Merton Council
Health and Wellbeing Board
20 September 2022
Supplementary agenda

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Health Inequalities

Merton Health and Wellbeing Board
20th September 2022

Dr Dagmar Zeuner, Director of Public Health

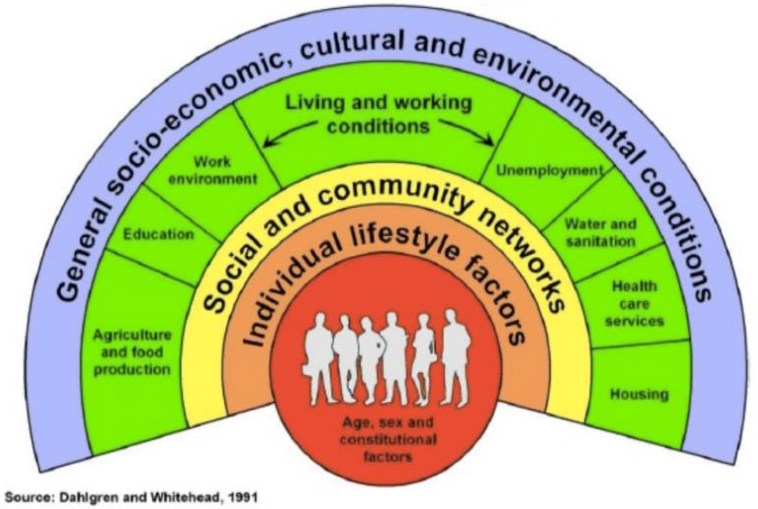
Health inequalities

What do we mean?

- Unfair and avoidable differences in health (outcomes, access to services, care experience) between different population groups (described by demographic characteristics and / or geography)

What are the causes of health inequalities?

- Social determinants; risk factors (i.e. food/diet, physical activity, smoking, alcohol, underpinned by mental and social wellbeing); health and care services (especially primary and community)



Source: Dahlgren and Whitehead, 1991

What are ways of reducing health inequalities?

Marmot policy objectives

- Give every child the best start in life
- Enable all to maximise capabilities and have control over their lives
- Create fair employment and good work
- Ensure healthy standard of living
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of health prevention

References

Marmot Review report – 'Fair Society, Healthy Lives

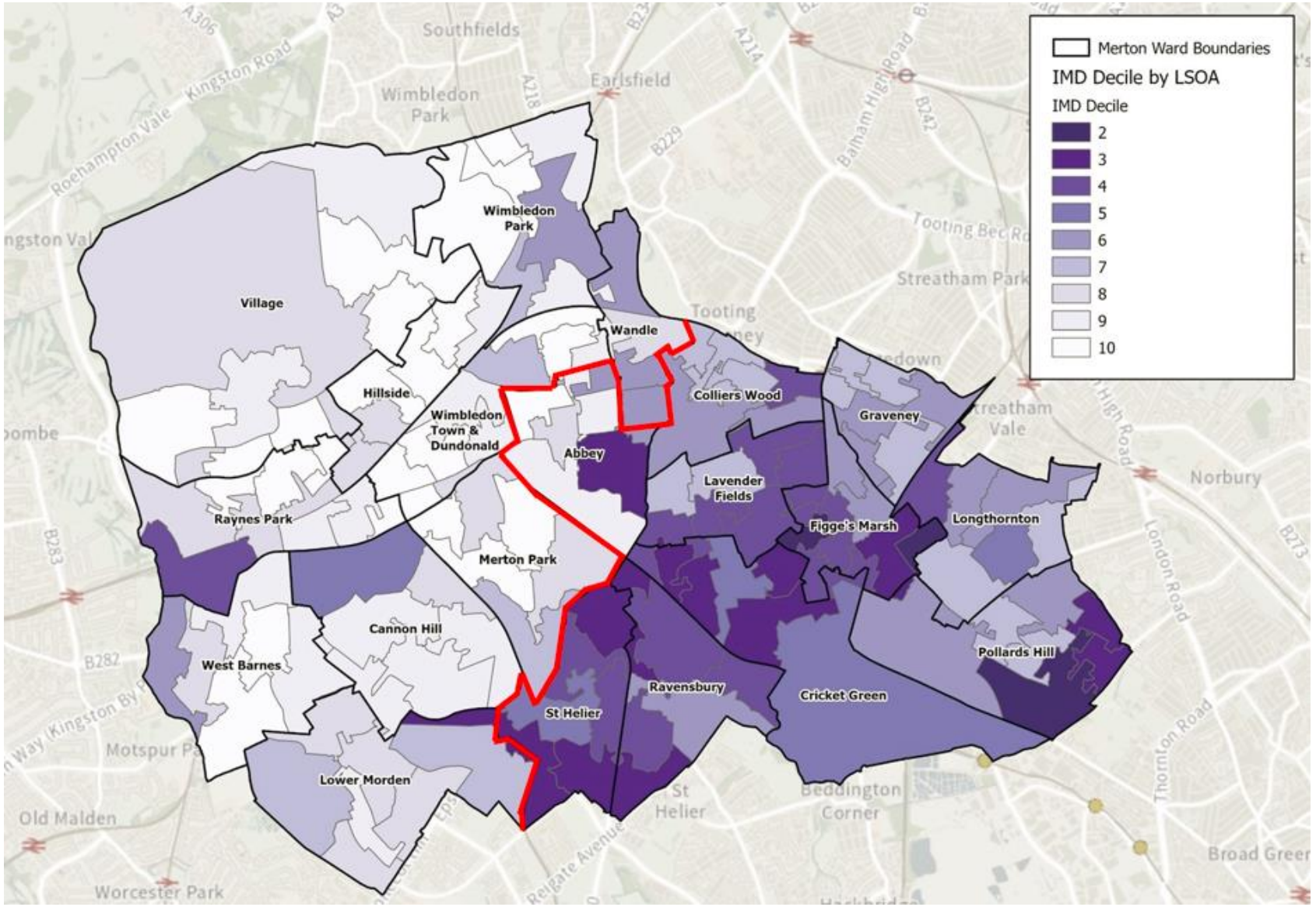
What are health inequalities? | The King's Fund (kingsfund.org.uk)

Health inequalities: place-based approaches to reduce inequalities - GOV.UK (www.gov.uk)

Learning points about implementation

- Health in All Policies - embedding health equity in policy, service design and performance/quality monitoring
- Long-term commitment, working with patients, residents/community, staff and within planetary resources
- Whole Systems Approach, working on upstream and downstream causes together; agile (learning and adapting
- Understanding intersectionality/clustering of adversity and risk factors and adapting approaches (integrated vs single focus)
- Considering targeting vs universal vs proportionate universalism approaches and its pros and cons (stigma, focus, costs)

Index of Multiple Deprivation (IMD) in Merton



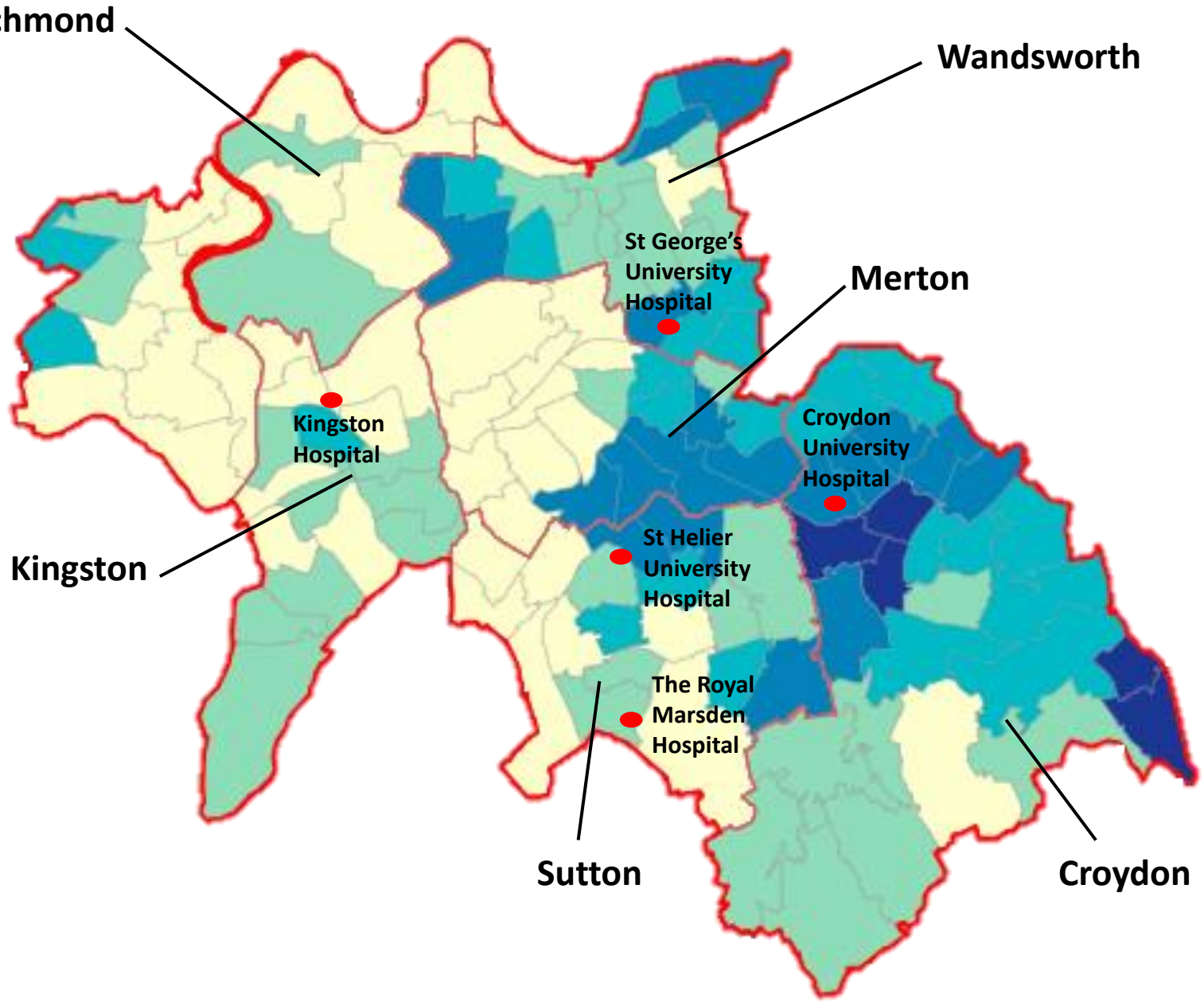
- **IMD** is a relative measure of deprivation showing where one area is more deprived than another.
- The indices are informed by seven indicators: income, employment, education, skills and training, health and disability, crime, barriers to housing and services and living environment.
- Areas with the highest level of deprivation are in the 1st Decile (Merton has none of these), those areas with least deprivation in the 10th decile.

IMD difference between east and west is mirrored by life expectancy and healthy life expectancy.

Source: English indices of deprivation 2019 - GOV.UK (www.gov.uk) Index of multiple deprivation 2019

South West London IMD by Wards and Acute Hospitals

as requested by Cllr McCabe



Index of Multiple Deprivation (IMD) based on IMD Score, 2019.

- 1.7 to 10.2 (Least Deprived)
- 10.3 to 15.0
- 15.1 to 21.6
- 21.7 to 30.1
- 30.2 to 87.1 (Most Deprived)
- N/A

Source: Ministry of Housing and Local Government, Office for Health Improvement and Disparities, 2019.

Please note, the locations of acute hospitals are approximate.

Health Inequalities – Risk Factors

	Number of adults in Merton (% of Adult population)	Risk Factors
	**37,300 (23%)**	**Inactivity** – Adults doing less than 30 minutes of moderate intensity physical activity per week.
	**75,800 (47%)**	**Diet** – Adults not meeting the recommended '5-a-day' on a 'usual day'.
	**36,700 (23%)**	**Alcohol** – Adults drinking above the recommended limit of alcohol a week.
	**21,300 (14%)**	**Smoking** – Adults who smoke.
	**25,200 (16%)**	**Mental Wellbeing** – Adults with a common mental disorder defined as depression or anxiety.
	**18,135 (11%)**	**Loneliness** – Adults who often or always felt lonely.

Sources: Exercise 2020/21 Active Lives Survey, Sports England; Healthy eating 2019/2020 Public Health Profiles, OHID; Alcohol 2015-2018 Public Health Profiles, OHID; Smoking 2020 Public Health profiles, OHID; Mental Well Being 2016/2017 Public Health profiles, OHID; Loneliness Oct 2020-Feb 2021 ONS national Opinion and Lifestyle Survey.

HWBB – next steps

Health in All Policies (HIAP)

HIAP approach agreed in principle (HWBB June 2022):

- Part 1 - ways of working;
- Part 2 – exemplar and learning; initial priority for scoping: physical activity, linking to borough of sport ambition.

For discussion / follow-up

- Assessment / measurement of progress: exploring use of Marmot principles; core20+5; tracking of other equity markers
- Support joint work on 'Actively Merton'
- Follow-up report to HWBB November 2022

Part 1 Ways of Working

Marmot principles: Looking to councils and communities specifically using the Marmot principles to steer and chart their progress in tackling health inequalities: **Kingston Council** developing and reporting an outcomes framework to demonstrate progress; **Thurrock Council's** 'whole systems approach to tobacco control'; and, **Coventry City Council's** 'system wide call to action' led by the Health and Wellbeing Board.

Part 2 Exemplar - *Actively Merton*

- **What** – physical activity and social activity for all people in Merton the way they want it complementing ambition of borough of sport.
- **Why** – multiple physical and mental health and wellbeing benefits; social cohesion/reducing inequalities; positive frame/fun, no stigma
- **How** – connecting people with opportunities/services *at scale*
  - Menu of opportunities and services: use existing ones; add highly visible evidence-based new ones (beat the street; living longer better); enable menu to evolve
  - Connecting: use of networks; use of digital; scale up existing connectors such as social prescribing, link workers etc
  - PR/comms: to support the above in a visible and recognisable way
  - Evaluation: SWL exemplar; component evaluation and overarching system evaluation/action research (with HIN tbc)
- **Timeline** – prep and staged start from September increasing scale from next year
- **Resources** – distributed modest contributions from all partners including expertise, money, staff time; match funding (ie Sport England)

Merton Health & Wellbeing Board

20th September 2022

Children and Young People's Voice

Lola Kareem and Anna Huk, Young Inspectors

Overview

- Introduction
- How CYP voice is heard – participation in Merton
- Engagement Survey key findings for ‘Being Healthy’ theme
- Leading participation:
  - Learning from participation work during COVID
  - Examples of young people leading participation
- Discussion

Introduction

Our Young Inspectors have defined Participation as:

"Participation is the act of allowing children and young people to have an equal and equitable say on matters that relate and are important to them."

- Young Inspectors are young people who work to empower other children and young people to have their voice heard in addition to hold decision-makers accountable on what has been pledged to young people's services.

- We currently have four Young Inspectors in post, who are working across Education and Public Health to ensure young people's views are being heard.

How CYP voice is heard – overview of participation in Merton

Youth voice is facilitated and captured in many ways: from questionnaires and feedback forms, to targeted forums such as:

- our Children in Care Council called **'Our Voice'**

Designed by a young person

- the Participation team run a **Youth Parliament** for young people studying or living in Merton

- New **youth voice project** to take place at Morden Hall Park, after a successful bid and 'Dragon's Den' style pitch
- Opportunities for young people with **SEND** to attend a **Youth Advisory Forum**
- **Black Lives Matter equalities forum** for young people to feedback on matters relating to diversity within our education system
- Workshops with the **MET Police and young people** on the topic of stop & search which includes reverse mentoring
- '**Rights and Entitlements'** workshop to support **care leavers** with knowing what they are entitled to

Merton Youth Residents Survey – impact of COVID key findings for 'Being Healthy' theme

Safety

Only one in ten (11.6%) said that they felt unsafe or very unsafe in Merton, with four times as many (45.1%) saying they felt safe or very safe.

- Areas like Colliers wood and Pollards Hill being seen as more unsafe.
- Certain groups were more likely to be very worried or worried, like those with care experience (23.7%), disabled young people (26.9%) and young carers (31.3%)

We heard in interviews and focus groups that feeling worried about staying safe from Covid-19 was often from young people who were at risk or had family members shielding. Young people were less concerned about getting Covid-19 themselves, as they had heard the experiences of peers who were okay, or they had it already and it wasn't serious.

Food Poverty

- We found that many young people living and studying in Merton faced food poverty, skipping meals or not eating for a full day because there isn't enough food. We only asked secondary school students as it was not appropriate for primary school students.
- One in ten young people has had to skip meals because there wasn't enough food, while one in twenty went a whole day without eating with young carers (22.2%) and care experienced young people (21.4%) more affected.

"I was lucky enough that I was getting support from a local food bank. So they would bring me food once a week… but there's not everything that you eat in there or that you will want or need."

Mental Health

- Covid-19 and lockdowns had a negative impact on the physical and mental health of young residents. During focus groups and interviews we were told that they sought informal support for their mental health, speaking to friends and family.
- One in four (25.1%) told us that they had found it harder or much harder to access services for their mental health with disabled young people (36.2%) and those in care (37.9%) more likely to find it harder.

https://www.merton.gov.uk/council-and-local-democracy/get-involved/young-residents-survey-2021

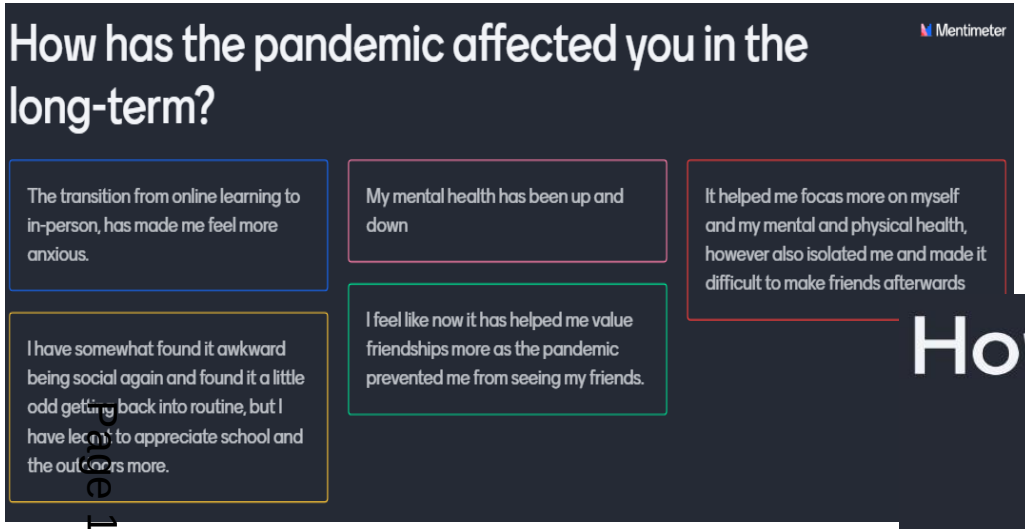
Leading participation –learning from COVID (3 mins)

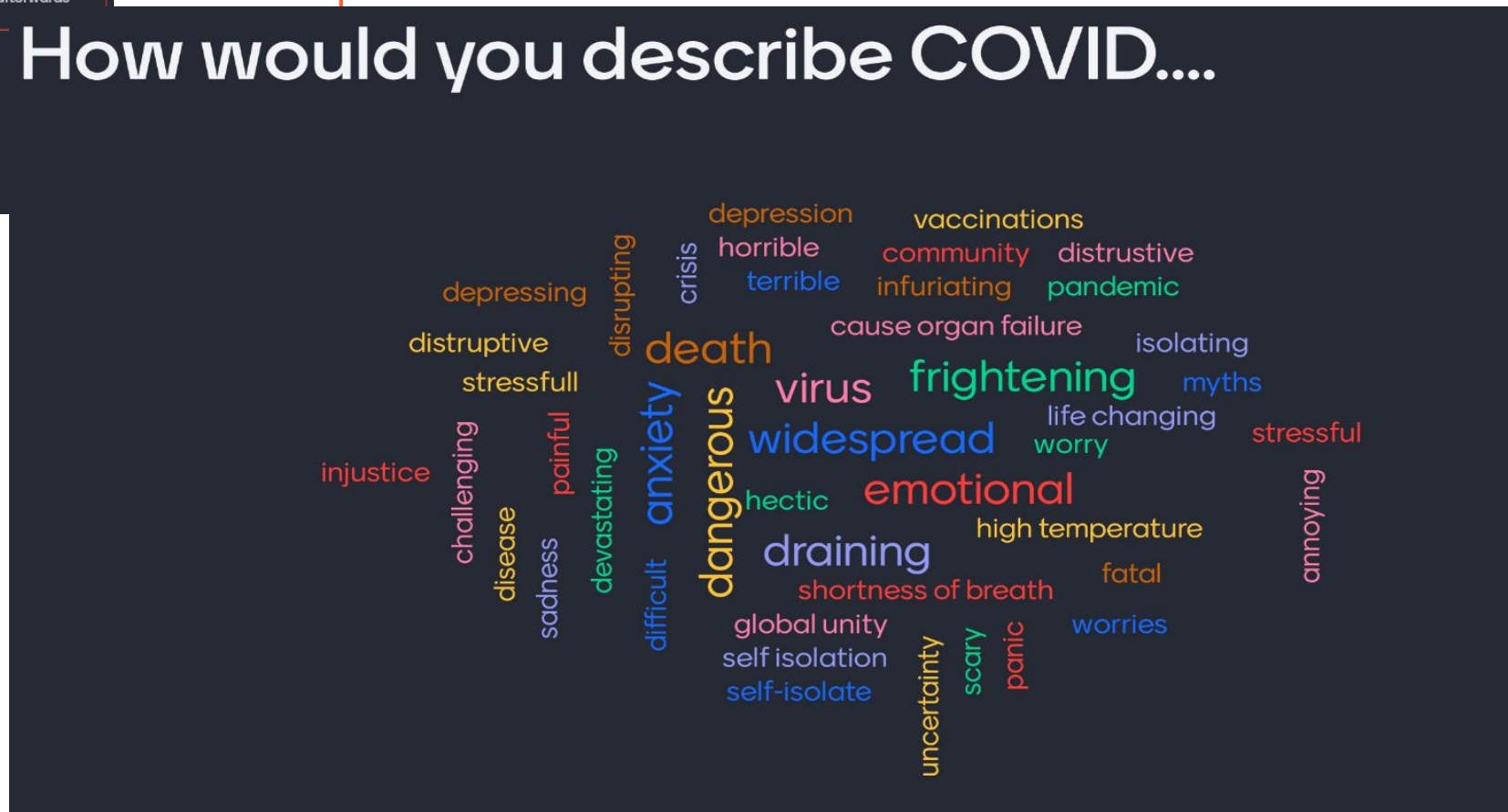
my voice merton youth

Under 18's COVID Community Champions

- Under 18s COVID Community Champions - mental health and social isolation
- Importance of safe spaces for discussion
- People rely on family/friends for info and support
- Importance of youth friendly messaging and engagement
- Hearing voices of young people – and taking action

Leading participation –learning from COVID





Leading participation - examples of young inspectors participation work

Peer Educator Project

- Peer education network for people aged 16-30 targeting underrepresented groups
- The aim of the project is to improve health and wellbeing of communities
- Peer Educators gain accredited training to design and deliver messaging within their community around aspects of COVID and COVID recovery which are important to them
- Monthly network meetings provide information sessions for young people to discuss issues and learn about services available
- Provides advocacy

MYHealth Pilot

- MY Health aims to improve health services for 16–21-year-olds in Merton using residents' experience when accessing local health services, including young people living with long-term illnesses and young carers. This will make sure health services reflect needs of young people.
- Survey development in collaboration with Young Inspectors and Health Watch. Plans to host focus groups with young people aged 16-21 to review young people survey questions.

Discussion

HWBB response to survey findings and current activity - comments and questions?

- How does the HWBB champion CYP voice and engagement?
- What are the HWBB doing to improve accessibility of services for young people?
- How can Young Inspectors work together with the HWBB (and possibly be part of the board)?
- What are the opportunities for CYP having more say in decision making for health?

Merton
South West London Integrated Care System

Kings Fund Health Inequalities Review Merton

Merton Health and Wellbeing Board 20th Sept 2022

Presented by:
Mark Creelman
Locality Executive Director Merton & Wandsworth
South West London Integrated Care System

The Kings Fund report on health inequalities

Merton South West London Integrated Care System

- NHS South West London Clinical Commissioning Group commissioned The King's Fund to undertake a focused review of health inequalities and levels of deprivation in Merton and Sutton following the

- This was to determine if inequalities had changed since previous equality impact assessments (carried out by internal and external organisations) were carried out as part of the decision making process for the Improving Hospitals Together programme.

The Kings Fund review concluded that:

  - There was not consistent data indicating that health and healthcare needs had changed significantly since the previous assessments and therefore there was not a need to reopen the Improving Healthcare Together (IHT) business case.
  - The general perception amongst local stakeholders is that the IHT programme itself will not impact on health inequalities in Merton and Sutton and that alongside delivery of the IHT programme, there is an opportunity to work differently on population health and inequalities.

- The Kings Fund did note rising trends in prevalence data for obesity, type 2 diabetes and mental health illnesses. The review also noted that the impact of the coronavirus pandemic worsened existing health inequalities.

- The review also reinforced the need to ensure the mitigation activities listed in the final integrated impact assessment are delivered.

Addressing the recommendations in the Kings Fund review

Merton South West London Integrated Care System

01

Ensuring mitigating actions are actioned

The actions in the mitigation impact report have been incorporated into the **Building you Future Hospitals Programme** plan.

For example the team have established a dedicated travel and transport working group has been set up by the Building your Future Hospitals Programme to look at the accessibility to all hospital sites to identify opportunities and tackle obstacles.

02

Prioritised health inequalities in the Local Health & Care Plan

The Merton local Health and Care Plan identifies addressing health inequalities in Merton as a priority; through focusing on prevention, promoting integrated care models and exploring innovative new ways to deliver and make services accessible across the life course areas of Start Well, Live Well and Age Well.

The Local health and care plan aims to focus on population health to tackle the causes of ill health, through pursuing projects and initiatives that create healthy and sustainable communities

03

Mitcham Health & Wellbeing Hub

The NHS is working really closely with health and care partners, including Merton Council, to design a new health and wellbeing facility in the east of the borough which meets the needs of local people.

The hub will support people to stay healthy and stop health conditions getting worse, through prevention work – because this is one of the most important ways we're able to tackle health inequalities.

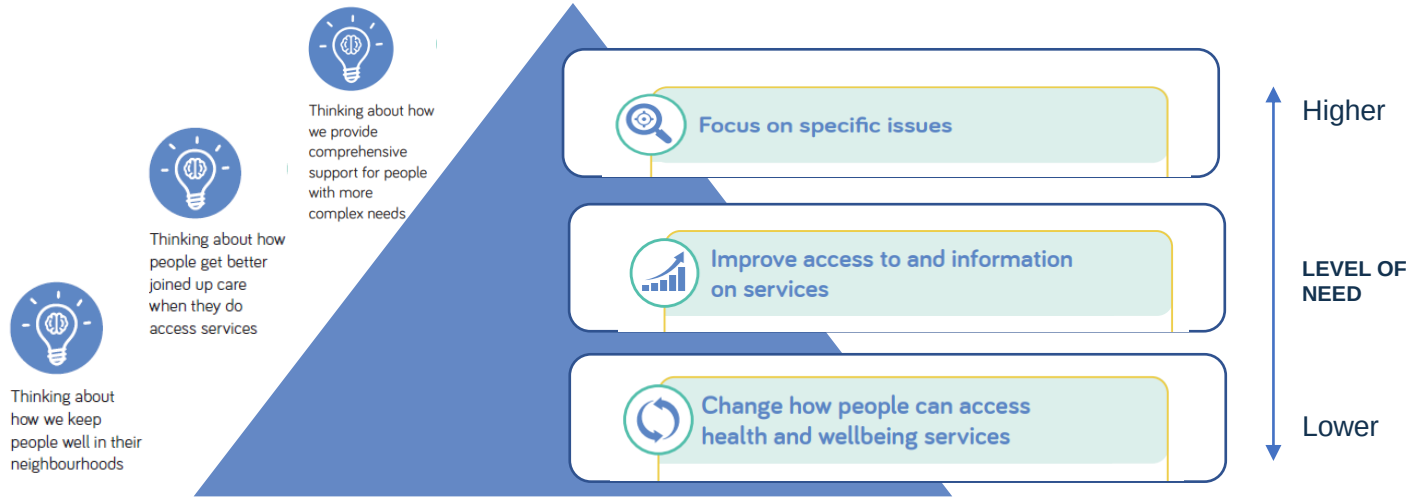
Addressing health inequalities in Merton

Merton South West London Integrated Care System

- Key priority in the Merton Local Health and Care Plan

- Across the three life course areas our plan has a strong focus on addressing health inequalities through:

  - Strengthening prevention and the role of health promotion
  - Strength based approach, working with our communities to develop and lead as equal partners
  - Intersectional approach; recognising the complexities and interconnections
  - Using population health management to focus targeted activities where necessary whilst also strengthening the universal offer



Start Well - programme of work

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

Live Well - programme of work

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

Age Well - programme of work

Merton Health and Care

What we will do	Description of initiative	What will be the impact?	How will we measure success?
Support older people to access community resources post covid	• Continued development of **Community Hub** provision with a focus on supporting the partners providing services for older adults e.g. Age UK Merton, Wimbledon Guild etc.	- Improved health and wellbeing for Merton residents through enhanced access to community and voluntary sector services - Greater sharing of assets and expertise across the statutory and voluntary sector	- Increased numbers of people accessing services - Increased range of services - Improved health outcomes and feedback from service users and carers
	• Implementing South West Merton PCN "**Tackling Neighbourhood Health Inequalities" project working with Wimbledon Guild**	- Improvements in quality of life and experience for Merton residents - Reducing health inequalities	- Improved health outcomes and feedback from service users and carers
Improve access to and information on integrated services	• Expansion of the **Integrated Locality team** model into lower risk cohorts	- More people able to live independently and for as long as possible, including people with dementia and other mental health conditions - More people providing unpaid care can balance their caring role with a life outside caring	- Improved health outcomes and feedback from service users and carers
	• Work with the voluntary and community sector partners to **expand personalized care approaches including social prescribing**	- Reduction in the impact of social isolation and loneliness through greater community involvement in health and wellbeing issues	- Improved health outcomes and feedback from service users and carers
	• Integrated approach to **improving rapid discharge and admission avoidance initiatives** such as 'D2A' or Virtual ward	- Improved wellbeing and outcomes for Merton residents, as more people remain or return quicker to independence in the community. - Improved access into intermediate care /reablement services, and better coordination of services - Increased resource and activity provided closer to home, reduction of unnecessary admissions in hospital and shorter length of stay	- Reducing unnecessary admissions to secondary care or premature entry to institutional care
Be focused on frailty	• Implementing the core components of the local authority led **frailty service model development (2 PCNs East Merton and Morden):** • Physical activity programme - this will include training community groups in strength and balance activity and a "train the trainer" approach working with community groups	- People, including those with disabilities or long term conditions, or who are frail, can live, independently as possible and at home in the community, as far as that is possible. - Reduce health inequalities, social isolation felt by older people living in the community.	- Improved health outcomes and feedback from service users and carers

Merton Health and Care Together

Primary Care Update – Merton Health and Wellbeing Board

- September 2022

Overview

- The Future of Primary Care – The Fuller Stocktake Report
- Primary Care Enhanced Access
- Colliers Wood Surgery Update
- The Rowans Surgery Update

The Future of Primary Care

The Fuller Stocktake report is the output of a national review of Primary Care which sets out a new vision for integrating primary care, improving the access, experience and outcomes for our communities. The vision centres around three essential offers:

1. **Streamlining access to care** and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
2. **Providing more proactive, personalised care** with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
3. **Helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

The report sets out 15 actions which are required in order to deliver the vision set out. These actions are shared across ICBs, shared between ICSs, NHS England, Health Education England and the Department of Health & Social Care.

The Future of Primary Care in the ICS

Merton Health and Care Together

Fuller Stocktake - Actions for the ICB

Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.
Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors.
Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams
Develop a primary care forum or network at system level,
Embed primary care workforce as an integral part of system thinking, planning and delivery.
Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care
Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods.
Work alongside local people and communities in the planning and implementation process of the actions set out above

Good progress has been made in SWL over the past 2 years in delivering;

- Improved access, increasing the number of appointments being delivered in general practice along with an increase in face-to-face appointments.
- Successful implementation of weekend telephony for patients to contact primary care rather than 111 throughout December and January and other bank holidays since the pandemic.
- Recruiting almost 500 new people across 12 new job roles in primary care and integrating them into the work of general practice and PCNs. This has seen a large number of personalised care services developed, for example in supporting access for patients into community and voluntary self-help groups.
- Embracing technology to improve access, for example around online consultations so patients can swiftly access the right care for them by the right person at the right time.
- Every PCN participating or leading multidisciplinary team meetings for care home residents, which will be expanded over the coming months to include patients at risk of an emergency admission.
- Supporting our workforce, both to focus on well-being and resilience but also in developing leaders for the future.

The Future of Primary Care in Merton

- Whilst the progress set out on the previous slide represents a strong start in delivering the actions required, we recognise there is a significant amount of work to still be achieved.
- Through our new Merton Health and Care Committee, the Merton Primary Care Board and in collaboration with Partners and colleagues in the SWL Team, we will be developing a local delivery plan for the actions identified in the Fuller Report.
- We already have a number of key building blocks in place in the form of our six strong primary care networks, our GP Federation with its track record of delivery, our integrated locality team model and our clinical leadership, all of which are crucial to delivering the necessary changes.

Merton Primary Care

- 22 GP practices
- 232,245 registered patients (as of 1st August 2022)
- 6 Primary Care Networks (PCNs) – All practices are part of a PCN
- One GP Federation – Merton Health Ltd.

- 128 FTE GPs, 35 FTE Practice Nurses (as of Jun-22)
- Additional Roles Reimbursement Scheme– PCNs able to recruit from 15 additional roles
  - 97 FTE Additional Roles staff employed across Merton PCNs from 9 different staff groups (as of July-22)
  - Each PCN has at least one Social Prescribing Link Worker, and one Mental Health Practitioner
  - Other roles recruited include: Clinical Pharmacists, Care Coordinators, Paramedics, First Contact Practitioners, Health and Wellbeing Coaches
  - PCNs decide on which roles to recruit based on needs of their population

Primary Care Enhanced Access

From 1st October 2022 there are changes to the way enhanced access is provided to patients

Current Provision (up to 30th September 2022):

- GP core hours (National specification – all 22 Merton practices deliver)
  - 8am – 6:30pm, Monday – Friday
  - Out of Hours Services provides cover outside these hours
- Improving Access to Primary Care (IAPC) (Local specification – all 22 Merton practices deliver)
  - GPs providing additional in and out of hours appointments for their own patients

- 8-8 Access (National requirement)
  - 2 Hubs covering 6:30pm-8pm M-F; 8am-8pm Sat/Sun/Bank holidays. Provided by Merton Health Ltd.
  - Open to all Merton registered patients. Located at The Nelson Health Centre and Wide Way Medical Centre

- Same Day Access (Local specification)
  - 4 additional hubs offering 55 hours of appointments a week Mon-Fri. Open to all Merton registered patients. Provided by Merton Health Ltd
  - Located at Mitcham Medical, Morden Hall, Wimbledon Medical, Lambton Road

- Primary Care Networks (PCN) Extended Access (National Specification – all 6 PCNs deliver)
  - 30mins per 1,000 registered patients per week outside of 8am-6:30pm Monday to Friday. Open to patients within the PCN. Provided by all 6 PCNs

- **Patients can access primary care 8am – 8pm 7 days a week**

Access up to 30th September 2022

Merton Health and Care Together

Service	Delivery / Site	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
GP Practices Core Hours	**All 22 practices deliver**	8am-6:30pm	8am-6:30pm	8am-6:30pm	8am-6:30pm	8am-6:30pm		
GP Out of Hours	**Accessible to all patients**	6:30pm-8am	6:30pm-8am	6:30pm-8am	6:30pm-8am	6:30pm-8am	24 hours	24 hours
IAPC	**All 22 practices deliver**	In and out of core hours – varies by practice						
PCN Extended Access	**All 6 PCNs deliver**	Outside Core Hours – varies by PCN						
Hub Services open to all Merton patients • **8-8 Access** • **Same Day Access**	**Wide Way Medical Centre** (East Merton PCN)	10:30am-8pm	10:30am-8pm	10:30am-8pm	10:30am-8pm	10am-8pm	8am-8pm	8am-8pm
	The Nelson Health Centre (South West Merton PCN**)**	4pm-8pm	5pm-8pm	4pm-8pm	5pm-8pm	4pm-8pm	8am-8pm	
	Merton Medical Practice (North PCN)	10am-1pm; 4pm-8pm	3pm-7pm	2pm-7pm	10am-1pm			
	Morden Hall Medical (Morden PCN)	4pm-8pm	4pm-8pm		4pm-8pm			
	Wimbledon Medical (North West PCN)	4pm-8pm			4pm-8pm		9am-1pm	
	Lambton Road Practice (West Merton PCN)		5pm-8pm				9am-1pm	

Patients can access Primary Care 8am – 8pm 7 days a week

Primary Care Enhanced Access

Services from 1st October 2022:

- GP Core Hours 8am-6:30pm (remains the same – all practices delivering)
- Improving access to primary care (IAPC) (remains the same – all practices delivering)

- Same Day Access (Local Specification)
  - Service to be reviewed to ensure coverage of 5pm-8pm Saturdays and 8am-8pm Sundays and Bank Holidays. Open to all Merton registered patients. Provided by Merton Health Ltd. from The Nelson Health Centre and Wide Way Medical Centre

- PCN Enhanced Access (National specification – all PCNs will deliver)
  - Funded by combining 8-8 access and PCN Extended hours
  - Minimum 60mins per 1,000 weighted patients per week (Merton plans exceed minutes currently offered)
  - Covering as a minimum 6:30pm-8pm Monday to Friday; 9am-5pm Saturday. Some provision outside these hours allowed
  - Delivered at PCN level and must be available to all patients in the PCN
  - Use of the multidisciplinary team. Staff as appropriate to needs of population – may include GPs, nurses, HCAs, pharmacists
  - All 6 Merton PCNs have had their plans approved to deliver this services

- **Patients can access primary care 8am – 8pm 7 days a week**
- **As a minimum the same number of minutes of additional access will continue to be provided**
- **Same minimum hours covered in each PCN**

Access from 1st October 2022

Merton Health and Care Together

Service	Delivery / Site	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
GP Practices Core Hours	**Practice Level**	8am-6:30pm	8am-6:30pm	8am-6:30pm	8am-6:30pm	8am-6:30pm		
GP Out of Hours	**Accessible to all patients**	6:30pm-8am	6:30pm-8am	6:30pm-8am	6:30pm-8am	6:30pm-8am	24 hours	24 hours
IAPC	**Practice Level**	In and out of core hours – varies by practice						
Hub Services • **Open to all Merton patients**	**Wide Way Medical Centre**						8am-8pm	8am-8pm
	The Nelson Health Centre						8am-8pm	
PCN Enhanced Access • **Sites within each PCN for their own patients** • **Hours are minimum coverage PCN must provide**	**East Merton PCN**	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	9am-5pm	
	Morden PCN	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	9am-5pm	
	North Merton PCN	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	9am-5pm	
	North West Merton PCN	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	9am-5pm	
	South West Merton PCN	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	9am-5pm	
	West Merton PCN	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	6:30-pm-8pm	9am-5pm	

Patients can access Primary Care 8am – 8pm 7 days a week

Colliers Wood Surgery

- Plans for the co-location of Colliers Wood Surgery main (CW High Street) and branch site (Lavender Fields) to a new single, fit for purpose, modern building equidistant between the two, are on track to be delivered in 2024.
- Additional revenue funding was approved by the ICB in July 2022 as the costs of the build increased beyond original estimates.
- MertonVision, a local charity for blind/visually impaired will occupy the ground floor of new building with the GP practice based on the first and second floors.
- A representative of the Colliers Wood Residents Association has been attending the steering group, along with local ward councillor Laxmi Attawar.

Colliers Wood Surgery Branch Site

- The Colliers Wood branch site, Lavender Fields has been sold by the owners for development. The sale will complete at the end of September 2022.
- Due to infection control compliance issues, the Colliers Wood Surgery Partnership have not operated any services from Lavender Fields since before the Covid-19 pandemic.
- As a result, all patients of the Colliers Wood Surgery have been accessing face to face services from the main site for over 2 years.
- There has been a long-standing plan for the branch site to close, once the new Colliers Wood Surgery building is ready, however, the sale of the building has brought this forward.
- The ICB will write to all patients of Colliers Wood Surgery to inform them of the sale and formal closure of the branch site.
- An Equality Impact Assessment has been completed and a number of actions identified to help minimize risks to vulnerable patient groups, these include sharing information on local transport routes and dial-a-ride.

The Rowans Surgery - Overview

NHS South West London

- The current GP Partners and Managing Partner who run the Rowans Surgery hold a contract with NHS South West London which is due to end on 31 October 2022. This means that important decisions need to be made very soon about how GP services are provided.
- Discussions have been ongoing for a number of years about the challenges facing the Rowans – particularly related to the premises and staffing. If services continue to be provided from the Rowans Surgery, we are concerned that these issues will impact on patient safety and the quality of care delivered.
- After considering all the options, NHS South West London is proposing to close the practice and ask that patients register with another practice of their choosing. All patients would be fully supported in making this move.
- We are currently engaging with Patients and the Public regarding this proposal.
- A final decision is needed by the end of September in order to ensure this dispersal process can be managed effectively.

What are the challenges?

NHS South West London

- The only GP at the practice gave notice of his resignation in July and the GP partners do not wish to renew their contract.
- GP partners have told us the building isn't safe and they're unable to recruit clinical staff – which makes the practice unsustainable in the long term.
- The issues at the Rowans Surgery are not new – NHS South West London has put extra funding into the Rowans over many years to address longstanding issues, but the building is just not fit for purpose.
- The Rowans Surgery has been managed by four different GP providers over the last five years. Even with extra funding, they have not been able to solve problems with the building and staff. Most recently, patients have needed to be seen at other practices in the area because of the inability to recruit.
- We are committed to developing a new health facility as part of the Rowan Park development, which will offer GP and community services, estimated to be deliverable in about 2-3 years.

What options have we considered?

NHS South West London

- Extend the contract – *This is not an option*. The current Partners (East Merton Primary Care Network) have agreed an extension of one month to 31st October 2022 however they will not extend beyond this date. They can not continue to deliver the contract without impacting service delivery at their own practices.
- Procure a new provider – *This is not an option*. The list size is less than 5000 patients and therefore the contract will not be attractive to bidders. Any new provider will be subject to the same premises and recruitment issues as the preceding four sets of Partners.
- Disperse the list – *recommended option*. The practice will close and patients will be supported to re-register at a local practice of their choosing, where they will receive a better quality and more consistent service offer.

Is there capacity at local practices?

NHS South West London

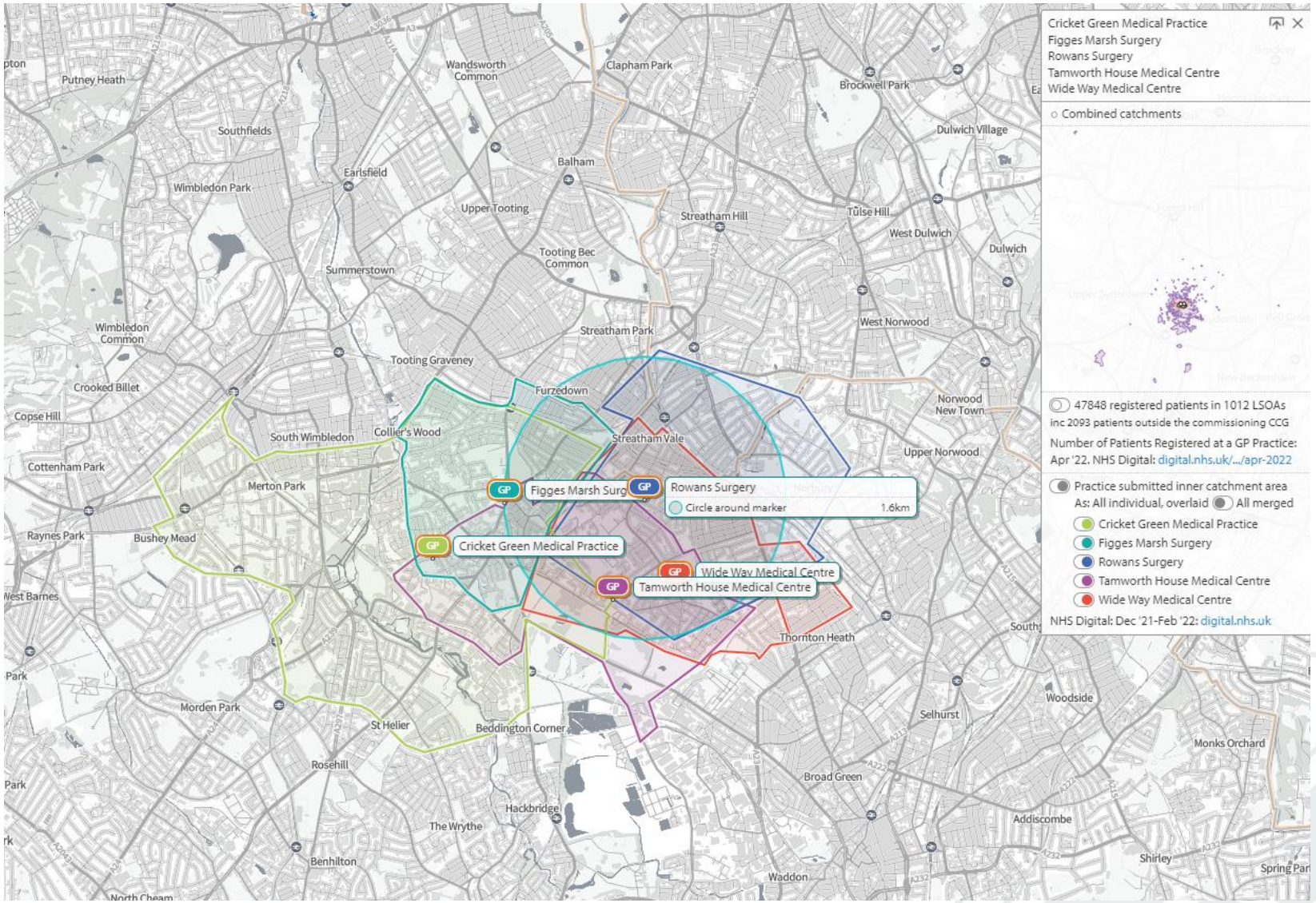
- If the decision is made to disperse the practice list, patients will be asked to choose a local surgery and register there for future treatment.
- We have assessed the capacity of local practices using local workforce data and have spoken directly with Partners at these practices to understand their views.
- In Merton, there is an average of 1 Full Time Equivalent GP to 1783 patients. In East Merton, there is a better ratio, with 1 FTE to 1352 patients*. The national average is 1 FTE GP to 2222 patients.
- The closest surgeries in East Merton have said they're willing and able to take on extra patients. They can offer better care with more doctors available for appointments. These practices are Wideway Medical Centre (0.8 miles from the Rowans); Tamworth House Medical Centre (1.0 mile) and Figges Marsh Surgery (1.3 miles).

(* based on local workforce data which reflects a fixed point in the year and therefore is prone to some fluctuation)

Is there capacity at local practices?

South West London

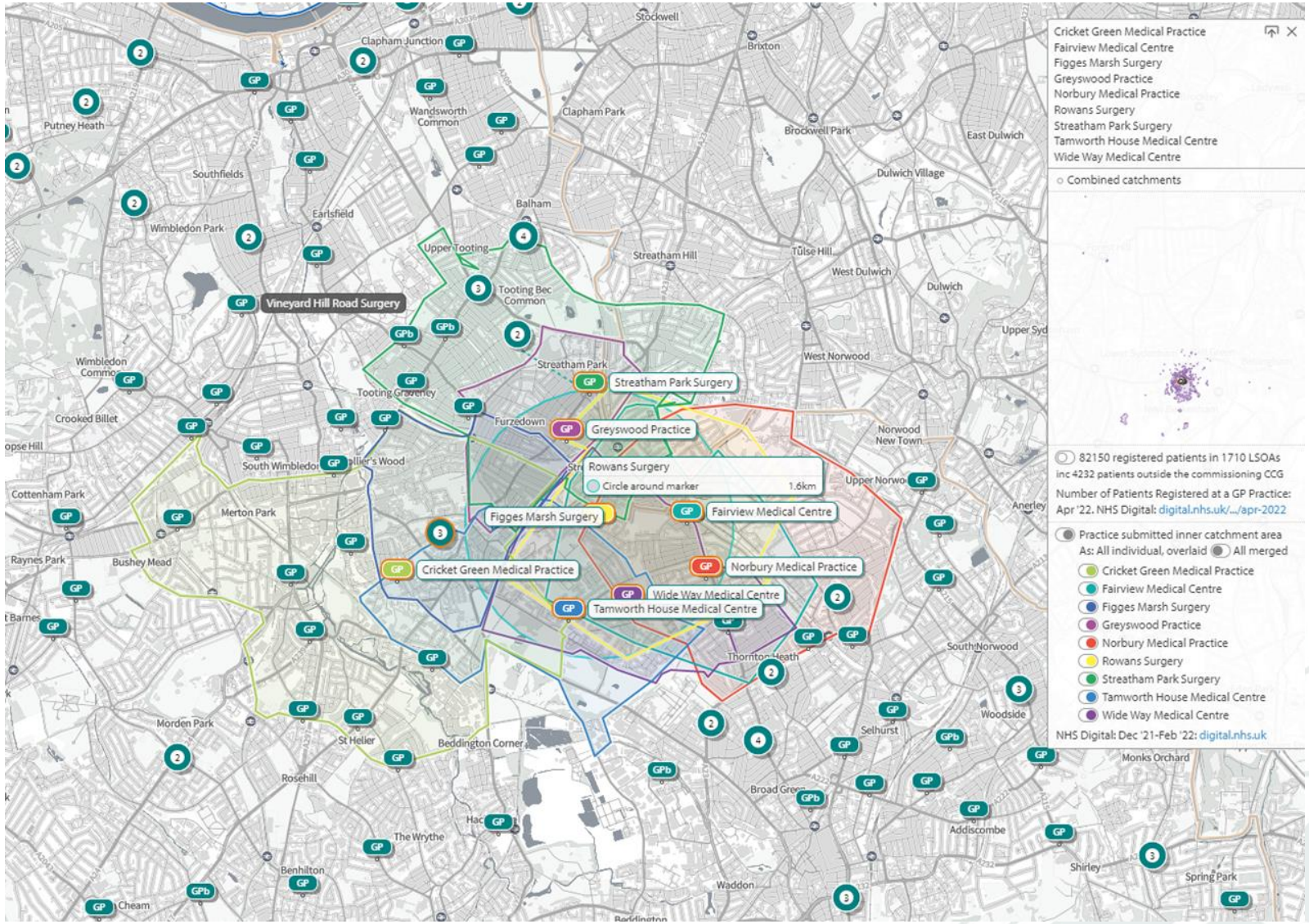
- We have mapped the patients registered with the Rowans Surgery and confirmed that they are included within the catchment area of the local practices referenced on the previous slide
- Map shows East Merton PCN combined catchment areas, in relation to 1 mile radius from Rowans Surgery



Is there capacity at local practices?

South West London

- Map shows East Merton PCN and inner catchment area of practices within 1.5 mile radius of Rowans Surgery



How will patients be supported?

NHS South West London

- If the decision is made to disperse the practice list, patients will receive a letter informing them of the closure and providing information on how to re-register. This will include contact details of local practices.
- Patients will need to complete a Patient Registration form to make the transfer. This can be done online as well as in person.
- We have completed an Equality Impact Assessment to help us understand which people will be most affected by the change, and we have identified a series of actions to help mitigate the impact for these groups. These include:
  - Support offered to help people with the re-registration process. This would involve staff working at the closest practices reaching out to offer support to people who have been identified as vulnerable.
  - Partners at the Rowans practice have committed to mobilising a team of care co-ordinators to assist patients where needed, this could be with filling forms or identifying their most local practice. Patients will be able to contact this team via the usual Rowans contact lines.
  - Information and advice around routes to alternative primary care settings and services such a dial a ride will be collated and shared with patients.

What are the longer term plans?

NHS South West London

- We are committed to developing a new health facility as part of the Rowan Park development, which will offer dedicated GP-led and community services and is estimated to be 2-3 years away.
- We will work with the site developers and our partners to expedite this in any way possible.
- The New Rowans will provide vital additional primary care estates capacity for the people of East Merton.
- The Primary Care space has been designed for clinical and non-clinical activity.
- In the coming months we would like to work with local stakeholders and residents to design the service model for the building and ensure our vision for the building meets the needs of the local population.

Next steps

South West London

- We have been talking to patients and the public about this proposal in the last few weeks.
- We will be considering feedback and any other options put forward, including what additional support might need to be put in place for vulnerable residents.
- A final decision will be made by the South West London Primary Care Contracting Group at the end of September.
- Patients registered at the practice have received a letter about the proposed changes and will receive a further letter once the final decision has been made.
- If the patient list is dispersed, we would share information about how patients can register at other local practices and vulnerable patients would be supported.
- In the meantime, patients will continue to be seen at local practices, who are working together to make sure people receive high quality care.

Merton Better Care Fund Plan for 22/23

By Annette Bunka and Keith Burns

to be presented at:

- SWLICB -Merton and Wandsworth Officers Meeting- 05/09/22
- LBM Corporate Management Team -06/09/22
- Merton Health and Care Together Committee – 14/09/22
- Merton Health and Well Being Board – 20/09/22

BCF – A Brief history

- Introduced in 2015, the programme is one of the government's national vehicles for driving health and social care integration. It established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:

- minimum allocation from NHS
- disabled facilities grant – local authority grant
- social care funding (improved BCF) – local authority grant

- Owned by the Health and Wellbeing Board (HWB), these are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

BCF – resource and infrastructure (1)

Funding

Table 1: minimum contributions to the BCF in 2022/23 in Merton

BCF funding contributions	2022/23 (£)
Minimum NHS contribution	15,057,573
Improved Better Care Fund (iBCF)	5,009,679
Disabled Facilities Grant (DFG)	1,452,224
Total	21,519,476

BCF – National Objectives and Conditions

The **national objectives for the BCF** have been updated in 2022-23 and are to:

- i. Enable people to stay well, safe and independent at home for longer.
- ii. Provide the right care in the right place at the right time.

National conditions (that all plans must meet)

- A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
- Invest in NHS commissioned out-of-hospital services.
- Implementing the BCF policy objectives, including supporting safe and timely discharge, ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

BCF metrics for 2022/23

Metrics

Beyond the national objectives and conditions, areas have flexibility in how the fund is spent over health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the following BCF 2022/23 metrics:

Metric	Proposed Ambition
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)	A modest reduction based on trends and impact of virtual wards
Improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence)	Maintaining position as Merton already above national and London average
Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes).	A modest reduction compared to 21/22 (but greater than 20/21)
Proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)	To meet an 82.4% target

BCF – local plans and priorities

The key priorities for integration within 2022/23 BCF Plan mirror the Merton Health and Care Together Programme and build on previous BCF Plans:

- Continued development of proactive, multi-agency working across health and social care to support the vulnerable in their own homes – **Integrated Locality Teams**, closer working with voluntary sector to build capacity and provide support for unpaid carers
- Improved flow from hospital to the community and **integrated intermediate care** (building on home first, virtual wards, recruitment drives in reablement and to support social care maintenance.)
- **Rapid response service**s (for those in a care home and in their own home)
- **Enhanced support to care homes** through the multi-agency care homes steering group
- Work to **reduce inequalities** (including Community Response Hub, Living Well Services run by Age UK)
- **Disabled Facilities Grant** to support these initiatives

Appendices

- BCF Narrative Plan
- BCF Planning Template
- BCF Intermediate Care Demand and Capacity Template
- How the BCF helps tackle health inequalities