Merton
Health and Care
Together

Merton Local Health and Care Plan

2022-2024

Contents

Merton Health and Care Together

1) Introduction

Introduction

Health, care and community organisations in Merton have worked closely for many years and, since the pandemic, remain committed to reduce inequalities, join up services and make real differences to people's lives. Our refreshed health and care plan set out here for 2022-2024 is just one element of work in Merton to continue to improve health and wellbeing post Covid. It outlines projects where we can have the greatest impact in Merton by working together.

Merton Health and Care Together

2) Vision for health and care in Merton

Our updated vision

Merton Health and Care Together

After talking to our community in Merton we have collectively refreshed our vision to:

"Working together to reduce inequalities and provide truly joined up health and care services with and for all people in Merton, so they start, live and age well in a healthy place"

We want all children in Merton, regardless of their background or circumstances, to have the support and care they need to grow and thrive. We will work to change the way young people access health and wellbeing services, continuing to develop support in the places they already go, such as schools and community-based locations.

We want to better support working age adults in Merton to improve their health and wellbeing. We want to make sure services are delivered in, and with, our diverse communities. We will pilot health and wellbeing offers on high streets and in community and faith venues. We will develop more options for people to personalise their care, based on needs, and focus on physical, mental health, and social issues, such as employment.

We want to connect older people with community networks in new and different ways post Covid. We will work with the voluntary and community sector to support older people to re-engage with and access community resources for their health and wellbeing post Covid. We want to ensure people's needs are matched with the services available.

Merton Health and Care Together

3) Merton in context

Our community in Merton

- **The Merton Story 2021**[1] outlines that in 2021 Merton has an estimated resident population of 212,882. Approximately 51% of Merton residents are female (108,476) and 49% are male (104,406). Around 52% (111,713) of Merton residents live in East Merton, while 48% (101,169) live in the West.

- Merton's population is ageing due to increased life expectancy and falling birth rates, resulting in a growing proportion of older residents and a falling proportion of younger residents. In 2021, an estimated 79,352 people (37%) in Merton are from Black, Asian and Minority Ethnic (BAME) groups, lower than the proportion for London (43.7%).

- On average, the population of Merton is healthy compared to London and England. However, there are significant health inequalities across the borough. These inequalities in population health correlate with differences in the demographic structure of the population, for example ethnicity and age structure, as well as differences in the wider determinants of health, such as socioeconomic circumstances. For example, compared to the West of Merton, the East of the borough has a high proportion of people from minority ethnic groups, a higher amount of socioeconomic deprivation and a lower average life expectancy. Factors that underpin these inequalities are discussed in detail throughout the Merton Story.

1 The Merton Story: The Merton Story 2021_final_21st_December_2021_0.pdf

Our challenges

- The Merton Story 2021 also outlines that Covid-19 has not impacted health and wellbeing in Merton equally:
  - Infection rates have been higher in the east of the borough
  - The risk factors for severe disease, such as long-term health conditions, are more prevalent in East Merton and in some BAME groups
  - 88% of Covid-19 deaths registered in Merton during 2020 were in people aged 60+

- The Covid-19 pandemic and the resultant measures have had indirect impacts on the population:
  - 6.6% of Merton residents were advised to 'shield' due to a higher risk of severe illness and death from Covid-19
  - Many routine healthcare services were interrupted or cancelled to prioritise the pandemic response
  - A sharp reduction in GP and A&E attendance occurred from March 2020 on entering the first lockdown which may have contributed to excess or avoidable deaths in Merton

- The Merton Story outlines the wide range of risk factors that contribute to this disproportionate impact and highlights that the pandemic has also had a number of wider impacts, such as economic hardship, impacts on mental health and wellbeing, and interruption to education and other services. Points from The Merton Story about key impacts on the life course areas of Start well, Live Well and Age Well, and Merton as a healthy place are outlined on the next pages.

Our challenges

Merton Health and Care Together

- Children and young people (CYP) experience good health outcomes compared to regional and national benchmarks but there is inequality in Merton
- Risk factors and vulnerabilities for CYP have been exacerbated by the pandemic, including an increase in domestic violence, which is higher in East Merton and an increase in child poverty with a widening gap between East and West Merton
- CYP in Merton obtain good levels of development and attainment, however lower proportions reach expected levels in East Merton and the move to online teaching may have widened the educational gap for disadvantaged students
- In Merton, 12.6% of school pupils received Special Educational Needs support in 2020/21 and there has been an increase in the number of children with an Education Health and Care (EHC) plan during the pandemic
- 1 in 12 children in Reception are obese in Merton, rising to 1 in 5 children in year 6 and a higher proportion of children in East Merton wards being obese compared to West Merton wards
- The mental health of young Londoners has declined in general during the pandemic, Merton has higher admission rates for self-harm in 15–19-year-olds compared to London
- Eating disorders and disordered eating in CYP have worsened during the pandemic, with a 50% increase in patients starting treatment nationally
- Under 5's immunisation rates in Merton are similar to London rates, although lower than the national average and below NHS targets
- The number of children with a child protection plan almost doubled from April 2020 to April 2021

- A large number of Merton residents have behavioural risk factors that contribute to ill health and premature death in Merton:
  - 1 in 4 residents are physically inactive
  - 1 in 7 residents are smokers
  - 1 in 2 residents are overweight or obese
- The pandemic has had a mixed impact on these risk factors:
  - 44% of residents in London report eating healthier meals while there has been an increase in the proportion of Merton residents being physically inactive compared with previous years
  - Alcohol-related hospital admissions and deaths in Merton have more than doubled compared to recent years, while the number of those accessing treatment has not increased accordingly
  - Smoking rates have dropped across Merton during the pandemic; however the rate remains higher in East Merton and among those in manual occupations
- The pandemic has impacted mental health and wellbeing for Merton residents. Before the pandemic the average anxiety score reported by residents in this period was 3.0 (out of 10). However, early in the pandemic (April 2020 – September 2020) this score increased to 3.3
- Diagnoses of syphilis and gonorrhoea per 100,000 have been increasing in Merton since 2012

Our challenges

- Many Merton residents live with multiple long-term conditions (LTCs); the proportion of people experiencing LTCs increases with age and is higher in areas of socioeconomic deprivation
- Prevention and management of LTCs have been impacted during the pandemic due to:
  - Impacts on physical activity, diet, and food poverty
  - Service interruptions as well as avoidance or inability to seek healthcare
  - Negative impacts on mental health, with reciprocal impacts on physical health and LTCs
- Pre-pandemic, Merton had lower cancer-related mortality among under 75 year olds than national and regional benchmarks, however the pandemic interrupted screening programmes, diagnosis and treatment which may adversely affect cancer outcomes for older adults in the future
- Ageing well and frailty have been negatively impacted by the pandemic due to physical deconditioning, and fewer opportunities for physical activities. The rate of falls has also been increasing over the past decade and we have anecdotal reports that this has been an issue over the past year
- Merton residents living with dementia have been affected by Covid also, with reduced diagnosis rates, deterioration of symptoms, stress and anxiety, increased loneliness and isolation, and difficulties accessing digital services
- Carers in Merton have reported their caring role has increased due to COVID-19, with increased stress and additional demands
- Many adults and older adults in Merton live with a learning disability, autism or physical disability and have been disproportionately impacted by the pandemic due to increased risk of isolation, interruption to services/ social activities/ employment, and requirements to shield

- Merton has a range of community assets that promote positive health and wellbeing and have provided valuable support during Covid, including;
  - Good schools, libraries and children centres
  - Active community groups and voluntary organisations
  - Diverse green spaces
- Covid has negatively impacted Merton's economy with a large number of people furloughed during the pandemic and unemployment is 6.2%; higher than the national average of 4.8% (the claimant rate rose to 7.4% during the pandemic with highest rates in East Merton, where more people work in jobs disproportionally affected by the pandemic)
- Housing in Merton is of good quality, however there are higher levels of overcrowding in East Merton and housing is less affordable than regional and national averages
- Merton is a safe borough with low crime rates relative to London and England, though a Public Space Protection Order area has been introduced to address antisocial behavior related to alcohol consumption in public places
- Merton has good transport links and levels of cycling are higher than the London and England average; however they are lower than neighbouring boroughs which have better cycling infrastructures
- Merton residents report traffic and congestion (associated with air pollution) as key neighbourhood concerns

Merton Health and Care Together

4) Developing our plan with our local people and partners

Approach to refresh our plan

- Partners across Merton Health and Care Together (MHCT) drew together feedback and wider intelligence to inform the local health and care plan refresh through a range of sources/ engagement including:
  - Start Well, Live Well and Age Well workshops held virtually during August/ September 2021 with over 100 attendees from local health, care, voluntary and community sector groups and patient and public representation
  - Review of post-workshop online survey responses
  - Review of The Merton Story update 2021 (JSNA update)
  - Review of Community impact reports
  - Feedback from Transition Team members and MHCT partner organisations
  - Merton and Wandsworth engagement themes from the SWL CCG Patient and Public Involvement and Equalities team – carried out prior to and during pandemic
  - Patient Engagement Group discussions and follow-on conversations with specific community organisations in Merton e.g., Merton Centre for Independent Living, and Covid Community Champions
  - Previous local health and care plan priorities and Health and Wellbeing Strategy intended outcomes
  - "Your Merton" survey high level themes
- The workshops and other engagement above followed a process of **reminding** people what was in the original local health and care plan 2019-2021 including what had been delivered; **reviewing** the impact of Covid-19, and **refreshing** the future direction for Merton based upon collective feedback and the data. The following pages summarise key findings during this process.

Merton Health and Care Together

Remind - what was delivered through the 2019-2021 plan?

How was the original local health and care plan developed?

- Merton's Local Health and Care Plan 2019-2021 was developed in partnership with local people and stakeholders with a wide range of co-production between August 2018 and July 2019 - hearing what they wanted from health and care services and testing ideas at different stages in the development of the plan, including a large engagement event in November 2018.
- It described an original vision *("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.")* and eight priorities and actions to meet the health and care needs of local people, and deliver improvements in their health and wellbeing through the life stages of: *start well, live well and age well.*
- **Start well priorities:** 1) Emotional health and wellbeing for Children and Young People; 2) Integrated children's services and 3) Developing pathways into adulthood
- **Live well priorities**: 4) East Merton model of health and wellbeing, 5) Diabetes, 6) Primary care at scale, 7) Primary mental healthcare
- **Age well priority:** 8) Integrated health and social care
- The plan focused on the collaborative action that communities, health, social care and the voluntary sector could take together to deliver quality health and care services that support local people.

What has been delivered?

- Overall, health and care partners continue to collaborate closely in Merton, reporting to the Merton Health and Care Together Board (MHCT Board). Integrated working between the NHS, adult social care and the voluntary sector, led by the Community Response Hub, ensured rapid discharge from hospital, and easily accessible support for vulnerable people during the pandemic.
- Mental health support teams are now in place in schools, building emotional resilience in young people from an early age. Merton Uplift continues to develop its counselling services for those with common adult mental health problems, and a wellbeing service, linking people into community activities.
- There are six established primary care networks of GP practices covering Merton, with significant progress in rolling out social prescribing, especially in East Merton, where need is greater.
- Across Merton we also now have a network of diabetes champions, who work with us and the council, helping local people understand more about the condition. Our champions share their experience to help others with diabetes live longer and more confident lives. Our integrated locality teams, based around primary care networks, support older people with complex needs to receive more joined-up care.
- The following pages give a high-level outline of what has been delivered against the original priorities in the plan.

Start Well – you said, we did

Priority	You said	We did
1) Emotional health and Wellbeing for Children and Young People	○ Increase access ○ Develop workforce ○ Deliver whole school approach ○ Pathway for CYP in criminal justice system ○ Early Intervention in Psychosis (EIP) for CYP from 14	○ All secondary schools and some primary schools in Merton now supported by a Mental Health Support Team through the Trailblazer programme ○ "Whole school approach" developed through Mental Health Support Teams delivering evidence-based interventions in or close to schools for those with mild to moderate mental health issues and signposting for those with more severe mental health needs to access the right supportI ○ Implementation of the Thrive framework
2) Integrated children's services	○ Integrated commissioning Strategy ○ Review of community health services ○ Integrated model of care	○ Community Health Services Contract extended ○ Integrated Commissioning work plan refreshed and being implemented
3) Developing pathways into adulthood	○ Commitment to work in partnership to identify and resolve any challenges that arise in transitions	○ Pathways to Adulthood Board in place progressing programme of work

Live Well – you said, we did

Priority	You said	We did
4) East Merton Model of Health and Wellbeing	○ Development of East Merton site ○ Enhanced East Merton Primary Care Hub ○ Social prescribing ○ Access to a wide range of service	○ Significant progress made by East Merton Primary Care Network with development of hub ○ Social prescribing rolled out and established across the borough ○ Work to develop options for an East Merton site ongoing with a wellbeing working group established for the Wilson
5) Diabetes	○ Supported patient self-care and self-management ○ Consistent and high quality primary care ○ A new Diabetes Clinical Advice service in the community	○ Commissioned Diabetes Complete ○ PCN-led approach to diabetes and inequalities commenced ○ Launched Diabetes Year of Truth ○ Diabetes Champions network created ○ Identified variations in National Diabetes Audit to improve achievement of the NICE recommended treatment and all practices in Merton have signed up to the local incentive schemes (outcome based KPIs implemented) ○ Delivered the uptake of training to front-line staff, e.g. Cambridge Diabetes Education Programme, behaviour change and 'structured conversations'

Live Well – you said, we did cont.

Priority	You said	We did
6) Primary Care at scale	○ Implement Primary Care Networks (PCNs) ○ Support/ develop workforce ○ Improve access ○ Improve organisational efficiency	○ Six primary care networks established in Merton ○ PCN Clinical Directors have developed as visible clinical leaders in Merton ○ PCNs can enable new services including extended access ○ Covid vaccination programme has shown what can be achieved by working together
7) Primary Mental Healthcare	○ Deliver a single point of access to adult mental health ○ Commission a wellbeing service ○ Expand psychological therapies ○ Commission a Primary Care Recovery Service (PCRS)	○ Merton Uplift launched in April 2019 ○ Service provision has been developed and Merton Uplift includes a wellbeing service, talking therapies service and primary care recovery service ○ Delivered in partnership with partners e.g. Carers Support Merton, Wimbledon Guild, Focus 4 1, Ieso, Silvercloud etc.

Age Well – you said, we did

Priority	You said	We did
8) Integrated health and social care	○ Proactive care and more effective reablement ○ Integrated Locality Teams ○ Support for the most frail	○ Significant progress through Covid-19 response on developing integrated health and social care e.g. enhanced support in care homes, discharge to assess, virtual wards ○ Integrated Locality Team (ILT) approach established across all practices with Integrated Locality Co-ordinators in place ○ Larger community integration piece of work delayed until April 2022 due to Covid19. Scope and remit of this work to be revised

Merton Health and Care Together

Review - what has happened recently and how has Covid impacted?

Listening to our community and understanding our needs together

- The Merton Story 2021 outlines the needs and issues in our borough reflecting on the impact of Covid-19
- The “at a glance” infographic was shared and discussed with stakeholders during the workshops and other forum to ensure conversations and future plans were shaped with an understanding of the current situation in the borough

The following pages highlight the general feedback themes from the full range of engagement and intelligence sources used to shape the plan; detailed feedback for each life course area can also be found at Appendix 1

- A summary of feedback related to the impact of Covid-19 is also described
- Across our work we have prioritised engaging with communities who experience health inequalities and have worse health outcomes.
- There is a strong and diverse community and voluntary sector in Merton, demonstrated by the rapid and successful partnership working during the pandemic response. We want to listen and work to share our assets and resources to increase impact.

The Merton Story 2021

Merton Health and Care Together

Merton Story 2021 – at a glance

Start Well

Increase in vulnerabilities for children and young people and worse mental health due to COVID-19

Staying safe, enjoying & achieving

- ↑ Child poverty
- *Worsening parental mental health and substance misuse
- ↑ Domestic violence
- ↑ In child protection plans
- *↑ Educational attainment gap

Being healthy

- Poorer mental health
- High self-harm
- Healthy weight challenges:
  - ↑ Obesity gap
  - ↑ Food poverty
  - *↑ Eating disorders
- *Immunisations interrupted

Age Well

Many residents with multi-morbidity and complex needs; prevention and management of Long Term Conditions impacted by COVID-19

Frailty & dementia

- Deconditioning
- ↓ Dementia diag.
- ↑ Falls

Disability

- *↑ Loneliness
- ↑ Burden on carers
- Digital exclusion

Cancer

*Delays in:

- Diagnosis
- Treatment
- Screening

Live Well

Many residents have unhealthy lifestyles and poor mental wellbeing, exacerbated by COVID-19

Obesity

- Half residents overweight
- ↑ Food parcel use
- ↓ Physical activity

Smoking

- 1 in 7 residents smoke
- ↑ Smoking cessation during COVID-19

Mental health

- 1 in 5 report anxiety
- *↑ Loneliness
- *Poorer mental health for those shielding

Alcohol / drugs

- ↑ Alcohol-related admissions
- ↑ Nationally in drug-related deaths

Sexual health

- ↓ Service use during COVID-19
- ↑ Syphilis and Gonorrhoea pre-COVID

Please note: * refers to likely based on national data

Merton as a Healthy Place

Borough with many assets; challenges include housing shortage and employment gap, increased by COVID-19

Assets

- Diverse green spaces
- Good transport links
- Low crime
- Good schools
- Resourceful libraries
- Active voluntary and community sector

! Challenges

- Affordable housing
- Insecure employment (↑ in East)
- Air pollution
- Climate change
- Cycling infrastructure behind neighbouring boroughs
- Street drinking

General feedback themes

Some consistent themes were found across all feedback:

- We need to talk to and listen to communities in their own spaces/ environments, understand their needs and invest in them and empower them
- Cultural sensitivity needs to be considered in all work we plan and deliver, and communities need to be part of this planning and delivery
- Mental health and emotional wellbeing are vitally important across Start Well, Live Well and Age Well
- Improving transitions between the three life course areas was consistently raised, and how each life course area implicitly impacts other areas e.g. parental mental health impacts children; smoothing transitions/ provision between organisations and borough boundaries is also important
- Improved information and communication about local services across the whole health, care, and VCSE spectrum is required, and we need to raise awareness about how to access/ refer to services
- We need to develop a strategy about how to share communications, outputs of engagement and information better across partners, to include building communities of practice for staff across organisations
- We need to consider living and working environments across the borough and how developing Merton as a healthy place can improve health and wellbeing. Regenerating high streets and making best use of green space is key for residents

General feedback themes (cont.)

- Prevention and early intervention are key, and considering all the social determinants of good health and wellbeing e.g. employment, housing, finance, and social networks amongst others
- We also need to think about a population health based approach and make plans with the people of Merton informed by data
- Discussions are useful but we need to be accountable – what has actually happened, what actions will take place next through the plan, and how will engagement continue?
- We must not over promise and under-deliver
- “Tackling inequalities” must not just be a strap-line
- You can’t legislate collaboration; we need to continue to work on the “hearts and minds” of Merton – we need to harness hope together and build resilience

Impact of Covid

The following negative impacts of Covid were identified:

- The impact of Covid has highlighted health inequalities and deprivation in the borough specifically for particular communities e.g. Black and other minority ethnic communities
- People report increased social isolation and a lack of connectedness
- People feel scared and confused and anxiety is high, we need to harness hope and particularly for young people bring back some joy/ happiness
- Health and care staff report increased workload and stress
- New ways of working have been implemented rapidly and delivery of business as usual has been impacted
- The pandemic has impacted on people's mental health, and people with learning disabilities, autism and/ or other complex needs may have been more disproportionately impacted

However there have also been reported positives:

- Accessing care and support from the local community and faith networks was a main positive aspect of the pandemic
- Covid has encouraged better team working and cooperation between public sector organisations
- There has been increased interaction and integration between health, care and the voluntary and community sector
- The vaccination effort has highlighted the benefit and opportunities to working collaboratively

Merton Health and Care Together

Refresh - what do we want to do next?

Developing the plan

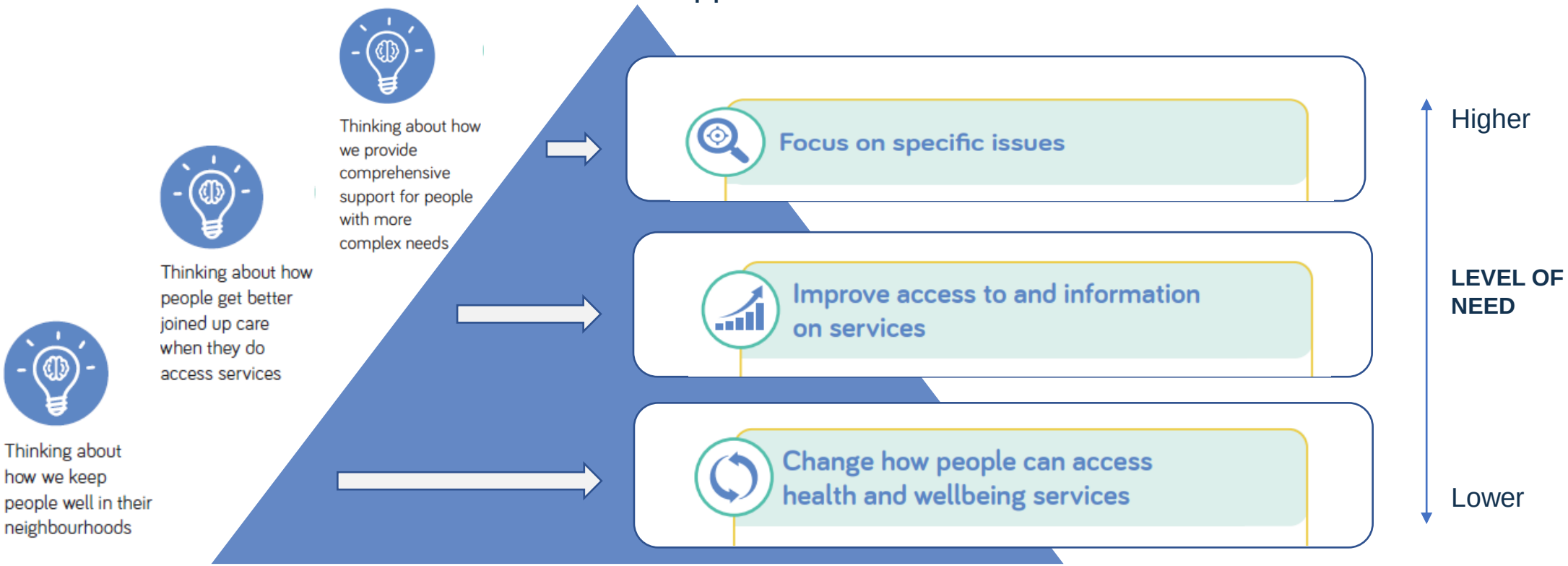
- The feedback outlined has been discussed at a high level through the Merton place based transition team and the Merton Health and Care Together Board meetings during late 2021. The approach and high level feedback was also discussed at the September 2021 Health and Wellbeing Board
- These groups helped shape the principles of the refreshed plan, and an understanding that to build resilience in Merton different approaches needed to be taken for different levels of need i.e. trying new ways to prevent ill-health and promote wellbeing for the broader population such as “Health on the High Street”, while focusing on specific issues for those with more complex needs across the life course such as frailty for Age Well
- A high level summary of the plan was then endorsed by the Merton Health and Care Together Board in November 2021 and then also at the November 2021 Health and Wellbeing Board

Merton Health and Care Together

6) Our refreshed plan – 2022-2024

Principles of the plan

- Across all our work we aim to:
  - Reduce health inequalities and embed equity.
  - Use a population health management approach to drive change.
  - Focus on sustainability and making Merton a healthy place.
  - Engage with service users, patients and communities so all work is developed with and by people in Merton.
- Based on all our feedback we will think about different approaches for different levels of need:



For Start Well we will:

- Change how young people can access health and wellbeing services:
  - a CYP **emotional health and wellbeing** hub in a community/ high street space
  - continuing to develop **mental health** support available in schools

- Improve integration of children's community services:
  - bringing together a new service model to deliver more integrated community services including a focus on support for the most vulnerable children, and a better understanding of high admission rates for under 2-year-olds providing **community-based health and wellbeing support** with the voluntary sector
  - connecting staff who work with children and young people across the borough such as **SEND**
  - we will continue to collaborate on ensuring children maintain a healthy weight **through schools and early years**

- Be focused on mental health and wellbeing:
  - continuing to roll out the **iThrive model**, "whole school" and "Think Family" approaches
  - developing support for transition to adult services particularly in **LD, LAC** and **CHC**

For Live Well we will:

- Change how people can access health and wellbeing services:
  - health and wellbeing hubs on high streets (Health on the High Street) and in community/ faith venues
  - pilot an Ethnicity and **Mental Health** Improvement Project (EMHIP) hub in Merton
  - developing more options for people to personalise their care - we will tackle obesity in all ages and demographics, supporting residents in reaching and maintaining a healthy weight, to prevent ill-health
- Improve and optimise access to and information on primary care:
  - building on learning from vaccination programme to reach all communities and promote all wider primary care services e.g. **pharmacy**, optometry etc.
  - Work to promote 'information equality' by developing information on services in a range of preferred formats and language and focussing on our deprived areas
- Be focused on prevention:
  - continuing established work on **diabetes** and **obesity** through PCNs and community organisations, using learning from diabetes prevention to now also look at long Covid, cancer and tackling increased alcohol consumption – thinking about how improving health outcomes in some of these areas may also reduce cardiovascular risk

For Age Well we will:

- Support older people to access community resources post covid:
  - empowering the voluntary and community sector to re-engage older people with services as the **community hub** develops and maximise social prescribing input
  - connecting older people with community networks in new and different ways
  - we will tackle **obesity** in all ages and demographics, supporting residents in reaching and maintaining a healthy weight, to prevent ill-health **(community garden, access to leisure)**
- Improve access to and information on integrated services:
  - connecting professionals better across community **multi-disciplinary teams**
  - ensuring older people can access more **personalised care**, matching their needs with services available through
  - Develop **hospital at home and the rapid response** service to avoid hospital admission and facilitate early discharge and maintain them at home
- Be focused on frailty:
  - Develop a **new frailty service model** based in the community

What will help make our plan happen?

Enablers/ other developments

1) Primary Care Network (PCN) Development

- Development of PCNs in our Merton community is vital particularly as we have seen them demonstrate enthusiasm for specific projects in diabetes, children's health, optimal aging, improving access to cervical smears, and home blood pressure monitoring to name but a few. We want to further develop our primary care networks in Merton so they are thriving and form the vital connection between patients, GP practices and the wider system.

- PCNs provide the right footprint for delivery of population health management projects and have shown their capability for this through specific projects, and there is now the opportunity for delivery of more ambitious projects with the support of MHCT Board and Merton "place"

2) Voluntary and community sector (VCSE) capacity and capability

- Key to the ongoing delivery of this plan will be working with our VCSE colleagues to build their resilience, and capability and capacity. This will require developing funding and resource provision in a longer-term and more sustainable framework to enable VCSE colleagues to:
    - Input to and support place-based governance arrangements
    - Deliver engagement support – linking health and care partners to wider community groups and those more seldom heard
    - Support shifting delivery of interventions from more acute health and care settings to community led preventative provision

3) Estates

- Developing Merton as a healthy place and considering use of our estate is also vitally important. Key to the ongoing delivery of this plan will be the need to:
    - Link in with and support delivery of the Merton Borough Estates Strategy
    - Specifically support the development of the Mitcham Wellbeing Hub at the preferred site

What will help make our plan happen?

Enablers/ other developments

3) Merton as a healthy place & developing social anchors

- Anchor institutions are large public sector organisations which are rooted in place and connected to their communities.Anchors have significant assets and spending power and can consciously use these resources to benefit communities. As well as providing health services, the NHS and other health organisations can use their resources and influence to maximise its social, economic and environmental impacts (social value) to improve the social determinants of health, health outcomes and reduce health inequalities.
- Identifying and exploring using fixed statutory assets as anchor organisations with projects such as 'Health on the High Street' could help reduce health inequality through improving accessibility and also aligning with wider economic development aims and objectives within the councils Merton 2030 pledges to regenerate Merton's community high streets.

Through greater partnerships with local community, delivery of this plan will recognise the assets and social capital that exists in our community to create a more responsive health and care system, ensuring more culturally competent service delivery options which will aid in reducing health inequalities.

4) Digital

We will ensure we teach people and staff in Merton to use digital technology in the best way to manage their health and wellbeing, ensuring we do not increase digital exclusion

We will also work to support delivery of the priorities within the south west London Integrated Care System Digital Strategy (digital infrastructure, shared care records, population health platform, personal health care record, innovation) in Merton

5) Workforce

Ensuring an effective and supported workforce across all partner organisations in Merton is vital to achieving our vision and delivering on our work plan. We are committed to supporting our staff, working more closely together to share learning and develop roles, and encouraging local people to work for us in the future

Start Well - programme of work

What we will do	Description of initiative	What will be the impact?	How will we measure success?
Change how young people can access health and wellbeing services	• Health and Wellbeing Hub Scoping a CYP emotional health and wellbeing hub in a community/ high street space (actively exploring and developing NHS social anchor at neighbourhood/PCN level)	- Improved access to services - Improved information and signposting and support to carers and families - Reduction in health inequalities through improving access	- Increased numbers of people accessing services - Increased range of services - Improved health outcomes and feedback from service users and carers
Improve integration of children's community services	• A model for the delivery of integrated community services for 0-5 Building on development work done around the family hub bid, scope a new service model to deliver more integrated community services learning from the COLLABORATE pilot for early years speech language and communication need (including a focus on support for the most vulnerable children, and a better understanding of high admission rates for under 2-year-olds)	- All children and their families are supported to flourish and achieve their potential with appropriate support and care they need. - Greater prevention focus, working with people preventatively to improve health and wellbeing	- Admission rates to acute care for under 2 years olds - Feedback and Children, young people and their families and carers
	• Child Healthy Weight Action Plan (Julia Groom , Hilina Assress) Continuing to collaborate and deliver on actions in the refreshed Child Healthy Weight Action Plan (2022-2025) and work with leisure and environment partners to encourage more use of open spaces, playgrounds and sporting activities	- Halt and begin to reduce the increase in children that are overweight or obese - Reduction in health inequalities between East and West Merton (levelling up)	- Reduction in BMI - Increase in hours of physical activity - Changes in family diet
	• (Safety Value) Improve outcomes for children and young people with SEND including autism– collaborative approach to supporting people with autism in Merton	- Improved access, experience and outcomes for people living with and supporting someone with Autism.	- Feedback mechanisms with local children and families and carers
Be focused on mental health and wellbeing	• Transformation of CYP Mental Health Ensuring delivery of improved mental health outcomes for children and young people, and those transitioning to adult services through implementation in Merton of the SWL Mental Health Strategy currently in development, due to be published in June 2022	- Improved health and wellbeing of children and young people - Improved access to mental health services for young people.	- Increases in service utilization, particularly increase in number of children accessing early intervention and prevention services. - Through co-production work and feedback from children and young people

Live Well - programme of work

What we will do	Description of initiative	What will be the impact?	How will we measure success?
Change how people can access health and wellbeing services	• Piloting a Health on the High Street hub/ approach to bring health and support the prevention agenda also and are tailored to local community needs	- Improved access, experience and outcomes and contribution to regeneration of the high street.	- Increased referrals to new services and increase identification
	• Piloting an Ethnicity and Mental Health Improvement Project (EMHIP) hub approach in Merton to actively reduce ethnic inequalities in mental health. Using	- Developing partnerships and enabling and empowering communities to tackle health inequalities and long term conditions using a prevention approach and a prevention framework - Improved access, experience and outcomes for those from Black, Asian and other. minority ethnic groups in the borough - Reduction in ethnic disparities in mental health services	- Questionnaires/surveys will measure the experience of those using the hub and enhanced therapeutic benefits and wellbeing from community care can be measured via community experience surveys.
	• We will work together to develop and expand community health checks and health clinics, enabling people at risk of diabetes or cardiovascular disease to be identified in a safe space in their community, empowering them to take control of their own health.	- Early identification, improvement in treatment of and prevention of the complications of diabetes and cardiovascular disease - Improved access as patients can access support closer to home, in the right place and at the right time.	- Improved patient experience and outcomes - Year in year increase in attendance at structured education courses and improvement in patient reported confidence to self-manage
Improve and optimise access to and information on primary care	• Developing profiles/ communications materials for all new ARRS roles and promoting these with health and care partners and the wider public	- Improved access and support for Merton residents	
	• Building on learning from vaccination programme to promote Merton's wider primary care services e.g. pharmacy, optometry etc. with a range of different community groups; continuing to also promote vaccinations for Covid	- Greater access and support for Merton residents particularly early intervention and prevention initiatives	
	• Work to promote "Information Equality" by developing information on services in a range of preferred formats and language	- Reduction in digital inequalities - Identification of various ways to communicate and engage with those digitally excluded and where English is not their first language	- Increased referrals to new services and increase identification particularly from groups previously facing digital exclusion
Be focused on prevention	• Providing Merton Health and Care Together partner support and collaboration with the "Living With and Beyond Cancer" work programme led by St George's	- Improved support for people in the community recovering from cancer and improvements in awareness and uptake in cancer screening programmes.	
	• Continue to develop the post-Covid syndrome service model with key partners e.g. CLCH, St George's and by linking in with groups such as Covid Community Champions	- Greater access and support for Merton residents particularly early intervention and prevention initiatives	

Age Well - programme of work

Merton Health and Care

What we will do	Description of initiative	What will be the impact?	How will we measure success?
Support older people to access community resources post covid	• Continued development of Community Hub provision with a focus on supporting the partners providing services for older adults e.g. Age UK Merton, Wimbledon Guild etc.	- Improved health and wellbeing for Merton residents through enhanced access to community and voluntary sector services - Greater sharing of assets and expertise across the statutory and voluntary sector	- Increased numbers of people accessing services - Increased range of services - Improved health outcomes and feedback from service users and carers
	• Implementing South West Merton PCN "Tackling Neighbourhood Health Inequalities" project working with Wimbledon Guild	- Improvements in quality of life and experience for Merton residents - Reducing health inequalities	- Improved health outcomes and feedback from service users and carers
Improve access to and information on integrated services	• Expansion of the Integrated Locality team model into lower risk cohorts	- More people able to live independently and for as long as possible, including people with dementia and other mental health conditions - More people providing unpaid care can balance their caring role with a life outside caring	- Improved health outcomes and feedback from service users and carers
	• Work with the voluntary and community sector partners to expand personalized care approaches	- Reduction in the impact of social isolation and loneliness through greater community involvement in health and wellbeing issues	- Improved health outcomes and feedback from service users and carers
	• Integrated approach to improving rapid discharge and admission avoidance initiatives such as 'D2A' or Virtual ward	- Improved wellbeing and outcomes for Merton residents, as more people remain or return quicker to independence in the community. - Improved access into intermediate care /reablement services, and better coordination of services - Increased resource and activity provided closer to home, reduction of unnecessary admissions in hospital and shorter length of stay	- Reducing unnecessary admissions to secondary care or premature entry to institutional care

Be focused on frailty	• Implementing the core components of the local authority led frailty service model development (2 PCNs East Merton and Morden):
	  • Physical activity programme - this will include training community groups in strength and balance activity and a "train the trainer" approach working with community groups
	  • Small grants programme - this will be available to resident, community and voluntary sector partners to run activities with older adults in the targeted area
		- People, including those with disabilities or long term conditions, or who are frail, can live, independently as possible and at home in the community, as far as that is possible.
		- Reduce health inequalities, social isolation felt by older people living in the community.
			- Improved health outcomes and feedback from service users and carers

How will we measure success?

- Some high-level outcomes and activities we want to see in Merton are:
  - Improved health and wellbeing of children and young people
  - Improved access to mental health services for young people
  - Increased numbers of people accessing services through the voluntary sector
  - Increased recovery rates for adults experiencing mental health problem
  - Improved access, experience and outcomes for those from Black, Asian and other. minority ethnic groups in the borough
  - A reduction in loneliness and isolation reported in older adults

- We will work with our communities and stakeholders to **define key outcomes for all projects listed in the MHCT programme of work**, and measure in detail if we have made a difference – reporting back to MHCT Board on each project's outcomes

Merton Health and Care Together

Ongoing engagement and delivery

A new approach to engagement

- People found the engagement and workshops to refresh the plan useful and were keen to be engaged on a more regular basis about progress with the plan, and to hear the user voice more
- We want to ensure we continue to engage and co-produce our delivery plans with local communities, so we can develop the best approaches possible which meet people's needs, therefore going forward:
    - Delivering engagement activities will be a key part of the delivery phase using creative methods to reach more people, particularly communities experiencing health inequalities and poorer health outcomes, being mindful of the digitally excluded.
    - We will work with trusted leaders to speak with local people and communities such as the Polish Family Association, BAME Voice etc. and develop relationships, being led by the community and their needs, asking and responding to how they would like to be engaged or involved
    - A high level **communications and engagement strategy for Merton Health and Care Together** will be developed by July 2022 in time for the ICS implementation, with key milestones and timelines for engagement and communications activities
    - Public, staff and stakeholder communications will be prepared on this final refreshed plan as part of that strategy focusing on actions and the difference it will make
    - We will share people-centred stories of delivery going forward outlining how partnership working is making a difference locally
    - We will build on the potential for joint communications campaign work across Merton Health and Care partners to influence behaviour in line with the plan's objectives

Delivery - programme management framework and measuring success

- To ensure delivery of the refreshed plan updates will be scheduled from 2022/23 onwards to be taken to the Merton Health and Care Together Board, with life course updates on Start Well, Live Well and Age Well to be received by the Board quarterly
- Quarterly reports will also be provided on other enablers such as the progress with the Mitcham Wellbeing Hub, and developing VCSE arrangements
- Additionally, each of the six Primary Care Networks (PCNs) will be supported to report on progress with their population health projects during the financial year to enable partners to share in learning about how health and wider inequalities are being tackled at a local level
- The communications and engagement strategy will report quarterly from July 2022 onwards on delivery of communications and engagement activities, supporting the new approach to a more ongoing and active dialogue about partnership work across Merton
- An annual review of the plan will also be taken to the Merton Health and Care Together Board in March 2023 and March 2024

Merton Health and Care Together

Appendices

Merton Health and Care Together

Appendix 1 – feedback by life course area

Start Well – feedback summary

Area	Feedback
Emotional health and wellbeing	○ Emotional health and wellbeing of our children and young people (CYP) is overwhelmingly important and even more so following Covid, also there has been a disproportionate impact on vulnerable children or those with additional needs ○ There was a real feeling that CYP need to have joy bought back into their lives – Covid has caused a lot of anxiety and worry ○ There is still work to do around reducing stigma and encouraging seldom heard CYP to seek help – some want this in schools, some don't and thinking about accessibility is key ○ Significant discussion about parental mental health and how this impacts CYP, enhancing support for new parents is key ○ The importance of early intervention for CYP mental health and wellbeing was raised at all ages and this should be accessible across many locations e.g. barbers, hairdressers, schools, faith communities etc.. Lack of provision for under 5s was also flagged ○ It is very clear information on what is on offer for CYP needs to be improved, and there may be learning from social prescribing for adults in Merton ○ Educational attainment and anxiety
Integrated services	○ We need to be innovative and creative to form teams around the child, and create communities of practice for our workforce across all CYP provision in Merton – how can we link front line workers up? ○ Key discussion about under 5s, tackling the immunisations backlog and how we can use early years services for prevention for e.g. promoting healthy weight and activity. Promotion of healthy weight and physical activity is also important for all CYP from a prevention perspective and how can this be more targeted for e.g. what exercise could be promoted for female teenagers for example ○ Lack of communications and lack of a shared common language across health and care services were raised as challenges. There were some good examples of integration given but also lots of areas for improvement ○ There needs to be more consideration given to the sharing of risk between organisations
Transitions	○ A strategic approach across all partners to transitions needs to be developed ○ As well as health and care transitional needs, more holistic needs should also be considered e.g. ongoing educational and employment opportunities for 16-25 year olds

Particularly for Start Well there were some cross-cutting pieces of feedback which apply to all of the three priorities:

- CYP need to be much more involved in the design and delivery of health, care and support services
- We must consider parents and families in all work - must have a "Think Family" approach
- We need to map and raise awareness about the voluntary and community sector offer as CYP enter/ access services, there is lots of support out there e.g. Kids First but needs better co-ordinated promotion
- Improving communications was raised consistently: between health and care professionals; across health, care and the voluntary and community sector; with CYP themselves and by harnessing digital/ social media positively

Live Well – feedback summary

Area	Feedback
Mental health	○ New roles are being developed e.g. Primary Care Network Mental Health Workers, and these will be crucial to support primary care in prevention of mental ill-health ○ These roles and other roles like the Health and Wellbeing coaches need to support the pre-clinical stages of mental health e.g. isolation and loneliness, Covid has had an impact but there are already significant unmet wellbeing needs across the borough ○ Need to ensure continuity of care and person centred care with mental health ○ We also need to continue to break down stigma, build trust and develop culturally sensitive mental health care – this should be done through experience and community led co-design and delivery ○ Long term conditions have an impact on mental health and vice versa, mental and physical health need to be considered together ○ Thought needs to be given to joining up primary and secondary mental health care, and ensuring smoother transitions for young and older people between different services; some of this will come through proposed community mental health transformation work ○ Thought also needs to be given to ensuring integration within and between NHS services, and being innovative ○ Consideration of staff wellbeing is key; need to care for the mental health of our workforce
Primary care	○ Primary care is not just about GPs, there are other roles within practice teams (e.g. social prescribers, nurses, paramedics and other new roles being developed) and other professions e.g. community pharmacy, dentistry and optometry ○ We need to work across the health and care system to promote primary care as a multidisciplinary team, showcasing its breadth and what can be done ○ There was a lot of feedback about investing in primary care capacity and extended access ○ Also a lot of feedback about improving communications from primary care about changes happening, and what is available and who key staff are ○ GP engagement in events (e.g. local funday) and Covid vaccination webinars was very positive across Merton and with the VCSE, and this helps to reach seldom heard voices and build trust ○ Primary care need to continue to encourage patient activation and consideration of holistic health and wellbeing ○ Significant feedback about consideration of mental health needs of patients and mental health expertise required in all practices/ interactions ○ Primary care Clinical Director development is important, as is Clinical Directors leading PCN specific projects e.g. on health inequalities ○ Need to build upon the benefits of having the pan PCN Merton Health primary care partnership in place and deliver their priorities in 2021/22

Age Well – feedback summary

Area	Feedback
Integrated health and social care	○ Decompensation of older people being experienced due in part to impact of Covid on service provision e.g. decreased dementia diagnoses ○ Older people experiencing isolation and loneliness which can be scary, anxiety provoking and confusing, as is transitioning back to normal patterns of behaviour ○ Service provision has been paused/ impacted. In particular the ongoing lack of capacity or return to business as usual of the Holistic Assessment Rapid Investigation (HARI service) is impacting care for older people ○ Digital exclusion is also an issue experienced by many older people ○ Older people do not seem to be considered a priority; there was strong feeling health services/ care for older people have got worse since the pandemic ○ Health and voluntary sector organisations are not always well linked up or sharing information (e.g. there was positive discussion of new work between Wimbledon Guild and Age UK to provide a more unified "front door" to voluntary sector services in Merton, but some health partners didn't know this) ○ Communication and information sharing broadly and through information systems was also thought to need improvement – how can we better share records and accountability about keeping other providers or organisations up to date with interventions/ medication/ input etc.? ○ Enhanced support in care homes and the provision of input and support to nursing and care homes need ongoing consideration ○ End of life care pathway has become more prominent and also needs focus from an integrated perspective ○ We need to think about prevention, particularly prevention of frailty and improving dementia diagnosis rates ○ We also need to think about the impact on carers, those in Merton who may age quicker, and those older people with complex needs e.g., autism or learning disabilities ○ How can we better integrate older people's services when people do need to access them, so assessments are more holistic for example? ○ How can we encourage independence and improved mental health for older people through low level and non-medical interventions? ○ We need to think about older people as an asset and engage with them in places they frequent to hear their voice ○ Ambulatory and domiciliary provision need to be equally as good ○ What can we learn from other areas where older people's services are better integrated or from other services e.g., learning disabilities provision where there may be greater integration?

This page is intentionally left blank