Merton Council

Health and Wellbeing Board

Date: **25 June 2019**

Time: **6.15 pm**

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

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

Future meeting dates

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

Merton Councillors

- Tobin Byers (Chair)
- Kelly Braund
- Oonagh Moulton

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
26 MARCH 2019

(6.15 pm - 8.00 pm)

PRESENT

Councillor Tobin Byers - Chair
Councillor Kelly Braund - Cabinet Member for Children's Services
Rachael Wardell – Director of Children, Schools and Families
Dr Dagmar Zeuner - Director of Public Health
Phil Howell – Head of Older People and Disabilitie
Dr Doug Hing – Merton CCG
Dr Andrew Otley – Merton CCG
James Blythe – Managing Director of Merton and Wandsworth CCGs
Andrew McMylor - CCG
Lucy Lewis - CCG
Khadiru Mahdi - Chief Executive Merton Voluntary Service
Brian Dillon – Chair of Merton Healthwatch
Dave Curtis – Merton Healthwatch

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for absence were received from:
Councillor Janice Howard
Dr Andrew Murray – Vice Chair and Chair of Merton CCG
Chris Lee – Director of Environment and Regeneration
Lyla Adwan-Kamara -Community Engagement Network

Apologies for late arrival were received from:
Racheal Wardell-Director of Children, Schools and Families

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

No declarations of Pecuniary Interest were received
In the interests of openness and transparency Councillor Kelly Braund declared that she works with Diabetes UK but that she did not believe this to be a pecuniary interest.

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

RESOLVED: That the minutes of the meeting held on 29 January 2019 were agreed as an accurate record.

4 THE WILSON (Agenda Item 4)

Andrew McMylor, SRO Wilson Programme, MCCG and Dr Doug Hing, Clinical Director for East Merton presented the report giving an update on progress made on

the development of the integrated health and wellbeing services for the Wilson Health and Wellbeing campus.

Councillor Kelly Braund asked about the intergenerational nature of the new Wilson H&WB Campus. Dr Hing said that there would be a strong focus on Children and Young People and also on engaging with the whole community.

The Chief Executive of Merton CCG said that community engagement was absolutely critical, and this had been seen in action at a visit to a Health and Wellbeing Campus in Bromley-By-Bow where members were able to see that this model is most effective when local people and the voluntary sector are fully involved.

Khadiru Mahdi said there had been a good start involving the voluntary sector and community groups. He emphasised the need to get all stakeholders involved including Councillors and MPs. Andy McMylor confirmed that he will be talking to ward Councillors

The Director of Public Health said that the Wilson is part of a broader approach to tackling health inequalities across Mitcham and east Merton and it would link to other assets; The Canons, the Dementia Hub and Vestry Hall, can be connected. The Head of Regeneration agreed that there was lots of synergy and he would funnel comments through the Canons Steering Group.

The Chief Executive of Merton CCG commented that he wanted the Wilson H&WB campus to be different and to have a different structural arrangement between statutory bodies and local communities; with real engagement and involvement in design. It needs to evolve in a dynamic way to meet the needs of the local community which will develop over time.

Andy McMylor, Merton CCG, said that he was confident that funding would be resolved soon and then further details will be available. He continued that he sees this project as a focus for many other assets and initiatives in Mitcham and Morden.

The Chair asked about the difference between screening and diagnostic testing and noted that screening involved the whole population and involved looking for a specific condition, and diagnostic testing was used when an individual presented with symptoms to try to determine cause.

The Chair asked how people will know where to present and Dr Hing replied that there will be a link to A&E services and training to ensure correct process. There are also opportunities for wider wellbeing activity on the site ahead of the full development.

RESOLVED

The Board noted :

A. The 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.

5 TACKLING DIABETES AND PROMOTING CHILD HEALTHY WEIGHT (Agenda Item 5)

The Director of Public Health presented the report on the approach taken to the development of the Health and Wellbeing Board's Tackling Diabetes Action Plan and refreshed Child Healthy Weight Action Plan. She asked the Board to note the Launch event for these plans, the Sugar Smart Campaign and the Merton Mile on the 4th April.

Dave Curtis informed the Board that Healthwatch were doing some engagement on diabetes in BME communities. He asked if the CCG could help with the next stage in this work and James Blythe agreed that the CCG had an educational offer and it would be helpful to get this out to more people.

Councillor Kelly Braund expressed her support for the plans and launch event. She emphasised the links between practical support and mental health support and said that stigma around conditions must be removed and support created within communities especially with Children and Young People.
Dr Hing emphasised the importance of removing any stigma and not shaming anybody with these conditions. People have to feel empowered and want to be educated and receive support

The Chair informed the Panel that there was a lot of political support for these plans. The Chair continued that he had invited from Tom Watson MP, who reversed his own Type 2 Diabetes through lifestyle changes, to the launch event. Although unable to attend, he sent a letter in reply that gave a positive endorsement of the event and Merton's plans.

The Chair asked the Board to remember their conversations with their buddies at the Diabetes Truth Event. He asked The Director of Public Health to use these conversations to create some case studies similar to those that were part of the Wilson presentation, rooted in lived experience.

RESOLVED

The Health and Wellbeing Board agreed 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.

6 MERTON HEALTH AND CARE PLAN (Agenda Item 6)

Josh Potter, Director of Commissioning Merton CCG presented his report on the Merton Health and Care Plan. He asked the Board to note that the final plan will be available in summer 2019. He asked the Board to note that the Health and Care Plan should be read in the context of the Health and Wellbeing Strategy.

The Board noted that when the delayed Green Paper on Health and Social Care is released any necessary inclusions will be made.

Councillor Kelly Braund spoke about 'start well' and emphasised the importance of additional time given to young people who are transitioning from children's' services to either adult services, or who will no longer be covered by any services. She said that stability in this process is critical, and also that developing and training the workforce was the key to successful interventions.

The Board discussed how schools could be key partners, but that consideration had to be given to the challenges they currently faced. They are now responsible for safeguarding, SEMH (social, emotional and mental health) and pastoral care, and there must be consideration of how to support them in this role.

The Managing Director of Merton CCG said he was delighted to put this report forwards as it does feel co-designed. He said that it is a discussion document and gives Merton Health and Care Together its work programme. He asked the Board to note how structural changes were occurring all the time, for example, GPs were now being asked to work in Primary Care Networks. He emphasised that with new demands being made on primary care there was a need to help build resilience in the front line delivery organisations including GP practices and schools

The Head of Regeneration said that this document would feed into the Estates Strategy Workshop.

The Chair concluded by saying that the Board should not underestimate the strength of its partnership relationships, and that this report is an example of what can be achieved when working collaboratively.

RESOVED

The Health and Wellbeing Board commented on the Merton Health and Care Plan, and noted the timeline following the discussion phase, towards a final document in July 2019

7 HEALTH AND WELLBEING STRATEGY UPDATE (Agenda Item 7)

The Director of Public Health presented her report on the Merton Health and Wellbeing Strategy 2019-24. She drew members' attention to the 'principles and ways of working', 'key themes and outcomes' and 'framework for accountability' i of the Draft outline of the Strategy (Appendix 1), and invited their views and comments. She felt that a strength of the Board was that it knew what it could achieve and who was best placed to do the work.

The Board noted that they had worked successfully in recent years through focussing on specific annual priorities for action as a rolling programme. It has been helpful to have this annual rolling programme as it has allowed the Board to continue learning from past achievements. This has been very useful in the work on diabetes and in specific issues such as changing the food offer at public events.

Board members gave the director of Public Health some feedback on factors to consider and focus on in the Strategy The Board noted that there should be consideration of the evidence and experience base in terms of what had worked elsewhere.

The Director of Children Schools and Families asked the Board to note that although the 'Think Family Approach' appears in the 'start-well' theme it is not just located in CSF and it should appear throughout the four strategy theme areas. She asked the Board to consider if there were other approaches that belong across the strategy. The Director of Public Health said she would be happy to add 'Think Family' as a Principle and way of working for the Board.

The Board agreed that they were happy with the direction of the Strategy as detailed in the report and presentation. The Chair asked the Board to note that they shouldn't underestimate how much work they had achieved as a board, and it was interesting to look back on this

RESOLVED

That the Health and Wellbeing Board:

A. Noted the methodology, findings and feedback from the engagement and workshop programme used to inform the outline Health and Wellbeing Strategy.
B. Approved 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. Agreed preferred format and style for the final strategy
D. Agree proposed further work to be completed for the final strategy
E. Agreed 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. Agreed to bring outline proposal for priority actions in Year 1 of the new strategy Year 1 to the June HWBB for consideration.

Committee: Health and Wellbeing Board

Date: 25 June 2019

Wards: ALL

Subject: Merton Safeguarding Adults Board Report 2017-2018

Lead officer: Teresa Bell, Independent Chair, Merton Safeguarding Adults Board

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

Contact officer: Sarah O'Connor, Business Manager, Merton Safeguarding Adults Board

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Recommendations:

A. To consider and approve Merton Safeguarding Adults Board Annual Report for the period 2017-2018

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

To provide information and account of the Safeguarding Adults Board's activity for the year period in line with its Business Plan and set objectives for that year prior to the report's publication.

2 BACKGROUND

The Safeguarding Adults Board has three core duties to:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an annual report detailing how effective their work has been
- commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

3 DETAILS

The Care Act 2014 states that the Safeguarding Adults Board Annual Report must be sent to:

- the Chief Executive and Leader of the local authority which established the SAB
- any local policing body that is required to sit on the Safeguarding Adults Board
- the local Healthwatch organisation
- the Chair of the local Health and Wellbeing Board.

As soon as is feasible after the end of each financial year, a SAB must publish a report on:

- what it has done during that year to achieve its objective,
- what it has done during that year to implement its strategy,
- what each member has done during that year to implement the strategy,
- the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
- the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),
- what it has done during that year to implement the findings of reviews arranged by it under that section, and
- where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

4 ALTERNATIVE OPTIONS

4.1. N/A

5 CONSULTATION UNDERTAKEN OR PROPOSED

Individual partner agencies to the Safeguarding Adults Board have submitted their accounts, which have informed the collective report. (individual agency reports can be accessed via the Annual Report).

The report has been presented and accepted / signed off by members of the Safeguarding Adults Board.

6 TIMETABLE

As indicated.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. As outlined in report

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. As outlined in report

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. As outlined in report

10 CRIME AND DISORDER IMPLICATIONS

10.1. As outlined in report

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. As outlined in report

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

APPENDIX 1 **-** Safeguarding Adult Board Annual report 2017/2018

13 BACKGROUND PAPERS

Merton Safeguarding Adults Board

ANNUAL REPORT
2017 / 2018

Foreword by the Independent Chair

I am very pleased to introduce the Annual Report for the Merton Safeguarding Adults Board 2017/18. As the Independent Chair of the Board, I continue to be very grateful to all partners for their support and contributions to the Board. The Annual Report reflects the partner's commitment and enthusiasm for taking forward shared vision and actions over the past year. There is a lot that we need to do and want to do to reduce the risks of abuse and neglect in our communities and support people who are most vulnerable to these risks. In these increasingly challenging times of resource constraints and growing demand on services, the work of our partnership demonstrates a real willingness to work together, making the best use of our combined resources, to make Merton a safe place for everyone.

This Report shows what the Board aimed to achieve on behalf of the residents of the London Borough of Merton during 2017/18, together as a partnership as well as through the work of individual partners. The Report provides a picture of who is safeguarded across the area, in what circumstance and why. The Report helps us to know what we should be focussing on for the future. It includes the Business Plan for the next year, which will be reviewed and updated as we continue to identify new priorities for improvement, as well as ensuring that we maintain good performance and quality across the area.

The Board's most essential functions are to provide assurance that safeguarding practice is continuously improving and to commission Safeguarding Adults Reviews (SARs). We want to make sure that the lessons learned are making a difference and recommendations from the SARs directly inform our Business Plan priorities. The Board's understanding of local safeguarding matters has been greatly improved this year by the work achieved by performance and quality sub group members on a new management information report for the Board. This has enabled us to have a much clearer picture of the challenges and how Merton compares with similar areas.

We are keen to ensure that the work of the Board is accountable to local people and we need to find better ways of hearing from and engaging with local individuals and community groups, so that our work is directly informed by learning from people's experience of local services. To this end, the Board has started to make helpful links with local community and voluntary groups.

I am very aware of the pressures on partners in terms of resources and capacity so would like to thank all those who have engaged in the work of the Board, for their time and effort. I would also like to thank Sarah O'Connor, the Safeguarding Board's new Business Manager, who joined us in June 2018. Sarah has quickly and efficiently moved into her pivotal role, bringing her valuable knowledge of adult safeguarding policy and practice, as well as organisational direction and support, which is so essential in helping our partnership deliver its aims and objectives.

Introduction

Merton Safeguarding Adults Board (MSAB) was established in 2015 as a response to statutory requirements, defined under the Care Act 2014. The Board has been on a significant developmental journey since this period and this work continues in terms of its structural development and exercising of its key functions. Our vision is that *"**people are able to live as independently as possible, free from risk of abuse or neglect, people are treated with respect and dignity promoting choice and control wherever possible and receive timely support when they need protection"***

The annual report provides a summary of the partnership achievements during this period which has shaped our objectives for the coming year and demonstrates the collaboration and commitment as a partnership and Statutory Board.

Who are we?

Merton Safeguarding Adults Board is made up of a collection of local organisation both statutory members (Local Authority, Clinical Commissioning Group and Police) and non-statutory members (provider health services, fire, ambulance, probation, Healthwatch and the voluntary sector and other provider services) We work together as a partnership to ensure adults at risk of abuse or neglect with care and support needs (whether or not those needs are being met by any agency) receive appropriate advice support and guidance to keep themselves safe and ensure they are safeguarded in a proportionate, empowering and responsive manner.

Key partners to the board are:

- St George's University NHS Foundation Trust
- Healthwatch Merton
- London Ambulance Service
- Probation Service
- London Fire Brigade (LFB)
- Clarion Housing Group Limited
- Mental Health Trust
- Merton & Wandsworth Clinical Commissioning Group (CCG)
- Central London Community Healthcare NHS Trust (CLCH)
- London Borough of Merton
- Metropolitan Police
- Safer Merton
- Merton Children's Safeguarding Board

What do we do ?

The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out at paragraph 14.2. of the Care Act Guidance. The Safeguarding Adults Board (SAB) has three core duties. We must:

- ✓ Publish a strategic plan for each financial year that sets how we will meet our main objectives and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be

evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.

- ✓ Publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adult's reviews and subsequent action.
- ✓ Conduct any safeguarding adults review in accordance with Section 44 of the Act.

The SAB can be an important source of advice and assistance, for example in helping others improve their safeguarding mechanisms. It is important that the SAB has effective links with other key partnerships in the locality and share relevant information and work plans. They should consciously cooperate to reduce any duplication and maximise any efficiency, particularly as objectives and membership is likely to overlap. The graph below shows links to our key partnerships

What have we achieved as a partnership against our priorities set for 2017-2018?

Priority 1:
We will ensure that partner agencies work together to prevent abuse and protect adults at risk of abuse and neglect.

Partners have worked together during this period to develop a number of forums in order to prevent and respond to the local and national safeguarding agenda in areas of complex case management and safeguarding work and to develop robust multiagency pathways. Key achievements have been the development and implementation of:

- Modern slavery learning forums
- Safeguarding learning forums
- Hoarding group
- SAM refresher training and working group.

Priority 2:
We will strengthen our communication and engagement across groups and communities in Merton to increase public awareness of safeguarding adults and to ensure that our plans and actions are informed by the experience of the widest range of local people.

In response to this key priority of the Board partners undertook a commitment to commence a programme of awareness raising and outreach within our community although this work continues to be developed. Partners have implemented:

- A programme of Voluntary Sector and Provider Services safeguarding training has been delivered free of cost.
- Safeguarding team links have been established to all social care community teams to review and monitor the nature of open safeguarding concerns and enquiries. This work has helped to identify emerging risk in "hard to reach" areas of our community whilst providing a supportive training and development opportunity for partners in addition to achieving a quality assurance mechanism in practice.

Priority 3:
Together we will learn from experience and support both paid and unpaid staff across the partnership to continually build confidence and the effectiveness of everyone's safeguarding practice.

Although this year we have been unable to progress to a full workforce development strategy as required by the Board, targeted priority work has been undertaken by the partners to progress learning and confidence by ensuring:

- Coordination of the Safeguarding Adult Review (SAR) evaluation group.

- Commissioning of 2 SAR's this year.
- Key training development and delivery

Priority 4:
We will understand how effective adult safeguarding is across Merton to ensure that we identify emerging risks and take action accordingly

The Board recognises the importance of developing data reporting methods and analysis of that data in order to identify and respond to emerging local risks and trends. As such partners have committed to specific task and finish groups (in the absences of an established performance and quality subgroup) to identify and report to the Board on relevant data and analysis from the following achievements:

- The local authority safeguarding team have established links to all social care community teams to review and monitor open safeguarding concerns and enquiries.
- Modern Slavery group – There has been partnership working with Safer Merton and Adult Safeguarding to develop a Modern Day Slavery strategy and protocol for the Borough.
- We have progressed the work on risks associated with hoarding this year by developing a dedicated meeting as part of the CMARAC (community multi-agency risk assessment conference) meetings and we are in the process of reviewing our multi-agency protocol.
- The partnership has begun work on developing a dashboard format for the MSAB to enable accurate reporting and overview by the Board to improve its understanding and response to local emerging needs and trends.

What are our priorities for the coming year 2018-2019?

The Boards Business plan for 2018-2019 is attached in appendix 1 of this report. The plan provides detailed activity across the partnership in order meet its set priorities for the coming year. However key initiatives are summarised below. For the 2018/19 period we commit to:

- ✓ Development of multi-agency subgroups- Training and development/Performance and Quality/Communication and Engagement
- ✓ Development of a MSAB website
- ✓ MSAB Data and Performance Dashboard
- ✓ Enhancing reporting mechanisms into the MSAB
- ✓ Maximising opportunity to engage with the community, voluntary and provider sector in the work of the MSAB
- ✓ Development of key strategies such as a communication strategy, workforce development strategy
- ✓ Ensuring a quality assurance framework for Safeguarding adults at risk is achieved.

How will we monitor the impact of our work and commitment?

The partnership is committed to developing formats to ensure the impact and actual outcomes for adult at risk in Merton are measured and inform our work and development as a collaborative partnership. It is anticipated that the development of subgroups in the coming year will enable development of effective methods to truly measure the impact of our work and what difference this makes to the residents of Merton.

Commitment to the engagement of wider community stakeholders will help us hear “the voice of the community” and the experiences of people who have required safeguarding services. This is crucial for not only promoting the Making Safeguarding Personal agenda but to enable the MSAB to measure the effectiveness and impact our individual agencies performance and wider strategy as a Board.

It is anticipated that development of the Quality Assurance Framework (QAF) for Safeguarding in Merton will incorporate a programme of regular audit in addition to “deep dive” focused audit in response to emerging areas of local or national trends in safeguarding adults at risk. Clear reporting mechanisms into the Board will support the assurance requirements of the Board and in turn drive the work of the Board and its wide range of stakeholders.

Safeguarding Data 2017/2018

During 2017/18 280 individuals had one or more safeguarding concerns raised amounting to 322 concerns being received by Merton Local Authority in total. This is significantly lower than report for 2016/17.

Section 42 Safeguarding enquiries were started for 76 of those individuals (totalling 80 enquires) this data shows a significant reduction in sec 42 enquires with a decrease of 32% from the previous year.

Overall the conversion rate from concern to enquiry showed a minimal increase from 20% in 2016/17 to 25% in 2018/19. Complete enquiries indicated the highest prevalence in type of abuse was neglect and acts of omission. There were issues identified in the recording of outcomes on completion of enquires however where the outcomes were recorded, risks were identified in 26 cases of which the risk was removed from 23 of those cases.

What Does the Data tell us?

- ***Comparator Data***- benchmarking of our statutory returns data highlights that Merton had a very low number of concerns and enquires undertaken during this period in comparison to other local authorities and the national average. Despite comparator data indicating steady increase year on year of safeguarding activity Merton saw a sharp decrease over the same period.

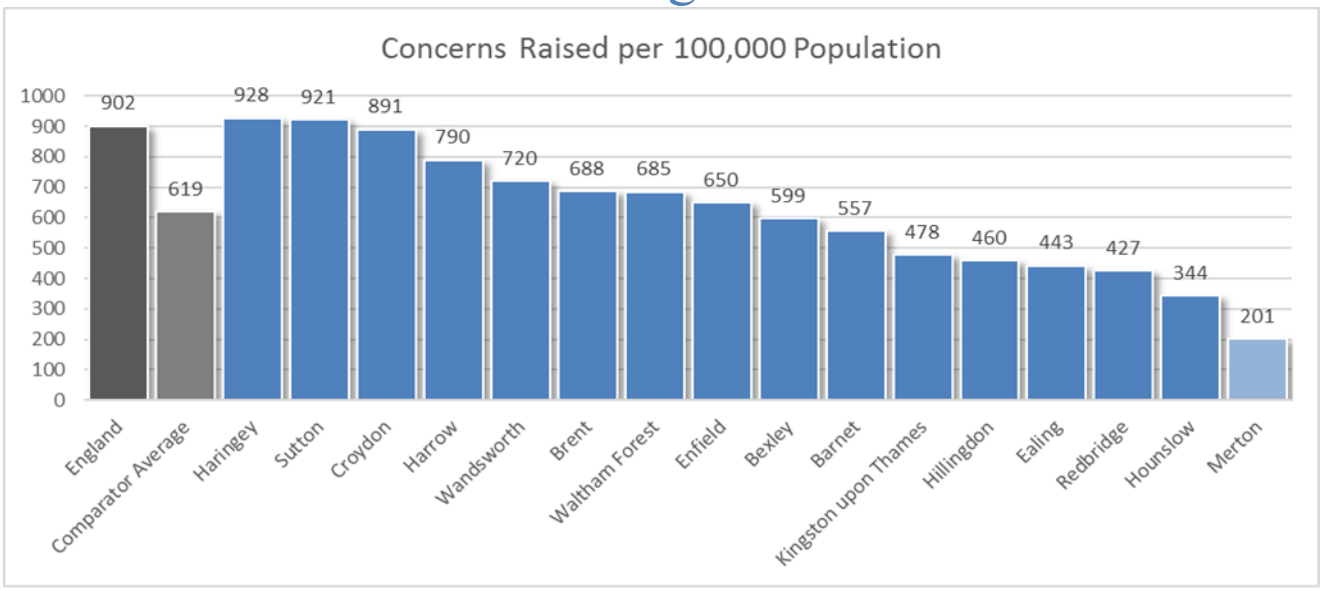
Acknowledgement of inaccuracies in published data.

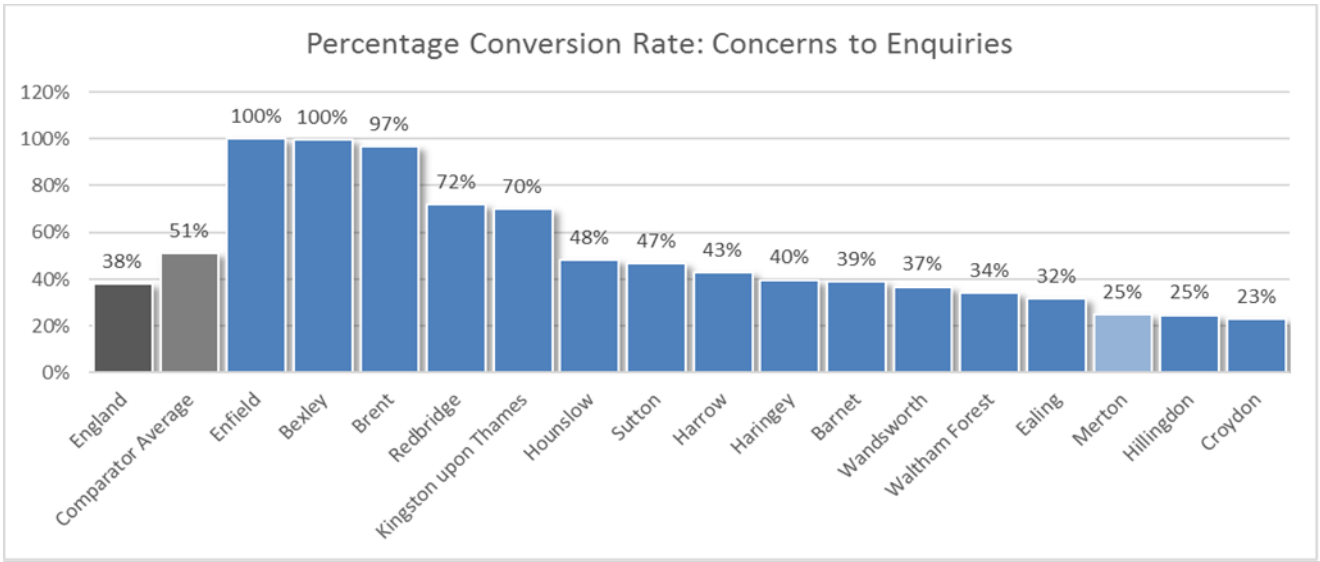
Whilst change and implementation of a new recording system within the borough was developing during this period, more detailed data and audit of activity is required to truly understand the causal factors for the data inaccuracies.
As such the Board highlights and recognises that the data contained within this report is most likely not an accurate reflection of concerns received from partner agencies and safeguarding activity undertaken within the borough. The Board is committed to assuring that safeguarding data for the coming year is truly reflective of safeguarding activity within the partnership.

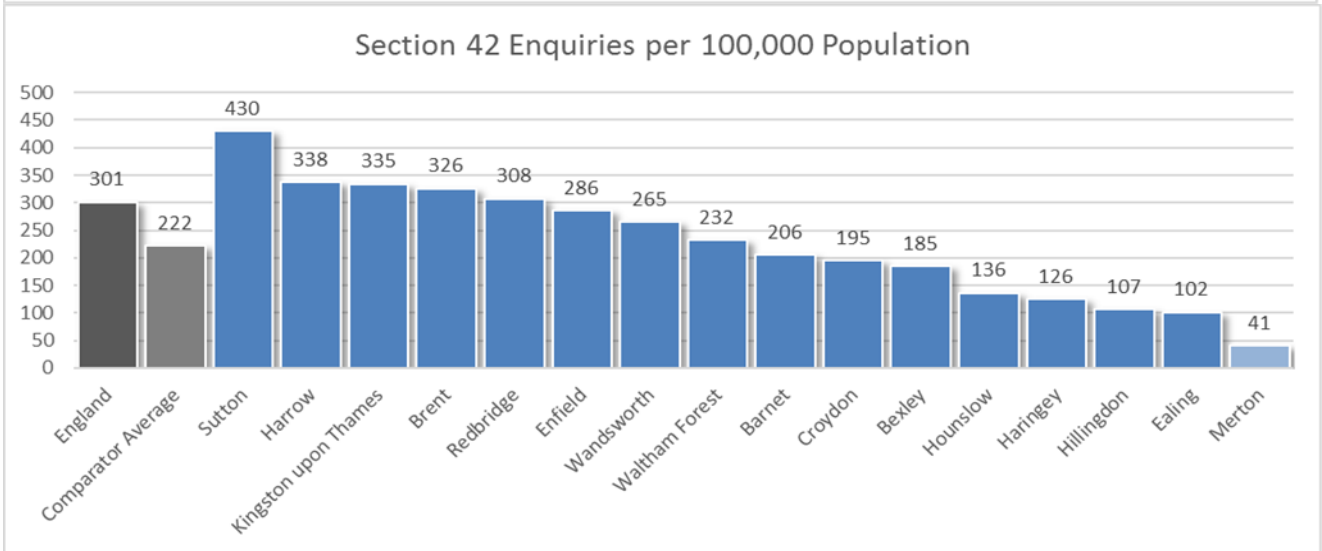
Merton Adult Safeguarding Board Financial Report 2017/18	
	Outturn £
Income	
Contributions Brought Forward from 2016-17	(21,000)
Contributions Received in Year	
Metropolitan Police	(5,000)
London Fire Brigade	(1,000)
Merton CCG	(25,000)
London Borough of Merton	(38,172)
Total Contributions	**(90,172)**
Expenditure	
Salaries:-	
Independent Chair	15,543
Safeguarding Manager	22,915
Admin Support	15,256
Other Expenses:-	
Fees	56
Travel	1,129
Room Hire	334
Refreshments	338
Total Expenditure	**55,571**
Total (Under)/Overspend	**(34,600)**
Carried Forward to 2018-19	**(34,600)**

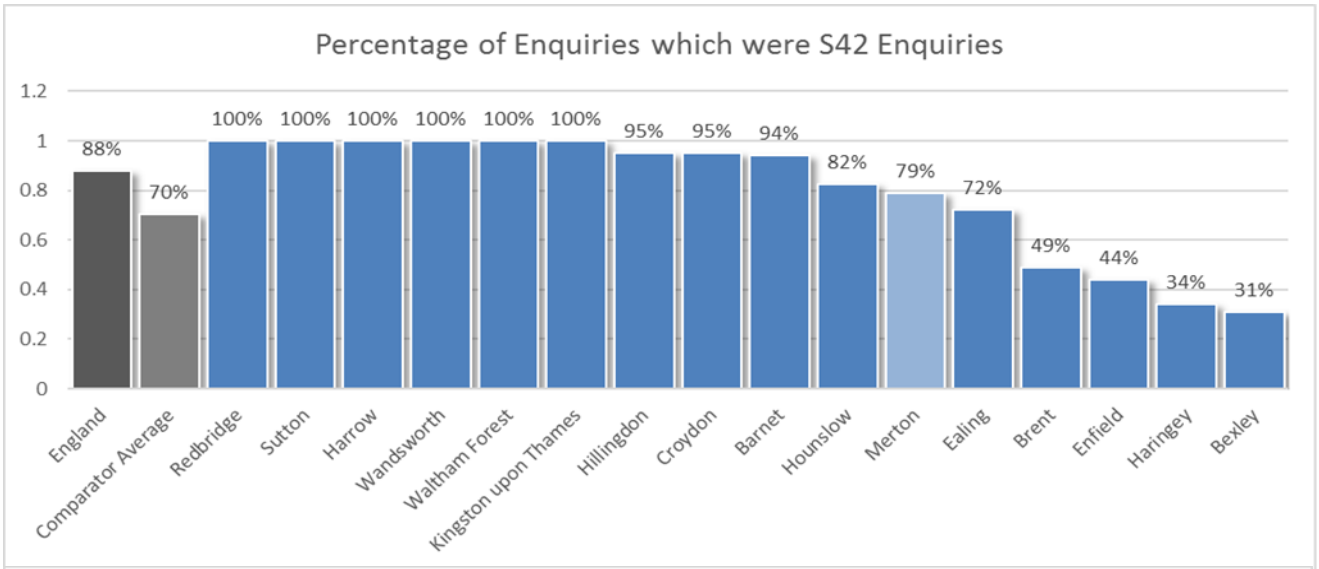
Financial year 2017-18 there was an under spend of £34,600 which was carried forward into 2018-19. The 2017-18 the board was in the early stages of scoping out its remit and agenda.

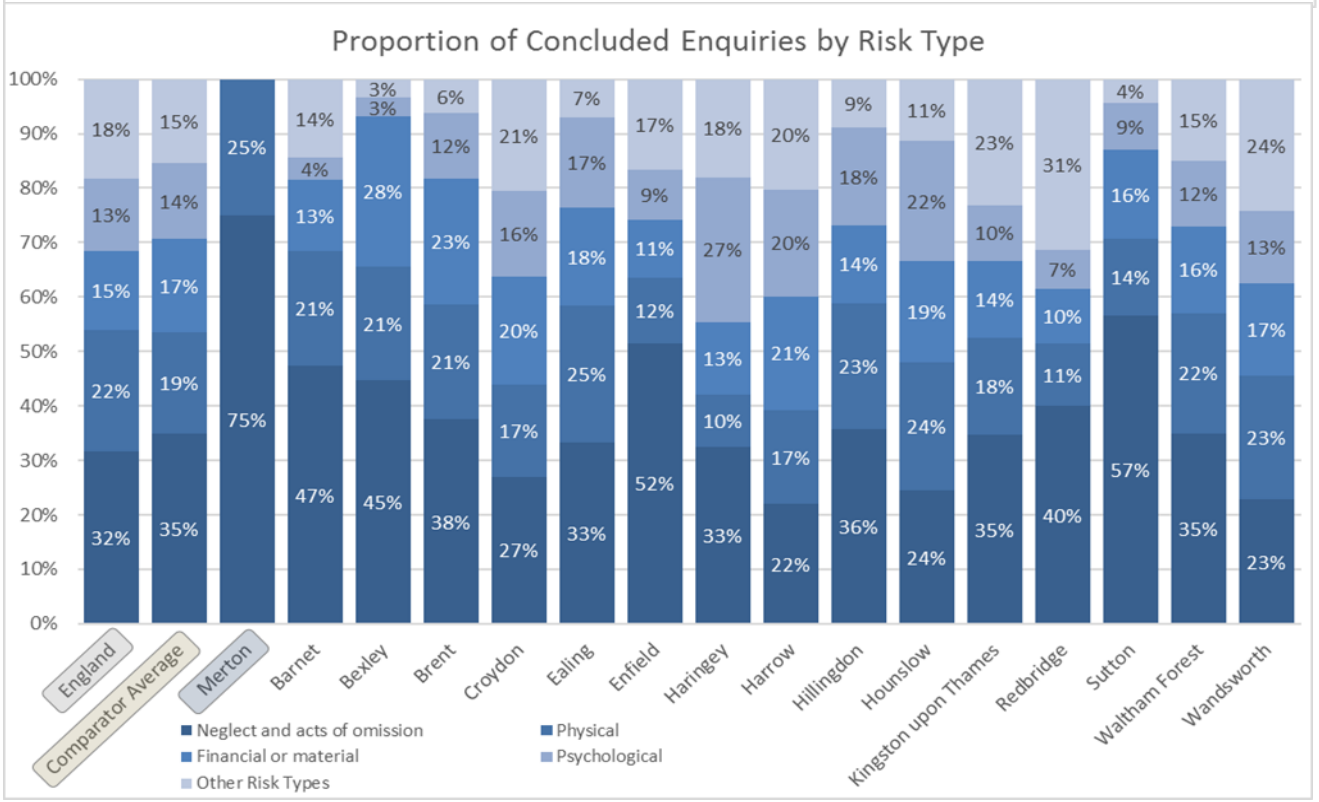
Merton Safeguarding Board Report
Benchmarking 2017-18







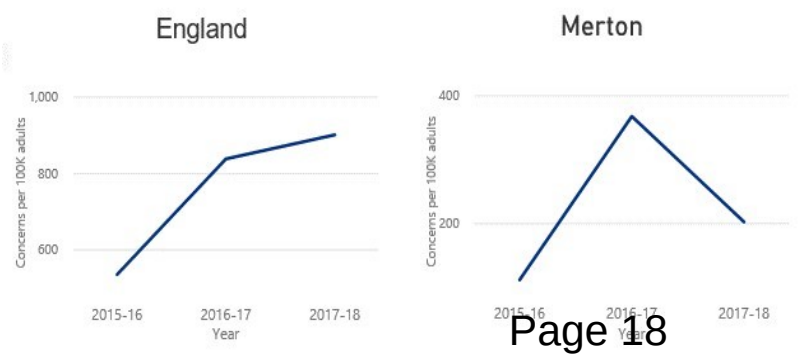




Note: Merton's concluded enquiries were for risk types other than Neglect and Acts of Omission and Physical Abuse are excluded from the benchmarking dataset as the numbers are too low.
Risk types included in the 'Other' category are discriminatory abuse, domestic abuse, modern slavery, organisation abuse, self-neglect,

sexual abuse and sexual exploitation.

Concerns per 100,000 population - Trend (Source: NHS Digital)



Key Points:

Benchmarking data shows that Merton had very low numbers of concerns and enquiries per 100,000 population compared to the whole of England and to other comparable authorities. The percentage of concerns converted to enquiries also remains low.

Across England, there has been an increase in numbers of concerns per 100,000 population, between 2016/17 and 2018/19, however Merton saw a sharp decrease over the same period.

Appendix 1- MSAB Business Plan 2018/19

Business Plan 2018-19.docx

Appendix 2- Individual Partners Assurance reports to the MSAB Annual Report

CLCH contribution to the Merton Safeg

Merton and Wandsworth CCG's

Merton Safeguarding Adult:

Partner agency contribution to the

Partner agency contribution to the

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Committee: Health and Wellbeing Board

Date: 25th June 2019

Agenda item:

Wards: Borough Wide

Subject: Merton Joint Sexual Health Strategy

Lead officer: Dr Dagmar Zeuner, Director of Public Health

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

Forward Plan reference number:

Contact officer: Julia Groom, Consultant in Public Health /Kate Milsted, Sexual Health Commissioning Manager

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Recommendations:

That the Health and Wellbeing Board members:

A. ***review and endorse the proposed vision and priorities for the borough wide sexual health strategy;***

B. ***consider their roles and opportunities for promoting sexual health in the borough;***

C. ***support the Fast Track Cities London programme.***

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report sets out the development to date of a joint local authority and CCG sexual health strategy (2020-2025) for the London Borough of Merton. This strategy takes a life course approach.

1.2. This report covers the commissioning responsibilities for sexual health, and gives an update on progress on the strategy to date including stakeholder engagement feedback. It outlines the proposed vision and priorities and the next steps for strategy development. It also gives a brief update on the Fast Track Cities (FTC) London Programme.

1.3. Board members are requested to review and endorse the draft vision and priorities for the strategy, consider their roles and opportunities for promoting sexual health in the borough, and agree to support the Fast Track London Programme.

2 BACKGROUND

2.1. Sexual health is a key public health issue. Access to quality sexual health services improves the health and wellbeing of both individuals and populations. In 2013 the Government published *A Framework for Sexual*

Health Improvement in England[1] setting out its ambition to improve the sexual health of individuals and populations within the context of a changing commissioning landscape.

2.2. With the introduction of the Health and Social Care Act in 2012, commissioning responsibilities for sexual and reproductive health, HIV prevention, detection and management have undergone major changes. These responsibilities are now shared between NHS England, Local Authorities and Clinical Commissioning Groups (CCGs)[2].

2.3. The transfer of public health to the local authority, which includes sexual health commissioning, took place in April 2013. Local authorities have a statutory duty to secure the provision, for their residents, of open access services for contraception and for testing and treatment of sexually transmitted infections (STIs).

Why do we need a sexual health strategy?

2.4. The past decade has seen great improvements in the quality and scope of sexual and reproductive health promotion and HIV prevention. Merton has seen one of the highest reductions in teenage conceptions in the country. However, alike the rest of London, Merton is experiencing a continuing rise in acute sexually transmitted infections (STIs), particularly Syphilis, Gonorrhoea and HIV. This has led to a higher demand for London services than any other area of the country, and as a result, a rising cost of sexual health services.

2.5. Sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), under 25 year olds and black and minority ethnic groups. Similarly, HIV infection in the UK disproportionately affects MSM and Black Africans.

2.6. A joined up approach is needed to meet the needs of the most vulnerable, working in partnership with a range of other services such as those dealing with sexual violence, gangs, child sexual exploitation, learning difficulties, mental health and substance misuse issues. Local authorities across London and across the country also need to continue to work together to tackle these issues.

2.7. The development of a sexual health strategy for Merton will provide a joined up response to sexual health, by detailing how partners will collaboratively respond to increasing STI and HIV rates and the subsequent pressure on services. It will detail the actions those in Merton will take, and the ways in which the borough will work with other local authorities. The long-term goal is to improve outcomes in sexual health and sexual well-being and access to

[1] A Framework for Sexual Health Improvement in England Dept. of Health, March 2013
[2] Making it Work: A Guide to Whole-System Commissioning for Sexual and Reproductive Health and HIV, Public Health England, September 2014 and Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities, Department of Health, March 2013

services in the borough, which should in turn reduce the cost to the broader health and social economy.

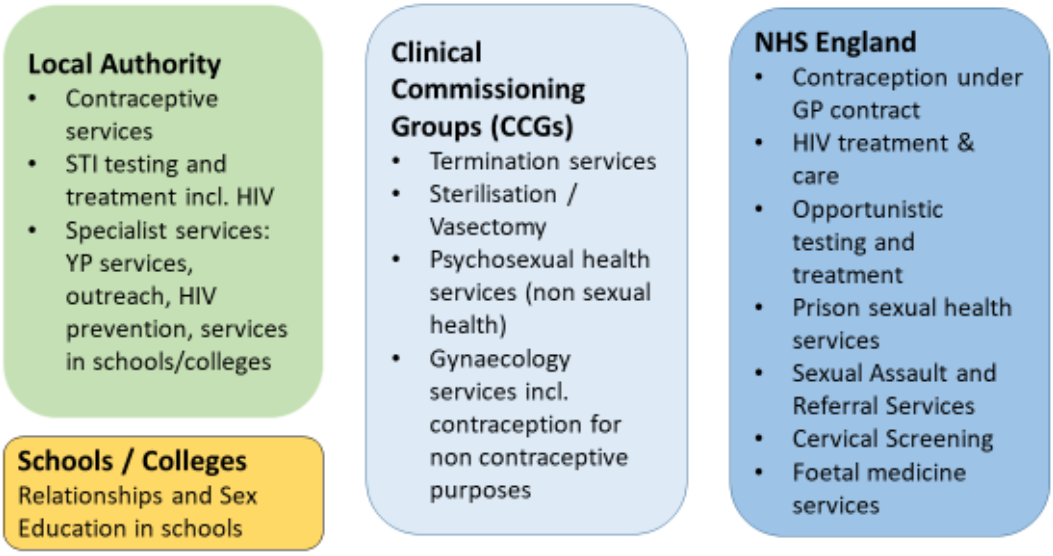
2.8. The sexual health strategy will be supported by a comprehensive implementation plan. The plan will detail how the strategy vision and priorities will be delivered over five years. Progress will be regularly reviewed and assessed by the strategy steering group, to ensure it remains fit for purpose and that milestones are met.

3 DETAILS

3.1 Commissioning and delivery of sexual health services

3.1.1. Sexual health is a complex issue with a complicated commissioning structure. The diagram below sets out sexual health services and who commissions them:

Diagram 1. Sexual Health Services and who commissions them



3.1.2. Due to sexual health clinics, being open access Merton residents can choose to access any service in the country, which can make budgets very hard to predict and control. Therefore, it is crucial that Merton works collaboratively with its neighbouring boroughs in South West London, and with all authorities London and England wide.

3.1.3. Merton contributes to the London Sexual Health Programme (LSHP). The objective is for all London boroughs to work together to transform and commission services, ensuring continued good practice whilst responding to current and future financial challenges by making the best use of resources. Future aspirations of the programme are to explore more locally integrated service models. To date the programme has achieved;

- introduction of a standardised integrated service model and a more effective pricing mechanism;

- co-commissioning of integrated sexual health services in clusters rather than by boroughs individually;
- procurement of an e-service for those who are asymptomatic and;
- co-ordination of London wide approaches to commissioning challenges.

3.1.4. In line with the LHSP objectives, Merton public health team have recently co-commissioned a local integrated sexual health service with the London Borough of Wandsworth and the Royal Borough of Richmond upon Thames. This service was commissioned using the London service specification and tariff. It is delivered by Central London Community Healthcare (CLCH), and provides specialist sexual health clinics across the three boroughs, as well as outreach programmes to young people. Having one provider across the three boroughs allows for an clearer patient pathway as well as economies of scale.

3.1.5. Key commissioning priorities for the integrated service are to encourage asymptomatic patients currently using sexual health clinics to use new online STI services; and seek to move Merton residents using sexual health services outside the borough into the local service. Achieving this will only be possible by commissioning in partnership and working closely together with partners, so this will be a key component of the strategy.

3.1.6. Consortia arrangements for commissioning HIV prevention and support services are also in place with the neighbouring boroughs of Sutton, Richmond upon Thames and Kingston upon Thames. The services are delivered by Spectra who sub-contract to Metro and Kwa Africa, who provide specialism on engaging with black Africans in community settings.

3.2 Fast Track Cities London Programme

3.2.1. Merton also contributes, along with all other London boroughs, to the London HIV programme. The programme has delivered a highly successful HIV prevention campaign called ‘Do It London’, which has proven high brand recognition. This is alongside outreach programmes for MSM and condom distribution.

3.2.2. The success of this programme was one of the drivers for the Mayor of London, London Councils, NHS England and PHE signing up to the global HIV Fast Track Cities (FTC) initiative, with ambitious goals of reaching zero new HIV infections by 2030 and zero HIV-related stigma.

3.2.3. A festival event to showcase London HIV initiatives is being organised for September, to coincide with London hosting the International Association of Providers of AIDS Care (IAPAC) International Conference. Merton are working with South West London commissioners and providers of HIV services to ensure the good work in the sector is highlighted at this event.

3.2.4. Health and well-being boards have been asked to support the FTC London programme and in particular the London showcase event.

3.3. Sexual health strategy approach

3.3.1. A strategy development steering group has been set up to oversee the development of the sexual health needs assessment, strategy and implementation plan. The group is co-chaired by Dr Tim Hodgson (GP lead for sexual health, Merton CCG) and Julia Groom (Public Health Consultant lead for sexual health). Members of this group include representatives from; the CCG, LBM social care and education departments, the local pharmaceutical committee, voluntary sector, the current integrated sexual health service provider and Merton Healthwatch.

3.3.2. The public health team have developed a comprehensive sexual health needs assessment, which uses a range of national and local data to examine trends in STIs and teenage conceptions in Merton. This needs assessment has informed the proposed vision and priorities for the strategy. See appendix 1 for key data findings.

3.3.3. Extensive engagement work has been undertaken, with over 500 people who live, work and learn in Merton. Those engaged included professionals working in Merton, residents, those studying in or looked after by Merton, and service users. Care was taken to engage with those disproportionately impacted by sexual ill health including those with disabilities, young people, Black Africans and men who have sex with men (MSM). See section 5.1 for details.

3.3.4. Engagement included focus groups, one to one interviews and an online survey, which received an above average response of 116 responses, and a school survey including sexual health questions, which received 1,167 responses. This engagement tested a draft vision and priorities for the strategy, as well as seeking insight into the knowledge and experience of sexual health services in the borough.

3.4 Strategy stakeholder engagement findings

3.4.1. Feedback from those engaged provided powerful information on borough needs in relation to sexual health with some strong key themes emerging:

Staff training – professionals who are not specialists in sexual health felt they needed more support to deliver the expected information and advice. Patients felt clinical staff would merit from more training to understand the needs associated with their sexual wellbeing, rather than just the medical issues. In particular, it was felt that more support was needed on:

- Engaging with LGBTQ+.
- Consultation skills for those with learning and physical disabilities.
- How to manage disclosures about sexual abuse/exploitation.
- Guidance on relationships & sex education (RSE) and how it should be delivered in schools.
- How to offer support relating to sexual wellbeing.

Resident education & awareness – in particular areas to address were:

- To ensure that those with learning and physical disabilities can access the same sex education as their peers.
- To improve awareness of sexual health services to allow greater understanding of what is available, where and when.
- To include more teaching on sexual wellbeing (at present the focus is on sexual disease and reproduction) i.e. LGBT, sexuality, relationships, sexual abuse and exploitation, relationships and consent.
- To improve education about sexual health and wellbeing for those over the age of 25. It was felt that there is a lot of focus on young people but older people are struggling with knowledge and access.

Improved access to clinic services – in particular areas to address were:

- Physical access and confidential access for those with both learning and physical disabilities.
- Locations that are central and not in open spaces to maintain anonymity.
- Outreach services to better access young people.
- Evening and weekend service to better access working people.
- Links with other services for easier referral access e.g. substance misuse services, voluntary services.
- Improved referral processes to other services when problems are identified e.g. social services (safeguarding), police (domestic violence or sexual exploitation).

3.4.2 **Strategy vision**

In relation to the vision for the strategy those consulted thought it important to differentiate between:

1) The prevention, diagnosis and treatment of sexual health conditions and reproductive health;
2) Sexual well-being.

It was felt that the latter needed more focus, in particular information and advice on healthy sexual relationships, sexuality and sex for pleasure as well as the emotional and psychological impacts of issues such as sexual violence, exploitation and dysfunction e.g. erectile problems. It was felt that services need to focus on both these areas in order to be labelled comprehensive.

3.5. **Proposed vision and priorities**

3.5.1. Taking account of both the stakeholder engagement undertaken to date, and the strategic needs of the borough, it is proposed that the vision and priorities for the strategy are as follows:

Vision:

"To improve the sexual health and wellbeing of those who live, work and learn in Merton by:

- ***facilitating information and development of skills to allow people to make informed choices about their sexual health and wellbeing;***
- ***providing confidential, easily accessible and comprehensive services and***
- ***reducing stigma, exploitation, ill health and inequalities"***

Priorities:

1) **Workforce development:** To provide training to healthcare and front line staff about sexual health and wellbeing, which supports and facilitates the ongoing prevention strategies and reduces the need for specialist services.
2) **Easy access:** Ensure accessibility to free, confidential, comprehensive sexual health and wellbeing services for those who live, work and learn in Merton, or who choose to access services in Merton.
3) **Comprehensive sexual health and wellbeing:** Enable all those in Merton to consider their sexual health and wellbeing in the context of their lived realities, by ensuring services are joined up and address the wider determinants.

3.5.2. The actions to be undertaken to meet these priorities will be detailed in the implementation plan but some examples are:

- planning and delivering a comprehensive staff training package on sexual health and well-being, with focus on supporting those with learning and physical disabilities and those identifying as Lesbian, Gay, Bisexual, Transgender (LGBTQ+).
- assessing and developing the specialist sexual health clinics to ensure confidential access for those with learning and physical difficulties.
- to ensure all LA and CCG commissioned services complement each other and so deal with all issues a person may have together e.g. substance misuse service can also deal with sexual health needs and vice versa.
- To support CYP initiatives, particularly the implementation of Relationships and Sex Education (RSE) in schools.

3.5.3 Although sexual health is not a specific priority within the Health and Wellbeing Strategy there are synergies with the Health and Wellbeing Boards' principles and ways of working, including:

- *Tackling health inequalities*: the strategy will have a strong focus on addressing inequalities in sexual health
- *Prevention and early intervention*: the strategy will give priority to sexual wellbeing, including healthy relationships and sex education.

- *Community engagement and empowerment*: Over 500 people have been engaged in the development of the strategy and continued engagement will be a priority.

3.5.4. The Health and Well-being Board are asked to:

- review, consider and endorse the vision and priorities for the strategy and;
- identify opportunities to champion sexual health and well-being.

3.6 Next steps

3.6.1. Once the vision and priorities for the strategy have been agreed the strategy will be finalised and the implementation plan developed. This is due to be completed by the end of August.

3.6.2 Findings from the engagement work will be used to develop the actions in the implementation plan. Further engagement with the CCG Patient Engagement Group, the Local Pharmaceutical Committee and clinical staff is planned for July 2019.

3.6.3 The strategy and implementation plan will be taken to all relevant local authority and CCG groups/boards for agreement and sign off.

3.6.4 The membership of the strategy development steering group will be reviewed and a new strategy implementation steering group formed. This group will oversee the agreed strategy implementation plan.

3.6.5. The Overview and Scrutiny Group will be holding a meeting with a focus on sexual health, which gives a great opportunity to raise the profile of this area of health.

4 ALTERNATIVE OPTIONS

Not applicable

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The following consultation has been undertaken:

- 123 face to face focus groups with young people at Ricards Lodge, Phipps Bridge and Pollards Hill youth clubs, SMART Centre, Merton College, Lavender Footballers, Youth Parliament, Uptown youth club and School Council Action Day.
- 116 people responded to an on-line survey on the Council's website.
- 1,167 school aged young people answered sexual health questions on the school-based survey.
- Face to face consultation with 300 professionals working in Merton via different meetings & networks, including; Involve, CSF DMT, Promote and Protect group, secondary/primary heads and governors, GP practice leads, CLCH practitioners, Preparation to Adulthood Board, PSHE co-

ordinators, YP Health Ref Group, health commissioners, Children's Trust, VAWG, and substance misuse partnership board.

6 TIMETABLE

Please see below some key milestones in the next steps for the strategy development:

End July 2019: all consultation on the strategy complete.

End August 2019: Final draft of sexual health strategy, implementation plan and needs assessment complete.

Sept 2019: Draft strategy and implementation plan highlights circulated to groups previously consulted for final review.

Oct – Nov 2019: Sign off of final strategy and implementation plan by the strategy steering group and relevant Local Authority and CCG boards

Dec 2019: Strategy implementation group is set up and work on the implementation plan commences.

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7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

There has been no cost incurred whilst developing the strategy except staff time. The implementation plan will be delivered within existing budgets and staff resources.

8 LEGAL AND STATUTORY IMPLICATIONS

The strategy will have oversight of the following areas, which are the legal and statutory responsibility of local authorities:

- The statutory duty to secure the provision, for their residents, of open access services for contraception and for testing and treatment of sexually transmitted infections (STIs).
- Statutory Relationships and Sex Education (RSE), which will come into effect in September 2020.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1 Assessment of need, research and consultation conducted thus far indicates that there is recognised disparity and inequality of sexual health between different population groups. Young people, gay men, and black and minority ethnic groups are disproportionately affected by poor sexual health.

9.2 The strategy and corresponding implementation plan aim to address this disparity, and ensure equality and equity of access to education and sexual health services in the borough, with particular emphasis on these most vulnerable groups.

9.3 A equality impact assessment will be carried out and will feed into the strategy and implementation plan.

10 CRIME AND DISORDER IMPLICATIONS

There are strong links between sexual health and wellbeing and domestic violence, sexual exploitation and abuse. The police and Sexual Assault and Referral Centres (SARC) are key partners in the strategy.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

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

Appendix 1: Merton sexual health – key data

13 BACKGROUND PAPERS

None

Appendix 1: Merton sexual health – key data

Sexual health indicators

The table below shows that when compared to England sexual health indicators for Merton are generally poorer. Sexual health across London, however is more varied. London as a whole has higher incidences of acute STIs such as Syphilis, Gonorrhoea and HIV.

Figure 1: Sexual Health Indicator Comparator, Merton and England.
Source: Public Health England Fingertips

Compared with benchmark Better Similar Worse Lower Similar Higher Not Compared

Benchmark Value
Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Merton			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate / 100,000	2017	↑	42	20.3	38.7	12.5	154.1		0.7
Gonorrhoea diagnostic rate / 100,000	2017	↑	256	123.8	228.4	78.8	654.4		12.1
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300	2017	→	408	1,979	2199	1882	939		4,463
Chlamydia proportion aged 15-24 screened	2017	↓	4,522	21.9%	24.0%	19.3%	9.1%		44.8%
New STI diagnoses (exc chlamydia aged <25) / 100,000	2017	→	1,582	1,124	1547	794	3,215		329
HIV testing coverage, total (%)	2017	↑	6,133	75.6%	72.3%	65.7%	26.1%		85.9%
HIV late diagnosis (%) (PHOF indicator 3.04) <25% 25% to 50% ≥50%	2014 - 16	–	39	41.5%	33.7%	40.1%	80.0%		18.2%
New HIV diagnosis rate / 100,000 aged 15+	2016	→	33	20.1	27.6	10.3	105.4		1.2
HIV diagnosed prevalence rate / 1,000 aged 15-59 <2 2 to 5 ≥5	2016	→	553	4.24	5.78	2.31	16.40		0.33
Population vaccination coverage – HPV vaccination coverage for one dose (females 12-13 years old) (PHOF indicator 3.03xii) <80% 80% to 90% ≥90%	2016/17	–	786	89.0%	83.8%	87.2%	73.6%		97.9%
Under 25s repeat abortions (%)	2016	→	83	29.9%	30.8%	26.7%	36.3%		15.7%
Abortions under 10 weeks (%)	2016	→	680	82.7%	82.2%	80.8%	67.5%		88.5%
Total prescribed LARC excluding injections rate / 1,000	2016	–	1,149	25.0	34.5	46.4	6.1		80.4
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	2016	↓	49	16.5	17.1	18.8	36.5		4.6
Under 18s conceptions leading to abortion (%)	2016	→	33	67.3%	63.7%	51.8%	31.6%		81.3%
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2016/17	↑	258	1.3	1.8	1.9	0.8		4.7

Sexually transmitted infections

In 2017, the rate of new STI diagnoses per 100,000 population in Merton was 973, this was higher than the England rate of 743 per 100,000 but lower than the rate in London of 1,335 per 100,000. Compared to the 33 local boroughs in London, Merton is ranked 20th (where 1st is the highest rate) for rates of new STI diagnoses. The rate of new STI cases in Merton has remained fairly stable since 2013.

Chlamydia

Genital *Chlamydia trachomatis* is the most commonly reported bacterial STI in England. Infection is asymptomatic in at least 70% of women and 50% of men and as a result the majority of infections remain undiagnosed. The chlamydia diagnosis rate is one of the Health Protection indicators within the Public Health Outcomes Framework (PHOF).

In Merton, 408 Chlamydia diagnoses in young people aged 15-24 were reported in 2017, a rate of 1,979 per 100,000 population in that age group. The rate is lower than the London average of 2,199 per 100,000 but higher than the England average of 1,882 per 100,000.

Gonorrhoea

High rates of gonorrhoea in a population can indicate high levels of risky sexual behaviour ***(Laser report, 2016)***. In 2016, the rate of diagnosis of gonorrhoea in Merton was 124.2 per 100,000, which was significantly lower than the London average rate of 227 per 100,000 but higher than the England rate of 78.5 per 100,000.

From 2012 to 2015 the rate of diagnosis of Gonorrhoea in Merton increased year on year, in line with both London and England. 2015/2016 has seen the first fall in gonorrhoea diagnosis rates in Merton, London and England with the rate in Merton falling by 13% between 2015 and 2016. The increase in rates of gonorrhoea England wide is particularly concerning as the bacteria is becoming increasingly resistant to antibiotics.

HIV

In 2017, 30 new diagnoses of HIV were seen in Merton in those aged 15 and over. This equates to a rate of new HIV diagnoses in Merton of 18.2 per 100,000, which is significantly higher compared to the rate in England of 8.7 per 100,000 but lower than the London value of 21.7 per 100,000. The rate in Merton has decreased between 2014 and 2016 and has remained stable between 2016 and 2017.

The UK is one of the first countries in Europe to witness a substantive decline in HIV diagnoses in gay and bisexual men. The decline is driven by large increase in HIV testing among gay and bisexual men attending sexual health clinics (from 37,224 in 2007 to 143,560 in 2016) including repeat testing in higher risk men, as well as improvements in the uptake of anti-retroviral therapy (ART) following HIV diagnosis. Other factors, including sustained high condom use with casual partners, introduction of online HIV testing and access to pre-exposure prophylaxis (PrEP), will also have contributed to the downturn in HIV diagnoses in this group. The decline has been most marked in central London.

Early diagnosis of HIV is paramount in order to initiate effective treatment and to minimise the risk of onward transmission. Late diagnosis is one of the biggest contributing factors to morbidity and mortality of people with HIV. Those with late diagnoses can have a 10 fold increased risk of mortality in the year following diagnosis. As such, reducing late diagnosis is used as an indirect performance measure for HIV prevention and has been incorporated into the Public Health Outcomes Framework ***(PHE, Spotlight on HIV 2016)***. Between 2014 and 2016, 41.5% of HIV diagnoses in Merton were made at a late stage in the disease process, such that the CD4 count was less than 350 cells/mm^3 within 3 months of diagnosis.

Teenage conceptions

Teenage conception technically includes all conceptions before the mother's 20th birthday, but the national focus is on conception under 18 as most potential mothers in this age group are in full time education or training. The conception rate is the number of pregnancies that

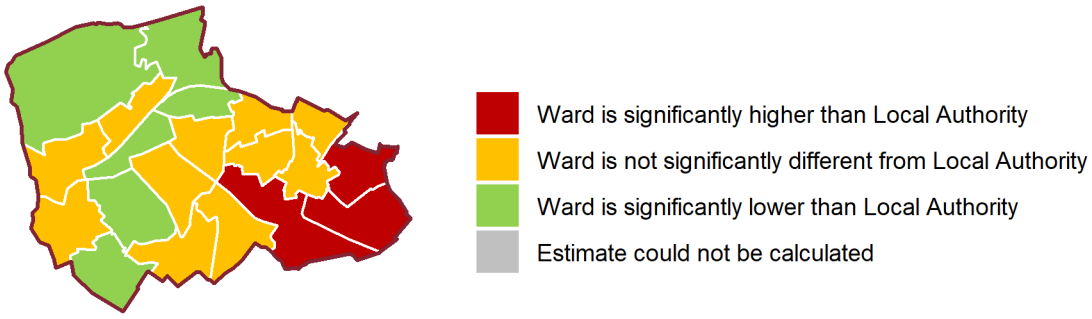
start before the mother's 18th birthday (per 1,000 young women) and includes pregnancies that end either in birth or in termination. Miscarriages are not included

Evidence indicates that high rates of teenage pregnancy are most often associated with low educational attainment and disengagement from school, economic deprivation, and poor mental health. Young people at increased risk of early parenthood and teenage pregnancy include children of teenage mothers, looked after young people, young people misusing alcohol, young people involved in crime, those with low self-esteem and some black and minority ethnic groups. Early onset of sexual activity, poor contraceptive use and repeat abortions are other significant risk factors ***(Laser Report, 2014)***.

In 2016, which is the most recent year for which data is available, there were 38 conceptions to Merton women under the age of 18; a rate of 12.8 per 1,000 women aged 15-17 years. In England, London and Merton, under 18 conceptions have been consistently falling since 1998. Between 1998 and 2017 there has been a reduction of 78.9% in the rate of teenage conceptions in Merton. This is a big success story for Merton with this decrease being the highest in Outer London.

Teenage conceptions disproportionately affect those in the east of the borough> the map below shows that the wards with the highest teenage conceptions are also some of the most deprived in the borough.

Estimated teenage conceptions 2014-2016 by ward, benchmarked against Merton



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Committee: Health and Wellbeing Board

Date: 25th June 2019

Subject: Merton Health and Wellbeing Strategy 2019 - 2024 Final Draft

Lead officer: Dagmar Zeuner, Director of Public Health

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

Contact officer: Mike Robinson, Consultant in Public Health; Clarissa Larsen, Health and Wellbeing Board Partnership Manager

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Recommendations:

That the Health and Wellbeing Board:

A. Consider and agree the final draft Health and Wellbeing Strategy 2019 – 2024.

B. Note and agree the proposed annual reporting of the Health and Wellbeing Strategy to the Board.

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is for the Board to consider and agree the final draft of the Health and Wellbeing Board strategy 2019 – 2024.

2. BACKGROUND

It is a statutory duty for the Health and Wellbeing Board to produce a Health and Wellbeing Strategy and this new Strategy, with its focus on healthy place, reflects the ways of working that this Board has adopted in recent years. Development of the Strategy has included broad engagement and an ongoing conversation with stakeholders and local connectors.

Members of this Board considered and agreed a draft outline of the Health and Wellbeing Strategy 2019 – 2024 at their March meeting. This final draft Strategy includes feed-back and some further details. To keep the main document concise, it is backed by a Supplementary Information Pack.

Health and Wellbeing Board members have driven the engagement process through the themed workshops and these have formed the focus of the Strategy on Healthy Place; building on the established commitment of the Board to promote fairness and reduce health inequalities.

At the Board's March meeting, members helped to refine the approach, their principles and ways of working and the key outcomes emerging from the engagement programme. The Board's continued ownership of the Strategy and its rolling programme of key priorities will be central to future achievement.

Synergy with the Local Health and Care Plan

Throughout the development of the Health and Wellbeing Strategy, close links have existed with the Local Health and Care Plan. We have worked 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 takes the same life course approach as the LHCP – start well, live well, age well – but with a focus on creating a healthy place.
- We have worked to explicitly align the two plans to make sure they complement each other.

3. DETAILS

Summary of Health and Wellbeing Strategy

The final draft Health and Wellbeing Strategy is attached in Appendix 1. In summary, the Strategy sets out:

P. 2 – 3	A summary of what makes us healthy and an introduction to how the Health and Wellbeing Board works.
P. 4	An outline of the methodology we followed in developing the Strategy.
P. 5 – 6	A brief overview of the Merton Story and learning from the last Health and Wellbeing Strategy.
P. 7 – 8 & Appendix Table 1	The Board's Vision, Principles and Ways of Working (as discussed at the March Health and Wellbeing Board, with the addition of Think Family and working from a strong evidence base).
P. 8 – 9 Table 2 & Appendix Table 3	The key healthy place attributes of: ○ Promoting mental health and wellbeing ○ Making the healthy choice easy ○ Protecting from harm and key outcomes for each by stages of the life course

P. 9 Table 4	The key healthy settings including healthy intergenerational settings, healthy schools, healthy work places and healthy homes.
P. 10	A description of our way of delivery and how we will determine our rolling programme of priority actions
P. 10	How we show progress and learn through our framework for accountability

Supplementary Information Pack

The Strategy has deliberately been kept concise backed by the Supplementary Information Pack included in Appendix 2.

There are links to this pack throughout the draft Strategy. It provides further details of the methodology and findings from the workshops, gives a rationale for each of the key outcomes, provides an explanation of the role of healthy settings and describes the types of actions the Board can take to influence most effectively.

4. NEXT STEPS

In recent years, Health and Wellbeing Board members have recognised that the partnership works best when it focusses at any given point in time on one or two key priorities. Within the new Strategy, we propose to continue this approach.

Initial consideration of priorities took place at the March Health and Wellbeing Board and criteria to identify proposals were discussed. It was agreed that it is important to keep momentum on the current Board priority of tackling diabetes.

Potential additional priorities include scaling up systematic work on promoting Healthy Workplaces - with a focus on mental health and active travel. It is proposed that a report be brought to the Health and Wellbeing Board's October meeting to consider this as a new priority for action together with the ongoing work with the Leadership Centre, to support further board learning in preparation for the future shape of the health and care system.

Subject to agreement, the Health and Wellbeing Strategy will be reported to the Council's Cabinet and partners' governing bodies. Following this, it will be designed, published and shared widely. We also plan to produce an accessible, single page summary.

We continue to work closely to align with the Local Health and Care Plan throughout.

5. ALTERNATIVE OPTIONS

None. It is a statutory duty of the Health and Wellbeing Board to produce a joint Health and Wellbeing Strategy.

6. CONSULATIONS UNDETAKEN OR PROPOSED

The comprehensive engagement programme is as set out in the report and appendices.

7. TIMETABLE

Date	Meeting	Purpose
June		
25 June 2019	Health and Wellbeing Board	Final HWS for sign off
26 June 2019	Children and Young People Overview and Scrutiny Panel	For information
July		
3 July 2019	MCCG Governing Body	Agreement for publication
15 July 2019	Cabinet	Agreement for publication
TBC	Healthwatch and MVSC	Agreement for publication

8. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

The Health and Wellbeing Strategy does not have any additional expenditure implications for partner members for Health and Wellbeing Board. The rolling programme of priority actions will be delivered through decisions within existing governance and, where there is the opportunity, external funding.

9. 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.

10. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

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

11. CRIME AND DISORDER IMPLICATIONS

A key outcome of the Health and Wellbeing Strategy is to less self-harm and less violence.

12. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A.

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

Appendix 1: Health and Wellbeing Strategy 2019-24 – Final Draft

Appendix 2: Supplementary Information Pack

BACKGROUND PAPERS

None.

Merton Health and Wellbeing Strategy 2019-24

A Healthy Place for Healthy Lives

FINAL DRAFT

FOREWORD

Insert – from Chair and Vice Chair *(to follow HWB agreement)*

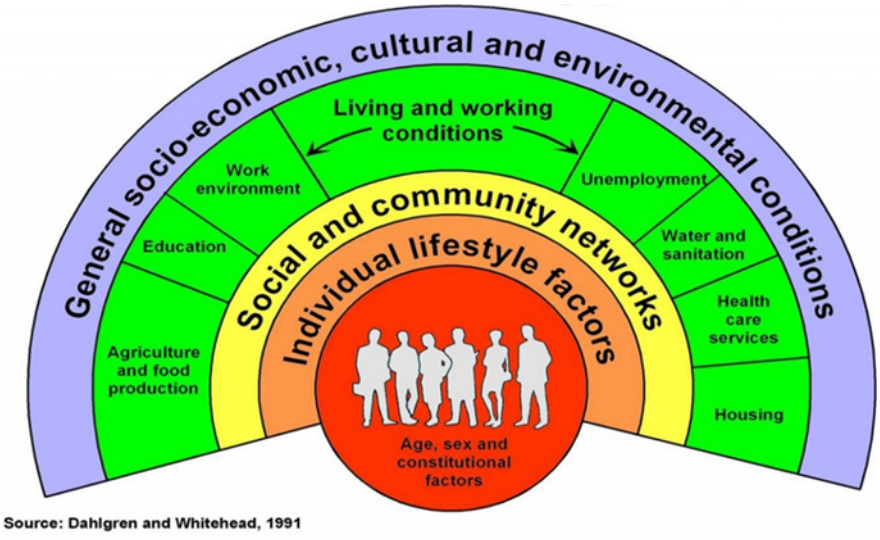
WELCOME

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.

Diagram 1 – Wider determinants of health



Source: Dahlgren and Whitehead, 1991

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.

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

The Health and Wellbeing Board is a statutory partnership 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 separate 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 focuses on making Merton a healthy place, meaning creating the social and physical conditions in which people can thrive; the Local Health and Care Plan focuses on provision of integrated high quality health and care services, as depicted in the diagram below.

Diagram 2 - Relationship between Health and Wellbeing Strategy and Local Health and Care Plan

Both the Health and Wellbeing Strategy and Local Health and Care Plan commit the Health and Wellbeing Board to championing its 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 Health and Wellbeing Strategy

The purpose of this Strategy is not to give a comprehensive overview of all major health issues. This is provided by the Joint Strategic Needs Assessment, which in Merton is called the Merton Story. The Health and Wellbeing Strategy is a tool to support the Health and Wellbeing Board as system leader where it can add most value. In particular:

- To champion our guiding principles and ways of working in everything we do;

- To focus on the key health outcomes we wants to achieve for people in Merton to Start Well, Live Well and Age Well in a Healthy Place, considering the key attributes of a Healthy Place and the main healthy settings;

- To select a rolling programme of priorities for action, a few at a time, which will be underpinned by specific implementation plans;

- To be accountable jointly as Board and as individual organisations to partners and the community we serve.

Our Methodology

The Health and Wellbeing Strategy has been developed on the basis of a thorough evidence base and comprehensive engagement programme.

- Desk research including the Joint Strategic Needs Assessment/Merton Story, Resident's Survey, data and latest publications
- A series of engagement workshops, involving over 100 people, led by Health and Wellbeing Board members, finishing with a lively session on Healthy Place.
- In-depth surveys circulated to workshop attendees, their networks and contacts.
- Stakeholder engagement with partners and learning from the Local Health and Care Plan deliberative event.

Navigating the Strategy

The Health and Wellbeing Strategy is divided into four main sections:

1. Our starting position
2. What we want to achieve
3. Our way of delivery
4. Our framework for accountability

The Strategy is a concise document with a separate *Supplementary Information Pack* for further details.

1. OUR STARTING POSITION

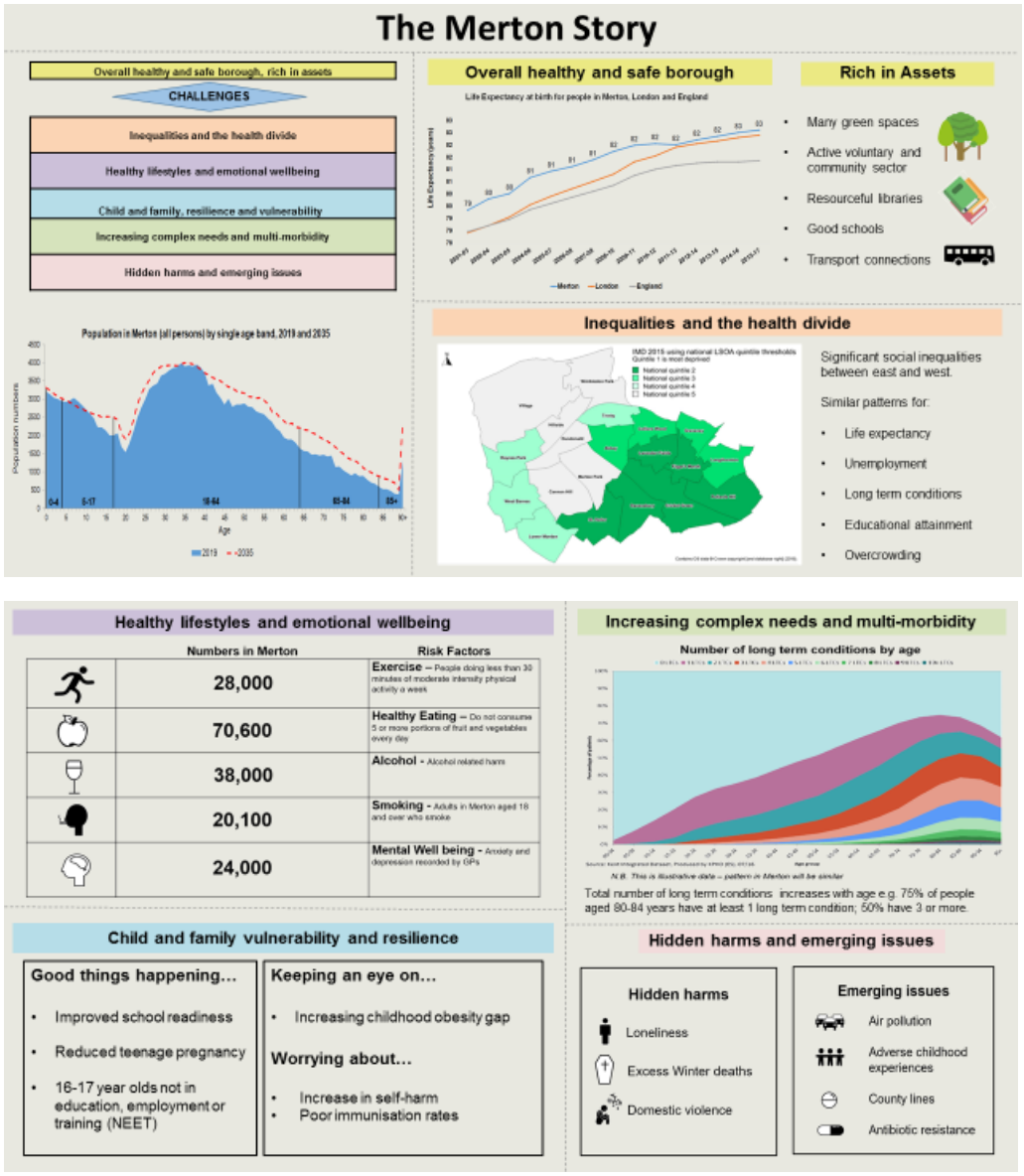
How healthy are people in Merton?

The Joint Strategic Needs Assessment, Merton Story, shows us that, overall, Merton is a safe and healthy place, rich in assets such as green spaces, libraries, good schools and strong transport connections and compares favourably with other London boroughs. Our 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 and alcohol misuse underpinned by poor emotional/mental health and wellbeing);
- Child and family vulnerability and resilience, i.e. 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.

The below diagram shows an infographic summary.

Diagram 3 – Merton story infographic summary



What people tell us matters to them about a healthy place

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 use of 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; and,
- Safety of the physical and social environment was another recurring theme of importance for people of all ages

The diagram below is a summary drawing of the findings from our Healthy Place workshop.

Diagram 4 - Healthy Place workshop illustration

Learning from the last Health and Wellbeing Strategy

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

- Reflective Board development work with the Leadership Centre;

- Promoting and embedding principles and ways of working based on shared values including social justice in partner organisations;
- 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 role for of all members in community engagement (i.e. 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 (i.e. whole system approach to tackle diabetes and childhood obesity; spotting the value of social prescribing and championing its development and roll out);
- Making best use of the fact that the Board is more than the sum of its individual members' contributions; and in a similar way it is part of a set of partnerships and other Boards whose potential impact as a system is greater than the sum of its parts.

2. WHAT WE WANT TO ACHIEVE

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 to complement the provision of holistic health and care services.

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.

Principles and ways of working

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

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

- Think Family – taking a whole family approach where seeing the parents means seeing the child and seeing the child means seeing the parents as a routine.

Table 1 in the Appendix shows the impact we can make through applying the above Principles and Ways of working and how we propose to measure progress.

Key Outcomes

For people in Merton to Start Well, Live Well and Age Well in a Healthy Place we have brought together a set of key health outcomes based on the main attributes of a healthy place. These are proposed to form the core of the Health and Wellbeing Strategy.

They are meant to be specific enough to clearly articulate the direction for the Board without unduly constricting its ability to adapt over the five- year period.

The key attributes for a Healthy Place that the Health and Wellbeing Board has identified 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).

Table 2 below shows how our outcomes for people to Start well, Live Well and Age Well fit within a matrix of the key attributes for a healthy place and allow easy cross reading to the Local Health and Care Plan.

Table 2 – Outcomes matrix of the Health and Wellbeing Strategy

Life course stage	Start Well	Live Well	Age Well
Key Healthy Place attributes:	**Key Outcomes of the Health and Wellbeing Strategy:**		
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 More people eating healthy food	More active older people
Protecting from harm	Less people breathing toxic air Less violence		

Table 3 in the appendix shows a set of indicators to track progress against each of the key outcomes. We are working with partners to develop targets where appropriate which will be included in the annual review to the Health and wellbeing Board.

The *Supplementary Information Pack* provides a rationale for the key outcomes.

Delivering Outcomes through Healthy Settings

People live their lives in various places or settings such as home, school and work. They experience a healthy place in a setting where the three attributes - promotion of mental health and wellbeing, easier healthy choices and protection from harm – come together. This forms a 'healthy setting' and creating healthy settings is a way to deliver on our key outcomes. The Health and Wellbeing Board has identified the most relevant healthy settings for people in Merton as shown in the table below.

Table 4 – Key Healthy Settings

Life course stage	Start Well	Live Well	Age Well
Healthy settings Key attributes of a Healthy Place • **Promoting mental health and wellbeing** • **Making the healthy choice easy** • **Protecting from harm**	**Healthy inter-generational settings (i.e. connecting care homes and nursery schools, links to Dementia-friendly Merton); Healthy Homes**		
	Healthy early years; **Healthy schools;** **Healthy school neighbourhoods**	**Healthy work places;** **Healthy libraries**	**Healthy health and care organisations**

Each of the above healthy settings has or can work towards a quality mark or level to help us track progress. Examples include the London Healthy Early Years scheme, London Healthy Schools award scheme, London Healthy Work Place Award, and Transport for London Healthy Streets descriptor.

We will work with partners to develop our healthy settings as part of our rolling programme of priorities for action, which will be included in the annual review to the Health and Wellbeing Board.

More details about healthy settings and their quality marks are set out in the *Supplementary Information Pack.*

3. OUR WAY OF DELIVERY

To deliver this Strategy the Health and Wellbeing Board will:

- Apply the Principles and Ways of Working set out earlier to all routine and statutory Health and Wellbeing Board business.
- Champion Principles and Ways of Working in our respective partner organisations and embed them into other strategies and plans.
- Focus on a rolling programme of a few priority actions at a time to promote key attributes of a healthy place, main healthy settings and corresponding outcomes using explicit rationale based on criteria below:

    - Consider evidence of need (using the Merton Story and community voice) together with an opportunism to tackle emerging and/or topical issues.
    - Investigate how the proposed priority will address the principles of the Health and Wellbeing Board (specifically promoting fairness, engaging and empowering communities and demonstrating a health in all policies / Think Family approach).
    - Be clear how will the Health and Wellbeing Board add value in a way that cannot be delivered in another way; how will the partner contributions create something bigger and more impactful together than individually, and how this will contribute to wider local and regional work.

    Examples of different types of actions that the Board might use for best influence are summarised in the *Supplementary Information Pack*.

4. OUR FRAMEWORK FOR ACCOUNTABILITY

The Health and Wellbeing Board is committed to learning and wants to understand whether it is delivering on its commitments.

An annual review of the Health and Wellbeing Strategy will be reported to the Health and Wellbeing Board. This will include:

- Progress on chosen priorities for action, including any chosen healthy settings.
- Application of Principles and Ways of Working.
- A summary dashboard of key outcomes.
- Ongoing development of the Health and Wellbeing Board as effective system leadership team (including work with the Leadership Centre).

There will also be ad-hoc exception reports to the Health and Wellbeing Board for any issue that requires the Board's attention.

Appendices

Table 1 – Applying our principles and ways of working – how we will track progress

Principle	Expected outcomes/impact	How we will know*	Timescale†
Tackling health inequalities *	People in deprived areas live longer healthier lives	Reduction in childhood obesity gap between east and west Merton.	Long
Prevention and early intervention *	Reduction in premature mortality from main long-term conditions	Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults). Percentage of physically active adults Smoking Prevalence in adults (18+).	Medium Short Short
Health in all policies	Impacts on health are considered across main policy areas	An annual review will be reported to the Health and Wellbeing Board which will include a qualitative description of significant Board activity across these four principles. This will be backed by any relevant quantitative data including for example from the Merton Resident's Survey.	Short
Community engagement and empowerment	More focus on main health challenges as residents perceive them		Medium
Experimenting, learning and applying the evidence base	Complex problems are tackled and evidence base applied		Short
Think Family	Policies and practice reflect impact on the whole family		Medium

*Indicators have been chosen as 'markers' for Tackling Health Inequalities and Prevention - as we cannot measure everything and the Health and Wellbeing Board cannot deliver alone but as part of a wider system.

†Timescales for impact vary, as shown in final column. "Short" means an estimate of 1-2 years before we will see an effect; "Medium" 3-5 years, "Long" 6 or more years

Table 3 –Key outcomes and corresponding indicators to track progress

Key Healthy Place attributes:	Key outcome of the Health and Wellbeing Strategy:	Indicator*	Timescale†
Promoting mental health & wellbeing	**Less self-harm** **Better relationships**	Hospital admissions for self-harm aged 15-19	Medium
	Less depression, anxiety and stress	Prevalence of depression as recorded by GP Quality Outcomes Framework	Medium
	Less loneliness **Better social connectedness**	% adult carers reporting as much social contact as they would like	Short
Making healthy choice easy	**More breastfeeding**	Prevalence at 6-8 week check	Short
	Less childhood obesity	Overweight or obese in Year 6	Medium
	Less diabetes	Diabetes: Quality Outcomes Framework prevalence (17+)	Long
	More active travel	% adults cycling three or more times per week for travel	Short
	More people eating healthy food	Percentage of adults eating recommended five portions of fruit and vegetables per day	Medium
	More active older people	Percentage of adults aged 65+ walking for travel at least three days per week	Short
Protecting from harm	**Less people breathing toxic air**	Deaths attributable to particulate matter (PM2.5)	Short
	Less violence	Violent offences per 1000 residents	Medium

* as for Table 1 above.

† as for Table 1 above

MERTON HEALTH AND WELLBEING STRATEGY 2019 - 2024

Supplementary Information Pack
June 2019

Preface

This supplementary information pack is to be read in conjunction with the main Health & Wellbeing Strategy, “A Healthy Place for Healthy Lives”.

This is not all the background information which has been developed, please refer to section 7, for a list of other material, which will be made available later in 2019 alongside the final version of the main document.

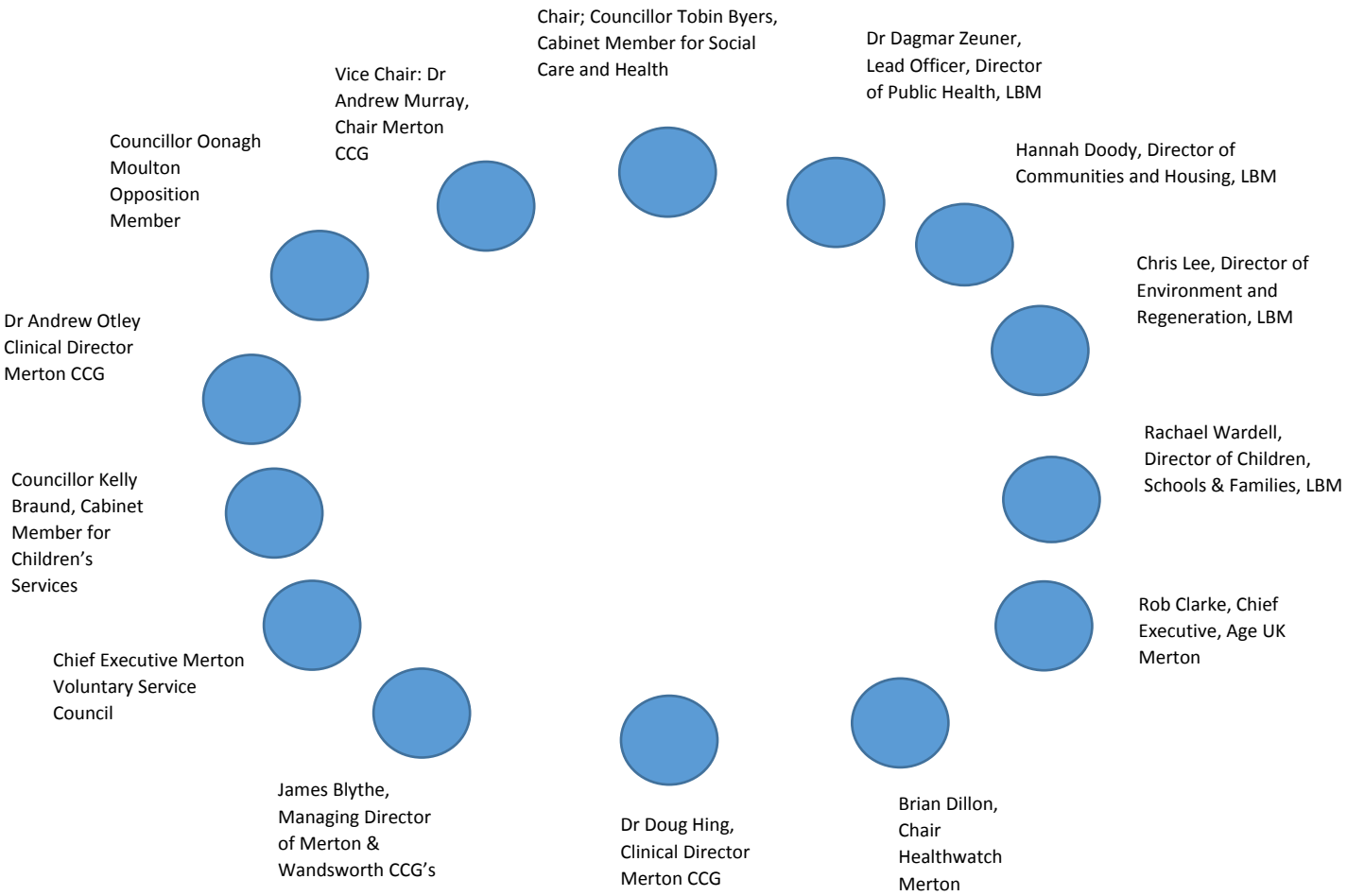
Contents

1. Who the Health and Wellbeing Board are and what they do

Merton Health and Wellbeing Board brings together a group of senior leaders from different sectors who provide leadership for health and who help mobilise the Council, the NHS and the Community to take action towards the vision set out in the Health and Wellbeing Strategy. The Health and Wellbeing Strategy is a document that sets out a vision for Merton residents to live healthy lives. The Health and Wellbeing Board (HWBB) are responsible for taking forward this vision.

See figure 1 for who the Board are. The Board also has agreed principles and ways of working, these can be found in the main strategy document.

Figure 1: The Health and Wellbeing Board



2. The workshops: what we did

The programme of four workshops on the themes of the Strategy 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.

Members of the Health and Wellbeing Board helped to lead the four themed workshops to facilitate discussion around the priorities for Start Well, Live Well, Age Well and Healthy Place.

In the workshops we discussed and reflected on what we think about the priorities for Start Well, Live Well and Age Well with a particular focus on what a healthy place would look like to help people flourish.

In the workshops we also discussed values and ways of working. Past experience suggested that the Health and Wellbeing Board is most effective when it focuses efforts on a few select priority areas, rather than a broader range of issues. Its success partly lies in the commitment of its members to promote shared values in their own organisation including social justice, prevention and a desire to learn and experiment. To build on this, there were opportunities in the workshops to help us further explore people's interests, motivations and values regarding the Start Well, Live Well and Age Well stages of the life course.

The Strategy refresh also builds on current work, for example continuing to promote 'health in all policies' and 'Think Family' as tools to create the conditions in Merton that help people lead healthy lives, as well as to explore new areas.

We also created short online surveys on the four themes, which were circulated to workshop attendees to circulate to their networks so more people could be reached. In total the workshops involved over 100 people and our online surveys received 78 responses, and the Children and Young People's Survey (whose findings also contributed) received around 1,300 responses.

Workshop timetable

Workshop	Date
Start Well	5 Nov 2018
Live Well	18 Dec 2018
Age Well	31 Jan 2019
Healthy Place	12 Feb 2019

3. Values that emerged from the workshops

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

At all the workshops we also asked the workshop participants where they thought the Health and Wellbeing Board could add most value. This is what they said:

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 (e.g. childhood obesity) and promote them**

Listen to, engage and partner **with communities,** empower **them by giving them a voice (e.g. 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 (e.g. 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 (e.g. 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**

4. Rationale for Key Outcomes

The purpose of this section of the supplementary information is to describe the rationale for each of the key outcomes in table 1 of the main report.

There are 12 key outcomes in total, 4 for Start Well, 4 for Live Well, 2 for Age Well and 2 which cover all 3 as part of the life course.

Key Outcomes

Start Well

Less self-harm

Self-harm is when somebody intentionally damages or injures their body. It's usually a way of coping with or expressing overwhelming emotional distress.[1]

- We have the fifth highest rate in London for emergency stays in hospital for self-harm by young people
- Feeling emotionally overwhelmed as well as experiencing loneliness can lead to self-harm. Situations such as poverty, bullying, violence, illness, disability, death, loss, relationship problems, family problems, abuse and pressure lead children and young people to feel emotionally overwhelmed
- The key causes/contributors to people self-harming and continuing to self-harm are the environment (culture social expectations, media, social media, spaces), services, processes, policies and people[2]

Better relationships

Connection occurs when a person is actively involved with another person, object, group or environment, and that involvement promotes a sense of comfort, well-being and anxiety reduction.[3]

- Connectedness can have a protective effect increasing the probability of a person overcoming disadvantage
- Research has found that young people who felt more connected to their parents and schools reported lower levels of depressive symptoms, suicidal ideation, non-suicidal self-injury, conduct problems as well as higher self-esteem and more adaptive use of time.
- Connectedness includes satisfaction with 'place' (e.g. parks, leisure spaces) offering increased opportunities for social interaction and play.

[1] https://www.nhs.uk/conditions/self-harm/

[2] Children and Young People Mental Wellbeing workshop, 28 February 2018, South West London Health and Care Partnership

[3] http://www.copmi.net.au/professionals-organisations/what-works/evaluating-your-intervention/youth-interventions/connectedness original source: Hagerty, Lynch-Sauer, Patusky & Bouwsema, 1993, p. 293

- Close links with family, friendship groups, community and schools can safeguard children and young people from harmful risk factors and may be an important aspect of early intervention.

Breastfeeding

Breastfeeding is a way of providing young infants with the nutrients they need for healthy growth and development[4]

- Breastfeeding is good for a child because it provides all the energy and nutrients the child needs in its first few months of life, promoting a strong immune system as well as sensory and cognitive development[5]
- Research has shown that infants who are not breastfed are more likely to have infections and become obese in later childhood.[6]
- Evidence shows that improving breastfeeding rates can also reduce hospital admissions and attendances in primary care, thus leading to financial savings.[7]
- Women are less likely to breastfeed at 6-8 weeks in the eastern wards of the borough including Cricket Green, Figges Marsh, Pollards Hill, St Helier and Lower Morden.[8]
- Data shows that in Merton and Sutton in 2012-13, (the most recent year for which this is available) breastfeeding initiation was 86.2% compared with 86.8% for London and 73.9% for England

Less childhood obesity

Overweight and obesity are defined as "abnormal or excessive fat accumulation that presents a risk to health".[9]

- Childhood obesity is one of the most serious public health challenges of the 21st century.
- In Merton, around 4,500 primary school children are estimated to be overweight or obese-this is equivalent to 150 primary school classes.[10]
- One in five children entering reception are overweight or obese and this increases to one in three children leaving primary school in Year 6.
- Rates of childhood obesity are higher in some communities in the east of Merton. For example, at age 4-5 years, one in ten children are obese in the east of the borough, whereas in the west one in 20 children are obese.

[4] https://www.who.int/topics/breastfeeding/en/
[5] https://www.breastfeedingwelcomescheme.org.uk/news/report-highlights-breastfeeding-welcome-scheme/
[6] https://www.merton.gov.uk/healthy-living/publichealth/jsna/children-and-young-people-and-maternal-health/breastfeeding
[7] https://www.merton.gov.uk/healthy-living/publichealth/jsna/children-and-young-people-and-maternal-health/breastfeeding
[8] https://www.merton.gov.uk/healthy-living/publichealth/jsna/children-and-young-people-and-maternal-health/breastfeeding
[9] WHO https://www.who.int/dietphysicalactivity/childhood_what/en/
[10] https://www2.merton.gov.uk/annual_public_health_report_2016.17.pdf

- Obesity affects children's social and emotional wellbeing, and can lead to children experiencing low self-esteem, anxiety and depression. This can affect how well they do at school which in turn can have a negative impact on their employment opportunities as adults.
- Childhood obesity increases the risk of developing health conditions including asthma, type 2 diabetes and cardiovascular risk factors during childhood. It also increases the risk of long term chronic conditions in adulthood and can lead to premature death.
- The estimated cost of being overweight or obese to the NHS in Merton is £52 million annually.
- Over half of young people agree that fast food is too widely available. More than half agree that schools do not support them to eat healthily. [11]
- 74% of respondents to the Great Weight Debate Merton stated that tackling obesity should be given top or high priority.[12]
- Respondents felt that children in Merton could be better supported to lead healthier lives through: cheaper healthier food and drink (51%); making parks safer & more accessible for people to be active in (35%); less marketing and advertising of high fat and sugary food and drink (33%); more places for children to be active in (31%)[13]
- The most valued local assets for encouraging a healthy lifestyle in children are parks (77%), local Leisure Centres (47%) and local sport and youth activities (35%)[14]

Live Well

Less depression, anxiety and stress

Common mental health disorders include depression and anxiety disorders. These mental health problems are called 'common' because they affect more people than other mental health problems.[15] **Stress is the feeling of being under too much mental or emotional pressure.**[16]

- There are an estimated 24,000 adults in Merton (16-74 years) with common mental health disorders such as depression and anxiety (2014/15), representing 16.1% of the adult population.[17]
- GP data shows for recorded mental health prevalence, the difference between east and west Merton is 0.24 percentage points (1.01% prevalence in east Merton compared to 0.77% in west Merton), using 2016/17 data
- 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

[11] CYPP Consultation 2019
[12] Great Weight Debate Merton 2017
[13] Great Weight Debate Merton 2017
[14] Great Weight Debate Merton 2017
[15] NICE https://www.nice.org.uk/guidance/cg123/ifp/chapter/Common-mental-health-problems
[16] https://www.nhsinform.scot/healthy-living/mental-wellbeing/stress/struggling-with-stress
[17] Merton Story 2018

- Work can help people look after their mental health by providing: a source of money and resources; a sense of identity; social contact and friendship; routine and structure; a healthy place where the healthy choice is easy; and opportunities to gain achievements and contribute. Healthy workplaces are one of the key settings identified in Table 2 of the main Strategy.
- It has been estimated that the cost to UK employers of mental-health related absence is £7.9 billion.[18]
- Research has found that people who are diagnosed with a chronic physical health problem like diabetes are 3 times more likely to be diagnosed with depression than people without it. Diabetes in Merton is increasing. In 2017/18 there were 11,160 people aged 17 years or over in Merton who had been diagnosed with the condition, equating to 6.2% of the population, (see diabetes on p4)

Less diabetes

Diabetes is a serious health condition that occurs when the amount of glucose (sugar) in the blood is too high because the body cannot use it properly.[19]

- Diabetes prevalence is increasing in Merton and predictions show this trend will continue into the future unless we take action.
- Recorded diabetes prevalence is 8% in east Merton compared to 4.85% in west Merton.
- Life expectancy for those with diabetes is on average 10 years shorter than for those without the disease.
- Diabetes can cause significant health problems including damage to vision, poor circulation, damage to kidney function and cardiovascular diseases.
- Health and care costs are substantial. In England, diabetes costs the NHS about £10 billion, or 10% of the total NHS budget.
- In Merton in 2016, the total cost of diabetes was £25.1 million. If nothing changes, costs will increase by an extra £2.4 million per year in 5 years' time

Active Travel

Active travel means building walking and cycling and sustainable transport into daily routines and is one of the most effective ways to increase physical activity.[20]

- The most popular activities across all ages are walking, gardening and swimming.[21]
- One of the main barriers to physical health for 55-74 year olds is time, whereas 75+ is pain and mobility.[22]

[18] Mental health and employers: The case for investment. Supporting study for the Independent Review, October 2017
[19] Merton Diabetes Annual Public Health Report 2019
[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/523460/Working_Together_to_Promote_Active_Travel_A_briefing_for_local_authorities.pdf
[21] Active Ageing Survey 2018
[22] Active Ageing Survey 2018

- People with caring responsibilities are less likely to be physically active. 91% said they would like to be more active, compared to an average of 80%. The main barriers to physical activity which carers report are time and family/caring responsibilities.[23]

People eating healthy food

A healthy place is one where healthy choices are the easy choices. This means healthy food is easily available & affordable and advertising of unhealthy food and drink is restricted

- See 'less diabetes' and 'less childhood obesity'
- When there are fast food outlets (FFO) close to a primary school, the easy choice is an unhealthy one. 81% of schools in the east have 1 or more FFO within 400 metres, whilst 68% of schools in the west have 1 or more.
- Since 2010, there has been a 31% increase in the numbers of children eligible for free school meals and in 2014/15 of the over 2,000 people who accessed support from food banks in Merton, 78% lived in the east of the borough[24]
- In Merton, 52.8% of children reported that they ate the recommended amount of fruit and vegetables each day; at least five portions[25]

Age Well

Less loneliness

Loneliness is a subjective feeling about the gap between a person's desired levels of social contact and their actual level of social contact. It refers to the perceived quality of the person's relationships.[26]

- People aged 50 and over are more likely to be lonely if they do not have someone to open up to, are widowed, are in poor health, are unable to do the things they want, or feel that they do not belong in their neighbourhood . [27]
- 15% of the older population in the UK are reported to experience loneliness.
- Social isolation, living alone and loneliness are linked with an approximate 30% higher risk of early death[28]

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[23] Active Ageing Survey 2018

[24] https://wimbledon.foodbank.org.uk/2019/05/09/40-increase-in-parcels-given-out-last-year/

[25] NCMP & Child Obesity Profile, Public Health England

[26] Age UK https://www.ageuk.org.uk/our-impact/policy-research/loneliness-research-and-resources/loneliness-isolation-understanding-the-difference-why-it-matters/

[27] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/loneliness/loneliness-report.pdf

[28] Association for Psychological Science. Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. 2015. Available from: www.ahsw.org.uk/userfiles/Research/Perspectives%20on%20Psychological%20Science-2015-Holt-Lunstad-227-37.pdf

- Loneliness can impact our physical and mental health and has been linked to conditions such as coronary heart disease, high blood pressure, cognitive decline and depression.[29]
- 59% of adults aged over 52 who report poor health say they feel lonely some of the time or often, compared to 21% who say they are in excellent health [30]
- For 3.6 million people aged 65, television is the main form of company.[31]

Better social connectedness

Social connectedness is an objective measure about the number of contacts that people have. The opposite is social isolation, which is linked to, but different from loneliness. Both can lead to the other and both can have detrimental impacts on our health and wellbeing. [32]

- In Merton, many people who use social care services would like more social contact. Only 39.5% of users reported that they had as much social contact as they would like (2016/17).
- Social activities can help older people feel less lonely, but they have to be supported to access these services
- Neighbourhoods that feel safe, welcoming, attractive and have things to do for all residents can help prevent people from becoming lonely[33]
- 38% of people with dementia said that they had lost friends after their diagnosis.[34]
- More than 1 in 3 people aged 75 and over say that feelings of loneliness are out of their control.[35]

Active older people

Approximately 4 million older people in the UK live with a limiting long-term condition, many of which are lifestyle related could have been preventable. **Error! Bookmark not defined.**

- Physical inactivity puts older people's physical, mental and emotional health at risk
- Physical activity can improve strength, balance, stamina, and it also has positive impacts on mental health, feelings of self- worth and social connection.
- It is a misconception that physical inactivity is a natural process of ageing

[29] https://www.campaigntoendloneliness.org/threat-to-health/
[30] Beaumont 2013
[31] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb_dec17_jocox_commission_finalreport.pdf
[32] https://www.ageuk.org.uk/our-impact/policy-research/loneliness-research-and-resources/loneliness-isolation-understanding-the-difference-why-it-matters/
[33] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/loneliness/loneliness-report.pdf
[34] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb_dec17_jocox_commission_finalreport.pdf
[35] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb_dec17_jocox_commission_finalreport.pdf

- UK Active reports that 'a concerted effort to encourage older people to be active can reduce, or even reverse, a decline in health and save billions across the health and social care system'.[36]

All Life Course Stages

Less people breathing toxic air

Air pollution refers to harmful substances in the air we breathe due to high levels of particulate matter

- Poor air quality is the largest environmental risk to public health in the UK.[37]
- Long term exposure to poor air quality (over several years) can reduce life expectancy due to cardiovascular and respiratory causes and from lung cancer
- Short term exposure to poor air quality (hours or days) can exacerbate asthma, affect lung function and lead to an increase in respiratory and cardiovascular admissions and mortality
- An estimated 9,000 deaths a year in London are attributable to the damaging impact of air pollution[38]
- In Merton about 70 deaths per year are attributable to the damaging impact of air pollution [39]
- In Merton, almost 60% of young people think that cleanliness of the air in their areas is a problem, a big problem, or a very big problem[40]
- Costs to society are estimated at more than £20 billion every year[41]

[36] UK Active, Moving More, Ageing Well, 2017
[37] PHE 2019 Evidence Review https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784055/Review_of_interventions_to_improve_air_quality.pdf
[38] Understanding the health impacts of air pollution in London: https://www.london.gov.uk/sites/default/files/hiainlondon_kingsreport_14072015_final.pdf
[39] Calculated using Public Health Outcomes framework and number of deaths for people over 30yrs in Merton
[40] Merton Children and Young People's Survey 2019
[41] Royal College of Physicians (RCP). Every breath we take: the lifelong impact of air pollution. Report of a working party 2016. Accessed 19/07/18. Available from: www.rcplondon.ac.uk/file/2914/download?token=qjVXtDGo.

Less Violence

Tackling violence means looking at violence not as an isolated incident or solely a police enforcement problem, but as a preventable consequence of a range of factors, such as adverse early-life experiences, or harmful social or community experiences and influences[42].

- Overall crime in Merton has risen during 2017/18 by 2.2%, however results from the 2017 Merton resident's survey show that almost 96% of residents feel safe when outside in their local area during the day and 85% after dark[43]
- In 2018/19 there were 1,815 cases of domestic abuse offences recorded in Merton. This is a 19.4% increase from 2017/18 where 1,520 offences were recorded.[43]
- In 2018/19 there were 3,809 total violence against the person offences. This was a 7.96% increase on the figures for 2017/18. In relation to total sexual offences, during 2018/19 there were 354 offences. This was a 5.35% reduction on the figures for 2017/18.
- In 2018/19, 220 knife crime offences were recorded in Merton. This is a 17.7% increase from 2017/18. In 2018/19, the sanction detection count for knife crime was 30, this was one less than in 2017/18.[44]
- The Mayor of London has introduced an initiative to bring together public sector institutions, voluntary organisations and communities to act together to help cut violence. The Violence Reduction Unit (VRU) has been set up to tackle violent crime and the underlying causes, through information sharing on what works in spotting the early signs of what might lead to criminal behaviour and focusing attention and resources on what can make a difference. 42

[42] https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence
[43] Resident Satisfaction Survey 2017. Available at https://www.merton.gov.uk/assets/Documents/residents_survey_research_report_2017.pdf
[44] MPS FY 2018/19 Crime Statistics. Available at https://www.met.police.uk/sd/stats-and-data/met/year-end-crime-statistics/

5. Healthy Settings

People experience a healthy place in a setting where the three attributes (promotion of mental health and wellbeing, easier healthy choices; protection from harm) come together. This forms a healthy setting and healthy settings are vital in order to deliver our priorities.

Here is a brief description of each key setting for the Strategy. Each of the healthy settings has or can work towards a quality mark or level that is also set out below.

Box 1: Healthy Settings and quality mark

Healthy Setting	Quality mark
Healthy Early years settings Early years settings support young children to have a healthy start to life across themes that include healthy eating, oral and physical health and early cognitive development.	London Healthy Early Years London awards scheme https://www.london.gov.uk/what-we-do/health/healthy-early-years-london
Healthy schools Schools support the mental, emotional and physical wellbeing of young people and provide an environment that meets their needs.	London Healthy Schools awards scheme https://www.london.gov.uk/what-we-do/health/healthy-schools-london/awards/home
Healthy school neighbourhoods Schools are surrounded by a healthy urban zone that contributes to creating the conditions for good physical, mental and emotional wellbeing.	School Neighbourhood Approach https://publichealthmatters.blog.gov.uk/2019/03/05/creating-healthier-spaces-for-londons-children-to-live-learn-and-play/
Healthy Work places Businesses and workplaces that proactively respond to the physical and mental health needs of their staff and the wider community	London Healthy Workplace Award https://www.london.gov.uk/what-we-do/health/london-healthy-workplace-award
Healthy Libraries A community hub where people of all ages and backgrounds can be supported to become more enterprising, offering support, help, education, digital technology	Libraries Taskforce Outcomes Framework (2016) https://www.gov.uk/government/groups/libraries-taskforce

and awareness of the health solutions available to the community.	
Healthy Health and Care organisations Easy to access, efficient and high quality health and care services that provide holistic care	NHS Employers Health and Wellbeing Framework (2018) https://improvement.nhs.uk/resources/workforce-health-and-wellbeing-framework/
Healthy Homes Housing that makes the healthy choice easy and minimises risks to safety. Homes which are smoke free.	Smoke Free Homes Promise http://ash.org.uk/wp-content/uploads/2018/11/FINAL-2018-Smokefree-Housing-report-web.pdf
Healthy Streets Welcoming spaces, 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.	Transport for London descriptor http://content.tfl.gov.uk/healthy-streets-for-london.pdf

6. Examples of Different Types of Board Actions

There are a number of different types of actions that the Board can take to maximise impact. These examples are demonstrated in the table below.

Box 2: Types of Actions

Types of Action	Examples
Engagement/Community Conversations	Understanding the patient on chronic diseases e.g. COPD
Bringing different sectors together to problem solve	Less tobacco dependency
Supporting whole systems exemplars	Social prescribing
Spotting opportunities for quick wins	Active travel
Raising awareness for emerging or hidden issues	Self-harm in children and young people
Further board development to be fit for changing health and care systems	Work with the Leadership Centre
Resurrecting previous priority actions to keep momentum	Diabetes

A definitive list of actions will be agreed as part of the rolling priorities (please see the main strategy for more details).

7. Other Materials

There are a number of other documents which contain further background material, most of which will be published on the website to accompany the main strategy.

Aspect of strategy to which document refers	Title	Location
Population need for heath	Joint Strategic Needs Assessment and Health of the borough	https://data.merton.gov.uk/jsna/
Context	Map of how the Health and wellbeing strategy fits in with other strategies and partnerships	Not currently available. To be published with final version
Start Well	Young people what matters to them mind map	
Live Well	DsPH Briefing – Mayors transport strategy	
Age Well and all other aspects	Health and Wellbeing strategy learning pack	

Further additional material may be added in response to feedback from the Board and others.

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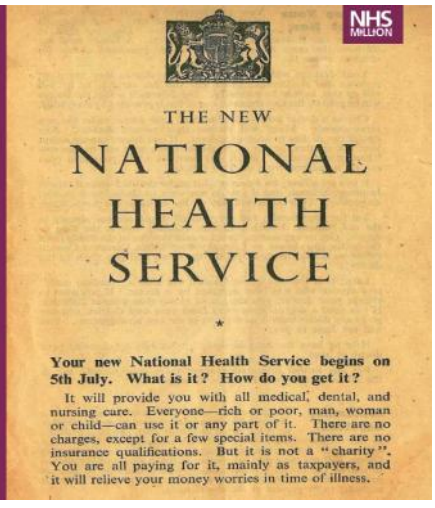
The NHS Long Term Plan, CCG merger discussions and thinking about Place-based Committees

Dr Andrew Murray

The NHS was established in 1948.

And it remains one of the finest health care systems in the world.



The NHS is at the heart of the UK's affections. For many Brits, the universal healthcare service has become **a symbol of a fair society**, delivering free at the point of access services for all, irrespective of wealth or financial contributions.

We believe in an inclusive and innovative approach to care. www.swlondon.nhs.uk

High level messages from the NHS Long Term Plan

- Focus on **prevention and reducing health inequalities** – specific new evidence-based NHS prevention programmes
- **New clinical standards** will be set to build on successes of stroke etc – Clinical standards review will be published in Spring 2019
- **NHS priorities for care quality and outcomes improvement** for the next 10 years, wider than in FYFW - cancer, mental health, diabetes, multimorbidity, healthy aging including dementia, children's health and wellbeing, maternity and neonatal, cardiovascular and respiratory conditions and learning disability and/or autism
- **Reforms to hospital emergency care** - every hospital with a type 1 A&E dept will move to a Same Day Emergency Care model; hospitals will establish acute frailty services
- Roll out of **NHS Personalised Care** model across the country

High level messages - continued

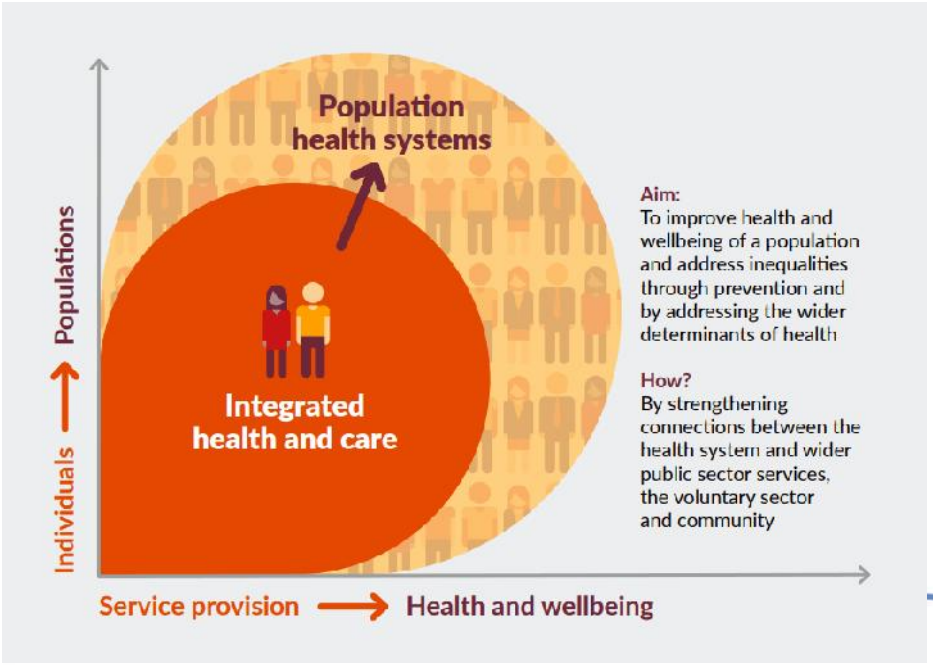
- The NHS and social care will continue to improve performance at **getting people home without unnecessary delay**
- **Boost "out of hospital care"** - Primary care and community care funding and requirements
  - Urgent community response and recovery support to deliver within two hours of referral
  - Reablement care within 2 days of referral
  - Primary care networks created with new "shared savings" scheme
- Renewed commitment that **mental health services** will grow faster than the overall NHS budget – new ringfenced investment fund created (£2.3 bn by 2023/24)
- Guaranteed NHS support to people living in **care homes** – vanguard model rolled out
- Greater recognition and support for **carers** – Quality Markers in primary care that highlight best practices in carer support and identification

High level messages - continued

- **Workforce** is a significant focus - Expansion in nursing and other undergraduate places; new routes into nursing and other disciplines include apprenticeships; flexible rostering will become mandatory; doubling of volunteers
- Better use of **data and digital technology**
- **Integrated Care Systems** across the country by April 2021
- **Funding**
  - Major reforms to NHS financial architecture, payment systems and incentives
  - New financial recovery fund and "turnaround" process established
  - Expectation that over the next 5 years the NHS, trust sector, local systems and individual organisations will return to financial balance
- **Legislative changes** that would support more rapid progress outlined

Integrated Care Systems (ICS)

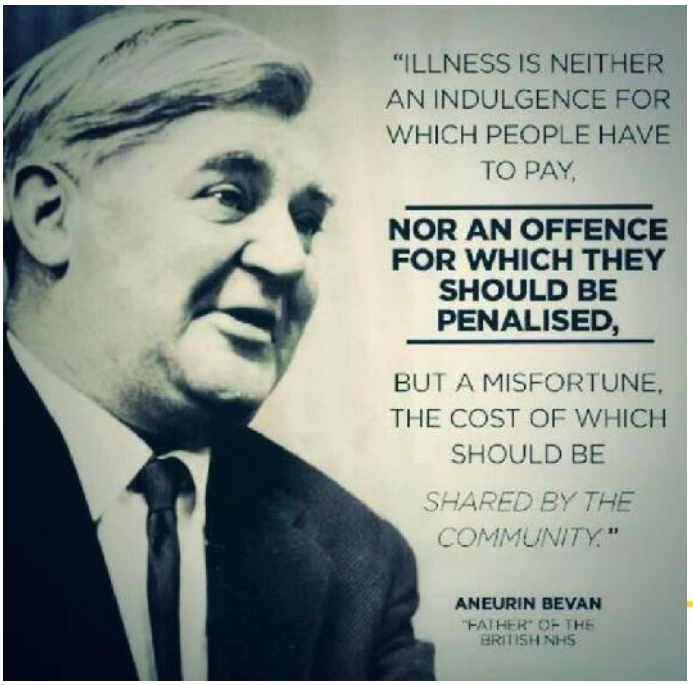
- In an integrated care system, NHS organisations, in partnership with local councils and others, take **collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve**.
- Local services can provide **better and more joined-up care for patients** when different organisations work together in this way. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations. And systems can better understand data about local people's health, allowing them to provide care that is tailored to individual needs.
- By working alongside **councils**, and drawing on the expertise of others such as **local charities and community groups**, the NHS can **help people to live healthier lives** for longer, and to stay out of hospital when they do not need to be there.
- In return, integrated care system leaders gain **greater freedoms** to manage the operational and financial performance of services in their area.



South West London Health & Care Partnership

ICS

www.swlondon.nhs.uk



South West London Health & Care Partnership

Next Steps on the NHS 5 Year Forward View:

"there are still substantial opportunities to cut waste and increase efficiency in the NHS, just as there are in every other country's health care system. In a tax-funded health service, every pound of waste saved is a pound that can be reinvested in new treatments and better care for the people of England."

NHS Long Term Plan:

"Chapter 6 - Taxpayers' investment will be used to maximum effect"

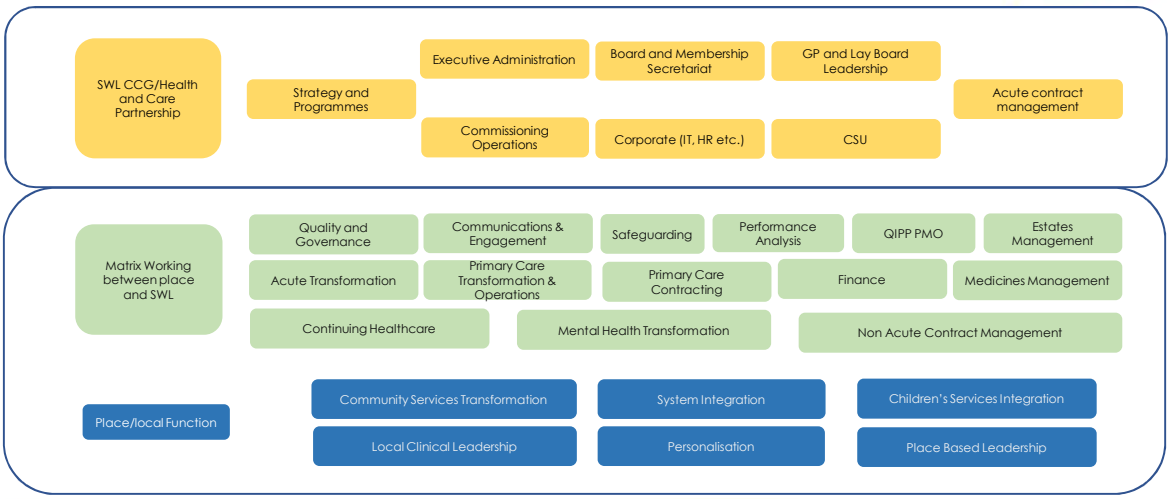
www.swlondon.nhs.uk

Our case for change in South West London

SWL CCG – The Foundations

- We have a number of workstreams and work programmes , however there are some foundations that are needed in order to progress
  - **Functions** – what is done, by who, across SWL and local place teams
  - **Delegation** – what decisions will be made at what level
  - **Place based governance** – how delegated decisions are made collaboratively with partners

Our current view of where functions will sit



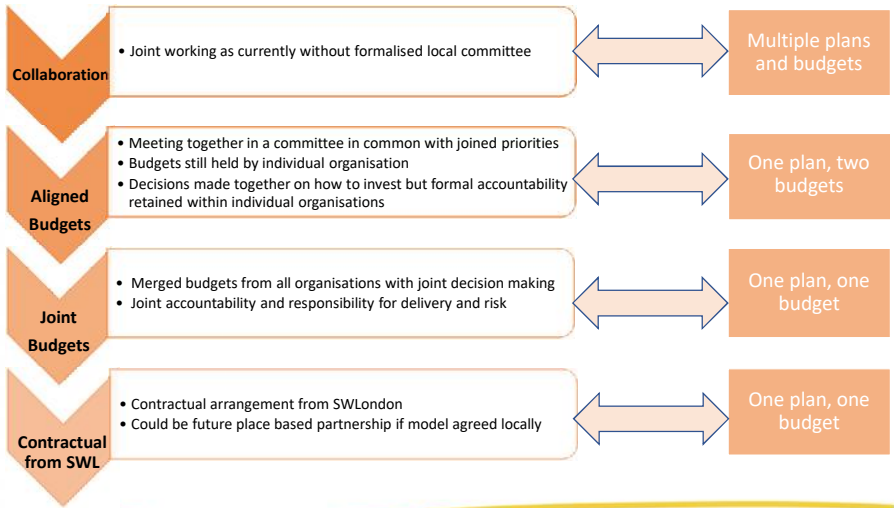
Delegation

- CCGs can delegate responsibility to another person or body to carry out specific duties
- The delegating person or body remains accountable for the outcome
- SWL will work with partners to agree how oversight of SWL accountability will take place
- We want to agree where delegation will sit in a place and SWL model
- This needs to work at place and SWL level
- There are 3 levels of delegation

CCG Delegation Models – a discussion

Delegation	Description	notes
Commissioning - **Full delegation to place – permissive model**	Delegation of CCG planning and commissioning functions to place (delegated back up to SWL level for any agreed centralised functions) - priorities, outcomes and associated investment determined locally, at individual borough level.	Likely to secure local support – from CCGs and Local Authorities Change is focused on single governance structure and reduced costs in back office – retains the ability to delegate back up to scale/system level
Commissioning - **Partial delegation** – with local agreement	Delegation to be driven by local agreement on place based model and health and care plans Areas that could be retained at SWL - Coordination of planning and commissioning - Acute commissioning - Place teams retain influence on all	Could be seen to reduce direct influence and responsibility. Could reduce local risk Would provide a strong single voice with those services retained at SWL Would also deliver savings associated with back office
Commissioning – **No delegation** – delivery, system management and development at place	Coordination of all functions undertaken at scale/once across SWL - Place based interest in and influence on both the above, including generation of local priorities to feed in to SWL wide approaches Place/borough based teams – delegated responsibility for local delivery and development	Unlikely to receive support– as reduces direct influence and responsibility Supports a single strategic commissioning focus with more staff directed at the how Would deliver savings but may impact on localised focus and ownership

Place based approaches



- ❑ Contractual model not yet clear but may be a future option
- ❑ All models can be considered for each place and differential models can happen across SWL
- ❑ Places can progress or move between approaches
- ❑ Joint and aligned could happen in same place based committee (ie. S75)

Place based approaches - what this means for Merton

- The CCG and LBM already have **aligned and joint** commissioning arrangements in relation to some services for older people, mental health and children's services. We also collaborate with the wider system via the **Merton Health and Care Together Board**
- We will need to set up a **place based committee** for Merton that can
  - Take decisions which are delegated from the SWL CCG
  - Take decisions and set overall strategy, with partners, on a collaborative, aligned or joint basis
- We think the **Merton Health and Care Together Board should act as the place based committee** for many decisions
- Where this creates a conflict of interest, commissioners may meet on their own. This might be just CCG clinicians and staff or might be jointly with LBM officers
- The MHCT Board will continue to **report into the Health and Wellbeing Board** as well as the SWL CCG Board. The CCG and LBM are working through how this dual reporting will work
- However we will also need to work with partners in Wandsworth to make decisions in relation to our **partnership with St George's Hospital**

We are also supporting the development of Primary Care Networks

- Primary Care Networks are being formed across the NHS so that groups of practices, serving populations of 30 – 50,000, can come together to
  - provide a wider range of local services by working together
  - work collaboratively with other local health and care providers
  - support each other with challenges like workforce, IT and estates
- They will be responsible for services such as social prescribing, extended access and in-practice physiotherapy
- We have approved 6 Primary Care Networks in Merton
- The Primary Care Networks will be represented on the MHCT Board and are working together with Merton Health, our local GP Federation

Primary Care Networks in Merton

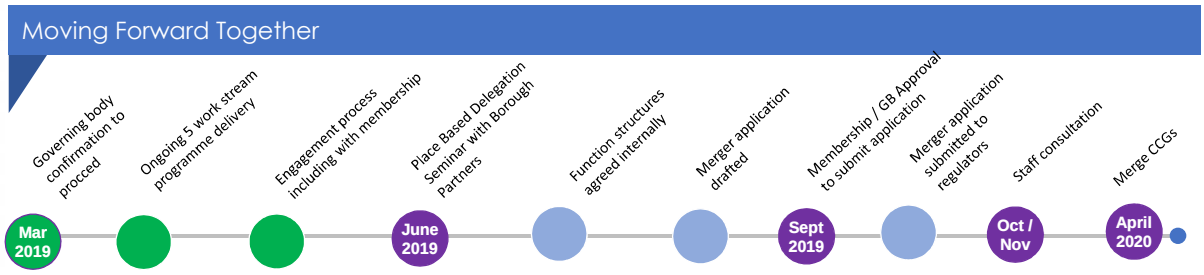
Primary Care Network	Practice	List Size	Collective List Size
North Merton	Mitcham Family Practice	3625	37411
	Riverhouse Medical Practice	5822	
	Merton Medical Practice	8163	
	Mitcham Medical Centre	8988	
	Colliers Wood Surgery	10813	
East Merton	Rowans Surgery	7330	45728
	Figges Marsh Surgery	8083	
	Tamworth House Medical Centre	9241	
	Wide Way Medical Centre	9486	
	Cricket Green Medical Practice	11588	
South West	Grand Drive Surgery	8870	39441
	Nelson Medical Practice	29571	
Morden	Ravensbury Park Medical Centre	5515	37735
	Stonecot Surgery	8586	
	Central Medical Centre	8909	
	Morden Hall Medical Centre	14725	
North West Merton	Vineyard Hill Surgery	4333	31748
	Alexandra Road Surgery	5646	
	Wimbledon Medical Practice	9358	
	Wimbledon Village Practice	12411	
West Merton	Francis Grove Surgery	13720	31517
	Lambton Road Medical Practice	17797	

Summary:
- 6 networks of 30-50,000 registered patients.
- 100% coverage of patients and practices.
- Geographically contiguous.
- Clinical Director appointed for each network.
- Strong foundations for joint working built during 2018/19 through Primary Care at Scale programme and other initiatives such as Integrated Locality Teams.

Priorities in Year 1:
- Employment of new roles at network level – social prescribing link workers and clinical pharmacists.
- Delivery of extended access services.
- Significant focus on OD and planning to enable delivery of new services in future years.
- CCG to consider how other services will integrate with Network arrangements and what support may be required.

Aims:
- More resilient, sustainable and integrated Primary Care.

High level timeline



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