Merton Health and Care Together

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

A Local Health and Care Plan for Merton

Discussion Document: March 2019

Merton Health and Care Together:

Start Well, Live Well, Age Well

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Merton Health and Care Together:

Start Well, Live Well, Age Well

Introduction

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

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

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

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

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

The Vision for Merton Health and Care Together:

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

We will deliver this through:

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

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

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

Merton Health and Care Together

Our Context and Challenges

Merton Health and Care Plan, in context

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

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

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

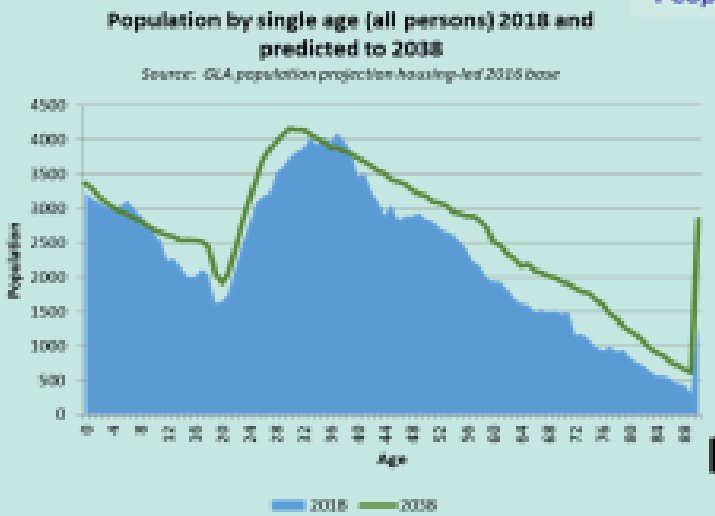
South West London Health and Care Partnership:
A partnership of the organisations providing health and care in the six South West London boroughs, divided into four local partnerships in Croydon, Kingston and Richmond, Sutton and Merton and Wandsworth. The partnership enables commissioning and transformation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

Joint Strategic Needs Assessment: The Merton Story 2018

Key challenges:

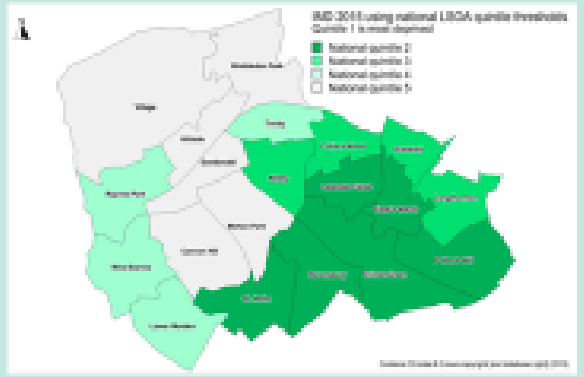
- Emotional Wellbeing and Mental Health
- Supporting wellbeing and independence
- Long term conditions
- People with complex needs
- The need to take a holistic approach

Demographics of Merton



Inequalities and health divide

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



Healthy lifestyles and emotional wellbeing

Males

65.4

Longer than London (63.2) and England (63.5)

Females

66.3

Longer than London (64.0) and England (64.8)

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

Exercise

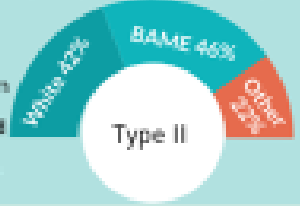
In 2016/17, just over 17% (28,000) of adults aged 19 and over were doing less than 30 minutes of moderate exercise a week. This is lower than London (23% and England 22%)

Increasing complex needs and multi-morbidity

Diabetes (Types I and II)

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

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



Dementia

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

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

Child and family vulnerability and resilience

Children in care

England 62 per 10,000

London 50 per 10,000

Merton 36 per 10,000

Merton has a lower rate than London and England

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

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

Emergency admissions due to injuries from falls

England 2,114 per 100,000

London 2,201 per 100,000

Merton 3,262 per 100,000

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

Hidden harms and emerging issues

Air pollution

Tuberculosis

London 22.2 per 100,000

SW London 12.8 per 100,000

Merton 18.0 per 100,000 (about 40 people)

Seasonal mortality

More people die in the winter than the summer

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Merton's changing population and rising demand for services

Our growing population means that by 2030 there will be:

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

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

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

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

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

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

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

Quality, Performance and Financial Context

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

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

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

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

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

What residents tell us

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

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

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

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

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

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

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

Merton Health and Care Together

Our Work

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

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

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

Merton Health and Care Together: 5 prevention priorities

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

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

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

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

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

Merton Health and Care Plan on a Page

Our Vision:

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

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

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

Merton Health and Care Together:

Start Well

Together we will focus on:

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

Community Health Services for Children and Young People

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

Developing Pathways into Adulthood

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

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

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

Let's take some facts...

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

What are we doing to improve services?

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

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

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

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

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

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

WHAT
will the impact be?

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

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

WHO
are we trying to help?

Around 64,000 young people aged 0-24

Around 2400 children with mental health problems

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

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

Let's take some facts...

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

What are we doing to improve services?

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

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

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

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

WHAT
will the impact be?

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

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

WHO
are we trying to help?

Around 64,000 young people in Merton

Around 1600 Children with an Education, Health and Care Plan

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

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

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

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

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

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

Merton Health and Care Together:

Live Well

Together we will focus on:

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

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

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

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

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

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

Let's take some facts...

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

What are we doing to improve services?

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

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

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

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

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

WHAT
will the impact be?

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

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

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

WHO
are we trying to help?

Around 140,000 adults living in Merton

Around 24,000 people living with common mental health conditions

Around 16,000 people living with a long term condition

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

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

Let's take some facts...

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

What are we doing to improve services?

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

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

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

We will work to support our workforce by:

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

We will continue to improve access by:

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

We will improve organisational efficiency by:

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

WHAT
will the impact be?

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

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

All Merton registered patients able to access primary care services online

All patients have access to social prescribing services.

Patient care is holistic and joined up across multiple agencies

WHO
are we trying to help?

Merton has a GP registered population of 220,000
Around 140,000 adults
Around 16,000 people living with a long term condition

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

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

Let's take some facts...

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

What are we doing to improve services?

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

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

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

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

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

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

WHAT
will the impact be?

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

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

WHO
are we trying to help?

Adults and
Children across the
whole of Merton

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

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

Let's take some facts...

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

What are we doing to improve services?

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

Supported patient self-care and self-management

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

Consistent and high quality primary care

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

A new Diabetes Community Service

Establishment of a Diabetes Clinical Advice Service:

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

WHAT
will the impact be?

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

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

WHO
are we trying to help?

Around 13,500 people with diabetes

Estimated 2,000 living with undiagnosed diabetes.

Merton Health and Care Together:

Age Well

We will deliver this through:

Integrated Health and Social Care

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

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

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

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

Let's take some facts...

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

What are we doing to improve services?

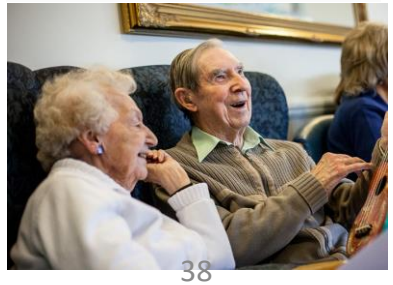
We will provide proactive, integrated and responsive care, including particular enhancements for those most frail and in need of services

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

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

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

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



WHAT
will the impact be?

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

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

WHO
are we trying to help?

Around 25,000 older people in Merton

Estimated 1700 people in Merton with dementia

Around 850 care home residents

Merton Health and Care Together

Creating the right environment for change

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

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

Let's take some facts...

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

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

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

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

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

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

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

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

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

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

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

Delivering the plan: the Merton Health and Care Together Board

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

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

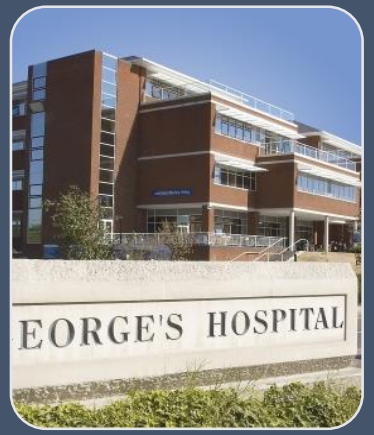
The Merton Health and Care Together Board is co-chaired by Merton Clinical Commissioning Group's Managing Director, and the Director of Communities and Housing of the London Borough of Merton. Held on a monthly basis, it oversees the development of the health and care plan, drives delivery, and ensures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

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

Other work

Acute Transformation: Planned Care and Urgent & Emergency Care

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



Planned Care

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

Urgent and Emergency Care

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

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