Committee: Health and Wellbeing Board

Date: 28th November 2023

Agenda item:

Wards:

Subject: Report on progress of Local Health and Care Plan

Lead officer: Mark Creelman, Place Executive Merton & Wandsworth SWL ICB

Lead member:

Forward Plan reference number:

Contact officer: Gemma Dawson, Deputy Director Merton Health & Care Together

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Recommendations:

A. ***Note the progress of the Merton Local Health and Care Plan***

B. ***Provide a steer on the suggested area of focus for the remaining 6 months of the plan.***

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

TO UPDATE ON THE PROGRESS OF THE DELIVERY OF THE LOCAL HEALTH AND CARE PLAN IN MERTON.

TO SEEK SUPPORT THAT THE FOCUS OF THE REMAINING SIX MONTHS OF THE LOCAL HEALTH AND CARE PLAN DELIVERY SHOULD BE ON STRENGTHENING EVALUATION AND ADDRESSING THE START WELL PRIORITIES OF FOCUS ON MENTAL HEALTH AND WELLBEING.

2 BACKGROUND

2.1. The Local Health and Care Plan (LHCP) is one element of work being undertaken by health, social care and community partners in Merton and across Southwest London to improve health and wellbeing. The priorities identified are focused on the areas where the greatest impact can be made by working collectively to prevent ill health, keep people well and support them to stay independent.

2.2. The current Merton LHCP was developed for the duration of two years covering 2022-24 building on a previous two-year plan that ran from 2019 to 2021.

2.3. The vision of the plan is; ‘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”. The plan then identified key priorities across the life course (Start Well, Live Well and Age Well) to achieve this vision for the residents of Merton.

2.4. In Start well the plan aims to develop partnership projects that are focused on improving how children and young people access health and wellbeing

services, improving the integration of children's community services and a renewed focus on mental health and wellbeing.

2.5. In Live Well the plan aims to develop partnership projects to improve how people access health and wellbeing services through exploring new and innovative approaches. To take a renewed focus on prevention and improve access to and into primary care.

2.6. In Age Well the plan aims to develop partnership projects to improve integration to provide timely and joined up care for residents, to focus on frailty and support people to access and reengage with services and community support post covid.

2.7. Across the plan and in all our work together, we aim to:

(i) Reduce health inequalities and embed equity.

(ii) Use a population health management approach to drive change.

(iii) Focus on sustainability and making Merton a healthy place.

(iv) Engage with service users, patients and communities so all work is developed with and by people in Merton.

2.8. The plan complements and references existing strategies and plans in Merton, such as the Health and Wellbeing Strategy in that it shares commitment to tackling health inequalities, focus on prevention and early intervention through a commitment to empowering and engaging communities.

2.9. The plan is monitored and delivered through the Merton Health and Care Together Partnership that brings together all key partners in Merton across NHS, London Borough of Merton and the community and voluntary sector and the cross organisational Merton Health and Care Together Committee.

3 DETAILS

3.1. The Merton LHCP focuses on nine priorities, three for each of the life course area and identified 16 projects aligned to the priorities. For each life course area, a results chain has been developed which links the priorities, wider outcomes and the activities in the project, ensuring focus remains on initiatives that will deliver the priorities.

3.2. In Start Well good progress has been made against the priority of 'changing the way people access health and social care services, with the expansion children and young people's social prescribing. Over 200 appointments have taken place, supporting 98 young people helping to improve access and awareness of community-based activities that meet their needs. The new Family Hub work has made progress in improving integration of children's services as two physical hubs opened in the summer of 2023.

3.3. In Live Well through delivery of seven projects great progress has been made against the priority to be focussed on prevention and to innovate and change the way people access health and wellbeing services. Through the whole borough 'Actively Merton' project many existing support and services to help strengthen social connections and get people being physically active

were promoted and the gamification of Merton through ‘Beat the Street’ saw 48% inactive adults in Merton become more active. There was also a 9% increase in the proportion of game players achieving 150mins and over of physical activity per week. The learning and engagement from Beat the Street is now informing the next phase of work targeting three key groups to improve their social connections and physical activity: Women and girls, people with a disability and older people. A small grants programme to engage with these groups to gather insights about what support and what motivates them is in progress, ensuring a coproduced approach to projects and initiatives in the project.

3.4. Wider projects in the Live well section include the group consultations project which involved three Primary care networks working with local community groups that support underserved communities to co-design health interventions that will improve maternal and newborn health outcomes and people at risk or living with diabetes. Over 27 group sessions have been delivered serving 22 patients bringing together volunteers and health and social care professionals and over a hundred people from the community. The sessions delivered structured education, practical information sharing and cooking sessions and ultimately provided a space to connect and learn. Participants demonstrated an overall change in their wellbeing and attitude towards health living and strengthened access to health promotion and prevention services.

3.5. In Age Well the frailty project brought partners from across health and social care together to review data on those at risk or who are already identified as frail living within our community. Informed by the population level data, partners innovated and developed new service model to proactively support those at risk or identified as frail in our community and through a multi-disciplinary team meeting to take holistic action to promote health and wellbeing. The project supported 297 people through the collaborative working. Feedback so far has been really positive as people reflect on the wider connections made and the value the third sector (Age UK) have made to the discussions. The project finished in September with the evaluation due to report in December.

3.6. Health on the High Street project has strengthened community ability to impact local health and wellbeing through multiple events in and around the high street and in many cases forging new partnerships that sustainable beyond the project interventions. A series of Dementia Cafes in partnership with Alzheimer’s Society and local cafes in Morden increased awareness and access to local dementia information and support services. A series of health and wellbeing days showcased range of local community support reaching over 100 people and provided the space for wider connections and new projects to start. A final round of small grants to develop new projects seeing local organisations leading improvements to health delivery are underway before evaluation begins at the close of the project.

3.7. Delivery has been greatly improved by access to the South West London Investment Funds (Innovation and Health Inequalities funds) or external grand funds which have enabled projects and delivery against the priorities to get off the ground.

3.8. Most of the project implementation has been at a hyper community level, with many projects operating in a small geographical area focused on a target population. Some have used Primary Care Networks as boundaries but very few have been at the ‘place’ or whole Merton level. We have had great success at the grass roots level, particularly useful in reaching and engaging with communities experiencing health inequalities but it poses a challenge around how to scale and spread good practice and effective ways of working.

3.9. A final challenge is to ensure that all the projects are robustly evaluated to determine the impact. Additional support from Optum for some of the SWL Investment funded projects is being utilised and it is hoped the tools and techniques can be spread across the programme.

3.10. For the remaining six months of the plans duration, it is suggested that a focus on identifying or making progress against the Start Well priority; ‘be focused on mental health and wellbeing’. This is an area that is a key priority in the newly published ICP Strategy and the Joint Forward Plan.

3.11. Lastly a focus on robust evaluation should be the second key focus of the remaining duration of the plan, to ensure informed conclusions on the impact the plan has made on the health and wellbeing of Merton residents can be understood.

4 ALTERNATIVE OPTIONS

4.1. Not applicable.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. Not applicable.

6 TIMETABLE

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. Not applicable

8 LEGAL AND STATUTORY IMPLICATIONS

8.1.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1.

10 CRIME AND DISORDER IMPLICATIONS

10.1.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1.

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

Please include any information not essential to the cover report in Appendices.

13 BACKGROUND PAPERS

Accompanying slide deck is shared.

Merton Local Health and Care Plan 2022-24

Mid-way Review

Merton Health and Care Together October 2023 (version 5)

Our partnership

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

Health, care and community organisations in Merton will **“work 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”.** Some of these include:

The Local Health and Care Plan

Our refreshed health and care plan, 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. This will be delivered through projects across Merton's three life courses:

Start Well	Live Well	Age Well
Change how people access health and wellbeing services	Change how people access health and wellbeing services	Support older people to access resources in the community
Improve integration of children's services	Improve and optimise access to information on primary care	Improve access to and integration of services
Be focused on mental health and wellbeing	Be focussed on prevention	Be focussed on frailty

Merton's Health and Wellbeing Strategy

The Local Health and Care Plan has been informed by, or contributed to, several major strategies as part of South West London ICB.

Merton's Health and Wellbeing Strategy 2019-24

Merton's Health and Wellbeing Board committed Merton to a set of principles to adhere to in future service design in the borough:

- Community Engagement and Empowerment
- Experimenting and Learning
- Think Family
- Tackling Health Inequalities
- Prevention and Early Intervention
- Taking a **Health in All Policies Approach**

Read more here.

	Start Well	Live Well	Age Well
Promoting mental health & wellbeing	• Less self-harm • Better relationships	• Less depression, anxiety and stress	• Less loneliness • Better social connectedness
Making healthy choices easy	• More breastfeeding • Less childhood obesity	• Less diabetes • More active travel • More people eating healthy food	• More active older people
Protecting from harm		• Less people breathing toxic air • Less violence	

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 healthy choices is easy.

Merton's 5 Prevention Priorities are:

1. **Wellbeing Digital Hub -** a 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; a healthy maternity pathway including smoking, alcohol and maternal obesity

SWL ICB Joint Forward Plan

The Joint Forward Plan (JFP) is a strategic document that outlines the vision for health and care in South West London over the next five years, and needs to be considered in the local plans for Merton. The JFP sets out four key priorities:

- **Improving health and wellbeing:** The JFP aims to improve the health and wellbeing of people in South West London by reducing health inequalities, increasing access to preventive care, and promoting healthy lifestyles

- **Improving care for people with long-term conditions:** The JFP aims to improve the care for people with long-term conditions by providing coordinated care across different settings, supporting people to self-manage their conditions, and providing early intervention and prevention services

- **Improving mental health and wellbeing:** The JFP aims to improve mental health and wellbeing in South West London by reducing stigma and discrimination, increasing access to treatment and support, and promoting positive mental health

- **Improving the quality of care:** The JFP aims to improve the quality of care in South West London by embedding a culture of improvement, ensuring that care is person-centred and coordinated, and using data and evidence to drive improvement.

Critically, the JFP states that SWL will work with partners across the ICB to ensure that **health is considered in all areas of policy making.**

SWL ICB Joint Forward Plan

Merton Health and Care Together

Some of the key activities boroughs must undertake to deliver the JFP include:

- Investing in preventive care and early intervention services
- Expanding access to community-based care
- Developing new models of care for people with long-term conditions
- Improving mental health and wellbeing services
- Reducing health inequalities
- Improving the quality of care

Merton has committed to 14 projects across the life stages, and these are included in the plan, from pages 107-111.

The gap in life expectancy between the **10%** most deprived and the 10% least deprived in Merton is **7.7** years for males and 5 years for females.

1 in 5 residents are physically inactive

1 in 9 adults feel lonely often/always

Living with obesity and being overweight: 1 in 5 children in reception are overweight and obese rising to 1 in 3 children in year 6.

Of the **340,000** population in Southwest London that have the most health needs, **29,000** are located in East Merton

The gap in life expectancy between the **10%** most deprived and the 10% least deprived in Merton, is 7.7 years for males and five years for females

Frailty is higher in Morden and East Merton. An estimated **10%**, or **2,764** residents aged over **65** live with frailty

There are **16,000-20,000** unpaid carers in Merton

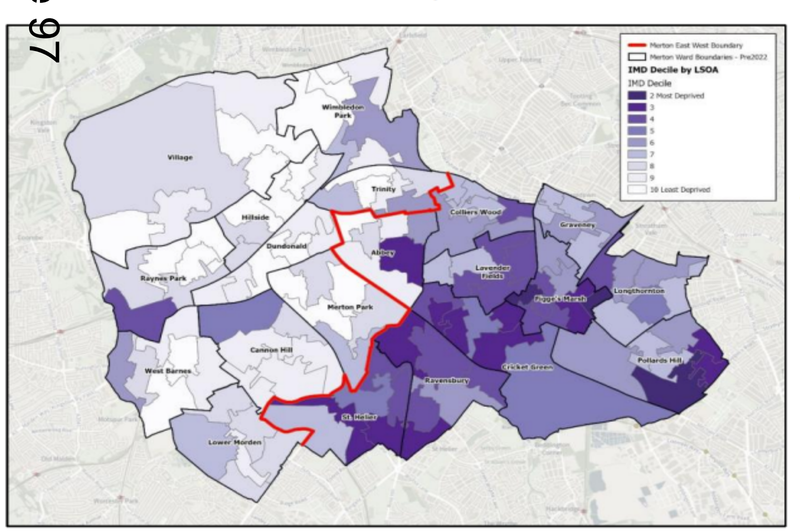
More than half of Merton's population is of working age and is projected to increase by almost 3,000 people by 2035.

Merton’s Population in Brief

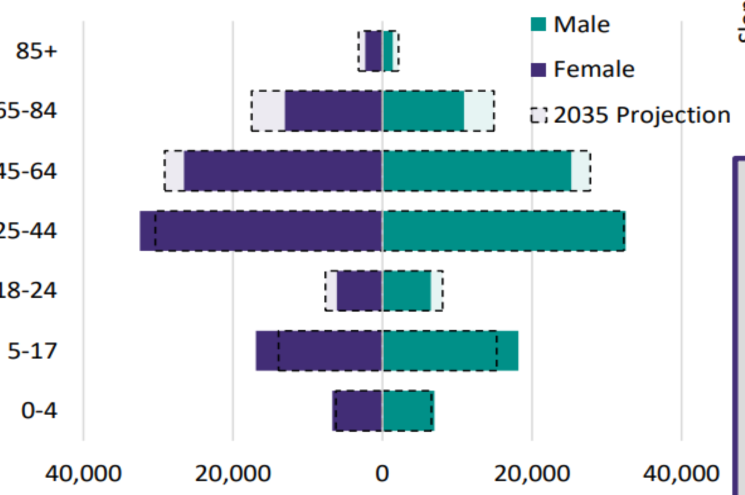
Headlines

- Merton’s population is ageing, with falling births, and is becoming more diverse.
- Population growth is slow but churn is high.
- Persistent significant social and health inequalities between the East and West of the borough.
- The gap in life expectancy between the 10% most deprived and the 10% least deprived in Merton, is 7.7 years for males and 5 years for females.

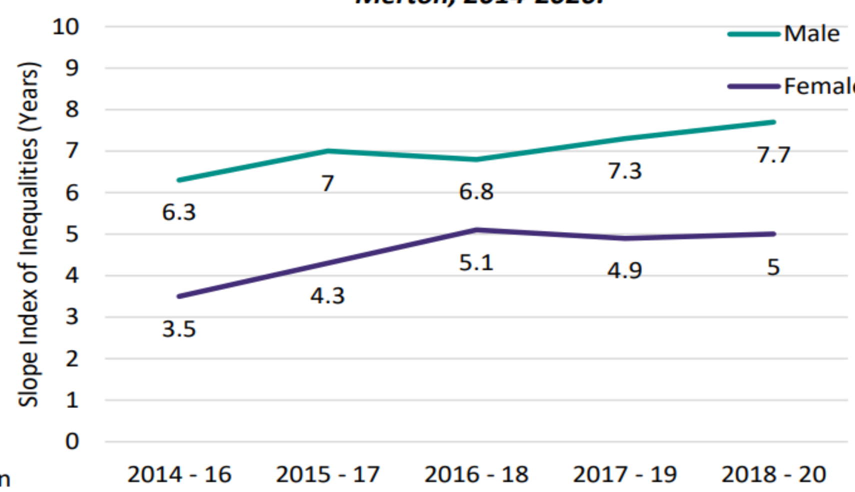
Merton Deprivation (IMD) Decile, based on the old ward boundaries, 2019.



Merton Population Pyramid, 2022.



Slope Index of Inequality for males and females in Merton, 2014-2020.



Conclusions to inform priorities

- **Our people are our biggest asset**
- **Using common projections for joint planning**
- **Embedding health inequality reduction in all we do: health in all policies (HIAP) approach**
- **Exploring further use of Core20 with health partners to monitor inequalities**

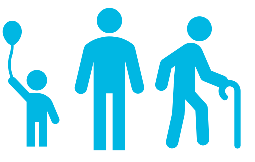
***Core20: The Core 20 represents the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).**

What Residents Tell Us

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. Insights and feedback from community groups, service users, carers and families informed the refresh of the Merton Local Health and Care Plan in 2022.

We need to talk to and listen to communities in their own spaces/ environments, understand their needs and invest in them and empower them

Mental health and emotional wellbeing are vitally important across start well, live well and age well



Improving transitions between the three life course areas e.g. parental mental health impacts on children; smoothing transitions/provision between organisations and borough boundaries

Cultural sensitivity needs to be considered in all work we plan and deliver, and communities need to be part of this planning and delivery

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

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 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

Delivery of our LHCP Priorities

Across the life course areas MHCT have 16 projects identified to achieve change and improvement against our priority areas in the local health and care plan. These include schemes awarded funding by the Health Inequalities and Innovation Funds in 2022. Projects are at different stages ranging from initiation to delivery.

Start Well

1. Developing a new CYP mental health hub
2. Developing a Family Hubs model in Merton
3. Delivery of the Child Healthy Weight Action Plan
4. A project to better support SEND residents
5. Delivery of the recommendations in Merton from the SWL MH Strategy

Live Well

1. EMHIP Merton
2. Health on the High Street
3. Deliver community led health checks
4. Develop the Mitcham Health and Wellbeing Hub
5. Actively Merton; developing networks and awareness of existing community and voluntary sector organisations to encourage support tailored to the community and improve uptake
6. Group consultation health inequalities project
7. Community Health Inequalities projects:
   I. Online and F2F counselling for BAME residents
   II. Schedule of activities on mindfulness and health targeting BAME residents
   III. Project to increase Eastern European Community engagement with health services

Age Well

1. Project to develop a new frailty pathway
2. Working to reduce social isolation
   I. Befriending project
   II. Increase opportunities for physical activity
3. Integrated approach to improving rapid discharge and admission avoidance initiatives such as 'D2A' or Virtual ward
4. Expansion of the Integrated Locality Team model into lower risk cohorts

Start Well

- Change how people access health and wellbeing services
- Improve integration of children's services
- Be focused on mental health and wellbeing

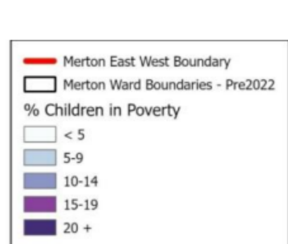
Start Well – Population Health

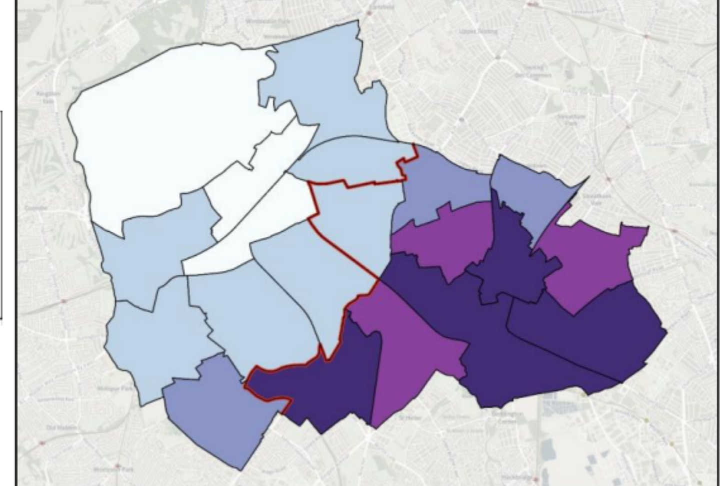
Merton Health and Care Together

Headlines

- Most CYP in Merton have better health and related outcomes than London and England. However, inequalities and the health divide is evident from the start of life.
- The COVID-19 pandemic negatively impacted CYP, spanning mental health, disordered eating, child healthy weight, school readiness and educational attainment, and are likely to be further aggravated by the cost-of-living crisis.
- This translates into increased referrals for mental health support. There has been a continuing increase in referrals for Education, Health and Care Plans (EHCP) however, recent activity indicates this may be levelling off.

The percentage (%) of children (aged 16 and under) living in Absolute low income families by Merton Wards, 2021.





Children Living in Absolute Low-Income 2020/21:

- 12%, or 5,234 children aged 16 and under

Healthy Weight

- Living with Overweight & Obesity:
  - 1 in 5 children (400) in Reception rising to 1 in 3 children (680) in Year 6
  - Higher in East at 43.1% than West at 25.6% (Year 6)
- Children not physically active enough: 50.4%, or 16,326 children
- Nationally, 58.2% of 17 to 19 year olds possibly have eating problems, urgent referrals for eating disorders have almost doubled, increase in SWL from 16 patients in 2020/21 to 87 patients in 2021/22
- Food poverty is an increasing challenge for families

Mental Health Disorders (MHD)

- Estimated prevalence of MHD: 9%, or 2,943 children aged 5-16

Education

- Good level of development in early years: decrease from 75.5% (2018/19) to 69% (2021/22)
- 12.6% of pupils receive SEN support (2020/21)
- EHCP (2020/21)
  - Merton: 1,583 pupils, or 4.8% of pupils
  - London: 3.8% of pupils

Conclusions to inform priorities

- **Further developing strategies to meet the needs of CYP with SEND on the basis of new NA**
- **Holistic mental health support offer in response to increasing demand / need**
- **Healthy Weight Programme considering disordered eating and food poverty**
- **Responding to multiple adversity through Think Family and Healthy Place links**
- **Specific concerns for further exploration:**
  - **Increasing CYP vaping**
  - **Increasing school absence**
  - **Air pollution impact, especially around schools**

Start Well Results Chain

Project	Owner & Inputs : Funding and staffing resource	Outputs Products and services delivered	Outcome Effects or behaviour change resulting from outputs	Impact Long term widespread change
1. Develop a new CYP Hub	• Steering group established with representation from across sectors to develop the model and idea. • Bid made to SWL Innovation funds, awaiting outcome.	• Develop a new service model co-produced with CYP and pilot it in Merton • Review existing model in place in K&R	• Improved access to services • Improved information and signposting and support to carers and families	• Increased numbers of people accessing services, which are more convenient • Increased range of services • Less stigma around CYP MH
2. Family Hub	• London Borough of Merton and wider partners. • Awarded grant funding from central government to establish hubs.	• Accessible universal and early help provision • Networks of support in local communities • Appropriate models of integration across various points of the early help system	• All children and their families are supported to flourish and achieve their potential with appropriate support and care they need • Improved access to these services	• Better long term care and prevention for issues such as child weight, mental health, poverty and overall health • There is a clear simple way for families to access help and support through a hub building approach
3. Delivery of child health weight action plan	• To be confirmed	• Train front-line partners to provide brief intervention and signposting on Child Healthy Weight • Embed healthy weight and think family approach into all work; identifying opportunities to bring in additional funding • Improve/enhance Merton's service support offer for families that need it • Provide a social prescribing offer for CYP that need support with achieving a healthy weight and supporting low level mental health issues • Enhance the support children and families receive in schools and early years	• Halt and begin to reduce the increase in children that are overweight or obese and reduce the gap between East and West Merton • coordinate consistent messaging and address stigma and levelling up.	• Reduction in BMI in CYP and care givers • Increase in hours of physical activity • Changes in family diet • Children enabled to grow up with knowledge of healthy diet and lifestyle, preventative way of managing obesity
4. SEND improvement projects	• To be confirmed	• Promote collaboration between organisations supporting children with SENDs • Hold feedback groups with parents and carers to inform iterative development of services • Develop a programme of improvement of MDT approach to children with SENDs	• Improved access, experience and outcomes for people living with and supporting someone with Autism and other SENDs	• Better offer provided for children and young people with SEND, borough and exemplar for supporting these patients
5. Delivery of recommendations of SWL MH Strategy in Merton	• To be confirmed	• Implement the recommendations from new MH Strategy: • Participate in SWL MH Strategy focus groups to develop the framework for MH in SWL	• Improved health and wellbeing of children and young people • Improved access to mental health services for young people.	• Increases in service utilisation, particularly increase in number of children accessing early intervention and prevention services. • Through co-production work and feedback from children and young people
6. Expansion of CYP Social Prescribing	• Public Health Merton • £57,000 ICB HI Fund	• F2F Social prescribing support with the CYP Link worker for eligible service users • Connect CYP with appropriate non-clinical support available in the local area and support them to access it	• Enabled CYP needs to be supported and referred to preventative and non-medical interventions within the community • Expanded the pilot to Morden PCN that enabled more young people to benefit and strengthen the programme	• Service users receive improved access to and awareness of community-based activities and support that meets their individual needs • Service users co-produce and achieve goals, with a positive impact on their subjective wellbeing

Measuring the impact of start well

Projects (activities) How resources are used to generate products and services	Who are we helping?	Expected Outcome?	How will this be measured?
1. Develop a new CYP Hub	• Steering group established with representation from across sectors to develop the model and idea. • Bid made to SWL Innovation funds, awaiting outcome.	• Develop a new service model co-produced with CYP and pilot it in Merton • Review existing model in place in K&R	• Improved access to services • Improved information and signposting and support to carers and families
2. Family Hub	• London Borough of Merton and wider partners. • Awarded grant funding from central government to establish hubs.	• All children and their families are supported to flourish and achieve their potential with appropriate support and care they need • Improved access to these services	• Improved scoring and maturity across descriptors and criteria (Early help systems guide and Family Hub Framework)
3. Delivery of child health weight action plan	• To be confirmed	• Train front-line partners to provide brief intervention and signposting on CHW • Embed healthy weight and think family approach into all work; identifying opportunities to bring in additional funding • Improve/enhance Merton's service support offer for families that need it • Provide a social prescribing offer for CYP that need support with achieving a healthy weight and supporting low level mental health issues • Enhance the support children and families receive in schools and early years	• Halt and begin to reduce the increase in children that are overweight or obese and reduce the gap between East and West Merton • coordinate consistent messaging and address stigma and levelling up.
4. SEND improvement projects	• To be confirmed	• Promote collaboration between organisations supporting children with SENDs • Hold feedback groups with parents and carers to inform iterative development of services • Develop a programme of improvement of MDT approach to children with SENDs	• Improved access, experience and outcomes for people living with and supporting someone with Autism and other SENDs
5. Delivery of recommendations of SWL MH Strategy in Merton	• To be confirmed	• Implement the recommendations from new MH Strategy: • Participate in SWL MH Strategy focus groups to develop the framework for MH in SWL	• Improved health and wellbeing of children and young people • Improved access to mental health services for young people.
6. Expansion of CYP Social Prescribing	• CYP aged 13-18 and adults with additional needs aged 19-25 affected by childhood obesity and/or low-level mental health and emotional wellbeing in East Merton and Morden PCN.	• Enabled CYP needs to be supported and referred to preventative and non-medical interventions within the community • Expanded the pilot to Morden PCN that enabled more young people to benefit and strengthen the programme	• **SWL ICB + Optum** will be running a Logic model workshop to map out metrics and outcomes of the project by identifying inputs, outputs and short, medium and long term outcomes for your project • Public Health Merton will also have commissioned **Ottoway** Strategic Management to conduct an evaluation of this pilots

Merton Family Hubs

Change Service Access		Improve Integration		Mental Health Focus	

Project aims	Project timescales	Project resources	Project partners
Family Hubs aim to improve access to and take up of universal provision and improved coordination across our early help system to enable all families to access the right help at the right time and in the right place. They aim to make Merton a place where all children and young people belong, stay safe and can thrive.	January 2023 through to summer 2024	National funding programme	London Borough of Merton, Voluntary and community sector partners and NHS

What's been delivered?
Family Hub branding developed and released
Engagement strategy and surveys undertaken to map activities and provision
Co-design of the family hubs progressing through workshops and online surveys for wide range of stakeholders
2 physical Family hubs site open from summer 2023 bringing together 24 different service options

What's the feedback?
Positive and encouraging

What's the impact?
In early implementation

CYP Wellbeing Hub

Change Service Access	X	Improve Integration	X	Mental Health Focus	X

Merton Health and Care Together

Project aims	Project timescales	Project resources	Project partners
1. Reduce waiting list for CAMHS services 2. Provide a suitable space dedicated to CYP physical and mental wellbeing	Potential to access SWL Investment funds in the 2023-24 round	No project resources other than project manager time within MHCT	SWL St Georges Off the Record Croydon Talk Bus Stem4 Spectra

What's been delivered?
Extensive consultation with partners
Submitted bid for Health Innovation Fund (unsuccessful)
Research of other models in SWL
Engagement with a new delivery partner Bus model (Croydon Talk Bus)
Refreshed bid, including CAMHS data, contributed to by Project Partners
Commissioned Young Inspectors Report on CYP mental health needs
Engagement with Merton Youth Parliament for input on the proposal

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What's the feedback?
Following the redevelopment of the proposal, for the

What's the impact?
Anticipated impacts are: the reduction in those waiting for CAMHS support Prevention of worsening mental health issues amongst young people Better engagement with young people

Expansion of CYP Social Prescribing

Change Service Access		Improve Integration	X	Mental Health Focus	

Project aims	Project timescales	Project resources	Project partners
• Support CYP needs, scale up and extend EM PCN CYP SP pilot to Morden PCN and enable more young people to benefit. • Refer to preventative and non-medical interventions • Aim to reach 150 service users across Morden PCN • Addressing health inequalities, impact of the COVID-19, unmet need in the borough and prevent further escalation of health issues facing by CYP	Started: April 2023 Due to finish March 2024 (12 months)	Project Manager Additional Link work Total budget: £57,000	Public Health Merton East Merton PCN Morden PCN

What's been delivered?

- East Merton PCN pilot data includes:
  - Over 200 appointments held so far
  - Over 98 individuals seen so far
- Inward service referrals from eligible: GP surgeries, secondary schools, Talk Off The Record, School Nursing service
- Outward service referrals to: Mental Health support, food and housing support
- Development of trust between CYP Link Worker and service users resulting in positive feedback.
- Developed an engaged Steering Group made up of organisations from across the borough who support and help guide the pilot

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What's the feedback?

- Time required to engage wider stakeholders and set up referral pathways into the pilot service and the importance of continued partnership working to maintain referrals.
- Initially, it was challenging to obtain referrals for CYP living with obesity. However, as partner relationships have developed, have seen more referrals.
- Qualitative feedback on experience of service, their work with the CYP link worker and the community-based activities they undertook.
- Number of co-produced goals achieved.

What's the impact?

- Service users received improved access to and awareness of community-based activities and support that meets their individual needs.
- Service users co-produced and achieved goals, with a positive impact on their subjective wellbeing.
- The proportion of unmet need (individuals who have risks to their wellbeing but do not meet clinical referral thresholds) is reduced.
- Pilot data (KPIs) recommendations and reflections for a best practice CYP social prescribing offer for this group and the borough

Delivery Plan – Start Well

2023-2024

Project	MILESTONES	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
Merton Family Hubs	Implement the Family Hub programme in line with agreed project plan	■	■	■	■	■	■	■	■	■			
	Evaluation impact and next steps/scaling							■	■	■	■		
Expansion of CYP Social Prescribing	Implement projects from SWL Inequalities funding	■	■	■	■	■	■	■					
	Undertake evaluation to determine impact and next steps					■	■	■					
CYP Wellbeing Hub	Submit business case/expression of interest for Investment funds	■	■										
	Implement projects with SWL Investment funds				■	■	■	■	■	■			
	Undertake evaluation to determine impact and next steps								■	■	■		

Live Well

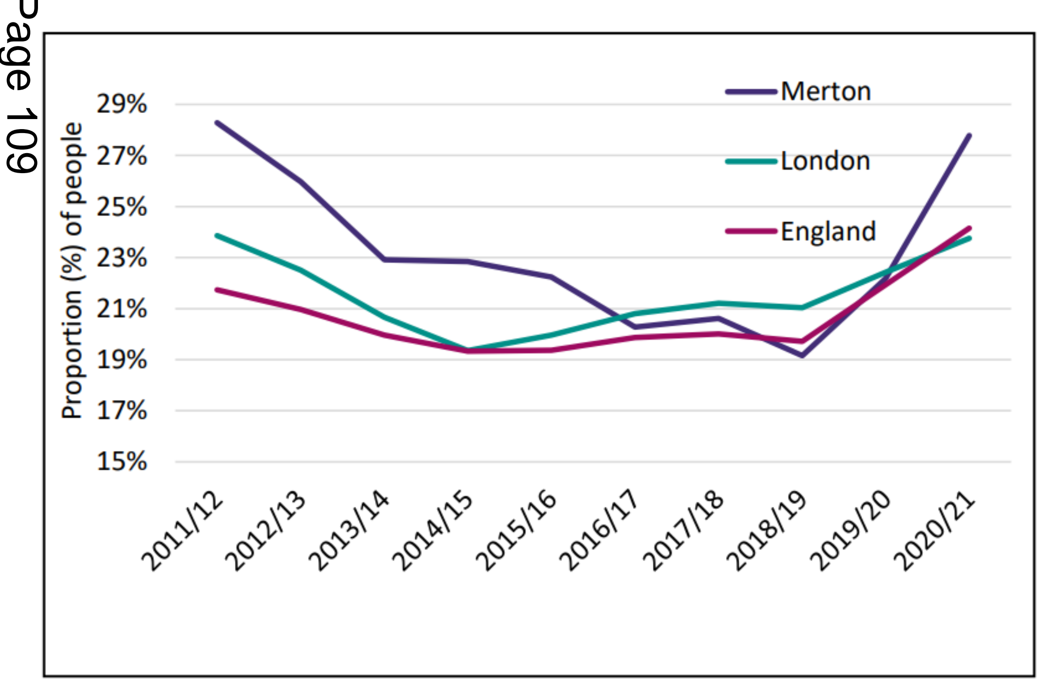
- Change how people access health and wellbeing services
- Improve and optimise access to information on primary care
- Be focussed on prevention

Live Well – Population Health

Headlines

- Persistent large numbers with public health risk factors such as unhealthy diet, lack of physical activity, smoking, alcohol misuse, underpinned by poor mental wellbeing; undiagnosed clinical risk factors, or exposure to environmental risks.
- These risk factors are preventable and leading causes of premature deaths.
- Favourable comparison with other London boroughs only means they are worse.

Proportion (%) of people reporting a high anxiety score in Merton, London, and England 2011/12 to 2020/21.



Inactivity

- 31,334, or 1 in 5 residents physically inactive

Smoking

- 21,300, or 1 in 7 residents smoke

Diet

- 75,800, or 1 in 2 residents not meeting the 5-a-day

Alcohol

- 36,700, or 1 in 4 adults drinking above the recommended limit per week

Mental Health

- 25,258, or 1 in 6 residents with depression or anxiety

Conclusions to inform priorities

- **Embedding prevention into clinical and care pathways (healthy food, physical activity, smoking, alcohol, mental wellbeing)**
- **Guarding essential evidence-based prevention services from savings**
- **Supporting Actively Merton, synergistic with Borough of Sport**
- **Supporting health and wellbeing of joint workforce**
- **Maximising health co-benefits of climate action especially air quality, active travel, energy-efficient housing**
- **Working with primary care on clinical risk factor detection and management, especially hypertension**
- **Equitable access to primary care and community services**

Live Well Results Chain

Project	Owner & Inputs : Funding and staffing resource	Outputs Products and services delivered	Outcome Effects or behaviour change resulting from outputs	Impact Long term widespread change
1. EMHIP Merton	• £15,000 from SWL Health Inequalities Fund • Project Management from Merton Connected	• Establishment of Merton EMHIP partnership representative of Merton community; 15 people with lived experience of MH services to join • Co-Development and delivery of bespoke training for MH staff	• Methodology for co-production in mental health services with target communities; to collectively review data collectively and design interventions to improve access, experience and outcomes in mental health services	• A greater understanding of health inequality in Merton's MH services through data and lived experience • Improved trust and elevated voice for the black, Asian and other minority groups in Merton
2. Health on the High Street	• £25,000 LBM Public Health • Project Manager funded by LBM & SWL ICB • Until funding is exhausted	• Deliver different activities across the borough based on proposals received from communities themselves • Project management support for organisations delivering services	• Improved access to health and wellbeing services, such as information shared at HWB days • Increased use of existing assets in Merton, on the high street, such as more residents using the SMCA • Increased knowledge of community offer • Delivered services in different ways • Successful projects, such as the dementia work, will become part of business as usual of the organisation	• Developed sustainable partnerships that had been strained following Covid-19 – supporting the move to SWL ICB • Wider health inequalities identified in borough - led to scoping of new ways to support these community • Better understanding of issues faced by VCSE organisations (funding and capacity etc)
3. Community Led Health clinics	• Project management from SWL ICB • £60k	• Delivery of community-based clinics and training for new community health coaches in Merton for minority communities • New relationships and networks for health prevention and access	• Earlier identification and improvement in treatment and prevention of diabetes and cardiovascular disease • Patients receive support closer to home, in the right place and at the right time • Focus on prevention to educated residents on how to manage long term conditions independently	• Reduction in health inequalities • Long term improved health and wellbeing for Merton residents • Appropriate engagement with downstream health services • Sharing health and wellbeing information in culturally competent ways will strengthen relationships between ICB and communities
4. Mitcham Health and Wellbeing Hub	• 2 part-time staff & volunteers • £85k total (£60k for delivered services) • Until March 2024	• Establish a hub to host community activities	• New wellbeing activities offered at the Hub • Service users given opportunity to socialise; reduced isolation; education about healthy living and mindfulness • Cost of living support	• Parity of care between East and West Merton • Success of the project may lead to more secure funding for future developments in Mitcham • Potential to deliver more services at the hub, and shore up a permanent community asset

Live Well Results Chain

Project	Owner & Inputs : Funding and staffing resource	Outputs Products and services delivered	Outcome Effects or behaviour change resulting from outputs	Impact Long term widespread change
5. Actively Merton	• £65,000 Health Inequalities fund • £214,000 Beat the Street (with Sport England paying half) • Project management support from LBM & SWL ICB	• Introduce Beat the street initiative in Merton in spring 2023 • Develop single brand identify for Actively Merton to bring together initiatives and promote existing resources	• Sustainable behavioural change • Engaged communities, shared knowledge of the foundations of good health, and provide data analysis for actionable insight. • Delivering sustainable health at scale, increasing long term physical & social activity, improving mental wellbeing and connecting people to nature	• Supported to build the resilience essential to combat inactivity, loneliness and poor mental health. • Sustainable health at scale, increased long term physical activity, mental wellbeing and connecting people to nature in their neighbourhood. • Residents were provided a method to get out in their community and make small changes to daily behaviour by being active.
6. Group Consultations health inequalities Project	• £80,000 NHS Charities Together Grant Funding	• Delivery of group consultations model for people with diabetes and new parents across three PCNs in partnership with the community	• Intended to address immediate and urgent priorities identified as necessary for to support vulnerable groups • Building capacity over the longer term to build a foundation from which to address other long-standing health inequalities in particular communities.	• Reduction in health inequalities • Improve maternal and new-born health outcomes and outcomes for people at risk of or living with diabetes
7. Community SWL Health Inequalities Projects				
7.1 Believe In Yourself	£10,250, project managed by Ethnic Minority Centre	• Deliver series of wellbeing activities, such as a mindfulness sessions, Yoga and Zumba classes	• Reduction in social isolation • Health information shared, with issues that disproportionately affect BAME residents, such as different types of cancer, worse mental health outcomes • Increased confidence; developed sense of community	• Celebration of less heard voices in the community • Developed health exercise habits • Success will be considered for the next round of Inequalities funding in 2023
7.2 Online and F2F Counselling for BAME	£28,908, led by Wimbledon Guild	• Delivered online and in person counselling sessions	• BAME residents receiving culturally competent mental health care; confident to access	• Supports the need for permanent funding of culturally competent mental health support • Prioritising EMHIP in Merton
7.3 Eastern European Engagement Project	£31,500 led by Polish Family Association	• Coffee morning with health workshops for mothers and young children • Support community fridge initiative	• Cost-of-living support • Health education • Genuine engagement with the Eastern European community	• Success will be considered for the next round of Inequalities funding in 2023 • Recognises discrimination and health inequalities faced by Eastern European population

Live Well Measuring Impact

Projects (activities) Resource used to generate products and services	Who are we helping?	Expected Outcome?	How will this be measured?
1. EMHIP Merton	• Black and minority ethnic residents in Merton • 37,000 people are recognised to be part of SWL Core20 population with over half residing in East Merton	• Methodology for co-production in mental health services with target communities; to collectively review data collectively and design interventions to improve access, experience and outcomes in mental health services	• Cohort of people (12-15 people) with lived experience of mental health in Merton contributing to Methodology • Methodology shared and approved by the Merton Menta Health Partnership
2. Health on the High Street	• Project is led by organisations and groups representing patients in the borough, including BAME, LGBTQ+, those with dementia, as well as organisations with small budgets/lower Merton profile	• Improved access to health and wellbeing services, such as information shared at HWB days • Increased use of existing assets in Merton, on the high street, such as more residents using the SMCA • Increased knowledge of community offer • Delivered services in different ways • Successful projects, such as the dementia work, will become part of business as usual of the organisation	• Patient surveys; assertiveness and boundaries, and wellbeing workshops – participants take questionnaire before and after to measure impact • Number of attendees; has service seen increase in users following events • Feedback from partners delivering activities • LGBT Activities – number of sign-ups to mailing list for MertonPlus; new connections made
3. Community Led Health clinics	• Using Core20 data to focus community led clinics to target those not accessing existing primary care or prevention services, this has included the Tamil, Polish and different Muslim communities in Merton	• Earlier identification, improvement in treatment of and prevention of the complications of diabetes and cardiovascular disease for targeted patients • Patients can access support closer to home, in the right place and at the right time • The focus on prevention and helping educate residents on how to manage long term conditions themselves at home	• Number of health checks conducted • Count of different community groups engaged • Varied locations across the borough to ensure wide reach • Feedback collected and participants surveyed
4. Mitcham Health and Wellbeing Hub	• Mitcham residents (Mitcham has historically had less funding for health and wellbeing services compared to elsewhere in Merton)	• Many new wellbeing activities offered at the Hub for residents in Mitcham and surrounding areas • Service users given opportunity to socialise, reducing isolation, as well as learn more about healthy living and mindfulness • Cost of living support provided to service users	• Count of different activities • Different kinds of activities offered • Feedback from service users

Live Well Measuring Impact

Projects (activities) Resource used to generate products and services	Who are we helping?	Expected Outcome?	How will this be measured?
5. Actively Merton	**Everyone in Merton** to be more physically and socially active, and some targeted initiatives to those who are least active (based on age, location etc)	• Sustainable behavioural change • Engaged communities, shared knowledge of the foundations of good health, and provide data analysis for actionable insight. • Delivering sustainable health at scale, increasing long term physical & social activity, improving mental wellbeing and connecting people to nature	• Actively Merton will be evaluated by The NIHR Public Health Intervention Responsive Studies Teams (**PHIRST**) scheme. • Each individual initiative will be evaluated and reviewed by using existing mechanisms • Evaluation partner will ensure live learning more robust evaluation of the effectiveness of the actively Merton approach. • Testimonials, case study/story, feedback will be reviewed.
6. Group Consultations Health Inequalities Project	Targeted at people who are at risk or newly diagnosed with diabetes within 3 PCN areas (East Merton, SW Merton and Morden PCNS) New parents within the 3 PCN areas	• Intended to address immediate and urgent priorities identified as necessary for to support vulnerable groups • Building capacity over the longer term to build a foundation from which to address other long-standing health inequalities in particular communities.	
7. Community Health Inequalities Project			
7.1 Believe In Yourself	Black, Asian and other minority residents who are at risk of social isolation, long term conditions, or disengagement with health services	• Reduction in social isolation • Health information shared, with issues that disproportionately affect BAME residents, such as different types of cancer, worse mental health outcomes • Increased confidence; developed sense of community	• Number of participants • Feedback • Cost benefit analysis based on staffing, funding inputs and number of people engaged
7.2 Online and F2F Counselling for BAME	Black and Asian community with MH need	• BAME residents receiving culturally competent mental health care; confident to access	• Number of service users • Feedback before starting therapy, and after • Cost benefit analysis based on staffing, funding inputs and number of people engaged
7.3 Eastern European Engagement Project	Eastern European population in Merton	• Cost-of-living support • Health education • Genuine engagement with the Eastern European community	• Number of service users • Feedback – awareness of service has spread by word of mouth • Cost benefit analysis based on staffing, funding inputs and number of people engaged

EMHIP in Merton

Change Service Access		Information Sharing		Prevention	

Project aims	Project timescales	Project resources	Project partners
Undertake focused community development and co-production work to build a partnership comprised of statutory partners (NHS and London Borough of Merton), community and voluntary sector and Merton residents with lived experience of mental health, to tackle ethnic inequalities in mental health services in Merton	March 2023 – March 2024	£15,000 from SWL Health Inequalities Fund Project Management from Merton Connected with steer from the Merton Mental Health Programme group	SWL St Georges Merton Connected

What's been delivered?

Engagement with young men in barbershops in Merton – going in person to engage with residents where they socialise (bringing the service to the users), to collect information. This sets residents at ease and allows for conv

What's the feedback?

To be confirmed

What's the impact?

This project has not concluded, and the final report has not been prepared. However, expected impacts are:

- A greater understanding of racism in Merton's MH services, and the impact on residents will inform future commissioning decisions
- The partnership will be embedded within the emerging Merton place governance; project becomes embedded in engagement workstream
- Improved trust and elevated voice for the black, Asian and other minority groups in Merton and their relationships with NHS and LBM

The programme has embedded genuine co-production between service providers and users with actual experience as moniroty ethnic patients in MH services. We can use these people's experiences to improve services, following in footsteps of EMHIP in Wandsworth.

Health on the High Street

Change Service Access | Information Sharing | Prevention

Project aims	Project timescales	Project resources	Project partners
1. Strengthen local communities 2. Led by local organisations 3. Focus on place 4. Change the way existing services are delivered	Scoping from April 2022, but delivery began in September 2022 The project is ongoing until funding is exhausted	Dedicated project manager £25k investment and ~£11k spent so far Looking for further projects as we move into year 2	Alzheimer's Society SMCA Lantern Arts Centre Wimbledon Guild MertonPlus Metronome & More

What's been delivered?

Dementia Cafés Begins with Alzheimer's Society

Lantern Arts Health and Wellbeing Day

SMCA Health and Wellbeing Day

LGBT History Month Activities

- Movie Night – 8 attendees
- Quiz Night - ~20 attendees
- Houseplant Wellbeing Event – 21 attendees
- Merton Police M&G
- Crafternoon – 15 attendees
- Coffee Social - ~7 older adult attendees

Sporting Memories at SMCA with FFC – funded for 36 weeks

Wellness Programme begins with Wimbledon Guild – 15 people enrolled

Assertiveness and Boundaries workshops begin with Wimbledon Guild – final session in September

Second Funding Round as of 21/08/2023

What's the feedback?

Wellness Workshops
15 people enrolled; of the 9 group members who responded to the post course survey all 9 said they would recommend the MBHL Course to friends or family. 7 rated it as 'excellent' and 3 rated it 'good'. 8 people said they felt kinder to themselves.

LGBT Workshops
All said they would like more activities to bring the community together in Merton.

Health and Wellbeing Days
SMCA received a lot of positive feedback verbally on the day and the networking between the professionals was also a great success. Some "really useful" partnerships were created or strengthened as a direct result of the event

What's the impact?

- Strengthened community ability to impact local health and wellbeing through multiple events, forging new partnerships that are sustainable beyond the project interventions. E.g. The Health and Wellbeing Day at the SMCA led to a partnership between Fulham Football Club and the Centre to provide physical activity sessions for older service users. This was funded by us for 18 weeks, matched by FFC for 36 weeks total. FFC will train staff at SMCA to deliver these in house when funding ceases.

- Local organisations leading improvements to health delivery e.g. Working with MertonPlus has led to engagement with LGBTQ+ residents, feeding into the SWL ICB Forward Plan. Support for this through MHCT has also led to training programme with PCNs bespoke in borough. There have also been a large increase in sign-ups to the mailing list and interest in LGBTQ+ issues.

Health on the High Street – activity map

(not exhaustive!)

Wellbeing Workshops

Assertiveness Workshops for BME women

Wimbledon

Assertiveness Workshops for BME women

Wellbeing Workshop

Health and Wellbeing Fair (Lantern Centre)

Colliers Wood

Raynes Park

LGBT Crafts and Mindfulness

Mitcham

Morden

Pollards Hill

Health and Wellbeing Fair (SMCA)

Dementia Cafes

Sporting Memories

Assertiveness Workshops for BME women

Health and Wellbeing Days

We worked directly with the SMCA in Mitcham and the Lantern Centre in Raynes Park to hold health and wellbeing days for organisations working in the borough to advertise their services to the public. Both organisations said their service users had asked for information, and we wanted to promote all the excellent work ongoing in the borough.

The events were popular, with 35+ attendees in Raynes Park (in January!), and over 80 at the SMCA. We provided a free hot lunch. Organisations who participated fed back that an added benefit, aside from meeting the public, was also networking amongst themselves.

Dementia Cafes

We worked with Alzheimer's UK and Metronome Café in Morden to host weekly dementia drop ins for the public to get information if they were worried about memory loss. These picked up engagement as the weeks continued. From summer 2023, these moved to monthly.

LGBTQ+ History Month

We engaged with the LGBTQ+ community as they face significant health inequalities. Each event was well attended. We worked with partners to hold 9 events across the borough. The Wellbeing and Houseplants event was particularly popular, 20 people attended, and everyone who fed back said they felt closer to their community. These activities raised the group's profile, and they followed up with a community pride event in July. This has also led to the development of a Pride training project working with PCNs in the borough, bespoke to Merton with a community training partner organisation.

Wellbeing Workshops Around the Borough

Wimbledon Guild approached us with 2 ideas which had been requested by multiple service users of their counselling services: information about wellbeing and mindfulness, as well as better engagement with women from minority backgrounds who struggle with making their voices heard.

We funded an 8-week online programme helping Merton residents to lead healthier lives, setting fitness goals amongst other things, with coaching and group support to help realise their goals.

They also are running 4 assertiveness and boundaries workshops over 4 months around the borough. Both initiatives have been hugely popular and have been oversubscribed.

Community Led Health Clinics

Change Service Access		Information Sharing		Prevention	

Project aims	Project timescales	Project resources	Project partners
• Deliver community-based health and wellbeing events, including health and wellness checks, health education and awareness raising and health coaching • Better understand the needs of residents, as well as build trust with vulnerable communities	March 2022-March 2024	Project management from SWL ICB £60k for 2022-2023 across Merton and Wandsworth	WCEN working with Merton's: Tamil community Ghanaian community (Power Church) Muslim community (such as at Merton High St Mosque) Polish community (through the PFA)

What's been delivered?	What's the feedback?	What's the impact?

The Wilson Wellbeing Hub

Change Service Access | Information Sharing | Prevention

Project aims	Project timescales	Project resources	Project partners
To set up a community wellbeing hub at the Wilson Hospital in Mitcham	Delivery from January 2023-2024	2 part-time staff & volunteers £85k total (£60k for delivered services)	Jigsaw4U Hosting different organisations such as Wimbledon Guild, Merton Talking Therapies

What's been delivered?

A launch event was held in April (with some HOTH funding).

The Hub hosts different activities each month and is also available as a community space. For August and September 2023, this includes:

- Regular wellbeing focussed coffee mornings
- Assertiveness and Boundaries workshops (part of Health on the High Street)
- Clothes Bank
- Self-care and Relaxation Workshop
- Kid's craft and play sessions
- Back to School event with new uniform for ages 4-16, and school supplies, available to take for free

What's the feedback?

What's the impact?

East Merton has historically received less investment in health and wellbeing services, and the Wellbeing Hub is now able to meet the needs of residents in East Merton.

The Wilson is being used a wellbeing hub, not just for services provided by Jigsaw4U but also used by other organisations such as Wimbledon Guild, Merton Talking Therapies and MertonPlus. This shows the Wilson as a invaluable community resource and demonstrates parterships between organisations in the borough.

Actively Merton

Change Service Access | Information Sharing | Prevention

Merton Health and Care Together

Project aims	Project timescales	Project resources	Project partners
1. Supporting residents to be more physically active and socially active 2. Raising awareness of existing activities, development of menu of activity 3. Connecting resident to activities through development of movements and building connections 4. Develop a comms and engagement plan across all partners	March 2023 – March 2024	Dedicated programme Lead and Project manager £362K investment	Public Health Merton SWL ICB Intelligent Health Merton Borough Sports Sports England VCSEs, London Borough of Merton; leisure centres, Education, Health

What's been delivered?

- Beat the Street (6-week gamification between March-April)
- 22,527 players (10% of total population), 250636 travelled,
- 46 schools participated, delivered assemblies in school
- 33 community groups were engaged and will continue to work
- Actively Merton Workshop and wider Networking event in June
- Soft launch of Borough Sports to improve wider sports activity in Merton
- An Actively Merton grant launched to do engagement and activity to improve connection
- Organised Actively Merton workshop. As an outcome agreed to focus 3 potential group to identify actions and opportunities
  - Woman and Girls
  - Older people
  - People with disability
- Produced Actively Merton Healthy living booklet to promote the ways to be active and healthy

What's the feedback?

- Beat the street offered an opportunity to highlight existing assets, services and provisions in Merton
- Provided an opportunity to work with local partners, organisation and venues
- Real opportunity to leave significant legacy and work closely with Borough of Sport, one of three LBM priorities
- Developed community participation in the East of the borough
- Supported and promoted volunteering and opportunities e.g. walk and talk, park run and befriending scheme
- Informed next steps of Actively Merton, including small grants and insight and engagement; with a focus on the most inactive groups
- Actively Merton will be evaluated by The NIHR Public Health Intervention Responsive Studies Teams (**PHIRST**) scheme.

What's the impact?

- 48% inactive adults become more active, and 46% of children
- 9% increase in the proportion achieving 150+mins of activity per week
- Physical activity behaviour change was even stronger for women and adults living in areas of high deprivation
- Improved mental wellbeing and resilience for adults. The proportion reporting very high or high levels of life satisfaction and worthwhileness increased by 8% and 3%, respectively
- 68 tonnes saving of CO2 *measured by carbon footprint calculator

Actively Merton, as an agreed local priority, will have a significant comms and engagement plan, substantial delivery plan, increasing over time with new activities coming under the umbrella brand and as we deliver and learn.

- Will continue to signpost participants to local activities, events, places or services, support and promote volunteering and opportunities e.g. walk and talk, park run and befriending scheme
- Take forward initiatives as agreed at AM workshop for three potential groups: woman and girls, older people and people with disability

“I just moved from Ukraine. The game helped me to discover Merton and find many interesting places/parks.”
“Gave me an incentive to get out and walk at a pace where I was breathless. It was lovely bumping into familiar faces.”

“Instead of driving to school now I walk so I can join in with beat the street!” - Year 5 Pupil, Aragon Primary School

“I love that there’s one so close to school and I can do it every day!” - Year 5 Pupil, Aragon Primary School

"I love it because we can do it when I walk my dog." - Year 5 Pupil, Aragon Primary School”

"After our visit from Chloe (BTS coordinator) the whole school was buzzing with excitement to get going. The younger children love the fact that they had their own card, (like mum and dad's back card) that they could use to swipe on the beat boxes. On the first few days of launch It was fantastic to see the child walking around with maps to navigate their way, which is a skill we are all forgetting to use as we become more reliant on mobile devices”

“I have had some children tell me that they have changed their route to school and now leave a bit earlier so they can scan more boxes on their way. Others are meeting with friends to go for bike rides at the weekends and family walks. It's been great and the whole Poplar community are really enjoying being part of it."

Group Consultations
(with NHS Charities)

Change Service Access | Information Sharing | Prevention

Project aims	Project timescales	Project resources	Project partners
• 3 Merton PCN working with local community group that support underserved community to co-design health interventions that will improve - Maternal and new-born health outcomes - Outcomes for people at risk of or living with diabetes • Support a cohort of patients to access a course of structured education sessions relevant to their needs • Strengthen health promotion and build community capacity to address long-standing health inequalities	May 2021 - September 2023 90% delivered	Project manager GPs Health Coaches £87,141 investment £71,726 spent so far	• 3 Merton PCNs • 7 Merton community groups across 3 PCNs • HiN • Mencap Merton • WCEN and PHC • CLCH

What's been delivered?

- 27 group sessions delivered across 3 PCN's for both workstreams (Diabetes and Child-Maternal Health), 7 community groups, 22 patients, 14 volunteers and 164 people from the community.
- The project uses a 'group clinic' model, where trained facilitator supports a cohort of patients to access a course of structured education sessions relevant to their needs.
- Co-production with community groups (develop education materials, contents, take culturally appropriate approach, development of culturally appropriate recipes that are healthy and affordable)
- Organised practical cooking sessions, organise series of fortnightly sessions offering access to expert advice and skills.

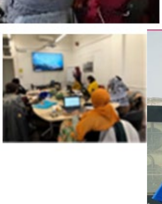
What's the feedback?

- Overall rating was "Very satisfied" and participants were "Extremely Happy".
- 85% Extremely happy, 10% happy, 5% OK, 0% dissatisfied, 0% dissatisfied
- We have received consistently positive feedback from the attendees
- Participants have enjoyed all session delivered so far and came back for the following one.
- Engagement and communication and networking went well. Using a direct comms approach were able to bring many community group on board were able to planned and deliver the maximum session as scheduled.

What's the impact?

- Participants able to demonstrate the effectiveness of this unique programme
- Overall change in their well-being and attitude towards healthy living and feeling in control of their health
- Overcome many of the traditional barriers to access that impact on poor outcomes, e,g, poor health literacy (knowledge of statutory services, how to access them) poor access (language barriers, digital exclusion)
- Group clinic sessions helped these cohort of patients to strengthen health promotion and form community capacity to address health inequalities.
- Improve health outcomes for BAME/ESOL/LSES groups across the life course within 3 PCNs.

Group consultations NHS Charities project



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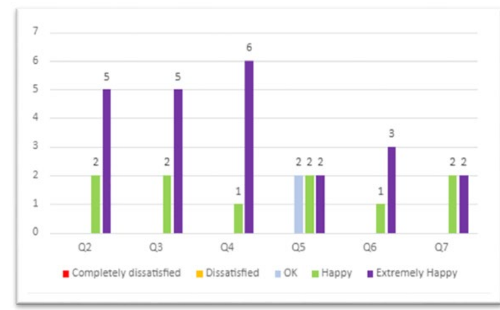
Child Health and Maternity

- *I have gained a lot of useful tips and information. I will apply all the tips given learnt how produce more milk and which hormones are help for that*
- *knowledge about everything*
- *Learnt breast feeding stuff that I did not know*
- *I am learning a lot from the session. Especially about bathing and safe sleeping*
- *learnt about caring for the cord stump, learnt about trapped wind*

Diabetes

- *Consistently positive feedback*
- *A number who attended reported how having the sessions at the mosque helped them to engage*
- *One patient found to have atrial fibrillation, others with hypertension and obesity who were not aware and could be signposted to their GP.*

<u>'Cook Smart' for those with learning difficulties</u>



- Overall very positive feedback
- Participants have enjoyed the cooking session
- They would like to come back again
- They would recommend this kind session to others

‘Believe in Yourself’

Change Service Access		Information Sharing		Prevention	

Project aims	Project timescales	Project resources	Project partners
“Believe in Yourself” project aims to address Health Inequalities faced by the Core20 population, seeking to build confidence among participants through Mindfulness Yoga, Zumba, walking sessions and workshops on Health Issues.	02/03/2023 – 30/05/2023	Dedicated Project Manager £10,250 funding	Ethnic Minority Centre at Vestry Hall and Mitcham Library

What’s been delivered?

- Phase 1 included 20 weekly yoga and Zumba sessions, lasting 40 minutes. They have also had 15 weeks of outdoor walks.
- Phase 2 was made up of 5 weeks of health information sessions and workshops at Mitcham Library

With attendants numbering regularly in the 20s, the Believe in Yourself programme has also provided support and information regarding:

- Cost of living support and information
- Information about accessing MH support
- Information how to better access primary care
- Information shared about bowel cancer, signs to look for, Crohns disease and others (with the St Georges Cancer Team)

The Merton Comms and Engagement team have also been invited to meet the group to collect feedback on how to improve health services for Core20 residents.

What’s the feedback?

The EMC collected feedback each week from participants of the course, this was always positive:

03/03/2023 – ‘We are happy… It makes us feel very energetic. Lovely music, rhythm and movement makes us feeling younger. EMC’s staff and volunteers are always very welcoming, encouraging and energetic’

16/03/2023 – ‘The session is so beautiful which reflects on project name “ Believe In Yourself”. It gives us happiness, as our body, mind and spirit work together’

What’s the impact?

- Older adults have reported more confident using technology, and participants have also been supported with wider IT lessons at Vestry Hall
- Participants feel more connected with one another, reducing social isolation
- Through the health information sessions, some participants enrolled in mental health support from Wimbledon Guild
- NHS Merton has been better able to understand the needs of people whose voices are less heard

Online and F2F Counselling for BAME Residents

Change Service Access		Information Sharing		Prevention	

Project aims	Project timescales	Project resources	Project partners
	06/2023-06/2024	£28908 inequalities funding	Wimbledon Guild Ethnic Minority Centre

What's been delivered?

The BAME counselling service will provide counselling on Mondays and Fridays at Vestry Hall, Mitcham, and on Tuesdays from Wimbledon Guild House.

The counsellor presented to members of the Believe in Yourself project to generate interest from the target group. T
e a presenting to community members of the EMC in generating interest from this group in signing up for sessions just before the project launched which resulted in people signing up for the service.

In partnership with the EMC we have received referrals from GPs, Merton Uplift, the Wilson centre and social prescribers so far.

As of 26/7/23 we have assessed 5 potential clients where three have been allocated to start sessions. One client was referred to our long term service due to their presentation not being suitable for short term therapy and one has been referred to our community services department as they needed financial support. We are currently in the process of assessing three more clients and predict by September the service will be full for the time being.

Wimbledon Guild have also set up a new triage day on the 3rd Wednesday of the month at 9:30am to start the assessment

What's the feedback?

The project has not been running long enough to collate any feedback, though engagement at a session with the Believe in Yourself group (through the Ethnic Minority Centre) resulted in sign ups for the service.

This service is unique in Merton in that it exclusively serves the BAME community, who through EMHIP, we know experience worse mental health outcomes.

What's the impact?

- 30 people from the BAME community will receive up to 16 sessions of one to one counselling
- 70% will experience a positive and reliable change because of accessing the service
- We expect over 90% positive feedback
- The majority of the clients will access the service face to face and we will aim to refer onto suitable additional services with the voluntary sector
- 100% of the clients will be from the BAME community
- 70% of clients will come from the more deprived wards of Merton including Pollards Hill, Mitcham and Lavender Fields So faith

Eastern European Engagement Project

Change Service Access		Information Sharing		Prevention	

Project aims	Project timescales	Project resources	Project partners
• Increase the level of engagement between the Eastern European community in Merton, with health care services • Share health information about maternity, Covid-19, mental health and primary care and other topics as necessary	January 2023 – January 2024	£31,500 inequalities funding	Polish Family Association New Horizon Centre Colliers Wood Community Centre

What's been delivered?

The PFA have delivered weekly sessions with the Eastern European community, working from the Colliers Wood Community Centre for coffee mornings for mothers with young children, and supporting a community fridge at the New Horizon Centre in Pollards Hill. The project shares information over 4 KPIs, and the table below shows the numbers engaged on each.

1. Covid-19 Vaccination awareness
2. Testing
3. Long Covid
4. Health Information – breastfeeding, asthma, cancer and dementia awareness

What's the feedback?

What's the impact?

The table below shows continued engagement from the community with the project across all for KPIs. The necessity for informant sharing around Covid-19 has dropped (particularly around distributing test kits), which aligns with this as a reduced priority for the NHS.

Importantly, this project has revealed that Merton has a large Eastern European community who want to be engaged further with the health and wellbeing system in the borough.

KPI	Jan	Feb	Mar	Apr	May	June	Jul
1	5	4	5	5	7	4	5
2	110	84	75	59	17	10	9
3	9	11	13	10	10	8	7
4	22	28	48	43	36	27	24

Delivery Plan 2023 – Live Well

Merton

Project	MILESTONES	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC
EMHIP Merton	Design and prepare project	■											
	Deliver co-production project in line with SWL Inequalities bid		■	■	■	■							
	Review project and present findings and next steps for EMHIP Merton						■						
Health on the High Street	Dementia Cafés Begins with Alzheimer's Society				■	■	■	■	■	■	■	■	■
	Lantern Arts HWB Day	■											
	SMCA HWB		■										
	LGBT History Month Activities • Movie Night • Quiz Night • Houseplant Wellbeing Event • Merton Police M&G • Crafternoon • Coffee Social		■										
	Sporting Memories at SMCA with FFC					■	■	■	■	■	■	■	
	Wellness Programme begins with Wimbledon Guild				■	■	■	■					
	Assertiveness and Boundaries workshops begin with Wimbledon Guild						■	■	■	■			
Community led health checks	To be confirmed												
Mitcham Health & Wellbeing Hub	To be confirmed												
Actively Merton	Implement beat the street initiative			■	■	■							
	Develop Actively Merton identify and promote existing initiatives		■	■	■								
	Implement networking and improved connections project				■	■	■	■					
	Design and implement evaluation of Actively Merton							■	■	■			
	Joined collaboration activities with Borough Sports									■	■	■	■
Group Consultations health inequalities Project	Complete NHS Charities funding pilot			■	■	■	■	■	■				
	Share learning and evaluation and plans for scaling and expansion						■	■	■				
Community health inequalities project	Implement projects		■	■	■	■	■	■	■				
	Review and evaluation								■	■			

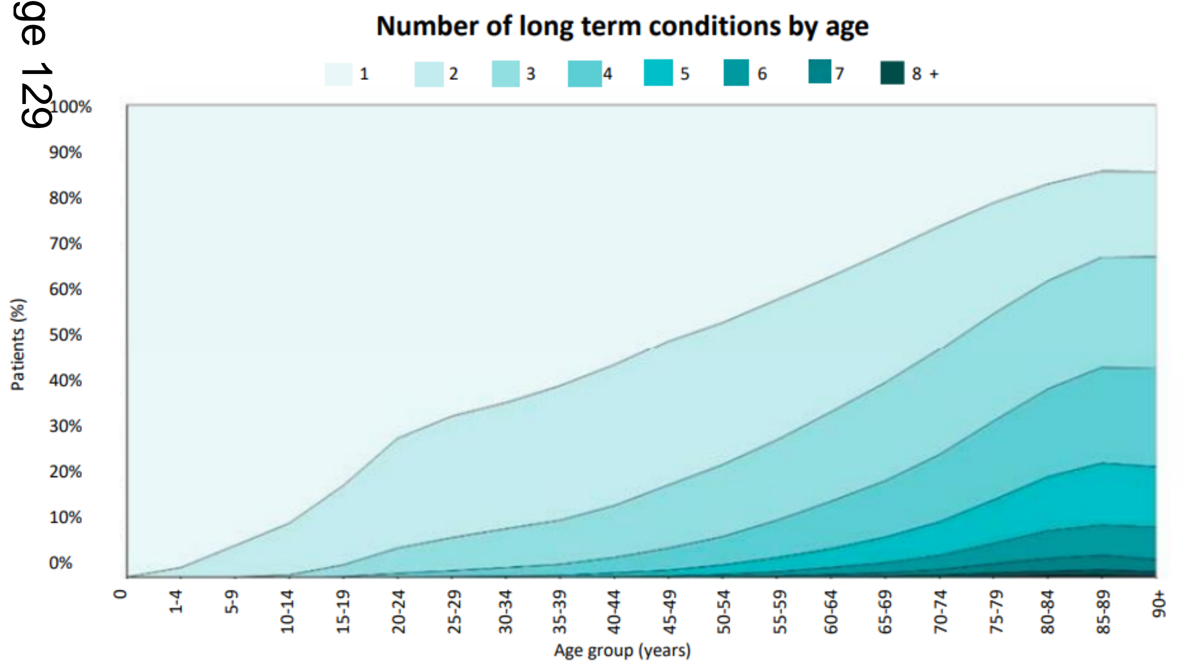
Age Well

- Support older people to access resources in the community
- Improve access to and integration of services
- Be focussed on frailty

Age Well – Population Health

Headlines

- Majority of older people are healthy; however, an ageing population, the pandemic and now cost-of-living crisis, is leading to greater complexity of need due to several long-term conditions (multi-morbidities), increasing dementia rates, sensory impairment, frailty and loneliness/isolation.
- People with learning disabilities face health inequalities including access to healthcare, such as cancer screening.
- Carers, health, adult social care, and voluntary sector partners reporting greater complexity, including social and welfare needs, increasing pressures on services. For example, people with both a learning disability and autism.



Source: Kent Integrated Dataset. Produced by KPHO (TG). 03/18. This is illustrative data – pattern in Merton would be similar.

Loneliness and Isolation

- 18,135, or 1 in 9 adults feel lonely often/always

Frailty

- Frailty is higher in Morden and East Merton PCNs
- An estimated 10%, or 2,764 residents aged over 65 live with frailty
- Falls in ages 65+: 575 emergency admissions, a rate of 2126.6 per 100,000
- Hip Fractures in ages 65+: 115 hip fractures, a rate of 429.4 per 100,000

Carers

- 16,000 to 20,000 unpaid carers

Learning Disability

- 3,789 residents aged over 18 have a learning disability

Conclusions to inform priorities

- **Developing whole system frailty pathway**
- **Supporting carers**
- **Greater awareness, greater provision of reasonable adjustments to improve access to health services and annual health checks for people with learning disabilities**
- **Autism support throughout the life course, especially focusing on transition and highly complex adults with associated learning disability**
- **Better understanding of pattern of increasing complexity in health, care and welfare**

Age Well Results Chain

Project	Owner & Inputs : Funding and staffing resource	Outputs Products and services delivered	Outcome Effects or behaviour change resulting from outputs	Impact Long term widespread change
13. Frailty Project	• Project management support SWL ICB • Optum population health management support through workshops • £255 SWL Innovation fund to support pilot model	• Mapping out existing frailty services across Merton • Using population health management approach to developing new frailty model and pilot the approach • Work and liaise with wider partners to develop integrated frailty pathway across Merton. • Linking up Social Prescribing and Virtual Ward to the frailty intervention, and to take holistic approach to people's health and wellbeing.	• People with severe/moderate Frailty, incl. those with disabilities or LTC, can live as independently as possible and at home in 3 Merton PCN.. • Improvement of the quality-of-life measures (AKUM Older Person Assessment) • Reduction in GP and A&E attendances (financial savings and reduced winter pressures) • Greater understanding of population health management around improved capabilities • Established MDT, work collaboratively that prompt in taking action. taken	• Improved ability to identify, prevent and support those who are identified severe/moderate frail in 3 Merton PCN. • Identified patients with frailty using risk stratification and prioritise on clinical need. • Patient perspective: service receiver are more empowered, improved quality of life and be able to remain at their home setting. • PHM development of using Optum tools to create an intervention model for the frailty cohort driven by MDT.
14. Tackling social isolation project	• SWL health inequalities fund • Project management support SWL ICB	• Deliver the health inequalities projects and encourage more residents from Black, Asian and other minority ethnic communities into physical exercise • Encourage more men aged 50+ into physical exercise • Provide more choice to support a wider range of interests and physical abilities across more locations in the borough	• Improved health and wellbeing specifically achieving increased numbers of Merton residents accessing physical exercise activities • Reductions in health inequalities and most specifically increased men and those from Black, Asian and minority ethnic background accessing physical exercise activities	• Improved experience and access to community resources • Improved participation in exercise • Reduction in loneliness and isolation reported • Improved mental and physical wellbeing of clients – measured through qualitative feedback from clients
15. Integrated approach to improving rapid discharge and admission avoidance initiatives such as 'D2A' or Virtual ward	• Project management from SWL ICB • Leverage capital SWL inv £1.3m (22/23)	• Building on virtual ward developments locally as per national requirement • According to planning guidance SWL was required to work towards **40-50 beds** (per 100,000) by 2023 • An expansion of digitally enabled approaches to manage and support patients virtually	• Significant opportunity to work collaboratively at ICS footprint (including health, LA and VCS partners) • Deliver a central SWL remote monitoring hub (RMH) that will work in partnership with and act as a key component of each local virtual ward system. • Local multi-agency team, with links to PCN workforce, with the ability to mobilise interventions around the persons needs • Every patient discharged into a virtual ward will have a shared care plan agreed with the senior accountable virtual ward clinician.	• Multidisciplinary teams based on an individuals needs • Borough "Acute" virtual wards • 24/7 support • Care delivered at home • Provided tech enabled wearable devices
16. Expansion of the Integrated Locality team model into lower risk cohorts	• Tbc	• Tbc	• Tbc	• tbc

Measuring the Impact of Age Well

Projects (activities) How resources are used to generate products and services	Who are we helping?	Expected Outcome?	How will this be measured?
Frailty Project	• Identified target group through using PHM data for severe/moderate housebound frailty patients across 3 Merton PCN (Morden, SW Merton, East Merton) who would benefit from a proactive visit to enhance health and wellbeing with the aim to avoid admission and improve quality of life • Cohort 1: People at risk of moderate to severe frailty with 2+ LTCs and in deprivation deciles 1-4 (approx. 3222 in Merton) • Cohort 2: People at risk of moderate to severe frailty in deprivation deciles 1&2 (approx. 2064 across Merton)	• People with severe/moderate Frailty, incl. those with disabilities or LTC, can live as independently as possible and at home in 3 Merton PCN.. • Improvement of the quality-of-life measures (AKUM Older Person Assessment) • Reduction in GP and A&E attendances (financial savings and reduced winter pressures) • Greater understanding of population health management around improved capabilities • Established MDT, work collaboratively that prompt in taking action	• Changes and impact measured through the PHM dashboard by included data on activity, both numbers visited and urgent care plans created. • Report will be provided on data of the impact on quality of life for patients involved using the wellbeing score. • Testimonies and feedback from the service provided, that would include feedback from individual patients involved and also from staff involved in the scheme. • Currently pulling together an evaluation of the work undertaken thus far and will be able to provide more information when this has been done.
Tackling social isolation (through the delivery of two key projects; befriending service for isolated people with mental health needs and increased activity programme for older people who are socially isolated)	• The service will support 15 people with mental ill health who are physically able to get out but are housebound or rarely leave home • Very isolated people with mental health needs living in LB Merton. • Older residents of Merton to improve their health and wellbeing by reducing the impact of long-term conditions such as frailty and dementia	• Improved health and wellbeing specifically achieving increased numbers of Merton residents accessing physical exercise activities • Reductions in health inequalities and most specifically increased men and those from Black, Asian and minority ethnic background accessing physical exercise activities	• Age UK outcomes measures will be used for clients mental well-being and connectedness with the community • Exercise based activities will be completed and an initial review or check-in with each individual around their physical wellbeing • Qualitative measures will be used such as conversations with client feedback, returning numbers of clients and feedback from family members to measure the impact of the project.
Integrated approach to improving rapid discharge and admission avoidance initiatives such as 'D2A' or Virtual ward	• Patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home or place of residence	• Ambition is to deliver a central SWL Remote Monitoring hub (RMH) that will work in partnership with and act as a key component of each local virtual ward system. • RMH could save the equivalent of 31 beds in the first year, potentially increasing to 111 beds in the second year with gross savings of £21.6 million over two years	Consistent evaluation, learning and adaptation will be critical to assess how well virtual wards supported by remote monitoring hub are delivering the potential benefits of better patient experience and outcomes, and the impact on health inequalities. The Impact will be measured at 3 levels: • Level 1: SWL ICS level • Level 2: SWL and all 'places' – real deal *(Level 1 PLUS) • Level 3: Service based KPIs - need not be reported to SWL, more so for internal and continuous quality improvement (CQI)

Supporting Frailty Patients to Stay at Home

Access Community Resources | Service Integration | Frailty

Project aims	Project timescales	Project resources	Project partners
1. Developing a new frailty pathway and piloting this across 3 PCN (M, EM, SWM) for housebound patients with severe/moderate frailty. 2. Establish an MDT to take holistic approach to housebound frail patient's health and wellbeing. 3. Improve proactive care by reducing pressures on general practice and acute trusts 4. Reach potential cohort: 2026 moderate and 3222 severe frailty patients.	February 2023 - September 2023	• Project manager • £155K + £100K investment	• Morden, SW Merton & East Merton PCN • CLCH • Optum • AUKM • Epsom and St. Heliers Hospital

What's been delivered?

- Morden PCN discussed **176 unique patients** from the start of the pilot till the end of May in the MDT meetings (91 were for action by the GP surgeries/PCN team, 56 for Age UK, 42 for St Heliers and 10 for CLCH)
- SW Merton had discussed **121 patients**, 107 were for action by the PCN/GP surgeries, 24 by age UK, 37 for St Helier, 6 for CLCH
- A Frailty Logic model has been developed with the support from PHM/Optum.
- Provided proactive visiting to housebound patients with moderate or severe frailty
- Physical, mental and social health needs are addressed using a comprehensive individualised approach.
- Urgent care plans are created in collaboration with patients and their carers aiming to reduce unnecessary hospital admissions
- Holistic visits were undertaken by at least one of the organisations collaborating on the pilot sometimes more than one agency was involved to fully address the patient's needs

What's the feedback?

Feedback has been extremely positive about the collaborative nature of the project and the clinical and operational connections made with multiple agencies in particular Age UK and the St Heliers team.

The MDT aspect of the project has also been found to be useful as patients from practices are discussed amongst a group of clinicians from not only different organisations but also different practices within the PCN.

Weekly MDT discussions and triage meetings have brought collaboration in an enhanced and new way.

What's the impact?

- Collaborative working was quickly established between the organisations involved in the scheme.
- Both Morden and SW Merton PCNs quickly established weekly MDTs meeting with Age UK Merton, St Heliers team and CLCH as per the project plan where patients were triaged
- In the process of evaluating data of individual patients which will include information on their experience of the service and interventions provided.
- As per Age UK OPA (older person assessment) quality of life measures have been enriched.
- Significantly reduced the A&E attendance and hospital admission.
- Expected to finish in September 2023 with a final report in December 23

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Reduced Social Isolation

Access Community Resources | Service Integration | Frailty

Project aims	Project timescales	Project resources	Project partners
• To provide emotional and friendship support for 15 people with mental ill health • To help clients find activities, groups or services and to support them to travel and take the steps to participate • 1:1 support by trained volunteer befriender and support clients for their recovery journey	Start: April 2023 End: September 2023	Project Lead Activity Lead	Age UK Merton Wimbledon Guild

What's been delivered?

- **January and February** 2023 combined we had **143 unique clients, April and May** combined this increased to **158 unique clients**, accessing all our exercise activities available
- A range of taster sessions of new activities delivered
- A community sports day delivered
- Activity Lead recruited to run activities for older adults
- Planned an implemented session and ongoing expanded exercise/activity provision
- Run a one off community sports day event
- Promoted new opportunities and sports day event with men and diverse community groups
- Provided more choice to support a wider range of interests and physical abilities across more locations in the borough
- Encourage more men aged 50+ into physical exercise
- Encourage more residents from BAME communities into physical exercise
- Review and evaluate success of expanded provision

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What's the feedback?

- Very positive feedback from attendees
- Received excellent qualitative feedback from clients related to the Sports Day
- Increased numbers of clients accessing physical exercise activities
- Increased # of men and those from Black, Asian and minority ethnic background accessing physical exercise activities

What's the impact?

- Improved mental and physical wellbeing of clients
- Encourage people to attend the Sports Day worked very well it was an enjoyable experience and improved their wellbeing
- Created a positive environment with multiple exercise activities available for the day
- It was so successful that a free monthly Sports Day incorporated into WG quarterly calendar of events from July to September 2023.
- Provide friendship and support to build confidence to go out to connect in their community that helped to reduced isolation.
- Helped to avoid relapse

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Integration of Community Services

The existing community contract, with CLCH, is held jointly by SWL ICB and the London Borough of Merton, expires in March 2025. The aim of this project is to develop integrated community services in line with national policy and local strategic plans within the contract timetable. Strengthening community services with enhanced prevention and bringing care closer to home has been a long-standing policy ambition across health and social care.

Integration work taken so far includes:

- Integrated Locality Teams; multi agency working across health and social are to support vulnerable people proactively in their own homes
- Streamlined integrated discharge pathways, building on home first; Virtual Wards models
- Better Care Fund, pooling resources and working together across health and social care
- Healthy Child Programme (HCP) Public Health services integrated with ICB commissioned specialist children's services within the community services contract
- Family Hub programme

Delivery Plan 2023 – Age Well

Project	MILESTONES	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC
Frailty Project	Implement the frailty project from the PHM workshop approach												
	Evaluation impact and next steps/scaling												
Tackling social isolation	Implement projects from SWL Inequalities funding												
	Undertake evaluation to determine impact and next steps												
Integrated approach to improving rapid discharge and admission avoidance initiatives such as 'D2A' or Virtual ward	Tbc												
Expansion of the Integrated Locality team model into lower risk cohorts	tbc												

Start Well Summary

Start Well priorities	Projects identified to deliver the aims
➢ Change how people access health and wellbeing services ➢ Improve integration of children's services ➢ Be focused on mental health and wellbeing	1. Developing a new CYP mental health hub 2. Developing a Family Hubs model in Merton 3. Delivery of the Child Healthy Weight Action Plan 4. A project to better support SEND residents 5. Delivery of the recommendations in Merton from the SWL MH Strategy

- Excellent progress introducing Family Hubs and social prescribing for children and young people, with both projects expected to finish implementation in spring and summer 2024.

- Some projects are still being delivered and not expected to finish until summer 2024, some are ongoing embedded within business as usual

- Developing a new CYP mental health hub has not begun as is dependent on securing resources to pilot and further work to identify any projects to implement the recommendations of the SWL MH strategy is required.

Live Well Summary

Start Well priorities	Projects identified to deliver the aims
➢ Change how people access health and wellbeing services ➢ Improve and optimise access to information on primary care ➢ Be focused on prevention	1. EMHIP Merton 2. Health on the High Street 3. Deliver community led health checks 4. Develop the Mitcham Health and Wellbeing Hub 5. Actively Merton 6. Group consultation health inequalities Project 7. Community Health Inequalities Projects I. Online and F2F counselling for BAME residents II. Schedule of activities on mindfulness and health targeting BAME residents III. Project to increase Eastern European Community engagement with health services

Excellent progress innovating and exploring community led approaches to expand access to prevention and early intervention. Strengthened community ability to impact local health and wellbeing through multiple events, forging new partnerships that are sustainable beyond the project interventions. E.g. The Health and Wellbeing Day at the SMCA led to a partnership between Fulham Football Club and the Centre to provide physical activity sessions for older service users. This was funded by us for 18 weeks, matched by FFC for 36 weeks total. FFC will train staff at SMCA to deliver these in house when funding ceases.

- Variety of projects that strengthen health promotion and build community capacity to address long-standing health inequalities; working in partnership with voluntary and community providers. Examples such as community health clinics, group consultations led by three PCNs, community led diabetes information sharing. All have received consistently good feedback, well attended and led onto wider improved access to healthcare. Particularly the projects worked with communities to improve their access to primary care (e.g. those at risk of diabetes through the group consultation project, and the Eastern European community)
- Strong focus on reducing health inequalities woven throughout the project delivery against the priority areas; lots of examples of using data and intelligence to target specific communities in need and working in partnership with local voluntary groups.
- Strong focus on prevention, particularly on improving underlying determinants of health such as social isolation and living more active lifestyle. Through Actively Merton initiatives; of Beat the street players 48% inactive adults become more active, and 46% of children and 9% increase in the proportion achieving 150+mins of activity per week

Age Well Summary

Start Well priorities	Projects identified to deliver the aims
➢ Support older people to access resources in the community ➢ Improve access to and integration of services ➢ Be focused on frailty	1. Project to develop a new frailty pathway 2. Working to reduce social isolation 3. Befriending project 4. Increase opportunities for physical activity 5. Integrated approach to improving rapid discharge and admission avoidance initiatives such as 'D2A' or Virtual ward 6. Expansion of the Integrated Locality Team model into lower risk cohorts

- Excellent partnership and population health approach to developing the frailty pathway in Merton. Innovative new projects designed collaboratively between partners and put into action bringing proactive and preventative change to improve the life of people who are frail in Merton.

- Successful delivery of a project to reduce social isolation of older people with a mental health condition. The project reached high numbers of people and has developed wider activities and connections.

- Larger integration project around community services has just began.

Lessons Learned

- Delivery has been greatly improved by access to the SWL Investment funds (innovation and Inequalities) or external grant funds which have enabled projects and delivery against the priorities to get off the ground. Much of the LHCP did not have resources attached so the funds have been a fantastic enabler.

- Majority of project implementation has been at hyper community level, very few projects implemented at 'whole Merton level' how can we scale up what works?

- Gaining external access to support evaluation is crucial and supports understanding of the impact of the projects.

- Some initial projects identified had their own governance, structure and ways of working and didn't lend well/risked duplication of effort, being part of the LHCP/MHCT partnership. The projects that flourished were those had more traditional project definitions; time limited with clear aims and objectives.

Year 2 Focus

Priorities not focused on so far:

Start Well
- Be focused on mental health and wellbeing

Gaps/potential areas of focus:

- Digital
- Green/climate change and impact on health inequalities
- Evaluation of impact and outcomes