Merton Council
Health and Wellbeing Board

Date: **26 March 2019**

Time: **6.15 pm**

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

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

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Future meeting dates

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Health and Wellbeing Board Membership

Merton Councillors

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

Council Officers (non-voting)

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

Statutory representatives

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

Non statutory representatives

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

Quorum

Any 3 of the whole number.

Voting

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

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HEALTH AND WELLBEING BOARD
29 JANUARY 2019

(6.15 pm - 8.10 pm)

PRESENT Councillor Tobin Byers - Chair
Dr Andrew Murray - Vice Chair and Chair of Merton CCG
Councillor Janice Howard,
Councillor Kelly Braund - Cabinet Member for Children's Services
Rachael Wardell – Director of Children, Schools and Families
Chris Lee – Director of Environment and Regeneration
Dr Dagmar Zeuner - Director of Public Health
John Morgan – Assistant Director Adult Social Care
Dr Doug Hing – Merton CCG
Dr Andrew Otley – Merton CC
James Blythe – Managing Director of Merton and Wandsworth CCGs
Khadiru Mahdi - Chief Executive Merton Voluntary Service
Lyla Adwan-Kamara -Community Engagement Network
Brian Dillon – Merton Healthwatch
Dave Curtis – Merton Healthwatch

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies were received from Hannah Doody.
John Morgan, Assistant Director for Adult Social Care attended in her place

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of interest.

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

RESOLVED: That the minutes of the meeting held on 27 November 2018 were agreed as an accurate record.

The Chair welcomed Andrew Otley to his first meeting of the HWBB

4 MENTAL HEALTH AND WELLBEING (Agenda Item 4)

The Director of Public Health presented her report on Mental Health and Wellbeing, which the Board noted and endorsed.

The Board were pleased to note the opportunity to lever support from Thrive London to help campaign and raise awareness locally. Partners agreed to engage with this, emphasizing the need that it should link up with existing local engagement and avoid the risk of 'over consulting' with the same communities. The Board also committed to press on healthy workplace activity in their own organisations, particularly recognised

the benefits of trained Mental Health First-Aiders in the workplace and expressed support for a proposed 'light touch' common framework for workplace health.

The Director of Children, Schools and Families stressed the 'infrastructure for wellbeing' and links between programmes and agencies that can help Children's' Mental Health. This programme links with the 'Think Family' approach as the mental health of parents are the key indicator of mental health of children, by improving the mental health of parents there will be a positive impact on their children's mental health.

The Chair of Healthwatch offered assistance in reaching seldom heard groups, and the Director of Public Health agreed that the joint resources of the Board would be needed to promote this work.

James Blyth emphasised the enhanced offer from the new providers of Mental Health services to the borough from 1 April, and also asked the Board to note the benefits of providing clinical support as early as possible to those who need it.

Dr Andrew Murray presented his report on the Children and Young People Wellbeing Programme: Whole Schools Approach and trailblazer. (Note: this presentation is published in the Supplementary Agenda)
The Board welcomed this programme and were pleased to note the successful bid for National Trailbazer Funding and noted that Trailblazer complements the iThrive programme. The Board noted that results will be evaluated in the Spring term and repeated next year with the aim to roll this out to all Schools in the Borough

The Chair thanked all the schools involved in the programme. He commented that it was fantastic to get this additional support and funding

RESOLVED

That the HWBB:

A. Agree to engage residents, in partnership with Thrive London, in order to understand what matters to them around mental health and wellbeing, to campaign against stigma and to identify areas of improvement in mental health and wellbeing in Merton.
B. Commit to improving the mental health and wellbeing of the workforce across Merton, discuss approaches that would secure improvements and nominate a lead in their respective organisations to deliver programmes in partnership with Public Health.
C. Note recent successes and to promote and champion key programmes related to mental health and wellbeing in Merton in order to secure further improvements.
D. Note the on-going negotiations between Merton Council and South West London & St Georges Mental Health NHS Trust on the Section 75 agreement

5 SUSTAINABLE COMMUNITIES PLAN (Agenda Item 5)

Darren Tulley, Borough Commander for the Fire Brigade presented his report on the Sustainable Communities Plan 2019-25. He emphasised that the focus and ambition of the plan will be on building Social Capital in the borough. Social Capital is a measure of the links between different groups, organisations and individual people.

All Board Members welcomed the work on the Sustainable Communities Plan, and Members emphasised that the Plan had clear synergies and links with other work and plans;

- There are clear links with this plan and the other plans on this agenda; the Health and Wellbeing Strategy and Merton Local Health and Care Plan.
- There are synergies between this Plan and the East Merton Model of Health and Wellbeing.
- This plan also links to social prescribing and there need to be links to partners.
- That a lot of engagement/ consultation ongoing at the moment – this must all tie together and not duplicate.
- This Plan will bring together the views and enthusiasm of the voluntary sector.
- There are links to community cohesion, and it would be helpful to revisit the issues that emerged from the Merton Partnership Conference for the themes and thoughts of the voluntary sector.

Board members gave examples of current work that supports this Plan:

- My Futures work to provide employment opportunities for vulnerable young adults
- The Family Information Service, a directory of services which should feed into any future directories and the 'Think Family' approach to support vulnerable families
- The recent Young Peoples' survey that received 1700 replies that fed into the Children and Young Peoples Plan, the Health and Wellbeing Strategy as well as the Sustainable Communities Plan.
- Neighbourhood funding provided from CIL (Community Infrastructure Levy)
- Work done by the Dementia Action Alliance.

The Board emphasised that joint thinking will ensure that all of this work and these Plans will complement and support each other.

The Board thanked the Borough Commander, and he thanked the Board for their comments and said he would write to the individually asking them to take forward the resolutions of the HWBB

RESOLVED
The Health and Wellbeing Board:

A. Noted the progress so far on the development of a new Sustainable Communities Plan for the borough and the links that can be built with the review of the Health and Wellbeing Strategy;

B. Highlighted any examples of projects the have been overseen by the Board or that are upcoming which promote or build social capital;
C. Outlined how the Board engages with the subsidiary groups and organisations that feed into it and any engagement channels that could be used to support the development of the Sustainable Communities Plan; and
D. Considered whether there are any places or communities they wish to prioritise for the engagement work with hard to reach groups and suggest any channels or mechanisms for how to engage with them.

6 LOCAL HEALTH AND CARE PLAN UPDATE (Agenda Item 6)

The Managing Director of Merton CCG presented his report on the progress of Merton Health and Care Together and the development of Merton Local Health and Care Plan. (Note: this presentation is available in the Supplementary Agenda). A video was shown of the Merton Health and Care Plan deliberative event which highlighted the positive feedback received and supporting the priorities of Merton Health and Care Together.

The Managing Director of Merton CCG emphasised the need for partnership working to co-produce the Local Health and Care Plan and explained that the plan would need to align with the NHS long term plan. He said that the production of the Local Health and Care Plan built on the continuity of the work of the Health and Wellbeing Board and was another step on the journey that the Board has been on for some time. A further report will be brought to the Board at a future date.

The Chief Executive of Merton Voluntary Service Council noted that discussion of this Item and Item 7 – Merton Health and Wellbeing Strategy – were closely linked.

7 HEALTH AND WELLBEING STRATEGY UPDATE (Agenda Item 7)

The Chair asked the Board to approve a letter responding to a request from NHS England for the Board to comment on the ways in which the CCG has taken account of Merton Health and Wellbeing Strategy. The request was received 22nd January with a deadline for the response of 31st January.. Board members received a copy of the letter of response in the meeting, and the letter was published in the Supplementary Agenda. The Board approved the letter.

The Director of Public Health presented her report on the Merton Health and Wellbeing Strategy 2019-24. She emphasised the focus on creating a ‘Healthy Place’. She also reminded members that this was refresh of the current Strategy.

Board members welcomed the HWB Strategy, were pleased with the outcomes from the themed workshops already held, the Director of Environment and Regeneration commented that this had a been a thorough process of engagement and all looked forward to the Age Well and final Healthy Place workshops to come.

The Board welcomed the emphasis on ‘Healthy Place’ and considered what this might look like. The Director of Children, Schools and Families suggested that this should include encouraging children’s freedom and sense of belonging, and also provided suitable spaces for adolescents that made them feel safe and not excluded.

A question was asked about preparedness for a no-deal Brexit, and any difficulties this may cause for services to more vulnerable residents, such as Lunch Clubs. Council and CCG Officers replied that such issues were being considered and planned for.

The Chair requested that the HWB Strategy be brought back to the Board on 26 March 2019.

RESOLVED

The HWBB:

A. Considered the update on the refresh of the Merton Health and Wellbeing Strategy 2019-24 and the particular focus on ‘healthy place’.
B. Noted the findings from the Start Well and Live Well workshops and plans for further engagement.
C. Approved the letter responding the NHS

8 UPDATE ON NHS 10 YEAR PLAN (Agenda Item 8)

The Managing Director of Merton and Wandsworth CCG gave the Board a verbal presentation on the NHS Long Term Plan. He described some of the elements of the plan:

- A more holistic model of support
- Future funding
- Primary care network of GPs
- GP support for Care homes
- Reducing pressure on A&E with a same day emergency service
- Full roll out of social prescribing
- Digitally enabled primary care/pilots for telemedicine
- Personal Health Budgets
- A Renewed Focus on Preventable diseases
- A new focus on prevention with further detail to follow
- Commitment to Mental Health, especially for Children and Young People

There will now be work on the Merton response and Healthwatch will receive national funding to support local responses. He continued that a South West London summary was being prepared and that he would circulate this to the Board when it is available. The Chair added that the Board would consider a full report on the full implications of the Long Term Plan at a future meeting.

The Assistant Director of Adult Social Care expressed his concern regarding the delay to the Adult Social Care Green Paper. The Board noted that there will be linkages between this plan and the Green Paper regarding future funding of Adult Social Care.

9 DEMENTIA FRIENDS TRAINING (Agenda Item 9)

RESOLVED
Board members agreed to attend the Dementia Friends Training on 26 March at 5pm in Committee Rooms CDE

Committee: Health and Wellbeing Board

Date: 26th March 2019

Wards: All

Subject: The Wilson Update

Lead officer: James Blythe, Managing Director Merton CCG

Andrew McMylor, SRO Wilson Programme

Contact officer: Lucy Lewis, Service Design Lead Wilson Programme
(lucy.lewis@swlondon.nhs.uk)

Recommendations:

The Committee is specifically asked to note:

A. Progress made on the design and development of integrated health and wellbeing services for the Wilson Health & Wellbeing Campus to help people to start well, live well and age well;

B. The importance of community, patient and stakeholder engagement in the design and development of services.

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1. Purpose of Report

1.1 The purpose of this report is to present the Board with an up to date summary of proposed services for the new Wilson Health & Wellbeing Campus and describes how health and wellbeing services will integrate at the new site, via primary care and social prescribing, to link to wider objectives and meet the needs of the population.

1.2 Appendix A contains four patient stories to illustrate how the patient journey and experience might be different at the Wilson Health & Wellbeing Campus, along with potential benefits and outcomes. Although they are fictional, our patient stories are based on data and research, as well as GPs experience of real patients and have been voiced in the patient's 'own' words.

1.3 The paper recognises the importance of engagement and continuously involving the local community and voluntary sector in the decision making process via the Wilson Community Reference Group, future Wilson Wellbeing Steering Group and the CCG's own Patient Engagement Group.

2. Executive Summary

2.1 Proposed services located at the new Wilson Health & Wellbeing Campus with

links to services based elsewhere in the community will create a 'healthy place' where people go to support them to start well, live well, age well and prevent illness, rather than a traditional health facility where patients go when they are unwell.

2.2 Enabling access to activities that promote wellbeing (such as community gardening or a walking group) and creating a welcoming environment is important to engage those on very low incomes and people who would not normally access healthcare but may have unmet needs. In order to promote health and wellbeing at the Wilson earlier than 2022 and build strong links locally for the long term, there are plans underway to explore what activities can be established sooner at the site away from the main building works, or via outreach under a 'Wilson Wellbeing' banner at other nearby locations.

2.3 Even though the majority of services will be health services in the broader sense, many clinical services will be configured in a more pro-active way, e.g. primary care diabetes, which will fully integrate with wellbeing services so that the patient's journey at the campus is seamless.

2.4 Patients with complex needs or those seen more frequently can access additional support provided by a multi-disciplinary team (MDT) where appropriate. This approach aims to reduce unnecessary appointments and travel time for all involved by providing a suitable location closer to home and may include families and carers if appropriate.

2.5 The Wilson will be part of the future integrated community service provision in Merton and the model is in keeping with the objectives of the NHS Long Term Plan[1].

3. Background

3.1 Merton Clinical Commissioning Group (MCCG), along with strategic partners, is transforming the health and wellbeing of the population of Merton. This is already underpinned by an integrated approach (Merton Health & Care Together) to support people to start well, live well and age well.

3.2 The design team have ensured services address the specific and identified health needs of the local population. Looking at the healthy life expectancy at birth, the gap between the 30% most and least deprived wards in Merton is over 9 years for men and women. In the east of the borough the population is younger, poorer and more ethnically diverse with a higher prevalence of risk factors and

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[1] https://www.england.nhs.uk/long-term-plan/

social determinants, later diagnosis and more co-morbidities. There are also four times as many children living in poverty in the east of the borough.

3.3 The population of East Merton is twice as likely to attend their local A&E department as GP surgery. Rates of admissions caused by unintentional and deliberate injuries in 0 – 24 age group are higher than London and England average. The proportion of deprived older people in East Merton (22.1%) is double that of those in West Merton (11.3%). East Merton has 36% of the % of adults eating the recommended 5 portions of fresh fruit and vegetables daily (vs 44% of same in West) and higher rates of alcohol related admissions.

3.4 Previous community engagement and conversations established public enthusiasm and need for health services embedded within a 'community destination' - providing flexible, sessional and bookable space for resources and activities that are at the forefront of the new facility and available to all – not 'just a health centre'.

3.5 By going beyond traditional medical care primary care teams have the opportunity to influence the wider social determinants of people's health. Signposting services such as social prescribing will provide better access to community based wellbeing voluntary sector services as an enabler. This will better address people's local needs and support them to self-manage their conditions and to help support lifestyle and behavioural changes to stay healthy.

3.6 We are also continuing to explore links to the Heritage Lottery Canons House project which shares many of the same wellbeing objectives. We will ensure we are building on, not duplicating or destabilising, what is already working well for the community and local people.

4. What are the benefits of a Health & Wellbeing 'Campus' at the Wilson?

- Ensuring access to high quality and sustainable care and increasing years of healthy living and improving quality of life from birth onwards – better care and a better patient experience;
- Attractive new purpose built and landscaped destination in Mitcham – a place where people want to go to stay healthy and build connections, a place to be proud of;
- Providing local employment opportunities and attracting the best skilled staff and volunteers – a place people want to go to work and where health professionals can educate and learn from each other;

- Providing a safe and welcoming space that improves early detection of disease (via diagnostics), prevents ill health and encourages people to self-manage their health & wellbeing;
- Encouraging and improving access to Children's Adolescent Mental Health and other support services for young people;
- Encouraging inter-generational links with mutual support to combat loneliness and isolation experienced by all ages;
- Improving access to a range of fully integrated adult mental health services;
- Improving access to primary care (via the GP hub) wellbeing and community based voluntary sector services (via social prescribing);
- Reducing cost of lengths of inappropriate hospital stay, outpatient waiting times, acute activity and non-elective admissions;
- Reducing episodes of crisis by consciously focusing support for people who are vulnerable or have unmet needs;
- Reducing inappropriate non-health related GP appointments, leading to more efficient use of patient and clinician's time, and
- Improving quality and ensuring value for money for the wider health economy through early identification of emerging local quality innovation prevention and productivity opportunities.

5. What work has been done on the technical aspects of service design over the past 12 months?

5.1 Work on the service design has been supported by clinicians and commissioning leads from primary care, mental health, planned care, unplanned care, public health and children's services; led by the Wilson Service Design Lead and East Merton Model of Health & Wellbeing Clinical Director, and governed by the Wilson SRO, Wilson Programme Board, Merton CCG's Governing Body and Primary Care Commissioning Committee. The minutes of these meetings are available to the public.

5.2 Space requirements have been developed by looking at current activity across a range of services. By reviewing how some existing services require patients to move between multiple sites and how much space activities such as administration and back office functions currently take up, we were able to look at how service providers can integrate better and work smarter without destabilising existing pathways. The outcomes were recorded in the participant's requirements which will be regularly checked with strategic partners to ensure they remain accurate throughout the project.

5.3 Work was undertaken to review how new and existing services being located at a single site at the Wilson would have a positive impact on the wider system. Some of this work was undertaken by researching comparable models elsewhere in the UK which operate using similar underlying principles.

5.4 In order to build up a complete picture we reviewed a selection of patient journeys over the course of a year, looking at frequency of 'touch points' – i.e. the number of times they visited their GP; had an avoidable non-elective admission or a referral to hospital outpatient; or visited their local A&E department.

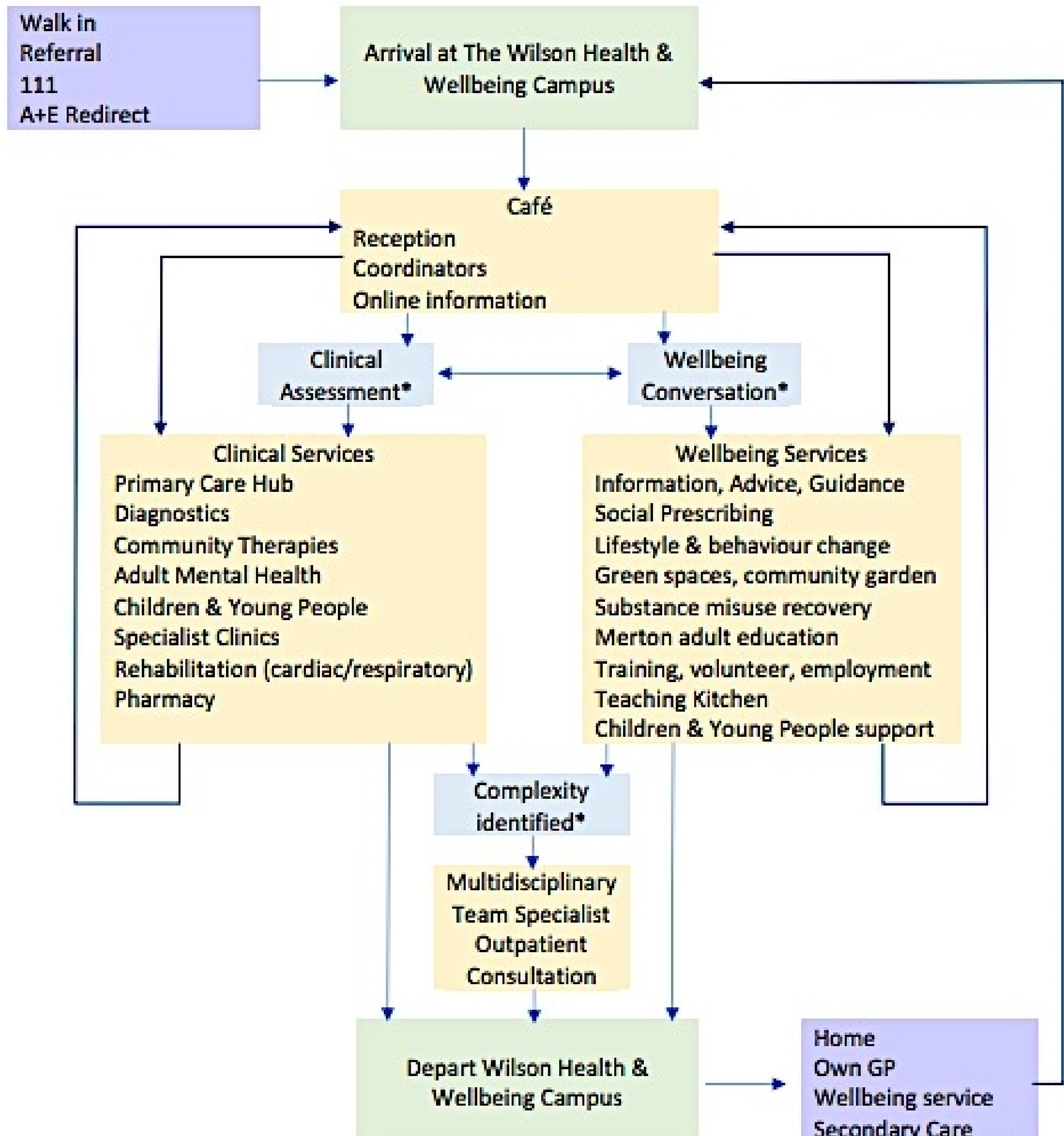
5.5 We also looked at relevant acute and non-elective activity in East Merton, and across the whole borough, over the same period. We then considered how services at the Wilson may improve people's experience, and how they could be better supported.

5.6 Project support has been secured beyond end March 2019 to establish a Wilson Wellbeing Steering Group. The group will identify emerging needs and appropriately shape existing and future wellbeing services and activities at the campus. The group will also explore what activities can be established sooner at the site away from the main building works, or via outreach under a 'Wilson Wellbeing' banner at other nearby locations.

5.7 The Wellbeing Steering Group will link with the Wilson Community Reference Group to ensure an effective approach to communications and engagement is maintained.

6. **What will the patient journey look like at the Wilson Health & Wellbeing Campus and what services are proposed?**

(*The outcome may identify another service outside the Wilson campus that is more appropriate.)



7. Will people be able to see a GP at the Wilson outside of normal surgery hours?

7.1 Improved access to primary care at the new Wilson Campus will be via on the day and pre-bookable advance appointments, ensuring people can see a doctor or other health professional when they need to in modern, fit for purpose premises. In addition, pre-bookable nursing appointments for patients requiring wound care will be available.

7.2 Local health professionals will pool responsibility for same day care and extended access and provide non-list based core and enhanced primary care.

7.3 There will not be a walk-in service but will save people time by avoiding lengthy waiting times. Anyone registered with a local Merton GP practice will be able to access appointments. Patients who arrive at the Wilson with an urgent need, or who are not registered with a local GP, may be triaged and booked in on the same day, or signposted to other suitable services including their own GP practice or another community-based provider. There will be more appointments available for children and working people.

8. What about other Primary Care based services at the new Wilson?

8.1 Place-based primary care led integrated health and wellbeing services at the Wilson will support local practices, GPs and other local health professionals to manage the patients they see frequently or those with complex needs as part of a multi-disciplinary team (MDT) model, where appropriate.

8.2 This approach creates opportunities to improve patient's experience of care that complements and supports local GP practices without risk of duplication or destabilising and does not require practice mergers or relocation.

8.3 Local GPs will work together at the Wilson along with other health professionals to provide a range of clinics and consultations, including group consultations if appropriate. Engagement and joint work with primary care colleagues is already underway to develop optimal ways of working which includes building on existing integrated models, and learning from successful models elsewhere in the country. In addition, primary care networks are being established as part of the government's Long Term Plan.

8.4 The MDT service at the Wilson will involve the GP as part of the bigger team and will be appropriate for an agreed specific patient population identified as being more likely to benefit from the services located at the site and those that need support to self-manage their condition. For example, patients diagnosed with diabetes who may need particular support with diet and exercise and who may

benefit from related group activities.

8.5 Patients can also be triaged and can be signposted back to their own GP or other service where appropriate but will be equipped with a range of support mechanisms to help them better self-manage their care.

8.6 There are benefits to having services in a community setting such as the Wilson, both for the patient and surrounding teams. Service design leads will explore virtual MDTs through advanced technology and the development of community based specialist and diagnostic services for all age groups, and how links with existing teams and clinics can be supported.

Patient Story - MARIA

Maria is a young working woman who lives with her husband and cares for her mother-in-law who has Chronic Obstructive Pulmonary Disease (COPD). The family experience money and employment problems when Maria's husband loses his job. Maria is feeling increasingly low and has back pain which is getting worse. Maria's GP refers her to the Wilson where the issues affecting her life are addressed, along with her back pain via the Musculoskeletal (MSK) service. Maria builds up confidence to include her family in her recovery.

Maria's full story can be read in Appendix A.

8.7 The new model at the Wilson for Musculoskeletal (MSK) services will see physiotherapists directing patients for Social Prescribing (via primary care) and better integration with mental health via the MDT. We can think about Group consultation with MSK if needed. We will encourage non-clinical staff to be aware of the self-referral options and physios could give free exercise information.

8.8 Intervention, effective diagnostics and links to mental health services have good associated evidence based results:

- Avoidance of inappropriate non-elective admissions;
- Fewer inappropriate A&E attendance and visits to GP;
- Improvements to patient quality of life and health outcomes;
- Increased uptake of appropriate physiotherapy.

9. Diagnostics at the Wilson – what are they and why are they important?

9.1 Diagnostic modalities within the facility are planned to support the clinical services provision. With a key focus on the detection and management of long term conditions and cancer, it is important that diagnostics are available to investigate and diagnose conditions earlier, including exacerbations and potential exacerbations without recourse to acute services.

9.2 Critical to this will be the availability of phlebotomy, plain x-ray and ultrasound, all of which will be available for referrals originating within the Wilson, and direct referrals from GPs.

9.3 Diagnostics will include:
- Plain X-Ray
- Ultrasound
- Echocardiogram and ECG will be available to investigate, diagnose and support patients, including those suffering with long term cardiac issues;
- Linked to the management of diabetes will be the provision of diabetic retinal screening;
- Phlebotomy will be provided to support the MDT specialties and available to GPs for direct referral;
- Facilities for near patient testing will be accommodated.

10. When it opens, the new Wilson Heath & Wellbeing Campus will be the new home for Primary Adult Mental Health services

10.1 A Primary Mental Health Care service will be based at the new Wilson campus. This service provides mental health & well-being care to residents of Merton and those registered with a Merton GP. Services are fully integrated to provide a comprehensive service in primary care and has links with secondary care specialist mental health services, social prescribing and community-based support services.

10.2 The three service components to the integrated service model are:
- Primary care management of people with more severe mental health concerns;
- Coordinated Wellbeing Service;
- Improved Access to Psychological Therapies (IAPT).

10.3 The service will focus initially on establishing effective care pathways for the following co-morbid long-term conditions:
- Diabetes
- Cardiology
- Respiratory Disease

10.4 The service will provide interventions that include the provision of sign-posting and supported referral into local services and organisations (e.g. debt, housing support, domestic violence services and self-help resources).

10.5 Although the vast majority (90%) of people presenting with a mental health problem are managed in primary care, there is increasing recognition that more

service users with mental health problems could be treated in primary care instead of specialist mental health services. The service at the Wilson will improve identification and awareness of common mental health disorders and promote onward referral for assessment and intervention and improve the interface between services for people with common mental health disorders, to ensure a seamless transfer between services.

10.6 Improving access to, and having an infrastructure for greater low-intensity mental health and wellbeing provision would offer support to a greater range of people in Merton and include those who may fall under the radar of acute services, people who feel lonely, isolated or have low self-esteem and have associated physical health problems, as well as those who could benefit from support with a range of social problems (e.g. housing and money issues).

10.7 Individual factors that increase the likelihood of developing mental health problems include homelessness, long-term illness, youth crime and low levels of physical activity. In Merton, levels of physical activity are lower than England and London averages. First time entry into the youth justice system is also a higher prevalence risk factor in Merton than elsewhere.

11. How will the new Wilson campus address the needs of children, young people and their families (including carers) to start well?

Patient Story - KARIM

Karim is a 16 year old with problems at home due to domestic violence. He is also being bullied at school and gets into fights. He began self-harming as a way of gaining control but things are getting worse. Karim's journey at the Wilson begins on a school trip when he meets someone at the Campus he feels he can trust. From there he is encouraged to talk about his problems and seek help for himself and his family. Karim's full story can be read in Appendix A.

11.1 The Wilson Health & Wellbeing Campus is an opportunity to develop multi-agency partnership working that will reduce the number of unnecessary appointments and streamline pathways for children, young people and families as well as provide a non-medicalised environment that will actively seek to engage children and young people. Services will interface with wider health and community wellbeing services and activities, encouraging young people and their families to come to the site.

11.2 The proposal for children, young people and families at the Wilson includes a centre for children with complex needs. Having one point of access to several services on one site is important for improving family journeys and supporting

early intervention. The centre will provide flexible space for multidisciplinary team (MDT) working to streamline services, including improved links to social services via outreach; community paediatrics, physiotherapy, Occupational Therapy (OT); Speech and Language Therapy (SaLT); psychology; Special Educational Needs & Disabilities (SEND). Having local Child and Adolescent Mental Health Services (CAMHS) based on site working in partnership with Community Paediatrics was also identified as an opportunity to improve the experience for children and their families.

11.3 Meeting the needs of the wider family would be beneficial, for example a child with complex needs may be accessing appointments and there may be services available for siblings to access at the same time. Service provision for children, young people and adults with Autism Spectrum Disorder (ASD) was identified as an opportunity on the site, including early assessment and diagnosis of autism, pathways and support for adults.

12. What additional services will be available to support people to live well and age well?

12.1 At the Wilson the social prescribing service will be a critical enabler to signpost people to a wide range of services based elsewhere in the local community and at the Wilson site that will support them with addressing some of the wider social determinants that affect their health and wellbeing. Patients who have been referred by their GP to existing social prescribing services have reported a positive impact on their health, wellbeing and lifestyle.

12.2 The scale of social prescribing planned for the Wilson means that we would expect any investment to have significant benefits on the local health economy, as well as:

- Improvements in physical and mental health patient outcomes;
- Improvements to patients' wellbeing and lifestyle;
- Better management and self-care;
- Better patient experience of health care;
- Improved access to supporting community based voluntary services in the locality.

Patient Story - WES

Wes is a 64 year old veteran who is having problems managing his diabetes and anxiety about his housing issues. Wes uses alcohol to cope and usually ends up at A&E when he is most vulnerable. It is at one of these visits that he is referred to the Wilson. Wes soon finds out his health and wellbeing really matter to the health professionals and other members in his diabetes group consultation sessions. He feels encouraged and supported to tackle his alcohol dependency and get help from a social prescribing coordinator. Wes's full story can be read in Appendix A.

12.3 Links to training volunteering, employment and community resources via social prescribing will support address health inequalities. This is may help relieve pressure on GPs by tackling the root cause of unemployment and making accessing help easier.

12.4 Information, Advice & Guidance (IAG) services will be available on sessional basis from the bookable rooms at the Wilson. These services are linked to the overall wellbeing model to provide support mechanisms and strategies for those suffering with ill health with regard to housing, benefits, employment, money and debt.

12.5 Lifestyle and behaviour change services will include stop smoking services, National Diabetes Prevention Programme (NDPP) and Expert Patient Programme (EPP). Benefits will be realised in fewer unnecessary hospital admissions for smoking related diseases and improvement to health outcomes leading to longer life expectancy. Prioritising obese individuals under the NDPP may help to obtain the greatest health benefits per individual targeted.

Patient Story - MARTA

Marta has been diagnosed with type 2 diabetes and has put on a lot of weight. English is not her first language and she is struggling to cope with her two children and the demands of her job which means she is lonely. Her GP referred her to the Wilson where she joined the diabetes expert patient programme and got involved in a community gardening scheme which had benefits not only for her, but for her children and some of the elderly people she came into contact with. Marta also learned about nutrition and how to manage her diet. Marta's full story can be read in Appendix A.

12.6 As well as ensuring an attractive and well-maintained environment, providing space at the Wilson campus for community gardening, or reciprocal growing schemes which connect people who have no garden with untended green space, is important to encourage inter-generational links to combat isolation and improve mental health. Benefits have also been reported in long-term reductions in overall reported health problems including heart disease, cancer and musculoskeletal conditions. Active environment schemes to encourage higher levels of physical activity have been linked to reductions in levels of obesity.

12.7 A Community Kitchen/Café will provide visitors, staff and patients with light refreshments as well as providing training and education to support management of diabetes and other related diseases. The café will be an essential meeting point for signposting and further navigation around the campus. We do not envisage competition with other local commercial cafes, however we will

continue discussions with Canons House to explore possible similarities and opportunities as plans develop.

13. Ongoing Community Engagement

13.1 Over the past months there has been renewed focus on the importance of community engagement to promote a positive story about the work to date. There is an agreed plan in place to seek engagement as the project progresses.

13.2 The Wilson Community Reference Group (WCRG) is now the overarching community engagement forum and provides regular updates to the Wilson Programme Board. The group focus is on shaping communications and engagement plans for future phases of work and advising on communications and engagement activity undertaken through the work of the wellbeing work stream in agreeing mechanisms for selecting activities and priorities. The group aims to provide representation from a broad range of patients and community and voluntary groups and has met twice since its inception in November 2018.

13.3 Members have also been involved in research to develop our initial Equalities Impact Assessment, ensuring we are clear of the impacts on different groups due to the development of the Wilson Health and Wellbeing Campus.

14. Conclusion & Next Steps

14.1 This paper has set out a new model for health and wellbeing at the Wilson that will see a significant improvement in health outcomes and experience for the residents of East Merton, along with commissioning and wider system savings mainly derived from a reduction in the reliance on hospital based acute services.

14.2 As shown in our patient stories, the Wilson will be a key place for people of all ages and backgrounds to stay healthy. Not only do proposed services provide people with the majority of support systems they require to self-manage their care but they will also have reasons to come back to the campus as a community destination to continue their journey outside of direct health-based care, with improved links to other services and activities available in the locality.

14.3 Further to recent updates we are working with partners on estimated plans to open the Wilson by the end of 2022. The Wilson will be part of the future integrated community service provision in Merton. The next step will be to confirm a set of outcomes for the Wilson in order to develop the required specifications for commissioning integrated health and wellbeing services at the appropriate time. Specifications will also align to the NHS Long Term Plan, with particular reference to improvements in workforce skills mix, recruitment and retention,

integration and digital advancement.

15. ALTERNATIVE OPTIONS

15.1 N/A

16. CONSULTATION UNDERTAKEN OR PROPOSED

16.1. Undertaken with clinical and commissioning leads for accuracy and viability.

17. TIMETABLE

N/A

18. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

18.1. N/A

19. LEGAL AND STATUTORY IMPLICATIONS

19.1. N/A

20. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

20.1. EIA undertaken.

21. CRIME AND DISORDER IMPLICATIONS

21.1. N/A

22. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

22.1. Managed as part of the wider Wilson Programme and included in the CCG corporate risks, along with mitigations.

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

Appendix A – Wilson Health & Wellbeing Campus Patient Stories

24. BACKGROUND PAPERS

N/A

Wilson Health & Wellbeing Campus
HWBB Appendix A – Patient Stories

Lucy Lewis – Head of Estates Merton CCG
Dr Doug Hing – Clinical Director Merton CCG

March 26th 2019

Wilson
Health & Wellbeing

Introduction

Wilson Health & Wellbeing

- Although they are fictional, our patient stories on the next few pages are directly based on local GP's experience of real patients in East Merton and have been voiced in the person's 'own' words.
- In order to build up a complete picture we reviewed a selection of patient journeys over the course of a year, looking at frequency of touch points – i.e. the number of times they visited their GP; had an avoidable non-elective admission or a referral to hospital outpatients; or visited their local hospital's A&E department. We also looked at relevant local A&E and non-elective activity over the same period.
- We then considered how services at the Wilson may improve the person's experience of accessing healthcare and how they could be better supported by improving signposting to services located at the Wilson Health & Wellbeing Campus and in the local community.

"My name is Karim. I'm 16 and live in Mitcham. I share a room with my two little brothers. I support Chelsea and I want to go to college and learn to design computer games. This is my life right now."

I am bullied at school. I had a mentor but people found out so I haven't been to my meetings.

I keep getting into fights at school. I can't seem to control my temper and I've been told I'll be kicked out if I don't change.

Dad was a refugee. He has mental health issues and doesn't work. He shouts at Mum, nothing is ever right. Most of the time I hate being at home and stay in my room.

I feel very angry a lot of time. I don't know what's wrong with me. I can't tell my family and I don't trust my friends.

Mum takes me to the doctor when I say I'm ill. He asked me if I was OK but he goes to the same Mosque as Dad so I don't trust him with my secrets.

I try to protect my brothers from my Dad. He gets really angry. He can't help it but he hits us all the time.

I cut myself when I feel really out of control. It calms me down but I had to go to hospital a couple of times because a cut got infected.

I have exams coming up and can't concentrate. I argue with my teachers. I don't really care anymore.

Wilson
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"Last week we went to the new Wilson Campus on a school visit. This guy called Dylan showed us round. He's a Youth Worker and coaches football on Saturdays. I liked him because he supports Chelsea and when he was a kid he tried out for them. When I got home I checked out the Wilson website and messaged a support worker who said I could drop in anytime and see Dylan if I wanted to.

When I got to the Wilson I messaged Dylan. It was cool because he met me in a private space just off the café area. I told him a bit about myself. It was hard but I told him about getting angry at school and being in trouble. I showed him my arm which was sore because of a wound. He said he thought it would be good for me to get a clinical assessment while I was there, he explained about confidentiality and I trusted him so I said OK."

Karim met with a triage nurse with mental health background who reviewed his wound and asked him about some of the things that were going on his life. After a while he felt able to talk about his moods and thoughts of harm. He also felt safe enough to share some details about domestic violence at home, including the physical and emotional abuse by his father who has a mental illness and how he worried about his Mum and brothers and getting kicked out of school.

The nurse felt reassured there was no immediate risk but explained the focus on safety. She told Karim that a discussion with the GP at the Wilson was required and explained why. The GP diagnosed Karim with depression and discussed some options for management. He also explained the role of social services and the multidisciplinary team meeting at the Wilson.

Karim felt a little overwhelmed – he didn't have anyone to go to the meeting with and it sounded intimidating - but the GP said he could ask Dylan to come along if that would help. He messaged Dylan who agreed to come and they made the appointment.

At the multidisciplinary meeting Karim and Dylan met various professionals including a GP; Child and Adolescent Mental Health Services (CAMHS) consultant; Social Services worker and his mentor from school. Karim was surprised that the discussions very much involved him, what he thought he needed and what he thought could help. He was asked about what links he could see between school, home and his condition.

Karim admitted to being systematically bullied at school, having all his money taken daily which meant he could not buy anything to eat. Recently he had been harassed on his way to and from school too and called names on social media.

"At the end of the meeting, I felt like I knew what all the different professionals did and who I needed to meet with again to support me. I felt more confident about sharing how things are with my Mum too. She was upset at first but agreed to come to future meetings with me. She's going to talk to Dad too and hopefully get him help at the Wilson with his mental health issues.

Dylan set me up with a football trial for a local team next month and I'm really looking forward to it. Things are better at school and I'm not ashamed of seeing my mentor now. He's helping me apply for college so that I can go to Uni in a few years – watch this space!"

Wilson
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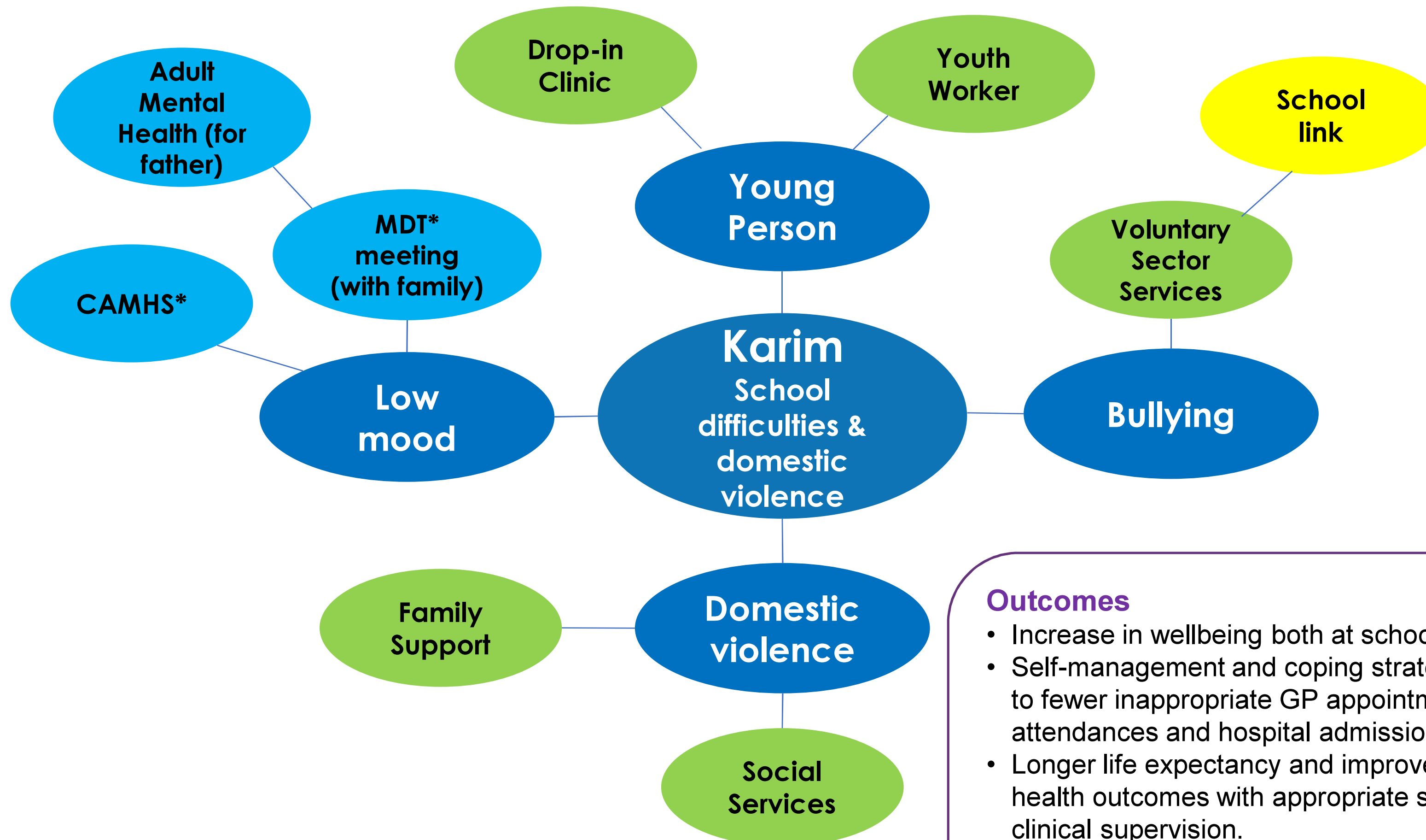
Karim's proposed pathway at Wilson Campus



Outcomes

- Increase in wellbeing both at school and home;
- Self-management and coping strategies leading to fewer inappropriate GP appointments, A&E attendances and hospital admissions;
- Longer life expectancy and improved mental health outcomes with appropriate support and clinical supervision.

**CAMHS – Children's & Adolescent Mental Health Service*
**MDT – Multidisciplinary Team*

Wellbeing services
Health services
Other community links

Wilson
Health & Wellbeing

"**My name is Wes.** I'm getting on for 65 and was in the army for 30 years. I have diabetes and when I get anxious I drink too much. This is my story."

I live on my own and that gets me down. I feel better when I have a drink but I know I'm not coping well.

I worry about money. My housing situation gets me down too. I used to be so independent but now I'm on housing support and feel I've got no purpose.

My neighbour found me on the floor unconscious a couple of times – she saved my life by calling the ambulance.

I go to A&E a lot. I know I shouldn't but I don't know where else to turn. The nurses are lovely but I know I'm wasting their time.

I don't see my daughter anymore, she said I can't see my grandkids unless I stop drinking.

My GP talked to me about diabetes. She gave me some Insulin but I keep forgetting what to do. I don't know anyone else with diabetes, it scares me a bit.

I don't cook for myself since my wife died so my diet isn't good. I've lost a lot of weight and I get quite unwell.

A lot of bad stuff happened to me in the army. I try not to dwell on it and it's hard to talk about. Some situations make me feel anxious.

"One day I went to the Emergency Department. I totally broke down. I was really worried about my health. The triage nurse said that my condition was stable and I didn't need to be seen in hospital that day, but he said he could book me in to the new Wilson where I could talk to someone about my anxiety, as well as learn how to manage my diabetes if I wanted to. The nurse told me my notes could be shared so that wouldn't be a problem. I agreed, he called them and booked me in for a review straight away. I took the bus from the hospital which took about half an hour. I followed the signs to the Wilson Health & Wellbeing Campus which was easy to find.

When I got there it wasn't like an other health centre I've ever been to. It was friendly and relaxed with people of all ages sitting in and around the café. I went to Reception and they said they had been expecting me when I said my name. I was still quite worried but a volunteer got me a cup of tea and we had a nice chat which made me feel better. She said she'd been helping a group of people to learn to use the internet. I said I'd probably have a go myself when I felt more confident."

Before long, a nurse called Wes into a room just off the cafe and asked about his symptoms before doing some basic checks. Wes then saw a GP who had access to both his hospital and GP records and asked him why he had gone to the A&E earlier that day. The GP noted that there were up to date blood tests but no diabetic review and asked Wes if he would be interested in having that done today, as well as exploring the services at the Wilson to support him.

Wes spoke to the GP about his current lifestyle and how he felt about his drinking. He knew the time had come for him to take control of his health in order to be able to see his daughter and grandchildren. Wes also spoke about his fear of diabetes and its effects on his life. He agreed to have some tests done now and to being referred for a Group Consultation meeting to review his results. Wes went for the diabetes review which included having his eyes checked, and spoke to a Coordinator about Social Prescribing who explored what was important to him and the issues about his housing and worries about money.

The Coordinator explained the various Wellbeing services, including a teaching kitchen where Wes could learn how to cook some basic meals for himself and also helped Wes to make appointments with organisations to help him get advice on his housing and money worries. A week later, at the Group Consultation meeting, Wes was greeted by the same coordinator and met several other patients who had all agreed to sharing their results. He felt reassured by the opportunity to get to know the other patients and to plan some of the questions everyone wanted to ask.

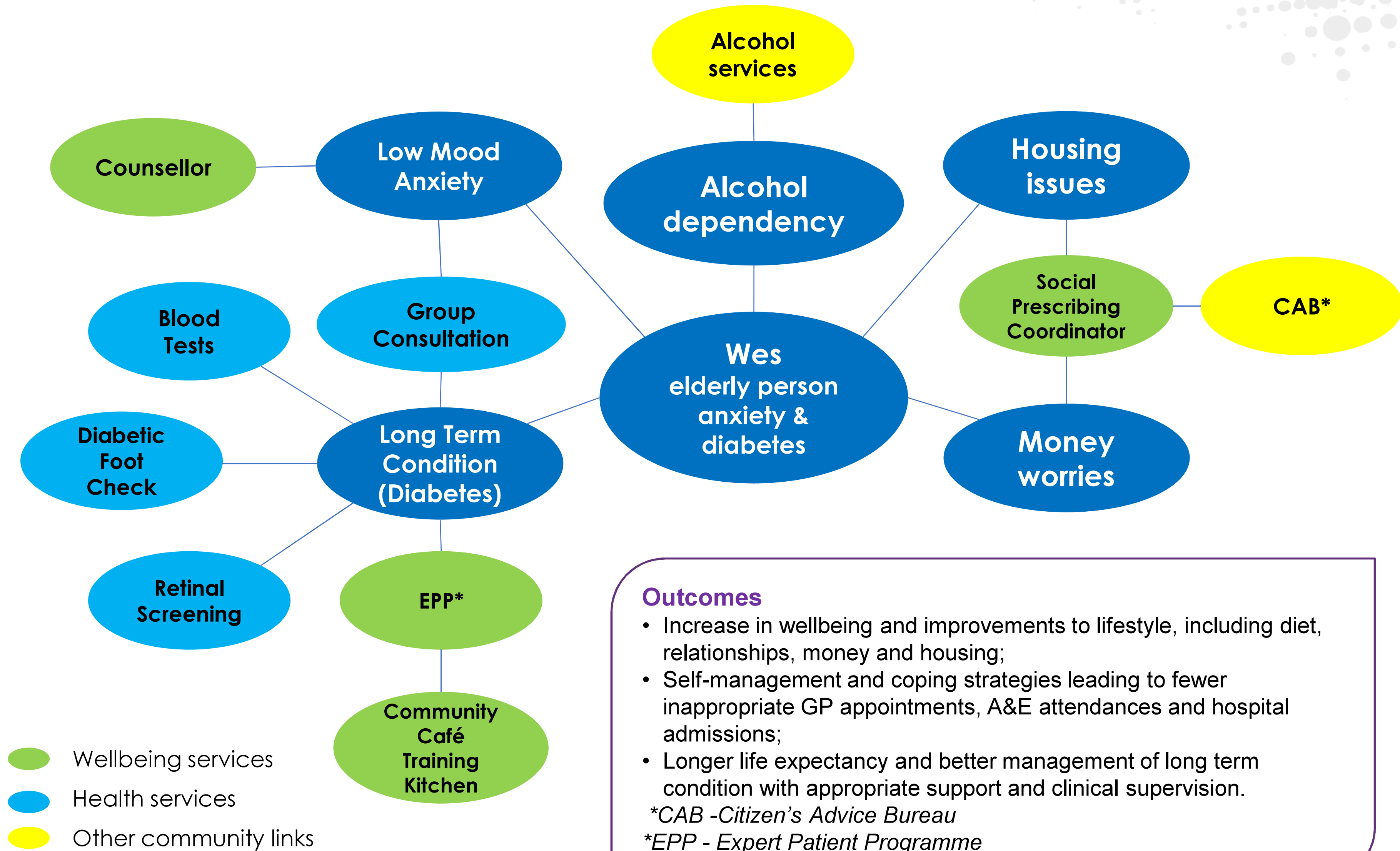
A consultant from the local hospital then came and talked about everyone's results before spending some time with each patient to think about an individualised plan. Wes found it helpful to hear the discussions and the ideas his colleagues came up with. By the time it was his turn, he had already started thinking about what he could do.

Wes was surprised that the discussion very much involved him: what he thought he needed and what he thought could help. He was asked what links he could see between his lifestyle and his condition. It was surprising for Wes to hear how concerned the consultant was about alcohol, diet and diabetes. Wes felt safe and supported enough to talk about his mood and some of the things that worried him, and this highlighted another reason for his alcohol use.

"I felt a lot clearer after the meeting. I now know when to go to the Emergency Department and when to see my GP. I learned about what I can do to help myself in between clinic visits and have got help to sort out my finances and housing issues. After a while I decided to access the alcohol support as well as the diabetes expert patient programme. I've met so many people and we all support each other – some are now good friends. I've enrolled for a course at the teaching kitchen and about 6 weeks ago I started talking with a counsellor about my anxiety which the counsellor felt was related to PTSD and my time in the army.

I would say I'm starting to feel more in control and am definitely coping better. I've been in touch with my daughter and told her all about what I'm doing. It was lovely to talk to her and I can't wait to see my grandkids when she's ready. I've told her I'll cook them all a meal - so no pressure!"

Wes's proposed pathway at Wilson Campus



Outcomes

- Increase in wellbeing and improvements to lifestyle, including diet, relationships, money and housing;
- Self-management and coping strategies leading to fewer inappropriate GP appointments, A&E attendances and hospital admissions;
- Longer life expectancy and better management of long term condition with appropriate support and clinical supervision.

**CAB -Citizen's Advice Bureau*

**EPP - Expert Patient Programme*

Wilson
Health & Wellbeing

"**Hi I'm Maria.** I live with my husband and mother in law. I work as an admin assistant. I have back pain and it isn't getting better."

My mother in law is lovely but she is often unwell and I look after her personal care. We want her to stop smoking.

I do all the housework even though both of us work full time. I am often in pain and get really tired.

I have always had asthma but when I was given pain killers it got worse.

I was in a minor car crash recently, it wasn't serious but I have had problems with my lower back ever since.

I used to love going out with friends but my back pain often means I come home early and my friends have stopped asking me now.

I worry constantly about money.

I get pains in my wrist and shoulder at work. My boss said he'll get me a special chair but nothing has been done yet.

"I went to A+E after my accident. They did some X-rays but they didn't show anything serious, they gave me pain killers but they made me feel awful and brought on my asthma. The pain didn't go away and I started to get really irritable and exhausted. Then my husband was made redundant. It has been hard to cope on even less money and my back pain has got worse.

I went to my GP - I wanted an MRI but she suggested some basic exercises and blood tests first to exclude arthritis. She also gave me the option of a physiotherapy review at the new Wilson Campus. I was a bit dubious at first – surely I should be going to hospital for all this, but she said that they could look after me at the Wilson which would save me time and be easier to get to. My husband drove me and dropped me at the temporary parking bay. He said he'd come and get me later so we could visit the leisure centre together."

After arriving for her appointment, Maria had some blood tests done. She also saw a physiotherapist who checked her previous scans and arranged an ultrasound scan and joint injections for her shoulder. Maria also saw a pharmacist who advised her about medications. She was offered a course of physiotherapy.

Months later although Maria's shoulder improved, she was getting worsening back pain and after a few regular physiotherapy sessions, she was referred to a pain clinic which included seeing a psychologist. Maria talked about her finances, having to look after her mother in law who was unwell with COPD and her worries about her husband's recent redundancy which was making him depressed.

At home, Maria told her husband about her appointment. She told him there were people that could help them at the Wilson and made an appointment to speak to a Social Prescriber who arranged an appointment for them both with Information, Advice and Guidance regarding employment, money and debt.

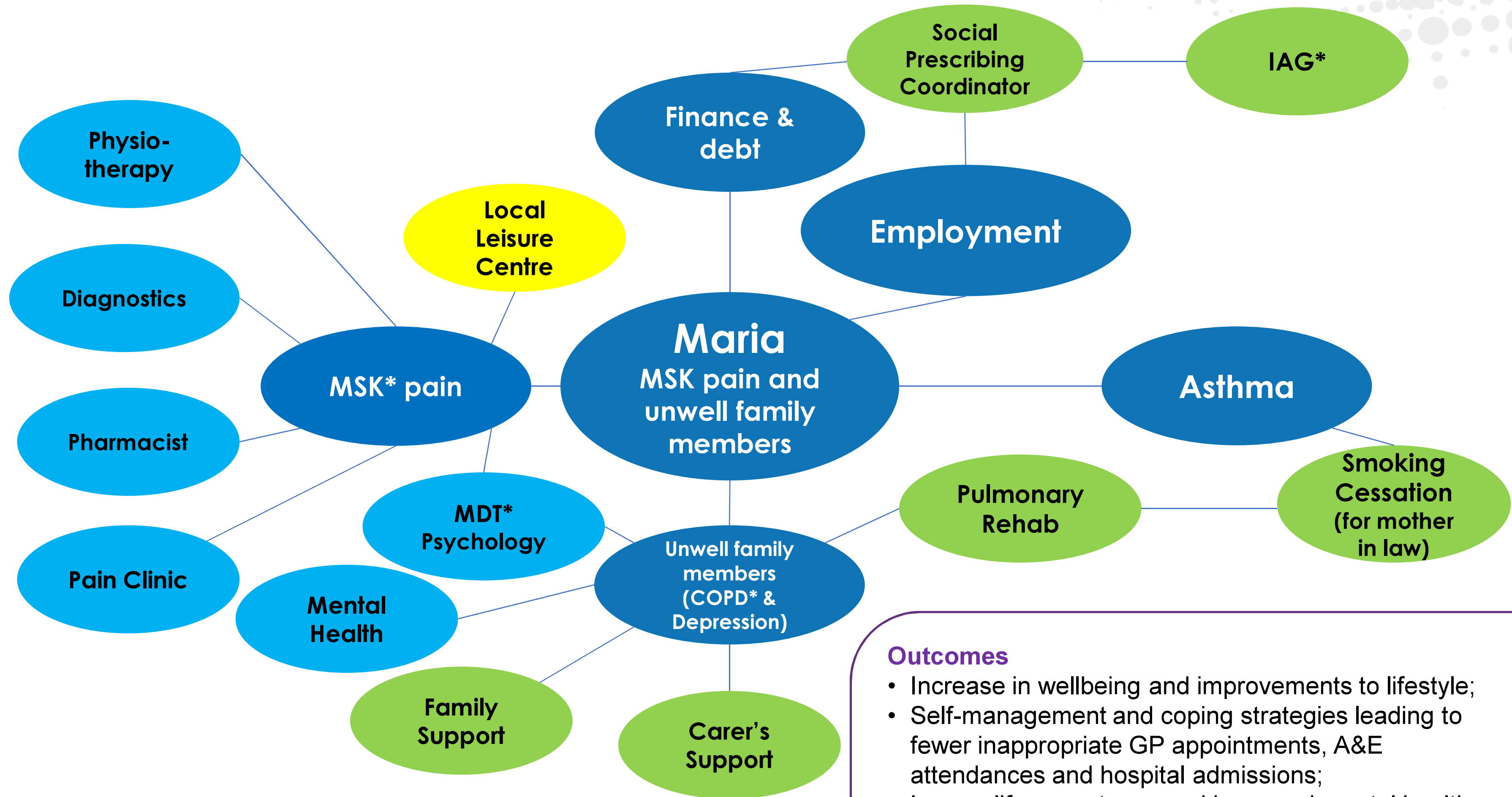
Maria and her husband received helpful support during their appointment. A multi-disciplinary team meeting was also arranged where Maria could bring her family. Maria went with her husband and found it very helpful as she didn't know how to address the strain of caring for his mother directly with him. A facilitator at the multi-disciplinary team meeting helped them both to identify their issues and explained the different teams and services available, including what they could access at the Wilson site and what they needed to go back to their own GP for.

They were pleased to learn about mental health support for her husband, carers support for herself and the respiratory services including pulmonary rehabilitation for her mother in law. Maria could bring her husband and his mother to future appointments also. Together, they made use of the garden spaces after each visit and all agreed to help the mother in law to reduce her smoking and increase their exercise at the nearby leisure centre too.

"It has been a while since we all started going to the Wilson. Facing up to issues around debt and caring for my mother in law have really helped our relationship. My mother in law has given up smoking now that she has support and goes to the Wilson for her pulmonary rehab and gets a dial-a-ride lift up the road to the leisure centre for a gentle keep fit class.

My husband found another job and is helping out much more at home. My back pain is better as a result of taking time to care for myself and regular physio. I've even been out with the girls again!"

Maria's proposed pathway at Wilson Campus



- Wellbeing services
- Health services
- Other community links

Outcomes

- Increase in wellbeing and improvements to lifestyle;
- Self-management and coping strategies leading to fewer inappropriate GP appointments, A&E attendances and hospital admissions;
- Longer life expectancy and improved mental health outcomes with appropriate support and clinical supervision.

**COPD – Chronic Obstructive Pulmonary Disease*
**MDT – Multidisciplinary Team*
*MSK – Musculoskeletal
*IAG – Information Advice & Guidance

"**My name is Marta**. I live on my own with my two children. I am a part time cleaner on a zero hours contract. I was diagnosed with Type 2 diabetes."

If I spoke better English I could say hello to the Mums from school, and maybe join one of their coffee mornings.

My family are far away and my husband has gone back to Poland for a bit to help his father out.

Looking after children is hard on my own. My eldest is in trouble at school. They send me letters but I don't understand what they say so I ignore them.

I have put on a lot of weight. I don't like the way I look now and try to hide under baggy tops and leggings.

I love gardening but there is no outside space where I live now.

I would like to look after elderly people like I did in Poland. I did their cooking and cleaning and kept their gardens nice.

"I went to see my GP who spoke to me through the interpreting service. She diagnosed me with Type 2 diabetes and prescribed Metformin but then she asked me if there was anything else because I was nearly in tears. I told her I was feeling unhappy – I had put on so much weight and was finding it hard to make friends because I didn't understand the language. The GP referred me for an appointment the following week at the Wilson Health & Wellbeing Campus.

It was lovely, with a landscaped entrance and right in the middle of the main building was a café. A man carrying an iPad came up to me and told me his name. He said he was a volunteer greeter and asked if he could help. I said I didn't speak English but told him my name. He found my appointment on his iPad which also translated a message to me in Polish. I was a bit early so he said I could wait in the café and leave my youngest son in the temporary play area if I wanted. He came to find me when it was time for my appointment."

The GP had shared Marta's notes with a support coordinator and informed her that she spoke Polish so an interpreter service had been pre-arranged. The coordinator had also downloaded and printed a leaflet about self-managing diabetes in Polish and had a meeting with the diabetes specialist consultant at the Campus. One of the first questions the coordinator asked Marta when she came in for her consultation was what mattered to her most at the moment?

Marta thought for a moment and found herself sharing some of the things that were worrying her - her eldest child getting into trouble at school, letters from the school which she didn't understand, lack of knowledge about her newly diagnosed diabetes and fear about the implications of her condition, her weight gain and that she had been lonely and depressed since her husband had left to manage his father's business back in Poland for 3 months.

The coordinator listened carefully, he heard Marta say that back home in Poland she had looked after several elderly people in the community where she had lived, preparing their meals, looking after their homes and tending their gardens. The coordinator helped Marta prioritise and decide what she wanted to do. He advised her to take small steps and keep in touch with him so that he could see how she was progressing, and help to motivate her if needed.

Between them they agreed a plan for Marta which focussed on understanding her diabetes and how to manage it by joining the Expert Patient Programme; learning English to help her communicate better and hopefully start to make friends and understand her diabetes and lose weight.

Marta agreed to come once a fortnight to help out with the community gardening project – children were welcome to join in too so that young and old could mix. This was very beneficial to the elderly people who often lived far from grandchildren, or who were lonely. The coordinator fed back a summary of Marta's consultation to her GP and gave updates at MDT meetings.

"At the end of the meeting I felt like a sense of relief. I am looking forward to improving my English and can't wait for the Expert Patient Programme to start. I know being with other people who are going through the same thing and trying to lose weight will help me so much.

I have started volunteering at the gardening club. We are growing carrots and lettuce and the kids are so excited. The older people we met are lovely and they made such a fuss of the boys. One lady has invited us over for Sunday lunch. She has a big garden we can visit anytime – I can't wait!"

Marta's proposed pathway at Wilson Campus

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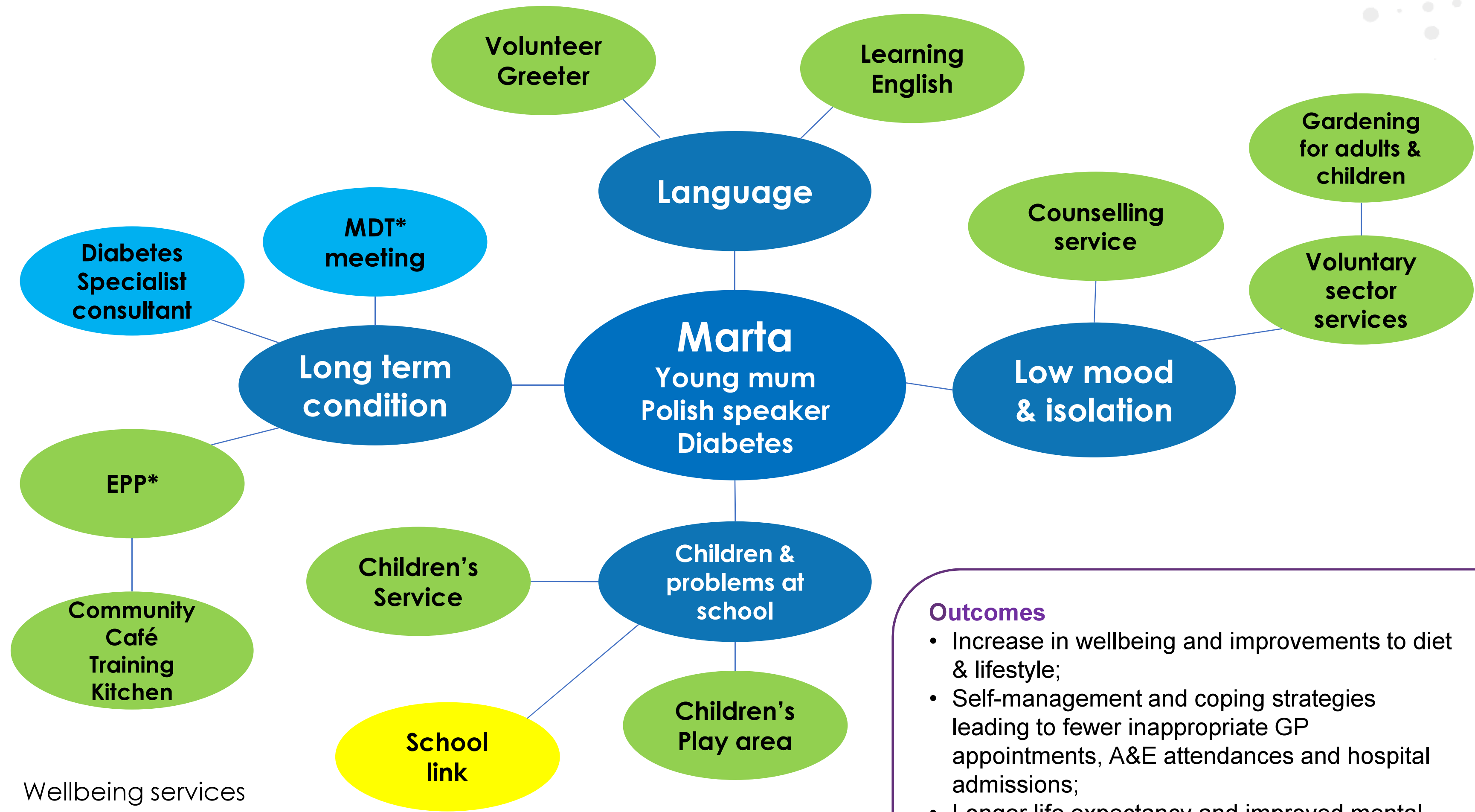

Wellbeing services
Health services
Other community links

Outcomes

- Increase in wellbeing and improvements to diet & lifestyle;
- Self-management and coping strategies leading to fewer inappropriate GP appointments, A&E attendances and hospital admissions;
- Longer life expectancy and improved mental health outcomes with appropriate support and clinical supervision.

**EPP – Expert Patient Programme*
**MDT – Multidisciplinary Team*

Understanding local health and wellbeing needs
Vision for the campus
Design phase
Wellbeing services for East Merton
Planning application process
Building work
Services and staff move into campus
Campus opens to the public
The community will be involved every step of the way

Wilson
Health & Wellbeing

Committee: Health and Wellbeing Board

Date: 26th March 2019

Wards: All

Subject: Tackling Diabetes and promoting Child Healthy Weight

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

Lead member: Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health and Councillor Kelly Braund, Cabinet Member for Children's Services.

Contact officer: Barry Causer, Head of Strategic Commissioning (Public Health).

Recommendations:

HWBB members are asked to:

1. Note the key messages from the Annual Public Health Report on Diabetes, which will complement the Tackling Diabetes Action Plan and refreshed Child Healthy Weight Action Plan.
2. Discuss and endorse the Health and Wellbeing Board's Tackling Diabetes Action Plan and the refreshed Child Healthy Weight Action Plan.
3. Note the launch of the Tackling Diabetes and Child Healthy Weight Action plans, Sugar Smart Campaign and Merton Mile on the 4th April 2019 and confirm their attendance.
4. Register for the Sugar Smart Campaign (www.sugarsmartuk.org/get_involved/take_a_pledge/) with a view to agreeing a pledge to champion and implement in their respective teams/organisations.

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1 Purpose of report and executive summary

1.1. The purpose of this report is to share the approach taken to the development of the Health and Wellbeing Board's Tackling Diabetes Action Plan and refreshed Child Healthy Weight Action Plan, to ask the Board to endorse the action plans and to note the planned launch event for the 4th April 2019. It also gives key messages from the Annual Public Health Report on Diabetes complementing the action plans.

2 Background

2.1. In June 2017, the Health and Wellbeing Board agreed to build upon its previous work on promoting child healthy weight and to focus as a partnership on tackling diabetes. This followed a presentation to the Board by local GPs highlighting the unabated epidemic and insufficiency of trying to tackle diabetes as a medical problem only.

2.2. In response the Board agreed to adopt a ‘whole system approach’ across the life course, using the focus on diabetes as an exemplar for developing holistic care (covering physical, mental and non-clinical personal support) hand in hand with creating a healthy place. Both with a strong focus on understanding what most matters to local people and actively engaging all board partners across Merton; whilst accepting and encouraging lessons learnt along the way.

2.3. The first phase of the Whole System Approach to tackling diabetes was the Diabetes Truth Programme (see background papers). Running between January and March 2018, it connected the HWB members with residents who have a lived experience of diabetes; bringing to life the challenges that residents face on a day to day basis and identified areas that the HWB can focus on. It showed us what matters to residents and also reinforced our commitment to working with residents and communities as an integral part of the solution.

2.4. The engagement was continued in October 2018 through two mini-conversations, where we delved deeper into the issues and challenges that were identified in phase one of the programme. These mini-conversations, attended by 37 residents, were designed and delivered by Merton CCG and Merton Public Health and amplified the messages heard during the diabetes truth programme.

2.5. This insight alongside data analysis and a review of the evidence, when aligned with significant partnership work led by Public Health and the CCG, has informed the development of a Tackling Diabetes Action Plan.

2.6. There are clear synergies between tackling diabetes and promoting child healthy weight and with childhood obesity still high and remaining a local priority, the Child Healthy Weight Action Plan, originally approved by the Health and Wellbeing Board in March 2017, has also been refreshed.

2.7. The 2018/19 Annual Public Health report has been designed to support both Plans, by providing context and describing opportunities for further learning.

3 Details

<u>2019 Annual Public Health Report</u>

3.1 Under the Health and Social Care Act 2012, the Director of Public Health is required to produce an Annual Report on a topic of their choice and published by the Council. In 2019, the Annual Report is complementary to the Tackling Diabetes Action Plan and refreshed Child Healthy Weight Action Plan. The report will be published at the same time as the action plan, on the 4th April 2019.

A brief overview and the key messages of the report is attached at Appendix one.

<u>Tackling Diabetes Action Plan.</u>

3.2. Approximately 6% (11,160) of the registered adult population in MCCG are currently diagnosed with diabetes; a further 2% (2,585) are estimated to be undiagnosed, and 11% (18,450) have non-diabetic hyperglycaemia (pre-diabetes). If nothing changes, it is estimated that the total prevalence will

rise by 5,000 to 9% over the next 10 years. Diabetes currently consumes approximately 10% of the overall NHS budget, and this too is projected to rise. The Annual Public Health Report has additional facts and figures, which complements the action plan.

3.3. The Tackling Diabetes Action Plan (see appendix two for full plan and a 'plan on a page')) has 15 high level actions over the initial five years of what is proposed to be a ten year plan (aligned to the NHS Long Term Plan). It is not an exhaustive list of all activities and actions that contribute to tackling diabetes; it contains a small number of high value actions that, when delivered together, are expected to have the most impact in Merton.

3.4. The plan has been developed across 3 themes (see below), each with a lead organisation or where appropriate joint leads. Actions have been developed in direct response to the findings of the Diabetes Truth programme, the review of existing and emerging evidence on what works to prevent and manage diabetes and significant partnership work with colleagues across Merton including MCCG, CLCH, SWL Diabetes Team, VCS partners and colleagues across Merton Council.

Tackling Diabetes Action Plan
(2019-2024)

Theme 1: Clinical Oversight and Service Improvement (MCCG)	**Theme 2: Holistic Individual Care (MCCG & LBM)**	**Theme 3: Healthy Place (LBM)**

3.5. Due to the nature of the partnership approach, the Tackling Diabetes Action Plan has a number of high value actions for organisations across Merton, including Merton Council and other partners across the health and care system. These actions include the commissioning of evidence based services, securing sufficient places (for when existing capacity is fully used) in the national diabetes prevention programme to avoid disease onset in very high risk patients, better education programmes for those who have been diagnosed, the on-going engagement of residents in service improvement, and developing holistic pathways that link services together e.g. mental health services for people with diabetes and access to non-medical support e.g. social prescribing.

3.6. Theme 3 of the Tackling Diabetes Action Plan and the refreshed Child Healthy Weight Action Plan have been aligned to focus on the importance of creating a 'Healthy Place'. When we talk about healthy place, we mean the physical, social, cultural and economic factors that help us lead healthy

lives by shaping the places we live, learn, work and play. These factors also shape the choices we face, for example around the food we eat. Actions within this theme include promoting the sugar smart campaign, managing fast food takeaways near schools, tackling unhealthy advertising and taking action in key settings such as workplaces and schools e.g. through the School Neighbourhood Approach Pilot (SNAP).

3.7. With regards to the resources needed to tackle diabetes, a business case has recently been approved by MCCG, which will deliver a new model of patient-centred diabetes care through developing and transforming existing diabetes care. An additional investment of approximately £1.2 million over 3 years in primary and community care will result in improved management of those who are at risk of living with diabetes, through screening, identification and annual monitoring of patients. For the council, leading on creating a 'Healthy Place', a focus will be on the effective use of existing mechanisms such as the Local Plan and galvanising political support to use new opportunities to work across the council on cross-cutting issues e.g. the use of parking charges to reduce car use and sedentary behaviour.

Childhood Healthy Weight Action Plan 2019-2022.

3.8. It is clear that if we are able to reduce obesity levels we could potentially reduce the numbers of people with type two diabetes in the future and there are clear synergies between the two action plans; the Tackling Diabetes Action Plan and the Child Healthy Weight Action Plan.

3.9. In Merton, 1 in 5 children entering reception class (4-5 year olds) and over 1 in 3 children leaving primary schools in Year 6 (10–11 year olds) are either overweight or obese with higher rates seen in the east.

3.10. Obesity is a complex problem and there is no single solution. Evidence indicates that a comprehensive programme that focusses on delivering population wide changes across aspects of the physical, food and cultural environment is most likely to be successful, and cost effective, together with approaches with specific communities and groups and hence the approach in Merton.

3.11. The previous Merton Child Healthy Weight Action Plan was developed and implemented from 2016-2018. This plan has had significant successes in progressing work to tackle childhood obesity locally. The refreshed Plan is based on a review of the evidence, engagement with residents in east Merton (The Great Weight Debate Merton- see background papers) and considerable partnership working over the past 3 years; including discussions at the multi-disciplinary and multi-sectoral Child Healthy Weight steering group.

3.12. A number of lessons were learnt in successfully delivering the first Child Healthy Action Plan which have also informed the refresh process and draft plan presented here. These key lessons include:

- **Maintaining a broad and committed partnership approach -** This has led to the refreshed plans theme 1 focus on 'making childhood obesity everyone's busy' – taking a whole system approach and emphasising partnership working.

- **Maintaining momentum and engagement -** This has led to the focus on developing an effective partnership communications and engagement plan, to provide a co-ordinated approach to maintaining the momentum and reach of messages and interventions to tackle childhood obesity.
- **The challenges of co-ordinating an ambitious action plan –** relationships between partners have now matured to the point where the proposed refreshed action plan can focus on a small number of 'high impact' actions.
- **Making the most of what other people do -** With the challenge of limited resources, a key focus of the refreshed plan is to make the most of the opportunities and assets available to us including drawing on learning from elsewhere.

3.13. The refreshed 2019-2022 action plan (see appendix three for full plan and a 'plan on a page') has been divided into three key themes (see below).

Merton Child Healthy Weight Action Plan (2019-2022)

Theme 1: Making Childhood Obesity Everyone's Business	Theme 2: Supporting Children, Young People and their Families	Theme 3: Healthy Place

3.14. Theme 3 as detailed above has been aligned in both the Child Healthy Weight Action Plan and the Tackling Diabetes Action Plan to focus energy and resource. Creating a 'Healthy Place' will also feature within the refreshed Health and Wellbeing Strategy and the Merton Health and Care Together Plan (MHCTP) recognising its importance in promoting health.

3.15. The Tackling Diabetes Action Plan will be managed on a day to day basis by the CCG led Diabetes Steering Group and the Child Healthy Weight Action Plan will be managed by the Public Health led Child Healthy Weight Steering Group. Each will report performance to the Merton Health and Care Together Board and ultimately to the Health and Wellbeing Board.

Launch event

3.16. An event has been planned for 4th April 2019, which will launch the following 'bundle' of initiatives:

- The Tackling Diabetes Action Plan and Annual Public Health Report.
- The refreshed Child Healthy Weight Action Plan (2019-22).

- Sugar Smart campaign[1]
- The Merton Mile: A one mile signposted route around Figges Marsh to support families and individuals to be active, building on The Daily/Active Mile initiatives delivered in schools.

3.17. The launch will provide an opportunity to bring together senior leaders and partners to celebrate progress, listen to people's lived experience, look forward to make a positive impact through the delivery of the action plans and will include an opportunity for invitees to join children from a local school to run or walk the Merton Mile route in Figges Marsh.

3.18. Following on from his leadership in raising awareness of diabetes at a national level and his personal success in tackling his own type two diabetes, Tom Watson MP has been invited to attend the launch by Councillor Stephen Alambritis.

3.19. Members who have not done so already are also asked to register for the Sugar Smart Campaign with a view to agreeing a pledge to champion and implement in their respective teams/organisations. This can be done at the following www.sugarsmartuk.org/get_involved/take_a_pledge and pledges in advance of the 4th April will be promoted at the launch event. Registration will prompt contact from the Public Health to discuss and agree suitable pledge/pledges.

4 Alternative options

Not to develop a strategic framework to tackle diabetes or promote child healthy weight and not to work with HWB and communities to better understand diabetes.

5 Consultation undertaken or proposed

Significant consultation has taken place and informed the action plans including the Diabetes Truth programme and subsequent mini-conversations, a presentation at the MCCG led Patient Engagement Group and discussions with key stakeholders including VCS representatives.

6 Timetable

None

7 Financial, resource and property implications

None

8 Legal and statutory implications

None

9 Human rights, equalities and community cohesion implications

[1] Sugar Smart campaign information: https://www.sugarsmartuk.org/

The Action Plans are specifically aimed at tackling health inequalities.

10 Crime and Disorder implications

None

11 Risk management and health and safety implications

None

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

12.1. APPENDIX 1: Overview and the key messages of the APHR

12.2. APPENDIX 2: Tackling Diabetes Action Plan.

12.3. APPENDIX 3: Child Healthy Weight Action Plan

13 Background papers

13.1. HWB paper (28 November 2017) Diabetes Strategic Framework (Whole System Approach)

13.2. HWB paper (June 2018) Diabetes Strategic Framework (Whole System Approach)

13.3. HWB paper (June 2018) Findings of the Diabetes Truth programme.

13.4. Findings of the Great Weight Debate Merton.

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Diabetes in Merton – Learning from a whole systems approach

Annual Report of the Director of Public Health 2019

About this report

- This is an independent annual report on the health of the population of Merton, in fulfilment of the statutory duty of the Director of Public Health.
- This year's report is focussed on diabetes. Diabetes is a priority for the Merton's Health and Wellbeing Board. Numbers affected are increasing year on year. Working together to make Merton a healthy place and providing holistic care will reduce the burden of disease and the future costs of care.
- The purpose of this report is firstly, to provide context for the Health and Wellbeing Board's Diabetes Action Plan which is published alongside the APHR; secondly to be a learning resource, to encourage further development of the whole systems approach which is necessary to tackle all long term conditions, not just diabetes.
- The report aims to provide a reference for officers, partners and residents about diabetes and to explore how learning from elsewhere can be applied in Merton
- Most of the report is focussed on Type 2 diabetes, but the whole system approach will benefit people with Type 1 diabetes too.
- The report summarises the statistics about diabetes, the views of patients and carers, and case studies of particular approaches.
- It's not just for diabetes that the whole system of healthy place and holistic care will produce benefits. The same approach can be adopted for other long term conditions, and the context set by new NHS Long Term Plan provides the opportunity to do this locally.

Key Messages for APHR 2019

Tackling diabetes in Merton

Learning from a whole systems approach

Diabetes has a big impact on health & wellbeing as well as care costs in Merton

1. Numbers are rising and there are inequalities between groups
2. Life expectancy is reduced with frequent complications from other diseases
3. Health and care costs are substantial and will increase further if nothing changes

Working together to create a healthy place and holistic care and learning as we go is the way forward

4. The root causes for diabetes lie in the unhealthy environment we live in
5. Living with diabetes can be confusing – services can seem fragmented
6. We can create a healthy place which will make the healthy choice easy
7. Holistic care means listening to people's whole story, taking account of their physical and mental health, and considering social circumstances
8. There is a way of working together combining healthy place and holistic care which can be applied beyond diabetes

Theme 1 - Clinical oversight and service improvement. Lead org: CCG

Vision: Merton delivers evidence based services, providers and commissioners actively seek out opportunities for service improvement and share learning and uses data to identify areas of best practice and variation.

In order to deliver this vision, we will

Action 1) develop a 'diabetes dashboard' to monitor outcomes and use data to identify variation and empower practices to improve services, **Action 2)** keep services and pathways under review & use patient views to identify and secure improvements in existing and future projects, **Action 3** provide access to training for staff to ensure that they are up to date with clinical guidelines, evidence based management and emerging approaches e.g. very low calories diets**, Action 4)** approach commissioning of diabetes services in a manner that empowers and supports quality improvement across two levels; at a federation level and in individual practices, **Action 5)** increase access to and uptake of evidence based and highly effective structured education programmes e.g. Desmond and DAFNE and deliver culturally specific programmes e.g. DoSA.

Theme 2 - Holistic Individual Care. Lead org: LBM & CCG

Vision: Merton takes a holistic care approach to diabetes and delivers what matters to residents, uses local assets and takes a partnership approach to increasing the uptake of NDPP and the wider digital prevention offer.

In order to deliver this vision, we will

Action 6) roll out social prescribing at scale and consider wider opportunities to connect residents to services, **Action 7)** increase resilience of communities and residents by ensuring that diabetes services are linked to mental health services, **Action 8)** produce a Directory of Services e.g. Adult Education and cooking classes that support residents at risk of or living with diabetes, **Action 9)** develop a network of 'connectors' to enable the community as a whole to take action to prevent diabetes, **Action 10)** increase uptake of the NDPP and deliver wider prevention programmes, **Action 11**) promote the wider Merton digital prevention offer, **Action 12)** actively engage communities and residents living with diabetes (T1 and T2) in service design and improvement.

Theme 3 – Healthy Place. Lead org: LBM

Vision: Merton as a place to live and work encourages people to be more active and make healthier choices.

In order to deliver this vision, we will

Action 13) work in key settings to ensure they support healthy lifestyles e.g. delivering Healthy Workplaces across Merton in (a) organisational members of the HWB and (b) external businesses, **Action 14)** create a healthier food environment in Merton by working with partners and businesses, **Action 15)** increase and promote opportunities to be physically active.

Merton Tackling Diabetes Action Plan

<table>
<tr><td colspan="7"><u>THEME 1: Clinical oversight and service improvement.</u></td></tr>
<tr><td>Vision:-</td><td colspan="6">Merton delivers evidence based services, providers and commissioners actively seek out opportunities for service improvement and share learning and uses data to identify areas of best practice and variation.</td></tr>
<tr><td>Actions:-</td><td colspan="6">To achieve this vision, we will deliver the following actions:-

Action 1) We will develop a ‘diabetes dashboard’ to monitor outcomes and use data to identify variation and empower practices to improve services.
Action 2) We will keep services and pathways under review & use patient views to identify and secure improvements in existing and future projects.
Action 3 We will provide access to training for staff to ensure that they are up to date with clinical guidelines, evidence based management and emerging approaches e.g. very low calories diets.
Action 4) We will approach commissioning of diabetes services in a manner that empowers and supports quality improvement across two levels; at a federation level and in individual practices.
Action 5) We will increase access to and uptake of evidence based and highly effective structured education programmes e.g. Desmond and DAFNE and deliver culturally specific programmes e.g. DoSA.</td></tr>
<tr><th>Actions</th><th>Tasks</th><th>Lead responsibility</th><th>Monitoring indicators /targets</th><th>Timescale</th><th>Lead Officer responsible</th><th>Progress</th></tr>
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1) We will develop a 'diabetes dashboard' to monitor outcomes and use data to identify variation and empower practices to improve services.	**1.1)** Use the NDA to develop and strengthen the diabetes dashboard as a tool to reduce variation, and expand to cover a NDH register and annual recall.	CCG Federation	• Dashboard developed and used by practices, localities and LDU Steering Group.	June 19	Kemi Eniade Ruben Reggiani	TBC
	1.2) Identify variations in NDA to improve achievement of the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure) and drive down variation between East & West and between GP practices	CCG Federation Practices	• Individual Practice action plans.	June 19	Kemi Eniade Practice leads	
	1.3) Develop projections for NDH and T2 diabetes for next 10 years.	PH	• Projections and ROI modelled.	May 19	Mike Robinson	
2) We will keep services and pathways under review & use patient views to identify and secure improvements in existing and future projects.	**2.1)** Consider the needs of particular target groups e.g. patients with learning disabilities and the protected characteristics in service design and improvement.	CCG	• Key target groups identified and plans to tackle underperformance identified. • Equalities Impact Assessment of services completed. • PSED report published	Sept 19	Kemi Eniade Fiona Gaylor Equalities	TBC
	2.2) Deliver a Public Health profile on the Protected Characteristics and diabetes.	PH	• Profile published.	Sept 19	Mike Robinson	
	2.3) Gain insight on patient perspective of gaps and opportunities to secure service improvement.	CCG	• 'You said, we did' account published in PSED.	Dec 19	Kemi Eniade Fiona Gaylor Equalities	

	2.4) Explore opportunities for enhancing pathways and services e.g. behaviour change opportunity at diabetic retinal screening.	CCG PH Federation Practices CLCH	• Examples of enhancements published.	Sept 19	Kemi Eniade Barry Causer Ruben Reggiani Practice leads Sam Kelly	
3) We will provide access to training for staff to ensure that they are up to date with clinical guidelines, evidence based management and emerging approaches e.g. very low calories diets**.**	**3.1)** Horizon scanning for areas of potential service improvement and new guidance e.g. NICE Quality Standards on physical activity.	LDU Steering Group	• Merton participating in emerging practice.	July 2019 (and on-going)	Kemi Eniade Barry Causer	TBC
	3.2) Deliver and monitor uptake of appropriate training to front-line staff e.g. Cambridge Diabetes Education Programme, behaviour change and 'structured conversations'.	CCG PH	• Training for front-line staff developed and uptake monitored.	Sept 2019	Kemi Eniade Barry Causer	
	3.3) Develop leadership for clinical leaders through regional and national programmes e.g. Clinical Physical Activity Champions.	CCG PH	• Evidence of leadership development • Physical Activity Champion attending CEPN meeting.	Dec 2019	Kemi Eniade Barry Causer	
	3.4) Make for the case for Merton to participate in pilots of emerging practice e.g. very low calorie diets or digital tools.	LDU Steering Group	• Merton participating in emerging practice.	Sept 19	Kemi Eniade	

4) We will approach commissioning of diabetes services in a manner that empowers and supports quality improvement across two levels; at a federation level and in individual practices.	**4.1)** Include outcome based KPI's in the LIS that drive improvements in service delivery, education and pathways.	CCG	• Key LIS KPI's monitored.	April 19	Kemi Eniade Jo Thorne	TBC
	4.2) Reduce variation in outcomes and practices to provide better care across the 9 care processes.	CCG	• Practice performance across the 9 diabetes care processes.	Sept 19	Kemi Eniade Jo Thorne	
	4.3) Deliver the 'test-bed' programme and use lessons learnt to deliver service improvement.	SWL	• Performance data from test bed programme. • Lessons learnt report.	Ongoing	Chris Gumble	
	4.4) Review the LIS on a quarterly basis and feedback performance to appropriate groups e.g. LMC and LDU Steering Group.	CCG	• Notes of performance management and minutes of LMC and LDU Steering Group.	Quarterly	Kemi Eniade	
5) We will increase access to and uptake of evidence based and highly effective structured education programmes e.g. Desmond and DAFNE and deliver culturally specific programmes e.g. DoSA.	**5.1)** Develop communications to GP's and patients to promote **https://www.diabetesbooking.co.uk/**	CCG SWL Diabetes Team	• Comms materials developed. • Performance figures on usage of the site.	April 19	Kemi Eniade Chris Gumble	
	5.2) Increase the referrals and uptake of the structured education across Merton.	SWL CCG	• Performance data for structured education, including referrals, uptake and completion.	Sept 19	Chris Gumble Kemi Eniade	TBC
	5.3) Commission evidence based culturally sensitive structured education.	SWL CCG	• New service in place. • Performance data for structured education,	Sept 19	Chris Gumble	

			including referrals, uptake and completion.		Kemi Eniade	

THEME 2: Holistic Individual Care

Vision:-	Merton takes a holistic care approach to diabetes and delivers what matters to residents, uses local assets and takes a partnership approach to increasing the uptake of NDPP and the wider digital prevention offer.
Actions:-	**To achieve this vision, we will achieve the following actions:-** **Action 6)** We will roll out social prescribing at scale and consider wider opportunities to connect residents to services. **Action 7)** We will increase resilience of communities and residents by ensuring that diabetes services are linked to mental health services. **Action 8)** We will produce a Directory of Services e.g. Adult Education and cooking classes that support residents at risk of or living with diabetes. **Action 9)** We will develop a network of 'connectors' to enable the community as a whole to take action to prevent diabetes. **Action 10)** We will increase uptake of the NDPP and deliver wider prevention programmes. **Action 11**) We will promote the wider Merton digital prevention offer. **Action 12)** We will actively engage communities and residents living with diabetes (T1 and T2) in service design and improvement.

Actions	Tasks	Lead responsibility	Monitoring indicators /targets	Timescale	Lead Officer responsible	Progress
6) We will roll out social prescribing at scale and consider	**6.1)** Evaluate delivery of SP, including the impact on primary care, secondary care and individual health gain.	MCCG	• Performance data from SP, including referral numbers by practice, reason for referral and uptake of VCS activities.	Sept 19	Mohan Sekeram	TBC

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wider opportunities to connect residents to services.			• CSU data report on impact. • LSHTM Student reports			
	6.2) Seek information from Frome and other places where SP already rolled out to identify impact on PWDs.	PH	• Lessons learnt report and notes of meeting. • Lunch & Learn in LBM and CCG.	June 19	Mike Robinson	
	6.3) Deliver digital social prescribing to compliment face to face offer and self-care access to VCS services (tier 0).	CCG PH	• Business case developed for tiered approach to SP. • Service goes live and key performance data.	March 20	Mohan Sekeram Barry Causer	
	6.4) Explore funding opportunities for social prescribing for young people and their families.	CSF	• Business case developed for YP social prescribing. • Service goes live and key performance data.	March 20	Barry Causer	
7) We will increase resilience of communities and residents by ensuring that diabetes services are linked to mental health services	**7.1)** Work with Merton Uplift (IAPT) to inform roll out of new tiered service, including sharing insight from diabetes truth programme, to deliver what matters to residents.	MCCG PH	• Insight from diabetes truth informs mobilisation of Merton Uplift service.	April 19	Barry Causer Patrice Beveney	TBC
	7.2) Performance manage Merton Uplift (IAPT) service to include core offer to patients with LTC inc T1 and T2 diabetes.	MCCG	• Performance data Merton Uplift service.	June 19	Patrice Beveney	
8) We will produce a Directory of Services e.g. Adult Education and cooking	**8.1)** Map wider prevention services and promote through single on-line portal which will support holistic care.	PH	• Map prevention services • Performance data from on-line portal (see theme 3).	Jan 20	Rebecca Spencer	TBC
	8.2) Link wider support activities and programmes to clinical pathways e.g. cooking classes.	CCG	• Evidence of pathway enhancement.	Dec 19	Kemi Eniade	

classes that support residents at risk of or living with diabetes.	**8.3)** Explore opportunities to assist carers to provide support to residents at risk of or living with diabetes.	PH	• Publish Carers Strategy	TBC	Dan Butler	
9) Develop a network of 'connectors' to enable the community as a whole to take action to prevent diabetes.	**9.1)** Map current connectors – across workplaces, VSC, primary care and commissioned services.	PH	• Map connectors across Merton.	June 19.	Rebecca Spencer	TBC
	9.2) Learn from Wandsworth diabetes champions model.	CCG	• Lessons learnt session taken place and notes used to inform Merton approach.	May 19.	Amrinder Sehgal	
	9.3) Develop a network of diabetes and diabetes prevention champions.	CCG PH	• Number of diabetes champions trained and supported to use Diabetes UK resources	June 19.	Amrinder Sehgal Barry Causer	
	9.4) Develop structured conversation training package, beyond MECC to support connectors and front line staff across health and care system.	CCG PH CEPN	• Training undertaken and training feedback.	June 19.	Fiona Gaylor Barry Causer Zehra Safdar	
	9.5) Develop links to local Diabetes UK branch, to access trusted resources which can be promoted.	CCG	• DUK invited to LDU Steering Group • DUK involvement in campaigns and outreach.	June 19.	Kemi Eniade	
10) We will increase uptake of the NDPP and deliver wider prevention	**10.1)** Establish recorded prevalence of NDH in each practice.	Federation	• All practices have completed baseline search of NDH.	April 19	Ruben Reggiani	TBC
	10.2) Increase the referrals and uptake of the NDPP across Merton, through coordinated and successful	PH Federation CCG	• Notes of meetings. • Performance data for NDPP, including referrals, uptake and completion.	On-going	Rebecca Spencer	

programmes	communications to make best use of existing capacity.				Ruben Reggiani Kemi Eniade	
	10.3) In-line with NHS LTP, submit business case for increasing the number of places for NDPP (subject to additional capacity being needed – see 10.2).	CCG	• Evidence of additional capacity and uptake of services.	TBC	Kemi Eniade	
	10.4) In-line with NHS LTP, explore evidence based alternatives to the NDPP, including digital opportunities e.g. digital test bed.	CCG	• Evidence of additional capacity and uptake of services.	TBC	Kemi Eniade	
11) We will promote the wider Merton digital prevention offer.	**11.1)** Co-create with residents and VCS partners key messages for services that are culturally appropriate, inc link to other programmes e.g. childhood obesity.	PH CCG	• Write up of co-creation and evidence of implementation.	Sept 19	Barry Causer Kemi Eniade	TBC
	11.2) Identify key online community support groups to actively promote via services and single point of access (covering T1 and T2).	PH	• Mapping and promotion in place.	Sept 19	Rebecca Spencer	
	11.3) Explore opportunities for self-directed digital self-care in key community venues e.g. use of 'know your risk tools' community libraries.	Libraries	• Libraries promoting self-care including 'know your risk' tools.	Sept 19	Anthony Hopkins	
	11.4) Promote digital tools that support prevention of diabetes including mental health e.g. Good Thinking.	PH	• Usage figures for good thinking.	June 19	Barry Causer	
	11.5) Deliver the diabetes digital test bed.	SWL	• Usage figures for test bed.	TBC	Chris Gumble	

12) We will actively engage communities and residents living with diabetes (T1 and T2) in service design and improvement.	**12.1)** Deliver a programme) on a diabetes challenge e.g. lack of take up in structured education.	CCG SWL Comms	• Challenge identified and target programme delivered and evaluated.	TBC	Charlotte Gawne Fiona Gaylor	TBC
	12.2) Work with partners to develop an approach to patient engagement to actively engage with men, residents with a disability, from south Asian communities and families.	CCG	• Develop and review of EIA to inform priority groups. • Engagement plan includes specific diabetes workstream.	TBC	Aman Nathan	

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THEME 3: Merton as a Healthy Place.						
Vision:	Merton as a place to live and work encourages people to be more active and make healthier choices.					
Actions:-	**To achieve this vision, we will achieve the following actions:-** **Action 13)** We will work in key settings to ensure they support healthy lifestyles e.g. delivering Healthy Workplaces across Merton in (a) organisational members of the HWB and (b) external businesses. **Action 14)** We will create a healthier food environment in Merton by working with partners and businesses. **Action 15)** We will increase and promote opportunities to be physically active**.**					
Actions	**Tasks**	**Lead responsibility**	**Monitoring indicators /targets**	**Timescale**	**Lead Officer responsible**	**Progress**
13) We will work in key settings to ensure they support healthy lifestyles e.g. delivering Healthy Workplaces across	**13.1)** Develop a light touch framework for joint action inked to HWC London Excellence level.	PH	• Framework developed and available for use.	June 19	Mike Robinson	TBC
	13.2) Deliver healthy workplace programmes by organisational members of the HWB e.g. Merton Council, MCCG and MVSC.	HWB	• Organisational action plans in place.	Sept 19	Mike Robinson	
	13.3) Pilot and evaluate a programme of healthy workplaces in the 3 Business Improvement Districts in Merton.	PH	• Programme delivered and evaluation disseminated widely including via GLA.	March 20	Rebecca Spencer	
	13.4) Actively seek ops for joint work across health and care system e.g. mental health first aid.	PH CCG	• Examples of joint work and commissioning.	Sept 19	Dan Butler	

Merton in (a) organisational members of the HWB and (b) external businesses.					Nicky Bamford	
14) We will create a healthier food environment in Merton by working with partners and businesses	**14.1)** Implement the "School Neighbourhood Approach Pilot"(SNAP) and produce recommendations in response to the evaluation findings.	Child Healthy Weight Steering Group	• Evaluation response completed and recommendations implemented.	August 19	Julia Groom	TBC
	14.2) To support businesses that have achieved the Healthier Catering Commitment and explore ways to expand the number of businesses signed up to the Commitment in Merton.	Child Healthy Weight Steering Group	• Review of current arrangements completed and recommendations for future approach agreed and implemented.	May 2019	Julia Groom	
	14.3) To manage and monitor proposals for new fast food takeaways (A5 uses) located within 400 metres of the boundaries of a primary or secondary schools in order to promote the availability of healthy foods.	Child Healthy Weight Steering Group	• Proposals to manage and monitor A5 use category produced, agreed and implemented as part of Local Plan. • No. of applications for A5 use affected and outcome.	Ongoing	Julia Groom	
	14.4) To review existing approach to managing public events and implement a new approach to ensure the food and drink offered at council events are healthier, facilities are breastfeeding friendly and promote free drinking water.	Child Healthy Weight Steering Group	• Evaluation response completed and recommendations implemented.	Ongoing	Julia Groom	
	14.5) To review existing advertising and sponsorship policies and agree and implement a new policy that tackles unhealthy advertising and promotes wellbeing.	LBM Environment & Regen	• Review completed and new policy implemented.	TBC	James McGinlay	
15) We will increase and promote opportunitie	**15.1) T**he Active Travel and Transport Subgroup to develop an active travel action plan, including further consideration around parking policy.	AT&T Subgroup	• Task and Finish Group set up. • Work programme agreed.	Sept 2019	Mike Robinson	TBC

s to be physically active.	**15.2)** Deliver a ‘Merton year of physical activity, with a different focus for each month e.g. Merton Mile, active travel, leisure centres, parks and open spaces, sport, strength and balance, family fun, active workplace, active schools, NHS, MECC and accessing funding.	PH London Sport	• Delivery plan for ‘Merton year of physical activity.	June 2019	Barry Causer Shaz Avazzadeh	

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Merton Child Healthy Weight Action Plan 2019 - 2022

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Introduction

Reducing Childhood Obesity in Merton has been a key priority within the Health and Well-being Strategy since 2015. The refreshed Health and Well-being Strategy (2019-2024) maintains this focus and includes childhood obesity as one of 3 priorities within the 'Start Well' children and young people's theme. Childhood obesity is a complex issue and there is no single solution. Therefore a preventative, whole systems approach is required, which recognises the influence of the places where we live, work and play on our health and well-being, as well as our individual behaviours and choices. Sustained and consistent action is therefore required, to have a positive impact on childhood obesity and partners in Merton are committed to this issue.

This Child Healthy Weight Action Plan (CHWAP) provides the framework for taking forward actions which will support achieving the "Start Well" theme. The Action Plan reflects the learning over the past 3 years as well as aligning to national and regional work to reduce childhood obesity. There are a number of other action plans and strategies which support reducing childhood obesity and this action plan will not seek to duplicate these but include priority actions that enhance the work over and above work included in wider action plans for the next 3 years. Therefore, this should be noted by readers to understand the scope of this Child Healthy Weight Action Plan. The Plan has been refreshed alongside the Tackling Diabetes Action Plan and has some shared themes and actions. The approach recognises that is we reduce childhood obesity levels, we could potentially reduce the numbers of people with type two diabetes in the future and there are clear synergies between the two action plans. We also regonise that we need to have a Think Family approach which recognises the importance of taking a whole family approach rather than thinking of an individual (child or adult) in isolation. Without this approach, we often miss the bigger picture around that individual's life and opportunities to support.

Our key CHWAP aims are to:

- Continue to develop a sustainable whole systems approach to addressing childhood obesity locally, focusing on 4 themes (see below)
- Increase proportion of children who are a healthy weight
- Reduce the 'gain' in excess weight between reception (4-5 year olds) and Year 6 (10 – 11 year olds)
- Reduce the gap in obesity between the east and the west of Merton (by improving the east)

This Child Healthy Weight Action Plan is split into 4 key themes (see page x for summary):

1) *Making childhood obesity everyone's business*
2) *Improving our food environment*
3) *Improving our physical environment*

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4) *Supporting for children and young people and their families*

The Director of Public Health's Annual Public Health Report (APHR) 2016-17 (Tackling Childhood Obesity Together) available on the following link provides the local context on childhood obesity on Merton http://www.merton.gov.uk/health-social-care/publichealth/annualpublichealthreport.htm. The APHR sets out the challenge of childhood obesity in Merton and is a call to action to partners to work together on the solutions. It brings together data and information from a range of sources and provides evidence about what works as well as examples of action to tackle obesity at the population, community and individual level, to provide a local reference and resource to support our joint effort. It recognises the good work already taking place across the borough and highlights some examples underway.

Merton context

- In Merton an estimated 4,500 children aged 4-11 years are overweight or obese– equivalent to 150 primary school classes.
- One in five children entering Reception year are overweight or obese and this increases to one in three children leaving primary school in Year 6.
- There has been a slight reduction in reception from 21.2% in 2016/17 to 18.5% in 17/18 (lower than England – 22.4% and London – 21.8%).
- There has been a slight increase in excess weight in Year 6 from 34% in 2016/17 to 35.6% in 17/18 (higher than England (34.3%) but lower than London (37.7%)
- Childhood obesity contributes to health inequalities - the gap in overweight and obesity between the east and west of the borough is widening in both Reception and Year 6 and is 11% higher in east Merton in Year 6 (2014/15–2016/17).
- There are a number of primary schools in Merton where over 50% of children in year 6 are classed as overweight or obese.
- Fast food outlets are an important and popular food source for children and young people –providing a significant proportion of their fat, salt and sugar intake.
- Evidence indicates that a child is more likely to be obese if they are from:
    - a lower income household
    - a black British , black African or black Caribbean ethnic background, and have one or more overweight parents
- Overweight and obese children are more likely to experience bullying and stigma. This can affect their self-esteem and may in turn affect their performance at school.
- Children who are obese are more likely to become obese adults and they risk the early development of obesity related problems such as diabetes, heart disease, cancers and have reduced life chances. Obesity can harm people's prospects in life, their self-esteem and their underlying mental health.

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Celebrating successes - Child Healthy Weight Action Plan 2015-18

Over the past 3 years, there have been concerted efforts through the Child Healthy Weight Steering group and partner organisations which have supported achieving the 2015-2018 action plan. Overall, 47 actions were achieved out of 52 originally agreed as part of the plan. Listed below are examples of some of the key actions that were achieved by the plan through the work of the Child Healthy Weight steering group:-

- **Merton Council signing the Local Government Declaration on Sugar Reduction -** This is an initiative developed by charity Sustain aimed at encouraging local authorities to take significant actions to across six key areas essential to tackle the obesity crisis (including tackling unhealthy advertising, supporting healthier food business and public messaging)

- **Delivering the Great Weight Debate Merton engagement to inform work to tackle obesity** – following the London-wide "Great Weight Debate", a further local consultation was commissioned through the Child Healthy Weight Plan to undertake focused communication and engagement focusing on East Merton residents, BAME communities and parents and young people. The communication and engagement was an intervention in itself to raise awareness of childhood obesity and providing consistent messaging on healthy eating and physical activity. GWD Merton provided in-depth insights into Merton residents' views and opinions on childhood obesity and the findings of the consultation have been used by partners and as a basis for the refreshed plan presented in this report.

- **Developing a child healthy weight support service** – the "Family Start" service has been commissioned and established to support children identified as 'obese' through the National Child Measurement Programme (NCMP). This service is delivered by the Merton School Nursing service and consists of 3 one-to-one consultations with families and their children to support lifestyle change. From Sept 17-Aug 18, 241 appointments were held through the service.

- **Supporting the Healthy Schools London Programme locally** - Building on the work of a targeted Healthy Schools programme in the east of the borough previously, Merton is now aligned to the Healthy Schools London (HSL) programme. Merton School Sports Partnership (MSSP) were commissioned to support schools in the borough to achieve Healthy School status. Currently, 14 schools have achieved their Bronze award and 3 of those schools have also achieved their Silver award.

- **Training for 378 school staff on raising awareness and talking about childhood obesity and weight** – School staff from 19 schools have benefited from training and a further 6 schools have been offered training which will be delivered within the 18/19 academic year. The training is to better support primary school staff around the issue of childhood obesity, increasing confidence, delivering consistent messages, taking a whole school approach on healthy weight and improving their ability to signpost to support.

- **Developing a food poverty action plan -** Merton was successful in bidding for additional funding from the GLA and Sustain to support development of a Food Poverty action plan (2018-2020). Sustainable Merton were commissioned to lead the development of the plan and its first year of implementation. A partnership steering group has been established to deliver the action plan, with a focus on three themes: ensuring a joined up approach to food poverty, tackling food waste and surplus and strengthening existing food poverty initiatives.

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• **Delivering family learning courses for healthy eating on a budget** -These courses were developed following consultation feedback from the Great Weight Debate Merton on the need for clear messaging and support for families, especially those on low incomes. The courses focused on clear messaging around physical activity, meal planning, nutrition and healthy lifestyle changes and target children aged 5-7 years and their families.

• **Healthier Catering Commitment (HCC):** The Healthier Catering Commitment (HCC) is a voluntary award scheme that supports food businesses to offer healthier food options and cooking practices. 37 Merton food businesses have been fully signed up with nearly 50 premises visited (some on more than 1 occasion) to support them to make positive changes such as reducing portion size and changing oils through the HCC. The HCC has been used to recognise food businesses that demonstrate a commitment to offering healthier options, and has been targeted in the east of the borough.

• **Promoting the Daily Mile** – The Daily Mile is a free initiative that has been promoted in Merton schools aiming to get children to run or jog for 15minutes every day at primary and nursery levels. Currently over 20 schools across the borough are delivering the Daily Mile with promotion still ongoing.

• **Children's Community Services UNICEF Baby Friendly Initiative Level 3 Re-accreditation** – The Baby Friendly Initiative (BFI) is an accreditation programme run by UNICEF that supports organisations to offer high quality support for families for breast feeding and infant feeding. Merton's Health visiting service has successfully achieved re-accreditation at the highest level (Level 3), for its provision of breastfeeding and infant feeding support to mothers and families.

Lessons Learnt

A number of lessons were learnt in successfully delivering the first Child Healthy Action Plan, and these were used to inform the refresh and development of the updated action plan presented here. These key lessons are summarised below:

• **Maintaining a broad and committed partnership approach** – a key lesson learnt from the first Child Healthy Weight Action Plan was the importance of having a broad partnership approach that engaged local leaders across the local authority, NHS, voluntary and community sector and schools. The range of expertise, resources and ideas generated through the Child Healthy Weight steering group played a significant role in the success of the plan. This has led to the refreshed plans focus on 'making childhood obesity everyone's business' – taking a whole system approach and emphasising partnership working.

• **Maintaining momentum and engagement** – tackling obesity often involves taking actions across many years, repeating or adjusting interventions as needed and challenging behaviour change. Maintaining the engagement of both partners and the public when 'quick wins' can be hard to achieve was a key challenge. This has led to the focus of the refreshed plan on developing an effective partnership communications and engagement plan, to provide a co-ordinated approach to maintaining the momentum and reach of messages and interventions to tackle obesity.

• The challenges of a co-ordinating an ambitious action plan – the first Child Healthy Weight Action Plan focused on mapping and drawing together the whole breadth of work happening in Merton to tackle obesity. This led to an action plan that had a significant number

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of actions, with some being relatively minor. This created challenges in terms of the project management support needed to manage such a large number of actions. While necessary at the time to ensure that links were made, relationships between partners have now matured to the point where the proposed refreshed action plan can focus on a small number of 'high impact' actions.

• **Making the most of what other people do** – in delivering the first Child Healthy Weight Action Plan, actions were most successful when working with, or supported by, work being undertaken by others nationally and regionally. For example, building on the London Great Weight Debate to commission a Merton specific consultation, or developing a food poverty action plan with support from the GLA. With the challenge of limited resources, a key focus of the refreshed plan is to make the most of the opportunities and assets available to us. Key opportunities include building on TFL's breakthroughs on the restrictions of unhealthy advertising and learning from the work of other boroughs in delivering effective communications campaigns.

The Child Healthy Weight Action Plan (2019-2022) has been refreshed through a process of engaging partners through the Child Healthy Weight steering group, reviewing the evidence of what works nationally and regionally, listening to feedback from local resident's and families and reviewing the successes and challenges of the previous plan. The action plan also builds on regional work and opportunities across London and nationally supports the actions included in the National Childhood Obesity Action Plan, Chapter 2.[1]

Monitoring the Action Plan

- The Children's Trust Board (CTB) is responsible for monitoring the delivery of "Start Well" childhood obesity priority of the Health and Wellbeing (HWB) Strategy with escalation and reporting to HWB Board as appropriate.
- The Child Healthy Weight Steering Group which includes a range of partners in Merton will lead on ensuring this plan is operationally delivered. Monitoring metrics are already included and any others will be developed during implementation. New and emerging actions will be incorporated into the action plan over time, building on the evolving evidence base as agreed through the steering group.
- It is recognised that many activities and initiatives are already underway across Merton which have a positive impact on child healthy weight. This action plan does not aim to map all activity across the borough, rather it focuses on actions that are additional or enhance existing priority activities over the next 3 years and not featured in other plans.

[1] National childhood obesity action plan Chapter 2: https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2

Merton Child Healthy Weight Action Plan 2019-2022

Theme 1: Making Childhood Obesity Everyone's Business

Vision: *We have a joined-up approach to tackling obesity in Merton with partners taking a coordinated, whole systems approach with a focus on effective communication and engagement.*

In order to deliver this vision, we will achieve the following actions:-

Action 1) We will communicate effectively with a shared approach across all partners through delivering a co-produced partnership communications plan.

Action 2) We will work in partnership to make best use of available resources through pooling resources and supporting joint funding bids.

Action 3) We will ensure that tackling childhood obesity and a "Think Family" approach is built into all the work we do including through our commissioning practices and the use of social value.

Theme 2: Supporting children, young people and their families

Vision: *Schools and early year's settings support all families to live healthily and children that need additional help are offered high quality and effective support by services.*

In order to deliver this vision, we will achieve the following actions:-

Action 4) We will work with schools and early years settings to support children and families to live healthily through delivering key programmes such as the Healthy Schools London and Healthy Early Years London programmes.

Action 5) We will ensure that our services offer effective help to children and families that need support through reviewing Merton's child weight support offer and GP pathways.

Theme 3: Healthy Place

Vision: *Merton as a place to live and work encourages people to be more active and make healthier choices.*

In order to deliver this vision, we will achieve the following actions:-

Action 6) We will work in key settings to ensure they support healthy lifestyles through delivering the School Neighbourhood Project to improve the environment around schools

Action 7) We will create a healthier food environment in Merton by working with partners and businesses through continuing to support the Healthier Catering Commitment, delivering a local Sugar Smart campaign and tackling the advertising of unhealthy food and drink

Action 8) We will increase and promote opportunities to be physically active through delivering a Merton "Year of Physical Activity" and increasing and increasing opportunities for active travel.

Merton Child Healthy Weight Action Plan for preventing and reducing childhood obesity

<table>
<tr><td colspan="7"><u>THEME 1:</u> Making childhood obesity everyone's business</td></tr>
<tr><td>Vision:-</td><td colspan="6">We have a joined-up approach to tackling obesity in Merton with partners taking a coordinated, whole systems approach with a focus on effective communication and engagement.</td></tr>
<tr><td>Actions:-</td><td colspan="6">To achieve this vision, we will achieve the following Actions:-

Action 1) We will communicate effectively with a shared approach across all partners through delivering a co-produced partnership communications plan.

Action 2) We will work in partnership to make best use of available resources through pooling resources and supporting joint funding bids.

Action 3) We will ensure that tackling childhood obesity and a "Think Family" approach is built into all the work we do including through our commissioning practices.</td></tr>
<tr><td>Other Relevant Plans/ Strategies:-</td><td colspan="6">Merton Health & Wellbeing Strategy</td></tr>
<tr><td>Action</td><td>Tasks</td><td>Lead responsibility</td><td>Monitoring indicators /targets</td><td>Timescale</td><td>Lead Officer responsible</td><td>Implementation resources/ support</td></tr>
<tr><td>1) We will communicate and engage effectively</td><td>1.1) Develop a refreshed communication and engagement strategy around child healthy weight to support a co-ordinated approach across partner organisations. To include a focus on: 1)) young</td><td>CHW Steering Group</td><td>Comms strategy produced and agreed by partners.

BAME groups and young people involved in development of</td><td>January 2020</td><td>Hilina Asrress / Philip Williams (PH)</td><td></td></tr>
</table>

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with a shared approach across all partners.	people and their families **2)** reaching BAME groups **3)** making best use of digital platforms **4)** support for the Early Years		Comms strategy.			
2) We will work in partnership to make best use of available resources.	**2.1)** To actively seek out and explore opportunities to bid for funding and promote opportunities to relevant partners, with a menu of potential interventions produced if funding is identified	**Child Healthy Weight Steering Group**	Standing agenda item at steering group meetings to share opportunities. Menu produced and refreshed annually.	**Ongoing**	Hilina Asrress / Philip Williams (PH)	
3) We will ensure that tackling childhood obesity and a “Think Family” approach is built into all the work we do.	**3.1)** To develop resources to support commissioners to utilise social value clauses within their commissioning to reduce childhood obesity.	**LBM Public Health**	Resources produced. Increase in the number of contracts including clauses monitored.	**August 2019**	Hilina Asrress / Philip Williams (PH)	
	3.2) To deliver the actions agreed as part of the Local Government Declaration (LGD) on Healthier Eating (these individual actions are included in the plan below marked with the following: **LGD Action**) *The Local Government Declaration (LGD) on Healthier Eating and Sugar Reduction is an initiative developed by Sustain London, supporting local authorities to make pledges of action across 6 key areas essential to tackling the prevalence of obesity.*	**LBM Public Health**	Annual monitoring and refresh return submitted (ongoing) All agreed actions achieved (January 2020)	**January 2020** (first annual monitoring return)	Lead officers specified per action	Philip Williams (PH)

THEME 2: Supporting Children and Young People and Their Families

Vision:-	*Merton's schools and early years settings support all families to live healthily and children that need additional help are offered high quality and effective support by services.*
Actions:-	**To achieve this vision, we will achieve the following Actions:-** **Action 9) We will work with schools and early years settings to support children and families to live healthily** through delivering key programmes such as the Healthy Schools London and Healthy Early Years London programmes. **Action 10) We will ensure that our services offer effective help to children and families that need support** through reviewing Merton's child weight support offer and GP pathways.
Other Relevant Plans/ Strategies:-	*Merton Health & Wellbeing Strategy* *Merton Children and Young People's Plan*

Action	Tasks	Lead responsibility	Monitoring indicators /targets	Timescale	Lead Officer responsible	Implementation resources/ support
9) We will ensure that	**9.1)** Explore piloting new approaches to delivering the child healthy weight support service, including family	**CLCH**	Proposal developed and implemented.	**Dec 2019** (evaluatio	Iona Baker (CLCH)	Hilina Asrress (PH)

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our services offer effective help to children and families that need support.	peer learning opportunities and incentivisation (i.e. with Leisure centre offer)		Evaluation conducted	n date tbc)		
	9.2) Evaluate the previous cohorts that have successfully completed the Family Start Service to inform future service development and commissioning. *The Family Start service is Merton's child weight support service, delivered by the CLCH School Nursing team.*	**CLCH**	Evaluation proposals agreed (Jan 2019) Evaluation results presented (Dec 2019)	**Jan 2019 –** evaluation agreed **Dec 2019 –** evaluation results presented	Iona Baker (CLCH)	Hilina Asrress (PH)
	9.3) Explore opportunities and need for a local Tier 3 Childhood Obesity Weight Management Service with MCCG in response to outcomes from Family Start Evaluation and the needs in Merton	**Merton CCG**	Review completed and recommendations implemented as appropriate.	**tbc**	Hilina Asrress / Philip Williams (PH)	Monica Henny (MCCG)
	9.4) All Merton Children's Centres to achieve UNICEF BFI Accreditation Level 1 as a minimum, with an aim to achieve Level 2 during the lifetime of the plan. *The Baby Friendly Initiative (BFI) is an accreditation programme run by UNICEF that supports organisations to offer high quality support for families for breast feeding and infant feeding.*	**LBM Early Years**	Accreditation Level 1 Achieved – timelines tbc Accreditation Level 2 achieved (stretch goal) – April 2021	**tbc**	Allison Jones (CSF)	Hilina Asrress / Philip Williams (PH)
	9.5) To review and update the current GP DXS pathways for childhood obesity, to include pathways for children aged 0-5 years and promote.	**LBM Public Health /MCCG**	GP DXS pathway evaluated and updated. Pathway for childhood obesity 0-5 years developed. Both promoted with GPs	**January 2020**	Monica Henny (MCCG)	Hilina Asrress / Philip Williams (PH)
10) We will work with schools and early years settings to support	**10.1) LGD Action:-** Continue to support and deliver the Healthy Schools London Programme *The Healthy Schools London Programme is a London-wide accreditation programme to support schools to make changes to help children lead healthy lives.*	**LBM Public Health**	Support maintained for HSL programme Increase in number of schools at Bronze, Silver and Bronze. Maintain accreditation of those who have already achieved	**Ongoing**	Hilina Asrress (PH)	

children and families to live healthily.	**10.2) LGD Action:-** Continue to support and deliver the Healthy Early Years Programme. *The [Healthy Early Years Programme] is a London-wide accreditation programme to help early years settings, children's centres and childminders support child health, wellbeing and development in the early years.*	**LBM Early Years**	Follow up with 350 settings who have previously been contacted about HEYL(information and publicity previously disseminated) 100% of Network/peer to peer support meetings to include an update on HEYL and sharing of HEYL resources 120 settings/ childminders signed up with First Steps (pre-bronze) by end of 2021 30 settings/ childminders achieving bronze status by end of 2021 5 settings/childminders achieving silver status by 2021	**Ongoing**	Allison Jones (CSF)	Hilina Asrress / Philip Williams (PH)
	10.3) Public Health to support CSF with auditing of local school's use of the Healthy Pupil Capital Fund and Schools Sports Premium to share learning and best practice	**LBM Public Health**	Bids evaluated for HCPF and all funding allocated. Audit of spend completed and best practice shared.	**August 2019 –** audit complete	Tom Proctor (CSF)	Hilina Asrress / Philip Williams (PH)
	10.4) Develop recommendations to support schools to deliver an increased curriculum offer around healthy eating and cooking education through conducting a snapshot audit of the current offer and challenges.	**LBM Public Health**	Audit completed and recommendations implemented.	**Dec 2019**	Philip Williams (PH)	

THEME 3: Healthy Place

Vision:	**Vision:** *Merton as a place to live and work encourages people to be more active and make healthier choices.*
Actions:- Page 77	**To achieve this vision, we will achieve the following actions:-** **Action 6) We will work in key settings to ensure they support healthy lifestyles** through delivering the School Neighbourhood Project to improve the environment around schools **Action 7) We will create a healthier food environment in Merton by working with partners and businesses** through continuing to support the Healthier Catering Commitment, delivering a local Sugar Smart campaign and tackling the advertising of unhealthy food and drink **Action 8) We will increase and promote opportunities to be physically active** through delivering a Merton "Year of Physical Activity" and increasing and increasing opportunities for active travel.
Other relevant plans and strategies:-	*Merton Health and Wellbeing Strategy* *Merton Food Poverty Action Plan* *Merton Open Spaces Strategy* *Merton Active Travel Strategy* *Merton Air Quality Action Plan* *Merton Local Plan*

Action	Tasks	Lead responsibility	Monitoring indicators /targets	Timescale	Lead Officer responsible	Implementation resources/ support
6) We will work in key settings to ensure they support	**6.1) LGD Action:-** To refresh the action plan for Merton Council's Healthy Workplace Programme and achieve accreditation at excellence level	**LBM Public Health**	Action Plan refreshed and accredited at excellence level.	***tbc***	Rebecca Spencer (PH)	
	6.2) LGD Action:- Implement the "School	**Child Healthy**	Evaluation response completed	**August 2019**	Philip	

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healthy lifestyles	Neighbourhood Approach Pilot“ (SNAP) and produce recommendations in response to the evaluation findings. *Merton is a pilot site for the London-wide PHE “School Superzones” pilot, known in Merton as the “School Neighbourhood Approach Pilot” (SNAP) This project is supporting local authorities to work with schools locally to develop an improved approach to improving the physical environment around school sites to support health and wellbeing.*	**Weight Steering Group**	and recommendations implemented.		Williams/ Natalie Lovell (PH)	
7) We will create a healthier food environment in Merton by working with partners and businesses	**7.1) LGD Action:-** Launch a local Sugar Smart campaign. Including ongoing implementation support and promotion by partner organisations. *Sugar Smart is a national campaign that works with local authorities to support local organisations to make pledges to reduce their sugar consumption.*	**LBM Public Health**	Year-on-year increase in no. of pledges made as part of Sugar Smart campaign. All HWBB members signed up the campaign through committing to pledges to reduce sugar consumption.	**April 2019 –** launch of campaign **May 2020** – first year campaign review complete	Philip Williams (PH)	
	7.2) Develop and implement project plan to increase uptake of Healthy Start food (i.e. through piloting incentives for businesses to accept vouchers)	**LBM Public Health**	Uptake of Healthy Start Food vouchers monitored with an increase from baseline (baseline – xxxx 2019) Project plan developed and implemented.	**May 2019 –** project plan developed	Hilina Asrress (PH)	
	7.3) Develop and implement project plan to increase uptake of Healthy Start vitamin vouchers building on the previously completed pilot to increase the number of participating settings available.	**LBM Public Health**	Uptake of Healthy Start Vitamin vouchers monitored with an increase from baseline (baseline – xxxx 2019) Project plan developed and implemented.	**May 2019 –** project plan developed **January 2020 –** action completed and reviewed	Hilina Asrress (PH)	
7) We will deliver changes to	**7.4)** To monitor and implement the Merton Food Poverty Action Plan (through the Food Poverty Operational Group)	**LBM Public Health**	Six monthly updates on implementation at the CHW Steering Group	**April 2020 –** first FPAP implemented and reviewed	Philip Williams (PH)	

create a healthier food environment in Merton by working with partners and businesses	**7.5) LGD Action:-** To review existing approach to managing public events and implement a new approach to ensure the food and drink offered at council events are healthier, facilities are breastfeeding friendly and promote free drinking water	**LBM Environment & Regen**	Approach developed and implemented. All LBM managed public events to include healthier options.	**March 2019** – start of review.	Francis McParland (E&R)	Philip Williams (PH)
	7.6) LGD Action:- To manage and monitor proposals for new fast food takeaways (A5 uses) located within 400 metres of the boundaries of a primary or secondary schools in order to promote the availability of healthy foods	**LBM Environment & Regen**	Proposals to manage and monitor A5 use category produced, agreed and implemented as part of Local Plan. No. of applications for A5 use affected and outcome (quarterly)	**Ongoing**	Ann Maria Clarke (Planning – LBM)	Natalie Lovell (PH)
	7.7) LGD Action:- As part of the Merton Council Healthy Workplace programme, work with the current internal council catering contractor to meet the Bronze Food for Life Catering mark and to then consider Silver and Gold awards within the lifetime of the contract. *Food for Life is a national accreditation mark that recognises businesses that use freshly prepared, ethically sourced and natural foods.*	**LBM Public Health**	Bronze Food For Life Standard met and work underway to consider Silver and Gold awards.	**January 2020 (tbc)**	Rebecca Spencer (PH)	
	7.8) LGD Action:- To continue to support businesses that have achieved the Healthier Catering Commitment and explore ways to expand the number of businesses signed up to the Commitment in Merton. *The Healthier Catering Commitment is a voluntary scheme that supports food businesses to offer healthier food options and cooking practices.*	**LBM Environment & Regen**	Review of current arrangements completed and recommendations for future approach agreed and implemented. Current 37 businesses maintain HCC status.	**May 2019 –** HCC review complete	Rebecca Spencer (PH)	Andrew Bradley (Environ. Health)
7) We will deliver	**7.9) LGD Action:-** Promote the developed Merton School Food Policy guidance, and encourage schools to adopt elements of the policy. *The Merton School Food Policy provides an*	**LBM Public Health**	School Food Policy promoted to Merton schools.	**July 2019**	Hilina Asrress (PH)	Nicola Ryan (MSSP)

changes to create a healthier food environment in Merton by working with partners and businesses	*exemplar policy that local schools can adapt. It includes guidance on how to manage the range of aspects of food in schools, including birthday treats, school trips, pack lunches and drinks.*					
	7.11) LGD Action:- CSF commissioners to deliver school meals contract health and nutrition outcomes.	**LBM Children, Schools & Families**	School meal contract meets contractual health and wellbeing outcomes.	**September 2021**	Murray Davis (CSF)	Rebecca Spencer (PH)
	7.12) LGD Action:- To review existing advertising and sponsorship policies and agree and implement a new policy that tackles unhealthy advertising and promotes wellbeing.	**LBM Environment & Regen**	Review completed and new policy implemented.	**January 2019 –** Project timelines agreed	James MacGinlay (E&R)	Philip Williams (PH)
	7.13) LGD Action:- To explore encouraging developers to include public water drinking fountains within their development sites and increasing the number of public water fountains.	**LBM Environment & Regen**	Review completed and recommendations implemented for planning guidance. Number of planning applications including public water fountains Increase in the number of public water fountains	***tbc***	Ann Marie Clarke (E&R)	Natalie Lovell (PH)
Page 80	**7.14) LGD Action:-** Develop approach to supporting local businesses to promote free drinking water (based on existing local schemes around promoting available toilet facilities)	**LBM Environment & Regen**	Develop approach to supporting business to promote free public drinking water. Increase in the number of businesses offering free public drinking water.	***tbc***	Sara Williams (E&R) (tbc)	Natalie Lovell (PH)

8) We will increase and promote opportunities to be physically active	**8.1)** Ensure that plans for the “Merton Year of Physical Activity” include a focus on promoting and support opportunities for families, children and young people to be physically active. *The “Merton Year of Physical Activity” is a planned yearlong public campaign with each month focused on promoting different elements of increasing physical activity (i.e. ensuring a healthy workplace, accessing funding, NHS services)*	**LBM Public Health**	Each “Merton Year of Physical Activity” month includes a focus on support for children, young people and their families.	*tbc*	Barry Causer (PH)	
	8.2) Explore and pilot provision of free family cycle training provision in current commissioning plans.	**LBM Environment & Regen**	Review completed and recommendations implemented.	**May 2019**	Charmaine Jacques (E&R)	Natalie Lovell (PH)
	8.3) Promote the “Daily Mile”/Active Mile initiative locally to ensure that all primary schools in the borough are delivering the programme. *The “Daily Mile”/Active Mile is a national initiative to increase physical activity among school children by encouraging schools to run, jog or walk a mile outside.*	**LBM Public Health / MSSP**	Year on Year increase in number of participating schools (with an aim of all primary schools delivering Daily Mile/Active Mile by 2022)	**Dec 2022**	Hilina Asrress / Philip Williams (PH)	Hilina Asrress / Philip Williams (PH)
	8.4) Work with the Active Travel and Transport Subgroup of the Sustainable Communities and Transport Partnership, to promote active travel for children, young people and their families in Merton. *The Active Travel and Transport Subgroup has been set up by the Sustainable Communities and Transport Partnership and will be developing a work programme to increase levels of active travel in Merton.*	**LBM Public Health**	Active Travel and Transport Subgroup action plan includes significant actions focused on increasing active travel for families and children.	*tbc*	Barry Causer (PH)	

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Committee: Health and Wellbeing Board

Date: 26 March 2019

Wards: All

Subject: Merton Health and Care Plan

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

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

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

Recommendations:

A. The Health and Wellbeing Board is asked to comment on the Merton Health and Care Plan, and note the timeline following the discussion phase, towards a final document in July 2019

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1 Purpose of report and executive summary

This report presents the "discussion" document format of the health and care plan for Merton. Overseen by the Merton health and care together board, the plan identifies those areas where working across the entire health and care system should drive greater improvements for Merton residents.

The current document outlines the Merton health and care together vision, the case for change; driven by demographic change, needs assessments, and community and public intelligence and engagement, and outlines at a high level the areas of focus of the partnership and the impact they will have on Merton residents. The areas of focus are:

- Shared commitment to 5 prevention priorities
- Start well: emotional wellbeing and mental health for children; children and young people's community services, pathways into adulthood
- Live well: east Merton model of health and wellbeing, diabetes, primary mental health care, primary care at scale
- Age well: integrated health and social care

The final published document will include a financial/sustainability assessment of the impact of these schemes (in the context of other work outside of the plan to improve sustainability e.g. In outpatient redesign), and a delivery plan covering the next two years. The discussion document is intened not to engage on the areas of focus, which have been subject to significant engagement to date, but on the detail of the delivery plans.

The Merton health and care plan should be read in the context of the health and wellbeing strategy refresh. Whilst aligned along the "start well, live well, age well" categories, the health and wellbeing strategy focuses on the priorities to make Merton a healthy place, and how the wider determinants of health can be influenced. The health and care plan however, focuses on joint working and transformation of health and care services themselves.

2 BACKGROUND

2.1. The Merton Health and Care Plan has been under development over the last 6-9 months.

2.2. All boroughs in South West London are developing a Local Health and Care Plan, to describe the local, partnership priorities aligned to the ambitions within the South West London Health and Care Partnership.

2.3. The health and care plan has been developed under the auspices of the Merton Health and Care Together Board, first established in December 2017. A true collaboration between all partners, including voluntary sector and HealthWatch from the start, it seeks to develop a new relationship between providers and commissioners of services for Merton residents, focusing on delivering significant improvements to services in Merton and considering how the system can change to encourage further improvements, and achieve sustainable change.

3 DETAILS

3.1. See report

4 ALTERNATIVE OPTIONS

4.1. NA

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The Merton Health and Care Plan has been developed as a result of significant engagement with circa 20 engagement meetings held with local groups

5.2. On 21st of November a large scale engagement event was held to present the areas of focus and engage patients, the public, front line teams and partners. One key theme was the challenge to fully engage schools in attempts to improve children's health and wellbeing.

5.3. The Health and Care Plan as attached is a "discussion document" and will be used as the basis for further engagement. Whilst it is believed that the overall areas of focus won't change significantly, the detail of what should be in the delivery plans will be influenced by this next period of engagement, ahead of a final version in July 2019

6 TIMETABLE

Discussion document published: March 2019

Final version published: July 2019

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. Work within the Merton Health and Care Plan will have positive implications for the financial sustainability of the health and care system. Many of the schemes for example, are incorporated into Merton CCG's commissioning intentions and drive savings related to greater quality, and a reduced reliance on emergency care.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. NA

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. NA

10 CRIME AND DISORDER IMPLICATIONS

10.1. NA

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. NA

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

12.1. Merton Health and Care Together: Start Well, Live Well, Age Well

13 BACKGROUND PAPERS – N/A

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Merton Health and Care Together

Merton Health and Care Together: Start Well, Live Well, Age Well

A Local Health and Care Plan for Merton

Discussion Document: March 2019

Merton Health and Care Together:

Start Well, Live Well, Age Well

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Merton Health and Care Together:

Start Well, Live Well, Age Well

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Introduction

All the partners of Merton Health and Care Together want to ensure that people enjoy even better health and outcomes than their parents and live, longer healthier lives.

Within Merton, there is still an unacceptable difference between the life expectancy of people who are relatively wealthy compared to those who are not. We also know that some of our communities have particular needs that we are not always meeting. There is some excellent work being carried out across the Borough, but we are aware that:

- Whilst Services do a good job in reacting to people's needs, we need to do better proactive work to avoid ill health
- Some services are not joined up, with a resulting lack of continuity for service users
- Information sharing between services in the whole system is difficult
- There is huge value to be gained through better partnership working between statutory services, carers, communities and the voluntary sector
- We have problems recruiting and retaining the right workforce and getting the best out of them
- Both commissioners and providers of care have financial challenges

The Health and Care system is facing very significant challenges. People are living longer but many of us are, or can expect to, live with a series of long term conditions such as dementia, cardiovascular disease and diabetes. We recognise that services need to enable people to live healthy and rewarding lives and as such should take their individual circumstances into account.

We all share a responsibility to continue to ensure that our services are as joined up as they possibly can be in a whole system approach to wellbeing. We have formed a 'Merton Health and Care Together' Board to help us all work together in the best interests of Merton residents. Representatives from the NHS, Local Authorities, , and other key health and wellbeing providers will regularly review progress and make sure we are on track to meet the current and future needs of people in Merton.

The Vision for Merton Health and Care Together:

"Working together, to provide truly joined up, high quality, sustainable, modern and accessible health and care services, for all people in Merton, enabling them to start well, live well and age well"

We will deliver this through:

Supporting independence, good health, and wellbeing: people are enabled to stay healthy and actively involved in their communities for longer, maintaining their independence. People will be at the heart of the system, and care will wrap around them. The effective use of technology and data will help us understand people and their needs to provide the right advice, support or treatment.

Integrated and accessible person centered care: Joint teams in the community will provide a range of joined up services, seven days a week, that help people to understand how to take care of themselves and prevent the development or rapid progression of long-term physical and mental health illnesses. People will be helped by their health and care professionals and wider wellbeing teams, to make use of a much more accessible and wider range of services.

A partnership approach: Local communities will become more resilient, with voluntary sector organisations playing an increasingly important role in helping to signpost vulnerable people to the right service and in some cases providing that service. Peer support will have a vital role to play in counteracting loneliness and contributing to people's overall mental health and wellbeing.

Merton Health and Care Together

Our Context and Challenges

Merton Health and Care Plan, in context

The Merton Health and Care Plan is one element of work in Merton, and across South West London, to improve health and wellbeing

The Merton Health and Care Plan seeks to improve services through strong partnership working between providers and commissioners of health and care services in Merton. Reporting to the Health and Wellbeing Board, we will do this in the context of, and in conjunction with, the Merton Health and Wellbeing Strategy, and the South West London Health and Care Partnership:

Merton Health and Wellbeing Strategy:
Led and owned by Merton Health and Wellbeing Board, this seeks to create a healthy place that enables people to start well, live well and age well. Whilst health and care services are a partner in this strategy, it focuses on making significant improvements to those things that create good health and wellbeing such as the built environment, green spaces, and supporting healthy lifestyles.

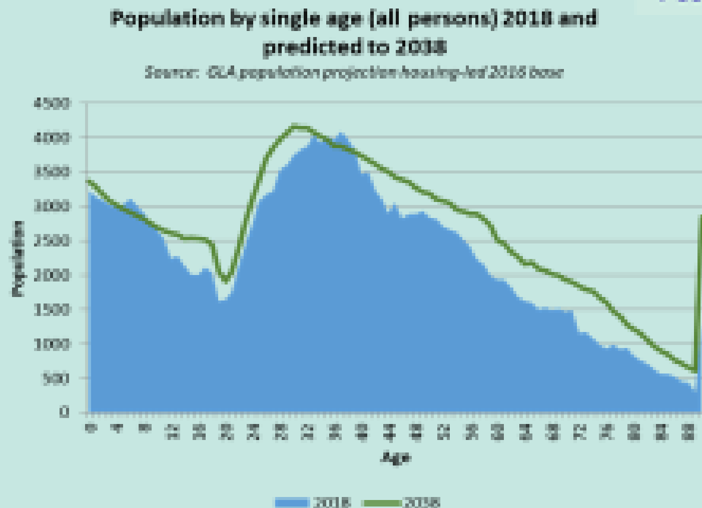
South West London Health and Care Partnership:
A partnership of the organisations providing health and care in the six South West London boroughs, divided into four local partnerships in Croydon, Kingston and Richmond, Sutton and Merton and Wandsworth. The partnership enables commissioning and transformation of services where this is best done across more than one borough, for example in cancer commissioning, transforming hospital services, and specialist mental health

Joint Strategic Needs Assessment: The Merton Story 2018

Key challenges:

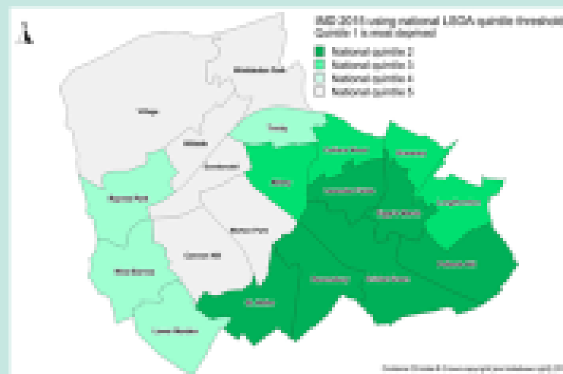
- Emotional Wellbeing and Mental Health
- Supporting wellbeing and independence
- Long term conditions
- People with complex needs
- The need to take a holistic approach

Demographics of Merton

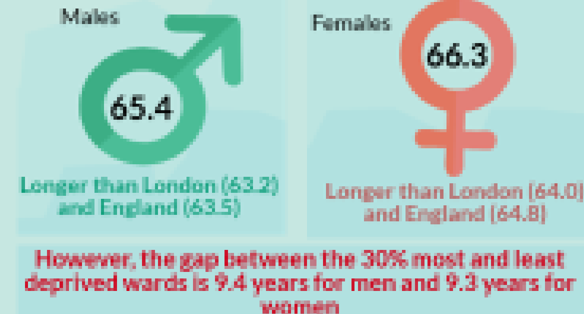


Inequalities and health divide

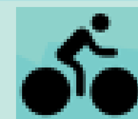
"People in East Merton have worse health and shorter lives"



Healthy lifestyles and emotional wellbeing



However, the gap between the 30% most and least deprived wards is 9.4 years for men and 9.3 years for women



Exercise

In 2016/17, just over 17% (28,000) of adults aged 19 and over were doing less than 30 minutes of moderate exercise a week. This is lower than London (23% and England 22%)

Increasing complex needs and multi-morbidity

Diabetes (Types I and II)

6.1% have diabetes which is slightly lower than London (6.5%) and England (6.7%).

Type II diabetes is more common in people of South Asian and African/Afro-Caribbean origin and affects people from BAME backgrounds at a younger age.

Dementia

An estimated 1,700 people aged 65 and over have dementia in Merton; 74.4% have received a formal diagnosis.

This is higher than London (71.1%) and England (66.4%).

Emergency admissions due to injuries from falls

England 2,114 per 100,000

London 2,201 per 100,000

Merton 3,262 per 100,000

Falls are the leading cause of older people being admitted to hospital as an emergency.

Child and family vulnerability and resilience

Children in care

England 62 per 10,000

London 50 per 10,000

Merton 36 per 10,000

Merton has a lower rate than London and England

16-17 year-olds not in Employment, Education or Training

3.5%, lower than London (5.3%) and England (6%).

Hidden harms and emerging issues

Air pollution

Tuberculosis

London 22.2 per 100,000

SW London 12.8 per 100,000

Merton 18.0 per 100,000 (about 40 people)

Seasonal mortality

More people die in the winter than the summer

Merton's changing population and rising demand for services

Our growing population means that by 2030 there will be:

- 45% more people with diabetes
- 50% more people with heart disease
- 80% more people with dementia

The number of births in Merton in 2016 was 3,246. There is a general downward trend. By 2025 it is projected that there will be an estimated 2856 births.

By 2025 there will be a 17% increase those aged 11-15 years. East Merton currently has a higher proportion of younger people compared to west Merton however, it is forecast that the number of younger people will decline in east Merton by 2030

There are 141,000 people of working age in Merton, increasing by 3.1% by 2025

The over 65 population in Merton is projected to grow by 10.3% by 2025. The Over 75 population will double

37% of Merton's population are from a Black, Asian, or Minority Ethnic (BAME) group; remaining unchanged by 2025. English, Polish and Tamil are the most commonly spoken languages in Merton. Children and young people from BAME backgrounds make up 67.9% of those attending a Merton school

These trends have important, well-reported, impacts on health and care demand as well as public space and housing. Working-age disability, with more disabled people surviving longer and the costs of their support increasing, means social care for people of working age now costs local authorities as much as that of older people.

Quality, Performance and Financial Context

We have a number of challenges to the quality and performance of our current services, in the context of significant financial challenges across the public sector

Quality and Performance Context: the NHS quality agenda sets out the three key elements for commissioning high-quality care: safety, effectiveness and experience. Through this process there is ongoing work to improve issues of staffing and workforce, and spread of best practice

There has been an ongoing challenge, in common with the wider NHS, in achieving standards for hospital waiting times for outpatient care and emergency care. Merton has also worked hard to achieve the standards for access to psychological therapies, and will introduce a new service model in order to make this sustainable. Performance against indicators of integrated health and social care perform well in Merton, for example levels of delayed transfers of care are some of the lowest in London.

Financial Context: Growth in population, and demand for new treatments and therapies will outstrip the budget. The NHS in Merton needs to achieve an annual efficiency of £11.5m to live within its means. The London Borough of Merton needs £10.4m in savings over the next 4 years.

Providers of services need to deliver significant service redesign on top of the already challenging financial position they face, most notably at St Georges Hospital. Local Authorities continue to face significant financial and sustainability challenges, as do many of their suppliers in the care market.

What residents tell us

Continuity of care remains a priority for people in Merton, with a particular reference to ongoing support for managing long term conditions such as diabetes.

Accessibility of services is very important to people in Merton, particularly for services they have to use regularly

There is significant support for better **integration of health and social care services**. Services do not always feel **person centred** and did not always take into account the background and preferences of the individual.

People in Merton place a lot of value in **therapy support, and other specialist input**. However people did report concerns about the capacity of these teams and their ability to recruit and retain good staff

People are very positive about the move towards services **encouraging wellbeing and independence**. The social prescribing pilot in East Merton has held up as being a particularly good example of this.

Mental Health is a clear priority for people in Merton. Access to mental health services was raised as a concern, particularly for services for common mental health issues.

We held a partnership health and care event on 21st November to get feedback on the areas of focus and come up with ideas to improve our work for people in Merton:

Merton Health and Care Together

Merton Local Health & Care Plan

South West London Health & Care Partnership
Start well, live well, age well

Electronic app to self-identify needs

Dr. Andrew Murray

What makes merton special?

Mental health & housing is a big concern in merton.

lots of green spaces!

How we work together

How do we help people live happy & fulfilling lives?

It's a challenging time of cuts & reductions

We need better linking services

Dr. Dagmar Zeuner

Zoë

We are swimming in data... the trick is making sense of it

Start well
Live well
Age well

We have a problem with unhealthy lifestyles!

& hidden harms like lonliness & winter deaths.

Needs to be more done to prevent people sliding into crime, illness & poverty

More clubs & activities for young people & support groups for older people.

More mental health support from an early age

Better communication about & between available services

STIGMA stops people seeking help

MORE FUNDING!

ONE STOP SHOPS for therapies & other services in schools.

PREVENTION

Understanding social media & modern pressures on young people

More holistic solutions like classes, groups...

Teach people to use technology.

More variety of peer support

Looking after ourselves

More Diabetes & Dementia nurses in hospitals

DISCOUNTED GYM MEMBERSHIPS

Invite local councillors to represent their views

Existing services

MINIMISE FAST FOOD SERVICES

'RED BAG' FOR MENTAL HEALTH

Medication
Background info
change name to 'my bag'

DIRECTORY listing all services UPDATED REGULARLY

Support for mums, pre & post natal

Service Improvement

Physical health checks for over 50's

SUPPORTING CARERS

Public health campaign around advance care planning

A PERSON CENTRED APPROACH

Children's development services

BETTER SIGNPOSTING

ONE BIG IDEA!

Link young people with marginalised communities

Increased healthy eating knowledge

"Wellness" surgeries

'YOU DAY' school activity & engagement day

More variations of peer support groups

Shared online space

Get the issue on primetime TV

"Red Bag" App

Well advertised MHS for young people

Highlight choice in end of life care

www.creativeconnection.co.uk

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Merton Health and Care Together

Our Work

Our Work: Underpinned by The Merton **Prevention Framework**

Prevention means helping people stay healthy and independent. It focuses on healthy lifestyles, underpinned by social, emotional and mental wellbeing, and creating a healthy place, where people can flourish and making health choices is easy.

We will focus on the evidence, which shows that support at a personal level is most effective as a core part of services provided by health and care teams, in both the statutory and voluntary sector

<u>Merton Health and Care Together: 5 prevention priorities</u>

1) Wellbeing Digital Hub
Single directory for health and wellbeing, for use by residents and front-line staff

2) Network of 'connectors' to link patients to wellbeing services and activities
Supporting the wide community of people providing health and wellbeing advice and support to do so consistently, accurately, and with an up to date knowledge of the community assets within Merton

3) Structured conversations training for front line staff
Skills for health and care staff to encourage users of services to engage in healthy lifestyles and support people to change their behaviour where required

4) Delivering healthy workplaces
Support our workforce to have good health and wellbeing, knowing that this is good for them, and those they support. We will focus on key issues such as mental health, joint health, healthy lifestyles through a common workplace framework

5) Embedding healthy lifestyles in clinical pathways
For example; healthy maternity pathway incl smoking, alcohol and maternal obesity

Merton Health and Care Plan on a Page

Our Vision:

Working together, to provide truly joined up, high quality, sustainable, modern and accessible health and care services, for all people and partners of Merton, enabling them to start well, live well and age well:

- Supporting Independence, good health and wellbeing
- Integrated, person centred care
- A partnership approach

		Responding to the needs of Merton Residents…	…Merton Health and Care Together will Focus on…	…to improve the lives of Merton residents
Prevention Framework across the life course	Start Well	**Integrated support for children and families** - More children in need due to abuse, neglect or family dysfunction, than London and England - Greater increase in children with special education needs than London and England . - Higher rate of A&E attendances in children under 18 years of age, than England. **Emotional Wellbeing and Mental Health** - Increase in children's use of substance misuse service, in contrast to a reduction across England - Rate of child admissions for mental health conditions higher than local authority nearest neighbours and England. - The fifth highest rate in London of emergency hospital admission for self-harm	**Emotional Wellbeing and Mental Health**: Children and young people to enjoy good mental health and emotional wellbeing, and to be able to achieve their ambitions and goals **Children and Young People's Community Services:** Create an integrated commissioning strategy identifying opportunities for integration **Developing Pathways into Adulthood**. Children and young people should continue to receive high quality services as they become young adults	Improved experience of and access to mental health provision Service tailored to individual and family needs Reduced need for emergency intervention
	Live Well	**Wellbeing and Log Term Conditions** - The main causes of ill health and premature deaths in Merton are cancer and circulatory disease - Steady increase in diabetes prevalence; an additional 1,500 people in Merton - Fewer than 1 in 5 adults are doing 30 minutes of moderate intensity physical activity a week - 1 in 4 adults are estimated to be drinking at harmful levels - Over half of adults in Merton are overweight or obese - Only 16.5% use outdoor space for exercise/health reasons, lower than London and England - 10% of the working age population have a physical disability **Mental Health and Wellbeing** - Higher reported levels of unhappiness and anxiety than in London and England - 16% of adults estimated to live with common mental health disorders like depression and anxietyHigher rate of emergency hospital admission for self-harm than London and England	**East Merton Model of Health and Wellbeing:** Developing a wellbeing model that underpins a holistic approach to self-management of long term conditions **Diabetes:** life course, whole system approach. Focus on prevention and health inequalities. **Primary Mental Health Care:** Single assessment, primary care recovery, wellbeing and Psychological Therapies **Primary Care at Scale:** improve quality, reduce variation and achieve resilience and sustainability	Improved wellbeing and independence Greater LTC control and outcomes Improved access to primary and community services Improved access to mental health support
	Age Well	**Complex health and care needs** - More people are living into older age with multiple long-term conditions - An estimated 1,686 older people have dementia in Merton - Merton currently supports around 4,000 adults with social care needs - Fewer people remain at home 3 months after reablement than both London and England - 11% of people have a long term illness, disability or medical condition - 5,900 people aged over 75 live alone. - Emergency admissions due to falls are significantly higher than London and England	**Integrated Health and Social Care:** Proactive and preventative services, rapid response, improving discharges, enhanced support to care homes, falls prevention, dementia care and high quality end of life care	Improved experience, and control of care Reduction in falls and ambulance callouts Fewer emergency admissions and A&E

Merton Health and Care Together:

Start Well

Together we will focus on:

Emotional health and Wellbeing for Children and Young People: Mental health issues amongst young people in Merton are on the rise and outcomes can be poor. We will deliver integrated, easily accessible mental health services for children and young people

Community Health Services for Children and Young People
We have an opportunity over the next two years to review our portfolio of children's community services, and recommission a truly integrated model of care

Developing Pathways into Adulthood
Services should respond to needs without using age as a barrier and it is up to us to facilitate this with flexible commissioning arrangements, so that different rules can apply

Why have we chosen **emotional wellbeing and mental health for young people** as an area of focus?

Mental health issues amongst young people in Merton are on the rise and outcomes can be poor

Let's take some facts…

- We have more children admitted for mental health conditions than the average for London and England
- We have the fifth highest rate in London for emergency stays in hospital for self-harm by young people
- We have very high numbers of children in need of support due to abuse, neglect or family dysfunction, compared with London and England
- The number of children with an Education Health and Care Plan or Statement of Special Education Need is growing faster than London, and England
- The number of young people accessing substance misuse services is rising, against the national trend

What are we doing to improve services?

We will deliver integrated, easily accessible mental health services for children and young people

Increasing children and young people's access to high quality mental health services, with a focus on the most vulnerable

Develop the local workforce to ensure the capacity and expertise to deliver high quality, and evidence based services

Work in partnership with schools and colleges to deliver a 'whole school' approach to emotional health, well-being and mental health

A **robust healthcare pathway is in place for children and young people in the criminal justice system**, on the edge of offending and antisocial behaviour.

To deliver a high quality Early Intervention in Psychosis service for children and young people from age 14

WHAT
will the impact be?

Children and young people will receive high quality support leading to:

- Access to mental health services improving by over 30%
- Access to support in schools via Mental Health Support teams
- Improved waiting times for children and adolescent mental health services
- Improved experience of services through better advice and support
- Reduction in the rate of hospital admission

WHO
are we trying to help?

Around 64,000 young people aged 0-24

Around 2400 children with mental health problems

Why have we chosen **community health services for children and young people** as an area of focus?

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The number of young people in Merton is set to rise significantly and we want to give them the best start in life:

Let's take some facts…

- 'School readiness' is a key measure of a child's development. In 2016/17, 73.94% of children living in Merton achieved this standard, similar to London, but we want to do better
- Parental mental health problems, parental misuse of alcohol and drugs and domestic violence are the most significant risk factors that impact on a child's health and wellbeing. Merton has a higher rate of these issues than London and England
- There has been a greater increase in children with an Education Health and Care Plan (EHCP) or Statement of special education needs (SEN) than London and England, driven by increases in diagnosis of autism, but also through an increase in social, emotional and mental health needs.
- Childhood immunisations are below the national target of 95%.
- 4,500 primary school children are estimated to be overweight or obese. One in 5 children entering reception are overweight or obese and this increases to 1 in 3 children leaving primary school in Year 6 who are overweight or obese.
- There is a higher rate of A&E attendances for children than the England average

What are we doing to improve services?

We have an opportunity over the next two years to review our portfolio of children's community services, and recommission a truly integrated model of care

The creation of an integrated commissioning strategy: this will include a focus on joint outcomes for children, young people and their families CYP and families; review of current commissioning arrangements and identifying opportunities for integration in borough aligned with the refresh of the Health and Wellbeing Strategy.

Review of community health services: we will review our community services for children and families, with a view to developing and commissioning an integrated model of care by April 2021

Integrated Model of Care: we will ensure that the commissioning strategy and community services review delivers integration of community paediatrics, child and adolescent mental health services, public health services and community services. These services will address children and young peoples individual needs. We will also seek to embed the Pathways into Adulthood principle that services will be available up to the age of 25 where this is preferable for individual young people

WHAT
will the impact be?

Development of truly integrated and person centred community services for Children and Young people, resulting in:

- A reduction in children attending A&E and being admitted as an emergency
- Improvements in school readiness
- Improved health and wellbeing
- Improved experience of services
- Shorter waiting times
- More responsive services for those with the greatest needs

WHO
are we trying to help?

Around 64,000 young people in Merton

Around 1600 Children with an Education, Health and Care Plan

Why have we chosen **developing pathways into adulthood** as an area of focus?

Young people experience significant difficulties in the “transition” from children’s to adult services. We need services that provide support into adulthood, that focus on the needs of individual young people, and do not discriminate based on age.

There is currently a Pathways to Adulthood Board, that exists in the context with children with complex special needs that are likely to be eligible for adult health services once they turn 18yrs, looking at what that transition looks like.

Statutory duties for children’s services go up to the age of 25yrs with a requirement in the Care Act that the planning starts in year 9, or 14 years old. Adult services will need to think about their growth and development and we must collectively seek to smooth this transition.

Care leavers also have a level of care up to the age of 25. They will often have complex mental health needs and may be traumatised but may not meet the statutory criteria of adult social care. Although their legal status changes at the age of 18, they may become adults at different stages/ages. These young adults need an adolescent service to chaperone them through this time rather than being excluded due to artificial boundaries.

Services should respond to needs without using age as a barrier and it is up to us to facilitate this with flexible commissioning arrangements, so that different rules can apply. There is not yet a full and clear understanding yet from children’s and adults services of the legal complications that may arise from this work, but it is our commitment to work in partnership to identify and resolve any challenges that arise

Merton Health and Care Together:

Live Well

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Together we will focus on:

Primary Mental Healthcare
We will deliver high quality and easily accessible services that take account of peoples wider health and wellbeing

Primary Care at Scale
Increased demand for care, and changes to national policy and workforce means we must transform how primary care is delivered

East Merton Model of Health and Care
Deprivation and need in East Merton demands a new approach to health and wellbeing. We will spread this learning across Merton to help all residents

Diabetes
The number of people with diabetes, or at risk of diabetes is growing significantly in Merton. We will develop primary and community care services to ensure people are supported to manage their condition effectively

Why have we chosen **primary mental health and wellbeing** as an area of focus?

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Many people with common mental health problems do not get the care and support they need, and this has a significant impact on their health and wellbeing

Let's take some facts…

- Around 8% of people in Merton reported low levels of happiness, broadly in line with London and England.
- A greater number of people in Merton reported high levels of anxiety compared to London and England.
- There are an estimated 24,000 adults in Merton with common mental health disorders such as depression and anxiety, around 16% of the adult population, which is lower than London but higher than England
- Only 7% of these adults are known about by Merton GPs. This suggests that many adults in Merton experiencing common mental health conditions remain undetected, and potentially unsupported
- Common mental health problems are proven to make managing diabetes, and other long-term conditions, much more challenging, with poorer overall health outcomes as a result

What are we doing to improve services?

We will deliver high quality and easily accessible services that take account of peoples wider health and wellbeing

We will deliver a single point of access to adult mental health services to help manage the demand for secondary mental health care

We will commission a wellbeing service to provide social support, including psycho-social interventions, to people with a range of mental health problems. This may include vocational support, benefits advice, housing advice, information workshops, and social peer group development.

We will commission an expanded Psychological Therapies service to provide clinically effective psychological therapies for common mental health problems. It will be integrated with physical health care pathways to provide targeted psychological therapy to clients with specified long term conditions

We will commission a Primary Care Recovery service to facilitate discharge from secondary mental health services, provide psychological therapies, and ongoing mental health care support

WHAT
will the impact be?

Increase access rate from 19% to 25% over the next two years, an additional c1600 people who will receive psychological therapies support

Around 1,800 people a year recovering from common mental health problems

Around 1000 more people living with long term conditions better supported, leading to a 25% reduction in use of emergency services

WHO
are we trying to help?

Around 140,000 adults living in Merton

Around 24,000 people living with common mental health conditions

Around 16,000 people living with a long term condition

Why have we chosen **primary care at scale** as an area of focus?

Challenges such as increased demand and complexity of care, workforce shortages as well as changing national policy means we must transform how primary care is delivered

Let's take some facts…

- The primary care workforce has changed with a shift towards more GPs working part time and in a salaried or locum capacity. This can cause gaps in frontline clinical time for consultations but also in a reduction in leadership capacity within practices
- National policy demands the provision of primary care 8am-8pm care 365 days a year.
- There is an increasing number of elderly and more complex patients needing care in the community.
- There are differences in the quality of services between different GP practices in Merton
- There are significant health inequalities between the east and west of the borough.
- The existing infrastructure (IT & estates) are not always fit for purpose to deliver high quality care

What are we doing to improve services?

A new GP contract sees practices increasingly working together to improve resilience and quality, increase capacity and provide local care alongside other local services in the community.

We will realise the benefits of the new GP contract by:

- Supporting all practices to come together in networks to deliver a range of new services;
- This will include significant new investment for the creation of new front line posts, embedded at network level
- Identifying opportunities to align community contracts and staff with these network arrangements

We will work to support our workforce by:

- Enhancing skill mix and using community services staff appropriately;
- Training existing practice staff to work in different ways e.g. receptionists sign posting people to community resources
- Delivering economies of scale
- Ensuring staff want to work in Merton and are retained

We will continue to improve access by:

- Development of the locality access hubs
- Embracing opportunities from technology and innovation where it makes sense to
- Explore the possibility of a single point of triage
- Joining up urgent care systems with primary care so that patients are seen in the most appropriate place to meet their needs.
- Improving public education in relation to self-care

We will improve organisational efficiency by:

- Maintaining and scaling up back office functions in practices
- Investigating efficiencies of scale could be achieved and also utilisation of collective purchasing power

WHAT
will the impact be?

High quality, sustainable Primary Care which is accessible, pro-active and co-ordinated, delivered across the Borough.

Over 20,000 more appointments available, including ability for patients to be seen on the day where clinically necessary

All Merton registered patients able to access primary care services online

All patients have access to social prescribing services.

Patient care is holistic and joined up across multiple agencies

WHO
are we trying to help?

Merton has a GP registered population of 220,000

Around 140,000 adults

Around 16,000 people living with a long term condition

Why have we chosen the **East Merton Model of Health and Care** as an area of focus?

Deprivation and need in East Merton demands a new approach to health and wellbeing. We will spread this learning across Merton to help all residents

Let's take some facts...

- Significant social inequalities exist within Merton. Largely as a result, people in East Merton have worse health and shorter lives: There is a gap of 6.2 years in life expectancy for men between the most deprived and least deprived areas in Merton. The gap is 3.9 years for women
- Premature mortality (deaths under 75 years) is strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts.
- Marked social inequalities are important drivers of the health divide. However Merton's plans for economic growth and regeneration have the potential for improving life chances and securing better health outcomes over time.
- Unemployment claimant rates in Merton are lower than London; however rates are more than double in the East of the borough, compared to West Merton. Unemployment in East Merton is higher than London and England
- 16% of households are overcrowded in Merton, but there are nearly doubled the proportion of overcrowded households in East Merton than West Merton

What are we doing to improve services?

We will seek to embed wellbeing into health and care services, and make the most of our community assets

We will deliver a whole health and wellbeing system working together: We recognise that health is about whole people (physical, mental and social) who are part of whole communities

We are working together on the vision for East Merton, driven by a requirement to address health inequality and rationalise and improve estates through the **development of the Wilson Hospital** site in Mitcham

At the core of the Wilson Health & Wellbeing Campus will be an **enhanced East Merton Primary Care Hub** offering significant scope for GP's working at scale for the whole population of East Merton.

Social Prescribing supports people to take control and explore behaviour change, as well as building social networks and enhancing community cohesion.

Local people will have **access to a wide range of services** on the site, to include community services, acute specialist consultants, social prescribing, diagnostics and community based voluntary services

WHAT
will the impact be?

Social prescribing available in every GP practice in Merton leading to:

- Improvements in wellbeing of around 25% as measured by the wellbeing star, for those referred to the service
- Around 30% reduction in use of GP services for those referred to the service
- Around 25% reduction in emergency hospital visits, for those referred to the service
- Greater utilisation of community assets and voluntary sector groups

WHO
are we trying to help?

Adults and Children across the whole of Merton

Why have we chosen **Diabetes** as an area of focus?

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The number of people with diabetes, or at risk of diabetes is growing significantly in Merton. We will develop primary and community care services to ensure people are supported to manage their condition effectively

Let's take some facts…

- Unhealthy diet, smoking, lack of physical activity, and alcohol account for around 40% of total ill health. The main causes of ill health and early death in Merton are cancer and circulatory disease
- Six percent of our residents are already diagnosed with diabetes
- Over half of adults living in Merton are overweight or obese. One in three children leaving primary school in Merton are overweight or obese
- We know type 2 diabetes can be prevented or reversed through better diet and more exercise. Fewer people in Merton exercise regularly than the London and England average
- Around £10bn - ten percent of the national NHS budget - is spent on treating diabetes every year in England.

What are we doing to improve services?

We will develop primary and community care services to ensure people are supported to manage their condition effectively

Supported patient self-care and self-management

- Healthy lifestyle, diet and exercise.
- Social prescribing.
- Mental health/IAPT.
- Online resources and local support services information.

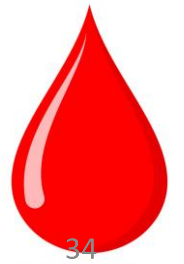
Consistent and high quality primary care

- Register for patients who are pre-diabetic.
- All people with pre-diabetes or diabetes receive annual HbA1C testing, diet, lifestyle advice, social prescribing interventions or referral to structured education
- Population analysis to target high risk patients
- Provide primary care diabetes clinical teams with appropriate education and training
- Offer injectable therapy
- Annual support from consultant diabetologist and pharmacists

A new Diabetes Community Service

Establishment of a Diabetes Clinical Advice Service:

- Single point of contact for diabetes-related advice and guidance
- Supportive GP visits from Community Services providing additional clinical capacity, as well as both face-to-face and virtual GP Practice support in the delivery of care.



WHAT
will the impact be?

Better care and support for people living with diabetes, or who are at risk of diabetes:

- Increased uptake of diabetes prevention programme
- Increase proportion of people receiving the 9 care processes as outlined by NICE
- 5% reduction in emergency hospital visits due to diabetes complications
- Reduction in medicines costs

WHO
are we trying to help?

Around 13,500 people with diabetes

Estimated 2,000 living with undiagnosed diabetes.

Merton Health and Care Together:

Age Well

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We will deliver this through:

Integrated Health and Social Care

The population is ageing and increasing numbers are living into older age with multiple long-term conditions such as heart disease, diabetes, and dementia. Complex needs require services that put the person in the centre. We will deliver:

- Proactive care for those at highest risk
- Improved response to crises and more effective reablement
- Integrated Locality Teams
- Support for the most frail and those with the highest need for services, such as those with dementia, and the end of life, and residents of care homes

Why have we chosen **Integrated Health and Social Care** as an area of focus?

The population is ageing and increasing numbers are living into older age with multiple long-term conditions such as heart disease, diabetes, and dementia. Complex needs require services that put the person in the centre.

Let's take some facts…

- The population is ageing and increasing numbers are living into older age with multiple long-term conditions such as heart disease, diabetes, and dementia
- Merton currently supports around 4,000 adults aged 18 and over with social care needs. Merton performs well for providing social care support to people in the community, higher than comparable local authorities and England
- Merton has comparably low rates of delayed transfers of care from hospital to home but the proportion of older people who were still at home 91 days after discharge from hospital following reablement is lower than London and England
- 10.8% of people in Merton were diagnosed with a long term illness, disability or medical condition
- Merton has around 17,000 carers. We know that caring can have a negative impact on the carer's physical and mental health, and that caring can adversely affect education and employment.
- Feeling isolated and lonely has a profound negative effect on physical and mental health and wellbeing. This is particularly important given we have an estimated 5,900 people aged over 75 living alone
- Falls are the leading cause of older people being admitted to hospital as an emergency, and rates are very high compared to London and England

What are we doing to improve services?

We will provide proactive, integrated and responsive care, including particular enhancements for those most frail and in need of services

Proactive care for those at highest risk. This will include the identification of high risk individuals, allocation of a key worker, person-centred planning and a common care plan across organisations

Improved responses to crises and exacerbation of conditions, including rapidly available alternatives to hospital admission, supported hospital discharge, rehabilitation, intermediate care and reablement

Integrated Locality Teams comprising of General Practice, social workers, community health services and mental health professionals. These teams will provide oversight and coordinated care to older people in Merton

Enhanced support for those most frail and those at the end of life. This will include supporting Care Homes with dedicated primary care support, enhanced community services, additional therapy input and dietetics and improved IT infrastructure

WHAT
will the impact be?

Provision of preventive, proactive, holistic and patient centred care, resulting in:

- Improvements in quality of life and experience
- Care Homes residents will require c500 fewer visits to hospital as an emergency, and will be admitted less often

WHO
are we trying to help?

Around 25,000 older people in Merton

Estimated 1700 people in Merton with dementia

Around 850 care home residents

Merton Health and Care Together

Creating the right environment for change

What needs to be in place to create the right environment for change?

The population is ageing and increasing numbers are living into older age with multiple long-term conditions such as heart disease, diabetes, and dementia. Complex needs require services that put the person in the centre.

Let's take some facts…

- Our current systems do not always talk to each other, and information sharing is inconsistent
- Whilst we aspire to person centred care, this can mean different things to different people, and different professionals approach it in different ways.
- Whilst we aspire to be able to support people to maintain independence and take care of their health and wellbeing, this requires a shift in mind-set and an appreciation of individuals circumstances and resources
- Providers of services do not always work together proactively
- The contracts we have in place with providers do not always encourage integrated care, and in some cases make it more difficult
- We have a workforce that is ageing, and we have challenges recruiting to certain professions
- Certain parts of the health and social care system have critical challenges in remaining sustainable.
- Some of the health and care estate is not fit for purpose
- There is limited use of technology to improve the delivery of services

What do we need to do to create the right environment for change?

We recognise that we need to make significant changes to the way health and care services work

Common Outcomes: We will ensure that services work together towards a common goal, and have a demonstrable impact on health and wellbeing

Developing a person centred approach: We will define a common approach to person centred care across and within providers of care in Merton

Provider development: We will develop greater collaboration between providers of services, and break down any barriers that get in the way of great care

Market development: We will address current risks in the market of health and care provision

Workforce: We will work with partners across South West London to address workforce gaps and training and development needs

Reforming our contracting and incentives: Contracts for services will encourage integration, and reward person centred care

Estates: We will develop a single estates strategy that supports integration and ensures community based integrated care

Digital: We will take the opportunities afforded by the NHS Long Term Plan to incorporate digital approaches to the delivery of services for people in Merton

Delivering the plan: the Merton Health and Care Together Board

Senior leaders from across the local authority, NHS and voluntary sector meet on a monthly basis to ensure improvements are delivered for people in Merton

The Merton Health and Care Together Board oversees the development and delivery of the Merton Health and Care Plan. Every major provider and commissioner of health or care services in Merton is represented (see right)

The Merton Health and Care Together Board is co-chaired by Merton Clinical Commissioning Group's Managing Director, and the Director of Communities and Housing of the London Borough of Merton. Held on a monthly basis, it oversees the development of the health and care plan, drives delivery, and ensures that the benefits of the plan are tracked and quantified. By having all of the leaders in the system in one place, the Merton Health and Care Together Board can effectively unblock any issues and manage any risks to successful delivery for people in Merton

The Merton Health and Care Together Board reports into the Health and Wellbeing Board on a regular basis. Each partner organisation also takes regular updates back to their organisations. Merton Health and Care Together is supported by a small programme team, who oversee and support delivery of the work programme.

Other work

Acute Transformation: Planned Care and Urgent & Emergency Care

Outside of the Merton Health and Care Together Programme, the NHS is working to ensure the quality and sustainability of acute hospital services meets our aspirations

Planned Care

- Developing primary care to support people outside of hospital where possible
- Cancer: new diagnostic tests to reduce the need for invasive procedures. Psychological support for people living with and beyond cancer
- Effective Commissioning Initiative, ensuring that procedures are evidence based
- New community services to manage hospital demand e.g. community ophthalmology services
- Clinical Assessment Services
- Outpatient redesign. Development of virtual clinics online and over the phone
- Diagnostic pathway improvement

Urgent and Emergency Care

- Ambulatory care. Same day medical support for adults and children to avoid admissions to hospital
- Integration of primary care expertise and capacity to avoid A&E attendances where possible
- Alternative Care Pathways: working with London Ambulance Services to identify where patients can receive support quickly rather than attend A&E
- Older Peoples' Advice and Liaison Service: providing tailored support to older people when in A&E
- Integrated Urgent Care (NHS 111)

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Committee: Health and Wellbeing Board

Date: 26th March 2019

Subject: Merton Health and Wellbeing Strategy 2019-24

Lead officer: Dagmar Zeuner, Director of Public Health

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

Contact officer: Natalie Lovell (Healthy Places Officer) Natalie.lovell@merton.gov.uk /Clarissa Larsen (Health and Wellbeing Board Partnership Manager) Clarissa.Larsen@merton.gov.uk

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Recommendations:

A. Note the methodology, findings and feedback from the engagement and workshop programme used to inform the outline Health and Wellbeing Strategy.

B. Discuss and approve the content of the outline Health and Wellbeing Strategy for development to a full draft. In particular:

   Principles and ways of working;

   Key themes and outcomes

   Ways of delivery

C. Discuss and agree preferred format and style for the final strategy

D. Note and agree proposed further work to be completed for the final strategy

E. Agree to receive a full draft Health and Wellbeing Strategy in the June HWBB for sign off and subsequent publication (following cabinet approval in July).

F. Discuss and agree to bring outline proposal for priority actions in Year 1 of the new strategy Year 1 to the June HWBB for consideration.

PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1 The purpose of this report is for the board to discuss the outline Health and Wellbeing Board strategy and give steer and approval to progress the work for final sign off in June. This report collates feedback and findings from the engagement programme and workshops that underpin the strategy development, presents an outline draft and asks for specific comments on content and format of the strategy.

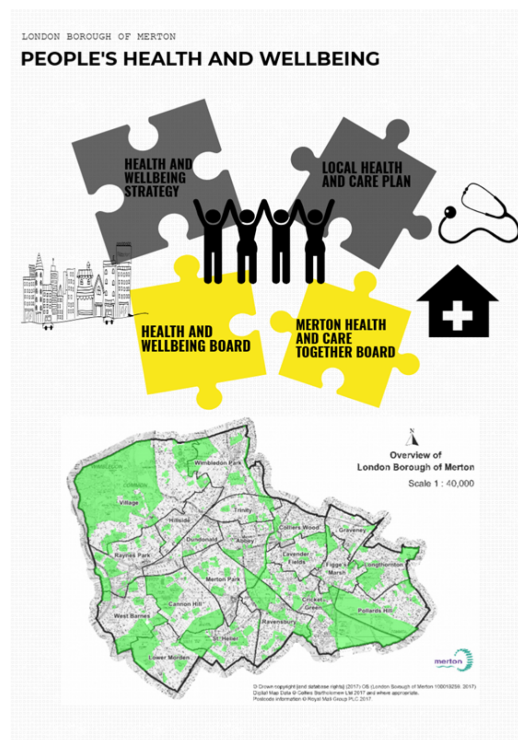
BACKGROUND

Synergy with the Local Health and Care Plan

2 At the January Health and Wellbeing Board members discussed the close links between the Health and Wellbeing Strategy and Local Health and Care Plan. We are continuing to work closely with colleagues to coordinate both of these plans and make sure they complement each other (see Figure 1. below).

Figure 1: How the Local Health and Care Plan and Health and Wellbeing Strategy fit together

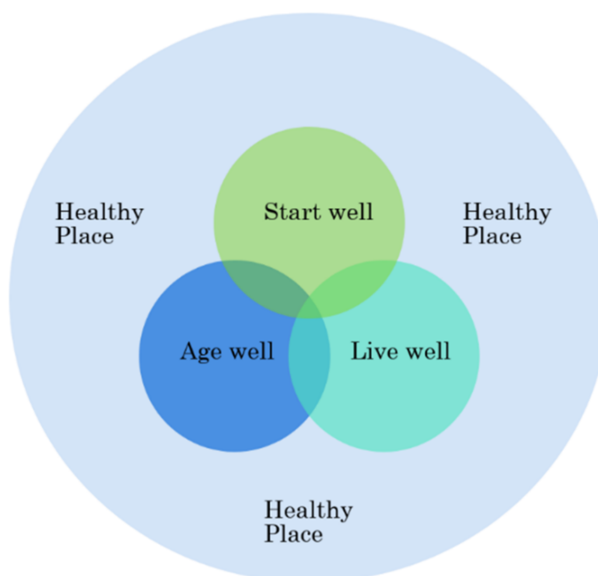
- The Local Health and Care Plan (LHCP) is overseen by the Merton Health and Care Together (MHCT) Board.
- MHCT Board focuses on health and care services and integration and reports to the Health and Wellbeing Board (HWBB).
- The HWBB is the statutory council committee to provide overall vision, oversight and strategic direction for health and wellbeing in Merton, including the wider determinants of health.
- The refresh of the HWBB strategy covers the same themes as the LHCP – start well, live well, age well – but with the addition and focus on creating a healthy place.
- The intent is to explicitly align the two plans to make sure they complement each other.



Summary of the Health and Wellbeing Strategy 2019-24 themes

3 Members of this Board have previously agreed the overarching themes (see Figure 2) for the new Health and Wellbeing Strategy of: Start Well; Live Well; Age Well in a Healthy Place with a particular focus on what a healthy place would look like to help people flourish, building on the ongoing work of the Health and Wellbeing Board in this area and its commitment to fairness, promoting early action and reducing inequalities.

Figure 2: Themes of the Health and Wellbeing Strategy 2019-24



DETAILS

Methodology

4 The Health and Wellbeing Strategy is a statutory duty for the HWBB and this refresh builds on existing work and aims to set its future direction. The Strategy reflects on the ways of working that the HWBB has adopted in recent years and its agreed principles and has taken forward, through the engagement programme, an ongoing conversation with stakeholders and local connectors. Work to date has included:

- **desk research** including the JSNA, Resident's Survey, data and latest publications to identify and inform initial priorities. This has helped us understand what matters to local people and informed the programme of workshops
- **engagement workshops** on themes of Start Well, Live Well, Age Well and a summary workshop on Healthy Place. Each led by HWBB members the workshops have involved over 100 stakeholders.
- **surveys** circulated to workshop attendees on themes of Start Well, Live Well, Age Well and Healthy Place to share with their networks and contacts. Results are being analysed and will feed into the final strategy.
- the Children and Young People's survey with covered questions relevant to Health and Wellbeing Strategy. Over 1,000 young people responded and results are being analysed and will feed into the final strategy.
- stakeholder engagement through reports to Merton Partnership, Scrutiny and Children's Trust Board for feedback on HWS development.
- learning from the Local Health and Care Plan deliberative event.

The workshop programme

5 The workshops allowed stakeholders to reflect on where the Health and Wellbeing Board can add most value, through its role in bringing the people of Merton together to work towards a shared vision of health and wellbeing.

6 Overall 100 participants from partner organisations and the voluntary and community sector took part in the four workshops, including community connectors and diabetes truth participants. An open, lively and participative discussion took place at each workshop and there has been positive feedback.

7 Summary findings are collated in **Appendix 1** and have informed the outline strategy.

Outline draft strategy

8 The draft Health and Wellbeing Strategy 2019-24 is attached to this report in **Appendix 2.**

9 The Board is particularly asked to discuss the content of the main sections:

- Principles and ways of working;

- Key themes and outcomes
- Ways of delivery

10 It is proposed that the format of the strategy is kept concise and uncluttered with supporting information referenced. If the board would find it helpful, we could collate in a separate supplement, or just use links.

11 There is outstanding work to be done to finalise the strategy, in particular the refinement of key outcomes and development of accountability framework including meaningful indicators.

NEXT STEPS

12 It is planned to bring the final draft Health and Wellbeing Strategy to the June HWBB which can then be published and shared widely. We aim for publication from July 2019 and will continue to work closely with the Local Health and Care Plan throughout.

13 The HWBB has worked successfully in the recent years through focussing on specific annual priorities for action. The new HWS suggests continuation of this practice (Ways of delivery – see above). Currently the focus is on tackling diabetes as a whole system approach with the action plan coming to this March board and our launch event taking place at the beginning of April. While it is important to keep momentum to ensure implementation, it is recommended that the HWBB receives an outline proposal for priority actions in Year 1 of the new strategy at the June Board so that work can start on developing a more detailed plan.

14 Potential priorities that have been discussed recently and where there is already work ongoing that we could build on include: scaling up systematic work on promoting Healthy Work places; CYP conversation about air pollution and their leadership role for a healthy place; and the possibility of an offer from the Leadership Centre to support further board learning in preparation for the future shape of the health and care system.

15. ALTERNATIVE OPTIONS

None for the purposes of this report.

16. CONSULATIONS UNDETAKEN OR PROPOSED

The consultation programme is as set out in the report.

TIMETABLE

Date	Meeting	Purpose
March		
26 March	Health and Wellbeing Board	Draft HWS to be discussed
June		
25 June TBC	Health and Wellbeing Board	Final HWS for sign off
July	Cabinet	HWB sign off

Key dates are next HWBB in June for sign off of the final draft and cabinet for approval in July 2019.

17. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purposes of this report.

18. LEGAL AND STATUTORY IMPLICATIONS

It is a statutory duty for the Health and Wellbeing Board to produce a joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment.

19. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Health and Wellbeing Strategy is directly concerned with improving health equity.

20. CRIME AND DISORDER IMPLICATIONS

None.

21. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A.

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

Appendix 1: Summary findings from the workshops

Appendix 2: Draft Outline Health and Wellbeing Strategy 2019-24

23. BACKGROUND PAPERS

None.

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Appendix 1

Health and Wellbeing Strategy Workshops

Summary findings

1. Background

Four workshops took place between October 2018 and February 2019, on the themes of Start Well, Live Well, Age Well and Healthy Place. Over the course of these workshops we had table discussions on specific topics, outlined in section 3 below.

The workshops allowed stakeholders to reflect on where the Health and Wellbeing Board can add most value, through its role in bringing the people of Merton together to work towards a shared vision of health and wellbeing.

Overall 100 participants from partner organisations and the voluntary and community sector took part in the four workshops, including community connectors and diabetes truth participants. An open, lively and participative discussion took place at each workshop and there has been positive feedback.

2. Values that emerged from the workshops

At each workshop we asked participants to tell us their values associated with the workshop theme. *Table 1* below summarises the values participants identified for each theme.

Table 1: Values

Values identified in the workshops
Start Well
• The importance of freedom • The right to play • Sense of belonging/identity • Access to healthy places and spaces • Building strong relationships • Family • Reducing inequality
Live Well
• Empower people

- Collaborate
- Ask what matters to people
- Social responsibility
- Build a strong community and social cohesion

Age Well

- Empower communities
- Social and intergenerational awareness
- Holistic approaches
- Collaborate & play to strengths
- Sense of belonging
- Think creatively
- Tackle stigma

Healthy Place

- Children are our future
- Build a sense of community
- Reduce inequality (health, social)
- Create a healthy place that creates health and wellbeing
- Mutual care, support and respect
- Accessibility (to physical environment) and connectedness (social networks)
- Space is intergenerational-push for an intergenerational approach
- Give people a healthy choice
- Build on what we already have and our assets
- Family

3. Workshop discussions

Over the course of 4 workshops we had table discussions around the following topics: Good start in life, childhood obesity, mental health and emotional wellbeing, diabetes, stress and resilience, healthy workplace, social connectedness, dementia friendly borough, active ageing, and healthy place.

Table 2 on the following page summarises the ideas that emerged from the workshop discussions. The table also includes the priority areas for Merton's Local Health and Care Plan, to show how both this plan and the Health and Wellbeing Strategy are complementary.

Table 2: Ideas emerging from workshops

Merton Local Health and Care Plan	Merton Health and Wellbeing Strategy
Start Well	
Emotional Wellbeing and Mental Health: Children and young people to enjoy good mental health and emotional wellbeing, and to be able to achieve their ambitions and goals **Children and Young People's Community Services:** Create an integrated commissioning strategy identifying opportunities for integration **Developing Pathways into Adulthood.** Children and young people should continue to receive high quality services as they become young adults	**Examples for emerging actions:** **Good start in life**: • Champion breastfeeding friendly workplaces • Champion 'child friendly' borough • Support for single parents in the home • Community cooking classes for families • Pop up play areas in streets, parklets • Adopt a 'Think Family' approach **Childhood obesity**: • Schools as key setting eg create 'School Superzones'-improve the urban environment around a school, School Travel Plans, healthy food offer at schools • Food growing initiatives in the community • Tackle advertising of unhealthy food • Improve families' access to cooking equipment and activities • Raise awareness of healthy eating and physical activity opportunities in the community • Galvanise all the levers there are to take action • Maintain a sustained focus on childhood obesity • Interventions in the built environment • Health in all policies **Mental and emotional health and wellbeing**: • Increase access to green space

	• Develop self-resilience • Support families • Create an environment that supports relationship building • Educate and help young residents to talk about their feelings • Build community spaces where people can come together • Empower children and young residents- hear their voices
Live Well	
East Merton Model of Health and Wellbeing: Developing a wellbeing model that underpins a holistic approach to self-management of long term conditions **Diabetes; life course, whole system approach.** Focus on prevention and health inequalities **Primary Mental Health Care:** Single assessment, primary care recovery, wellbeing and psychological therapies **Primary Care at Scale:** improve quality, reduce variation and achieve resilience and sustainability	**Examples for emerging actions:** **Diabetes:** • Healthy high streets make it easier to walk and cycle • Tackle advertising of unhealthy food • Increase community food growing opportunities & access to healthy food in the high street • Make the healthy choice the easy choice (eg in the food environment, with active travel) • Share stories and learning • Increase access to the right information • Community health champions • Community activities eg cooking lessons • Create a community centre/space for people to support each other and connect • Social prescribing approach is key • Prevention-start in schools **Stress and resilience**: • Improve access to green space • Social clubs in parks • Workplaces to focus on mental health and emotional wellbeing

<table>
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- Public art to encourage discussion
- Informal spaces in the community to drop in and connect
- Map community assets and identify the areas of greatest need
- Social civic responsibility
- Provide support for single parents

Healthy Workplace:

- Create social interaction through design in workplace
- Mental health training for staff

- Travel plans for workplaces/incentives for active commute eg cycle to work scheme
- Encourage businesses to sign up to healthy catering commitment
- Encourage businesses to sign up to Merton wider Breastfeeding Friendly Scheme
- Provide leadership for workplace health and model the way
- Share learning about what a healthy workplace is

</td></tr>
<tr><td colspan="2">Age Well</td></tr>
<tr><td>Integrated Health and Social Care: Proactive and preventative services, rapid response, improving discharges, enhanced support to care homes, falls prevention, and high quality end of life care</td><td>

Examples for emerging actions:

Social Connectedness:

- Intergenerational hub in community
- Signpost to activities in the community
- Community cafés/book clubs
- Push for intergenerational approach and use community spaces to do so
- Housing designed to promote social connectedness
- Roll out social prescribing
- Time banking approach

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	Active Ageing: • Age Friendly and accessible urban spaces for older people eg benches, flat pavements, accessible toilets • Businesses sign up to 'Take a Seat' campaign • Make leisure centres older people friendly • Engagement and commitment to action outside of health and care sector • Target people who have not yet reached older age • Buddying with older and younger people • Reframe ageing as positive **Dementia Friendly Merton**: • Dementia friendly libraries • Businesses trained to be Dementia Friendly • Intergenerational approach to Dementia • Build on what is already happening
Healthy Place	
	Examples for emerging actions: **Mental health and emotional wellbeing**: • Create safe spaces for young people to hang out in • Place makers and shapers need to speak out and break down damaging divides • Look at safeguarding issues as part of place • Connectedness is the root cause of social isolation-we need to connect assets together (eg libraries and youth centres) • Use design to make places feel attractive, safe and pleasant • Use places as spaces they wouldn't normally be used for eg film night in the fire station

	• Link housing and mental wellbeing- go beyond minimum planning requirements **Active ageing**: • Make the intergenerational connections eg young people with autism visiting care homes • Create environments that inspire, are accessible and green • Toilet facilities in public spaces- need more of • Build trees around new developments and in local areas • Help housebound people feel connected to their community • Cultural activities in the community to help people relax eg music • Community spaces and places that bring people together **Healthy workplace**: • Enable conversations about mental health • Walking clubs at lunchtime • Support small and medium sized businesses to ensure they are supported with health • Flexible working conditions • Create opportunities for socialising through the workplace **Childhood obesity:** • Tackling cars idling around schools • Create a healthy food system • Green planting • Encourage active travel

4. Priority areas

The Health and Wellbeing Strategy priorities for each theme have been developed and explored at the workshops held to date and the vision for each is outlined in *Table 3* below:

Table 3: Priority areas and vision

Theme	**Priority area to tackle**	**Vision**
Start Well	**A good start in life**	Every child and young resident has a fair opportunity to have a good start in life through being loved, playing, learning and having access to good work and living opportunities, socialising, feeling safe and growing up healthy in a healthy place
	Mental health and wellbeing	Every child and young resident has a fair opportunity to be listened to, build confidence and self-esteem, feel valued by and connected to their community and supported with their mental health and emotional wellbeing in a healthy place
	Childhood obesity	Every child and young resident has a fair opportunity to be a healthy weight by taking into account the multiple and interacting factors in their environment that contribute to the issue of childhood obesity and creating a healthy place
Live Well	**Diabetes**	People with, at risk of, or caring for someone with diabetes are supported by creating a healthy place that provides a healthy food environment, healthy streets and spaces that make it easier to walk, cycle and exercise, easy access to help, information and activities in the community, and takes into account the impact that poverty can have on affordability of healthy food and cooking equipment

	Stress and resilience	People at risk of or suffering from poor mental and emotional health are supported by creating and increasing access to outdoor spaces and nature, community and urban spaces (leisure, creative eg music/art/libraries, cafes, healthy food), healthy workplaces and good work, and services such as social prescribing which offer debt advice, in order to facilitate social connection and build resilience
	Healthy workplace	Businesses and workplaces proactively respond to the physical, mental and emotional health needs of both their staff and the wider community, as well as issues regarding social responsibility and a healthy planet
Age Well	**Social connectedness**	Social connectedness among older people is increased by ensuring we live in an age-friendly borough where older people feel welcome, safe and supported both through the physical built environment and also the social environment. Age-related stigma is tackled and social interaction between generations is facilitated in the community
	Active ageing	Older people are enabled and supported to be physically active in their community by creating a safe, accessible and welcoming physical built environment, increasing access to and choice of community and leisure activities, preventing falls and tackling age related stigma
	Dementia	People with dementia and their carers are supported through creating a dementia friendly community, defined as one that enables them to: find their way around and be safe; access the local facilities that they are used to

		and where they are known (such as banks, shops, cafes, cinema and post offices); and maintain their social networks so they feel they belong, as well as facilitating social interaction between generations

5. Key healthy place settings

The **Healthy Place** theme is integral to the first three themes. By 'healthy place' we mean the physical, social, cultural and economic factors that help us lead healthy lives by shaping the places we live, learn, work, and play. These factors also shape the choices we face, for example around the food we eat.

Key healthy place settings that have emerged from the workshops are:

- **Healthy homes**: Housing that helps create health and is free from health harms
- **Healthy schools**: Schools are surrounded by a healthy urban zone and inside create the conditions for good physical, mental and emotional wellbeing
- **Healthy food system**: Easy access to affordable, healthy food
- **Healthy businesses and workplaces**: Businesses and workplaces that proactively respond to the physical and mental health needs of their staff and the wider community
- **Healthy streets**: Welcoming, where people choose to walk and cycle, feel safe and relaxed, easy to cross, clean air, places to stop and rest, things to do and see, and shade and shelter
- **Healthy communities**: Where partnerships, relationships and community services and activities support health and wellbeing, and combat stigma. A built environment that supports social connectedness. A community that is enabled to make use of community assets that support health and wellbeing.
- **Health and care services**: Easy to access, efficient and high quality health and care services that provide holistic care

Figure 1 below captures the discussions that took place at the Healthy Place workshop.

Figure 1: Healthy Place Workshop Illustration

6. Where the Health and Wellbeing Board could add most value: Suggestions

The following list emerged from the workshops regarding where the Health and Wellbeing Board could add most value.

- Galvanise all the levers we have in Merton to make change happen
- Build on what is already happening and the assets we have
- Ensure a sustained focus on specific priorities (eg childhood obesity) and promote them
- Listen to, engage and partner with communities, empower them by giving them a voice (eg community conversations)
- Share positive stories and learning across the community
- Advocate more for children and younger residents
- Connect, build awareness and influence the key players in the system; community, voluntary and business sector, health and care sector, politicians and LBM – to take action on creating a healthy place
- Push for health in all policies
- Communicate about the link between health and wellbeing and healthy place (eg healthy workplace) and promote action on it
- Build an aspiration/vision for healthy places across the whole borough, rather than in pockets
- Promote the importance of healthy workplaces focusing on mental health, by modelling the way, supporting businesses to do so (eg by providing a framework for action) and share learning about what works

- Promote the importance of air quality and make it fun (rather than focusing on punitive policies)
- Push for intergenerational working
- Use Councillors' knowledge of their local places to understand where improvement is needed
- Be brave and take risks

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Merton Health and Wellbeing Strategy 2019-24

A Healthy Place for Healthy Lives

Draft outline

FOREWORD

Insert – from chair and vice chair

WELCOME

What makes us healthy

The physical and social conditions that make us healthy are all around us; for example the air we breathe, our schools, workplaces, homes, our relationships with friends and family, the food available, how easy it is to move around in the borough, how safe we feel in our streets.

These are known as the wider determinants of health, shown in the diagram below. Differential access and exposure are the main drivers for health inequality.

The main unhealthy lifestyles that are responsible for over a third of all ill health are smoking, alcohol misuse, poor diet and sedentary behaviour, underpinned by lack of emotional and mental wellbeing. Rather than due to individual choice, they are shaped by the physical and social conditions in which we are born, grow, live, work and age.

This is why our Health and Wellbeing Strategy focuses on making Merton a healthy place for healthy lives.

Insert Dahlgreen diagram

What is Merton Health and Wellbeing Board and how does it operate?

The Health and Wellbeing Board is a statutory council committee to provide overall vision, oversight and direction for health and wellbeing in Merton, including service provision and the wider determinants of health. It brings together local Councillors, GPs and community representatives supported by officers, as system leaders to shape a healthy place and health and care services.

The Board operates as a partnership where members are accountable to their respective organisations.

Merton Health and Care Together Board is a non-statutory partnership between Council and NHS commissioners as well as the main local health and care providers including acute and mental health hospitals, community trust and GP federation that reports to the Health and Wellbeing Board. It focuses on health and care service provision and integration.

The Health and Wellbeing Board and Merton Health and Care Together board have agreed to develop complementary strategies to best cover the breadth of health and wellbeing and avoid duplication.

The Health and Wellbeing Strategy will focus on making Merton a healthy place, meaning creating the social and physical conditions in which people can thrive; the Local Health and Care Plan will focus on provision of integrated high quality health and care services.

Both the Health and Wellbeing Strategy and Local Health and Care Plan commit the Health and Wellbeing Board to championing their guiding principles and key aspirations. Health and Wellbeing Board members have a collective and individual responsibility to ensure these are reflected in the business of their own and partner organisations, are heard in other groups and committees and become embedded in strategies and commissioning across the health and care system.

About the HWS

The purpose is not to provide a comprehensive overview of all major health issues; instead it is a tool to support the Health and Wellbeing Board as system leader where it can add most value: to champion guiding principles/ways of working, focus on key themes / outcomes, select a rolling programme of annual priorities for action and be accountable to partners and the community it serves.

The strategy is divided into 4 main sections:

- Where are we now - our starting position;
- Where do we want to go – what we want to achieve
- How do we get there – our way of delivery
- How do we know we got there – our framework for accountability

WHERE WE ARE NOW- OUR STARTING POSITION

Merton story/JSNA (Joint Strategic Needs Assessment) headlines- how healthy are people in Merton

Overall Merton is a safe and healthy place, rich in assets such as green spaces, libraries, good schools, and compares favourably with other London boroughs. However, the main challenges are:

- significant social inequalities between the East and West of the borough that drive a health divide including a persistent gap in life expectancy and ill-health;
- large numbers of people with unhealthy lifestyles (smoking, poor diet, sedentary behaviour, alcohol misuse and poor emotional/mental health and wellbeing);
- child and family vulnerability and resilience, ie increase in self-harm; childhood obesity
- increasing numbers of people with complex needs and multi-morbidity including physical and mental illness, disability, frailty and dementia; and
- hidden harms and emerging issues such as air pollution, loneliness, violence and exploitation.

Diagram 2 gives an infographic overview; more details see JSNA (insert link)

What people tell us matters to them about a healthy place

Through conducting desk research, 4 workshops and 4 surveys the following topics have emerged as being particularly important to local people:

- Mental health, good relationships and feeling connected to their communities and networks is one of the most frequently raised topics;
- Air quality is a top concern to people of all ages, but especially young people;
- Inter-generational opportunities had significant support, to connect older and younger people and build social cohesion;
- The food system needs to be tackled as adverts, fast food outlets, price of food, lack of healthy alternatives make the healthy choice difficult.
- Libraries and green spaces are assets that are very valued and people would like more community spaces and places to connect socially.
- Work places are a key setting with influence on people's health and offer a great opportunity to improve mental wellbeing and healthy lifestyle choices.
- Safety of the physical and social environment was another recurring theme of importance for people of all ages.

Diagram 3 depicts findings from the 'Healthy Place' workshop in February and includes descriptions of key 'healthy settings' such as homes, schools, work places, streets and health & care organisations. Further details are available – insert link.

HWBB learning from the last HWS about how to add most value

Over the 3 -year period of the last Health and Wellbeing Strategy (2015-18) the board has explicitly sought to experiment and learn about its challenge to be an effective system leader. This covered:

- Reflective board development work with the Vision Leadership Centre;
- Quarterly dashboard reviews replaced by an annual review that combines quantitative and qualitative information to produce insights for the board role, rather than replicate performance management approach;
- Practical active engagement of all members in community engagement (ie community conversations about the Wilson health and wellbeing campus and the diabetes truth programme, where members were connected to residents with diabetes bringing to life the day-today challenges);
- Selecting a small number of priority areas for action as a rolling programme with clear rationale for concerted effort rather than trying to cover a wide range of issues at the same time (ie whole system approach to tackling diabetes and childhood obesity; spotting the value of social prescribing and championing its development and roll out);
- Promoting and embedding principles and ways of working based on shared values including social justice in partner organisations.

A detailed summary of recent achievements and previous annual reports – insert link.

WHERE WE WANT TO GO- WHAT WE WANT TO ACHIEVE

Vision for Merton Local Health and Care Plan

Working together to provide truly joined up, high quality, sustainable, modern and accessible health and care services, for all people in Merton, enabling them to start well, live well and age well

Vision for Health and Wellbeing Strategy

Working together to make Merton a healthy place by creating the physical and social conditions for all people to thrive and complement the provision of holistic health and care services.

Principles and ways of working

The Health and Wellbeing Board is committed to the following principles and ways of working underpinning everything that we do including delivery of this strategy:

- Fairness – reducing health inequalities, especially the east/west health divide in the borough that is driven by social inequality and the wider determinants of health.
- Prevention/early intervention – helping people to stay healthy & independent and preventing, reducing or delaying the need for care.
- Health in All Policies (HIAP) approach – maximising the positive health impacts across all policies and challenging negative impacts.
- Co-production - working with and for the people/communities we serve; explicitly using and developing assets/strengths;
- Experimenting and learning- the problems we want to tackle are complex and there are no single or neat solutions; using data and intelligence transparently to understand and monitor impact and adjust accordingly.

Key themes and outcomes

Table 1 below gives a summary**.** The structure covers the life course using the same themes of Start Well, Live Well and Age Well as the Merton Local Health and Care Plan. This allows for easy cross reading and complementarity. Key themes and outcomes are meant to be specific enough to clearly articulate the direction for the board without unduly constricting its ability to adapt over the 5- year period of the strategy.

The key attributes for a healthy place that the Health and Wellbeing Board aims to enhance are:

- Promoting good mental health and emotional wellbeing;
- Making the healthy life style choice easy (with focus on food, physical activity, alcohol & drugs, tobacco);
- Protecting from harm, providing safety (with focus on air quality, violence)

The key healthy settings to bring together the above attributes that the Health and Wellbeing Board has identified as opportunities for focus are:

- Early years; schools; school neighbourhoods; work places; homes; intergenerational settings; and health & care organisations.
- Creating dementia friendly Merton.

Key outcomes as listed in table 1 need to be further defined and translated into indicators (more under delivery below). Further specific backing information about rationale for the key themes and outcomes are provided elsewhere (develop summary and insert link).

Table 1 - Key themes and outcomes

	Start Well	**Live Well**	**Age Well**
Key Healthy Place attributes	**Key Outcomes**		
Promoting mental health & wellbeing	Less self-harm Better relationships	Less depression, anxiety and stress	Less loneliness Better social connectedness
Making healthy choice easy	More breastfeeding Less childhood obesity	Less diabetes More active travel Healthier food choice	More active older people
Protecting from harm	Cleaner air Less violence		
Healthy settings – combining the above attributes	Healthy Inter-generational settings Healthy Homes		
	Healthy Early years settings; Healthy schools; Healthy school neighbourhoods	Healthy Work places	Healthy Health and Care organisations; Dementia-friendly Merton

HOW WE GET THERE - OUR WAY OF DELIVERY

Principles and ways of working

The Health and Wellbeing Board is committing to:

- Applying the above to all routine and statutory Health and Wellbeing Board business;
- Championing principles and ways of working in our respective partner organisations and embedding them into other strategies/plans.

Key themes and outcomes

Delivery will include:

- Development of a rolling programme, focussing on a few selected major/minor annual priorities for joint action;
- Discipline of seeking clear rationale about need for concerted board action to add value and specificity about who needs to do what to affect change or amplify impact; while allowing and encouraging experimentation and learning;
- Consideration of a variety of types of actions the board might best use to influence (informed by Health and Wellbeing Board experience about adding value- see above) including: engagement/community conversations, convening/bringing different sectors together to problem solve; supporting whole system exemplars; spotting opportunities for quick wins; raising awareness for emerging or hidden issues; further board development to be fit for changing health and care system; resurrecting previous priority actions to keep momentum.

HOW WE KNOW WE ARE GETTING THERE - OUR FRAMEWORK FOR ACCOUNTABILITY

Further work required on development of accountability framework, to include:

- Annual review + ad-hoc exception reports for any issue that requires board attention, covering principles & ways of working; key themes & outcomes; annual priorities for action and brief overview of previous annual priorities
- Quantitative 'markers' for Health and Wellbeing Board dashboard and qualitative information
- Lean approach; no performance monitoring (done elsewhere)

GLOSSARY– recognising how important language and terminology is for effective partnership working