

In regard to truancy rates and children going away for holidays, the department work with headteachers and provide briefing for governors. There are also early help workers. The truancy levels in Merton are better than London and national rates.

If parents are home schooling, they are responsible for the curriculum but there is a link to the school nursing service.

During pandemic remote working made writing difficult. There is expertise in advisory teams working with schools to help with key stage two writing.
There are plans underway to mark the 75th anniversary of Windrush both within the council and in schools.

The Cabinet Member for Education and Lifelong Learning highlighted the high level of success in Merton schools.

7 DEPARTMENTAL UPDATE REPORT (Agenda Item 7)

Congratulations were extended to the Executive Director for Children Lifelong Learning and Families for being shortlisted for an LGC Award.

A panel member asked if the pay allowance is an issue for foster carers. It was reported that during exit interviews, allowance was not an issue as Merton pay above the minimum allowance.

8 PERFORMANCE OVERVIEW REPORT (Agenda Item 8)

The Head of Performance, Improvement and Partnerships gave an overview of the report.

A panel member noted several red and amber indicators and asked about the impact of this on children. The Assistant Director for Children's Social Care and Youth Inclusion said the impact is different for each target. If there are any concerns, it is escalated to senior managers.

9 PLANNING FOR THE 2023 -2024 WORK PROGRAMME (Agenda Item 9)

A panel member said a fact sheet for this panel would be helpful. This would be similar to ward profiles and include data on schools, Ofsted rating, school population. It could be provided at the start of the scrutiny year.

A panel member said accessibility and availability of reports can make scrutiny difficult. More time is needed to consider reports.

A panel member would like more in-person visits to community organisations and more service users attending the panel meetings.

Children and Young People's (CYP) Overview and Scrutiny Committee

Date: 21st June 2023

Subject: 0-19 Healthy Child Services update report

Lead Director: Jane McSherry, Director of Children's and Life Long Learning (CLLF)

John Morgan, Director of Adult Social Care, Integration and Public Health

Lead officer: Dr Dagmar Zeuner, Director of Public Health

Lead members: Cllr Peter McCabe, Cabinet Member for Health and Social Care

Cllr Brenda Fraser, Cabinet Member for Children's Services

Cllr Sally Kenny, Cabinet Member for Education and Lifelong Learning

Contact officer: Hilina Asrress, Head of Public Health Services

hilina.asrress@merton.gov.uk

Recommendations:

For CYP Overview and Scrutiny members to:

A. note and discuss the support available for children aged 0-19 and their families through the Public Health commissioned services

B. Note the timeline for the re-procurement of the 0-19 services with a new commissioned service to be in place by April 2025

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report provides a background and overview of the 0-19 healthy child services commissioned by Public Health. The services included are Health Visiting, School Nursing and the Young Parents Support service delivered by Central London Community Health NHS Trust. The service supports CYP and their families up to the age of 25 if the child is Looked After or has Special Educational Needs and/or Disabilities (SEND). The report will also cover service delivery model, service review, performance and future commissioning arrangements. Appendix 1 also includes two case study which highlights the work of the services with two local families.

1.2. CYP Overview and Scrutiny members are asked to note and discuss the support available for children aged 0-19 and their families and note the indicative timeline for the re-procurement of the 0-19 services with a new contract to be in place by April 2025

2 BACKGROUND

2.1. The 0-19 service is primarily made up of the Health Visiting team who support children under the age of 5yrs and the School Nursing team who support children aged 5-19yrs. The 0-19 services are a key provider of the Healthy Child Programme (HCP) and work with families and other services

to ensure children have the best start in life.[1] The Healthy Child Programme is an evidence based national programme framework aimed at improving the health and well-being of children, young people and their families through:

- Health and developmental reviews
- Health Promotion
- Parenting Support
- Screening and immunisations programmes (promotion of these rather than delivery)

2.2. The service model is universal in reach and tailored/ personalised in its response as set out in the HCP. The service also provides a targeted offer for families with additional vulnerabilities such as safeguarding or additional health needs. The model for Health Visiting and School Nursing has been updated to reflect the totality of the work which the services deliver over and above the mandated visits and assessments. The model reflects that their role is universal, targeted and specialist.

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3 DETAILS

3.1. The details in this report have been split into five key areas; Service overview, service review, performance and future commissioning. The council through the Director of Public Health (DPH) has statutory duties relating to the delivery of 0-19 Healthy Child Services and specifically has mandated functions which include five health review checks for children and the National Child Measurement Programme (NCMP) as detailed in the service overview below. The council has a joint contract with NHS South West London Integrated Care Board (NHS SWL ICB) who are the lead commissioner, to deliver our services alongside the ICBs children's and adult community health services. The provider of the service is Central London Community Health NHS Trust who have delivered the services in Merton since April 2016. CLCH also deliver 0-19 services in 7 other boroughs (Brent, Ealing, Hammersmith and Fulham, Kensington and Chelsea, Richmond, Wandsworth and Westminster). The Merton contract with CLCH has been approved by Cabinet to be extended until March 2025. The services are co-located within Merton's Children's Centres.

Service Overview

3.1.1 Health Visitors (HVs) and School Nurses (SNs) are Specialist Public Health Nurses (SCPHN) with HVs leading the under 5yrs element and SNs leading the 5-19yrs elements of the Healthy Child Programme. The service provides mandated visits and assessments and critical safeguarding services.

3.1.2 Health Visitors support families from the antenatal period up to school entry. The service is delivered in a range of settings including families' own homes, and local community e.g. Children's Centres. School nurses offer support for children and young people both in and out of school settings.

3.1.3 Both services are led by HVs and SNs as Specialist Public Health Nurses (SCPHN), however it is important to note there is also a skill mix within the

[1] Healthy Child Programme updated model https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model

teams, including community staff nurses and nursery nurses delivering different elements of the service.

3.1.4 HV and SN teams utilise their clinical judgement and public health expertise to identify health needs early, determining potential risk, and providing early intervention to prevent issues escalating. Utilising the Specialist Public Health Nurse skills provides vital early identification, intervention and prevention, maximising the benefits for parents, children and young people.

3.1.5 The service provides continuity of care through taking a 'navigating role' to support families through the health and care system. Utilising the right skill set, at the right time, including supporting effective signposting to other support and information.

3.1.6 The co-location of the services with Merton's Children's Centres facilitates more collaborative and integrated working with early years services to support improving outcomes for children and families.

Health Visiting

3.1.7 There are 5 mandated reviews for health visiting services which should be offered universally to all families (see Figure 1). These include:

- Antenatal check/review (from 28 weeks pregnant)
- New birth visit/check (14 days)
- 6-8 week check
- 1 year check (from 9 months to 1 year)
- 2-2.5 year check

Figure 1: Health Visiting review/contacts

**Please note the antenatal check/review is not universal in Merton but targeted. The 3 months and 6 month contacts are not mandated but are suggested contacts and are undertaken on a targeted basis in Merton.*

3.1.8 Each visit includes an assessment of critical developmental milestones. Trusted and expert advice is provided. If a family is assessed as vulnerable due to physical, mental, or social stressors, more support is available. The Merton service includes a specialist outreach team which proactively engages with families in temporary housing and in refuges, a perinatal mental health and breastfeeding specialist to support families.

3.1.9 Where families are identified as requiring additional contact and support either through the mandated checks or by referral to the service by professionals and subsequent assessment, additional contact would be made or signposting/referral to appropriate services.

3.1.10 Evidence based High Impact Areas for HVs have also been identified as part of the Healthy Child Programme:

- supporting the transition to parenthood
- supporting maternal and family mental health
- supporting breastfeeding
- supporting healthy weight, healthy nutrition
- improving health literacy; reducing accidents and minor illnesses
- supporting health, wellbeing and development: Ready to learn, narrowing the 'word gap'

3.1.11 The Health Visiting Service in Merton includes these more specialised roles to support families in line with supporting some of the high impact areas above and reducing health inequalities:

- Homeless health- specialist health visiting team. This team hold a caseload of children and family who are placed in temporary accommodation, they also provide expertise and support to wider team.
- Perinatal Mental Health Specialist: This is a senior health visitor who also holds a caseload of families who are experiencing mental health issues and they also lead a weekly specialist stay and play group, co delivered with the children's centre staff.
- Young Parents Support Service (see 3.1.18 for further details) – This is led by 2 specialist Health Visitors who hold a targeted caseload for mothers up to the age of 24 years. These families are highly complex with multi vulnerability
- MASH (Multi- Agency Safeguarding Hub) health navigator – This specialist Health Visitor is co-located with the Local Authority with the MASH team.
- Single point of access for health visiting – Administration team who act as the first port of call for all CLCH children's services.
- Infant Feeding and specialist Clinic (see 3.1.12 for further details) – Merton has a specialist infant feeding clinic which is led by Nutritionist

and lactation consultant which is part of the HV team. They provide specialist support for breast feeding mothers in the community.

3.1.12 The Merton HV team successfully achieved Stage 3 reaccreditation of the UNICEF Baby Friendly Initiative (BFI)[2] scheme. The service is preparing to go for UNICEF gold accreditation in May 2024. The excellent training and skills reviews taking place has resulted in staff who are extremely confident and competent in supporting mothers. UNICEF assessors fed back that "Staff were extremely knowledgeable about close loving relationships and talked about conversations they may have with mothers in a very sensitive way. The pioneering work and research the Merton Specialist Breastfeeding Clinic is doing was selected by UNICEF and showcased at the annual BFI conference, which had 1800 attendees from the UK and internationally.

3.1.13 **Appendix 1** provides two anonymised case studies of a families supported by the Health Visiting service in Merton. This highlights some of the work of the services and how they support improving family health and well-being outcomes and reducing inequalities.

School Nursing

3.1.14 School nurses (SNs) advocate for optimum health for all school-aged children and young people, seeking to ensure that services are fair, inclusive, equitable, anti-discriminatory and positively influence health and wellbeing. SNs build mutually trusting relationships with school-aged children and young people, parents/carers and families. Importantly, school nurses actively listen to school-aged children and young people, taking account of what matters to them and always putting their needs, welfare and safety first. School nurses provide early interventions which aim to promote positive choices and reduce risk-taking behaviours. The mandated element of the SN service is the National Child Measurement Programme (NCMP). This requires the service to measure the height and weight of all Reception (4-5 yr olds) and Year 6 (10-11 yr olds) pupils to identify their Body Mass Index and share the results through a letter to parent/carers. This generates intelligence about children who are underweight and overweight/obese in Merton. The service is also commissioned to offer the Family Start programme to all families where the child has been identified living with obesity to support the family and child with healthy lifestyles advice on a one to one basis.

3.1.15 Each local authority school in Merton is supported by a school nurse. As part of the overall support provided by the SN services, the service also undertakes a school entry questionnaire for parents/carers of 4-5 yr olds starting Reception to identify needs early on and provide appropriate support. SN service receives referrals from a number of groups including schools staff, social care, GPs, self-referrals etc.

3.1.16 Evidence based High Impact Areas for SNs have also been identified as part of the Healthy Child Programme:

- supporting resilience and wellbeing

[2] https://www.unicef.org.uk/babyfriendly/accreditation/maternity-neonatal-health-visiting-childrens-centres/

- improving health behaviours and reducing risk taking
- supporting healthy lifestyles
- supporting vulnerable young people and improving health inequalities
- supporting complex and additional health and wellbeing needs
- promoting self-care and improving health literacy

3.1.17 CLCH is reviewing their school nursing model across all boroughs to standardise an approach which ensures that school nursing is equipped for the future ('Time to Shine' project)

Young Parents Support Service

3.1.18 The Young Parents Support Service provides more frequent support for young, vulnerable mothers/families whose babies are particularly at risk of poor outcomes. These families are also encouraged to access peer support sessions facilitated by the service in Children's Centres as well as wider support from other professionals and services. Those who accept to go on the programme are provided with all the universal elements of the HCP as well as more intensive frequent face to face contact and support from the service up until the baby turns 2yrs old.

3.1.19 There is very positive feedback from those who are benefiting from the programme. Additional investment has been made in the service to support the demand and increased complexity presenting. The maximum capacity of the service is 50 families and this is envisaged to be reached by July/Aug 2023. Caseload is closely reviewed and managed.

The services' contribution to safeguarding and for those with additional needs

3.1.20 The mandated visits made by Health Visitors are critical for the early identification of development delays which may indicate a child has an additional need or a disability. They deliver interventions which can improve outcomes for these children. They also make referrals for more specialist assessment and care.

3.1.21 In addition to the mandated components of Health Visiting and School Nursing service, the service makes a significant contribution to safeguarding children. Their systematic engagement of children and families means they are able to identify safeguarding concerns early on. Their health expertise means that they can make a critical contribution to multi-agency processes. They provide advice and contribute to Individual Health Care Plans (IHCP), Education Health and Care Plans (EHCP), receive notifications from Accident and Emergency, and provide the majority of health leadership in Strategy meetings for Children in Need (CHIN) and those with Child Protection (CP) Plans. Children with additional health and social needs are handed over from health visiting to school nursing as they enter school.

3.1.22 The services benefits from the leadership and clinical skills of CLCH's Safeguarding and Specialist Therapies Leads who provide advice and support the teams as this is delivered under the same joint contract, although therapies are funded by NHS SWL ICB. There is a Looked After Children's (LAC) lead who works to ensure Looked After Children;

a) Receive high quality health assessments and health care plans that focus on their individual needs,
b) Are actively engaged in their health assessment process,
c) To improve the quality of life of young people leaving care by developing an agreed enhanced health care plan and providing relevant personal health information to support them in making a successful transition to adulthood.
d) To improve their health and wellbeing outcomes by embedding a multiagency integrated approach, working in partnership across health social services education, and other related organizations

The service achieved high take up in undertaking Review Health Assessments and Leaving Care Summaries for LAC in Merton.

3.1.23 Following a written statement of action in December 2019 under the SEND Inspection framework[3] (Joint Ofsted and Care Quality Commission visit for areas), CLCH developed action plans to address areas for improvement. The actions included intensive work to provide training (jointly developed by CLCH & LBM SEND lead) activities to inform staff and improve practice in planning and implementing aspects of the SEND reform. New templates developed and shared with staff to write appropriate advice for EHCPs. A quality assurance process was also established where advice would be reviewed before submission and more regular meetings between partners established.

3.1.24 A specialist School Nurse also focuses on Youth Offending Service, Pupil Referral Unit, Children Missing in Education and home-schooled children.

3.1.25 The 0-19 service consistently prioritise those with safeguarding and more complex needs but note the needs of the population are changing with more need and complexity being identified. This requires more capacity to support but ultimately still need to be managed within existing resources whilst delivering the universal and targeted element of services.

0-19 Service Review

3.2. To support the recommissioning of our 0-19 services, a rapid high level review was undertaken in July 2022. Some of these findings are presented below. As part of the review, an assessment of the strategic policy context for child health, education and social care suggests that the future for child health is integrated. System (Integrated Care System, ICS), Place (local authority) and Neighborhood (e.g. Primary Care Networks-PCNs) will become the geographies at which services are planned and delivered. Merton does not currently have a shared strategy/approach for integrated working, however there are opportunities for progressing more integrated working e.g. Family Hubs[4] and Maternity Hubs[5] models.

3.2.1 Engagement with some stakeholders through focus groups, interviews and survey showed pprofessionals in health, education, community, and

[3] https://www.gov.uk/government/publications/local-area-send-inspection-guidance-for-inspectors/guidance-for-carrying-out-re-visits-to-local-areas-required-to-produce-a-written-statement-of-action

[4] https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme

[5] https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/maternity-and-neonatal-services/

voluntary sector and the local authority recognise and value the expertise of Health Visitors and School Nurses and want to create opportunities for them to engage with their patients, pupils, service users, and residents. Relationships are reported to be stronger between Health Visitors and GP practices, and between school nursing and schools. Continuity of care and relationships is valued by GP practices and school settings. Issues that were highlighted by interviews, groups, and surveys often arose when there was a lack of continuity of staff during staff changes. Health Visitor and School Nursing's role in Team around the Family meetings, Case Conferences, and EHCPs were cited as positive examples of integrated practice. Going forward a strengthened role with increasing school attendance was highlighted.

Investment, Workforce, and Capacity

3.2.2 Investment in the Healthy Child Programme varies between local authorities. Merton's investment is above the median compared to its statistical neighbours and local authorities in SWL ICS.

3.2.3 Investment in School Nursing is significantly lower per head of population compared to Health Visiting. This is consistent with other local authorities' investment. It reflects the additional intensity of the Health Visiting investment and evidence on the efficacy of investing early in childhood to achieve health and wellbeing across the life course.

3.2.4 There are no national standards for the number of Health Visitors and School Nurses per head of population in England. There is no national standard for the caseload of Health Visitors although the Institute of Health Visiting guidance states 250 per WTE HV, which is significantly lower than the caseload in Merton of around 730. To better manage the caseload, an internal trust wide initiative called 'Reimagining Health Visiting' was developed in consultation with staff. The Reimagining Health Visiting Model separates the caseload into 'active' (children aged 0-2.5yrs and targeted children, London Continuum of Needs-LCON levels 2-4) and 'community' caseloads (children aged over 2.5yrs and universal) which brings the 'active' caseload down to 450 per qualified HV. The active caseload indicate those who are seen relatively more often (whether through mandated health checks or those requiring more support).

3.2.5 There are currently 43 Primary schools, 8 Secondary schools, and 3 Special schools in Merton. The School Nurses cover around 6 schools each. The caseload in PRUs is allocated to a Band 7 Nurse, due to the added complexity of needs presented by the pupils.

3.2.6 The supply and retention of Health Visitors and School Nurses is a systemic problem reported nationally, regionally, and locally. In Merton, the service assessed the vacancy rate for Health Visitors as being better than in other London authorities during the review, although this does constantly change. An aging workforce with a high proportions of HVs over the age of 55yrs means that training new HVs has become even more important. Some pan-London workforce planning work on 0-19 services is currently taking place with a new document published which looks at the challenges and enablers

for recruiting Specialist Community Public Health Nurses – SCPHN in London as a 'road map to success' to start to address the workforce issues.[6]

3.2.7 CLCH uses a range of strategies to recruit Health Visitors and School Nurses, these include international and national recruitment campaigns and developing training routes for staff nurses.

3.2.8 The 0-19 review highlighted the need to make some service improvements in some of the mandated checks (a new IT system has had an impact on performance) which the service has been working on.

3.2.9 The Young Parents Support service at the time of the review was experiencing significant challenges in managing the complex caseload and prioritising the waiting list. To resolve this issue, multiagency actions were implemented and additional investment was provided to allow the service to expand the support provided and to reduce the waiting list.

3.2.10 Visibility of the SN service and lack of understanding by some young people and professionals e.g headteachers, SENCO's, on the service offer was also highlighted in the review which the service is also working on.

3.3. Performance

3.3.1 From January to March (Q4) 2023, the HV service undertook 2,043 mandated health reviews with children and their families in Merton, roughly 680 per month. This does not include any additional contacts the service would be making with families who require additional support outside of the mandated health reviews.

3.3.2 Before the pandemic, Merton's Health Visiting Service was performing better or similar to the London average. 2020/21 saw some reduction in performance in 12-month and 2.5-year reviews however the service had performed significantly better than its statistical neighbours with the exception of the 2.5-year review. In 2021/22 performance has been variable where some indicators are better than London, England and some neighbouring/statistical borough whilst others have been lower. A new IT system introduced last year has also had an impact on the quality of the data. This is being managed with specific meetings with provider to understand and resolve.

3.3.3 COVID-19 restrictions had a significant impact on the provision of 0 to 19 services, including the need for virtual contacts and pausing of some services, re-deployment and prioritisation of safeguarding concerns.

3.3.4 **Table 1** below shows the latest national reporting on the coverage of the mandated health checks/review in 2021/22 for Merton with comparison to London and England. The table also includes performance pre COVID 19 pandemic (2019/20) for comparative purposes. The COVID 19 pandemic has had a significant negative impact on coverage of the mandated checks as shown by the decrease seen in all indicators from 2019/20 to 2021/22. Some caution must be place on interpretation of the 2021/22 data as recovery from the COVID 19 pandemic nationally as well as a change of IT systems locally has had a negative impact on the metrics.

[6] https://ihv.org.uk/wp-content/uploads/2023/05/PAN-London-Report-and-infographics-FINAL-VERSION-18.05.23.pdf

3.3.5 Although performance is lower than pre-pandemic for those receiving a review when they are due, the service continually works to ensure those who may not have had their check in the time for any reason are followed up and contacted to offer the checks. They undertake more checks than are due each month/quarter to ensure more children are seen. Those who are more vulnerable they receive a targeted package of care for mandated checks which means they will be seen at home for all reviews and seen regularly for additional input. If a vulnerable child was not seen, this is followed up by the health visitor and appropriate escalation. All vulnerable children known to the HV service will be seen, if this is proving difficult the service works closely with partners including social care to resolve.

Table 1: Health Visiting metrics on mandated checks 2019/20 and 2021/22

National Health Visiting Metrics	Merton Pre COVID 2019/20	Merton* *2021/22*	London *2021/22*	England *2021/22*
New birth visits completed within 14 days	95.3%	85.5%	87.8%	82.6%
6 - 8 week reviews completed by 8 weeks of age	92.7%	81.4%	74.3%	81.5%
12 month reviews completed by 12 months of age	80.7%	62.5%	56.1%	71.9%
2.5 year reviews completed by 2.5 years of age	77%	53.2%	64.2%	74%

Source: *OHID using interim reporting of health visiting metrics: https://www.gov.uk/government/collections/child-and-maternal-health-statistics#health-visitor-service-delivery-metrics and local data**

3.3.6 An Ages and Stages Questionnaire (ASQ) assessment is undertaken as part of the 2-2.5 year review and covers five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development. There has been a general decrease in those achieving expected levels in 4 domains from 2019/20 (pre-pandemic) to 2021/22, apart from the problem solving domain which had increased.[7] Caution needs to be applied in interpreting these results as the overall coverage in the 2-2.5 year reviews had decreased in 2021/22 (see table 1 above) and does not reflect a high proportion of children who were not seen by 2.5 years.

3.3.7 From January to March (Q4) 2023, the School Nursing service received around 214 referrals which the team would then review and follow up. Delivery of the mandated National Child Measurement Programme (NCMP) by the School Nursing service is a key focus area. **Table 2** below shows the proportion of children in Reception and Year 6 where their height and weight was measured. Latest 2021/22 data shows Merton coverage has declined compared to pre-COVID and is now lower than London and England for both Reception and Year 6. To highlight the scale of the programme, in 2021/22 there were a total of 3,830 children measured by the service. The programme was paused during the pandemic with some nurses re-deployed and only a small sample of children measured in 2019/20 and 2021/22 when children returned to school following COVID restrictions.

[7] Public Health Outcomes Framework online

Table 2: NCMP coverage/participation 2018/19 and 2021/22

	Merton Pre COVID 2018/19	Merton *2021/22*	London *2021/22*	England *2021/22*
Reception (4-5 year olds)	98.7%	89.1%	92.3%	92.8%
Year 6 (10-11 year olds)	98%	89.7%	92.6%	91.9%

Source: Public Health Outcomes Framework (PHOF)

3.3.8 CLCH has a Care Quality Commission (CQC) 'Good' rating including a 'Good' rating for its Community Health Services for Children and Young People.[8]

3.4. **Future commissioning and procurement**

3.5. The provision of our 0-19 services is held under a joint contract with NHS SWL Integrated Care Board (ICB) who are the lead commissioner for the contract. The 0-19 services sit within a wider contract for delivery of community health services (adults and children) for Merton and is managed jointly. There is a collaborative agreement between LBM and NHS SWL ICB which sets out roles and responsibilities.

3.6. The contract has been extended for a further 12 months through Cabinet as a prerequisite to support achieving the council's corporate ambition to have holistic, responsive and integrated services focussed on the needs and views of residents, users and communities, strengthening prevention, ensuring focus on inequalities and achieving value for money. NHS SWL ICB plans to develop more integrated community and primary care model/strategy in 2023/24 which present opportunities for our services and required alignment of procurement timelines to allow this to happen.

3.7. Working closely with primary and community health services during the planned SWL re-modelling work, will ensure services and pathways are more streamlined, easier to access, effective, efficient, and value for money. The ultimate aim being to improve the health well-being of residents with better and greater health impact across organisational boundaries that better meet the needs of service users.

4 NEXT STEPS

4.1. The contract for the delivery of 0-19 services in Merton has been extended to March 2025 with approval through Cabinet in March 2023.

4.2. The Public Health team supported by Procurement, Finance and Legal services will undertake steps required to procure a new service working jointly with NHS SWL ICB as lead commissioner (see section 8 below) to commence April 2025.

4.3. Commissioners will continue to work with CLCH to monitor and improve service performance and outcomes

5 ALTERNATIVE OPTIONS

[8] CQC more detailed rating for CLCH available https://www.cqc.org.uk/provider/RYX

N/A

6 CONSULTATION UNDERTAKEN OR PROPOSED

6.1. A high level service review was undertaken in July 2022 to support the future commissioning and procurement of the service as well as identifying any areas for improvement in the short, medium and long term. This included engagement with service users, staff and stakeholders.

7 TIMETABLE

7.1. Contracts joint contract for the provision of services has been extended until end of March 2025 through Cabinet.

7.2. Table 1 below shows indicative procurement timelines for a new contract to be in place by April 2025

Table 2: Indicative Procurement Timelines

Procurement schedule	Indicative dates
Gateway 1 to Departmental Procurement Group (DPG) & Procurement Board	Early January 2024
Notice to CLCH (end of contract) – 12 months notice	Latest by March 2024
Publish tender notice (ITT)	End March/begin Apr 2024
Evaluation of tender	Between May - June 2024
Gateway 2 Award report approval (Finance, legal & procurement)	End June 2024
Gateway 2 report to Procurement Board	Mid July 2024
Leaders Strategy Group (LSG)	Beginning Sept 2024
Cabinet	Mid Sept 2024
Intention to award letter to bidder	End Sept 2024
Mobilisation	Oct 2024 – March 2025 (6 months)
New contract start date	April 2025

8 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

8.1. The 0-19 service is funded through the Public Health Grant given to Local Authorities.

9 LEGAL AND STATUTORY IMPLICATIONS

N/A

10 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

10.1. The 0-19 services have been designed as part of approaches to tackle health inequalities in the borough and the inequities in terms of access. These services provide early identification of needs with appropriate support and referral for children and young people and their families.

11 CRIME AND DISORDER IMPLICATIONS

11.1. N/A

12 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

12.1. Risk management and health and safety implications of the contract are monitored through commissioners' performance management arrangements.

13 APPENDIX – SUPPORTING VULNERABLE FAMILIES CASE STUDIES – CONFIDENTIAL APPENDICES

A) YOUNG PARENTS SUPPORT

B) FAMILY SEEKING ASYLUM SUPPORT

14 BACKGROUND PAPERS – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

14.1. None

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NHS England

Report on Immunisation Services in the Borough of Merton

Prepared by: NHSE (London) Immunisation Commissioning Team

Presented to: Merton Health Scrutiny Committee

June 2023

Contents

Aims

This paper provides an overview of Section 7a immunisation programmes in the London Borough of Merton. This paper focuses on childhood immunisations.

It covers the vaccine uptake for each programme and an account of what NHS England London Region is doing to improve uptake.

Members of the Merton Health Scrutiny Committee are asked to note and support the work that system partners across London, including NHSE (London), the Local Authority, and the Integrated Care Board (ICB) are doing to increase vaccination uptake in Merton.

Background

The World Health Organization (WHO) states that vaccinations are one of the public health interventions that have had the greatest impact on the world's health. Vaccination is also one of the most cost-effective public health interventions. High immunisation rates are key to preventing the spread of infectious disease, protecting from complications and deaths. Childhood immunisation in particular helps to prevent disease and promote child health from infancy, creating opportunities for children to thrive and get the best start in life.

Section 7a immunisation programmes are population-based, publicly funded immunisation programmes that cover the life course and include:

- Routine Childhood Immunisation Programme for 0-5 years
- School-age vaccinations
- Adult vaccinations
- COVID-19 vaccination programme

Routine Childhood Immunisation Programme for 0-5 years

Age Due	Diseases protected against
8 weeks	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B
	Meningococcal group B (MenB)
	Rotavirus gastroenteritis
12 weeks	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B
	Pneumococcal (13 serotypes)
	Rotavirus
16 weeks	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B
	MenB
1 year	Hib and Meningococcal group C (MenC)
	Pneumococcal
	Measles, mumps and rubella (German measles)
	Meningitis B (Men B)
Eligible paediatric age groups	Influenza (each year from September)
Three years four months	Diphtheria, tetanus, pertussis and polio (4-in-1 pre-school booster)
	Measles, mumps and rubella

The full immunisation schedule can be found in the Green Book. Changes to this schedule are regularly reviewed and recommendations are made at the UK Joint Committee on Vaccination and Immunisation (JCVI).

The European Region of the World Health Organization (WHO) currently recommends at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control, specifically, diphtheria, neonatal tetanus, pertussis, polio, Haemophilus influenzae type b (Hib), Hepatitis B, measles, mumps, and congenital rubella.

There is an expectation that UK coverage rates of all routine childhood immunisations up to 5 years of age achieve 95%.

Roles and responsibilities

The Department of Health and Social Care (DHSC) provides national strategic oversight of vaccination policy in England, with advice from the independent Joint Committee on Vaccination and Immunisation (JCVI) and the Commission on Human Medicines. They also set performance targets.

NHS England (NHSE) is responsible for commissioning national immunisation programmes in England under the terms of the Section 7a agreement, National Health Service Act 2006. NHSE is accountable for ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels. NHSE is also responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.

The UK Health Security Agency (UKHSA) undertakes surveillance of vaccine-preventable diseases and leads the response to outbreaks of vaccine-preventable diseases. They provide expert advice to NHSE immunisation teams in cases of immunisation incidents.

Integrated Care Systems (ICSs) have a duty of quality improvement, and this extends to primary medical care services. ICBs provide opportunities for improved partnership working across NHSE (London), local authorities, voluntary and community sector partners to improve immunisation uptake and reach underserved areas and populations. NHSE (London), alongside ICBs, local authorities and others, will work to progress delegated commissioning for vaccination and screening. It is anticipated that the first wave of delegation of the commissioning of immunisation services will be in Spring 2024.

Local authority public health teams deliver population health initiatives including improving access to health and engagement and promotion of immunisations overall.

Pre-school and adult vaccinations are usually delivered by GP surgeries. They are commissioned through the NHS GP contract. Five core GP contractual standards have been introduced to underpin the delivery of immunisation services: a named lead for vaccination service, provision of sufficient convenient appointments, standards for call/recall programmes and opportunistic vaccination offers, participation in nationally agreed catch-up campaigns, and standards for record-keeping and reporting. One of the five Quality and Outcomes Framework (QOF) domains is childhood vaccinations and shingles vaccination, rewarding GP practices for good practice.

School-age immunisations are commissioned by the seven regional NHSE teams and delivered through School Age Immunisation Services (SAIS).

Vaccinations are also provided by maternity services, some outreach services, and community pharmacies.

Inclusion and Equity

The problem is not just overall coverage but the variation in coverage across groups, which can increase the likelihood of preventable outbreaks locally. Groups with lower coverage include migrants, urban communities, more deprived communities, and certain ethnic groups.

People migrating to the UK can have different vaccination schedules or lower vaccination rates overall. This may be due to different national vaccination schedules, missed vaccinations in the country of origin, or missed opportunities for vaccination after arrival to the UK.

Geographic vaccine coverage varies, with lower coverage in urban areas and London, compared to England as a whole.

At a national level, there are some small inequalities by socioeconomic status, with coverage being slightly lower in lower socio-economic groups.

For the routine childhood vaccinations, there is no simple relationship between ethnicity and coverage. The relationship varies by immunisation programme and by area. However, coverage does appear to be more consistently lower than White-British children in certain ethnic groups, for example, Black Caribbean, Somali, White Irish, and White Polish populations. Some ethnic groups, notably South Asian ethnicities, have broadly similar and sometimes higher vaccination coverage than White children. For MMR these relationships were less consistent, in that coverage in children of White ethnicity could be lower or the same as other non-White groups, thought to perhaps reflect differences with respect to awareness of the MMR controversy. For HPV, lower indicators of coverage were consistently seen for non-White ethnic groups.[2]

Data Nationally

Overall, coverage for most vaccines in England is high and comparable with other high-income countries although there has been a small but steady decline in the last few years. Nationally, in 2021-2022, vaccine coverage decreased by 0.2% to 1.1% depending on the vaccine. No vaccines met the 95% target. Coverage for the 6-in1 at 5 years decreased from 95.2% in 2020-21 to 94.4% in 2021-22.

Data Regionally

Historically and currently, London performs lower than the national (England) average across all the immunisation programmes. Uptake in London has also fallen over the past 6 years and has fallen further than elsewhere in the country.

Every borough in London is below the 95% WHO target. For some vaccines such as MMR, all London boroughs have an uptake below 90%. Two-thirds of all measles cases in 2023 in England were in London.

London has a highly mobile population, a large migrant population, and areas of high deprivation. In London, vaccine uptake is lower in areas of higher deprivation compared with areas of low deprivation across all ethnicities.

Data for Merton

Immunisation	England	London	SWL	Croydon	Kingston upon Thames	Merton	Richmond upon Thames	Surrey	Sutton	Wandsworth
12m_DTaPIPVHib3	↓ 91.9%	↓ 87.9%	↑ 89.7%	↑ 85.2%	↓ 89.6%	↑ 91.0%	↑ 85.3%	↑ 91.6%	↑ 91.5%	↑ 89.4%
12m_MenB	↓ 91.6%	↓ 87.4%	↑ 89.6%	↑ 84.6%	↓ 91.0%	↑ 90.3%	↑ 85.9%	↑ 91.5%	↑ 91.5%	↑ 89.3%
12m_PCV	↓ 94.0%	↑ 90.5%	↑ 92.0%	↑ 88.6%	↓ 92.4%	↑ 93.0%	↑ 88.2%	↑ 93.9%	↑ 93.9%	↑ 90.4%
12m_Rota	↑ 89.3%	↑ 85.9%	↑ 88.3%	↑ 85.7%	↓ 89.2%	↑ 89.1%	↑ 83.3%	↑ 89.7%	↑ 91.1%	↑ 87.4%
24m_DTaPIPVHib3_Primary	↑ 93.0%	↑ 88.8%	↑ 90.9%	↑ 88.3%	↓ 90.3%	↑ 90.9%	↑ 91.0%	↓ 91.9%	↓ 91.2%	↑ 90.8%
24m_HibMenC_Booster	↓ 88.9%	↓ 81.6%	↓ 80.7%	↓ 77.2%	↓ 85.7%	↓ 80.7%	↑ 81.8%	↓ 79.8%	↓ 83.0%	↑ 83.4%
24m_MenB_Booster	↓ 87.8%	↓ 80.0%	↓ 80.7%	↓ 78.1%	↓ 83.9%	↓ 81.0%	↑ 80.8%	↓ 79.6%	↓ 84.5%	↑ 83.7%
24m_MMR1	↓ 89.0%	↓ 82.2%	↓ 81.8%	↓ 79.5%	↓ 86.5%	↑ 82.7%	↑ 83.6%	↓ 79.7%	↓ 86.2%	↑ 85.2%
24m_PCV_Booster	↓ 88.5%	↓ 80.6%	↓ 81.5%	↓ 79.0%	↑ 86.3%	↑ 83.4%	↑ 82.4%	↓ 80.0%	↓ 84.9%	↑ 83.7%
5y_DTaPIPV_Booster	↑ 84.0%	↑ 74.7%	↑ 77.4%	↑ 74.0%	↑ 80.1%	↑ 72.3%	↑ 74.5%	↓ 81.7%	↑ 79.5%	↑ 68.4%
5y_DTaPIPVHib3_Primary	↑ 93.5%	↑ 89.0%	↓ 90.3%	↓ 87.3%	↑ 90.9%	↑ 90.3%	↑ 92.9%	↓ 90.9%	↓ 91.5%	↑ 89.0%
5y_HibMenC_Booster	↓ 91.0%	↑ 85.5%	↑ 87.4%	↑ 84.4%	↑ 87.1%	↑ 84.4%	↑ 86.7%	↓ 90.0%	↑ 88.3%	↑ 83.9%
5y_MMR1	↑ 92.9%	↑ 87.5%	↑ 90.0%	↑ 86.3%	↑ 90.8%	↑ 85.9%	↑ 90.0%	↑ 92.6%	↑ 91.3%	↑ 86.2%
5y_MMR2_Booster	↑ 85.2%	↑ 75.2%	↑ 79.1%	↑ 73.7%	↑ 80.0%	↑ 73.4%	↑ 74.3%	↑ 83.1%	↑ 80.7%	↑ 76.5%

Cover of vaccination evaluated rapidly (COVER) Programme 22-23. Date July-Sept 2022.

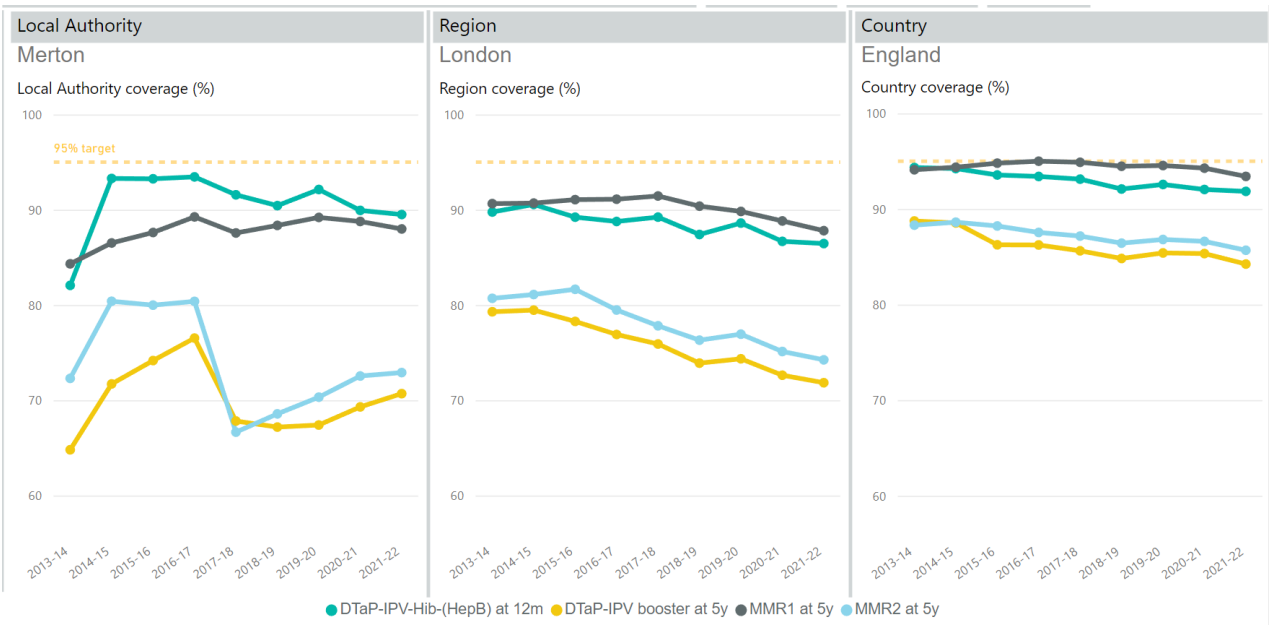
In Quarter 3 (July-September 2022) there was a slight overall increasing trend across almost all of the childhood vaccinations (green arrow), except for the two booster doses of Hib/MenC booster and the Meningitis B booster.

For the primary childhood dose Merton has a higher uptake of the 6 in 1 primary dose at 2 years (91%) than the London average (89%).

Uptake for the 4 in 1 pre-school booster dose of DTaP/IPV is lower in Merton (72%) than the London average of 75%.

Uptake for MMR1 at 2 years is slightly higher in Merton (83%) than the London average (82%).

Uptake of MMR2 at 5 years in Merton (73%) is lower than the London Average (75%).



Following a similar pattern to nationally and in London, uptake of the primary 6 in 1 dose and MMR1 in Merton has decreased slightly over the last 3 years.

The uptake for the booster dose of DTaP/IPV at 5 years in Merton has increased over the last 3 years and is now approaching the London average.

The uptake of MMR2 in Merton has increased over the last 5 years but remains below the London average.

Challenges

System

- COVID-19: pausing some programmes, redeployment of workforce and introduction of the COVID-19 vaccination programme.
- Complexities in data collection: some data is not recorded, not uploaded, not correctly cleansed, or the denominator population may not be up to date.
- Access to appointments: wider pressures on GP services and limited workforce.
- Inconsistent reminder systems- call/ recall.

Community

- London's high population mobility affects data collection and accuracy. There is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions. A 2017 audit showed that by the age of 12 months, 33% of infants moved address at least once.
- Large numbers of underserved populations who are associated with lower uptake of vaccinations than the wider population.
- Large migrant population who may not be registered or have their past immunisation history accurately recorded.

Individual

- Lack of trust or confidence in vaccines or other health service or complacency.
- Saturation of vaccine offer post the COVID-19 pandemic and COVID-19 vaccination programme.
- Increasing disinformation
- Lack of awareness of the immunisation schedule

Actions

Increasing vaccination uptake is complex and requires a suite of interventions. Work is ongoing at a national, regional, system, and place level to increase uptake in Merton.

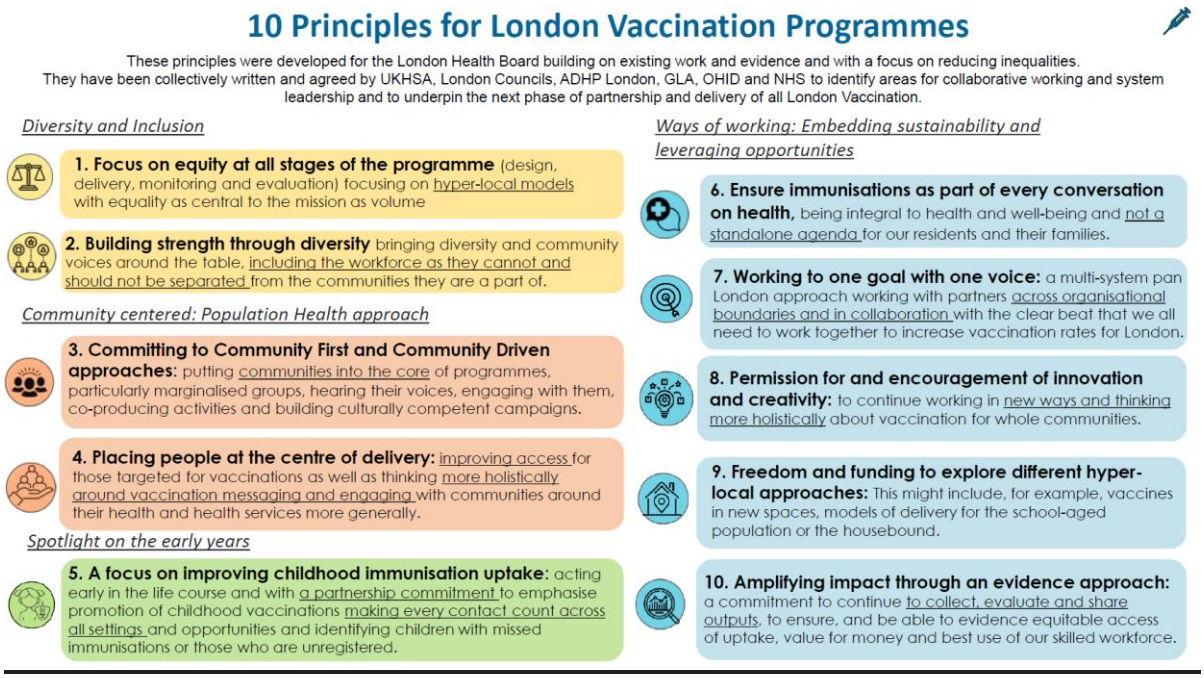
A strong focus for Merton, SWL and London is to increase childhood immunisation coverage overall to pre-pandemic levels and to identify the communities which are persistently missed from vaccination and other health services. A particular high risk in 2023 is the sub-optimal childhood MMR1 and 2 coverage (below 95%) which increases the risk of preventable measles outbreaks. To reduce the risk of poliovirus transmission, a strong focus remains on identifying and supporting underserved communities of Merton and London.

National and Regional

- A London Immunisation Strategy is currently being developed to both improve vaccination uptake and reduce inequalities. The first draft of the London Immunisation Strategy will be reviewed by the London Immunisations Board in late June 2023.
- NHSE London funds local Immunisation Coordinators across the region. These coordinators provide a critical interface between GP practices, ICBs and NHSE-L to ensure that immunisation strategic plans get delivered through services on the ground.
- A national NHSE MMR vaccination call and recall service was implemented between September and December 2022. This promoted the take-up of the MMR vaccine amongst individuals between the ages of 1 to 25 years through letters and texts.
- NHSE-L has commissioned UKHSA to deliver immunisation training to all vaccinators in London. Confident and competent staff are crucial to building and maintaining trust and delivering a high-quality service. This includes listening to parental concerns or reservations and preventing any vaccine incidents.
- Vaccinations have been added to the Making Every Contact Count London resource hub to facilitate using every available opportunity to engage with the public to increase vaccination.
- A regional communications campaign took place across London in March 2023 to encourage the uptake of missed MMR doses. This included media, social media, health ambassadors, translated materials, and attendance at local events and community groups.
- In a concentrated effort to reach all missed children and ensure London remains polio-free, a funded regional catch-up programme through the School Age Immunisation Service and GP practices is underway to provide DTaP catch-up, MMR catch-up, and full-schedule catch-up. We anticipate

that the first quarter findings and uptake rates for London will be available by January 2024.

- The London Immunisation Board, The Mayors Health Board, and SW London Integrated Care Board have all agreed on the 10 principles for London vaccination. Action will now focus on developing this into a comprehensive delivery approach tailored to community needs and building on Borough-led health initiatives.



System and Place

- A three-year immunisations strategy for South West London (SWL) is being developed with partners, which will include six borough-specific immunisation delivery plans. It is anticipated this will be available in the late summer or early autumn. The aim of the strategy will be to support boroughs by providing a framework within which to operate, setting key priorities for SWL as well as at borough level based on local need.
- The focus of the immunisation strategy for Merton is improving the uptake of preschool boosters and MMR.
- Working with local GP practices to ensure correct coding of vaccination data, unregistering children who have moved, sending text reminders, and opening additional vaccination clinic slots in the school holidays.
- Insight-led behaviour change campaigns: multiple channels to reach Merton's local community: digital advertising including social media, google, and advertising on other relevant websites, radio adverts, ad-vans, billboards, street ambassadors, and community champions.

- Developing partnerships: fortnightly meetings are held with the ICB and Local Authority communications colleagues and regular meetings with providers. The Merton Immunisation Steering Group meet quarterly and reports into a SWL Operational Delivery Group chaired by the ICB. Partnership working has been used to: develop and share content, provide up-to-date information for community champions, host webinars, and engagement opportunities, and identify relevant pop-up locations for the local community.
- Working with the voluntary sector: a new grants programme for community organisations. Funding was prioritised for events likely to reach communities experiencing health inequalities. During the events, residents received tailored messages which focused on vaccinations and included other information including cost of living support and mental health services.
- Information to support an informed decision: responding to misinformation circulating on vaccinations using local insight. Recently, an audit of the feedback from over 6000 South West London residents was used to create a new leaflet responding to misinformation. This was shared in a range of different languages.

Case study example

Local Vaccine Coordinator working with Merton's GP practices

GP practices are supported to review their immunisation records. For example, at one Merton GP surgery preschool booster uptake rose from 50% to 75% when already delivered vaccine doses were correctly recorded. These reviews also identify all the children with incomplete vaccine schedules for targeted action. Reasons identified include refusals amongst some families for all vaccinations, patients who have left the country but have not been deregistered from the GP practice, doses given a few days early so they are not recognised in the data collection process, and some children who have recently moved to Merton from abroad but have not given their vaccination history to the GP practice. There is a recognition that opportunistic vaccination when the child attends the GP practice for other reasons is key to accessing these groups: Making Every Contact Count.

Appendix 1: Immunisation schedule

Routine childhood immunisations				
Age Due	**Diseases protected against**	**Vaccine given**	**Trade name**	**Usual Site**
8 weeks	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
12 weeks	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
16 weeks	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	MenB	MenB	Bexsero	Left thigh
1 year	Hib and Meningococcal group C (MenC)	Hib/MenC	Menitorix	Upper arm/thigh

	Pneumococcal	PCV booster	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMRvaxPro or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Left thigh
Eligible paediatric age groups	Influenza (each year from September)	Live attenuated influenza vaccine LAIV	Fluenz Tetra	Both nostrils
Three years four months	Diphtheria, tetanus, pertussis and polio	dTaP/IPV	Boostrix-IPV	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMRvaxPro or Priorix	Upper arm
12-13 years	Cancers and genital warts caused by specific human papillomavirus (HPV) types	HPV (2 doses 6 to 24 months apart)	Gardasil	Upper arm
14 years Year 9	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y	MenACWY	Nimenrix	Upper arm

Selective childhood immunisation programmes

Target group	Age and schedule	Disease	Vaccines required
Babies born to hepatitis B infected mothers	At birth, 4 weeks and 12 months old	Hepatitis B	Hepatitis B (Engerix B/HBvaxPRO)
Infants in areas of the country with tuberculosis (TB) incidence >= 40/100,000	Around 28 days old	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country	Around 28 days old	Tuberculosis	BCG
Children in a clinical risk group	From 6 months to 17 years of age	Influenza	LAIV or inactivated flu vaccine if contraindicated to LAIV or under 2 years of age

Adult Immunisation Programme

65 years old	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)	Pneumovax 23
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple
70 to 79 years of age	Shingles	Shingles	Zostavax3 (or Shingrix if Zostavax contraindicated)
Pregnant women	At any stage of pregnancy during flu season	Influenza	Inactivated flu vaccine
	From 16 weeks gestation	Pertussis	dTaP/IPV (Boostrix-IPV)

The complete routine immunisation schedule from February 2022 (publishing.service.gov.uk)

Appendix 2: Data Collection

Data is uploaded into Child Health Information Service (CHIS) from GP practice records via a data linkage system. The CHIS provides quarterly and annual submissions to the UKHSA for their publication of statistics on 0-5s childhood immunisation programmes. This is known as Cohort of Vaccination Evaluated Rapidly (COVER) and these are the official statistics. Annual data is more complete and should be used to look at longer-term trends.

COVER monitors immunisation coverage data for children in the UK who reach their first, second, or fifth birthday during each quarter. Children having their first birthday in the quarter should have been vaccinated at 2, 3, and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.

There are known complexities in collecting data on childhood immunisations. Indeed, since 2013, London's COVER data is usually published with caveats, and drops in reported rates may be due to data collection or collation issues for that quarter.

Production of COVER statistics in London involves a range of individuals and organisations with different roles and responsibilities. London has four CHIS Hubs – North East London (provider is North East London Foundation Trust, NELFT), South East London (provider is Health Intelligence), South West London (provider is Your Healthcare CIC), and North-West London (provider is Health Intelligence). These Hubs are commissioned by NHSE to compile and report London's quarterly and annual submissions to UKSA for COVER.

A 'script' or algorithm is utilised to electronically extract anonymous data from the relevant data fields to compile the reports for COVER within the caveats specified. For example, for the first dose of MMR, any child who had their MMR vaccination before their first birthday is not included and so appears unvaccinated.

CHIS Hubs are commissioned to check the reports run and are expected to refresh the reports before final submission to UKHSA. CHIS Hubs are also commissioned to 'clean' the denominator by routinely undertaking 'movers in and movers out' reports. This is to ensure the denominator is up to date with the children currently resident in London. They are also expected to account for the vaccinations of unregistered children in London. There are ongoing issues with CHIS Hubs keeping up to date with movers in and removals which is picked up in contract performance meetings with the NHSE (London) commissioners.

Immunisation data is extracted from London's general practices' IT systems and uploaded onto the CHIS systems. This isn't done directly by the CHIS Hubs. Instead, data linkage systems provided by three different providers provide the interface between general practices and CHIS. Two of these providers – QMS and

Health Intelligence – are commissioned by NHSE whilst 4 boroughs in outer North-East London commission a separate system.

NHS (London) Immunisation Commissioning Team receives data linkage reports from QMS and Health Intelligence. This provides a breakdown by general practice of the uptake of vaccinations in accordance with the COVER cohorts and cohorts for Exeter (for payments). This information is utilized by the team as part of the 'COVER SOP', to check against the COVER submissions by CHIS to question variations or discrepancies.

While data linkage systems provide an automated solution to manual contact between CHIS and General Practices, data linkage does not extract raw data. General practices have to prepare the data for extraction every month. This will vary between practices how automated the process is, but it can be dependent upon one person to compile the data in time for the extraction by the data linkage system providers and should this person be on annual or sick leave, there will be missing data.

General practices have to prepare data for four immunisation data systems – COVER, ImmForm (although this is largely done by their IT provider of Vision, EMIS or TPP SystmOne, all of whom are commissioned by their ICS), CQRS (the payments system run by NHS England for the payment of administration of the vaccine) and Exeter (payments system, whereby practices receive targeted payments for achieving 70% or 90% uptake of their cohorts – these cohorts are different to the COVER cohorts of children). Preparation of data for the systems again will vary between practices but this can be time and resource intensive. There is also an array of codes that can be used to code the vaccination (if a code different to what the data linkage system recognises is utilised, it results in the child looking unvaccinated) and there are difficulties with coding children who received their vaccinations abroad or delays in information on vaccinations given elsewhere in UK being uploaded onto the system in time for the data extraction.

Whilst NHSE (London) immunisation commissioning team verify and pay administration of vaccines that are part of the Section 7a immunisation programmes, they do not commission General Practices directly. Vaccination services, including call/recall (patient invite and reminder systems) are contracted under the General Medical Services (GMS) contract. This contract is held by primary care commissioning directorates of NHSE.

For most newer vaccine programmes and for those targeting people older than 5 years vaccination and population data is extracted directly from general practice systems using ImmForm, an online platform.

Appendix 3: Contacts

Name, Role	Contact
Dawn Hollis, Head of ANNB Screening, Immunisations, CHIS, CARS & Digital Transformation NHS England - London Region	dawn.hollis@nhs.net
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Committee: Children and Young People Overview and Scrutiny Panel

Date: 21st June 2023

Wards: All

Subject:

Lead officer: Jane McSherry, Executive Director of Children, Lifelong Learning and Families

Lead member(s): Cllr Brenda Fraser, Cabinet Member Children's Services, and Cllr Sally Kenny, Cabinet Member Education and Lifelong Learning

Contact officer: Maisie Davies, Head of Performance, Improvement and Partnerships

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Recommendations:

A. Members of the panel to discuss and comment on the contents of the report

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report summarises the performance information for 2023/24, up to 30th April 2023, as set out in the accompanying document, the Children & Young People Overview and Scrutiny Panel Performance Index 2023/24.

1.2. With the change in financial year, the Performance team, alongside the Children, Lifelong Learning and Families (CLLF) senior leadership team have reviewed the provisional year-end data from 22-23 and the latest available benchmarking data at a national and regional level. With this review, some additional target measures have been identified and some targets have been adjusted based on recent performance and benchmarking against London and National performance. All subsequent changes to the dashboard are set out in the below details section of this report.

2 DETAILS

Exception Report

2.1. The following indicators are marked as amber or red.

No	Indicator	Rating	Service Commentary
7	% of reviews completed within timescale for Children with Child Protection Plans	R	This is an indicator that we monitor every month. Performance data shows that during 2022/23 our average monthly performance was 96% within timescale. Although performance in April was below the target of 95%,

			we are monitoring the situation closely.
9	% of Children that became the subject of a Child Protection Plan (CPP) for the second or subsequent time.	R	This indicator shows the % of children with an open CPP as at the end of the period who are the subject of a CPP for the second or subsequent time. Performance averaged 24% during 2022/23 and remained high at 26% in April. We are closely monitoring this indicator and a thematic audit has been undertaken, which gave assurances that thresholds were being applied correctly.
13	Average number of weeks taken to complete Care proceedings against a national target of 26 weeks	R	Performance declined in quarter 4 increasing from 25 weeks to 52 weeks; however, Q3 was an outlier due to only one care proceeding being completed during this period. See further contextual information in the commentary section below.
14	% of Looked After Children cases which were reviewed within required timescales	R	Performance during 2022/23 averaged 96% per month, and performance has dipped slightly from 94% in March to 93% in April. The Performance team are working with the service to monitor this closely.
17	Stability of placements of Looked After Children (aged under 16) - length of placement (in care 2.5 years, placement 2 years)	A	The target for this indicator has increased to 71% from 65% following performance consistently above target during 2022/23 and to bring in line with regional performance at 71%. It is currently RAG rated Amber as there was a slight dip in the most recent quarter to 70%, although this is in line with the national benchmarking rate.

28	Secondary school surplus places	R	See commentary below
33	Rate of proven re-offending by young people in the youth justice system - quarterly / annual	R	The service has agreed a target for this indicator (41.8% to align with our regional benchmarks) and the service will work towards this new target. Q3 and Q4 data is not yet fully validated, but is currently indicating that we are performing below the target set. However, this is in the context of Merton having a small cohort of young people in the youth justice system.
35	% agency social workers (HR data)	R	The service has agreed a target for this indicator (22.7% to align with London benchmarking) and the service will work towards this new target. This is a stretching target as last year the proportion of agency social workers peaked at 36% in September 2022, but with focused attention on this area the Department has reduced this to 26% in March 2023.

Commentary

Indicator 28: *Secondary school surplus places*

2.2. Surplus places in secondary school year 7 have reduced from 2.4% to 2.3%, remaining below the 5% target, hence has a red rating. However, as the lower roll numbers flow through from primary school there will be more surplus places in future years.

2.3. To reduce the surplus in primary schools, and within the context of the School Place Planning Strategy (which was brought to Scrutiny in autumn 2021), officers continue to review school admission numbers to reduce capacity, with two further schools reducing their reception intake in September 2022.

Indicator 13: Average number of weeks taken to complete Care proceedings against a national target of 26 weeks

2.4. Nationally, the duration of care proceedings has increased. This is a result of court closures during the pandemic.

2.5. A range of influences impact on the duration of court proceedings – some of which are outside of the authority's immediate control. These include court availability, the availability and timeliness of expert witness input, and the desire to engage effectively with the wider family network to explore alternatives (where appropriate and safe to do so).

2.6. The service has monthly court and PLO tracking meetings including legal representatives. On a quarterly basis, representatives from the Children and Families Court Advisory Services (Cafcass) attend. These meetings allow the authority to raise concerns about timeliness.

2.7. Merton continues to receive positive feedback from Merton's link judge on the Council's PLO work.

All indicators:

2.8. The service has reviewed the scrutiny dashboard and amended the following targets. Some new indicators have been introduced and others, which are no longer considered relevant, have been removed, this has resulted in some indicators being re-numbered.

No	Indicator	Service Commentary
3	% of Education, Health and Care (EHCP) Plans issued within statutory 20 week timescale (YTD Calendar Year /Monthly)	The target has increased from 60% to 65% owing to strong recent performance in this area in Merton and to stretch us to continue to perform better than the London and National averages.
7	% of reviews completed within timescale for Children with Child Protection Plans	The target has been revised to 95% to bring this more in line with benchmarking nationally and locally. The revised target remains more ambitious than national and local benchmarking performance.
8	% of Children subject of a CP Plan who had a CP visit within timescales in the month	This indicator was previously reported without a target. A target of 90% has been agreed.

12	Number of UASC children and young people	This indicator now shows the agreed quota of Unaccompanied Asylum Seeking Children (under the National Transfer Scheme Protocol, 0.07% threshold), although this is not a target.
16	Stability of placements of Looked After Children (aged under 16) - length of placement (in care 2.5 years, placement 2 years)	The target has been reduced from 11% to 10% to bring it in line with the regional and national benchmarks. Merton's performance last year was particularly strong but this indicator can be volatile.
17	Stability of placements of Looked After Children (aged under 16) - length of placement (in care 2.5 years, placement 2 years)	The target has been increased from 65% to 71% to bring it in line with national and regional benchmarking.
19	Number of in-house foster carers recruited	This indicator was previously reported without a target. A target has been agreed of 2 recruitments per quarter; 8 for the year.
22	% of total 0-5 year estimated Census 2011 population from areas of deprivation (IDACI 30%) whose families have accessed children's centre services (cumulative)	This target has been amended to an annual target due to the complexities of in year monitoring.
26	Persistent absenteeism - All Schools (10% or more sessions missed)	This indicator hasn't been reported against since Covid and had no agreed target. A target has now been set at 21%. The indicator has also been amended to incorporate all schools and not just secondary.
30	% of CYP (16 - 17 year olds) not in education, employment or training (NEET)	This indicator was previously reported without a target. A target has been agreed of 1.2%, which aligns with our internal corporate performance report.

32	Number of First Time Entrants (FTEs) to the Youth Justice System aged 10-17 (cumulative)	The target is currently 50, and the Performance team are currently reviewing this to check it is in line with the national benchmarking per 100,000 rate. Any possible change will be included in a future report.
33	Rate of proven re-offending by young people in the youth justice system - quarterly / annual (annual is 20/21)	This indicator was previously reported without a target. A target has been agreed of 41.8% to align with regional benchmarking.
35	% agency social workers (HR data)	This indicator was previously reported without a target. A target has been agreed of 22.7% given the focus on this area in Merton.

3 AMENDMENTS, CORRECTIONS AND DATA CAVEATS

Amendments, Corrections and Data Caveats

3.1. We are currently unable to report against the following indicators:

No	Indicator	Service Commentary
6	% of quorate attendance at CPP conferences	Following amendments to the system workflow, as part of the Mosaic Repair Project, a report has now been built to extract this data and we are currently in the process of user acceptance testing.
29	Youth services participation rate	This data is no longer collected nationally, and the indicator is on hold until new guidance is published later this year.
Previously 34	Number of families who will be eligible for support under Supporting Families programme.	It is suggested this indicator is removed from the dashboard as it does not provide an indicator of service performance.

		However, the Early Help Service with the Performance team will review alternative information that could come to OSC in light of the Department's roll out of Family Hubs and Insights to Intervention Programme.
Previously 35	% of commissioned services for which quarterly monitoring was completed	It is suggested this indicator is removed from the dashboard as the appropriate procedures are in place and this has consistently been at 100% for the last two years.

Proposed New Performance Indicator areas

3.2. Following the review of the dashboard, two areas were identified which members may consider helpful in their scrutiny of performance. They are as follows:

3.3. The dashboard currently does not include data relating to care experienced young people. Monitoring performance relating to care experienced young people is important given the Council's corporate parenting responsibilities and recent decision locally to treat care experience as a protected characteristic. The Department's Outstanding ILACS inspection also identified development of housing for care leavers as an area for improvement. It is therefore proposed that indicators relating to care leaver outcomes be added to the dashboard, for example, proportion of care leavers in suitable accommodation and in education, employment and training.

3.4. Indicator 9 measures the proportion of children that became subject to a Child Protection Plan for the second or subsequent time (ever). It is suggested that members may find it more helpful to receive data relating to children who have become subject to a Child Protection Plan for the second or subsequent time in the previous two years as this tends to be more reflective of service performance.

Appendices – the following documents are to be published with this report and form part of the report

- Children and Young People Overview and Scrutiny Panel Performance Index 2023/24.

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Children and Young People Overview and Scrutiny Panel - Performance Index 2022/23

Please note that Year to date performance - unless otherwise stated indicates April - March

No.	Performance Indicators	Frequency	Target 2023/24	Benchmarking and trend			BRAG rating	Merton 2021/22 performance												Merton 2022/23 performance											
				Merton 2022/23 PROVISIONAL	England	London		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Assessments																															
1	Number of Early Help Assessments undertaken by the Authority	Monthly	Not a target measure	165	No benchmarking available	No benchmarking available	Not a target measure	5	16	9	24	22	18	14	13	12	6	16	10	6	8	15	11	14	12	13	21	19	12	19	10	17
2	% of Single Assessments authorised within the statutory 45 days	Monthly	91%	89.7%	84.5% (DfE 2022)	86% (DfE 2022)	Green	97%	92%	85%	66%	87%	85%	93%	94%	90%	99%	94%	90%	91%	94%	92%	97%	94%	94%	94%	93%	89%	82%	90%	96%	97%
3	% of Education, Health and Care (EHCP) Plans issued within statutory 20 week timescale (YTD Calendar Year /Monthly)	YTD/Monthly	65%	81% (2022 calendar year)	59.9% (DfE: SEN2 Jan 2022 for the 2021 calendar year)	63.9% (DfE: SEN2 Jan 2022 for the 2021 calendar year)	Green	63% / 62%	61% / 56%	64% / 74%	61% / 42%	63% / 79%	66% / 87%	68% / 100%	69% / 76%	71% / 100%	100% / 100%	100% / 100%	89% / 78%	81% / 67%	76% / 67%	75% / 67%	71% / 60%	77% / 95%	77% / 82%	79% / 92%	80% / 92%	81% / 100%	100% / 100%	79% / 69%	69% / 56%	70% / 74%
Child protection																															
4	Child Protection Plans rate per 10,000	Monthly	Not a target measure	34.8	42.1 (DfE 2022)	37.5 (DfE 2022)	Not a target measure	37.1	36.3	32.5	30.0	30.8	27.8	28.1	26.8	24.9	22.0	22.0	34.8	21.2	24.1	23.3	21.6	24.7	25.3	26.4	25.3	26.6	27.0	31.6	34.8	35.4
5	Number of children subject of a Child Protection Plan - as at end of month	Monthly	Not a target measure	166	No relevant benchmarking available	No relevant benchmarking available	Not a target measure	176	172	154	142	146	132	133	127	119	105	105	166	101	115	111	103	118	121	126	121	126	129	151	166	169
6	% of quorate attendance at child protection conferences	Quarterly	95%	N/A	No relevant benchmarking available	No relevant benchmarking available	N/A			N/A			N/A			N/A			N/A			N/A			N/A			N/A			N/A	
7	% of reviews completed within timescale for Children with Child Protection Plans	Monthly	95%	97.6%	89.3% (DfE 2022)	92.6% (DfE 2022)	Red	100%	97%	95%	94%	95%	98%	100%	100%	97%	100%	100%	98%	98%	94%	95%	96%	97%	98%	98%	98%	94%	91%	95%	96%	92%
8	% of Children subject of a CP Plan who had a CP visit within timescales in the month	Monthly	90%	96%	No relevant benchmarking available	87% (Q4 2022/23)	Green	97%	97%	95%	93%	99%	91%	89%	96%	82%	90%	94%	96%	94%	86%	90%	91%	88%	95%	90%	93%	91%	94%	87%	93%	90%
9	% of Children that became the subject of a Child Protection Plan for the second or subsequent time (Ever)	Monthly	<20%	25.3%	23.3% (DfE 2022)	18.4% (DfE 2022)	Red	16%	14%	16%	13%	14%	14%	13%	12%	11%	12%	14%	25%	14%	19%	24%	24%	25%	24%	25%	25%	24%	28%	26%	25%	26%
Looked After Children																															
10	Looked After Children rate per 10,000	Monthly	Not a target measure	25.6	69.8 (DfE 2021/22)	52.5 (DfE 2021/22)	Not a target measure	30.0	30.6	31.0	30.6	30.0	29.7	29.1	28.9	27.6	26.4	26.4	25.6	26.4	26.2	25.1	25.6	25.8	25.8	25.3	26.2	25.3	25.8	26.0	25.6	26.0
11	Number of Looked After Children as at end of month	Monthly	Not a target measure	122	No relevant benchmarking available	No relevant benchmarking available	Not a target measure	142	145	147	145	142	141	138	137	132	126	126	122	126	125	120	122	123	123	121	125	121	123	124	122	124
12	Number of UASC children and young people	Monthly	48 (Agreed Quota)	25	No benchmarking available	No benchmarking available	Below Quota	23	21	20	19	19	22	22	23	23	18	19	19	19	19	19	20	19	23	22	22	23	22	24	25	26
13	Average number of weeks taken to complete Care proceedings against a national target of 26 weeks	Quarterly	26 weeks	53 (CAFCASS Avg 2022/23)	46 (CAFCASS Avg 2022/23)	No relevant benchmarking available	Red			42			69			39			41			57			64			25			52	
14	% of Looked After Children cases which were reviewed within required timescales	Monthly	96%	94%	No benchmarking available	95% (Q4 2022/23)	Red	99%	96%	94%	94%	97%	96%	96%	96%	98%	98%	97%	94%	94%	94%	96%	96%	98%	96%	97%	98%	97%	99%	98%	94%	93%
15	% of Looked After Children participating in their reviews in month (excludes children aged 0 - 4)	Monthly	Not a target measure	92%	No relevant benchmarking available	No relevant benchmarking available	Not a target measure	94%	88%	91%	100%	83%	73%	88%	86%	90%	94%	100%	87%	100%	80%	93%	92%	91%	100%	100%	100%	74%	100%	77%	100%	90%
16	Stability of placements of Looked After Children - number of placements (3 or more in the year)	Quarterly	10%	6.8%	10% (DfE 2022/23)	10% (DfE 2022/23)	Green			14.9%			12.7%			11.4%			10.3%			7.5%			7.3%			5.8%			6.6%	
17	Stability of placements of Looked After Children (aged under 16) - length of placement (in care 2.5 years, placement 2 years)	Quarterly	71%	70%	70% (DfE 2020/21)	71% (DfE 2020/21)	Amber			48%			64.4%			70%			68%			66%			71%			71%			70%	
18	% of Looked After Children in foster placements who are placed with in-house foster carers	Quarterly	60%	59%	No relevant benchmarking available	No relevant benchmarking available	Green			63%			58%			62%			67%			57%			61%			60%			61%	
19	Number of in-house foster carers recruited	Quarterly	2 per quarter	6	No relevant benchmarking available	No relevant benchmarking available	Green			1			2			2			2			1			2			1			2	
20	Number of Looked After Children who were adopted (YTD)	Monthly	Not a target measure	3	No relevant benchmarking available	No relevant benchmarking available	Not a target measure	0	0	0	0	1	2	3	3	3	3	3	3	0	0	2	2	2	2	3	3	3	3	3	3	0
21	Number of Looked After Children for whom agency Special Guardianship Orders were granted (YTD)	Quarterly	Not a target measure	1	No relevant benchmarking available	No relevant benchmarking available	Not a target measure			0			1			0			1			0			0			1			0	
Childrens Centres and Schools																															
22	% of total 0-5 year estimated Census 2011 population from areas of deprivation (IDACI 30%) whose families have accessed children's centre services (cumulative)	Annual	65%	47%	No relevant benchmarking available	No relevant benchmarking available	Initial RAG rating for new target to follow later in year			12%			24%			25%			32%			39%			46%			52%			47%	
23	% outcome of School Ofsted inspections good or outstanding (overall effectiveness)	Quarterly	95%	95%	87% (30/04/2022)	94% (30/04/2022)	Green	Ofsted dashboard		95%			95%			95%			95%			95%			95%			95%			95%	
24	Number of Primary* permanent exclusions (Number YTD Academic year)	Monthly	Not a target measure	0	4.9% (National exclusion statistics for AY 2019/20)	0.8% (National exclusion statistics for AY 2019/20)	Not a target measure	<5	<5	<5	<5	<5	0	0	0	0	0	0	0	0	0	0	0	n/a	0	0	0	0	0	0	0	0

No.	Performance Indicators	Frequency	Target 2023/24	Benchmarking and trend			BRAG rating	Merton 2021/22 performance																						
				Merton 2022/23 PROVISIONAL	England	London		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
25	Number of Secondary* permanent exclusions (Number YTD Academic year)	Monthly	Not a target measure	19	28.5% (National exclusion statistics for AY 2019/20)	14.6% (National exclusion statistics for AY 2019/20)	Not a target measure	<5	5	13	13	13	1	2	2	3	3	3	5	5	6	7	7	n/a	1	4	9	11	12	16	19	19
26	Persistent absenteeism - All Schools (10% or more sessions missed)	Annual	21%	NEW indicator	14.8% (DfE AY 2020/21)	13.1% (DfE AY 2020/21)	Initial annual RAG rating at end of academic year																								
27	% of Reception year surplus places*** (calculated October and January)	Reported Quarterly	5-10%	9.8%	No relevant benchmarking available	No relevant benchmarking available	Green			8.7%			11.1%			10.8%			11.6%			11.6%			11.6%			9.7%			9.8%	
28	% of Secondary school (Year 7) surplus places *** (calculated October and January)	Reported Quarterly	5-10%	2.3%	No relevant benchmarking available	No relevant benchmarking available	Red			5.6%			5.6%			3.0%			3.2%			3.2%			3.2%			2.4%			2.3%	
Young People and Services																																
29	Youth service participation rate	Annual	Not a target measure	N/A	No relevant benchmarking available	No relevant benchmarking available	Not a target measure																								
30	% of CYP (16 - 17 year olds) not in education, employment or training (NEET)	Monthly	1.2%	1.1%	2.6% (2021/22)	1.5% (2021/22)	Green	1.3%	1.4%	1.4%	1.4%	1.6%	1.4%	0.9%	1.3%	1.1%	1.1%	1.0%	1.0%	1.0%	0.9%	0.9%	0.9%	1.2%	0.6%	1.1%	1.5%	1.2%	1.2%	1.1%	1.1%	1.1%
31	% of CYP (16 - 17 year olds) education, employment or training status 'not known'	Monthly	Not a target measure	2.1%	2.2% (2021/22)	1.9% (2021/22)	Not a target measure	1.2%	1.2%	1.2%	1.2%	1.6%	1.1%	12.8%	2.2%	1.2%	1.1%	0.9%	0.9%	1.2%	1.4%	1.2%	1.5%	1.5%	Not published	11.3%	2.6%	0.8%	0.7%	0.7%	0.8%	0.8%
32	Number of First Time Entrants (FTEs) to the Youth Justice System aged 10-17 (cumulative)	Monthly	50	23	144 (rate per 100,000, 2022)	N/A	Green	3	4	8	10	13	14	16	18	20	23	24	28	0	2	4	5	8	10	11	12	17	18	18	23	1
33	Rate of proven re-offending by young people in the youth justice system - quarterly / annual (annual is 20/21)	Quarterly	41.8%	46.8% (Annual)	34.2% (2019/20 YJB pub)	41.8% (2019/20 YJB pub)	Red			45.5%			45.5%			40% / 45.2%			52.9% / 45.2%			27.3% / 46.8%			29% / 46.8%			24.6% / 46.8%			24.6% / 46.8%	
34	% agency social workers (HR data)	Quarterly**	20%	26%	17.6% DfE Census Sept 2021	22.7% (DfE Census Sept 2020)	Red			28%			37%			35%			34%			34%			36%			29%			26%	
35	Average total caseload for social workers (working with looked after children and/or children subject of child protection plans) (total caseload including non LAC and CPP cases as at end of month) ***Combines and replaces previous indicators 7 and 15***	Monthly**	Not a target measure	14	14.36 (DfE Census Sept 2021 - Awaiting validation)	14.6 (DfE Census Sept 2020)	Not a target measure	14	15	13	12	12	13	13	13	13	12	13	13	14	15	14	13	14	12	13	11	10	11	13	14	15

Indicators 27 & 28 : all pupils educated in Merton Schools (including special schools)*

*Indicators 29, 30 & 31: *** all pupils educated in Merton Schools (excluding special Schools)*

Indicators 35 & 36 Quarterly and monthly data reported from live date reported by Human Resource or Mosaic respectively. There is no direct comparable benchmarkable data as the DfE uses a different definition of a 'social worker' for the purpose of who is included in the annual Children's Social Workforce Census.*

Task Group Review of Eating Disorders and Self-Harm affecting young people in Merton

FINAL REPORT AND RECOMMENDATIONS

Merton's Children and Young People's Overview and Scrutiny Panel, April 2023

Task group membership:

Councillors:

Linda Kirby

Jil Hall

Samantha MacArthur

Acknowledgments:

The task group would particularly like to thank everyone who contributed to the task group's work and shared their experiences with us.

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Merton Schools' Mental Health Forum representatives

Parent and Young Person Case study contributors.

Young Peers Educators at their Health information event.

FOREWORD BY THE CHAIR – Cllr Linda Kirby

The impact of Covid on our society was, for many, very difficult. Our young people, in particular, had their education disrupted for almost two years. Many of those that had good support at home and school managed to cope well. Sadly, a lot of young people did not. Additional anxiety about health, Climate Change, the Cost of Living's impact on family budgets and for some the complex influence of social media also took their toll. The level of young people experiencing mental health issues rose dramatically throughout this period.

As a task group, we felt it was important to find out how well young people with Eating Disorders and/or Self Harm have been and are being supported in Merton. We hope our findings and recommendations will offer support to those experiencing these difficult issues and throw a light on what good practice and support there is for preventative action.

In September 2019, a Children & Young People's Scrutiny task group looked at Mental Health of our young people in Merton. It made a number of recommendations. We have included an update on progress made with those recommendations in this report.

TERMS OF REFERENCE

To throw a light on the level of self-harm and eating disorders in young people in Merton with the aim of improving support and preventative action.

Investigate the prevalence of Eating Disorders and Self-Harm in young people in Merton and identify what support there is.

Identify good practice and preventative action.

Report back to C&YP with recommendations

LIST OF RECOMMENDATIONS

Issue of concern relating to Eating Disorders and Self-harm in young people	Recommendation	Responsible Decision Maker
1. Understanding how widespread the problem is in Merton – not just those at the high end of assessment.	Records to be kept and regular monitoring to be done of young people at all stages of the ITHRIVE assessment levels.	Mental Health Forum CAMHS
2. Young people with cannot be left on a waiting list	CAMHS Referral numbers, waiting list times and staffing information should be regularly reported to C&YP Scrutiny panel.	CAMHS C&YP agenda
3. Good parental guidance is essential	Promotion of good practice guidance apps. Information resource pack made available.. Specific point of contact at schools or CAMHS to offer ongoing support or advice.	Schools Community Centre Merton Comms
4. Matching the right counsellor to the young person is vital for a successful outcome.	CAMHS needs flexibility in its approach to counselling	CAMHS
5. Primary school request from Mental Health Forum survey	Primary Schools needs training to identify early signs of eating disorders.	Keith Shipman
6. Secondary School request from Mental Health Forum survey	Secondary schools need ongoing training on how to support self-harming young people	Keith Shipman
7. Secondary School request from Mental Health Forum survey	South West London Eating Disorders, who diagnose conditions, should be invited to speak to Merton Schools' Mental Health Forum.	Keith Shipman
8. The community needs to be informed about these issues and what good practice.	Merton's Social Media should publish information on these issues and support available.	Merton comms
9. The community needs to be informed about these issues and good practice.	My Merton – Double page spread on these issues and information on what support is available	Merton comms
10. Social Media is responsible for the promotion and competitiveness of these issues which is dangerous.	Local & national government and national media need to put pressure on these platforms to address this issue	Merton Leader
11. **Emotionally-based school avoidance** - Merton's School attendance is running nationally at 2% below average.	Information needed on the research behind why this is the case.	Keith Shipman?

NHS NATIONAL STATISTICS ON YOUNG PEOPLE NEEDING HELP FOR SERIOUS MENTAL HEALTH PROBLEMS

In recent years, there has been a huge increase in the number of children requiring treatment for serious mental health problems including eating disorders and self-harm, figures show.

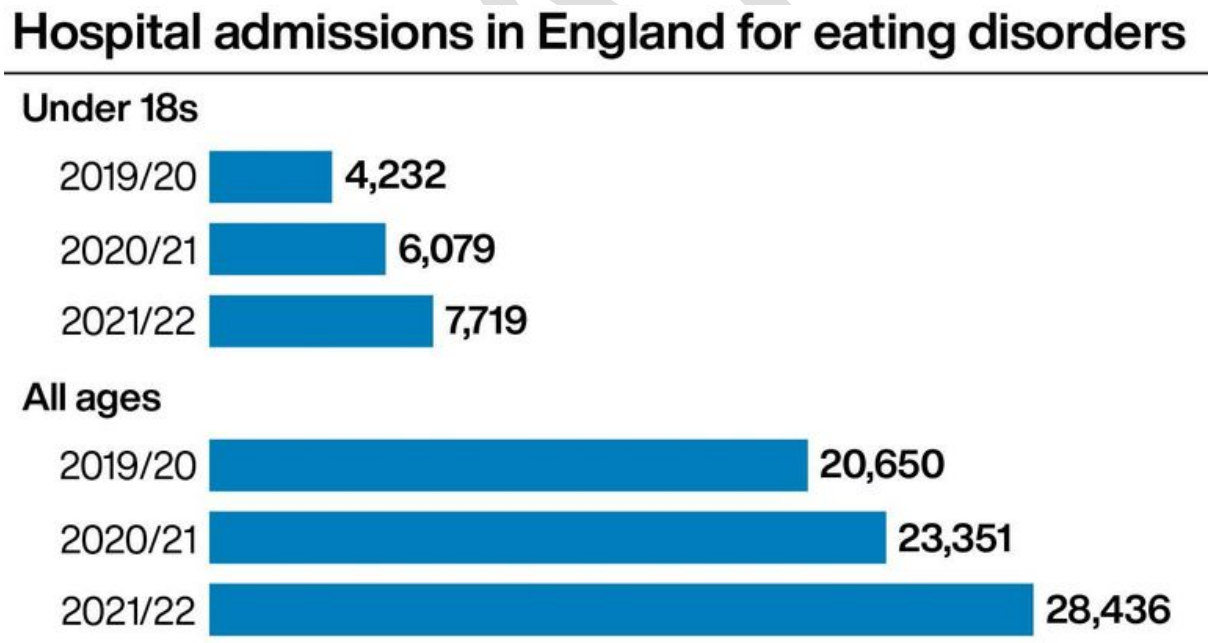
NHS data reveals a 39% rise in a year in referrals for NHS mental health treatment for under-18s to more than a million (1,169,515) in 2021/22.

By comparison, the figure was 839,570 in 2020/21, and in 2019/20 there were 850,741 referrals.

The England-wide data includes children who are suicidal, self-harming, suffering serious depression or anxiety, and have eating disorders.

Separately, NHS Digital data also shows hospital admissions for eating disorders are rising among children and young people.

There were 7,719 admissions in 2021/22 among under-18s, up from 6,079 the previous year and 4,232 in 2019/20 - which is an 82% rise across two years.



The most recent data available, from April to October 2022, reveals there were 3,456 admissions, up 38% from 2,508 for the same period in 2019, before the pandemic.

There were also 3,011 admissions from April to October 2020, as well as 4,600 for the same period in 2021 when the full effects of the pandemic were felt.

And the data suggests 2022/23 could see the highest number of hospital admissions for eating disorders, for people of all ages.

From April to October 2022, there were 15,083 admissions, compared with 28,436 for the whole of the previous year (2021/22).

There were 23,351 admissions a year earlier, and in 2019/20 there were 20,650, marking a 38% rise between 2019/20 and 2021/22.

Anorexia is the most prevalent eating disorder which is leading to hospital admissions among all ages, with 10,808 admissions in 2021/22.

The data also shows that bulimia is the next most common, with 5,563, while other eating disorders accounted for 12,893 admissions.

Dr Elaine Lockhart, chairwoman of the child and adolescent psychiatry faculty at the Royal College of Psychiatrists, said the surge of referrals for children and young people reflects a "whole range" of illnesses.

She said specialist services are needed to respond to the "most urgent and the most unwell", including youngsters who have psychosis, suicidal thoughts and severe anxiety disorder.

Dr Lockhart said more staff were needed and that targets for seeing children urgently with eating disorders were sliding "completely".

"I think what's frustrating for us is if we could see them more quickly and intervene, then the difficulties might not become as severe as they do because they've had to wait," she added.

An NSPCC spokesperson said: "These alarming figures are sadly reflected in the conversations we are having through Childline. The service delivers tens of thousands of counselling sessions every year to children and young people who are self-harming, suffering depression or anxiety, experiencing suicidal thoughts and have eating disorders."

CASE STUDY 1 – WHAT I LEARNED FROM THE TIME I HAD AN EATING DISORDER.

I first started dieting when I was 12/13 - at the time many girls at school were talking about their diets and exercise, and I decided that I wanted to start watching what I ate and exercising more (hitting puberty and body changes due to that were possibly also a factor).

At some point it switched from wanting to be a bit healthier to wanting to be extremely thin - I'm not sure exactly what triggered this change (at around the time this happened two close friends moved away, this was likely a factor). I began an extremely restrictive diet. It involved skipping breakfast and lunch whenever I could do so without it being noticed, and just eating dinner. However, I found that I wasn't able to stick to the diet, and would have bingeing episodes, where I ate vast amounts of food in short periods of time. At first my response to the bingeing episodes was to just continue restricting the next day, but soon I began purging after I had binged. At this point the bingeing episodes became much more frequent. Sometimes they were happening because I was incredibly hungry, other times as an emotional release. I continued this for some time, and maintained a healthy weight (although slightly lower than I was before I started dieting I believe).

After some time (between 6 months and a year after I had started purging) my parents became aware of the issue because they realised I was purging. They took me to my GP to get help, and I was put on the wait list to be seen at CAMHS. I believe that after this initial referral it was about 18 months before I received other treatment (other than one appointment with my GP where he tried to help by talking about the issues with me). During this time my eating disorder got significantly worse - the fact that my family knew about it and it had been given a name by my doctor meant that I was no longer trying so hard to hide it from my family (or convince myself that it wasn't serious) and this allowed the disordered behaviours to become much more severe. I was bingeing and purging almost every day, still severely restricting food, and beginning to lose significant amounts of weight.

After this period I received treatment both at CAMHS and the Priory, I don't remember exactly the order in which different things happened, but the types of treatments were:
- Cognitive behavioural therapy at the Priory for around 6 months. I think this therapy could have been useful - it was very focused around sticking to a regular meal plan to reduce the hunger induced binge-purge episodes, and also on identifying emotional triggers for episodes.

However, I was still obsessed with losing weight, and though I was able to stick to regular eating times, I wasn't willing to eat sufficient amounts in those meal times so there was no significant improvement in my behaviours. Without someone forcing me to eat more this therapy wasn't going to work.

Family therapy at CAMHS. We only had one session of this with my whole family present - it was frankly bizarre and unhelpful. It felt more like an episode of Jeremy Kyle than anything else, with the practitioners seeming to want to cause conflict. At no

point had I ever said that family issues were the primary (or any) cause of my eating disorder, so it wasn't clear to me why family therapy was considered a good way to treat them anyway, and the sort of family therapy which seemed designed to pit people against each other definitely wasn't helpful.

Sessions at CAMHS with just me and my parents. This was with the same practitioners as the family therapy had been. I still didn't find this particularly helpful. As far as I remember there was no concrete advice on steps to take (such as meal plans, or keeping a food diary like I was encouraged to do while receiving CBT). Instead my main memory of the sessions is the practitioners asking my "why won't you just eat". I was receiving weekly weigh ins during this, but I found it very easy to lose weight while hiding it from the practitioners by `water loading' or carrying weights in my pockets.

Eventually my parents realised that during my sessions with CAMHS I had lost significant amounts of weight while hiding it from them and the practitioners. I was made to do a proper weigh in at CAMHS without artificially increasing my weight at all and at that point I was diagnosed with anorexia and started seeing a doctor at CAMHS. I was also told that unless I started gaining weight I would be treated as an inpatient. This was something I was terrified of, so at that point I did gain weight and get back up to a healthy weight.

However by that point by binge-purge behaviours had become so ingrained that even though I was no longer restricting food, I used them as an emotional release, and I still suffered from bulimia for two more years after recovering from anorexia. At some point in those two years I stopped being seen at CAMHs, and my binge and purge behaviours fluctuated in frequency.

When I turned 18 I took a year out between school and university and focused on fully recovering. As part of this I was diagnosed anti depressants by my GP (high doses of anti depressants for short periods of time are a treatment that is sometimes used for bulimia). And I also saw the adult mental health services. I'm not sure exactly what worked that year, but I was able to recover from the bulimia (except for one relapse while I was at university). They key step in recovery was accepting that even if I binged, I had to stop myself purging. Eventually after forcing myself to do so I naturally stopped binging too.

I did gain significant amounts of weight that year (I was already at a healthy weight at the beginning of the year, by the end of the year I was still a healthy weight but a higher healthy weight). This was difficult, but I think gaining weight in bulimia recovery is fairly normal (even when starting at a healthy weight), and something that mental health services and families need to help patients come to terms with.

Eating disorder awareness at school: I didn't receive any treatment at school, and the only time my school was made aware of my eating disorder was when I started going home for lunch so that my parents could check I was eating it. The only time I recall eating disorders being raised at school was in a PSHE lesson (I don't remember what year I was in when it happened - I was experiencing disordered eating at the time, but I don't think the school were aware of it). We watched a video in class about a teenage girl with anorexia. The video was designed to raise awareness of body dysmorphia

and the dangers of anorexia, but for me it functioned more like a `how to guide' of ways to hide disordered eating from family & friends. The video showed a number of techniques the protagonist used to make it seem like she was eating at family meals and around friends. Some of these I was already using at the time, but others were new and I used many of them later.

Showing a film like this to parents may be useful to guide them on behaviours to look out for, but I think that showing it to students was very harmful, and care should be taken to make sure that no resources are shown to students which could give them ideas on how to hide disordered eating. (Admittedly advice on these kinds of behaviours can be found on the internet, but I think that policing internet use is a separate issue.)

Another issue I'd like to raise about the video is that it was very focused on the idea that people with eating disorders have extremely low body weight, and even showed images of the protagonist in her underwear a a dangerously low weight. While this image was designed to horrify students and make them realise how terrible anorexia is, at the time to me the image was motivational. It is common for people with eating disorders to be obsessed with comparing themselves to other people with eating disorders / people who are very underweight, and I don't think that schools should be encouraging this by showing those sorts of images. Anyone with an eating disorder is very likely to already be obsessed with body weight, and feeding this obsession is dangerous. While many people with anorexia do have very low body weight, those at the early stages of anorexia or with bulimia or binge eating disorder may be a normal weight (or overweight). Schools should be careful not to spread the myth that people need to wait until they are dangerously underweight before they are `deserving' of treatment. Overall thoughts Early intervention is really important for eating disorder recovery, but often by the time parents / teachers notice a young person has issues they have already been ill for some time. So swift treatment after the initial diagnosis is crucial. This is true even when the patient doesn't present as being significantly underweight. Bulimic patients may never be severely underweight, but they still deserve treatment. And anorexic patients / some bulimic patients who don't initially present as very underweight can deteriorate very fast while waiting for treatment, so long waiting times just lead to more treatment being needed in the long run. I think the time between family first becoming aware of the issue and receiving treatment is a particularly difficult time - both because the eating disorder is likely to be causing significant family conflict which can make the patient feel isolated, and because the problem being out in the open can lead to a loss of inhibition over the disordered behaviours which allows them to become worse. In order to make this time easier I think support for the parents is crucial. Both practical support about what kind of things they should be looking out for (i.e. ways patients might try and `fake' their weigh ins, or make it look like they've eaten when they haven't) and what they should be doing to help (i.e. should they be forcing the patients to eat, if so how much, what should they do if the patient tries to purge). These kinds of supports for the parents could still be useful after the patient has started treatment. Support groups for the patients can also be helpful, but it's crucial to remember that when people are in the grip of their eating disorder they may not want to get better yet (for me I wanted to try and recover

from the bulimia, but I didn't see any problem with being anorexic so I was not willing to stop restricting food). As such they may need the people around them to be actively involved in their recovery, and parents and families will need help with this. I don't think it necessarily makes sense for this help to be given in front of the patient (if they know what behaviours their parents are looking out for they'll try and find other ones), so I'm not talking about family therapy as much as support groups and information solely for parents. When treatment starts I think in an ideal world the patient & their family should have a say over what treatments are helping. Eating disorders aren't all the same, and what works for one person is not going to be the same as what works for another. It's a waste of NHS time and money to say that people have to sit through sessions which everyone knows aren't helping because the patient & their family know there is no other help available and they don't want to be discharged. I realise this may not be an easy thing to achieve on the NHS with limited resources, but even if there is no choice of practitioner, the practitioner could work with the patient and their family to find what sort of style works for them. Moreover, making sure that patients are getting a mix of emotional & practical support - I found that at some points in my treatment the support was all practical, and other times it was all emotional, but really what was probably needed was a mixture of both.

CASE STUDY 2 – PARENT'S OBSERVATION OF THEIR CHILD'S EATING DISORDER AND SELF HARM.

I have two children.. The younger one has generally breezed along through life but my oldest child has always been more complicated.

At the age of 13, I noticed that she was getting very picky about meals. I put this down to her being a grumpy teenager because she disguised what was really going on so well. However, over time it became clear from her moods and physique that something wasn't right. It wasn't easy to have conversations with her because she had distanced herself from members of the family and was generally quite stroppy. In her company, we were walking on eggshells. Luckily, the cry for help came when her periods stopped and she felt panicked and knew things were out of control.

Both my husband and I were fully supportive and keen to get her the help she needed. We read up on everything there was to read, looked at all the available apps for support and organised for her to get medical attention. She took time out from school for these visits. The person we worked with insisted on an eating diary and expected weight to be gained by each of our weekly appointments. There was a level of dominance from this person that installed some fear in my daughter who stuck with the diary and the regular appointments.

However, overseeing how someone eats every day is both intrusive and scary. Too much intervention and the compliance stops; not enough and panic ensued in me. Trying to control another's behaviour is challenging. Trying to control a teenager, dealing with hormone issues, social media and other teenage angst is a 24/7 nightmare that you wonder you'll ever wake from. The problem is you're dealing with a person who's in the grip of something awful; who's mind is locked in negativity; and who has mastered techniques to prevent you helping even though you know she wants your help.

When her periods returned, it felt like we were getting somewhere. She had put on weight too and seemed to be eating better. Her mood fluctuated but was, generally, less grumpy. We had some good times together again when she chose to be included. However, your antenna tells you not to switch off. You've become a detective snooping around looking for clues and when you find razor blades in her room and marks on her arms, your heart breaks. It's impossible to maintain a sense of calm when you're dealing with this. You thought it was an eating disorder but now it's something else as well – self harm.

I spent time looking at myself and how I have behaved with the children to see whether I needed to change and whether I was the cause of some of this. I took up meditation which helped. I softened my line on things; spent time, when she allowed it, to talk things through with her and share ideas I'd read about. Lisa Feldman Barrett's book – *How emotions are made*, particularly kept me sane during this awful period. It is an empowering read that really helped me think about emotions in a completely different and life-changing way.

My husband and I sought counselling sessions for her. However, it had to be the right kind of person. One that she felt comfortable talking about things that concerned her. It can take time to find that person and when you do you are so grateful because it really helps. A stranger telling you what your parents have told you over and over again actually registers. The emotion isn't there. That umbilical chord is never an issue.

I started to notice pleasant changes in my daughter's behaviour and was really impressed when a friend of hers was struggling with her own mental health and she stepped in to assist. It felt good to know she was able to empower another. That she had learned things that she could pass on.

5 years on and my daughter is taking her A levels and will be off to university soon. Am I worried still? She seems in control. She's healthy and seems to be eating well. I've not noticed any more cuts to her body. We can cuddle again. She talks to me a lot now and we've had a couple of holidays together just the two of us to build our relationship. But is it over? Will she be able to cope at University without our support. Time will tell. Fingers crossed.

Love, patience and family support and the earliest intervention that was possible have helped us deal with this. Plus all the amazing advice that support groups have taken time to produce through their apps for both young people, parents and peers. These are serious problems that need to be got on top of quickly. Luckily for us, my daughter recognised she was out of control and asked for help, that meant we were included in finding a solution. Also, we had the money to be able to buy the help we needed.

Knowing what we've been through and how challenging it is, time is of the essence. We have to ensure that no young person experiencing eating disorder or self-harm issues are left on a waiting list. The consequences for that are too awful to think about.

FINDINGS ON PREVALENCE OF EATING DISORDERS AND SELF HARM IN YOUNG PEOPLE IN MERTON

In Merton Self Harm is more common that Eating Disorders and more prevalent with teenagers.

Eating Disorders

Eating disorders can wreck lives, not just of the people experiencing them, but those of their family and friends too. Many of the issues are caused by society's praise of weight loss, celebrity culture, social media, objectification of bodies (both women's and men's but mostly women's and girl's).

Eating disorders are often symptomatic of other mental health issues which could include post-traumatic stress disorder, anxiety, depression, poor self-image, self-harm and OCD. Poor mental health can be the cause of poor attendance and concentration in lessons and can also affect other students as well as the young person's capacity for benefitting from their education at a crucial stage in their lives.

The numbers of children and young people presenting with eating disorders are relatively low in Merton.

By the end of December 2023 (the third quarter as the year runs April to April), the total number of children referred to Merton Single point of access with this as a presenting problem was 15, so unlikely to be much higher than that at the end of the year. It was eleventh in the list of reasons for referrals accounting for 0.8% of all referrals received in this time. However, there has been an increased focus on support for this aspect of children and young people's health.

70% of children with an eating disorder are from high achieving families. Pressure is often the key – they may put pressure on themselves or have pressure put on them to succeed. Not eating gives them a sense of control to prevent failure. An example of that pressure has been evidenced by a significant number of Merton children in Sutton Grammar Schools or independent schools experiencing this problem.

Some children may experience eating disorders that are trauma related or through abuse, severe neglect or triggered by lack of money, a sensory need or anxiety.

Self-Harm

The number of referrals for young people with self harm as the reason for referral was 160. It was six in the list of reasons for referrals, accounting for 8.7% of all referrals received in this timeframe.

Advice on working with the extreme end of self-harm adolescents before hospitalisation. "Young people might take themselves to the medical room with a self-harm wound. It's better for staff not to focus on the wound because that is likely to escalate the problem but to treat the wound and focus on the fact that the person is

going through a difficult time. Offering an hour a week of pastoral support when there is no self-harm is a better way of supporting the young person.

Sadly, self-harm is often a group thing of a competitive nature with social media involvement. "*My wound is worse that yours."*

WAITING TIMES

Once a referral is made to the Single Point of Access the referrals are triaged and assessed as to what the best way forward is for each case. It is worth noting that sometimes during this process the reason for referral may prove not to be the whole picture but a symptom of a different mental health need.

Access Metric	Target	% Achieved	Average Wait
Referral to Triage	24hrs	99.4%	99.6 Hours
Triage to Assessment	14 days	92%	7 days

It is worth noting that treatment times are likely to be quite individual as this will depend on the severity of the issue.

Emotionally-based school avoidance - Merton's School attendance is running nationally at 2% below average. Researching the reasons behind this is ongoing.

Findings from the two case studies.

The importance of early intervention. The situation can quickly deteriorate and other issues like self-harm can arise if left untreated, especially if the initial intervention is unsuccessful.

The importance of help for the family, in particular the parents. The parents are on the front line – dealing with the issue every day and often with very little support themselves. They also don't have the professional expertise to know how best to intervene. Questions like: Should they force eating? Oversee mealtimes? Do weigh-ins? need careful thought. Family therapy can be, at best unhelpful and at worst cause further issues. So good accessible guidance and information is essential.

Getting the right treatment and therapist.

This is so important and is raised in both case studies.

Concern that a *one size fits all* approach still pervades in the NHS. Whilst it is understandable, given cost implications, it ican lead to serious failure.

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WHAT SUPPORT IS AVAILABLE IN MERTON FOR CHILDREN AND YOUNG PEOPLE.

MENTAL HEALTH LEADS

Each of Merton's Schools has a Mental Health Lead (a bit like a Designated Safeguarding Lead but without payment.) The Mental Health Forum meets with these Leads every term.

There is money available to pay for services and training and Merton has a higher than national average coverage of a trained workforce.

TRAILBLAZER Ged Curran, SLAM (Croydon) and St George's worked together to set this up

This aims to give advice on how pupil/students and their families can access the latest support for emotional wellbeing.

Each School has a Mental Health Plan

100% of Merton's schools have a link to a team of:

- 2 Senior workers and 5 trainers.
- Extra Senior Therapist working at a low level of entry to Self-harm and Eating Disorders.

SCHOOL CLUSTERS
Merton operates in clusters:

- Holy Trinity (includes Catholic Schools)
- Cricket Green - Merton & Sutton Special Schools
- The ex CCG funded a cluster for Mitcham and Morden
- Further Education Cluster
- Bishop Gilpin group
- Band A seniors have a separate group to improve delivery.

ITHRIVE – is a model for all mental health services that looks at different ways of configuring support:

- THRIVING
- COPING - GETTING ADVICE AND SUPPORT
- GETTING HELP
- GETTING MORE HELP
- GETTING RISK SUPPORT.

There has been 4 years of working on this.

The Integrated Care Board is setting this up across SW London. Currently the language is there but service is not.

MELBURY COLLEGE AT THEIR LAVENDER CAMPUS

Offers high quality, bespoke education provision for highly vulnerable students who live in Merton and who are unable to attend mainstream school because of medical and/ or mental health needs.

Merton's NHS Education Wellbeing Services

This service is linked to and embedded within Merton CAMHS with a role of supporting young people, their parents and schools to think about mental health and wellbeing, and also specifically around self-harm.

In July 2022 a multi-agency group of professionals substantively updated Merton's protocol for supporting young people who self-harm or experience suicidal ideation: this included creating and updating practical guidance for those supporting young people, including decision making flowcharts, available resources locally and nationally for young people, parents and professionals. Attached pdf

Much of the support currently available in Merton for young people who are self-harming is overviewed in this document, page 4 has a decision making flowchart, pages 17-20 resources and key services for young people, parents and professionals. Some of the stated organisations have also been doing lots of work in the area

This service has delivered multi-agency workshops as part of the launch of the policy and has a number of resources on their Youtube channel including around self-harm and workshops for parents (as well as direct work in schools with young people):
https://www.youtube.com/channel/UCrRKV84Ib8Jr69Z7ZhjSjCg

OFF THE RECORD
For young people aged 11-25 that live in the London borough of Merton (or have a GP in the Merton borough) they can access emotional support ranging from one-off support through the walk-in counselling sessions and outreach work through to ongoing individual support online counselling and face-to-face counselling. Those under 13 will need the consent of parent/carers.

Young people can self-refer by calling 020 3984 4004 or emailing merton@talkofftherecord.org. 11-17 can also be referred through Merton CAMHS SPA (Child & Adolescent Mental Health Services, Single Point of Access).

Off the Record is an established charity which has been providing free, professional support to young people in Croydon, Sutton, and most recently Merton over the last 25 years. Staff share a vision of "Bringing an end to mental health misery for children and young people in South London".

Off the Record offers young people individual, face-to-face and online counselling across all three boroughs, and last year received over 1,200 referrals and offered young people over 7,000 counselling sessions. Their

work has been recognized through a national award programme with the charity receiving the prestigious 2019 GSK IMPACT award for work to improve young people's health and wellbeing.

STEM 4 - SUPPORTING TEENAGE MENTAL HEALTH

stem4 is a charity that promotes positive mental health in teenagers and those who support them including their families and carers, education professionals, as well as school nurses and GPs through the provision of mental health education, resilience strategies and early intervention.

This is primarily provided digitally through innovative education programme, pioneering mental health apps, clinically-informed website and mental health conferences that contribute to helping young people and those around them flourish.

Their supportive apps are available on their website https://stem4.org.uk/

BEAT **Contact:** info@b-eat.co.uk https://www.beateatingdisorders.org.uk/

BEAT has a dedicated helpline for England (0808 801 0677) and a range of services available for people who need support for their eating disorder.

Their national Helpline exists to encourage and empower people to get help quickly, because they know the sooner someone starts treatment, the greater their chance of recovery. People can contact BEAT online or by phone 365 days a year. They listen, help to understand the illness, and support taking positive steps towards recovery.

They also support family and friends, equipping them with essential skills and advice, so they can help their loved ones recover whilst also looking after their own mental health.

BEAT campaigns to increase knowledge among healthcare and other relevant professionals, and for better funding for high-quality treatment, so that when people are brave enough to take vital steps towards recovery, the right help is available to them.

The work they do means that every year lives are saved, families are kept together, and people are able to live free of eating disorders.

Input from Merton's Young Inspectors has been valuable – checking out sites to see how they work and pointing out problems.

TASK GROUP'S CONCLUSION

Adolescence is a crucial time for young people to start defining who they are, and role models can lead them into self-destructive behaviours, such as disordered eating and self-harm.

Schools can play a key role in monitoring the mental health of their students.

It is reassuring to know that all Merton Schools have a Mental Health lead and that they are linked in clusters to the Merton Schools' Mental Health Forum which meets termly and has good access to professional support. Also pleased that regular training takes place.

Referrals to CAMHS in Merton are lower than the national average for both these issues at the top end of the ITHRIVE assessment system - *getting risk support level*. However, we are unaware of how many young people in Merton who are not thriving, are at the *coping, getting help, getting more help* levels.

It is not always easy to assess whether people with disordered eating or who are self-harming are deteriorating. (Eg.Young people with Bulimia don't necessarily lose weight but can cause significant physical/mental harm to themselves). Hence why record keeping and close monitoring at the "lower levels" of the IThrive assessment system are important.

It is also important to evaluate whether the help being offered at these levels is sufficient. This information would be valuable because, as we have seen from our case studies, early intervention is vital if these serious issues are to be dealt with successfully.

Another concern from both our case studies is ensuring that the person offering counselling has a good rapport with the young person. There needs to be flexibility in who is available to offer support and a range of treatments available. Eg Cognitive Behaviour Therapy might work well for some but not others.

If support at this crucial stage is not working for the young person, it needs to be known. A satisfaction survey or assessment to evaluate what is working after a certain amount of time is needed. Other options available should be on offer. Time is of the essence. Also, we should investigate who is out there in the community that could offer support.

The satisfactory waiting times reported to us from CAMHS are 92%. However, that means 8% of young people with serious problems are not included in that target. It is vital that CAMHS is fully resourced as staff shortages at this crucial stage could be fatal.

We feel Children and Young People's Scrutiny Panel should be requesting regular feedback on staffing levels, satisfaction of support and waiting times from CAMHS.

Lots is being done in our schools. However, we feel a lot could be done in our communities to promote information and good practice and would suggest the following: Targeted poster campaigns; a double page spread in My Merton focused on these issues and support available; E-Merton promoting these campaigns.

One of the biggest worries we encountered was the impact of social media, particularly with the competitiveness of Self-Harm "*My wound is worse that yours."* We feel that national media, local authorities and government need to be putting pressure on these platforms to promote positive messages and remove negative material.

We have produced some recommendations in this report that we hope will help to address these important issues.

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Committee: Children and Young People Scrutiny Panel

Date: 21st June 2023

Wards: All

Subject: Departmental Update

Lead officer: Jane McSherry, Executive Director of Children, Lifelong Learning and Families

Lead member(s): Cllr Brenda Fraser, Cabinet Member Children's Services, and Cllr Sally Kenny, Cabinet Member Education and Lifelong Learning

Contact officer: Maisie Davies - Head of Performance, Improvement and Partnerships

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Recommendations:

A. Members of the panel to discuss and comment on the contents of the report

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The report provides members of the panel with information on key developments affecting the Children, Lifelong Learning and Families (CLLF) Department, and not covered elsewhere on the agenda. It focuses on those aspects of particular relevance to the department.

2 DETAILS

CHILDREN, LIFELONG LEARNING & FAMILIES

2.1 Since my last update in March, there have been several changes in the Children, Lifelong Learning and Families senior leadership team. Our previous Assistant Director for Childrens Social Care and Youth Inclusion, Dheeraj Chibber, has moved on to take up a Director of Children's Services role in Luton. I am delighted that David Michael, our Head of Corporate Parenting, is taking over the Assistant Director role in the interim. Current Heads, Teresa Hills and Michelle Waldron, have taken sideways steps to further develop their skills as Head of Corporate Parenting and Head of Adolescent & Safeguarding respectively. Tendai Dooley, a highly experienced and rated locum, will cover the vacancy created by David's interim promotion as the Head of Family Support and Safeguarding. Finally, Heather Smith has secured an internal promotion to become Head of Family Help and Assessment. These development opportunities will ensure stability of leadership and continuity of service provision.

2.2 Recently the CLLF Departmental Management team all attended the Leadership in Colour pan London conference. As a senior leadership team we are committed to ensuring that Children, Lifelong Learning and Families has an inclusive and diverse workforce from the top-down and engages best

practice in supporting children and families of colour. We were really proud to have one of our own Heads of Service, Teresa Hills, sharing her experiences as a leader and presenting her key takeaways for children's systems leaders at the Summit.

2.3 The rest of this report highlights some of the Department's key activity over the last few months.

LGC Awards

2.4 As reported previously, we were delighted in February to learn that we had been shortlisted for two Local Government Chronicle (LGC) 2023 Awards. Children, Lifelong Learning and Families was shortlisted for the 'Children's Services' Award. This is a testament to the commitment, passion and creativity of staff across the Department which contributes to positive outcomes for children and young people living and learning in Merton. It was a fantastic opportunity to showcase the Department's work, particularly around how CLLF puts children and young people at the heart of their work, strives to continuously improve, create and innovate; and works in close collaboration with partners. One of the Department's Young Inspectors, Denise Candengue, paired up with our Head of Family Safeguarding, Teresa Hills, to present to a panel of judges at the LGC in April 2023.

2.5 Jane McSherry was also shortlisted for the 'Outstanding Individual' Award. Our Young Scrutineer and former Young Inspector said of the nomination, *"I believe that she [Jane] has always had Merton's children and young people truly at the core of her focus and achievements, and this really shines through with the respect and value she has given to the Young Inspectors team as well as my role in scrutiny."* One of our Young Inspectors working in Public Health, Anna Huk, presented to the LGC judging panel alongside our then Assistant Director of Children's Social Care and Youth Inclusion, Dheeraj Chibber.

<u>Supporting Schools</u>

Beat the Street Initiative

2.6 This spring, over 22,000 people across Merton took part in 'Beat the Street', a free, fun walking, cycling and wheeling game aimed at increasing activity levels. All 47 primary schools, including three special schools, across Merton took part in the challenge, competing to see who could travel the furthest over the six weeks.

2.7 Behaviour Support Lead & PE Coordinator at Poplar Primary School said of the initiative: "*After our visit from Chloe [Beat the Street Local Engagement Coordinator] the whole school was buzzing with excitement to get going. The younger children love the fact that they had their own card. It was fantastic to see the children walking around with maps to navigate their way, which is a skill we are all forgetting to use as we become more reliant on mobile devices. I have had some children tell me that they have changed their route to school and now leave a bit earlier so they can scan more boxes on their way. Others are meeting with friends to go for bike rides at the weekends and family walks.*

It's been great and the whole Poplar community are really enjoying being part of it".

2.8 Over half of all children who took part in Beat the Street self-reported as being 'less active' (undertaking less than 30 minutes of activity a day). Data collected after the game show that physical inactivity levels declined and there was an increase in the proportion of children meeting the CMO guidelines for activity. One boy, under 11 years old, said: "*It helped me because it made me do exercise and it got me moving more faster and made me tired*."

2.9 Beat the Street Merton supported the community in coming together with children at the forefront. The PE Coordinator at the winning primary school, St John Fisher RC Primary School, said when they found out the school had won: "*We are all very proud. All the children and wider school community were so excited by the scheme and had so much fun!*".

2.10 Beat the Street is now moving into legacy stage, working closely with the Borough of Sport priority to promote the fantastic assets and programmes available in schools and communities all across Merton.

School admissions

2.11 Primary School Admissions offer day was 17 April, following on from Secondary School offer day on 1 March 2023. In both cases every Merton resident that applied received an offer of a place.

2.12 For primary schools we were able to offer 85% of school children a place at their first preference primary school – a further increase of 1% on last year and 3% on the year before. 94% of Merton children were offered a place in one of their top three preferred primary schools, with over 96% receiving a place at one of their six preferences.

2.13 We received 102 less on-time resident applications, further reflecting the drop in demand reported to this committee in November.

2.14 For secondary schools, nearly 90% of Merton children were offered a place in one of their top three preferred secondary schools. After a significant rise in demand, and therefore applications, over the past 10 or so years, there was a drop in applications this year; this was forecast. However, we are not expecting a significant drop in roll in any secondary schools this year as some neighbouring boroughs still have increasing demand in year 7.

Universal Free School meals for all primary school children

2.15 In February 2023, the London Mayor announced that the Greater London Authority (GLA) would fund Universal Infant Free School Meals for all Key Stage 2 (aged 7-11) primary school children for the academic year 2023/24. This follows on from the government introducing Universal Infant Free School Meals (UIFSM) in 2014, which was never extended to Key Stage 2.

2.16 36 of the Merton's 44 state primary schools and all 3 special schools choose to be part of the council's central catering contract, currently with Caterlink; this

gives Merton Council more control over delivering this initiative than some other councils. The increase in meals will present some logistical challenges but officers are confident that the Mayor's initiative can be delivered for September.

School Inspections

2.17 Since the last update (at the beginning of the spring term 2023) there have been 12 further inspections in Merton schools. Of these, nine are primary schools, two are secondary schools and one is a special school.

2.18 Eight of these inspections were ungraded inspections of previously Good schools. Ungraded inspections do not make graded judgements but report whether the school has sustained the same grade as at the school's previous graded inspection. While St John Fisher Catholic Primary school awaits the publication of its report, the other seven schools (Gorringe Park, Hillcross, Abbotsbury, Sacred Heart, St Matthew's CE, St Mark's CE Academy and Wimbledon College) continue to be Good schools.

2.19 Inspectors have reported that sufficient evidence of improved performance suggests that Hillcross Primary and St Mark's CE Academy could be judged outstanding if they had a graded inspection now. Their next inspections will be graded inspections within the next one to two years.

2.20 Cricket Green special school continues to be an Outstanding school.

2.21 St Peter and Paul Catholic primary had a graded inspection in March 2023 and is graded Good overall and for each judgement area. St Thomas of Canterbury Catholic primary and Stanford primary schools each had graded inspections; the reports have not yet been published.

2.22 In total, there have been 19 school inspections in academic year 2022 – 2023. Of the sixteen published reports, all but one is Good or better.

2.23 School inspections were suspended during the pandemic but in November 2020 Ofsted committed to inspecting all schools between May 2021 and July 2025. There could be up to nine further inspections of Merton schools in the final half term of this academic year.

School Attendance

2.24 Nationally we know that school attendance has been significantly affected by the Covid-19 pandemic. The national school attendance rate is approximately 2% below pre-pandemic level (2018/19 data) and children who attend school less than 90% of the time is approximately three times the level it was pre-pandemic. The Government has issued new guidance to schools and local authorities about how to support good attendance. Merton has been implementing this guidance across the school year. All local authorities are expected to produce a self-assessment against the new guidance and the Department for Education (DfE) will be holding support meetings with local authorities (likely in the Autumn term) to further advise on implementation of the guidance.

2.25 Merton has put in place an action plan, which is overseen by the multi-agency Prevention and Early Intervention sub-group of the Merton Safeguarding Children Partnership. We will be further developing our understanding of the new 'severe attendance' category (under 50%) and interventions to improve school attendance. We know that anxiety and mental health concerns are a significant driver in poor attendance and we have been working with our health colleagues, launching with Primary Heads a new tool to support better access to mental health support related to emotionally based school avoidance.

2.26 Attendance is monitored closely using the DfE's new WONDE system that tracks data on a daily basis on all children nationally (for those schools who have signed up to WONDE). It is important to note that the DfE's attendance data using WONDE is experimental and undergoing evaluation. There are some known issues with the national collection of this data which affect its accuracy locally, regionally and nationally. Therefore these figures should only be treated as indicative of the attendance picture.

2.27 The most recent WONDE attendance figures published nationally were for the period of September 2022 up to 12 May 2023. Merton's primary school attendance was 94.21% and secondary school attendance was 93.36%, both of which are better than national and London averages (94.07% and 93.74% respectively for primary; 90.92% and 91.95% respectively for secondary). However, at 82.94%, Merton's special school rates were below national and London averages (86.86% and 86.20% respectively). Overall, these figures show that Merton are performing well against our peers on school attendance; however, we recognise that there is more to do for children in special schools, and to increase attendance in the context of lower levels post-pandemic.

Exclusions

2.28 Schools can suspend a pupil for a fixed term or permanently exclude a child for a serious breach of the behaviour code in a school. Exclusions are monitored monthly to track any emerging trends and target support. In Merton, significant work is undertaken with children, families and teachers with the aim to reduce the use of exclusions.

2.29 Merton secondary schools have seen a rise in permanent exclusions this year, while fixed term exclusions are slightly lower than previous years. Last year permanent exclusion rates were particularly low (9), however the rate for this year so far (21) brings us in line with the pre-pandemic rate in 2018/19. In response to the recent rise in permanent exclusions, secondary school headteachers in Merton met with the Local Authority to analyse the reasons for exclusions and to identify solutions to address the increase. The analysis showed emerging themes around contextual safeguarding and exclusions of girls. However, significant multi-agency work to address contextual safeguarding issues in recent months (reported in the November 2022 Departmental Update to this Committee) has had a positive impact and our latest exclusions data suggests that the rise has started to level off. Discussions

with schools are also ongoing and they are sharing good practice around how they can support children and young people, for example, with the development of more community based or alternative curriculum options.

Supporting Vulnerable Children

Supporting Vulnerable Children and with Special Educational Needs and/or Disabilities

2.30 As at the 30th April 2023, Merton maintained 2,458 Education, Health and Care Plans (EHCPs).

2.31 In this calendar year (Jan to Apr 2023), the service has received 172 requests for an Education, Health, and Care Needs Assessment (EHCNA). This calendar year the Local Authority has agreed to undertake 145 EHCNAs, and agreed to issue 90 EHCPs.

2.32 The EHCNA process should be completed within 20 weeks. As of 30th April 2023, the year-to-date timeliness for completing an EHCNA is at 70% in the total number of EHCPs being issued within 20 weeks, excluding exceptions. Although we of course aim to ensure that all EHCPs are issued within this timescale, our performance is well above the national average, and continues to improve as a result of the concerted efforts of officers in the SENDIS team and the wider SEND partnership.

2.33 Following annual review processes the Local Authority has ceased to maintain 109 EHC Plans. 56 children and young people with an EHCP moved out of Merton to another Local Authority and 5 pupils moved abroad. In addition, 20 children and young people with an EHCP moved into Merton and their plan was adopted.

Stable Homes Consultation

2.34 In February 2023, the Department for Education (DfE) published their Stable Homes, Built on Love: Implementation Strategy and Consultation. The consultation responded to three independent reviews that were published in 2022 (The Competition and Markets Authority's Children's Social Care market study; Child Protection in England; and the Independent Review of Children's Social Care). The DfE's Implementation Strategy centres around six pillars to '*transform children's social care*.' These include:

- Pillar 1: Family Help provides the right support at the right time so that children can thrive with their families
- Pillar 2: A decisive multi-agency child protection system
- Pillar 3: Unlocking the potential for family networks
- Pillar 4: Putting love, relationships and a stable home at the heart of being a child in care
- Pillar 5: A valued, supported and highly-skilled social worker for every child who needs one

- Pillar 6: A system that continuously learns and improves, and makes better use of evidence and data

2.35 The Children, Lifelong Learning and Families Department consulted with a range of partners through our safeguarding children partnership and corporate parenting board in order to formulate an informed response to submit to the DfE. We also invited Our Voice, our local children in care and care experienced young people council to contribute their views to the consultation. They provided us with a range of views across the six pillars, which we also used to inform our response.

2.36 Merton is part of *Developing Together* alongside Kingston, Richmond, Sutton, Wandsworth and Surrey. Developing Together is a teaching partnership which offers an ambitious and comprehensive programme of education, training, support and professional development for Social Workers across the region. We have been successful in our bid for Developing Together to become an Early Adopters of the Early Career Framework pilot (linked with Pillar 5). Merton will be working with the DFE and other boroughs across the country to set the pilot methodology between June and September.

2.37 Overall, along with our partners and young people, we welcome the focus on early help, supporting family networks, embedding multi-disciplinary and specialist teams, improving recruitment and retention of social workers and strengthening corporate parenting principles. However, we also highlighted the challenges raised by our partners and young people that we would like to see addressed by the DfE – for example, the importance of local areas being able to co-produce solutions with families; provision of sufficient funding to embed the reforms; and ensuring alignment with other national strategies, plans and policies.

Immigration Pledge

2.38 Merton has been working with South London Refugee Association's (SLRA) Early Intervention Project (EIP) since 2018 to ensure that all of our unaccompanied asylum seeking children and young people are provided with prompt legal representation and support with their asylum applications at every step of the way. The EIP also provides guidance to Merton staff in respect of this very complex area of legislation, working alongside Merton social workers and Personal Advisers to help our looked after children and young people navigate the process of claiming asylum.

2.39 Earlier this year, the Corporate Parenting Board signed a Pledge to support all looked after children and young people with their immigration status, one of the first Local Authorities in the UK to do so. On 11th May, the Local Authority celebrated the signing of that Pledge, hearing stories from three of our young people about their own personal experiences.

Safety Valve

2.40 The end of year Safety Valve report for 2022/23 was submitted to DfE on the 19th May. The report demonstrated good progress against all of the conditions agreed with DfE as part of the plan. In particular, we have revised our processes to be more in line with other local authorities, have enhanced our support to schools and are expanding in-borough provision.

2.41 The number of Education Health & Care Plans (EHCPs) has stabilised in contrast to the pre-plan estimate of year-on-year growth in the number of plans on more than 300 per year. As at end of March 2023 there were 2,446 live EHCPs compared to 2,497 as at the end of March 2022. Underneath this headline figure there re new plans being agreed every month (around 7 per month) as well as plans being ceased due to young people leaving education or moving out of borough.

2.42 We have enhanced out support to mainstream schools to help them in supporting children with SEND in mainstream settings where that is the most appropriate outcome.

2.43 We have expanded in-borough special schools places at Whatley Avenue, with 41 new places filled so far, rising to 60 by September. We have also included Additional Resourced Provisions (ARPs) by 33 places. The further expansion of in-borough provision remains are priority for both ARPs and Special School places. We are currently working with DfE to identify a suitable site for a new special school in Merton, to complement our existing three schools.

2.44 As at year end, the in-year deficit was £10.7m, short of the £6.9m deficit set out in the plan. However, DfE brought forward £3.2m of their £28m contribution, reducing the year end position to £7.5m. The ongoing dependency on high-cost independent schools remains a significant issue, hence the priority around expanding in-borough places.

2.45 We remain on track to meet the plan over the five years agreed with DfE, and continue to achieve balance ahead of that timescale.

Scrutiny Topics Workshop 07 June 2023

Present: Councillor Usaama Kaweesa (Chair), Councillor Samantha MacArthur, Mansoor Ahmad, Co-opted Member

The Chair said he met with the following organisations to discuss scrutiny topics: Primary School Headteachers, Secondary School Headteachers, Acacia Adventure playground and youth parliament.

Topic	Discussion	How scrutiny will look at it
Youth Democracy	It was agreed to await the outcome of evaluation of young inspectors' pilot programme.	The Panel will evaluate the pilot programme of Young Inspectors involvement in scrutiny in 2024.
Conditions of local playgrounds	This was thought to be an important issue requiring a comprehensive report to include: How often do playgrounds receive maintenance and what state are they are in. How well are they being used, what is being down to encourage more young people to attend. Are some playgrounds more popular than others, if so why.	A Report to the panel
Early Years Provision	A lot of work is currently being undertaken in this area including strengthening the early years system. Regular updates will be beneficial. This work will include how childminders are supporting each other. Re-opening childminder drop-in within children's centres can be included within an update.	Departmental update report
Review into the education of the "disappeared	This is an issue of national concern. Regular updates of how schools are addressing	Departmental update report

children" from school rolls after covid.	this issue can be provided to the panel.	
Future of primary school places provision given birth rates are down.	The Panel would like an update on school places planning strategy and school budget planning. Cabinet Members should also be invited to the discussion.	A report to the Panel
School places in specialist schools and impact on primary schools	Specialist School places update can be included in the SEND update. To include a review on flow of information between organisations.	Department update report
Quality of School meals	The Panel should look at how procurement is focussing on the quality of school meals. Look at good practice across schools.	Department update report.
Democratic engagement and citizenship education for young people in schools	This area has a very wide remit from citizenship education in schools to impact of voter ID and work in the council to engage young people in democracy. The task group can receive an overview of these areas and decide an area for the review to focus on.	Agreed as a task group review
Sustainability and environmental programmes for young people	This is a broad area and Panel could seek feedback from youth parliament and young inspectors on work taking place.	Scrutiny officer to undertake research and feedback to the Panel.
Youth Services	Report to the panel: What work is being done to attract more young people to youth services. How do young people find information on what is available. Invite youth parliament to attend the session and contribute.	A report to the Panel

Mental health services	Invite youth parliament to share their feedback on accessing mental health services. NHS colleagues to be invited to talk about the work they have been doing to ensure young people can access services independently. Update on support provided to children suffering from trauma and who are at risk of entering criminal justice system.	Joint discussions and Report to the Panel
Support services for young people with dietary and nutritional issues linked to childhood obesity.	This is linked to the work on healthy weight programmes. The Panel would like existing healthy weight programmes to be assessed to determine how well they are working.	Report to the Panel
Additional Educational Support	Support will vary from school to school and is part of the Ofsted inspection.	Departmental update report.
Behaviour monitoring	Panel should look at activity to help schools and receive an overview of wider contextual issues.	Departmental update report.

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