Merton Council
Health and Wellbeing Board

Date: **26 June 2018**

Time: **6.15 pm**

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

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

This is a public meeting – members of the public are very welcome to attend.

Requests to speak will be considered by the Chair. If you would like to speak, please contact democratic.services@merton.gov.uk by midday on the day before the meeting.

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

Press enquiries: press@merton.gov.uk or telephone 020 8545 3483 or 4093.

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

Health and Wellbeing Board Membership

Merton Councillors

- Tobin Byers (Chair)
- Kelly Braund
- Janice Howard

Council Officers (non-voting)

- Director of Community and Housing
- Director of Children, Schools and Families
- Director of Environment and Regeneration
- Director of Public Health

Statutory representatives

- Four representatives of Merton Clinical Commissioning Group
- Chair of Healthwatch

Non statutory representatives

- One representative of Merton Voluntary Services Council
- One representative of the Community Engagement Network

Quorum

Any 3 of the whole number.

Voting

3 (1 vote per councillor)
4 Merton Clinical Commissioning Group (1 vote per CCG member)
1 vote Chair of Healthwatch
1 vote Merton Voluntary Services Council
1 vote Community Engagement Network

All minutes are draft until agreed at the next meeting of the committee/panel. To find out the date of the next meeting please check the calendar of events at your local library or online at www.merton.gov.uk/committee.

HEALTH AND WELLBEING BOARD
27 MARCH 2018

(3.00 pm - 4.25 pm)

PRESENT   Councillor Tobin Byers - Chair
                   Dr Andrew Murray Vice Chair and Chair of Merton CCG
                   Councillor Gilli Lewis-Lavender,
                   Councillor Katy Neep, Cabinet Member for Children's Services
                   Hannah Doody - Director of Community and Housing
                   Chris Lee - Director of Environment and Regeneration
                   Gordon Murray - Children, Schools and Families
                   Dr Dagmar Zeuner - Director of Public Health
                   Dr Doug Hing – Merton CCG
                   James Blythe - Chief Executive of Merton and Wandsworth CCG
                   Lyla Adwan-Kamara -Community Engagement Network
                   Brian Dillon – Merton Healthwatch
                   and Dave Curtis - Merton Healthwatch

1   APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies were received from Dr Karen Worthington, Khadiru Mahdi and Yvette Stanley.

Gordon Murray, Service Manger Permanency Placements & LAC Services, attended in place of Yvette

2   DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of interest.

3   MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The Chair commented that Merton had the best perfoming discharge rates in London in January 2018 and congratulated Hannah Doody and James Blythe on this result.

He continued by thanking all members of the HWBB for their work during the current administration

RESOLVED: That the minutes of the meeting held on 28 November 2018 were agreed as an accurate record.

4   MERTON STORY/ JSNA (Agenda Item 4)

The Director of Public Health presented the report on the refreshed Merton Story 2018 which provides a snapshot of local needs identified through the Joint Strategic Needs Assessment (JSNA). Producing the JSNA is a statutory duty of the Health and Wellbeing Board. At the request of HWBB members more demographic data and

trends are included this year. The Merton Story describes Merton is a good, healthy and safe place to live, but acknowledges that there are areas for concern and these are covered by the main headings of; Inequalities and the Health divide, Healthy lifestyles and emotional wellbeing, Child and Family vulnerability and resilience, Increasing complex need in an ageing population and lastly a new category of Hidden Harm and emerging issues.

Gordon Murray asked the Board to note that the figure on page 19 for Merton Resident Children with an EHCP had increased was now 1543.

The Director of Public Health confirmed that the information regarding Alcohol Harm related specifically to residents of the Borough. She also explained that it will be helpful to have partners input into the Hidden Harm and Emerging issues section. A member asked about the data that shows that disabled residents report lower levels of happiness than non-disabled. The Director of Public Health replied that she would look further at this point.

The Board discussed the proposed infographics and asked for 'Think Family' to be included, The Director of Public Health said she would circulate some ideas for the infographics.

Members asked for consideration to be given to addressing risk factors in specific groups, for example people with disabilities, to ensure that these groups have access to all the necessary care. Members also asked if Dental Health details could be included in future.

The HWBB agreed that they were happy with the categories covered by the Merton Story 2018.

RESOLVED

The Health and Wellbeing Board:

   A. Considered and commented on the refreshed *Merton Story (2018) – health and wellbeing in Merton*, part of the Joint Strategic Needs Assessment.
   B. Agreed to actively use the Merton Story as a tool to disseminate the key messages relating to the health and wellbeing of our local population, to inform strategic commissioning decisions.

5   HWB STRATEGY REFRESH, INDICATORS AND HIAP UPDATE (Agenda Item 5)

The Director of Public Health presented the report on Health in all Policies (HiAP), Health and Wellbeing(HWB) Strategy update and HWB Strategy Refresh.

Board Members welcomed the work that has been done as part of the Health in all Policies action plan and mentioned specifically the successful Prevention Matters workshop, the planned roll out to the social prescribing pilot, the development of the

Social Value commissioning toolkit and the work to promote Healthy Workplaces. The Board noted that Healthy Workplaces included Council Staff and that Smoking was discouraged. The Board also noted the Air Quality Action Plan included in Health in All Policies has been noted as good practice.

The Director of Public Health continued outlining the reporting on the HWB Strategy Indicators; some existing indicators are not for the best ways of measuring progress. Some are red and are longer term, for example the indicator on childhood immunisation. She was asked if there could be a new indicators based on points raised by residents survey that disabled people feel less safe in their communities. The Director of Public Heath said that new indicators will be developed and that that she was open to ideas.

Board Members noted that the CAMHS (Children and Adolescent Mental Health Services) waiting time indicator is another consideration, as the issue is not just about speed of access but also about how we support children with mental health issues and some of the data on this is not good quality. The single point of access is an improvement but needs ongoing consideration

The Director of Public Health concluded by talking about the refresh of the HWB Strategy from 2019 and how this will to link closely like to the Local Health and Care Plan, building on the Joint Needs Strategic Assessment (JSNA). The Local Health and Care plan will itself link to the SW London Health and Care plan. It was agreed that the October meeting of the HWBB will include a development session to discuss and potentially include consideration of the HWB Strategy but accepted that the timescales for the Local Health and Care Plan will require some elements to be completed before October 2018.

RESOLVED

The Health and Wellbeing Board Agreed:

A. To note and have oversight of the progress in delivering Health in All Policies across the Council and partners.
B. To consider the update on the outcome indicators measuring progress on the Health and Wellbeing Strategy (HWBS) 2015-18, which is coming to an end.
C. To agree to the proposed process for refresh of the HWBS, consider the relationship with the Local Health and Care Plan and proposed inclusion of the Health in All Policies action plan as a part of the new HWBS; achieving a single action plan for implementation

6   NEUROLOGICAL CONDITIONS UPDATE (Agenda Item 6)

James Blythe gave the board a verbal update on the ongoing Neurological Conditions work. He had considered the views of the representative with the Motor Neurone Disease who attended the November 2017 HWBB meeting, and received more detailed feedback especially regarding rehabilitation service gaps and counselling. This feedback has been balanced against the needs of a wide range of

neurological conditions and a proposal to fill the service gaps will be available in April 2018. It will be important to keep the engagement ongoing. A full report will come to HWBB later in the year

7   LOCAL PLAN UPDATE (Agenda Item 7)

The Director of Environment and Regeneration gave the Board a verbal update on the Local Plan, with an emphasis on the health related issues.
The Plan would support house building, and this raised three important questions for Health Infrastructure in the Borough:

1. Health sites currently owned by NHS, is there a need for investment?

2. Are there places in Merton that lack decent primary care premises – do we need to identify sites?

3. How do we find sites for new homes? What health infrastructure is needed to support the proposed housing growth and how will this be funded?

James Blythe asked if Chris has the necessary links into the CCG and suggested Lucy Lewis and Andy McMylor as the best contacts.

There was a discussion about levels of occupancy and affordability of new homes. The Director explained that the plan would make reasonable assumptions about the types of accommodation required. The Plan cannot control the market but it can require developers to provide affordable housing, but this is subject to viability. Also the definition of affordable has been stretched up to 80% of market rent. The Council is considering making public the Viability Assessments of Developers. The Council has set up the Local Authority Housing Company in order to build houses, initially 77 units on 4 sites, and will seek to deliver 40% affordable housing.

The next iteration of the Local Plan will be in October 2018 with the Examination in Public likely summer 2019.

8   ADULT SAFEGUARDING BOARD ANNUAL REPORT (Agenda Item 8)

The Director Of Community and Housing presented the Adult Safeguarding Board Annual Report, and asked HWBB to note the duties of the Adult Safeguarding Board in line with the care Act 2014. She highlighted the achievements of the Board over the last 6 month; the appointment of an Independent Chair, commitment from partners, gaining additional resources from CCG appointment of permanent Board Manager and working more closely with the Safeguarding Children's' Board including the recent successful conference.

The Director of Community and housing gave a 'health warning' regarding some of the data received from partners for the annual report and reported that work is being done to address this through including creation of a data sub group. The Board is also reviewing its current membership.
HWBB members noted that Advocacy services are reported on through the Mental Health trusts. They also noted that Children's Services are represented on the Board

by Paul Bailey and that the Board has linked with Community Safety to look at modern slavery and trafficking.

The Director of Communities and Housing continued by saying that the Board's next annual report would be looking at key themes across Merton. She would be happy to join with the Children's Safeguarding board in considering Trauma/PTSD. The HWBB noted that there would be an event to increase understanding of Adult Safeguarding in October 2018.

RESOLVED

The HWBB noted the Merton Adult Safeguarding Board Annual Report

9   PHARMACEUTICAL NEEDS ASSESSMENT (Agenda Item 9)

The Director of Public Health presented the Pharmaceutical Needs Assessment (PNA) report and explained that the Health and Wellbeing Board has a statutory duty to publish the PNA by 1 April 2018. The Board noted that Merton Public Health has worked collaboratively with neighbouring boroughs on the refresh of the PNA. The PNA is a useful tool for NHS England to regulate market entry for new pharmacies. Following the PNA consultation, extended opening hours have been introduced by some pharmacies, increasing the service offer. The conclusion on the current provision is that no gaps were identified, but this can be updated by a supplementary assessment once new housing developments are built and it is a requirement that the PNA is renewed every three years.

RESOLVED

That Health and Wellbeing Board members:

   A. note the collaborative work that has produced a Merton Pharmaceutical Needs Assessment (PNA) that is compliant with the regulations and best practice.

   B. note that the process of undertaking the PNA has led to extended opening times and therefore improvements in accessing community pharmacies in the east locality in evenings during the week and on Saturday afternoons.

   C. agree to adopt the PNA, attached in final draft form as an appendix to this report, in advance of the statutory deadline of 1st April 2018.

10   DATES OF FUTURE MEETINGS (Agenda Item)

Please note that Future Meetings will be held in Merton Civic Centre (unless otherwise advertised) at the new time of 18.15 – 20.15.

The Dates Are:
Tuesday 26 June 2018
Wednesday 3 October 2018
Tuesday 27 November 2018
Tuesday 29 January 2019
Tuesday 26 March 2019

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Committee: Health and Wellbeing Board

Date: 26 June 2018

Wards: ALL

Subject: Tackling Diabetes.

Lead officer: Dr Dagmar Zeuner, Director of Public Health & Dr Andrew Murray, Chair MCCG.

Lead member: Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health.

Contact officer: Barry Causer, Public Health Head of Strategic Commissioning & Josh Potter, Director of Commissioning, MCCG.

Recommendations:

The Health and Wellbeing Board is asked to:

A. Discuss and endorse the findings of the Diabetes Truth programme.

B. Consider the proposed approach to tackling diabetes, including the continued engagement of communities and the development of a Diabetes Strategic Framework.

C. Consider and agree (in principle) to support the launch of the Merton Mile, as part of the promotion of healthy living and as a celebration of community assets in Merton.

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1   PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1.   The purpose of this report is to share the findings of the Diabetes Truth programme, for endorsement by the HWB, and to propose an iterative approach to tackling diabetes that continues to engage with clinicians, the community and local residents who are at risk of, living with or caring for someone with diabetes.

2   BACKGROUND

2.1.   Diabetes is an area where the traditional 'medical model' centred on specialist and hospital based care has been unable to curb the rise in diabetes cases, serious complications and spiralling costs, and despite evidence-based guidelines there remains considerable variation in hospital, primary and community services, and patient outcomes.

2.2.   It is clear that just knowing the causes and risks of diabetes is not enough to change behaviour; healthy choices need to be easier choices through the right cues and support in the environment, workplaces and in our day to day lives.

2.3.   In recognition of this, the Health and Wellbeing Board, in June 2017, agreed to adopt a whole system approach to tackling diabetes across the life course. Rather than a focusing on diabetes as a specific disease, the aim of the approach is to use it as an exemplar for a whole system preventative approach because it lends itself to clinical, non-clinical and prevention approaches.

3   DETAILS

3.1. <u>Findings of the Diabetes Truth Programme.</u>

3.2. The Diabetes Truth Programme took place between January and March 2018. It connected the HWB members with Expert Witnesses who have a lived experience of diabetes; bringing to life the challenges that residents face on a day to day basis and identify areas that the HWB can focus on.

3.3. The findings of the programme were very rich and cover three areas: specific lessons about improving diabetes prevention and care; generalizable lessons about other long-term conditions; and lessons for the board about ways of working with the community we serve.

3.4. The report (see appendix 1) sets out the Expert Witnesses' stories and details the key findings. Some of the key messages are summarised below

   a) Type 1 diabetes is different to Type 2 – when focussing on 'diabetes' we need to be aware of, and do justice to, both types; making sure we connect the communities of each and to share learning as there is a lot of expertise and self-help available.

   b) Type 1 and Type 2 Diabetes are not just physical illnesses – they require an explicit focus on emotional and mental health resilience and support.

   c) We need to communicate and educate better about food. This is both culturally and socially important. Food's purpose is fuel but it is also a pleasure and there are confusing messages and uncertainty about what is good and bad, healthy and unhealthy.

   d) Our food choices are influenced by factors in our environment such as advertising and availability of fast food, and there are also issues around understanding e.g. portion size and food labels.

   e) There is plenty of information out there about diabetes but people do not always engage with it. People feel the plethora of advice can be confusing. We need to make better connection between those who produce the information, those that distribute it and those who need to use it.

   f) Physical activity is good for us in many ways and brings people together, but it can be difficult to make the time. We need to promote our assets such as parks and open spaces and find ways to build activity into our everyday lives.

   g) Peer to peer activity and community support has a huge role to play; we need to learn from those who have experience. This support can be face to face and/or online.

   h) Pressures relating to lifestyle, working hours, lack of sleep mean that just knowing the causes and risks of diabetes is not enough to change behaviour. Instead healthier choices need to become easier choices through the right cues and support in our environment, workplaces and in our day to day lives.

3.5. The findings of the report, and the learning by the HWB about their leadership role in tackling 'complex' issues, will inform a number of key work streams and priorities of the HWB. These include the refresh of the Health and Wellbeing Strategy and The Local Health and Care Plan and three specific

priorities of the HWB; the next phase of the Wilson, the on-going work to tackle childhood obesity and the delivery of social prescribing at scale.

3.6. We have shared the Diabetes Truth Programme report with the Expert Witnesses and some have expressed an interest in continuing the conversation. This should be welcomed and will be actively pursued in the next stage of the approach to tackle diabetes.

3.7. Health and Wellbeing Board members are now asked to discuss and adopt the report, consider how they can amplify the findings of the programme and support the on-going engagement of the community and stakeholders through a series of feedback sessions and mini-conversations (see 3.9.2).

Approach to developing a Strategic Framework to tackle diabetes.

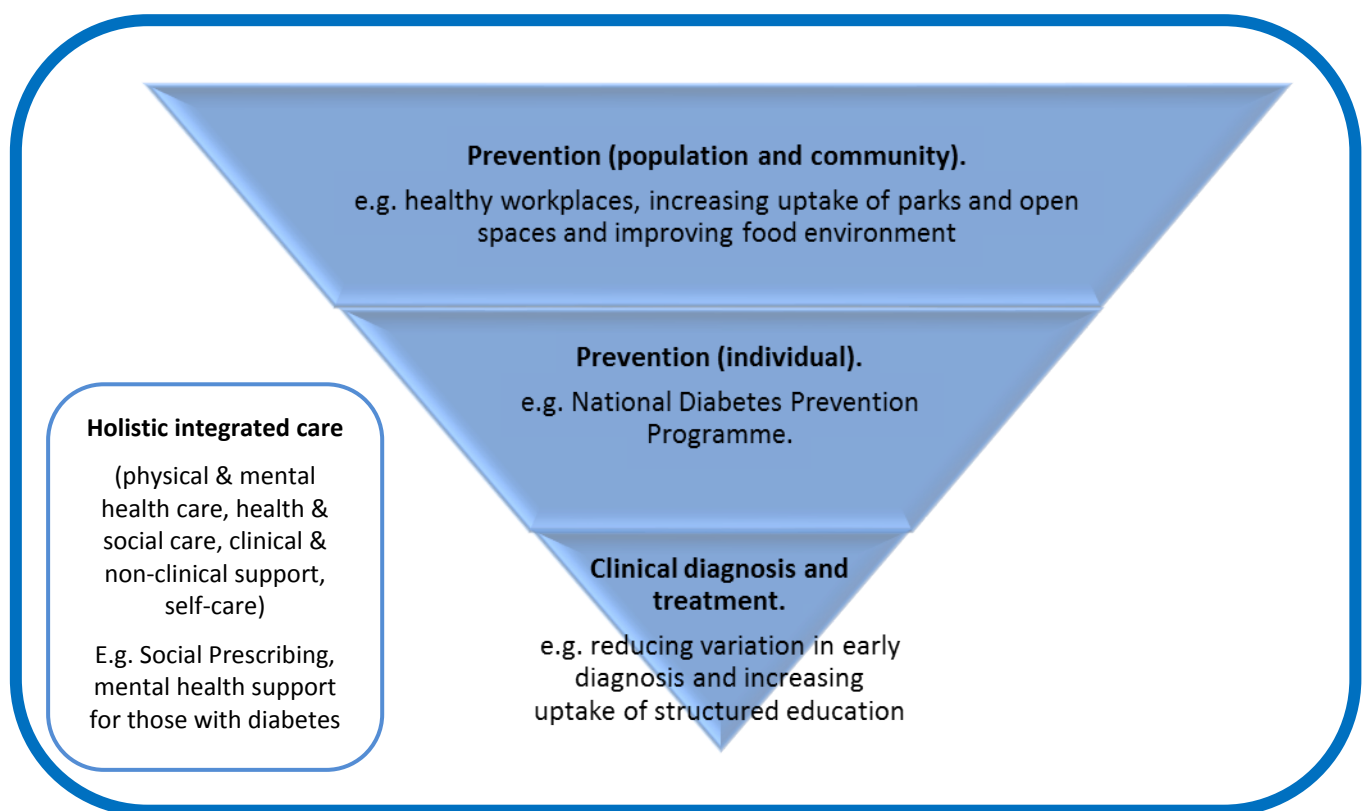3.8. The Strategic Framework will cover four facets of a whole system approach to diabetes as set out below.

Prevention (population and community).
e.g. healthy workplaces, increasing uptake of parks and open spaces and improving food environment

Prevention (individual).
e.g. National Diabetes Prevention Programme.

Holistic integrated care
(physical & mental health care, health & social care, clinical & non-clinical support, self-care)
E.g. Social Prescribing, mental health support for those with diabetes

Clinical diagnosis and treatment.
e.g. reducing variation in early diagnosis and increasing uptake of structured education

Figure 1 – key facets of tackling diabetes.

3.9. It is proposed that the framework will be developed over the next three months, using an iterative process and will be informed by-

3.9.1 The findings of the Diabetes Truth Programme (see 3.1 and appendix one).

3.9.2 A series of feedback sessions and mini-conversations that will seek to amplify and build upon the findings of the Diabetes Truth programme. These conversations, delivered alongside our Diabetes Truth Expert Witnesses, will be widely promoted to residents, communities and key stakeholders and link to the thematic workshops delivered as part of the refresh of the HWBS (Start Well, Live Well and Age Well…in a healthy place).

3.9.3 Our Clinical Leadership, who discussed the Prevention Framework (see appendix 2) at their Clinical Reference Group (CRG) meeting in June 2017 and have initiated six monthly Diabetes Summits.

(i) The discussion at the CRG meeting on the Prevention Framework had a particular focus on the personal prevention offer. The group proposed ways that the diabetes prevention offer could be modernised, be better integrated with local healthy lifestyles services; including the mapping of prevention services and identified ways to increase the uptake of structured diabetes education programmes (DAFNE for Type 1 and Desmond for Type 2).

(ii) The first of the Diabetes Summits, held in March 2018, brought together Merton and Wandsworth Clinical Commissioning Groups (with colleagues in Public Health) to discuss and agree key themes and actions that we can work together on to tackle diabetes. The first summit identified a number of areas for potential joint work e.g. the alignment of IAPT and mental health services with diabetes services but also acknowledged that the boroughs are distinct areas and there will be programmes of work that it makes sense to continue to work separately on. The next summit is planned for September 2018.

3.10. There has also been a proposal for a joint Scrutiny review by the Sustainable Communities and Healthier Communities and Older People Overview and Scrutiny Panels on Diabetes prevention. Although details are still to be confirmed, the focus could be on how the Council's place based services, such as its leisure centres and parks, can be used to support residents to lead healthy lifestyles to either prevent or better manage diabetes.

3.11. We will not create additional governance structures for the development and implementation of the diabetes framework, but will instead use existing arrangements. It is therefore proposed that the day to day management of the Strategic Framework is led by the LDU Diabetes Steering Group, which reports to the CCG's Planned Care Operations Board. Oversight of the framework will be by the Merton Health and Care Together Board and then ultimately the HWB.

Promotion of healthy lifestyles

3.12. We are keen to support HWB members to take part in healthy activity in the community and at the same time promote and increase the use of community assets e.g. parks, open spaces, community libraries and leisure centres.

3.13. As part of this we propose to celebrate the launch of the "Merton Mile", which has been developed as a result of the tackling children's obesity work led by the HWB. This physically marks an accessible route, approximately a mile long, in Figge's Marsh park and will encourage children, families and adults to be more physically active. As well as the sign-posted route, the project will include signage that provides clear advice and tips on how to increase physical activity levels.

3.14. Expected to be completed late August, it is proposed that a launch event will be held, in partnership with the Merton Schools Sports Partnership, to raise the profile of the project and promote its use by the children, families and communities around Figge's Marsh.

3.15. We would welcome support from the HWB on the launch; which will extend invitations to the Expert Witnesses and previous HWBB members who were part of the Diabetes Truth programme.

4   ALTERNATIVE OPTIONS

Not to develop a strategic framework to tackle diabetes.

Not to work with HWB and communities to better understand diabetes.

5   CONSULTATION UNDERTAKEN OR PROPOSED

TBC

6   TIMETABLE

Table 1: Proposed for development of Strategic Framework for WSA to Diabetes

Activity	Date
Discussion of approach at HWB	26 June 2018
Mini Conversations.	July, August & September 2018
Diabetes Summit (meeting two)	September 2018
CCG Commissioning Intentions	End of September 2018
Draft Strategic Framework for Diabetes	October 2018
Implementation of a Whole System Approach	Iterative and ongoing

7   FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None

8   LEGAL AND STATUTORY IMPLICATIONS

None

9   HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Strategic Framework is specifically aimed at tackling health inequalities.

10   CRIME AND DISORDER IMPLICATIONS

None

11   RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

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

12.1. APPENDIX 1: Diabetes Truth Programme report.

12.2. APPENDIX 2: The Prevention Framework.

13   BACKGROUND PAPERS

13.1. HWB paper (28 November 2017) Diabetes Strategic Framework (Whole System Approach)

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Merton Health and Wellbeing Board and
Expert Witnesses listening and learning together about diabetes

January - March 2018

CONTENTS

Foreword

In 2017, members of the Merton Health and Wellbeing Board connected with the many communities in east Merton through a series of community conversations. The purpose of these was to find out how people wanted to develop the Wilson Campus and other health and wellbeing services in the east of the borough, ensuring that the services we provide are co-designed by the people who will be using them.

We were both moved and inspired by what we heard, so much so that when we made tackling diabetes a priority late last year, we decided to start by listening to the voices of Expert Witnesses from right across the borough - people with Type 1 or Type 2 diabetes, people diagnosed as a pre-diabetic, at risk of developing diabetes, and people caring for someone with diabetes. We have called this the 'Diabetes Truth Programme' because, quite simply, we wanted to deepen our understanding about diabetes by hearing people's stories; surfacing some of the root causes; identifying some of the barriers and influencers of change; thinking about the support needed to prevent diabetes; finding out how best to support those living with it; and ultimately identifying ways people can support themselves.

As Health and Wellbeing Board members we came to these conversations as people who genuinely wanted to listen to the experience of people who understand and have experienced diabetes first hand. We know we cannot find solutions on our own, and the content and ideas within this document have been greatly enriched by the experience of all of our Expert Witnesses. This write up of our work together is just the start. We now have to work together to tackle some of the issues that have been raised. We hope to use our shared ideas to build a sustainable approach to diabetes in Merton and beyond.

I would like to thank the Leadership Centre which has provided the funding for this work, and Mari Davis who has guided us through it. I would also like to thank Dr Dagmar Zeuner, the Director of Public Health, and her team, as well as all of the other board members past and present who have contributed to this process. Most of all, I want to thank our Expert Witnesses for their time, energy, ideas, enthusiasm, comments, and for sharing their hopes and fears. I hope that they will recognise some of the content within this document and look forward to working together as we begin to implement the ideas we developed.

Councillor Tobin Byers
Chair of Merton Health and Wellbeing Board

Summary
– Diabetes truth programme

What did we do?

Each Health and Wellbeing Board member paired up with an expert witness, a 'buddy' who was living with, at risk of, or caring for someone with Type 1 or Type 2 diabetes. We had conversations together and then shared what we had found out at a workshop.

Why did we do this?

We chose the complex problem of diabetes as an exemplar; to find out the true day-to-day issues and choices that people living with diabetes face and to see how we as a Health and Wellbeing Board can work with our community to help identify solutions, rather than impose preconceived ideas.

What did we find out?

- Type 1 diabetes is really different to Type 2 and when focussing on 'diabetes' we need to be clear on this.
- Type 1 and Type 2 diabetes are not just physical illnesses; they also require a focus on emotional and mental health resilience and support.
- We need to communicate and educate better about food and recognise that our food choices are often influenced by factors in our environment such as advertising and availability of fast food.
- There is plenty of information out there about diabetes but people do not always engage with it. We need to work on this – making better connections between those who produce the information and those who need to use it.
- Physical activity is important to help prevent and manage Type 2 diabetes. It can bring people together, which can help with adherence but it can be difficult to make the time. We need to promote the assets we have such as parks and open spaces and include activity in our every day lives.
- Peer and community support has a huge role to play; we need to learn from those who have experience, face to face and on line.
- Pressures relating to lifestyle, working hours and lack of sleep mean that just knowing the causes and risks of diabetes, is not enough to change behaviour. Instead healthier choices need to become easier choices through the right cures and support in our environment and everyday life.

4

What will we do next?

Whilst some of the findings of this report are specific to diabetes, by exploring our approaches to this complex challenge we have created a new way of working as a Health and Wellbeing Board which we can use when addressing other conditions and wider work. This includes:

- Merton Health and Wellbeing Strategy, which sets the overall ambition for health and wellbeing in Merton, is being refreshed this year. The learning from the Diabetes Truth conversations will help to inform this Strategy and to shape the way we and our partners engage with our community.

- We are now working as partners on an action plan to tackle diabetes. The Diabetes Framework will be informed by the Diabetes Truth conversations, be based on a joint approach across all our partners and will be launched later this year.

The conversations have also helped mobilise our community and some of the expert witnesses have already expressed an interest in becoming health champions and working together with us to tackle diabetes.

Tackling diabetes in Merton together

The facts around diabetes are stark in Merton and the causes are complex. We worked together as public services, with people and communities, to try to tackle this.

The Diabetes Truth Programme has helped us as a Health and Wellbeing Board build relationships with our community and develop a new approach to our ways of working.

The facts about diabetes speak for themselves

- Type 2 diabetes affects 3.8 million people in England, with a further 5 million at high risk.
- The condition gives rise to complications such as cardiovascular disease, blindness, kidney failure and amputations.
- It accounts for 9% of the annual NHS budget.
- 6.1% of adults in Merton were diagnosed with Type 1 and Type 2 diabetes in 2016/17, almost 10,950 people.
- By 2020 that number is projected to rise to almost 12,550.

Type 2 diabetes is an issue where traditional medical models have been unable to curb the rise in cases, serious complications and spiralling costs. The impact of Type 2 is falling particularly heavily on specific ethnic groups and people living in some of our more deprived communities.

In the autumn of 2017 we as a Health and Wellbeing Board agreed an approach to tackle diabetes. In setting out this approach we considered that where standard complicated problems require expert analysis and a logical choice of solutions, truly complex problems, such as tackling diabetes, need more experimental approaches.

Using the Diabetes Truth conversations as an exemplar we can now start to apply our learning to other long term conditions and health and care issues; adopting an iterative development of plans rather than a more straightforward clinical approach. The Diabetes Truth Programme is the start of developing this new approach in Merton.

6

Developing the Diabetes Truth Programme

Our approach was to pair a Health and Wellbeing Board member with an Expert Witness – someone with a lived experience of Type 1 or 2 diabetes and then to have conversations about what mattered to us. No more complicated than that.

Health and Wellbeing Board 28th November 2017

We agreed as a Board that tackling diabetes was a priority. We worked through the facts and figures and what we knew about effective services as our evidence base. We began conversations about how we might approach this differently and really understand what the lived experience of diabetes was and then base next steps and actions around this. We used each other's contacts and our teams to find people who might be willing to get involved.

Planning with Expert Witnesses 16th January 2018

We met with our Expert Witnesses to explain the thinking behind the programme, hear people's stories and begin to plan what might be possible together. Hearing stories was very powerful right from the start. Two hours of just listening intently.

Workshop 1 30th January 2018

Health and Wellbeing Board members and Expert Witnesses met for the first time. Each shared their story in a group about why diabetes mattered to them. We paired up as 'buddies' and agreed when to meet each other. See appendix 1for a list of who paired with who.

Expert Witnesses meet their HWBB buddies

We met our buddies a couple of times between January 30th and March 25th in an open place and had focussed conversations.
We wrote, drew and recorded in our journals over the two months as a record of our thinking.
We had a crib sheet of ideas and questions in case we were stuck for words. Actually we weren't! The focus of our conversation was:

- Asking focussed questions
- Hearing each others stories

See appendix 2 for these questions.

Workshop 2 27th March 2018 We came back together again as Expert Witnesses and Board members to review our conversations and learning. We used our shared buddy conversations to create typical diabetic characters and looked at what life was like for them. We then action planned what we could do together.

Expert Witnesses' Stories

Our Expert Witnesses' stories speak for themselves. It was very humbling to listen to such inspiring people. Some have generously agreed to share their stories here too.

Angie Martin's story

It was Easter 1993. I spent a week lying around drinking Lucozade, eating chocolate (lots of it) and rapidly losing weight. I went to see my GP and was immediately referred to the hospital. I was instantly diagnosed with Insulin Dependent Diabetes (IDD) and my life changed forever! But not in the way I thought?

I spent some time in shock – more so as there was no history of diabetes in my family, Type 1 or Type 2. I was afraid. Where had it come from? Why me? How would I cope with all those injections? What would happen to me now? A period of adjustment and intensive learning followed. The learning actually never stops as medicine advances so rapidly but the most important lesson I learnt is to manage the diabetes not let it manage you.

The biggest change was subsequently losing my job in the City – related to a huge lack of understanding about diabetes (and legislation) back then. However, this presented me with a huge opportunity and led to me going to University and ultimately the job I have now, which I have loved for the last 17 years.

So you could say it was one of the best things that ever happened to me. Twenty five years on, I have still done all the things I have wanted to; going to University, sports and activities, travelling the world and following my dreams.

Annette Wiles' story

I'm Mum to Sam now aged 14 who was diagnosed with Type 1 Diabetes aged 9. I've always thought it was lucky that his symptoms came to the fore during half term when I was with him more. It meant that he wasn't as ill as he might have been at diagnosis and we only spent three days in hospital where they literally taught us how to keep him alive. Since then we've been on the diabetes rollercoaster, battling high and low blood glucose readings as we've learnt about the multitude of factors that can have an impact; obviously what he eats but also how much he exercises, how hot it is, whether or not he is anxious, if he is ill etc. Type 1 is an autoimmune disease where the

body produces no insulin at all. Sam can eat what he wants but we have to know exactly how much carbohydrate he consumes so we can give him insulin to match. Our life is full of maths! There are no hard and fast rules with how much insulin he needs. We've had to learn this by experience and sometimes we've got it very wrong. Parents with a Type 1 child live with a huge responsibility. We still get up every night to make sure he's okay as we won't let him go overnight without checking his blood glucose. Giving him his independence now as he gets older is difficult and something we work on constantly. Like lots of kids with Type 1, Sam has another autoimmune disease which causes him to have an underactive thyroid (more drugs) and he was born with a genetic condition that can affect his mobility. However, he is a big, tough kid who is currently seeking national qualification with his swimming. To look at him, you'd never know that he is battling with three life changing conditions daily. Like every Type 1 parent, I'd do anything to take away this burden from him.

David Chung's story

Paradigm shift: The guiding principle regarding my health and wellbeing moves away from the medical model which is in the control of the medical staff and towards my control.

On reflection it is regrettable that action was not taken at the pre-diabetic stage of my diabetes. I could have started to treat my diabetes. This should be implemented for all diabetic individuals. I would propose that a consultation takes place with a member of the medical team.

It has taken a while but I am now engaging in life style changes which should impact positively on my diabetes. This includes:

at the personal level: sleep (Why We Sleep – Matthew Walker); diet; exercise, including swimming; and, meditation to refine my self control. This is the most demanding aspect of my action plan for addressing my diabetes. It requires a high degree of self discipline. I must not punish myself when I don't get it right but keep on working toward my goal.

At the group level: joining a diabetic group which I see as very beneficial in terms of knowledge and support www.diabetes.co.uk

Support from family and friends

At the level of organisation: participating where possible in groups dealing with diabetes at the strategic level.

I do believe that with my strategy I could control my diabetes and possibly reverse it.

Thanks to the Diabetes Truth Programme.

Joan Henry's story

I am not diabetic myself but really wanted to get involved with this programme so I can work with my communities as a local Councillor and also my church so that I can ensure people have all the information they need to prevent the onset of diabetes.

My father was diagnosed with diabetes at the age of 77. He is now 89. He had a very sudden onset of confusion and was found to be diabetic. I had to learn a lot very quickly and was his carer for many years. A lot of the information out there was very confusing. He has now returned to the Caribbean and is doing just fine. We will all be getting together as a family this year, which will be amazing. My dad will be with us. I am concerned I may be at increased risk myself due to my family history and so I do take regular check ups.

Nicky Winter's story

I am now in my eighties and was diagnosed with Type 2 diabetes 10 years ago after suffering a fall and having a blood test.

I was commissioned in the Life Guards during the Suez crisis in 1956 and saw active service fighting terrorists in Cyprus in the same year and because of this experience in the Army suffered from what is now recognised as PTSD. I treated this with alcohol for many years becoming a full blown alcoholic. Champagne and Guinness, black velvet, earned me the nickname of "Champagne Nicky."

25 years ago, given just 6 months to live, I stopped drinking on August Bank Holiday and have not had a drink since. The drinking may or may not have been the cause of my eventual problem with diabetes - a still unanswered question.

I am using my own experience to help ex-military Veterans with mental health issues, in particular alcoholism to get back into a meaningful life style and maintain long term sobriety, by sharing the help and advice that gave me the support I needed.

Mr S Saleem Ullah's Story

My understanding of diabetes is that it is in part inherited and my South Asian background possibly makes it more likely. Certainly my mother had it and I have had it for nearly 40 years. My first symptoms were starting to feel tired and needing to lie down and sleep at lunchtime. I carried on for 3 years and then when I was tested at St Gregory's hospital found out the inevitable. Yes, I had Type 2 diabetes. I have a very sweet tooth. My heart specialist said to me 'you love sweets but you are going to have to cut down'. I did change my diet and have tried my best to control it but in the end you succumb to insulin. It hasn't stopped me doing anything so far – I did football and I ran – and my life has been and is incredibly fulfilling and active in so many ways with family a big part of this.

Wendy Tchilingirian's story

I have been in the pre-diabetic range for about 4 years or so found by a routine blood test, yearly MOT. No advice was given to me by GP or any suggestions made in life style changes. Maybe because I said I was aware of what I should be doing situation I was left. I had a blood test in early 2017, still in pre-diabetic range.

In summer of 2017 I was contacted by Healthier You, the NHS Diabetes Prevention Programme. I was invited to take part in a 9-month course giving advice on how to manage my pre-diabetic status and to prevent it developing to being classed as diabetic. I decided to accept the offer, had a HbA1c blood test on 11th September and started a course on 16th October. The course starts on a weekly basis, becoming fortnightly then monthly.

I have managed to attend all but one session. I have found them very worthwhile reinforcing things I already knew and teaching me new facts to manage my pre-diabetic state and stop it developing into full blown diabetes.

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I am more aware of what I am eating, know in theory what to avoid but do not find it easy. When buying food, I am now looking at labels and the traffic light system, avoiding high fat and salt etc.

Steve Bowman's story

I now know my early life sowed the seeds of my Type 2 diabetes. Classic case! A sedentary job, where I could have taken more exercise, but I didn't at the time. That coupled with a high milk consumption and cream, which is pretty high fat. Lunches were always the big problem. All that changed 10 years ago when I sadly lost a family member to diabetes. I found out I had it too. I tried diet and exercise for 3 years and then had to start on Metformin so I could get my blood glucose levels down. It's shock treatment that makes you change. If I was told that I would lose a leg, that would be it. At the moment I am ok and doing my best to exercise and eat the foods my doctor tells me are ok.

A typical day for Steve living with Type 2 diabetes
Time	***What I have to do..***
04:45	*Wake up. Usually aware if glucose is low but not so much if it's high. Shower and dress.*
05:15	*Test. Prick finger then use machine for blood test. Get reading – should be below 10 mmo (10 when going to bed). Take 35 units of insulin. If reading below 6, take 30 units. If reading 6.5 or more take 40 units.*
05:30	*Breakfast. Cup of tea with sweeteners. Small fruit juice. Maybe a couple of biscuits – digestive or rich tea. Cereal – Fruit and Fibre, Just Right or Cornflakes – all with full fat milk.*
11:00	*If active, maybe packet of crisps and coffee and sweeteners.* *Lunchtime – Egg on toast, cheese on toast, maybe marmalade, white bread. May take blood test.*
14:30	*Cup of tea and "sin of the day" – cake or Belgian bun or apple Danish.*
	Evening meal – cooked meal at mothers – walks for 8/9 minutes. Casserole or shoulder of pork or liver and bacon. Strawberries in summer. Cup of tea.
18:00	*Walk home.*
21:30	*Bedtime. Statin and blood pressure tablets. Blood test and injection. 10 or above – insulin injected.*

Frederick Springer's Story

In early March 2017 I attended my doctor's surgery to get my usual yearly over 70s check up - as I call it human Medical Overall Test (M O T). I went back after about three weeks and the doctor told me that I was in good health but my blood count was high at 41 and that 47 is at diabetic level. He suggested that I go along to the Pre-Diabetic program which is twenty-six weeks and at Wimbledon YMCA Centre and I am very pleased I did. It's been very useful indeed. It started with 22 of us and is now down to 10. Some thought it was monotonous but I have been very grateful for the learning. Many of us have improved over the time and it spurs you on when the doctor recognises this. I found out recently my dad had diabetes and now my older brother has it. Exercise is the key for me in keeping my count down and especially cricket. My grandad was very fit and died at 96 and I still plan to overtake him!

Edward Abu Maliki's Story

I am Edward Abu Maliki, Senior Pastor of the Power Centre Church located in central Mitcham. We are a ministry committed to ministering to the whole person as opposed to just addressing spiritual needs. We are a predominantly black majority church with a majority of members originating from Africa. We as a leadership recognise that the people we minister to are more susceptible to developing certain illnesses such as diabetes mellitus, particularly maturity onset Type 2 diabetes, according to epidemiological data. The reasons for these have been well documented in the literature, including dietary habits which include use of excess salt and seasonings. A contributory causal factor not often acknowledged and addressed is the spiritual dimension. Beliefs which include the impact of generational and family curses, which explain the perpetuating of diabetes within the same family

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from generation to generation. People who believe in a strong and powerful spiritual causal link will inevitably present a challenge when required to consider more significant causal links such as dietary habits. They come eventually to an entrenched position that the cause of the diabetes is spiritual and therefore the significant and only therapeutic modality to be employed is prayer and deliverance. Here at the Power Centre Church we are committed to providing teaching that will enable our members to accept that physical and socio-cultural causal factors must also be considered alongside their spiritual beliefs. We have set up a Wellbeing and Wholeness in Christ Strategy group and facilitated seminars on diabetes mellitus to reinforce understanding of causal factors, prevention and management of diabetes, in particular the maturity onset/Type 2 form of diabetes. The impact of the workshop has led to considerable shifts in mind set which we believe would yield in the long term, positive health benefits for the community God has privileged us to serve.

Shaun Dallison's story

My Type 2 diabetes started when I lived at Commonside East, Wandle Housing and I have had it for more than 8 years now.

My support worker went to the doctor with me, as I was starting to feel sick and the doctor told me to cut out all sugar and fats and do more exercise. I was really surprised when I was told I had diabetes. My eyesight was blurring and I couldn't read by this time. I used to go shopping with my sister and never gave my diet a thought especially around cakes and sweets. I used to love bread and butter with sugar. I didn't immediately listen to the doctor but my other sister dying had a big impact on me. Also knowing I might lose my limbs – no one wants that.

I am now more active and have a better diet. I have cut out smoking. My other sister often tells me what to eat but doesn't listen to her own advice. I enjoy diabetic biscuits, grapes, bananas and Weetabix. The gym is very expensive so that's a problem and I wouldn't mind more help with exercise. I used to work in a charity shop in Morden and now work in two charity shops in Mitcham and Wimbledon.

I have 3 lots of tablets and take my blood sugar reading twice a day. I do still drink Pepsi but not nearly as much – that's what I miss the most.

Why diabetes matters to Health and Wellbeing Board members

Two Health and Wellbeing Board members tell us why understanding diabetes is important to them.

Chris Lee - Director of Environment and Regeneration

An extract from Chris' recent Merton Council blog. As a member of the Health and Wellbeing Board I am involved in a very interesting initiative. Diabetes has been selected as the Board's priority for this year and all Board members are taking part in a "Diabetes Truth Programme." I have been paired up with a Diabetes "buddy" who suffers from Diabetes and with whom I meet every couple of weeks until the end of March for a cup of coffee and a chat. The intention is to provide a real life insight into the cause and effect of diabetes Whilst diabetes is a medical condition increasingly the solution is seen as a social one rather than purely clinical. The roots of diabetes are often genetic but also linked to exercise, diet and lifestyle. That's why this matter is so relevant to our Department where we have responsibility for leisure, parks, licensing, town planning and many other services and functions that can contribute positively to supporting healthy lives and helping people make the best choices.

**Karen Worthington
GP Rowans Surgery**

As a GP – diabetes is part of my everyday caseload. I have been a GP in East Merton for 27 years and have met very many diabetic patients. The current practice I work in is in Morden and has the highest prevalence of diabetes in Merton approx. 12%. It concerns me when I see patients with poorly controlled diabetes who are at increased risk of complication and I want to discover if there are any new tips or ideas that might help me to motivate patients to better look after their diabetes.
As a parent my daughter was diagnosed with Type 1 diabetes aged 9 years. So it has been a big part of my family life – she is now 25 and all grown up.
In my Clinical Commissioning Group role – I am aware of variation in outcomes in relation to diabetes care and one of my aims in my role is to try to understand and help colleagues reduce unwanted variations in care.

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Root causes of diabetes

Understanding causes is vital to identifying solutions! We have identified many causes from our shared perspectives.

Understanding root causes from the perspective of the Expert Witnesses helped us to understand the choices they face and what they believe might make a difference.

Causes of type 1 diabetes

There is no clear cause and there can be a sudden onset. Conversations showed potential confusion, particularly with Type 2, and sometimes a lack of understanding, from friends, families and even from medical professionals.

Causes of type 2 diabetes

A number of themes emerged from the conversations about the causes of Type 2 diabetes including:

1. Taking action too late

With our children
Many children with obesity are at risk of developing diabetes. We are not recognising this link and miss the opportunity to start education early. Much is being done to encourage children to live healthy lives. But more can be done and how much of this recognises the link with diabetes?

Talking to parents about the eating habits their children develop is difficult as parents can feel they are being blamed.
Displays of sweets and chocolate at supermarket tills don't help.

Having opportunities for children to be active in and around the school day are important, but also to find opportunities for them to play safely outside.

As adults
We were interested in what stops people from changing their lifestyle when they are at risk of diabetes or have a diagnosis of being pre-diabetic. In part, it seems to be about denial and fear – human nature basically. In many cases, diabetes is not accepted as an illness until it's too late.

Conversation on diagnosis..
"We suspect they know but don't want to know if that makes sense. There is a 'fear of finding out' - people don't want to know even when they have symptoms.

An attitude of 'this isn't going to happen to me'. It's far easier not to think about it until you become diabetic although when you do find out you then regret that you didn't do something earlier.

We have heard those people who are diabetic but don't do anything about it say 'it's no big deal. Family members have diabetes and are 'well'".

2. Lifestyle

The food we eat

Not eating the 'right' food or eating too much food and therefore carrying excess weight was seen by everyone as a cause of diabetes.

> **Conversation on healthy eating..**
> *"The way life is lived now often makes healthy eating difficult with irregular meal times and making do with 'fast food on the go'. The availability of any type of food day or night makes it more difficult to make the right choice. Eating outside the home has become so popular and normal food and drink at social outlets is top of so many people's lives (me included). A very different life style from only 30 years ago or even more recently".*

What we eat is influenced by the food industry, supermarkets and how food is labelled and packaged. It is often the least healthy foods which are advertised the most widely with prominent discount offers, cartoon characters to attract children and easy availability. The choice of what we eat is down to us but the environment we live in doesn't help us make healthy choices.

> **Conversation on food..**
> *"The pre diabetic classes at Wimbledon YMCA helped me to understand some of the food dilemmas.*
> *Starches fat and sugar are in almost every food we eat.*
> *Reading labels on processed food and drinks packaging can give you*

> *a good sense of calories intake in each meal..*
> *I have spoken to some of my friends who were quite surprised to find out all of this. We all know friends with diabetes but we didn't know this basic stuff".*

What we drink - Alcohol and fizzy drinks

Similar to food there was confusion about the impact of what we drink as a cause of diabetes. Some of us thought alcohol consumption had a link to diabetes because of the sugar content. Most of us identified fizzy drinks as a potential cause.

> **Conversation on drinks..**
> *One of our expert witnesses bought a bottle of flavoured water to our first meeting. Wow, did that cause us confusion. He had been told by some people he shouldn't have it, by others that it was ok.*

Exercise

Many of us cited not taking enough exercise as a contributory cause. We gave all sorts of reasons for this - no time for exercise with work and families; cycling is harder due to heavy traffic; not safe for children to play outside.

> **Conversation on exercise..**
> *"When I got my blood sugar results from the doctor he told me it was high. I then waited over 3 months to get into a local diabetic group where my count was tested again at Cheam Sports Centre and it had improved. I can only put this change of my health condition, down to the fact that it was in the*

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> *middle of my cricket season, where I was playing cricket two days a week. This taught me that exercise is a vital part of managing diabetes".*

Stress

Often we saw that our current lifestyles are not conducive to good health. Poor sleep quality was cited as a cause of diabetes. Stress was also mentioned – stress of work, of juggling with family life.

3. Cultural factors

We listened to our expert witnesses and they told us about the influence of cultural factors which can serve to heighten the impact of genetic factors. Cultural beliefs and practices can also make it more difficult to talk about diabetes and can lead to increased resistance to change.

The voices of the Asian community told us about the added significance of food in their cultural life. We also heard the voices of the African community.

> ***Conversation on beliefs..***
> *"In some communities many problems are thought to be spiritual and are only solved by prayer. These cultural beliefs can lead to a belief that there is nothing the person can do to impact on their health as it is God's will.*
> *There is a lack of understandable information about diabetes, often it is not intelligible and if it conflicts with existing beliefs it is disregarded anyway.*
> *Past experience of health, services*

> *and 'the system' mean people are cynical and sceptical of authority and advice by nature so will not seek out information or help. Time pressure is a big factor and often means people eat at the wrong times, don't make time for exercise and find organising their time difficult".*

> ***Conversation on overcoming cultural differences ..***
> *"Engaging people / helping them understand and choose to change People don't want to feel foolish Spending TIME – with the person and realising it takes TIME to change.*
>
> *Understand person's health beliefs – what they think has caused problem.*
>
> *Slowly step by step challenge beliefs. People feel safer where they are than to consider moving into an unknown world. Encourage them to believe the truth of what you are saying.*
>
> *Best by someone they can <u>trust</u> and who they feel has their best interests at heart such as a GP who can give messages like:*
> - *You only need to make minor changes to be healthy*
> - *Live longer and you can serve God better*
> - *Give clear information and help them think it through."*

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4. Information

There is a lot of information on websites, forums, support groups and diabetic specific websites about the causes and ways to deal with diabetes. Often this can be conflicting and in itself becomes overwhelming with people not knowing what to believe.

5. Genetics

There was a perspective from some people that diabetes was hereditary - 'my family has it therefore I might get it'. We didn't explore whether this was seen as being through inherited genes or inherited lifestyles.

Conversation on reactions ..
"Diabetes is such a hidden disease and not talked about enough. Significant damage has already been caused before you know you have it. I have noticed that:-

- *There are issues for those delivering services knowing the difference between Type 1 and Type 2.*
- *A lack of understanding about the impact of diabetes on other health issues such as exacerbating pressure sores for someone who is not mobile.*
- *Parents often react with shock and grief when their child is diagnosed with type 1. This is the same reaction as for other more visible illnesses. This surprised me".*

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Impact and behaviour change

People told us repeatedly about the links between food choices, exercise and the development and severity of their diabetes. We wanted to hear from our Expert Witnesses about what helps them to change behaviour and what gets in the way. Listening to each other and learning from each other at our March workshop seemed a powerful way of exploring change and how we make it more likely that we will change our behaviour and improve our health.

Type 1 diabetes – what the workshop told us:

Impact

There is no way to escape; every aspect of my life has an effect on my blood glucose.
I have to be smart – managing drugs, maths, knowing about food and technology and I need support!

Barriers to change

The complexity of every day life.

Influences to change

Aspiration keeps me well.
Using self help in Type 1 communities.

Technology presents opportunities, especially online and digital.

The big opportunity is

Differentiating messages more effectively between Type 1 and Type 2 diabetes.
Better understanding of Type 1.

> *Type1 diabetes is about managing a whole range of factors that affect your blood glucose. This can be overwhelming and oppressive. I see this typically in incidents of teenage type 1s who pretend they don't have diabetes and as a result their health can spiral dangerously out of control.*

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Type 2 At risk of diabetes – what the workshop told us:
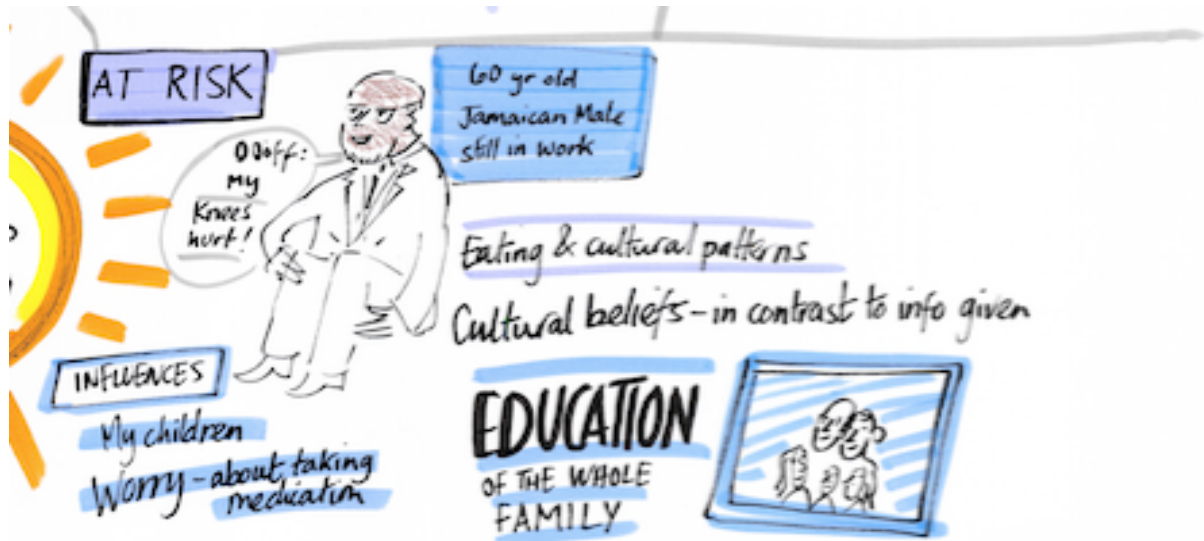
Impact

I worry that I will become a burden and my family will have to help me. I might have to give up drinking, and sweet things and have to take medicines.

My worries are all future tense. I may or may not decide to do these things. At the moment I have no symptoms.

Barriers to change

Time pressures leading to a lack of sleep and no time or enthusiasm for exercise.

My understanding of the risk and difficulty of taking medication regularly without lifestyle changes. Some confusion about what I should do for the best.

Influences to change

My children and fears about losing my independence.

Choice points

The impact of medical advice.

The big opportunity is

Reaching the whole family with information and education we all can relate to.

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Type 2 Pre Diabetic – what the workshop told us:

Impact
No physical impact yet but concern for future health.
I feel observant but I don't have to act yet.

Barriers to change
Family and friends, work, peer pressure and established habits from culture and upbringing.
'Fear of finding out'. People not wanting to know even when they have symptoms.

Influences to change
GP check ups and flagging warnings, feeling tired and slower recovery, peers and family being diagnosed and having problems, meeting new people and taking up new hobbies and sports.

More education, if necessary graphic and disturbing to show what can happen if I don't change.

Choice points
Change requires awareness of what needs to change and acceptance of it. This can relate to diet, exercise, reduced consumption of alcohol, even changed relationships.

The big opportunity is
Making the decision to change and then embracing the new challenges and opportunities with gusto.
Peer support and pre-diabetic clinics help.

Type 2 diabetes – what the workshop told us:
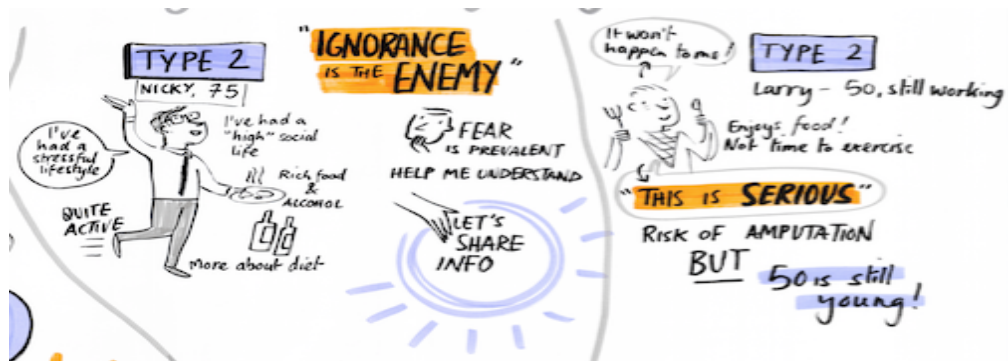
Impact

Watching my diet and being more careful about food and drink choices.
Having to lose weight and taking up exercise in a busy schedule.
Living with fear and the psychological impact of diagnosis.
Having to take lots of medication, some with side effects.
My condition affecting my family dynamic.

Barriers to change

Conflicting information, the current environment, having to give up things you like and balancing this with work.
My family: not being in full control of what is in the fridge, finances, understanding nutrition and cooking.

Influences to change

Fear is an influence. The knowledge that "this is serious".
The threat and risk of amputations.
Emerging medical evidence.

Choice points

From initial diagnosis: knowing what changes to make and making them OR living with the consequences.

The big opportunity is

Understanding the problem and sharing information.
Finding out how to access help and self-help.
Creating better choices and start at an early age – not 50!

> *"Please see people have more than one thing to contend with..*
> *One of our service users is going blind and has been undergoing laser surgery to try to correct this. They had previously been homeless for a short period and had struggled to keep their insulin correctly. This person is also looking after several children and experiencing a range of financial and other challenges, which make day-to-day management of their diabetes quite difficult".*

be like if we tackled diabetes differently and together and what some of our suggested ways forward might be like.

1. Personal – what can the individual do?

- Use online support forums and advice

> ***Online is a big opportunity***
> *There is a massive online diabetic community for Type 1 and 2 available to offer support. There are always concerns about the accuracy of the information provided but typically if there are sufficient numbers of contributors and the site is active enough any incorrect information is quickly corrected. I have found the Type 1 parental community endlessly supportive and informative. There is something reassuring about knowing others who are going through the same as you and really are walking in your shoes.*

- Challenge expectation that diabetes is a fixed health problem

> ***Mental health and diabetes***
> *We identified issues around mental health and diabetes management (which equally apply to Type 1 and Type 2). Diabetes management isn't simply about taking your medicine or doing certain exercises. It's about how you live your life all day every day. For those with Type 2 this is very much about what you eat and weight management and for those with Type1 it's about managing a whole range of factors that affect your blood glucose. This can be overwhelming and oppressive.*

2. Social – what can a group of people or community do together?

- Empowering people with diabetes to share their experiences if they want to, especially those who have got their diabetes under control.
- Recognising the value of sharing experiences through peer support from people with a 'lived experience' (this could build on the Expert Patient Programme).
- Identifying community champions and training them in movement building approaches.
- Creating healthy places, i.e. healthy streets, healthy schools, healthy homes – so that the whole environment makes healthy choices easy and normal for everybody instead of a daily battle.
- Workplaces, large and small, supporting their workforce to connect with each other, be it through exercise, food or something like a choir or book club.

> ***Creating hope that change is possible***
> *We talked about the need to give those seeking to avoid type 2 and those that are pre-diabetic or already diagnosed with type 2 hope and belief that they can change their health. It is likely that many may have struggled with their weight for a period of time (possibly their whole life). Seeking to change this later in life may seem overwhelming and simply impossible. Could the stories of those that have managed this or mentoring by those that have been successful be used as a potential approach?*

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The Family Centre

The Family Centre runs a group for people with mental health problems. I asked if they would be interested to talk to me. They said 'yes' so I paid them a visit. I noticed that there is a higher proportion of people with diabetes in this group than the wider population. It was quite an eye opener listening to their questions and comments.

This session gave me an insight into how it really is to have mental health problems and be diabetic. Some of my insights are:

- *There was a lot of misunderstanding and misconceptions and little or no understanding about the difference between Types 1 and .2*
- *People asking how do you know if you have diabetes?*
- *Little awareness of what a balanced diet is. What are carbs?*
- *No understanding of the importance of exercise.*

Better support to Type 1 diabetes

If Merton does want to consider how it better supports Type 1s, I would suggest the following:

- *Better diagnosis pathways (too many young children are diagnosed too late by GP services and using the wrong procedures).*
- *Doing more to raise awareness of the symptoms of Type1 amongst parents, teachers and school support staff.*
- *Providing help for admin support staff who are often those in primary schools that oversee day-to-day type 1 management.*
- *Ensuring that secondary schools are correctly reflecting the difference between Type 1 and Type 2 in their curriculum.*

Health Champions

Champions are ordinary people who are influencers in their own community. If their knowledge and skills are developed they help people to learn through ordinary conversations. They offer a real opportunity to bring a lived experience. Their skills include:

- *Relationship building.*
- *Happy to share their life experience.*
- *Communication skills.*
- *Mobility to befriend and support others.*
- *Mentoring skills, motivation of others.*
- *Knowledge they can use to educate.*
- *Nurturing and training skills.*

3. Institutional – how can organisations work together differently and better to support and enable people with diabetes?

Our approach
- Listen.
- Actively engage with communities and help them to help themselves.
- Connecting services, working together and putting people with diabetes at the heart of what we do.
- Starting with education at all levels, involving families, so everyone understands what diabetes is and the different types.
- Ensuring all our different plans and strategies fit and work together.
- Improving the support to health professionals so they better understand and work with people with diabetes.

Retailers

Working with retailers to avoid pushing sweets at tills, encouraging healthy food options, reducing prominence of fizzy drinks; a healthy high street food offer.

Schools

Starting healthy life approaches early as part of the national curriculum including school meals and the 'daily puddings' culture.

Community

Enabling the community to take action to support itself, working with the community and voluntary sector locally and nationally to co-deliver new ways of working.

Information, advice and messaging

Targeting and tailoring information to the individual, ensuring messages are culturally sensitive.

Empowering

Being positive - not telling people to stop things. Considering a borough website, MVSC newsletter thread.

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Impact of the programme for the Expert Witnesses

I enjoyed talking and having lunch with my buddy. I am afraid I did most of the talking. I told her about my childhood; growing up in Barbados; also a very short sketch of my working life here in England. .. she did not seem to be bored and listened gracefully to my story.

It would be great for some of us to have further training so that we can become diabetic friends and support other people. I am really keen to set up a support group at church and am taking the idea to our parish council meeting.

Between my meetings with my buddy, I thought more about how I am as a 'diabetic' and the importance of framing it positively and not asking for special treatment. Many people don't know they have diabetes so I am going to talk about it and how to take action before you get it. Thanks to my buddy.

I am pleased that Merton is leading on this work and glad to be part of it.

I feel strongly that an initiative like the Diabetes Truth Programme will help to give people the advice and guidance they need and whilst they still have a choice to give them the opportunity to take it. I would certainly be willing to be involved in a continuation of this programme. Sharing the problem with others who have it, provides help just by talking!

Impact of the experience for Health and Wellbeing Board members

Health and Wellbeing board members tell us what they have learned and the impact of being part of the Diabetes Truth Programme.

I can see how much good work is already going on in our communities. A better awareness of the barriers for some communities in accessing and benefiting from existing health care. It was nice to get to know my buddy who was very wise and insightful and to learn from him.

I knew very little about diabetes – now I know something it has helped me realise the impact on people's lives and the opportunities to get in early and change this. I found it really humbling to have a buddy and to get to know what it was like and how it affected him.

I never appreciated the complexity of living with Type 1 diabetes

It is important to the board to reconnect with its purpose and the energy and focus of the Diabetes Truth Programme did that.

My elderly next door neighbour – who has Type 2 – also pointed out that we are often looking at multiple morbidities with Type 2 which (can) require complex medication regimes.

Sharing the buddy between two board members was an unexpected opportunity to develop closer relationships; our buddy was a strong and very impressive example of the role and importance of a carer, a resource that as a system we could use much more effectively and should look after much more systematically; our buddy really exemplified the power of self-help and self-determination and the fundamental importance of a true partnership approach between professionals, carer and patient in management of long term conditions.

People have only a limited understanding of the implications of Type 2: they think it is caused by gluttony and sedentary lifestyles and can be successfully treated by strict dietary regimes. A little simplistic.

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It was very humbling to work with my buddy since it made me realise how much a person with diabetes is affected in every aspect of their life. It has made me realise that much needs to be done in terms of educating people how, where possible, to avoid becoming diabetic. It has raised a passion in me to want to move this project forward.

What was clear from across the sharing of experiences and stories is that, whilst there are commonalities, diabetes is something that needs to be looked at on an individual basis. People do not want to lose themselves and the way that they live and we need to find ways that enable them to make the right health choices but retain who they are.

I think what struck me most was the impact that living with diabetes has on people's lives, and how it affects so much more than just what you can eat. It was striking to hear how it had caused people to change their lifestyles in ways that extended far beyond merely diet and exercise. I was also struck by how varied the information on diabetes is, and how difficult it can be for a diabetic to know how best to control their diabetes, when they are presented with apparently conflicting recommendations on an almost daily basis.

In my particular conversation it was good to focus on the role of families and carers as part of the solution in long term condition management.

It was a good reminder to think about in the workplace and the way that we often use food as rewards and treats which can of course be an issue for people trying to live with diabetes – it is a challenge to me to think of other options instead.

I found the experience very humbling, both working with my buddy but also some of the wider conversations with others in the group. The willingness of people to give up their time and share their stories with a room of strangers in a bid to help others, either not develop diabetes in the first place, or to manage it once they have developed it was quite remarkable, and far more powerful than testimony from medical practitioners alone.

Conclusion

The Diabetes Truth conversations have allowed us as a Health and Wellbeing Board to reconnect with our purpose and focus our energy.

We have opened ourselves to a humbling level of insight from the expert witnesses. The richness and nuance of what they have shared has helped illuminate, not just our understanding of diabetes, but of what it might be like to live with other long term conditions.

Type 1 and Type 2 diabetes have been well researched and much work is in place to support the conditions. However, by sharing the day-to-day experience of people living with diabetes, we can begin to understand how that support might respond more directly to people's needs. Through working with the Expert Witnesses we have developed an approach to diabetes as an 'exemplar' – a way of engaging and understanding a condition which can apply in other areas.

Whilst some of the findings of this report are specific to diabetes, by exploring our approaches to this complex challenge we have created a new way of working as a Health and Wellbeing Board which we can use when addressing other conditions and wider work.

Specifically in working to tackle diabetes we have learned:

- Type 1 diabetes is really different to Type 2 – when focussing on 'diabetes' we need to be aware of, and do justice to, both types; making sure we connect the communities of each to share learning as there is a lot of expertise and self-help available.
- Type 1 and Type 2 Diabetes are not just physical illnesses – they require an explicit focus on emotional and mental health resilience and support.
- We need to communicate and educate better about food. This is both culturally and socially important. Food's purpose is fuel but it is also pleasure and there are confusing messages and uncertain science about what is good and bad, healthy and unhealthy.
- Our food choices are often influenced by factors in our environment such as advertising and availability of fast food, and there are also issues around blame, labels and discrimination.
- There is plenty of information out there about diabetes but people do not always engage with it. People feel the plethora of advice can be confusing. We need to make better connection between those who produce the information and those who need to use it.
- Physical activity is good for us in many ways and brings people together, but it can be difficult to make the time. We need to promote

our assets such as parks and open spaces and build activity into everyday lives.
- Peer and community support has a huge role to play; we need to learn from those who have experience, face to face and online.
- Pressures relating to lifestyle, working hours, lack of sleep mean that just knowing the causes and risks of diabetes is not enough to change behaviour. Instead healthier choices need to become easier choices through the right cues and support in our environment and day to day life.

Next steps

The Diabetes Truth work will help inform the way we work as a Health and Wellbeing Board in future and also the plans we are making and actions we take to tackle diabetes.

Merton Health and Wellbeing Strategy, which sets the overall ambition for health and wellbeing, is being refreshed this year. The learning from the Diabetes Truth conversations will help to inform this Strategy and to shape the way we engage with our community.

We are now working as partners on an action plan to tackle diabetes. This Diabetes Framework will be informed by the Diabetes Truth conversations, be based on a joint approach across all our partners and will be launched later this year. It will reflect on, and respond to, what our expert witnesses have told us and focus on four areas:

- **Prevention for the individual** – helping us to take action ourselves, for example, through a Merton offer including participation in the National Diabetes Prevention Programme.
- **Prevention for the population and community** – improving the environment in which we live, for example, creating healthier streets, homes and schools and through work to tackle childhood obesity.
- **Clinical diagnosis and treatment** – improving early diagnosis of diabetes and encouraging people to take part in education programmes.
- **Holistic integrated care** – providing physical and mental health care, health and social care, clinical and non-clinical support and promoting self care, for example, giving mental health support to people with diabetes.

As well as responding to what the Expert Witnesses have told us, we also want to learn from the experience of listening to our buddies. We have arranged a Health and Wellbeing Board development session later this year to help us explore our future role and working. This will be an opportunity to consider and build on the experience from the Diabetes Truth conversations and plan how we can continue to work closely with the communities we serve.

Work is also underway to help health and social care link more closely. The prevention of diabetes and other long term conditions are central to this and will be included in the work of the new Merton Health and Care Together partnership. The Diabetes Truth work can bring an insight to this and will also feed into other work in East Merton specifically plans to deliver a new health and wellbeing campus on the old Wilson Hospital site. More broadly, learning from the conversations can help inform the health and wellbeing policy of Merton's new Local Plan, which provides a vision for Merton's future environment.

Some of our Expert Witnesses or buddies have already expressed an interest in becoming health champions and we look forward to working with them in taking this forward. As champions they will be the most valuable assets in our continuing work to tackle diabetes.

Appendix 1: Who was involved in the Diabetes Truth Programme

Expert Witness	Health and Wellbeing Board Member	
Angela Martin	Brian Dillon	Chair Healthwatch Merton
Annette Wiles	Dr Dagmar Zeuner and Lyla Adwan Kamara	Director of Public Health, London Borough of Merton Chief Executive Merton CiL
David Chung	Dr Doug Hing	GP and Merton CCG Clinical Director
Edward Abu Maliki	Dr Andrew Murray	Chair Merton Clinical Commissioning Group
Frederick Springer	Hannah Doody	Director of Community and Housing, London Borough of Merton
Joan Henry	Dr Karen Worthington	GP and Merton CCG Clinical Director
Nicky Winter	Cllr Gilli Lewis Lavender	Councillor London Borough of Merton
Saleem Ullah Sheik	Cllr Katy Neep and Yvette Stanley	Cabinet Member for Children's Services Director of Children Schools and Families, London Borough of Merton
Shaun Dallison	Cllr Tobin Byers	Cabinet Member for Adult Social Care and Health, London Borough of Merton
Steve Bowman	Chris Lee	Director of Environment and Regeneration, London Borough of Merton
Tamil Community	James Blythe	Managing Director, Merton and Wandsworth Clinical Commissioning Group
Wendy Tchilingirian	Khadiru Madhi	Chief Executive Merton Voluntary Service Council

PAIRED WITH

Appendix 2: The focus of our conversations

Hearing stories

First and foremost the Diabetes Truth Programme was about hearing each other's stories. We heard:-

- What makes being part of the Diabetes Truth Programme important to us?
- What is our lived experience of diabetes?
- What is it like being part of the Health and Wellbeing Board?

Asking questions

The sort of questions we asked were:-

- What do we each think are some of the real causes of diabetes?
- What do we hear other people say about these causes?
- What are the choice points for people with diabetes?
- What pressures do we each live with?
- What are the barriers that stop us changing?
- What do we think actually influences people to change?
- How do we think health and care services might do better in supporting people with diabetes?
- What are the ways we might pick up people at risk of diabetes earlier and help stop them getting it?
- What do we think a truly connected approach might look like between health, community, schools, emotional support, voluntary services, and advice services?
- How might we involve people as 'champions' to help communities support themselves in tackling diabetes?

Prevention Framework

Start Well, Live Well, Age Well

SW London principles & priorities

June 2018

Prevention Framework

- Purpose = whole-system approach = interventions at different levels
  - Population/place & community & individual
  - **Optimisation of roles** and responsibilities across health & care system
  - **Rebalancing** of activity **between levels** (without creating false dichotomies**)**
  - **Embedding prevention** systematically**:** policy, strategy, commissioning & service delivery
  - → **Impact at scale** within resources available

- Scope = prevention across the life-course (start well, life well, age well)
  - Focus on **healthy lifestyle** (smoking, alcohol, diet, PA) underpinned by **social, emotional & mental wellbeing**
  - Specific other high priority areas**: falls, winter warmth, loneliness**
  - Interfaces with many other prevention activity incl **screening, immunisation,** sexual health, clinical risk factor reduction such as **high blood pressure, atrial fibrillation** etc

- Outcomes
  - Healthy start in life, prevention /delay of long term conditions; increase in resilience and independence
  - Cost-effective sustainable response to financial constraints

Priority areas for action

- **Making every contact count (MECC)** = staff training (to raise healthy lifestyles)
  - Training front-line health and social care staff (& wider front-line workforce such as benefits, fire service etc)
  - Training of commissioners / policy & strategy staff
- **Integrating prevention into care pathways**
  - Healthy lifestyle support for major LTCs (CVD incl diabetes; respiratory)
  - Healthy lifestyle support (ie BMI/smoking) for elective surgery/ECI policy
  - Falls prevention
  - Winter warmth
- **Social prescribing**
  - Linking clinicians (& others) with non-clinical support options (incl loneliness)
- **Healthy Workplace Charter**
  - All LAs, health & care providers (and other businesses)
- **Childhood obesity**
  - Whole system mobilisation at all levels (leadership & engagement; food and physical environment; earl yrs and school settings; family orientated services)
- **C&YP Emotional and Mental Wellbeing** (focus on reducing self harm)
- **Air pollution** (NHS role linked to healthy workforce & sustainability plans)
- **Diabetes** (whole system exemplar, cutting across all of the above priority areas)

Implementation considerations

- **Action plans for priority areas**
  - Focus on **how** to achieve defined outcomes **at scale**
  - Recognise this is **complex** with no blueprint; need to test & learn
  - Possibly bundle priorities for **concerted effort**; **stage** priority actions realistically
  - Essential to **work with the communities we serve** and the workforce
  - Build on what is already happening in individual boroughs/CCGs
  - Be clear about added value through STP footprint / or not
  - FYFV (NHS) and Care Act (social care) national reference points
  - Clarity of governance (STP, LTBs, HWBB); need for dedicated project/programme support

  Honesty about what prevention can and cannot achieve re short-term financial gap closure

  Roles & responsibilities
  - Who is doing what across NHS and LAs (and others), now and future
  - Covering all levels (Population, community, individual)
  - Main roles and supporting role, ie NHS = also place shaper, advocacy
  - New roles: ie fire service pilot (falls, stop smoking, winter warmth)

- **Funding sources** (in addition to better use of existing money)
  - Transformation money
  - HEE, PH academy, GLA; CQUIN
  - Social investment: London fund?, SIB

- **Synergies**
  - Mayor's strategies and initiatives (ie inequality strategy, London plan, Thrive)
  - Devolution asks (ie use of sugar tax); HLP priorities

Committee: Health and Wellbeing Board

Date: 26 June 2018

Wards: All

Subject: Annual Public Health Report 2018: Tackling health inequalities - progress in closing the gap within Merton

Lead officer: Dagmar Zeuner, Director of Public Health

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

Contact officer: Samina Sheikh (Principal Public Health Intelligence Specialist) samina.sheikh@merton.gov.uk, Clarissa Larsen (Health and Wellbeing Board Partnership Manager) clarissa.larsen@merton.gov.uk

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Recommendations:

The Health and Wellbeing Board are asked:

A. To receive and endorse for publication the attached Annual Public Health Report (APHR) 2018 on Health Inequalities.

B. To consider the recommendations of the APHR, how partners can work to tackle and monitor health inequalities and use existing infrastructure to take this forward.

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1   PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1.   There is a statutory duty for the Director of Public Health to produce an independent Annual Public Health Report (APHR). This annual report forms part of the wider Joint Strategic Needs Assessment (JSNA). The purpose of this paper is to share with CMT the final draft of the *Annual Public Health Report (APHR) 2018: Tackling health inequalities - progress in closing the gap within Merton*, and to set out the key findings and implications that these have for the development of the refreshed Health and Wellbeing Strategy (HWBS) from 2019, and other statutory and strategic assessments undertaken in Merton.

1.2.   The purpose of the APHR 2018 is to

   i.   Summarise what we know about defining, measuring and tackling inequalities in general, with a specific focus on health inequalities,

   ii.   Describe and analyse trends in key health inequality related indicators between the most and least deprived areas in Merton, and

   iii. Make recommendations about what we can learn from this piece of work to take forward into the HWBS 2019+ refresh and other local strategic work such as the Local Health and Care Plan.

         The APHR will be taken to MCCG Governing Body on 4 July and Cabinet on 30 July 2018. It will then be professionally designed, and published in August 2018.

2 DETAILS

2.1. The topic of the APHR 2018 is health inequalities in Merton – the current picture and progress in closing the gap – and this topic was selected for a number of reasons:

- It is a longstanding aim of the Merton Partnership to 'bridge the gap' between the east and west of the borough, addressing the disadvantage that some communities face;

- Our Public Sector Equality Duty obligations under the Equality Act 2010 mean that we need to pay due regard to equality and inclusion issues in all our decision making. Analysis in this report aims to support the Council and partners to meet this duty;

- Closing the gap in health inequalities was the overarching aim of the Health and Wellbeing Strategy (HWBS) 2015-2018; and this analysis is central to impact monitoring, and to informing the refresh of the HWBS 2019-2024;

- Analysis and recommendations from this APHR will also inform other strategic work underway in health and social care, including the development of the Local Health and Care Plan, the developing Merton Prevention Framework, and the development and evaluation of the East Merton model of health and wellbeing centred on the Wilson site;

- There is synergy with the continued focus on health inequalities in London, including the refresh of the Mayor's Health Inequality Strategy.

2.2. The APHR 2018 aims to provide a reference for officers, partners and residents to understand what we mean by inequalities, specifically health inequalities but also the underlying drivers of differences in health outcomes between different groups – inequalities in the social determinants of health such as poverty, education and employment. The purpose of the APHR 2018 is to inform a shared understanding of where we are now, how far we have come in bridging the gap between the most and least deprived using some key indicators, and how we might best approach and monitor health inequalities in future.

2.3. The APHR 2018 is split into the following sections:

- Part 1: an overview of what we mean by inequalities, specifically health inequalities; how we measure them; and what we know works to tackle them.

- Part 2: what we know about health inequalities in Merton over time (using a selection of health-specific indicators and others that represent the social determinants of health), and description of the methodology used to analyse the inequality gap

- Part 3: a summary of what we can learn from this piece of work to take forward into the HWBS refresh and other strategic work.

2.4. The APHR 2018 is complemented by a Supplementary Data Report with additional graphs and analysis.

2.5. <u>Key findings of the APHR analysis</u>

This APHR on Health Inequalities has investigated some of the key inequality gaps between the most and least deprived communities in Merton that impact on health outcomes. It casts new light and produces clear evidence to show a sustained gap in health and wellbeing across communities in Merton and provides robust data, on which our plans and policies can build, to address these inequalities.

i. We know that there are inequalities between the east and the west of the borough, but this is the first time that we have looked systematically at the scale and trend in inequalities in Merton over time. This process has shown that it is more complex to monitor health inequalities than it first appears, and has been very useful to identify an approach that will help us to effectively track inequalities going forward.

ii. APHR analysis shows that inequalities are evident in every indicator we studied, the vast majority of which show a worse picture in the most deprived areas, as we would expect. Recent supplementary analysis from Public Health England (PHE) reveals that the top three health indicators most strongly associated with deprivation in Merton are emergency hospital admissions; childhood obesity; and hospital stays for alcohol-related harm.

iii. These cumulative inequalities – which are evident throughout different life stages and in the environment within which our residents live – contribute to the overarching inequalities in health outcomes that we see in the significant differences in life expectancy of 6.2 years for men and 3.4 years for women between the most and least deprived areas.[1] Inequalities in *healthy* life expectancy are even starker, with a difference of 9 years of healthy life between most and least deprived areas.

iv. In terms of trend in inequalities in Merton, the picture is mixed. There are some success stories, for instance the reducing gap between the most and least deprived areas in life expectancy for women, in School Readiness, and in the proportion of the economically active population claiming jobseeker's allowance (JSA), and the apparent reduction in the Child Poverty gap. However, the majority of indicators either show the inequality gap to be stable over time, to be increasing, or to be reducing for the 'wrong' reasons (for instance because the situation for those in more affluent areas appears to be worsening whilst that for those in the more deprived areas remains stable, narrowing the gap). It is evident from this analysis that inequalities in Merton are intransigent, and we need to keep them under review over a longer time frame.

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[1] These figures are from the national 'Slope Index of Inequality' indicator which looks at inequalities in life expectancy at birth between the 10% most and 10% least deprived areas in a borough. CMT may be aware that these are different figures for the gap in life expectancy than previously reported, for instance through the JSNA 2013/14 which gave a figure of 9 years for men and 13 years for women. The APHR (Box 3, Chapter 1) gives a detailed explanation of the changes to the data, trend and methodology behind the figures, and why we recommend the use of this Slope Index going forward, as the headline life expectancy indicator.

As the analysis confirms that health inequalities are persistent, complex and difficult to shift, in order to make any progress, we have to actively and systematically target them through a long-term multi-sectoral approach across all partners; if we take our eye off the ball, health inequalities are likely to increase. Therefore we need to continuously monitor progress and review our approach over time.

2.6. <u>APHR recommendations:</u>

i. *Recommendations for tackling health inequalities in Merton:*

- We have Public Sector Equality Duty obligations under the Equality Act 2010, which means that we need to pay due regard to equality and inclusion issues in all of our decision making. The analysis in this APHR suggests that in order to make progress on closing the inequality gap in Merton, we need to actively and systematically target inequalities through a long-term multi-sectoral approach across all partners. This action should be based on detailed understanding of our population need, as set out in the Joint Strategic Needs Assessment (JSNA), and grounded in evidence of what works (discussed in more detail in the APHR, Part 1).

- Whilst recognising the role of personal prevention approaches to improve health (e.g. support for individuals to stop smoking), the evidence shows that we need to rebalance our efforts towards population level prevention, recognising both the increased cost-effectiveness of interventions at population level compared to personal level interventions, and the evidence of increased impact on health inequalities.

- In order to reduce the steepness of the social gradient in health outcomes, the evidence shows that a 'proportionate universalism' approach should be adopted, meaning that population-wide action is vital, but that universal interventions should be undertaken with a scale and intensity that is proportionate to the level of disadvantage. Action needs to be taken across the whole life course so that all Merton residents can start well, live well and age well.

- In order to be effective, the evidence shows that approaches must be underpinned by participatory decision-making and co-design, empowering individuals and communities.

- The Health and Wellbeing Strategy to be refreshed from 2019 will form a core strand of Merton's strategy to reduce inequalities, and will seek to address the health inequalities issues identified in this report through the approaches outlined above.

ii. *Recommendations for monitoring health inequalities in Merton:*

- The detailed analysis in the APHR 2018 will inform the suite of indicators for the HWBS from 2019. We want these indicators to be challenging, but also realistic and robust so that they give the Health and Wellbeing Board (HWBB) and partners a clear picture of how effectively we are working to tackle health inequalities. This will involve identifying indicators that can be scrutinised at sub-borough level to look at inequalities within Merton,

and which enable tracking of change over time. The summary indicator table (see APHR Section 5) highlights some of the indicators we think would be most useful, including measures of inequalities in life expectancy, deprivation, education, employment (taking into account the changes to benefits with the introduction of Universal Credit by 2020), and a selection of key healthy lifestyle and disease indicators for children and adults.

- We need to be realistic about timescales in which we can expect changes to the inequality gaps in Merton to occur: different types of interventions will take different amounts of time to demonstrate impact. When setting targets, we therefore need to be explicit about the timescales within which we would expect to see changes to different metrics, and that these timeframes are likely to sit outside any local and national political cycles, requiring coordinated action over time. This is discussed in more detail in the APHR, Part 1.

- Because some of the longer term health outcomes will take time to address, when developing a set of indicators to monitor progress through strategies such as the HWBS or the NHS's Local Health and Care Plan (covering 3-5 year time periods), it will be important to consider an underpinning logic model or theory of change, in order to choose shorter term 'proxy' measures that can help to suggest if change is occurring in the right direction. This is discussed in more detail in the APHR, Part 3.

- A standardised methodology should be used across Merton to be able to effectively monitor inequalities and progress towards closing the gap, and we recommend that the methodology set out in the attached APHR (Section 2.2) is adopted across the Merton Partnership.

- Although this APHR has focused on place-based deprivation-linked inequality (using most/least deprived wards, or East/West gap), this is not the only way in which data should be broken down to look at inequalities: where possible it is important to look at inequalities by age, sex, ethnicity and other protected characteristics.

- It is important to measure inequalities in a standardised way, but the attached report highlights some important limitations in the data available which make measurement of inequalities challenging. In particular, many nationally available health and wellbeing indicators are only available at borough not ward level which does not enable analysis of sub-borough health inequalities, do not have timely data available, or lack historic data which means that we cannot analyse the trend in inequalities over time. Given this, Merton Public Health will feed back to PHE about the availability of sub-borough indicator data in easy to use formats, to inform their ongoing support to local authority public health teams. We will also respond to the government's consultation on Universal Credit metrics, to ensure data supports monitoring of inequalities over time.

3 CONCLUSION

3.1. Health and Wellbeing Board members are therefore asked to receive the APHR (see Appendix) and endorse it for publication. It will be presented to MCCG

Governing Body on 4 July and Cabinet on 30 July 2018 before design and publication.

3.2. HWBB members are also asked to actively consider the recommendations of the APHR and how they apply to partners, in particular how partners work to tackle inequalities, taking into account the evidence on what works, as set out in the APHR;

4 ALTERNATIVE OPTIONS

4.1. None

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. APHR will be professionally designed, and published as part of the Merton JSNA website, and disseminated widely through officers, members and partners.

6 TIMETABLE

6.1. The APHR will be taken to MCCG Governing Body and Cabinet according to the timetable below. Following this, it will be professionally designed, and published in August 2018 as part of the Merton JSNA website.

Action	Date
HWBB – to be received and endorse publication	26 June 2018
MCCG Governing Body – to be received and endorse publication	04 July 2018
Cabinet – to be received and endorse publication	30 July 2018
Design and typesetting (TA2 design agency)	July/August 2018
Print / launch / disseminate report and supporting materials	August 2018

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. None for the purpose of this report. Implementation of the recommendations of the APHR is based on delivery within existing resources by changing ways of working of the Council and partners rather than new investment.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. Producing an independent APHR is a statutory duty of the Director of Public Health.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. The APHR focuses on health inequalities – with analysis of the current picture of inequalities in Merton, and recommendations on how to monitor them and how to address them in Merton.

9.2. It aims to support LBM to deliver its Public Sector Equality Duty obligations under the Equality Act 2010, which means that we need to pay due regard to equality and inclusion issues in all of our decision making.

10 CRIME AND DISORDER IMPLICATIONS

10.1. None

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. None

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

APHR 2018

APHR 2018: Supplementary Data Report

13 BACKGROUND PAPERS

13.1. None

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Annual Public Health Report 2018: *Tackling health inequalities - progress in closing the gap within Merton*

Contents

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May 2018

Foreword [to write]

Director of Public Health

Councillors (Cabinet Member for Adult Social Care and Health; Cabinet Member for Children's Services)

CCG Chair

EXECUTIVE SUMMARY

Context

This Annual Public Health Report (APHR) looks at health inequalities in Merton – the current picture and progress in closing the gap. This topic was selected for a number of reasons:

- It is a longstanding aim of the Merton Partnership to 'bridge the gap' between the east and west of the borough, addressing the disadvantage that some communities face;

- Our Public Sector Equality Duty obligations under the Equality Act 2010 mean that we need to pay due regard to equality and inclusion issues in all our decision making. Analysis in this report aims to support the Council and partners to meet this duty;

- Closing the gap in health inequalities was the overarching aim of the Health and Wellbeing Strategy (HWBS) 2015-2018; and this analysis is therefore central to impact monitoring, and to informing the refresh of the HWBS 2019-2024;

- Analysis and recommendations from this APHR will also inform other strategic work underway in health and social care, including the development of the Local Health and Care Plan, the developing Merton Prevention Framework, and the development and evaluation of the East Merton model of health and wellbeing centred on the Wilson site;

- There is synergy with the continued focus on health inequalities in London, including the refresh of the Mayor's Health Inequality Strategy.

Purpose

The APHR 2018 aims to provide a reference for officers, partners and residents to understand what we mean by inequalities, specifically health inequalities but also the underlying drivers of differences in health outcomes between different groups – inequalities in the social determinants of health such as poverty, education and employment.

The purpose of the APHR 2018 is to inform a shared understanding of where we are now, how far we have come in bridging the gap between the most and least deprived using some key indicators, and how we might best approach and monitor health inequalities in future.

The APHR 2018 is split into the following sections:

- Part 1 gives an overview of what we mean by inequalities, specifically health inequalities; how we measure them; and what we know works to tackle them;

- Part 2 outlines what we know about health inequalities in Merton over time (using a selection of health-specific indicators and others that represent the social determinants of health), and describes the methodology used to analyse the inequality gap.

- Part 3 concludes with a summary of what we can learn from this piece of work to take forward into the HWBS refresh and other strategic work.

The APHR 2018 is complemented by a *Supplementary Data Report* with additional analysis.

Summary of key findings

This APHR on Health Inequalities has investigated some of the key inequality gaps between the most and least deprived communities in Merton that impact on health outcomes. It casts new light and produces clear evidence to show a sustained gap in health and wellbeing across communities in Merton and provides robust data, on which our plans and policies can build, to address these inequalities.

- We know that there are inequalities between the east and the west of the borough, but this is the first time that we have looked systematically at the scale and trend in inequalities in Merton over time. This process has shown that it is more complex to monitor health inequalities than it first appears, and has been very useful to identify an approach that will help us to effectively track inequalities going forward.

- APHR analysis shows that inequalities are evident in every indicator we studied, the vast majority of which show a worse picture in the most deprived areas, as we would expect. Recent supplementary analysis from Public Health England (PHE)[1] reveals that the top three health indicators most strongly associated with deprivation locally are emergency hospital admissions; childhood obesity; and hospital stays for alcohol-related harm.

- These cumulative inequalities – which are evident throughout different life stages and in the environment within which our residents live – contribute to the overarching inequalities in health outcomes that we see in the significant differences in life expectancy of around 6.2 years for men and 3.4 years for women between the most and least deprived areas.[2] Inequalities in *healthy* life expectancy are even starker, with a difference of more than 9 years of healthy life between most and least deprived areas.

- In terms of trend in inequalities in Merton, the picture is mixed. There are some success stories, for instance the reducing gap between the most and least deprived areas in life expectancy for women, in School Readiness, and in the proportion of the economically active population claiming jobseeker's allowance (JSA), and the apparent reduction in the Child Poverty gap. However, the majority of indicators either show the inequality gap to be stable over time, to be increasing, or to be reducing for the 'wrong' reasons (for instance because the situation for those in more affluent areas appears to be worsening whilst that for those in the more deprived areas remains stable, narrowing the gap). It is evident from this analysis that inequalities in Merton are intransigent, and we need to keep them under review over a longer time frame.

The data gathered and analysis undertaken here will help inform the Merton HWBS which is being refreshed for 2019. This work represents the opportunity to act to address the identified inequalities by focusing on early intervention and a Health in All Policies approach.

As the analysis confirms that health inequalities are persistent, complex and difficult to shift, in order to make any progress, we have to actively and systematically target them through a long-term multi-sectoral approach across all partners; if we take our eye off the ball, health inequalities are likely to increase. Therefore we need to continuously monitor progress and review our approach over time

Recommendations for tackling health inequalities in Merton

A. Recommendations for tackling health inequalities in Merton

- We have Public Sector Equality Duty obligations under the Equality Act 2010, which means that we need to pay due regard to equality and inclusion issues in all of our decision making. The analysis in this APHR suggests that in order to make progress on closing the inequality gap in Merton, we need to actively and systematically target inequalities through a long-term multi-sectoral approach across all partners. This action should be based on detailed understanding of our population need, as set out in the Joint Strategic Needs Assessment (JSNA), and grounded in evidence of what works (discussed in more detail in Part 1).

- Whilst recognising the role of personal prevention approaches to improve health (e.g. support for individuals to stop smoking), the evidence shows that we need to rebalance our efforts towards population level prevention, recognising both the increased cost-effectiveness of interventions at population level compared to personal level interventions, and the evidence of increased impact on health inequalities.

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[1] PHE Health Inequalities Briefing for Merton, March 2018 (relevant findings included in this APHR)

[2] These figures are from the national 'Slope Index of Inequality' indicator which looks at inequalities in life expectancy at birth between the 10% most and 10% least deprived areas in a borough. Readers may be aware that these are different figures for the gap in life expectancy than previously reported, for instance through the JSNA 2013/14 which gave a figure of 9 years for men and 13 years for women. See Box 3 in Chapter 1 of this report for an explanation of the changes to the data, trend and methodology behind the figures, and why we recommend the use of this Slope Index going forward, as the headline life expectancy indicator.

- In order to reduce the steepness of the social gradient in health outcomes, the evidence shows that a 'proportionate universalism' approach should be adopted, meaning that population-wide action is vital, but that universal interventions should be undertaken with a scale and intensity that is proportionate to the level of disadvantage. Action needs to be taken across the whole life course so that all Merton residents can start well, live well and age well.

- In order to be effective, the evidence shows that approaches must be underpinned by participatory decision-making and co-design, empowering individuals and communities.

- The Health and Wellbeing Strategy to be refreshed from 2019 will form a core strand of Merton's strategy to reduce inequalities, and will seek to address the health inequalities issues identified in this report through the approaches outlined above.

B. Recommendations for monitoring health inequalities in Merton

- The detailed analysis in this APHR will inform the suite of indicators for the HWBS from 2019. We want these indicators to be challenging, but also realistic and robust so that they give the Health and Wellbeing Board (HWBB) and partners a clear picture of how effectively we are working to tackle health inequalities. This will involve identifying indicators that can be scrutinised at sub-borough level to look at inequalities within Merton, and which enable tracking of change over time. The summary indicator table (Section 5) highlights some of the indicators we think would be most useful, including measures of inequalities in life expectancy, deprivation, education, employment (taking into account the changes to benefits with the introduction of Universal Credit by 2020), and a selection of key healthy lifestyle and disease indicators for children and adults.

- We need to be realistic about timescales in which we can expect changes to the inequality gaps in Merton to occur: different types of interventions will take different amounts of time to demonstrate impact. When setting targets, we therefore need to be explicit about the timescales within which we would expect to see changes to different metrics, and that these timeframes are likely to sit outside any local and national political cycles, requiring coordinated action over time. This is discussed in more detail in Part 1.

- Because some of the longer term health outcomes will take time to address, when developing a set of indicators to monitor progress through strategies such as the HWBS or the NHS's Local Health and Care Plan (covering 3-5 year time periods), it will be important to consider an underpinning logic model or theory of change, in order to choose shorter term 'proxy' measures that can help to suggest if change is occurring in the right direction. This is discussed in more detail in Part 3.

- A standardised methodology should be used across Merton to be able to effectively monitor inequalities and progress towards closing the gap, and we recommend that the methodology set out in this report (Section 2.2) is adopted across the Merton Partnership.

- Although this APHR has focused on place-based deprivation-linked inequality (using most/least deprived wards, or East/West gap), this is not the only way in which data should be broken down to look at inequalities: where possible it is important to look at inequalities by age, sex, ethnicity and other protected characteristics.

- It is important to measure inequalities in a standardised way, but this report highlights some important limitations in the data available which make measurement of inequalities challenging. In particular, many nationally available health and wellbeing indicators are only available at borough not ward level which does not enable analysis of sub-borough health inequalities, do not have timely data available, or lack historic data which means that we cannot analyse the trend in inequalities over time. Given this, Merton Public Health will feed back to PHE about the availability of sub-borough indicator data in easy to use formats, to inform their ongoing support to local authority public health teams. We will also respond to the government's consultation on Universal Credit metrics, to ensure data supports monitoring of inequalities over time.

INTRODUCTION AND CONTEXT

The first priority of the Merton Partnership Community Plan is working to bridge the gap between the east and west of the borough and between different communities.

This Annual Public Health Report (APHR) aims to provide a reference for officers, partners and residents to understand what we mean by inequalities, specifically health inequalities but also the underlying drivers of differences in health outcomes between different groups – inequalities in the social determinants of health such as poverty, education and employment.

It aims to inform a shared understanding of where we are now, how far we have come in bridging the gap between the most and the least deprived areas in Merton for some key indicators, and how we might best approach and monitor health inequalities going forward.

It is a statutory duty for the Health and Wellbeing Board to produce a joint Health and Wellbeing Strategy (HWBS), based on the Joint Strategic Needs Assessment. The current Merton Health and Wellbeing Strategy 2015-2018 is coming to an end, and one aim of this APHR is explicitly to help inform the choice of indicators for the development of the Health and Wellbeing Strategy refresh from 2019.

This report is split into the following sections:

PART 1	Gives an overview of what we mean by inequalities, how we measure them, and what we know works to tackle them.
PART 2	Looks at what we know about health inequalities in Merton now and over time, and describing the methodology used to conduct inequality gap analysis, and using some key indicators to give an indication of the complex picture.
PART 3	Discusses what we can learn from this piece of work to take forward into the HWBS refresh and other strategic work such as the Local Health and Care Plan.

# 1. PART 1: WHAT DO WE KNOW ABOUT HEALTH INEQUALITIES?

1.1. What do we mean by 'health inequalities'?

Health inequalities are unfair and avoidable differences in health status or the distribution of health determinants between different groups of people or communities.[34] Inequalities in health are driven by inequalities in society – "the conditions in which people are born, grow, live, work, and age."[5]

Therefore this report looks at both health inequalities themselves (such as differences in life expectancy between the most and least deprived areas in Merton), as well as at inequalities in these broader determinants of health, such as poverty, education and employment.

There are many aspects of inequality that could be analysed, for instance by age, sex, ethnicity or other protected characteristics, but in this report, we focus on comparing geographic inequalities (between the East and the West of the borough) and/or socioeconomic inequalities (between the most and least deprived areas). In Merton, there is significant correlation between socioeconomic inequalities and geography, with the east of the borough being more deprived than the more affluent west.

Figure 1: Dahlgren & Whitehead diagram: determinants of health and wellbeing
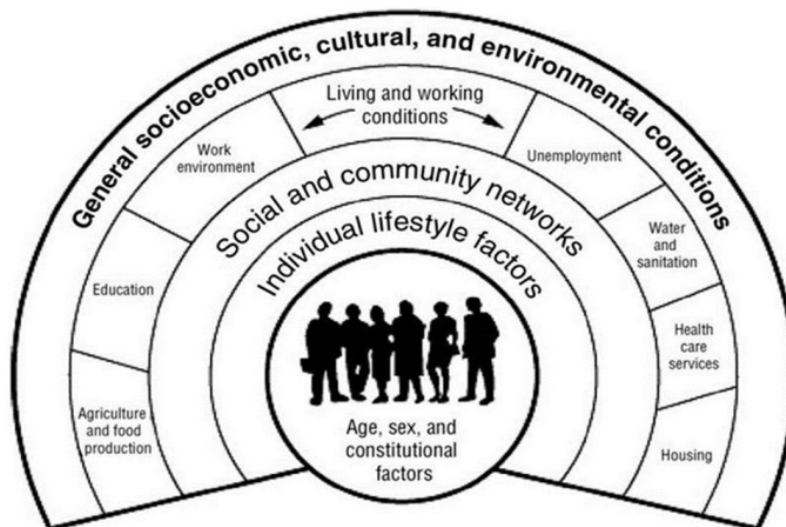
In 2008, Professor Sir Michael Marmot chaired an independent national review to propose the most **effective evidence-based strategies for reducing health inequalities** in England. The resulting report, 'Fair Society Healthy Lives' (2010) concluded that:

- **Health inequalities result from social inequalities** – the 'causes of the causes' or social determinants such as education, employment and living conditions. The result is a clear social gradient in health across society.

- This was demonstrated nationally by the **significant inequalities in life expectancy**, with those living in the poorest areas in England dying on average 7 years earlier than those in the richest areas at the time of the report.

- The more shocking finding was that **people in poorer areas not only die earlier but live more of their shorter lives in poor health** – on average living 17 years more of their lives with a disability than those in richer neighbourhoods (Figure 2).

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[3] World Health Organisation glossary http://www.who.int/hia/about/glos/en/index1.html
[4] PHE (2017) Reducing health inequalities: system, scale and sustainability
[5] Marmot Review (2010) Fair Society Healthy Lives

- However, the good news is that **health inequalities are not inevitable or immutable** – they *can* be prevented and rolled back, through coordinated action across all the social determinants of health, and across all sectors of society not just the most disadvantaged. This approach is called '**proportionate universalism**' – taking action **across the whole population** at sufficient scale and intensity to be universal but at the same time with effort **proportionately targeted** to particular groups in order to reduce the steepness of the social gradient in health inequalities over time (Figure 3).

Figure 2 – Life expectancy and disability free life expectancy at birth, persons by neighbourhood income level, England 1999-2003 (Source: Fair Society, Healthy Lives, 2010)
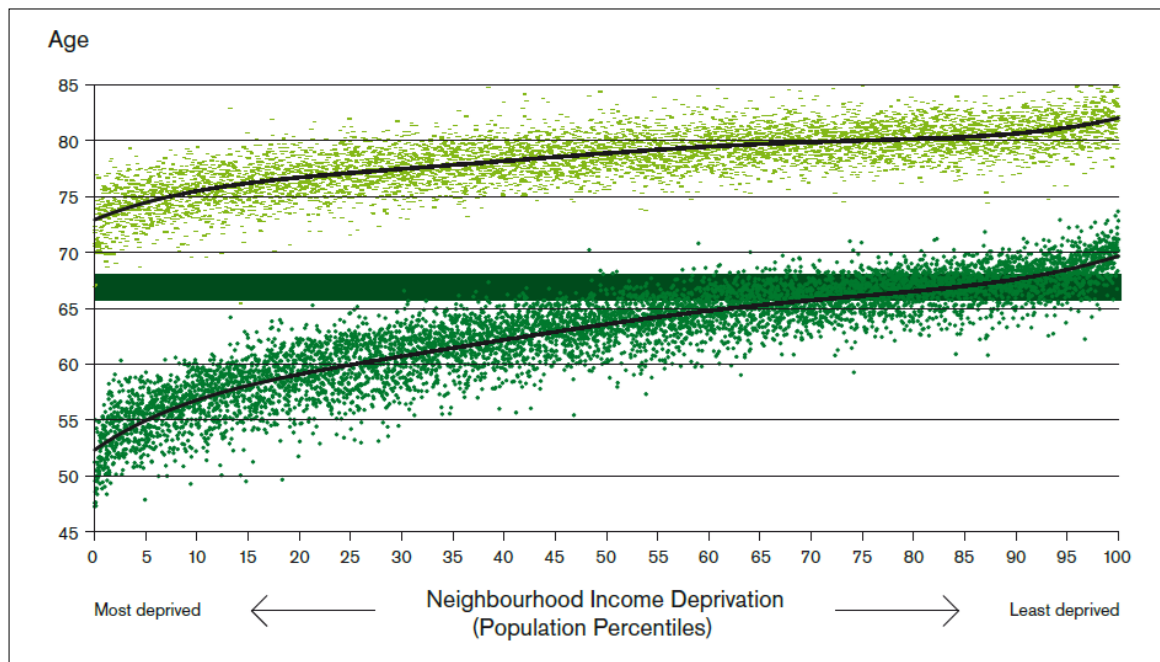
Figure 3 – Proportionate universalism: acting across the social spectrum to change the health outcomes and reduce inequalities (Source: UCL Institute of Health Equity)
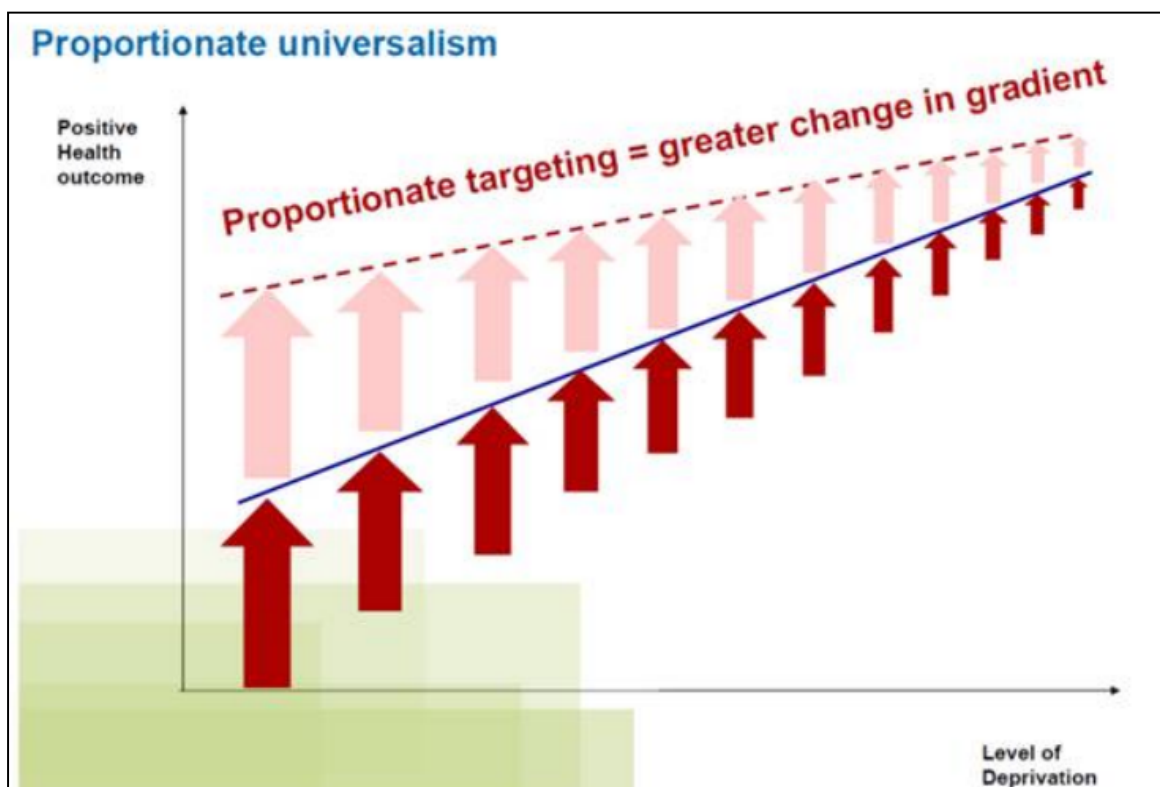
- The evidence set out in the Marmot Review also suggests that in order to shift health inequalities, **action needs to be taken across the life course**, even starting pre-conception, taking into account the accumulation of positive and negative effects on health and wellbeing throughout an individual's life (Figure 4). Marmot's six priority areas for action are given in Appendix 3.

- Marmot concluded that **reducing health inequalities is vital to a productive economy**, and that there is significant cost of inaction. Specifically, the Marmot Review estimated that inequality in illness can lead to productivity losses of between £31-33 billion per year, as well as the cost of lost taxes and higher welfare payments.

Figure 4 – 'Action across the life course' (Source: Fair Society, Healthy Lives, 2010)
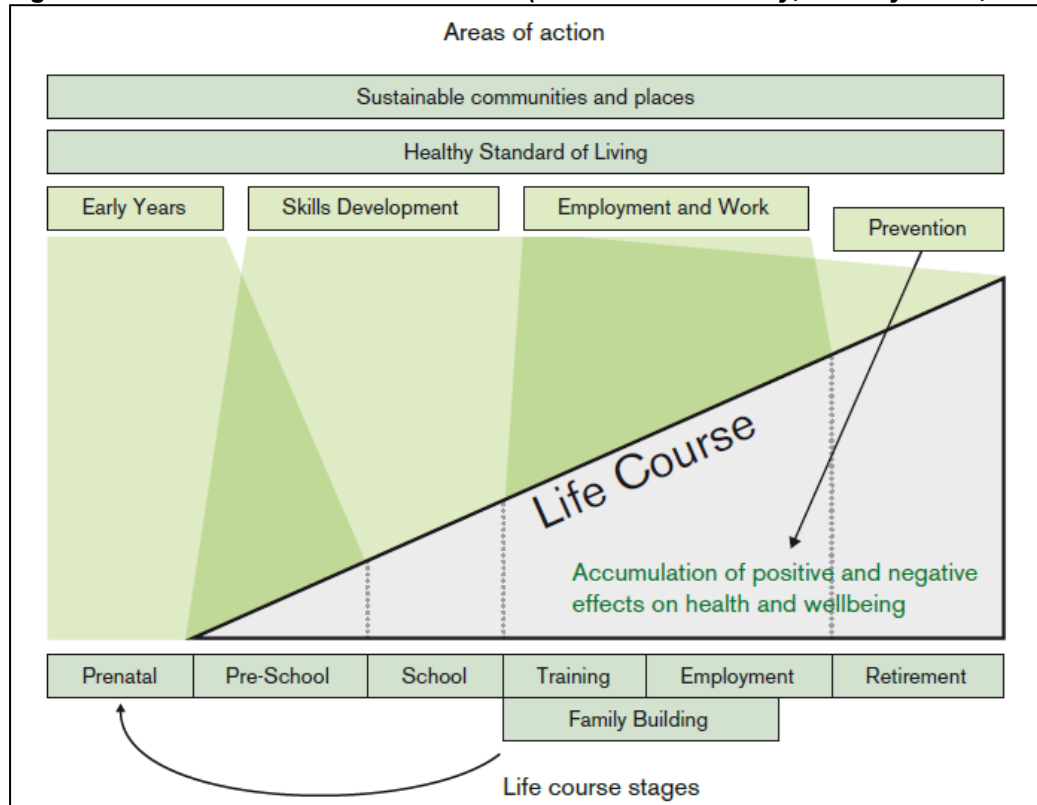
The most recent national data from Public Health England shows that over the past 15 years, **both life expectancy and healthy life expectancy in England have increased**, with the general population on average living longer and spending more years in good health. However, life expectancy has increased by more years than healthy life expectancy and so the average number of years lived in poor health has also increased.[6] The data also shows that despite the long term trend of improvement in life expectancy and other headline indicators, stark inequalities remain. There has been **little change in inequalities** in male life expectancy, male and female healthy life expectancy and premature cancer mortality between the most and least deprived tenth of areas. For female life expectancy, there has been a small widening of the gap between the most and least deprived areas.[7]

However, there is some evidence that a targeted and coordinated cross-government and NHS approach in some deprived areas **may be showing some impact** on inequalities.[8]

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[6] PHE (2017) Health Profile for England https://www.gov.uk/government/publications/health-profile-for-england

[7] PHE (2017) Health Profile for England: Chapter 5 – inequality in health https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health#trends-in-health-inequality

[8] BMJ (2017) Investigating the impact of the English health inequalities strategy: time trend analysis http://www.bmj.com/content/358/bmj.j3310

1.2. How we measure and interpret inequalities

<u>Absolute versus Relative inequality</u>

We can measure either absolute or relative inequalities. Relative inequality looks at ratios, or *proportional* differences between groups (an example is the internationally used Gini co-efficient which looks at income inequality); absolute inequality reflects the *magnitude* of differences between groups. Both are useful measures, but when thinking about tracking health inequalities in Merton in this report, we have concentrated on looking at the absolute rather than the relative gap as it is easier to interpret.

In this report, we look at the absolute gap between the most and least deprived communities in Merton. The specific methodology used, and how the use of most/least deprived communities aligns with East/West Merton, is set out in Section 2.2.

Box 1 – Absolute vs. Relative inequality: an example

Consider someone in East Merton with an income of £10,000 compared to a West Merton resident with an income of £100,000. The *relative inequality* is 1:10, and does not change if these incomes both rise to £20,000 and £200,000 respectively (i.e. the ratio remains the same, 1:10). However, the *absolute* gain to the resident in West Merton of a doubling in salary is much larger than the gain to the resident in East Merton - £100,000 compared to £10,000, shown by the increase in the absolute inequality gap, from £90,000 to £180,000.

<u>Interpreting changes in inequalities</u>

We have to be careful when interpreting headline statistics, as an overall 'reduction' in inequality (for example, a narrowing of the absolute gap) may not be due to improved circumstances or outcomes for the most disadvantaged, but actually due to worsening or flat-lining outcomes in more affluent groups. This is demonstrated by a recent report from the Institute for Fiscal Studies on living standards which shows that the gap between the UK's richest and poorest households has narrowed since the 2007-08 recession, but that some of this narrowing has been driven by falls in the incomes of middle and top earning households, many of whom are employed in hardest hit financial and insurance sectors.[9] This apparent 'reduction in the inequality gap' is not a positive outcome, and would not be a good news story for Merton residents.

Inequalities may also appear to shift if there are significant population changes over time in an area. For instance, inward migration of more affluent groups with better health status into an area over time, e.g. as a result of new developments, or outward migration of more deprived groups with worse health status e.g. due to lack of affordable housing may *appear* to improve data on inequalities, but will not actually represent a real terms benefit for local residents. An understanding of the local population demographics and how they are changing over time is vital when interpreting changes to inequalities data.

It is also important to note that inequalities are often entrenched and will take time to shift, so we need to be planning for coordinated action beyond local and national political cycles.

What we want is for *everyone's* health and wellbeing to improve but that of the poorest to improve *fastest*. As the evidence set out by Marmot shows, the best way to do this is through a 'proportionate universalism' approach. This approach is supported by the National Institute for Health and Care Excellence (NICE): "*Tackling the social gradient in health requires a combination of both universal (population-wide) and targeted interventions that reflect the level of disadvantage and hence, the level of need.*"[10]

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[9] IFS (2017) Living standards, poverty & inequality in the UK https://www.ifs.org.uk/publications/9539
[10] NICE 2012 Health Inequalities and Population Health
https://www.nice.org.uk/advice/lgb4/chapter/Introduction

1.3. What we know works to tackle health inequalities

So, to make sufficient progress at a population level on inequalities in health outcomes, such as inequalities in life expectancy and healthy life expectancy, the evidence tells us that sustainable and systematic action must be delivered at scale in the following ways:[11]

A. Intervening for population level impact

We know that in order to have an impact at population level, we need to take action at individual, community and population levels – separately, these are all important, but a combination of actions across these different levels will lead to greater impact. For example:

- *Individual level*: smoking cessation services delivered through primary care;

- *Community settings:* Health Champions and other peer support for healthy behaviours within community groups; health promoting environments and policies within schools, workplaces, high streets;

- *Population*: adopting a Health in All Policies approach across partners to influence the structural obstacles to good health, for example though healthy public policy (legislation, taxation, welfare etc) and a healthy urban environment.

This tiered approach in Merton underpins our developing 'Prevention Framework' (Figure 7).

Figure 7 - Merton Prevention Framework (Source: Merton Public Health)
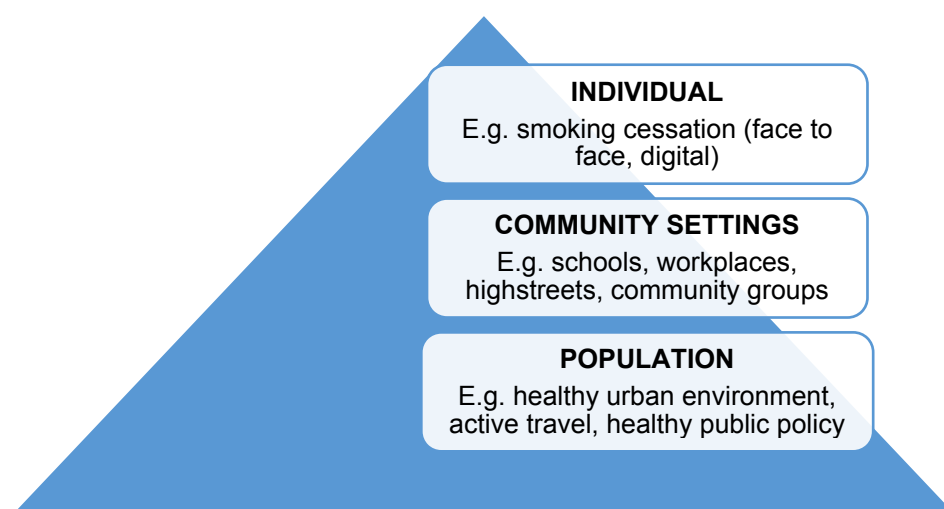
At an individual level, there is evidence of the importance of the role that health and care services can play, in particular **primary care and community services**, in reducing inequalities, especially as people grow older with multiple morbidities..[12]

The evidence also shows that, whilst recognising the role of individual level approaches to improve health, it is important to **rebalance our efforts towards population level prevention** and efforts to address the social determinants of health, recognising both the increased cost-effectiveness of interventions at population level compared to personal level interventions, and the evidence of increased impact on health inequalities.[13]

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[11] PHE (2017) Reducing health inequalities: system, scale and sustainability

[12] NHS Reducing health inequalities resources: https://www.england.nhs.uk/about/equality/equality-hub/resources/evidence/

[13] McDaid, D, Sassi, F & Merkur, S (2015) Promoting Health, Preventing Disease: The Economic Case. World Health Organisation: http://www.euro.who.int/__data/assets/pdf_file/0006/283695/Promoting-Health-Preventing-Disease-Economic-Case.pdf?ua=1

We also know that we need to take a strategic and coordinated approach, with **interventions that are evidence-based, outcomes orientated, systematically applied, scaled up appropriately, appropriately resourced, and sustainable**.

In order to be effective, approaches must also be underpinned by effective participatory decision-making and co-design of interventions at local level, through **empowering individuals and local communities.**[14]

B. Intervening at different levels of risk

We know that there are different types of risk factors that drive poor health:

- Physiological risks e.g. high blood pressure, high cholesterol, chronic stress, depression;

- Behavioural risks e.g. smoking, poor diet, low physical activity, excess alcohol;

- Psychosocial risks e.g. loneliness, poor self-esteem, poor social networks;

- These risks are all influenced by wider risk conditions, or determinants of health, e.g. poverty, unemployment, poor educational attainment.

These four levels of risk are all interconnected. Therefore the evidence suggests that is important that **strategies to tackle health inequalities contain population-level actions across each of these levels of risk**, rather than solely individual level approaches, in order to create impact at a sufficient and sustainable scale.

Figure 5: Intervening at different levels of risk affecting health and wellbeing (Source: adapted from PHE (2017) Reducing health inequalities: system, scale and sustainability, p11)

[FINAL REPORT TO INCLUDE MERTON-ISED FIGURE INCORPORATING BOTH BELOW]
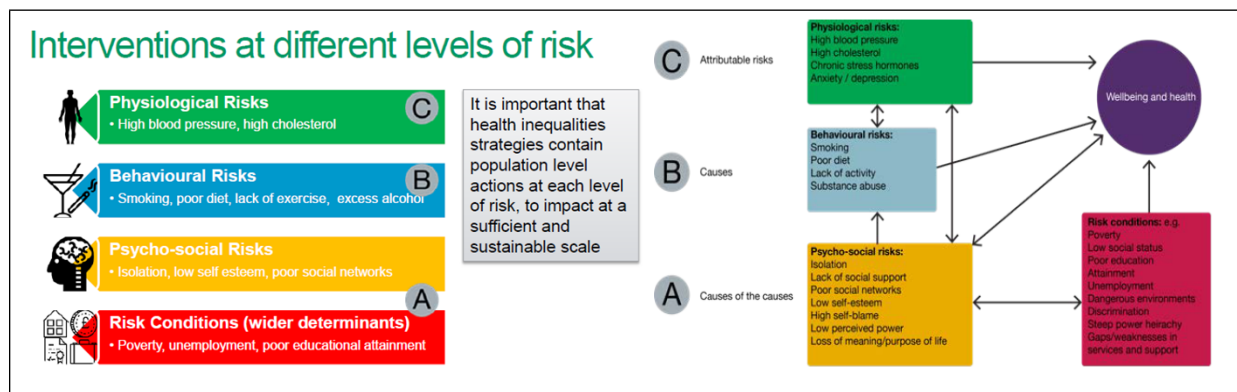
C. Intervening for impact over time

We know that different types of interventions will take different amounts of time to demonstrate impact. For example, stopping smoking is likely to show impact over a short time period in terms of improved health and wellbeing for an individual (in addition to the longer term improvements to life expectancy and healthy life expectancy across a lifetime), where as interventions to improve community green and built infrastructure – encouraging more people to walk and get active – are likely to take a decade or more for any impact on health to begin to become apparent. See Figure 6 for indicative timescales for different types of interventions.

Therefore **we need to be realistic about when we are likely to see any changes to different health outcome metrics,** depending on the type of intervention.

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[14] Marmot Review (2010) Fair Society Healthy Lives

Figure 6: Time needed to deliver outcomes from different intervention types (Source: adapted from PHE (2017) Reducing health inequalities: system, scale and sustainability, p11)

[FINAL REPORT WILL INCLUDE MERTON-ISED FIGURE – could consider using same colour scheme in Column 5 of the table in Section 5?]
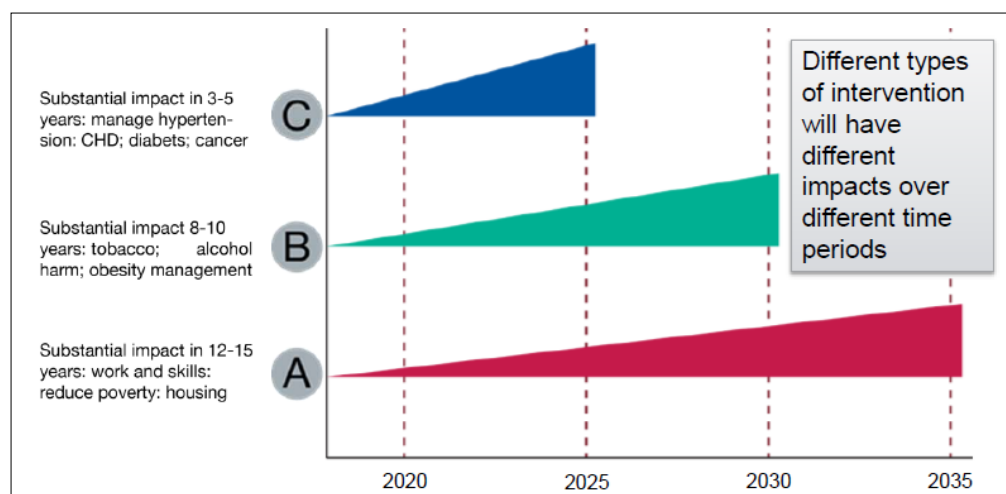
D. Intervening across the life course

We know that reducing health inequalities is most effective when we purposefully **tackle the wider determinants of health throughout the life course**, starting early in life (even before birth), ensuring every child has the best start in life, that children, young people and adults are able to maximise their capabilities and have control over their lives, and have access to fair employment and good work, within healthy and sustainable places and communities, all the way through to older age.[15] Marmot's six priority areas for action across the life course are set out in Appendix 3.

In summary, what we know about health inequalities and how to tackle them:[16]

- Health inequalities are persistent, complex and difficult to shift.

- In order to make any progress, we have to actively and systematically target inequalities through a long-term multi-sectoral approach across all partners – including the NHS, Council, voluntary sector and the community – working at individual, community and population levels.

- We need to base our approach on evidence of what works to shift inequalities:

  o Intervening for population level impact, particularly given the increased cost-effectiveness of population level interventions compared to personal level interventions, and increased impact on health inequalities

  o Intervening at different levels of risk, including the importance of the role that NHS primary care and community services play in reducing inequalities;

  o Intervening for impact over time;

  o Intervening across the life course;

  o The importance of community empowerment.

- If we take our eye off the ball, health inequalities are likely to increase. Therefore we need to continuously monitor progress and review our approach over time.

See Appendix 1 for further reading and other useful tools for tackling health inequalities.

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[15] Marmot Review - Fair Society Healthy Lives 2010
[16] Adapted from Kings Fund (2017) https://www.kingsfund.org.uk/blog/2017/08/reducing-inequalities-health-towards-brave-old-world

2. PART 2: ANALYSIS OF HEALTH INEQUALITIES IN MERTON

2.1. The Merton Story: overview of Merton as a place

Overall Merton is healthy, safe and has strong public and community assets. The health of people in Merton is generally better than the London and England average: life expectancy is higher than average and rates of death considered preventable are low. This is largely linked to the lower than average levels of deprivation in Merton. We have a range of public and community assets that are important to health; there are many green spaces, vibrant libraries, educational attainment is high, we have a wealth of small businesses and a strong Chamber of Commerce, as well as an active Voluntary and Community Sector and high levels of volunteering. We have good transport hubs, and a significant proportion of people who live in Merton also work in the borough.

However, despite this positive picture, there are areas of concern. Significant social inequalities exist within the borough, and these are important drivers of poor health and wellbeing outcomes.

The Index of Multiple Deprivation (IMD) map (Figure 8) illustrates the contrast between the east and west of Merton: the darker the shading, the higher the level of deprivation. This shows that the most deprived areas are concentrated in the East of the borough, and the least deprived in the West.

Figure 8: Index of Multiple Deprivation (IMD) 2015 for Merton Wards
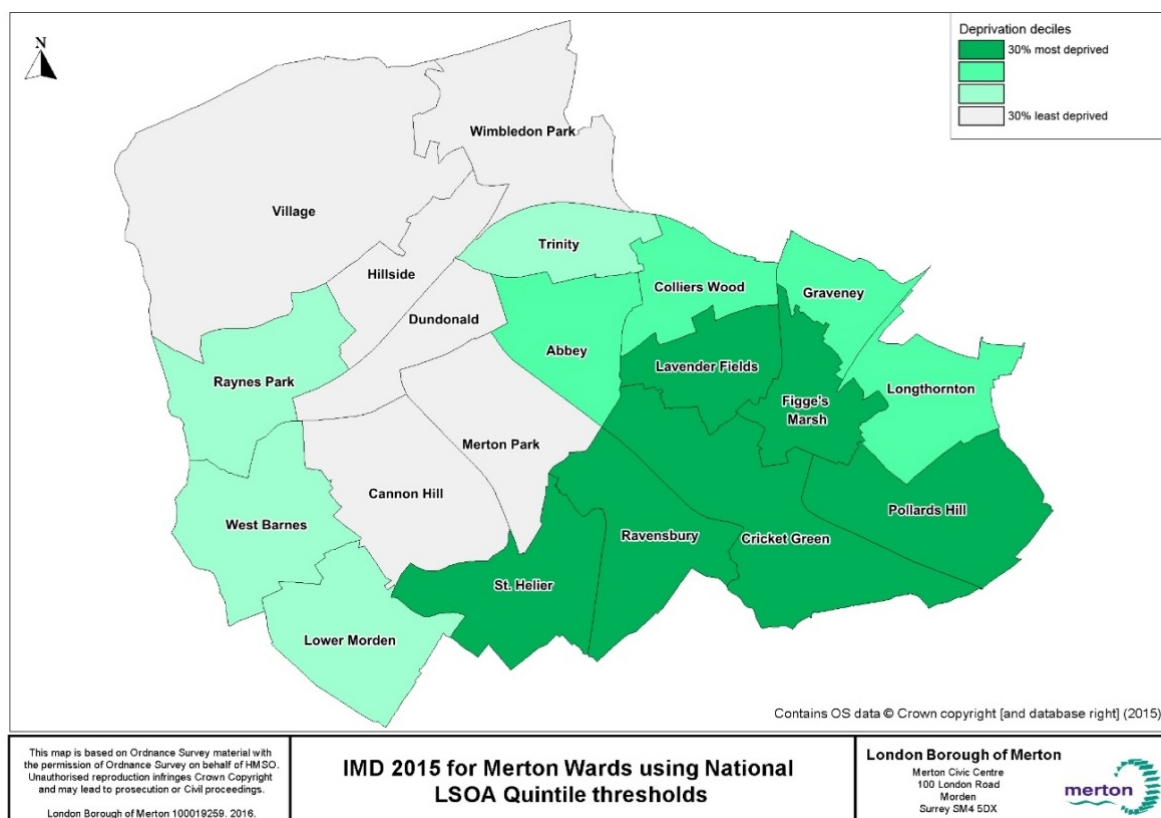
The Merton Story 2018 is a summary of the Joint Strategic Needs Assessment, and gives more detail of the distribution of risk and resilience factors for health and wellbeing in Merton, as well as the patterns of mortality and morbidity from disease.[17]

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[17] See the Merton Story 2018: https://www2.merton.gov.uk/health-social-care/publichealth/jsna.htm

2.2. Methodology for inequality 'gap analysis' used in this report

Inequality gap analysis: comparison of most and least deprived wards ('30/30')

This APHR on Health Inequalities uses a simple deprivation gap analysis to look at inequalities in Merton for a number of key indicators. Inequalities in health and the wider social determinants of health are often considered in terms of the gap between the most and least deprived groups of the population. Therefore, where possible in this report, the gap analysis carried out presents the difference between the averages of the 30% most and 30% least deprived wards in Merton based on the 2015 Index of Multiple Deprivation (IMD) deciles. Figure 9 below shows which wards fall into which category.

There are 20 wards in Merton, none of which fall into the IMD classification decile 1 or decile 2 (the most deprived). The 30% most deprived wards are classified in deciles 3 and 4, and the 30% least deprived wards are classified in deciles 9 and 10. The wards that are classified in deciles 3 and 4 are located in the east of the borough; similarly Merton wards in deciles 9 and 10 align with west Merton.

Gap analysis is useful in that it is a relatively easy concept to understand, and can be calculated easily without the need for statistical modelling. However, it is limited in that it only reflects the difference between the highest and lowest socioeconomic or deprived groups and can be potentially affected by extreme values within each of these groups.

This methodology was checked and agreed as valid by the Marmot team at the Institute of Health Equity at University College London.[18]

Figure 9: Wards in Merton split by deprivation decile, based on the 2015 IMD deciles

Decile	Ward name	Locality	
1	-	-	
2	-	-	
3	Cricket Green	East	
4	Figge's Marsh	East	30% Most Deprived
4	Lavender Fields	East	
4	Pollards Hill	East	
4	Ravensbury	East	
4	St Helier	East	
5	Longthornton	East	
6	Colliers Wood	East	
6	Graveney	East	
7	Abbey	East	
8	Lower Morden	West	
8	Raynes Park	West	
8	Trinity	West	
8	West Barnes	West	
9	Cannon Hill	West	30% Least Deprived
9	Dundonald	West	
9	Hillside	West	
9	Merton Park	West	
9	Wimbledon Park	West	
10	Village	West	

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[18] Institute of Health Equity: http://www.instituteofhealthequity.org

Inequality gap analysis: comparison of East/West wards ('E/W')

We were only able to calculate the gap between the most/least deprived for indicators where data was available by ward. For some indicators – particularly health related behaviours such as smoking, and morbidity data such as diabetes prevalence – local level data (and/or trend data) was only available by GP practice as it was based on GP-recorded interactions. In these cases, we have presented the results by East/West rather than most/least deprived. We make it clear for each indicator which analysis has been done, and why. See column 6 of the Summary Table of APHR Indicators in Section 5.

The two methodologies do correlate relatively well, as a comparison of the map in Figure 8 with the map below (Figure 10) shows that the 6 wards in the east of the borough are in the 30% most deprived in England, in contrast with the west of the borough which had 6 wards in the 30% least deprived. The E/W methodology is likely to underestimate the size of the gap, as it includes GP-registered data aligned with *all* wards in East compared to all GP-registered data aligned with *all* wards in West Merton, not just those in the 30% most and 30% least deprived wards. As any East/West inequality gap is based on GP-registered data rather than the 'Merton resident' ward based data used for the most/least deprived calculations, we cannot directly compare figures derived from the two different methodologies.

Figure 10: Merton's East/West split used for gap analysis where only GP level data is available
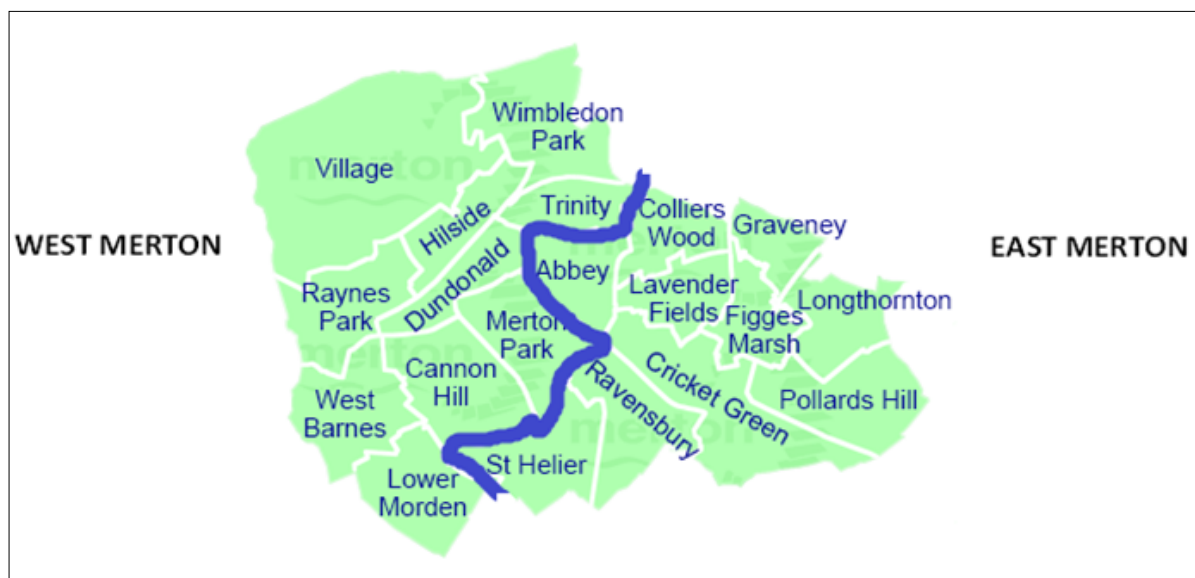
Other statistical calculations and comparisons

Where possible, we also calculated **Confidence Intervals** (see Appendix 4 - Glossary for definitions), in order to gain some indication of whether the inequality gap was likely to be a statistically significant difference, or was within the range of normal variation.

In some instances, where we had some trend data but no very recent data, **Regression Analysis** was conducted, using the current trend data to project more recent missing data points. This enabled us to estimate the inequality gap should current trends continue. This is something that we can do more of, for the chosen indicators, to help us to determine targets for the HWBS.

As the purpose of this report was to look at inequalities within Merton, we have purposefully *not* compared the Merton inequality gap to the gaps found either in statistical comparator boroughs, neighbouring boroughs, London or England, in order to keep the analysis focused on Merton and understanding our local picture as a first step to coordinated action on inequalities. The only exception is the Slope Index of Inequality, as a single overarching statistical measure of inequality calculated centrally by Public Health England (PHE).

We faced a significant number of limitations and challenges with the data available, which has restricted the choice of indicators that we were able to analyse to look at inequality within Merton, particularly over time:

- **Lack of ward level data.** For some indicators which would have provided useful insight into health inequalities, there was no ward level data available, only borough level, so we could not look at the inequality gap within the borough. In some instances, where data was available by GP practice we were able to look at the East/West gap rather than the gap between the most/least deprived, as described above. GP practice data aligned to East/West is useful proxy where ward level data is not available, but there are several caveats that need to be considered when interpreting this data, discussed in Box 2.

Box 2: Caveats when interpreting GP data (patients registered with a Merton GP)

GP Profile and/or Quality Outcomes Framework (QOF) data looks at the population of 'people registered with a Merton GP' rather than Merton residents per se. There will be a proportion of people registered with a GP (and therefore included in the data for that GP practice) who do not live near the GP practice, or even within the borough, for instance those registered with a GP near their work rather than home, or those who live near borough boundaries.

Additionally, compared to data collected in a standardised way across whole populations (e.g. the Census), GP recorded data relies firstly on an individual attending their GP, and then on GP diagnosis and recording of behaviours or conditions. It can therefore be difficult to know how closely the GP diagnosed prevalence correlates with the underlying true prevalence. For instance, if over time GPs get better at asking patients about their smoking status and recording it on the patient record system, then prevalence will appear to increase over the same time period, when in fact the data is just becoming more representative of the true prevalence in the population. In addition, patients in more affluent areas may be more proactive in registering with a GP and/or following up symptoms with their GP, and so diagnosis rates and prevalence may appear higher than in more deprived areas where access may be lower.

Therefore GP data (as with all data) needs to be interpreted carefully, with an understanding of the biases inherent in the collection methods.

- **Limited trend data.** To calculate an accurate trend analysis requires at least 3 points of historic data (i.e. 2014/15, 2015/16, 2016/17), and ideally more. The more historic data points available, the more robust the analysis. For a significant number of indicators, where sub-borough data *was* available, it was *only* available for a single recent time point rather than for a number of points over time, and so trend analysis could not be undertaken. For a few other indicators, due to sample size (small numbers), the data at ward level had to be 'pooled' or grouped over a number of year periods in order to allow meaningful comparison at ward level. This then limited the number of time points that were available for trend analysis. For instance, data on alcohol-related harm was only available for two time points: 2010/11-2014/15 and 2011/12-2015/16, and so trend could not be accurately analysed.

- **Changes to indicator definitions.** Changes to indicator definitions over time restricted the ability to conduct trend analysis, as we would not be comparing 'like with like' and so trend over time could not be accurately analysed. This is the case with indicators such as the Index of Multiple Deprivation (IMD). Changes to indicators in the future may hamper trend analysis going forward, so we need to be up to date with any changes, and aware of the most appropriate indicators to use, for instance with the shift by 2020 from recording claimants of Job Seekers Allowance and other benefits to those claiming Universal Credit.

2.3. Summary of indicators included in this report

The main focus of this report was to test out a methodology for calculating sub-borough health inequalities in Merton, and for tracking progress over time. Therefore the indicators included in this report are not meant to be comprehensive, but rather intended to provide a general picture of health inequalities in Merton, using a standard methodology that can be applied to other indicators, and by other partners not just health.

This report looks at both health inequalities specifically, but also at some of the social inequalities such as poverty, education and employment that drive health inequalities. The focus is on geographic and socioeconomic inequalities, although there are many other aspects of inequality that could be measured in future, for instance by age, sex, ethnicity or other protected characteristics.

Approach to choosing indicators for analysis

The starting point for the indicators chosen for review in this APHR were the two Public Health England (PHE) collections of indicators reported in the Public Health Outcomes Framework (PHOF):[19]

- PHE Marmot indicators (15 indicators), giving an overview of the key social determinants of health covered in the Marmot Review 2010;

- PHE Health Equity indicators (18 indicators, 5 of which overlap with Marmot indicators), covering core health indicators, PHE priority areas, and social determinants of health.

This gave us a total of 28 indicators to review. We looked to see what data was available for each of these indicators at ward level, in order to be able to compare the most and least deprived wards. Only a third (11/28) had any ward level data available to be able to calculate the latest sub-borough inequality gap, and of these, only one (life expectancy) had readily available ward trend data to be able to look at changes in the gap over time. See Appendix 2 for the full list of indicators in these PHE indicator sets.

However, we wanted to include a sample of indicators in this report that represented the key themes found in the Marmot Review on health inequalities, and that gave a picture of the situation in Merton with regards to:

- Risk and resilience factors for health and wellbeing at a personal level (Physiological risks e.g. hypertension; Behavioural risks e.g. smoking; Psychosocial risks e.g. loneliness);

- Wider risk and resilience conditions at a population level (e.g. wider determinants such as poverty, education, employment, housing);

- Some measures of morbidity e.g. diabetes prevalence;

- Some measures of mortality e.g. life expectancy, premature mortality.

Given the substantial limitations in the PHE Marmot and Health Equity indicator data readily available through PHOF to be able to look at sub-borough inequality gaps, let alone the trend in the gap, we therefore supplemented these data sets with other routinely available data sets, particularly those available through the PHE Local Health portal (which provides data at a ward level and allows comparison at a regional and national level), in order to give a picture of the current inequality gap across a range of indicators, but also to look at trend data and whether the situation is improving or worsening.

We focused on national data sources for this report, rather than locally collected Merton data such as the Residents Survey, on the basis that standardised national indicators are more likely to continue to be collected and reported on, and to be available on an ongoing basis. However, this does not mean that it would not be useful to apply this methodology to locally collected data sets in future.

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[19] PHE PHOF: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Structure of health inequalities data included in this report

The report is structured into the following Chapters, which are informed by the Marmot strategic priority areas for tackling heath inequalities, and which correlate with the Themes of the current Health & Wellbeing Strategy 2015-2018:

1. Key overarching indicators of inequality

2. Giving every child the best start in life

3. Prevention of poor physical and mental ill health

4. Creating the conditions for fair employment and good work for all

5. Ensuring a healthy standard of living for all

6. Creating and developing healthy and sustainable places and communities

Appendix 3 shows how the APHR Chapters map to the Marmot strategic priorities for action, and to the HWBS 2015-18 Themes.

Table 1 below summarises the indicators that we considered in detail for this report, by Chapter. Section 5 of this report gives the full list of indicators in table form, with a visual Red/Amber/Green ('RAG') rated summary of whether local level data and/or trend data is available, whether it is likely to be available in future, and whether each indicator would be worth considering for the HWBS refresh 2019+.

Table 1: Summary of indicators included in this APHR on Health Inequalities, by Chapter

Overarching indicators	Best start in life	Prevention of poor health	Fair employment	Healthy living standards	Healthy places and communities
• Life expectancy • Slope Index Inequality (inequality in life expectancy) • Healthy life expectancy • Premature mortality	• Child Poverty / Income Deprivation Affecting Children (IDACI) • School readiness (child development at age 5), all, and those with Free School Meal status • Child excess weight (Reception) • Child excess weight (Y6)	• Smoking prevalence • Alcohol related harm • Hypertension prevalence • Diabetes prevalence • Tuberculosis (TB) incidence • Mental health prevalence • Depression prevalence • Self reported wellbeing	• Economically active population claiming Job seekers allowance (JSA) • Benefit claimants - employment & support allowance (ESA)	• Deprivation IMD 2015 (ward) • Deprivation IMD 2015 (GP) • Deprivation affecting Older People IMD 2015 (by GP) • Overcrowded households • Fuel poverty	• Burglary • Theft • Criminal damage • Antisocial behaviour • Violence against the person • Older people (65+) living alone

Only a few graphs showing overarching indicators are included in the main body of the report – others are given in the *Supplementary Data Report* that sits alongside this APHR.

2.4. CHAPTER 1: Key overarching indicators summarising the inequality gap

Life expectancy

The strategic overarching indicator in the Health and Wellbeing Strategy 2015-2018, used to measure and monitor differences in health and wellbeing between different communities in the borough, is life expectancy.

Data from PHE Local Health[20] shows that in Merton as a whole over the last few years life expectancy has increased, from 79.7 (2005-9) to 80.4 (2011-15) in men and from 83.3 to 84.2 in women over the same time period.

However, the trend in inequalities between the most and least deprived wards has been mixed. Most recent data shows that the current gap is **4.1 years** for men and **2.7 years** for women, between the 30% most and 30% least deprived wards (2011-15 data). Our analysis shows that the trend for women is positive - the difference in female life expectancy between the most deprived and least deprived wards **reduced** over the period 2005 to 2015, from 4.5 years to 2.7 years. In contrast, the difference in male life expectancy between the most deprived and least deprived wards remained **stable** over this time, at 4.1 years. Comparable data for gap analysis is not available for London or England.

See graphs in the *Supplementary Data Report* for more detail.

We are likely to be able to continue to access LE data from PHE Local Health that will enable us to calculate the inequality gap in future years, and so monitor trend. However, the Slope Index of Inequality indicator discussed below may be a better more consistent indicator to use as it is a measure of inequality in life expectancy that is produced nationally and can be compared in a standardised way to other London boroughs.

Slope Index of Inequality (SII) – inequalities in life expectancy at birth

The slope index of inequality is a single score which represents the absolute gap in life expectancy at birth between the 10% most deprived and 10% least deprived areas. It is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation The larger the SII score (in years), the greater the disparity in life expectancy.[21]

In 2014-16, the SII showed that the gap in life expectancy between people living in the most and least deprived tenths of areas in Merton was **6.2 years** for males and **3.4 years** for females. The England figures are 9.3 years (males) and 7.3 years (females), and London, 7.4 years (males) and 4.8 years (females). We have been advised by PHE that the SII figures for Merton are not directly comparable to these regional and national figures, due to the statistical methods for calculating SII; however, we *can* compare directly to our statistical comparator boroughs, which shows that the SII for both men and women is lower than Barnet (M: 6.3, F: 5.0), Enfield (M: 6.7, F: 4.7), and Redbridge (M: 7.8, F: 4.3), but higher than Ealing (M: 3.4, F: 2.8).

[INCLUDE INFOGRAPHIC OF LIFE EXPECTANCY GAP HERE IN FINAL REPORT]

SII data over time appears to show an **increasing and then reducing** inequality gap for men so it is similar now to what it was a decade ago (6.3 in 2005-07 compared to 6.2 in 2014-16), and potentially a **slight decrease** in the inequality gap in women (from 5.2 in 2005-07 to 3.4), but the overlapping confidence intervals suggest that this does not yet appear to be a statistically significant reduction. See Figures 11 and 12 over the page. This is an important indicator to keep tracking, to look at overarching inequalities over time.

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[20] PHE Local Health http://www.localhealth.org.uk/

[21] SII is calculated by comparing the 10% most deprived deprivation deciles in an area with the 10% least deprived, so is a useful measure of inequality but is a different methodology from that used in the rest of this report (where we are comparing 30% most deprived wards with the 30% least deprived, or comparing East Merton wards with West wards).

Figure 11: Life expectancy and Slope Index of Inequality (males) from 2005-07 to 2014-16

Life expectancy and slope index of inequality in Males in Merton
Source: Office for National Statistics
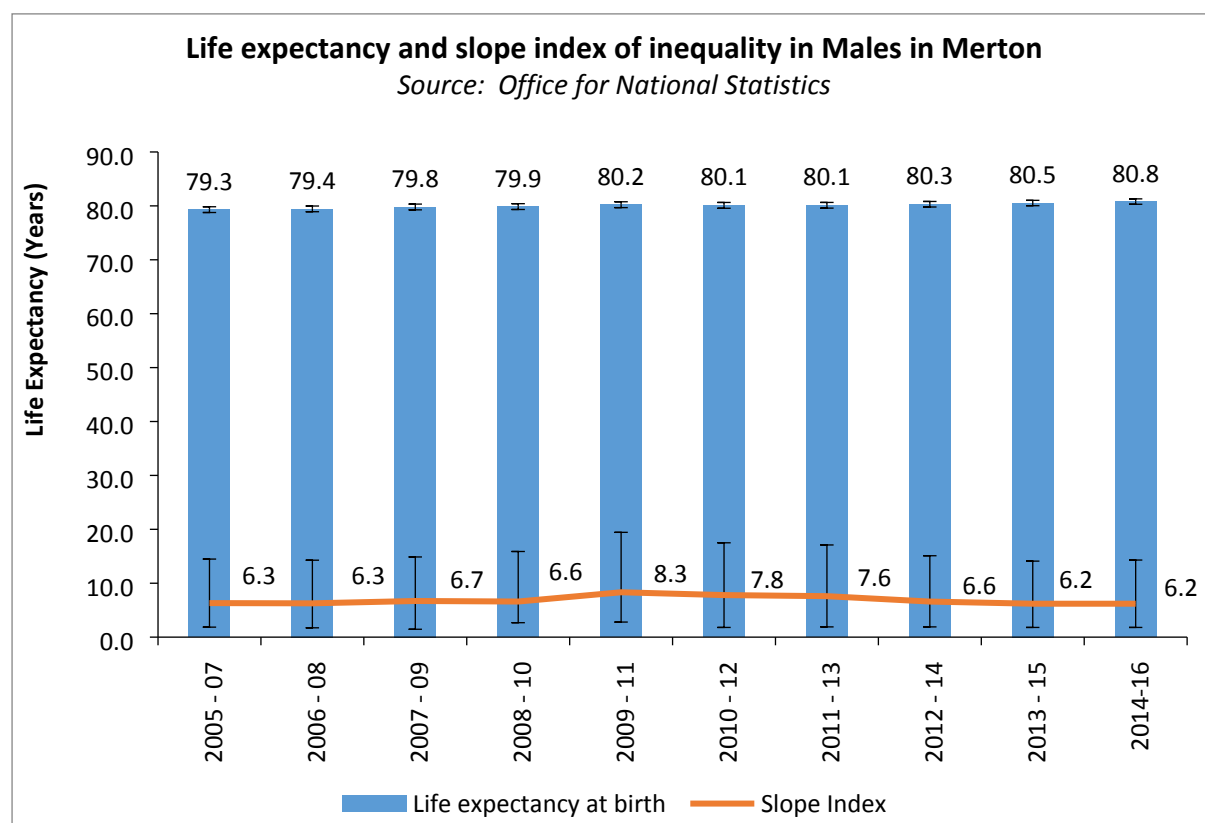
Figure 12: Life expectancy and Slope Index of Inequality (females) from 2005-07 to 2014-16

Life expectancy and slope index of inequality in females in Merton
Source: Office for National Statistics
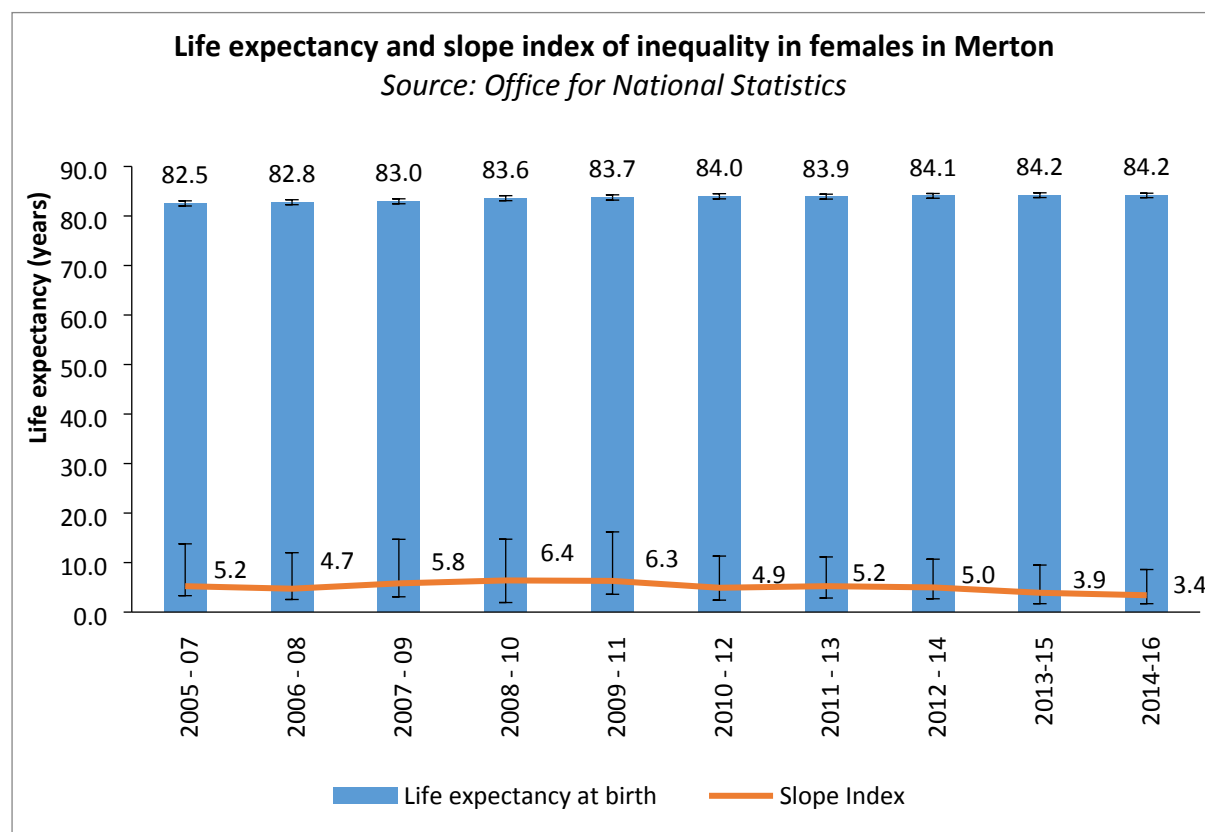
In the *2013/14 Joint Strategic Needs Assessment*, the life expectancy gap between the most and least deprived areas within the borough was reported as **9 years** for men and **13 years** for women (2006-10 data). This was based on the difference between the outliers – the most deprived ward compared to the least deprived ward.

The *Health and Wellbeing Strategy 2015-2018* uses an 'inequalities in life expectancy' figure of **7.9 years** for men and **5.2 years** for women. This was based on Slope Index of Inequality data from 2011-13, looking at the most and least deprived 10% of areas within the borough.

In this *APHR 2018*, we report the following:

* Life expectancy at birth: **4.1 years** (men), **2.7 years** (women)

* Slope Index of Inequality: **6.2 years** (men), **3.4 years** (women)

The difference is due in part to the use of more recent data, but more importantly, to the different methodology for calculating the inequality gap (see Table 2 below). Some of the reduction in the life expectancy figure for women is also due to the positive trend for the gap in life expectancy for women, discussed above in 2.4.1.

We recommend that going forward, the Slope Index of Inequality is used as the overarching measure of the life expectancy inequality gap, as it is produced nationally and can be compared to statistical comparator boroughs.

Table 2: How methodology, data source and trend over time have impacted on reporting of inequalities in life expectancy in Merton

Report	Indicator	Date	Inequality gap		Comment
			Male	**Female**	
JSNA 2013/14	Life expectancy at birth	2006-10	9	13	*Calculated by comparing the most deprived ward with the least deprived ward (e.g. the 2006-10 data shows life expectancy for men ranged from 76.1 in Ravensbury to 84.8 in Wimbledon Park, a gap of nearly 9 years).*
	Life expectancy at birth	2006-10	2.8	3	*Calculated by comparing the average for West Merton with the average for East Merton.*
HWBS 2015-2018	Slope Index of Inequality	2011-13	7.9	5.2	*Calculated by comparing the 10% most deprived deprivation deciles in an area with the 10% least deprived. (N.B. the figures reported here do not match with those shown in Figures 11 and 12 for the relevant years, because changes were made to the indicator definition in 2017 which retrospectively changed all the data since 2010-12).*
APHR 2018 (this report)	**Life expectancy at birth**	**2011-15**	**4.1**	**2.7**	**Calculated by comparing the 30% most and 30% least deprived wards (e.g. 2011-15 data shows an average life expectancy for men of 78.6 in the 30% most deprived wards compared to 82.7 in the 30% least deprived wards, a gap of just over 4 years).**
	Slope Index of Inequality	**2014-16**	**6.2**	**3.4**	**Calculated by comparing the 10% most deprived deprivation deciles in an area with the 10% least deprived.**

<u>Healthy life expectancy</u>

The gap in *healthy* life expectancy (HLE) is greater than the gap in life expectancy. The latest data (2009-2013) shows that the average healthy life expectancy at birth in Merton was 65.4 years for males and 66.3 years for females.

We cannot compare data on healthy life expectancy directly with that on life expectancy as the most recent data for each are from different data sources and time periods.[22] However, a general comparison shows that a significant amount of Merton residents' lives (c.15-18 years on average) are spent in ill health.

In addition, the gap between people living in the 30% most and 30% least deprived areas was **9.4 years** for males and **9.3 years** for females (see Table 3), so someone living in a deprived ward in the east of the borough is likely to spend more than 9 years more of their life in poor health than someone in a more affluent part of the borough, from around the age of 61 or 62 compared to 70 or 71, which will impact on the last years of working life, on family life and on a healthy and fulfilling retirement.

Table 3: Comparison of Healthy Life Expectancy from birth for the 30% most deprived wards and the 30% least deprived wards, for men and for women, in Merton (Source: ONS, 2009-2013)

HLE from birth (2009-2013)	Least deprived	Most deprived	Merton average	Inequality gap
Males	70.5	61.1	65.4	**9.4**
Females	71.2	61.9	66.3	**9.3**

Unfortunately, this data is now a few years old, we are **not able to calculate historic trend** for the inequality gap in HLE as the data is not available from ONS by ward for single years (due to small sample sizes), and it is unclear whether data on this indicator will be available in future years in a format that will enable us to look at future trend in inequalities.[23]

As well as Healthy Life Expectancy at birth, we also have inequalities data from ONS for 2009-2013 on the following metrics:

- Disability Free Life Expectancy (DFLE) at birth (male and female)
- Disability Free Life Expectancy at age 65 (male and female)
- Proportion living without a disability at birth (male and female)
- Proportion living without a disability at age 65 (male and female)
- Proportion of life spent in good health at birth (male and female)
- Proportion of life spent in good health at age 65 (male and female)

These are all different ways of looking at the same issue of how much of someone's life they can expect to spend in good health (see the Glossary in Appendix 4 for the difference in definition between HLE and DFLE; Section 5: Summary Indicator Table for a summary of the gap for each of these indicators; and the *Supplementary Data Report* for the current data).

For all of these, we can see that there is a significant gap between the most and least deprived areas in Merton. However, as with HLE, these are now quite out of date, we are not able to calculate historic trend, and are unlikely to be able to calculate trend in the future for the reasons given above.

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[22] Life Expectancy: Local Health, 2011-15; Healthy Life Expectancy: ONS, 2009-13)

[23] ONS report that trend data on HLE at ward level is only possible decennially currently and as wards change so often in boundaries, trend data will always be difficult. In addition, due to sample size, the data at ward level needs to be 'pooled' or grouped over 5 year periods in order to allow meaningful comparison at ward level.

<u>Premature mortality</u>

Figure 13 below demonstrates the correlation between income deprivation and premature mortality (deaths in those under the age of 75) within Merton. Figure 14 shows the percentage of premature mortality by the 30% most and 30% least deprived wards in Merton, out of all deaths in the respective wards. The key message is that there is a social gradient to premature mortality, with a **12.5 percentage point gap** between the 30% most and 30% least deprived wards. More people are dying prematurely in the most deprived areas – 38.5% (2 in 5) of all deaths are premature compared to 27% (1 in 4) in least deprived areas. What's more, this **gap has widened**. This is because premature mortality in the most deprived has remained more or less static over the last 3 year rolling averages since 2011-15, but premature mortality in the least deprived has declined slightly, causing the gap to increase. However, there are only 3 data points so the trend in the gap will need to be monitored over a longer time period to see if it is significant.

Figure 13: Premature mortality for Merton wards by percentage income deprived: deaths for all causes, under 75 years (2011-2015) (Source: PHE Health Inequalities Briefing Merton, 2018)
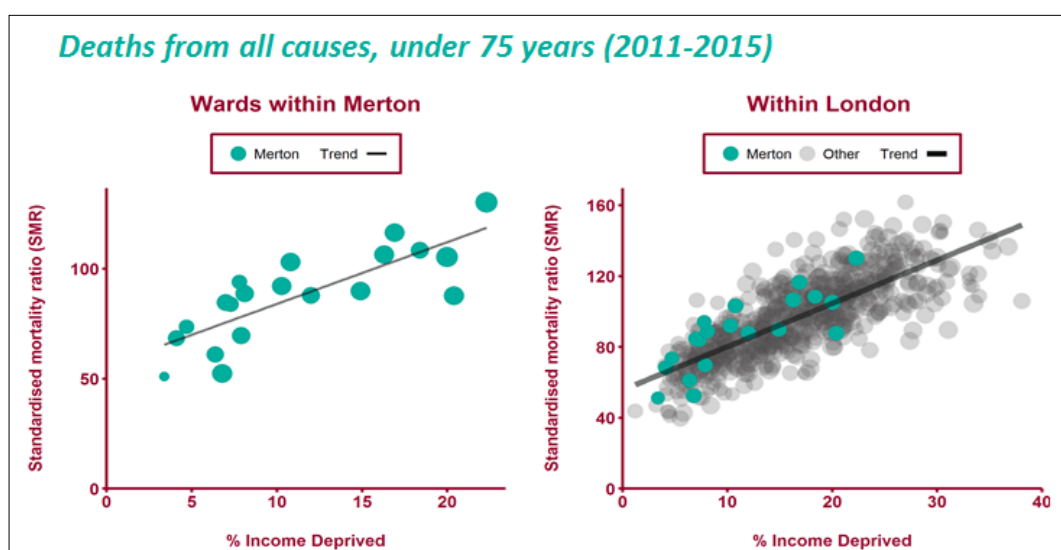
Figure 14: Premature mortality (under 75 years) as a percentage of all deaths, comparing the 30% most deprived wards in Merton with the 30% least deprived, from 2011-15 to 2013-17
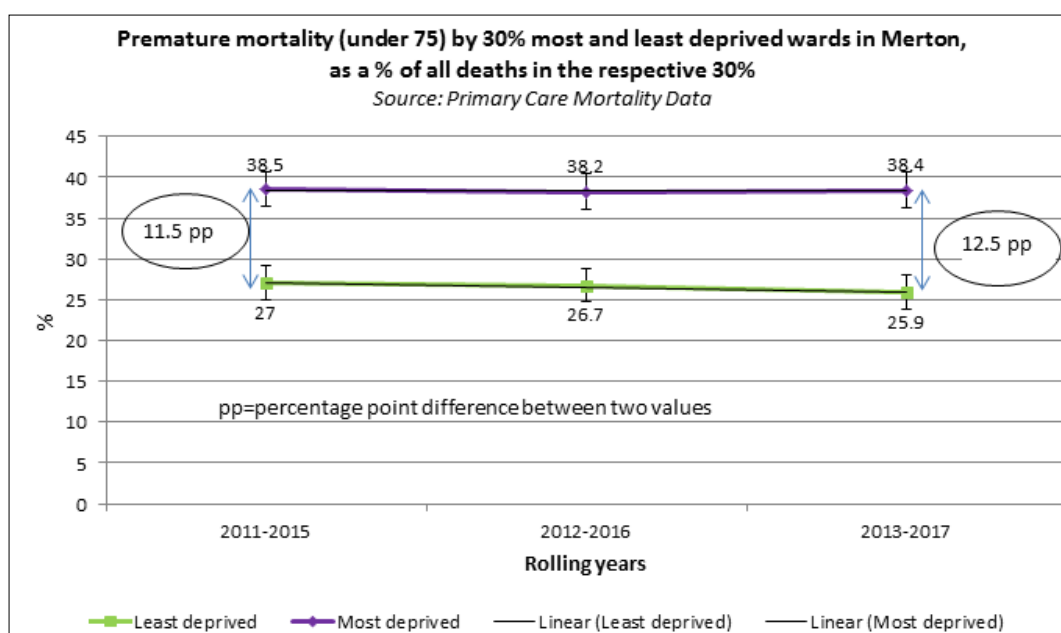
2.5. CHAPTER 2: Give every child the best start in life

Why is this important? *The early years are vital to future inequalities in health and wellbeing. The Marmot Report states that "giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status…Later interventions, although important, are considerably less effective where good early foundations are lacking."*

Child Poverty – children living in low income families

This 'Child Poverty' measure shows the proportion of children living in families in receipt of out-of-work benefits or in receipt of tax credits where their reported income is less than 60 per cent of UK median income. The indicator definition is "proportion of children aged 0–15 years living in income deprived households as a proportion of all children aged 0–15 years." It is also known as 'income deprivation affecting children' (IDACI).

Merton data shows that the gap is significant but appears to be reducing, but that the underlying picture is less positive. The gap between the most and least deprived areas in 2015 was **21 percentage points** (27% of children living in low income households in the most deprived 30% of wards compared to 6% of children in the least deprived 30%). Extrapolating the data statistically using regression analysis suggests that the current 2018 gap is likely to be significantly smaller than this, at 6 percentage points (19% of children in the most deprived areas v 13% in the least deprived areas). However, **although the gap appears to have reduced, the underlying picture is mixed** – the trend in child poverty in the most deprived areas is downwards (28% in 2010 to an estimated 19% in 2018) which is positive, but child poverty in the least deprived areas appears to be increasing over the same time period (from 7% to an estimated 13% in 2018), and it is this increase which partially drives the narrowing inequality gap. If published data confirms this anticipated trend, we need to understand what is driving this apparent increase in the least deprived areas.

We will be able to continue to monitor this indicator in the future, therefore it is important that this is an indicator that is included in the refreshed HWBS, and that we continue to explore trend as more recent data is published to compare to our extrapolated trend data.

Child development

Child development at age 5 (a measure of 'school readiness') is an important indicator to look at 'best start in life' for Merton's children. We have access to ward level data for 2013/14 from PHE Local Health so can calculate an inequality gap of **15.9 percentage points** (53.3% of children in the 30% most deprived wards reach a good level of development compared to 69.2% in the 30% least deprived wards).

However, this is relatively old data, and due to a lack of readily available recent ward level data, and/or ward level data over time, we were unable to calculate the *trend* in inequalities gap in the standardised way that we have approached measurement of health inequalities elsewhere in this report. In order to give us a proxy measure of the trend in inequalities, we looked at 'children with Free School Meal' (FSM) status (for which data is available at borough not ward level) as a proxy for 'most deprived' as we know that there is a correlation.[24] This data shows that 73.9% of all children achieve a good level of development in 2016/17, where as only 63.9% of children with FSM status achieve a good level of development in the same time period, a gap of **10.0 percentage points**. This difference is statistically significant. There has been an increase in 'school readiness' in Merton over time,

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[24] To note: in this analysis we are comparing data for a subset of the population with data for the whole population, rather than comparing two subsets of the population (most and least deprived), as for other indicators, so the methodology is not comparable to that used for other indicators.

including for those with FSM status, and it appears that the inequality gap as calculated this way has **reduced** slightly (from 13.1 percentage points in 2012/13 to 10.0 in 2016/17).

It will be important to keep an eye on this indicator in case more recent ward level data becomes available, but in the absence of any other way to measure sub-borough inequalities in child development, it may be worth continuing to look at the gap between children with FSM status and all children, as a measure of inequality.

<u>Child excess weight (overweight and obese)</u>

Childhood obesity is a significant problem in Merton, with around 4,500 children (age 4 - 11 years) overweight or obese and nearly a third of children leaving primary school overweight or obese. In addition, the problem is significantly worse in the most deprived areas, with the most recent 2014/15-2016/17 data showing a gap of **9.6 percentage points in excess weight at reception** (24.3% of children are overweight or obese in the 30% most deprived wards compared to 14.7% in the 30% least deprived) and **14.5 percentage points by Year 6** (40.2% in the 30% most deprived wards are overweight or obese compared to 25.7% in the 30% least deprived. For this reason, the gap in excess weight is a key indicator in the HWBS 2015-2018, and Merton HWBB has made tackling childhood obesity a priority.

In terms of trend, for reception age children, levels appear to be relatively stable in the most deprived areas but reducing slightly in the least deprived areas (although the reduction is not statistically significant), leading to a **slight increase** in the gap over time. Trend over time for Year 6 children (10-11 year olds) show levels of excess weight are reducing in the least deprived areas of the borough and increasing in the most deprived (although neither reduction not increase are yet statistically significant) and hence the **gap is increasing**.

There are some signs from the most recent data that the overall trend in excess weight at borough level for Merton may be beginning to stabilise or decrease in the last available year's data (from 2014/15 to 2016/17). How the trend in the sub-borough inequalities gap looks over time will need to continue to be carefully monitored, and action taken through a whole systems preventative approach targeted in the most deprived areas, as set out in the last APHR on Childhood Obesity, and the related child healthy weight action plan.

<u>Other 'best start in life' indicators:</u>

We would have liked to have looked at the Merton inequality gap for the following PHE Marmot/Health Equity indicators, but data was either not available at ward level or not available for sufficient years to be able to calculate trend:

- Infant mortality (Health Equity)

- Low birthweight of term babies (Health Equity)

- Proportion of 5 year old children with/without dental decay (Health Equity)

- 19-24 year olds not in education, employment or training (Marmot)

- GCSE achievement (% young people achieving 5A*-C including English & Maths) (Marmot). The most recent data for this indicator shows a gap of **15.4 percentage points** between the most and least deprived wards (2013/14). This data is relatively old, and trend data is not available due to a recent change in indicator definition, but future trend may be possible to track. There is also an indicator which looks at 'GCSE achievement with FSM status' so in a similar way to School Readiness, we could look at the gap between the whole population and the FSM sub-group as a proxy for inequalities by most/least deprived. However, unlike for school readiness, comparative data is currently only available at one time point (2014/15), and so no trend can be produced.

- Other indicators that may be worth investigating to look at the inequality gap over time include the rate of rate of hospital admissions between the most and least deprived areas for a number of key health conditions in children and young people, such as asthma, or injury.

2.6. CHAPTER 3: Prevention of poor physical and mental ill health

Why is this important? The main causes of ill health and premature deaths in Merton are cancer and circulatory disease (including coronary heart disease and stroke). Known risk factors (unhealthy diet, smoking, lack of physical activity, and alcohol) account for around 40% of total ill health, and despite the fact that Merton generally ranks positively against London and England, the numbers of people in Merton with unhealthy behaviours are substantial. Consequently, changing patterns of unhealthy behaviour needs to be an important focus for prevention efforts. Furthermore, most risk factors are inversely associated with socio-economic conditions, and there is marked variation in patterns of healthy behaviours, and health outcomes, within Merton.

Robust ward level data on the four behavioural lifestyle factors which impact most on preventable ill health is challenging to find, for both current inequality gap analysis as well as to look at trend in the gap.

As discussed in Section 1.3 looking at the different types of risk factors that drive poor health, in addition to the behavioural factors, there are also physiological risks such as hypertension (discussed below), and psychosocial risks such as loneliness (discussed in Chapter 6 – healthy and sustainable places). A few marker indicators for disease morbidity are also given below, to give a flavour of the inequality gaps seen in both physical and mental health in Merton, but these are not comprehensive, rather indicative of the issues.

Behavioural risk factor - Smoking

We do not have access to ward level trend data on smoking, so cannot look at the inequality gap between the 30% most and least deprived areas, but we can use GP data to look at the prevalence of smoking between east and west Merton, as recorded by GP Quality Outcome Framework (QOF) registers. This shows that the difference in recorded levels of smoking between east and west Merton is **6.2 percentage points** in 2015/16 (19.36% prevalence in east Merton compared to 13.12%% in west Merton), 2015/16 data. Due to the methodology for calculating this gap (by amalgamating data for individual GP practices), it is not possible to calculate accurate confidence intervals to be able to say whether this difference is statistically significant, but it is quite large.

The gap between east and west appears to have **increased** substantially, from 1.95% in 2012/13 to 6.23% in 2015/16, due to a general increase in smoking prevalence in east Merton and a general decreasing trend in west Merton. It is difficult to know if smoking prevalence is really increasing in east Merton (for instance, it may be that recording of smoking status is improving, rather than any change to underlying levels of smoking, as discussed in Box 2 in Section 2.2), but regardless, there is still a significant inequality gap, and smoking is one of the biggest preventable causes of ill health.

Physiological risk factor – hypertension

The difference in recorded levels of hypertension between east and west Merton is **1.5 percentage points** in 2016/17 (11.59% prevalence in east Merton compared to 10.06% in west Merton). This difference is statistically significant. There has been a slight **increase** in the gap between East and West (from 1.3 percentage points in 2011/12 to 1.5 in 2016/17), although the difference is unlikely to be statistically significant.

Morbidity – Diabetes prevalence

We have chosen diabetes prevalence as an example 'morbidity' indicator to look at the inequalities gap, as diabetes is a priority of the HWBB. The difference in recorded levels of diabetes between east and west is **3.1 percentage points** in 2016/17 (8.0% prevalence in east Merton compared to 4.85% in west Merton). This difference is statistically significant. There has been an **increase** in the gap between East and West (from 2.5 percentage points in 2011/12 to 3.1 in 2016/17), and this increase appears statistically significant.

Morbidity - Tuberculosis (TB)

The rate of TB in Merton overall is decreasing steadily. There is a significant difference in the rate of TB between the most and the least deprived areas of **25.6 per 100,000** (35.03 per 1000 population in the 30% most deprived wards compared to 9.37 rate per 100,000 in the 30% least deprived). Since 2011-13, there appears to have been a slightly faster rate of decline in the 30% least deprived areas, resulting of a **slight widening** in the gap from 23.4 per 100,000 rate difference in 2011-13 to 25.6 percentage points in 2014-16. However, the numbers are relatively small so it is unlikely to be a statistically significant increase.

Morbidity – prevalence of mental health conditions

Mental health is an important indicator as health and wellbeing is not just about physical health but also mental health and wellbeing. We do not have access to ward level data on mental health, so cannot look at the inequality gap between the 30% most and least deprived areas, but we can use GP data to look at the prevalence of mental health between east and west Merton, as recorded by GP QOF data.

This shows that for recorded mental health prevalence, the difference between east and west Merton is **0.24 percentage points** (1.01% prevalence in east Merton compared to 0.77% in west Merton), using 2016/17 data. Although a relatively small recorded prevalence, this difference is statistically significant, as shown by the confidence intervals. The prevalence of mental health conditions recorded by GPs in Merton has increased slightly in both the east and the west, but appears to have increased at a faster rate in west Merton. This means that the **inequality gap appears to have decreased** slightly from 0.30 percentage points in 2012/13 to the current 0.24 percentage point gap. As highlighted earlier, GP prevalence data can be complex to interpret, as this increased gap could be as a result of a real increase in prevalence of poor mental health, or, which is more likely, be a consequence of improved recognition and diagnosis of mental health conditions in primary care. If the latter is true, then this trend data may suggest that diagnosis rates are better in west Merton than east Merton, rather than that there has been an underlying increase in disease, and demonstrates the importance of primary and community care in tackling health inequalities, as discussed in Part 1. This data probably does not therefore tell a positive story of reducing inequality, rather points to poorer diagnosis for more deprived residents relative to their less deprived neighbours.

Morbidity – prevalence of depression

Again, we do not have ward level data for depression, but can use GP records of depression diagnosis to look at the inequality gap between east and west Merton. This shows that the difference in recorded depression is **0.45 percentage points** (7.14% in east Merton compared to 6.69% in west Merton, 2016/17 data). The difference in prevalence between the east and the west in 2016/17 is statistically significant. Between 2011/12 and 2016/17 the **inequality gap appears to have flipped**, from higher rates of depression in west Merton (difference of -1.81 percentage points) to higher rates in east Merton in 2016/17 (difference of 0.45 percentage points). **This is one of the only indicators we looked at where the rate of a disease or risk factor was higher in less deprived areas than more deprived areas at any point in the historical trend data** (the other indicators being rates of theft, and burglary, both higher in the least deprived areas).

As we know that major risk factors for poor mental health and wellbeing are those associated with deprivation (e.g. poor education, unemployment, social exclusion, and poor standards of living), this again points to an interpretation of historical better diagnosis of depression in west Merton compared to east Merton (rather than a true larger prevalence of disease), and therefore hidden inequalities in diagnosis/under-diagnosis of mental health conditions. However, the latest data suggests that this pattern may be in the process of being reversed. We need to continue to monitor this trend to better understand the picture of inequalities in mental health in Merton.

<u>Self-reported wellbeing</u>

The GLA has data on self-reported wellbeing at ward level. This presents a combined measure of well-being indicators based on 12 different measures, with scores over zero indicating a higher probability that the population on average experiences positive well-being. 2013 data, which is the most recent available, shows that the wellbeing score for the 30% most deprived wards was -2.3, suggesting poor wellbeing, compared to a score of 9.4 for the 30% least deprived areas, a gap of **11.7 points**. This supports our hypothesis above that the lower prevalence of depression seen previously in East Merton is likely to be an artefact of lower diagnosis rates rather than better mental health. Between 2009 and 2013, the difference between the most and least deprived wards **reduced slightly**, (from 12.3 to 11.7). However, again this is not really a positive outcome, as wellbeing scores worsened in both the most and least deprived areas, but at a faster rate in the least deprived areas.

<u>Limiting long term illness or disability</u>

'Limiting long term illness or disability' data is based on a Census 2011 question, so we do not have recent or trend data on this indicator, but PHE's recent Health Inequalities Briefing, based on the Global Burden of Disease study, highlights the social gradient in Merton:

Figure 15: Limiting long term illness or disability for Merton wards by percentage income deprived (2011) (Source: PHE Health Inequalities Briefing Merton, 2018)
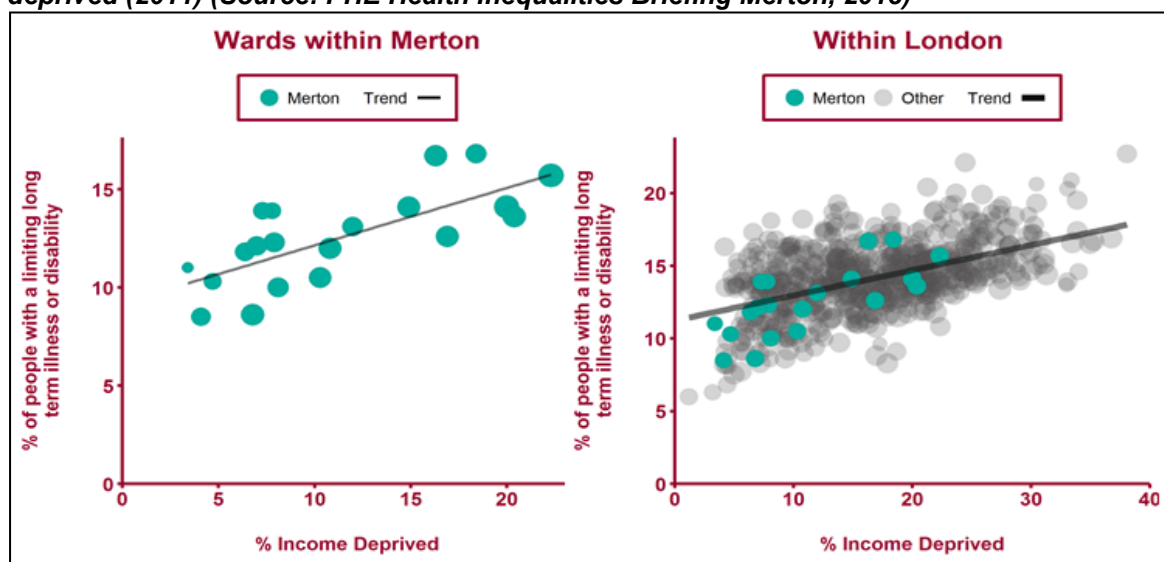
<u>Other 'prevention of poor health' indicators</u>

Premature mortality is included in Chapter 1 as an overarching indicator of health inequality. There are a range of other indicators that we could consider for the HWBS refresh, or the Local Health and Care Plan which will look specifically at health and care services, in order to track health inequalities, for example:

- Risk factors/morbidity: Hospital admissions for alcohol related harm. We would have liked to have analysed this in more detail, given the importance of alcohol as a public health issue and the strong associated with income deprivation (and that this is a PHE Health Equity indicator), but although we can see there is an inequality gap between the most and least deprived wards (see *Supplementary Data Report*, and summary indicator table in Section 5), there is a lack of robust trend data at ward level.

- Morbidity: disease incidence (e.g. cancer); or all-cause, or disease-specific, hospital admissions (e.g. for Coronary Heart Disease, Stroke, Chronic Obstructive Pulmonary Disease). See the *Supplementary Data Report* for single time point data on emergency hospital admissions related to income deprivation for which there is a strong relationship.

- Premature Mortality: Cardiovascular / Cancer mortality under 75 (both Health Equity)

- Mortality: Suicide (Health Equity)

Why is this important? *The availability and nature of employment is a key determinant of health inequalities. Good quality work and working environment is a key contributing influence on an individual's health and wellbeing, and that of their family and community. Employment is important because being unemployed or having a poor quality job is bad for health, and good quality appropriately paid employment is a protective factor for health (moving from unemployment into work can substantially reduce the risk of premature mortality) and can contribute to reduced health inequalities. Increasing the quality and quantity of work can help reduce health inequalities.*

Economically active population claiming Job Seekers Allowance (JSA)

Data on claimants of Job Seekers Allowance (JSA) is an important measure of those out of work but who are deemed fit for work. According to ONS NOMIS, JSA 'is not an official measure of unemployment, but is the only indicative statistic available for areas smaller than Local Authorities.' The latest available data from ONS on the percentage of the economically active population claiming JSA shows that there is a **2.5 percentage point gap** in Merton in 2015 (3.3% in the 30% most deprived compared to 0.8% in 30% least deprived wards). This difference appears to be statistically significant.

However, there appears to be a substantial **reduction in the inequality gap over time**, decreasing from a 4.7 percentage point gap in 2011 to a 2.5 point gap in 2015, driven by general decrease across the borough but also a faster decrease in the most deprived wards. This appears positive, although it is difficult to say whether this decrease represents a real reduction in inequality, or changes to the way that benefits are claimed (although the data presented here and in the *Supplementary Data Report* is up to 2015, prior to the introduction of Universal Credit (UC)). Anecdotally, the Mitcham Job Centre do report that they are seeing more people in sustained work than previously, and that those who are left claiming employment related benefits over the long term have much more complex needs, including poor mental health as a significant issue.

As the most recent data is only available to 2015, regression analysis (using the current trend data to project missing data points) has been undertaken, which appears to show that inequality gap in 2018 is likely to narrow further, to just under 1 percentage point difference between the 30% most deprived wards compared to the 30% least deprived. However, the picture will be further complicated by the introduction of Universal Credit in the meantime (introduced into the SM4 Morden area in around 2016, and the CR4 Mitcham area from the end of 2017 – any change of circumstances for claimants, for example a change of address, will trigger a move from JSA to UC). The west of the borough will start the move to UC at the end of June 2018, and the move over to UC is not due to be completed until 2020 – so the data will need to be interpreted carefully going forward.

The data reported here is 'all economically active population claiming JSA'; perhaps a more useful indicator to look at in more detail going forward would be *long term* claimants (for example those claiming employment related benefits for more than a year) – this is a Marmot indicator, but data is not currently readily available at ward level.

Benefit claimants - employment and support allowance (ESA)

Data on claimants of Employment and Support Allowance (ESA) is an important measure of those with a short or long term health condition or disability that impacts on their ability to work; eligibility is dependent on sickness certification. The latest available data from ONS on the percentage of the working age population claiming ESA shows that there is a **3.4 percentage point gap in Merton in 2017** (5.04% in the 30% most deprived compared to 1.64% in 30% least deprived wards). This difference is statistically significant. The inequality

gap appears to be **relatively stable over time** (3.2 percentage points difference in 2014 compared to the current 3.4 point gap).

As with JSA, ESA claimants will gradually be moved over to UC by 2020, with those in the east of the borough moving over sooner than those in the west, which will have implications for how the data available for the years between 2016 to 2020 is interpreted.

Other 'fair employment, good work' indicators

Other employment related data that we considered included 'Benefits claimants – income support' and 'Benefits claimants - Incapacity Benefit/Severe Disablement allowance' but the numbers were too small to be able to make meaningful conclusions at ward level.

At present NOMIS is still the only source of unemployment data, and 'Claiming UC' at borough level is all that is currently available for Universal Credit. In the future, it is likely that the data will be able to be split by reason for claiming UC, and by sub-borough geographies, and we will need to review in order to choose the most appropriate indicators for tracking progress related to fair employment and good work. The Government has recently launched a consultation on how to assess the number of people claiming unemployment-related benefits, and so there is opportunity to shape the way that the data is collected and reported to enable us to better monitor inequalities in the future as Universal Credit is rolled out.[25]

We would have liked to have looked at the Merton inequality gap for the following PHE Marmot/Health Equity indicators, but data was not readily available at ward level:

- Unemployment (Marmot)
- Long term claimants of Jobseekers Allowance (Marmot)
- Work related illness (Marmot)
- Employment gap for those with a long-term condition (Health Equity)

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[25] Consultation: Proposals for a new statistical series to count unemployed claimants
 https://www.gov.uk/government/consultations/proposals-for-a-new-statistical-series-to-count-unemployed-claimants

2.8. CHAPTER 5: Ensure healthy standard of living for all

Why is this important? *As the Marmot review sets out, "having insufficient money to lead a healthy life is a highly significant cause of health inequalities." An insufficient income can cause poor health as "it is more difficult to avoid stress and feel in control; access…material resources; adopt and maintain healthy behaviours; and feel supported by a financial safety net."[26]Additionally, those living with health problems are more susceptible to unemployment, lower earnings, and lower household income, and poorer standard of living, so poor health can then lead to deprivation, in a vicious cycle for poor health outcomes.*

Deprivation by ward

The overall ward scores for the IMD (2015) deprivation index shows that there is a difference in score between the 30% most deprived and the 30% least deprived wards of **17.01 points** (score of 24.24 in the most deprived compared to a score of 7.23 in the least deprived). The higher the score the more deprived the area.[27] No benchmarking or confidence intervals are available for this data, and **trend data is not available** for IMD either – although IMD is updated every few years, it is not recommended to compare scores year on year as the underlying indicators change over time.
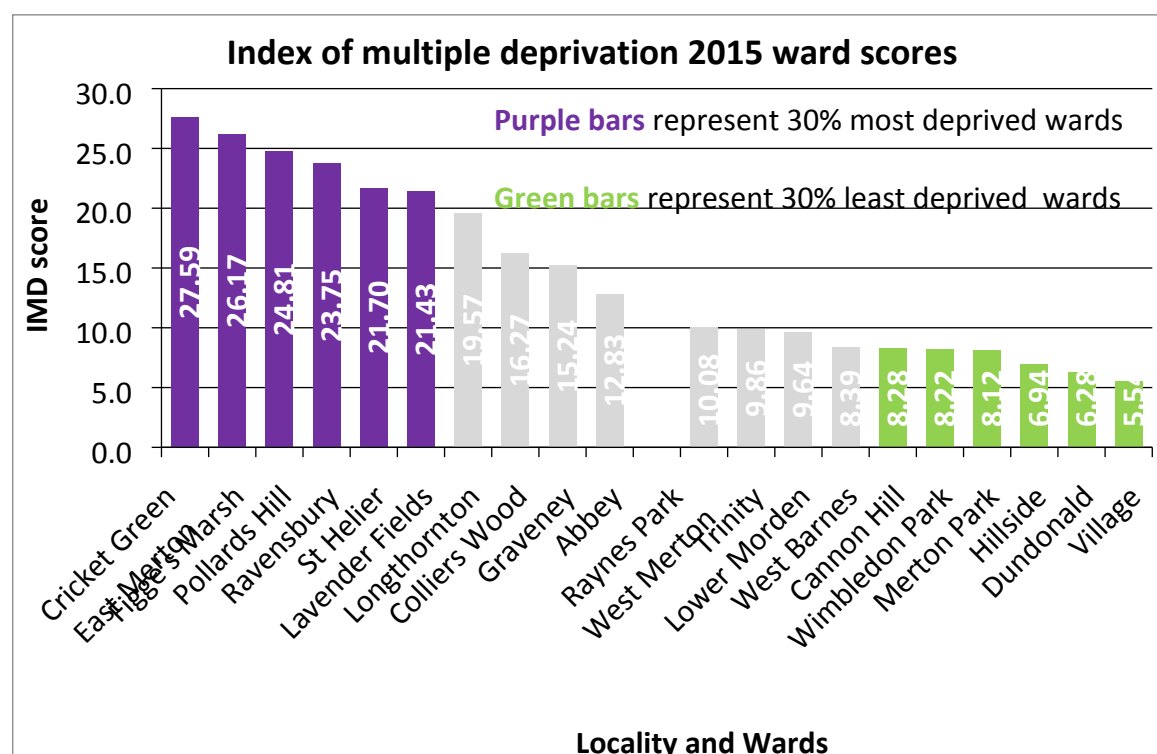
Deprivation by GP

Similarly, IMD 2015 data split by GP Practice IMD scores shows that there is a substantial difference between the average score of GP practices in east Merton and those in west Merton of **11.74 points** (score of 20.01 in the east compared to a score of 11.28 in the west). As before, the higher the score the more deprived the area.

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[26] Health Foundation (2018) What makes us healthy? An introduction to the social determinants of health https://www.health.org.uk/sites/health/files/What-makes-us-healthy-quick-guide.pdf

[27] PHE Fingertips definitions: "The Indices of Deprivation 2015 are relative measures of deprivation. This means it can tell you if one area is more deprived than another, but not by how much. The IMD 2015 is not a measure of affluence; all of the indicators used in the index are designed to identify aspects of deprivation, not affluence. Therefore the area ranked as the least deprived is not necessarily the most affluent"

IMD 2015 data by GP practice is also available looking specifically at deprivation affecting children, and affecting older people:

- Income deprivation affecting children index (IDACI):[28] there is a difference between the average IDACI proportion of GP practices in east and those in west Merton of **13.33 percentage points** (25.24% compared to 11.91%).

- Income deprivation affecting older people index (IDAOPI):[29] there is a difference between the average IDAOPI proportion of GP practices in east and those in west Merton of **8.63 percentage points** (23.38% compared to 14.75%).

Both of these look at the income aspect of IMD for younger and older people. However, any direct comparison between IDACI and IDAOPI is not appropriate as the measures are calculated in different ways.

As with IMD by ward, although previous data for IMD by GP practice is available for the years 2004, 2007, 2010, 2015, this data is not comparable as the weighting of indicators has been changed over time. Therefore **trend data is not available**.

Overcrowding

We only had access to data on household overcrowding at ward level from the 2011 Census. The borough average is 16.1% of households in Merton that are overcrowded, with an inequality gap of **10.2 percentage points** between the most and least deprived areas (21.2% of households are overcrowded in the 30% most deprived wards compared to 11.0% in the least deprived – twice as many). **No trend data** is available on household overcrowding.

Fuel Poverty

Fuel poverty is influenced both by housing typology, including the age and size of housing, as well as the ability of those living there to pay for utilities. We have data from 2015 on fuel poverty (the percentage of households that experience fuel poverty, based on the 'low income high cost' methodology) for wards in Merton which shows that the inequality gap is **1.4 percentage points** between the 30% most and least deprived areas (10.5% in the most deprived areas compared to 9.1% in the least deprived). This difference appears to be statistically significant.

This is a new indicator on the PHE Local Health portal, and so whilst **historic trend at ward level is not available** which means that we cannot look at the trend in the inequality gap to date, we may be able to monitor trend in the future.

Other 'healthy standard of living' indicators

We would have liked to have looked at the Merton inequality gap for the following PHE Marmot/Health Equity indicators, but data was not readily available at ward level:

- Households not reaching minimum income standard (Marmot)

- Homelessness (Health Equity)

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[28] Based on the same indicator as Child Poverty. LSOA level deprivation data are applied proportionally to GP practice populations.
[29] Based on the percentage of the population aged 60 and over who receive income support, income based job seekers allowance, pension credit or child tax credit claimants aged 60 and over and their partners (if also aged 60 or over). LSOA level deprivation data are applied proportionally to GP practice populations.

2.9. CHAPTER 6: Develop healthy, sustainable places and communities

Why is this important? *The places in which people live influence the health and wellbeing of individuals, families and communities. This includes the nature of the physical environment, the access to green spaces, and how safe, connected and represented people feel within their neighbourhoods and wider community.*

Reported Crime

Metropolitan Police Data for 2017 gives a picture of reported crime in the borough. Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.

- Burglary Difference in ward scores is **-3.4 per 1000 population rate difference** (5.3 per 1000 in the 30% most deprived compared to 8.7 per 1000 in the 30% least deprived wards).

- Theft: Difference in ward scores is **-8.5 per 1000 population rate difference** (18.0 per 1000 in the 30% most deprived compared to 26.5 per 1000 in the 30% least deprived wards).

- Criminal damage: Difference in ward scores is **4.2 per 1000 population rate difference** (8.5 per 100,000 in the 30% most deprived compared to 4.3 per 1000 in the 30% least deprived wards).

- Antisocial behaviour: Difference in ward scores is **7.0 per 1000 population rate difference** (19.5 per 1000 in the 30% most deprived compared to 12.5 per 1000 in the 30% least deprived wards).

- Violence against the person: Difference in ward scores is **14.5 per 1000 population rate difference** (28.9 per 1000 in the 30% most deprived compared to 14.5 per 1000 in the 30% least deprived wards).

The gap for burglary and theft are both in favour of the most deprived areas (i.e. there is less reported burglary and theft in the more deprived areas); however, this is to be expected as it is probable that the more expensive assets are likely to be found in the more affluent areas, and therefore be a target for theft. There may also be increased reporting of crime in the least deprived areas.

Social isolation

Social isolation is a psychosocial risk factor for poor health and wellbeing. We have some Census 2011 data at ward level on the number of people aged 65 and over living alone (as a percentage of the total number of people aged 65 and over), which shows a gap of **0.5 percentage points** between the 30% most deprived (34.2%) and the 30% least deprived (33.7%). However this metric doesn't tell us how many of those actually *feel* socially isolated, and there is **no trend data** available as the next Census is in 2021.

Other 'healthy and sustainable places' indicators

There is relatively little easily accessible and up-to-date ward level data for the social determinants of 'place' to be able to look at inequalities. This is an area we will need to think carefully about how to monitor in the forthcoming HWBS 2019+.

- We would have liked to have looked at the Merton inequality gap in 'Utilisation of outdoor space for exercise/health reasons' (PHE Marmot indicator), but data was not available at ward level.

- Other indicators that it may be worth investigating include measures of air quality, levels of volunteering, or the percentage of the population who vote.

3. PART 3: LESSONS FOR ADDRESSING HEALTH INEQUALITIES IN MERTON

This APHR on Health Inequalities has investigated some of the key inequality gaps between the most and least deprived communities in Merton that impact on health outcomes. It casts new light and produces clear evidence to show a sustained gap in health and wellbeing across communities in Merton and provides robust data, on which our plans and policies can build, to address these inequalities.

In particular, the findings from this piece of work can directly be used to inform the refresh of the Health and Wellbeing Strategy 2019+, as well as other data analysis and reporting such as the Joint Strategic Needs Assessment, other statutory assessments such the Community Safety Partnership strategic assessment, and the development of indicators and reporting for other strategic work such as the NHS's Local Health and Care Plan.

3.1. Conclusions

Measurement of inequalities

It is important to measure inequalities in a standardised way, but the process of analysing indicators for this report has shown that it is challenging given the limitations in the data available. In particular:

- Many nationally available indicators are only available at borough not ward level which does not enable analysis of sub-borough inequalities. For instance, most PHE Marmot indicators and PHE Health Equity indicators are not available at sub-borough level. This is surprising, and something that we will be feeding back to the data and intelligence team at Public Health England, as in order to track progress on health inequality and to effectively target interventions, sub-borough analysis is vital;

- Some indicators only had data available from a number of years ago, for instance the most recent Healthy Life Expectancy data was from 2009-2013, ward level data for School Readiness was only available for 2013/14, and the most recent data on 'Limiting long term illness or disability' and on 'Household Overcrowding' are from 2011 (as these are from Census data, only collected every 10 years). This means that making relevant conclusions from this data is difficult;

- Where sub-borough data was not available, in some cases there were other ways to look at the likely inequality gap, for example by comparing borough level Child Development data with data for a sub-set of the population with Free School Meal status;

- Where sub-borough data is available for nationally available indicators, often only single data points are readily available through data portals such as PHOF or PHE Local Health. This lack of historic data means that no trend can be calculated. Even where trend data is available, it is often only available for limited time points, which makes trend analysis less accurate. For example, Premature Mortality data was only available for three points, where as Slope Index of Inequality data was available for ten. We can be more confident to make conclusions about trend from more data points;

- Because of the different methodologies used for calculating the inequality gap (30/30 versus East/West), it is not possible to directly compare the magnitude of the gaps between the different methods;

- Using the data available, it is often difficult to calculate if the current gap is significantly different from a statistical perspective, and/or whether the trend is statistically significant.

We have only looked at two related aspects of inequality: geographic and socioeconomic inequalities. It would be worth looking at other measures of inequality, for instance age, sex, ethnicity or other protected characteristics. Where nationally available data cannot be broken down by these characteristics, we may need to look at locally collected data.

Inequalities in Merton

Despite the challenges, the analysis undertaken in this APHR shows that there is much that we can say about inequalities in Merton:

- **Inequalities are evident in every indicator** studied. The vast majority of indicators demonstrated a substantially worse picture in the most deprived areas. For example, we found a 14.5 percentage point difference in proportion of children who are overweight or obese in primary school (Year 6), between the most and least deprived wards in Merton.

   PHE's recent Health Inequalities Briefing for Merton (2018), based on the Global Burden of Disease study, states that the top three indicators **most strongly associated with deprivation locally** are: emergency hospital admissions for all causes, childhood obesity (Year 6), and hospital stays for alcohol-related harm.

   The only indicators that appeared to be in favour of the most deprived wards, or where there was an unclear picture were:

   i. Depression – between 2011/12 and 2016/17 the inequality gap appears to have flipped, from higher rates of depression in West Merton to higher rates in East Merton. The previous higher rates seen in the West of the borough are likely to be a measure of under-diagnosis in the East rather than less mental health need/better mental health.

   ii. Theft and burglary – the rates of these reported crimes are higher in west of the borough, which is not surprising given the socioeconomic picture, as this is where more expensive assets are likely to be, as well as potentially increased rates of reporting by residents.

- **The magnitude of the inequality gap varied**, and the relevance of the size of the gap to residents' health and wellbeing outcomes varies from indicator to indicator. For instance, the difference in percentage of overweight or obese children in Year 6 between the most/least deprived is 14.5 percentage points, which equates to 735 children (2014/15-2016/17) where as the difference in percentage of residents claiming ESA between the most/least deprived is smaller at 3.4 percentage points, but equates to 1,605 residents;

- **In terms of trend in inequalities in Merton, the picture is mixed**. The general message is that inequalities in Merton are intransigent, but that we need to keep them under review over a longer time frame.

   i. There are some success stories, for instance the reducing gap in life expectancy at birth for women in Merton (although the reduction is not yet statistically significant), the apparent reduction in the Child Poverty gap (although the main trend is based on extrapolated data due to lack of very recent published data); the reducing gap in School Readiness (comparing child development at age 5 for all children with that of children with free school meal status), and the reductions in the gap in the economically active population claiming jobseeker's allowance (JSA) between the most and least deprived areas;

   ii. There are a number of areas where the inequality gap appears to be stable (e.g. male life expectancy at birth, ESA claimants), or where picture is complex (e.g. recorded depression prevalence);

   iii. In some cases, the gap appears to be reducing for the 'wrong' reasons, for instance because the situation for those in more affluent areas appears to be worsening whilst that for those in the more deprived areas remains stable or worsening at a slower rate, or improving, all of which have the effect of narrowing the gap. This is the case for Child Poverty, mental health prevalence, and self-reported wellbeing;

   iv. Unfortunately, analysis also shows that there are a substantial number of indicators where inequalities appear to be increasing, including child excess weight, prevalence of smoking, diabetes and hypertension, and premature mortality.

- **Cumulative inequalities throughout life and the environments within which our residents live contribute to overarching inequalities in health outcomes.** We can see these most clearly in the significant differences in life expectancy between the most and least deprived parts of our borough, of around 6.2 years for men and 3.4 years for women borough (Slope Index of Inequality). Inequalities in *healthy* life expectancy are even starker, with a difference of more than 9 years of healthy life..

3.2. Recommendations

A. Recommendations for tackling health inequalities in Merton

The Public Sector Equality Duty obligations under the Equality Act 2010 mean that we need to pay due regard to equality and inclusion issues in all our decision making.

We know that health inequalities are persistent, complex and difficult to shift. **We therefore need to take consistent and intelligent action on health inequalities** in Merton, actively and systematically targeting inequalities through a long-term multi-sectoral approach across all partners – including the NHS, Council, voluntary sector and the community – in order to be able to make any progress.

This action should be:

- Based on evidence of need, driven by data – for example, detailed understanding of which groups have worst health outcomes and why;

- Grounded in evidence of what works and is cost-effective, for example using evidence-driven interventions such as those set out in NICE guidance;

- Grounded in evidence of what works to shift inequalities in particular, using the evidence-based approach of proportionate universalism, with both carefully considered universal approaches (even in times of austerity) and carefully targeted approaches to those who are most at risk of poor health and wellbeing. This includes:

  i. Intervening for population level impact, recognising the increased cost-effectiveness of population level interventions compared to personal level interventions, and increased impact on health inequalities

  ii. Intervening at different levels of risk, including the importance of the role that NHS primary care and community services play in reducing inequalities;

  iii. Intervening across the whole life course, giving all residents the best start in life, so they can start well, live well and age well;

To be effective, approaches must be underpinned by participatory decision-making and co-design, and driven through individual and community empowerment.

If we take our eye off the ball, health inequalities are likely to increase. Therefore we need to intervene for impact over time, and to continuously monitor progress.

B. Recommendations for monitoring health inequalities in Merton

1. The analysis set out in this report will inform the choice of a suite of indicators for the HWBS 2019+

The analysis within this report, particularly around which indicators *can* be tracked at sub-borough level to look at inequalities within Merton, and at changes to the inequality gap over time, should inform the indicators chosen to support the monitoring of the HWBS from 2019. The strategy is likely to cover a period of 5 years, from 2019-2024, and will form the core of Merton's strategy to reduce inequalities.

The table in Section 5 is the most accessible summary of the findings, set out by indicator. The last column indicates whether the indicator may be a good choice for the HWBS 2019+.

In terms of overall inequalities in life expectancy in Merton, we recommend that the Slope Index of Inequality is used as the overarching measure of the life expectancy inequality gap, as it is produced nationally and can be compared to statistical comparator boroughs.

Some borough level indicators will be important to monitor, but it is also important that some key indicators are also monitored at a sub-borough level to look at the inequality gap. Where no sub-borough and/or trend data is available (historic and/or future) in order to be able to calculate an inequality gap, we may need to think about how we keep eye on progress in closing the gap in other ways, for example using the methodology that we have used for Child Development by comparing borough level data for all children with borough level data for those with Free School Meal status.

When developing a set of indicators, it is important to think about an underpinning logic model or theory of change, in order to develop a hierarchy of indicators, with a clear logical progression and explicit assumptions on the relationships between each tier. See Figure 16 for an example of this tiered approach to developing a suite of indicators for monitoring.

Although this APHR has focused on place-based deprivation-linked inequality (using most/least deprived wards, or E/W gap), this is not the only way in which data should be broken down to look at inequalities. Although as this report has highlighted, there is a lack of data available at sub-borough level even broken down to ward level, but where possible it is important to look at inequalities by age, sex, ethnicity and other protected characteristics.

Figure 16: Proposal for a tiered approach to monitoring Health & Wellbeing outcomes
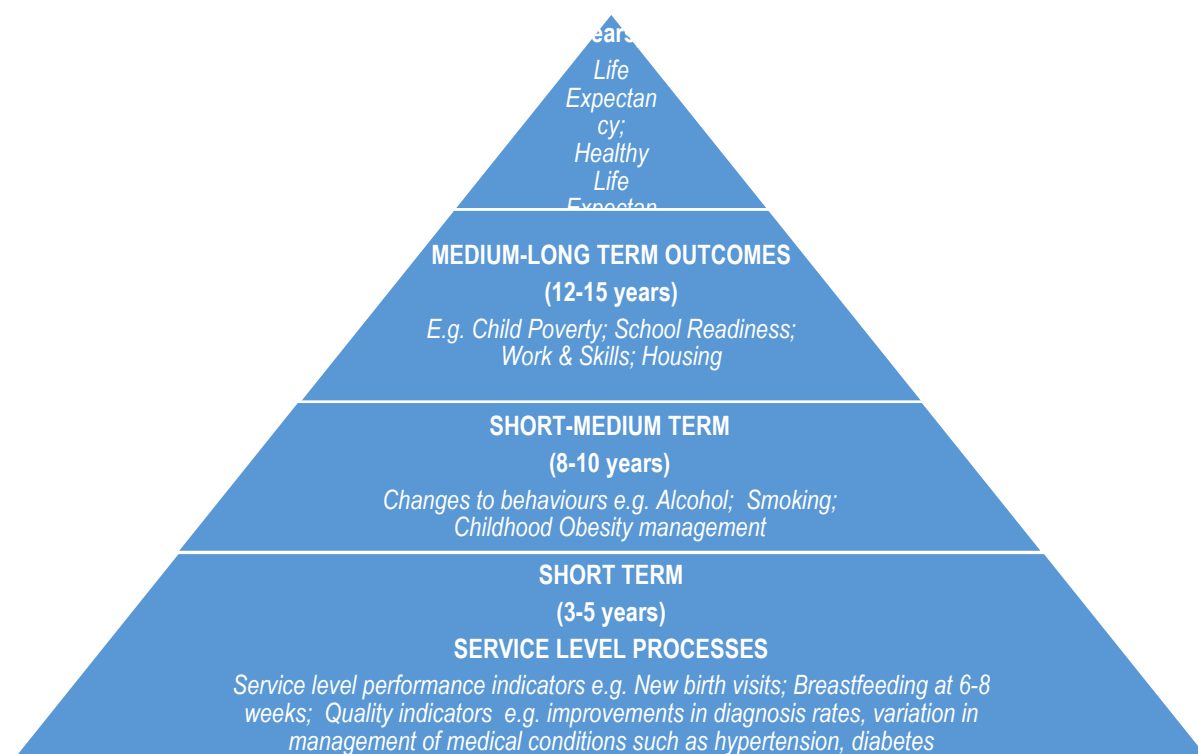
2. We need to be realistic about timescales in which we can expect to see changes to the inequalities gap in Merton

Part 1 (Section 1.3) of this report reminds us that different types of interventions will take different amounts of time to demonstrate impact. When setting targets, we therefore need to be explicit about the timescales within which we would expect to see changes to different metrics, and that these are likely to sit outside any local and national political cycles, requiring coordinated action over time.

Regression analysis for chosen indicators will help to set realistic but ambitious targets – recognising that sometimes these targets will be to *halt the rise* in the inequality gap, or to *hold the gap stable*, rather than to actually to be able to reduce the gap within the time frames of most strategies (3-5 years), especially given the recent context of financial austerity.

When choosing targets, it is also important to benchmark ourselves against our statistical comparator boroughs, neighbouring boroughs, as well as the London and England figures.

3. A standardised methodology should be used across Merton to be able to effectively monitor inequalities and progress towards closing the gap

We recommend that the methodology used for gap analysis and trend analysis in this report is adopted by the council and partners for calculating and reporting the gap in inequalities between the East and the West of the borough, to meet the 'bridging the gap' priority of the Merton Partnership.

This has implications for the choice of indicators for forthcoming strategic work such as the NHS's Local Health and Care Plan, and how we look at reporting inequalities as part of statutory assessments (for example the Community Safety Partnership Strategic Assessment), as well as for analysis of other locally collected data, particularly that which is done on a regular basis using relatively standard indicators, such as the council's Residents Survey.

Other partners may also be interested in thinking about taking a 'logic model' approach to developing a suite of indicators to monitor outcomes over defined time periods, with some that focus on short term change as a proxy for longer term progress.

We recommend that where possible, and where granularity of data is sufficient, that indicators from nationally available datasets are used for monitoring trend over time. Where data is collected locally, for instance through the Residents Survey, or in ad hoc surveys for regular reports such as the Strategic Assessment, it is really important to carefully consider how indicators are chosen and worded, to enable consistency of trend analysis over time.

C. Recommendations for monitoring health inequalities nationally

Given that data in many of the easily accessible national PHE data sets is only available at borough not ward level (therefore limiting analysis of sub-borough inequalities), Public Health Merton will feedback to PHE's data and intelligence team about the availability of sub-borough indicator data in easy to use formats, for instance through the online Local Health portal, and particularly for the PHE Marmot and PHE Health Equity indicator sets, to inform their ongoing support to local authority public health teams.

We will also respond to the government's consultation on Universal Credit metrics, as discussed in Chapter 4, to ensure that we are able to access ward level data on appropriate indicators to continue to measure trend in inequalities in the domain of fair employment and good work.

4. Appendices

Appendix 1: Resources for understanding and tackling health inequalities

- **Department of Health** (2008) Systematically Addressing Health Inequalities
  http://webarchive.nationalarchives.gov.uk/20130124043456/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086573.pdf
- **Department of Health** (2011) Health Inequalities National Support Team - A Generic Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Interventions
  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215615/dh_126331.pdf
- **Institute of Health Equity:** http://www.instituteofhealthequity.org/
- **Kings Fund** (2010): Tackling inequalities in General Practice
  https://www.kingsfund.org.uk/sites/default/files/Health%20Inequalities.pdf
- **Kings Fund** (2013) Improving the public's health: A resource for local authorities
  https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf
- **Kings Fund** (2013) Improving the public's health:
  https://www.kingsfund.org.uk/projects/improving-publics-health
- **Kings Fund** (2017) https://www.kingsfund.org.uk/blog/2017/08/reducing-inequalities-health-towards-brave-old-world
- **LGA** Feb 2018 'A matter of justice: Local government's role in tackling health inequalities' https://local.gov.uk/matter-justice-local-governments-role-tackling-health-inequalities
- **LGA:** Health in all policies: A manual for local government https://local.gov.uk/health-all-policies-manual-local-government
- **Health Foundation:** healthy lives infographics series
  https://www.health.org.uk/collection/healthy-lives-infographics
- **Health Foundation:** healthy lives quick guide
  https://www.health.org.uk/sites/health/files/What-makes-us-healthy-quick-guide.pdf
- **Marmot** (2010): Fair Society Healthy Lives
  http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf
- **NHS** Reducing health inequalities resources:
  https://www.england.nhs.uk/about/equality/equality-hub/resources/evidence/
- **PHE Local Health**: http://www.localhealth.org.uk/
- **PHE Public Health Outcomes Framework (PHOF):**
  https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
- **PHE Public Health Profiles**: https://fingertips.phe.org.uk/
- **PHE** (2017) Reducing health inequalities: system, scale and sustainability
  https://www.gov.uk/government/publications/reducing-health-inequalities-in-local-areas
- **WHO** (2015): McDaid, D, Sassi, F & Merkur, S (2015) Promoting Health, Preventing Disease: The Economic Case. World Health Organisation.
  http://www.euro.who.int/__data/assets/pdf_file/0006/283695/Promoting-Health-Preventing-Disease-Economic-Case.pdf?ua=1

Appendix 2: PHE Indicators sets (Marmot; Health Equity)

Marmot indicators
Life expectancy at birth – males and females
Healthy life expectancy at birth – males and females
Inequality in life expectancy at birth – males and females
People reporting low life satisfaction
Good level of development at age 5
Good level of development at age 5 with free school meal status
GCSE achieved (5A*-C including English & Maths)
GCSE achieved (5A*-C including English & Maths) with free school meal status
19-24 year olds who are not in employment, education or training
Unemployment % (ONS model-based method)
Long-term claimants of Jobseeker's Allowance
Work-related illness
Households not reaching Minimum Income Standard
Fuel poverty for high fuel cost households
Utilisation of outdoor space for exercise/health reasons
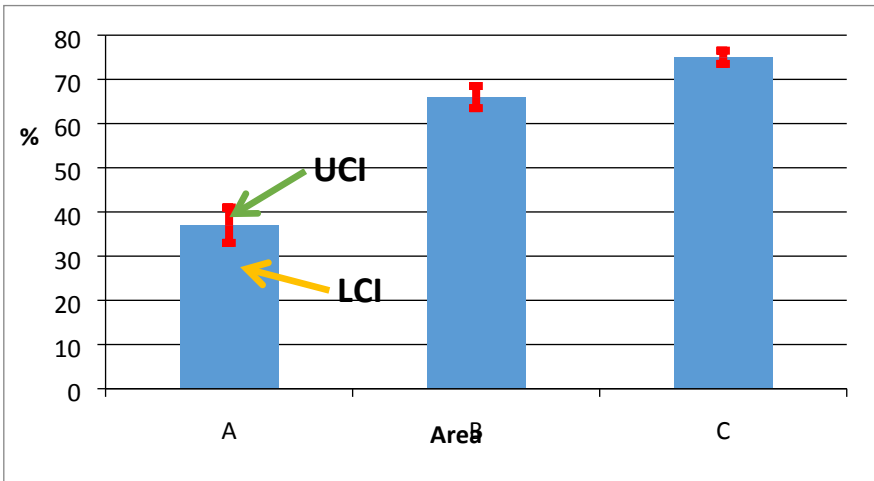
Health Equity Indicators
Life expectancy at birth
Healthy life expectancy at birth
Cardiovascular disease mortality under 75 years
Cancer mortality under 75 years
Infant mortality
Low birthweight of term babies
Proportion of five year old children with dental decay
Child excess weight in 4-5 and 10-11 year olds
Alcohol related hospital admissions
Prevalence of smoking among persons aged 18 years and over
Incidence of tuberculosis
Suicide
Self-reported wellbeing - low life satisfaction
Children in low income families (all dependent children under 20)
Readiness for school
Young people not in employment, education or training
Employment gap for those with a long-term condition
Homelessness

In **bold** – same or similar indicators between the two indicator sets

Appendix 3: Marmot priorities mapped to HWBS 2015-18 and APHR 2018

Marmot strategic priority areas for tackling heath inequalities	HWBS 2015 – 2018 Themes	APHR 2018 Chapters and indicators
-	-	Chapter 1: Overarching indicators
1. Giving every child the best start in life	Theme 1: Best start in life	Chapter 2: best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives	Theme 1: Best start in life Theme 3: Life skills, lifelong learning and good work	Chapter 2: best start in life
3. Creating the conditions for fair employment and good work for all	Theme 3: Life skills, lifelong learning and good work	Chapter 4: creating the conditions for fair employment and good work
4. Ensuring a healthy standard of living for all	Theme 5: A good natural and built environment	Chapter 5: Ensuring a healthy standard of living for all
5. Creating and developing healthy and sustainable places and communities	Theme 4: Community participation and feeling safe Theme 5: A good natural and built environment	Chapter 6: develop healthy and sustainable places and communities
6. Strengthening the role and impact of ill-health prevention.	Theme 2: Good health	Chapter 3: prevention of poor physical and mental ill health

Appendix 4: Glossary

Term	Definition
Confidence Intervals	Confidence intervals are an indicator of how accurate a set of data values is likely to be. Generally, the more values there are in a dataset, the more accurate the data is likely to be. Confidence intervals of 95% are routinely used. This indicates that 95% of the time, the values would be expected to fall within the range of the upper and lower confidence interval values, around the mean (average) value. It is possible to tell whether a value is statistically significantly higher or lower using confidence intervals. In the following chart, the red markers are the confidence interval levels and in area A, the arrows point to the upper (UCI) and lower (LCI) confidence intervals. An value is considered statistically significantly higher or lower than another value if there is a gap in values, for example, below the UCI in Area A is lower than the LCI in areas B and C, therefore Area A is significantly lower than areas A and B.
Decile	A decile is method of splitting up a set of ranked data into 10 equally sized subsections.
Directly Standardised Rate	Direct standardisation involves applying the rates of disease observed in the study group of people to a 'standard' population. The choice of the standard population depends on available data, and the purpose of the analysis.
Health Inequality	"Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs." -NHS England
Healthy life expectancy vs. Disability Free life expectancy	From the 2011 Census, one question was asked for each of the two indicators – healthy life expectancy (HLE) and disability free life expectancy (DFLE). Healthy life expectancy is a very general question about overall health and the DFLE question asked about longer term health problems or disabilities that would be expected to last for more than a year. These two questions are related in that they are enquiring about peoples' perceptions of their own health, however the responses would not necessarily be linked,

	for example, it is possible to be limited by a disability but still feel in good health. Census questions: • *Healthy life expectancy question: "How is your health in general?" Very Good/Good/Fair/Bad/Very bad.* • *Disability free life expectancy question: "Do you have any health problems or disabilities that you expect will last for more than a year?" Yes/No. If the answer was yes, a further question was asked; "Do these health problems or disabilities, when taken singly or together, substantially limit your ability to carry out normal day to day activities? If you are receiving medication or treatment, please consider what the situation would be without the medication or treatment" Yes/No.*
IMD	The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small areas in England (Lower Super Output Areas (LSOA)). It is a combined measure of deprivation based on a total of 37 separate indicators that have been grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area. The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area).
IDACI	The Income Deprivation Affecting Children Index (IDACI) is a specific subset of the Income Deprivation Domain relating to child poverty factors. The index is calculated by the Office of the Deputy Prime Minister and measures in a local area the proportion of children under the age of 16 that live in income deprived households. Income deprived families are defined as families that receive: • Income Support; or • income-based Jobseekers Allowance; or • income-based Employment and Support Allowance; or • Pension Credit (Guarantee); or • Working Tax Credit or Child Tax Credit with an equalised income (excluding housing benefit) below 60 per cent of the national median before housing costs
IDAOPI	The Income Deprivation Affecting Older People Index (IDAOPI) is another subset of the Income Deprivation Domain. This is based on the percentage of the population aged 60 and over who receive income support, income based job seekers allowance, pension credit or child tax credit claimants aged 60 and over and their partners (if also aged 60 or over).
Inequity	Inequity is an instance of injustice or unfairness. Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair. "Inequity and inequality: these terms are sometimes confused, but are not interchangeable, inequity refers to unfair, avoidable differences arising from poor governance, corruption or cultural exclusion while inequality simply refers to the uneven distribution of health or health resources as a result of genetic or other factors or the lack of resources." -Global Health Europe
Inequality	"Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different

	social classes." -World Health Organisation Absolute Inequality reflects the magnitude of difference in health between two subgroups. Relative Inequality measures show proportionate differences in health among subgroups.
Proportionate universalism	To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.
Slope index of inequality (years)	This is a single score representing the gap between the best-off and worst-off within a district for a chosen indicator. The slope index score represents the gap in years of life expectancy at birth between the most deprived and least deprived communities within a local authority area. The larger the index score (in years), the greater the disparity in life expectancy.
Social gradient in health	The social gradient in heath refers to the fact that inequalities in population health status are related to inequalities in social status; people who are relatively disadvantaged have progressively worse health outcomes than those who are more advantaged.
Standardised Admission Ratio (SAR)	The Standardised Admission Ratio (SAR) is a summary estimate of admission rates relative to the national pattern of admissions and takes into account differences in a population's age, sex and socioeconomic deprivation.
Wider determinants of health (also known as the social and economic determinants)	The wider determinants of health are a diverse range of social, economic and environmental factors which impact on people's health. These factors can be largely outside of an individual's direct control, and are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. Examples of wider determinants of health include: • Socioeconomic status • Education • Income • Smoking status • Employment • Alcohol use • Social networks

5. SUMMARY TABLE OF APHR 2018 INDICATORS

Chapter	Type of indicator	Indicator Green: analysis included in this report *Black*: not covered in this report in detail	Most recent data source (year)	Timescale for change[i]	Merton inequality gap[ii] *Method of calculating gap* 30/30	East/West	Other	Trend in Merton inequality gap[iii] (+/–; stable; mixed; Not Available)	PHE Marmot indicator (Y/N)	PHE Health Equity Indicator (Y/N)	Current Merton indicator?[iv]	Geography level for data availability[v]	Inequality trend to date?[vi] (Y/N) *i.e. can we measure historic trend in inequalities using gap analysis?*	Inequality trend in future?[vii] (Y/N/Maybe) *i.e. will we be able to measure future gap trend?*	Consider as a HWBS 2019-2024 indicator? (Y/N/Maybe)
CHAPTER 1: Overarching indicators of inequalities in health and wellbeing	Determinant	**Life Expectancy at birth (Males)**	Local Health (2011-15)	Long term	M: 4.1 years			Stable	Y	Y	HWBS	Ward; Borough	Y	Y	Y (SII may be more robust)
	Determinant	**Life Expectancy at birth (Females)**	Local Health (2011-15)	Long term	F: 2.7 years			Reducing (unclear if statistically significant)	Y	Y	HWBS	Ward; Borough	Y	Y	Y (SII may be more robust)
	Determinant	**Inequality in life expectancy at birth [Slope Index of Inequality] (Males)**	PHOF (2014-16)	Long term			M: 6.2 years	Stable	Y	N	-	Sub-borough[viii] (10/10 analysis)	Y	Y	Y
	Determinant	**Inequality in life expectancy at birth [Slope Index of Inequality] (Females)**	PHOF (2014-16)	Long term			F: 3.4 years	Reducing (but not yet statistically significant)	Y	N	-	Sub-borough (as above)	Y	Y	Y
	Determinant	**Healthy life Expectancy at birth (male)**	ONS (2009-13)	Long term	9.4 years			N/A	Y	Y	MP	Ward; Borough	N	N	Y (borough not gap)
	Determinant	**Healthy life Expectancy at birth (female)**	ONS (2009-13)	Long term	9.3 years			N/A	Y	Y	MP	Ward; Borough	N	N	Y (borough not gap)
	Determinant	*Disability free life expectancy from birth (male and female)*	ONS (2009-13)	Long term	M: 7.8 years F: 7.1 years			NA	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Disability free life expectancy at age 65 (male and female)*	ONS (2009-13)	Long term	M: 3.1 years F: 2.7 years			NA	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Proportion living without disability at birth (male and female)*	ONS (2009-13)	Long term	M: 4.7 % points F: 4.5 % points			N/A	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Proportion living without disability at age 65 (male and female)*	ONS (2009-13)	Long term	M: 8.7 % points F: 7.0 % points			N/A	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Proportion of life spent in good health at birth (male and female)*	ONS (2009-13)	Long term	M: 6.7 % points F: 7.2 % points			N/A	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Determinant	*Proportion of life spent in good health at age 65 (male and female)*	ONS (2009-13)	Long term	M: 13.4 % points F: 11.8 % points			N/A	N	N	-	Ward; Borough	N	N	M (borough not gap)
	Mortality	**Premature mortality (deaths in those under the age of 75)**	Primary Care Mortality (PCMD) (2013-17)	Long term	12.5 % points			Increasing (unlikely to be statistically significant)	N	N	-	Ward; Borough	Y	Y	Y

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap 30/30	E/W	Other	Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
	Determinant	**Child Poverty - children living in low income families**	HMRC and GLA (2015)	Medium to long term	21 % points (2015); 6 % points (2018 extrapolation)			Reducing (mixed underlying picture)	N	Y	-	Ward; Borough	Y	Y	Y
	Mortality	*Infant mortality*	PHOF	Medium to long term					N	Y	-	Borough	N	N	N
	Determinant / Morbidity	*Low birthweight of term babies*	PHE Local Health (2011-2015)	Medium to long term	0.8 % points			N/A	N	Y	-	Ward; Borough	N	Maybe via Local Health in future – to monitor	M
	Determinant	**School readiness - child development at age 5 (end of reception)**	Dep't for Education via PHE Local Health (2013/14)	Medium to long term	15.9 % points			N/A at ward level, only borough	Y	Y	-	Ward; Borough	N	N	M (borough not gap); lack of recent data
	Determinant	**School readiness - child development at age 5 (end of reception) with free school meal (FSM) status**	PHE Local Health (2016/17)	Medium to long term	10.0 % points (all children vs. those with FSM status: at borough not ward level)			Gap between all children and those with FSM reducing	Y	Y	HWBS (pupil premium not FSM)	Borough	Y but using different gap methodology	Y but using different gap methodology	Y (but gap analysis using different methodology)
	Determinant	GCSE achieved (5A*-C incl. English & Maths)	PHE Local Health (2013/14)	Medium to long term	15.4 % points			N/A – only two time points	Y	N	-	Ward; Borough	N – not robust as only two time points	Maybe via Local Health in future – to monitor	M if sufficient trend data available in future
	Determinant	*GCSE achieved (5A*-C incl. English & Maths) with FSM status*	PHOF (2015)	Medium to long term					Y	N	HWBS (pupil premium not FSM)	Borough	N	N	M (borough, not gap)
	Determinant	*19-24 year olds / young people not in employment, education or training*	GLA (2015)	Medium to long term					Y (19-24 year olds)	Y (16-18 year olds)	MP (16-17 year olds NEET)	Borough	N	N	M (borough, not gap)
	Morbidity	*Proportion of 5 year olds with dental decay*	PHOF	Short to medium term					N	Y		Borough	N	N	M (borough, not gap)
	Morbidity	**Child Excess weight (Reception)**	*National Obesity Observatory/ PHE (14/15-16/17)*	Short to medium term	9.6% points			Increasing	N	Y	-	Ward; Borough	Y	Y	Y – HWBB priority
	Morbidity	**Child Excess weight (Year 6)**	*NOO / PHE (14/15-16/17)*	Short to medium term	14.5% points			Increasing	N	Y	SP, MP, HWBS	Ward; Borough	Y	Y	Y – HWBB priority

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap			Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
					30/30	E/W	Other								
CHAPTER 6: Prevention of ill health	Lifestyle / behavioural risk factor	Smoking prevalence (as recorded in GP Profiles)	GP QOF (2015/16)	Short to medium term		6.2 % points		Increasing	N	N but similar (see indicator below)	-	GP; Borough	Y	Y	Y, in lieu of ward data for Health Equity indicator
	Lifestyle / behavioural risk factor	*Prevalence of smoking in those aged 18+*	PHOF	Short to medium term					N	Y	HWBS	Borough	N	N	N – use similar indicator
	Lifestyle / Morbidity	Hospital stays due to alcohol related harm (Standardised Admission Ratio, SAR)	PHE Local Health HES (2011/12 - 2015/16)	Short to medium term	38.2 difference in Standardised Admission Ratio			N/A – only two time points	N	N but similar indicator[30]	HWBS	Ward; Borough	N – not robust (only 2 time points)	Maybe via Local Health in future – to monitor	Y if sufficient trend data available in future
	Physiological risk factor / Morbidity	Hypertension prevalence (GP profiles)	GP QOF (2016/17)	Short to medium term		1.5 % points		Increasing (not yet statistically significant)	N	N	-	GP; Borough	Y	Y	Y
	Morbidity	Diabetes prevalence (GP profiles)	GP QOF (2016/17)	Short to medium term		3.1 % points		Increasing (Statistically significant)	N	N	-	GP; Borough	Y	Y	Y – HWBB priority
	Morbidity	Incidence Rate of tuberculosis (TB)	PHE (2014-2016)	Short to medium term	25.6 per 100,000 rate difference			Increasing (unlikely to be statistically significant: small no.s)	N	Y	-	Ward; Borough	Y	Y	Y
	Morbidity	Mental Health (GP profiles)	GP QOF (2016/17)	Short to medium term		0.24 % points		Decreasing (but complex picture)	N	N	-	GP; Borough	Y	Y	Y – parity of esteem
	Morbidity	Depression (GP profiles)	GP QOF (2016/17)	Short to medium term		0.45 % points		Unclear trend (complex picture)	N	N	-	GP, Borough	Y	Y	Y – MCCG investment
	Morbidity	Self reported wellbeing – low life satisfaction	GLA (2013)	Medium to long term	11.7 point gap (2013)			Decreasing (but complex picture)	Y	Y		Borough	Y	M – monitor to see if more recent data	M (borough not gap); lack recent data
	Mortality	*Suicide*	PHOF	Medium to long term					N	Y		Borough	N	N	N
	Mortality	*Cardiovascular disease mortality under 75 years*	PHOF	Long term					N	Y		Borough	N	N	N – use premature mortality
	Mortality	*Cancer mortality under 75 years*	PHE Local Health (2010-14)	Long term			Not calculated but available at ward level	N/A – only two time points	N	Y	-	Ward; Borough	N – not robust as only two time points	Maybe via Local Health in future – to monitor	M if sufficient trend data available in future

[30] PHE Marmot indicator is Directly Standardised Rate (Merton: 495 per 100,000 in 2016/17); however, this is only available at borough, whereas PHE Local Health shows Standardised Admission Ratios by ward.

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap			Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
					30/30	E/W	Other								
	Determinant	*Unemployment % (ONS model-based method)*	PHOF	Medium to long term					Y	N	-	Borough	N	N	Await new Universal Credit (UC) metrics
	Determinant	*Long term claimants of job seekers allowance*	PHOF	Medium to long term					Y	N	-	Borough	N	N	Await new UC metrics
	Determinant	*Work related illness*	PHOF	Medium to long term					Y	N	-	London, England	N	N	N – limited borough data available
	Determinant	*Households not reaching Minimum Income Standard*	PHOF	Medium to long term					Y	N	-	London, England	N	N	N – limited borough data available
	Determinant	*Employment gap for those with a long term condition*	PHOF	Medium to long term					N	Y	-	Borough, London, England	Limited	N	M (borough not gap); await new UC metrics)
	Determinant	**Economically active population claiming jobseeker's allowance (JSA)**[31]	ONS NOMIS (2015)	Medium to long term	2.5 % points			Reducing	N but similar (see above indicators)	N	HWBS	Ward; Borough	Y	Y but depends on new UC metrics	Y (in lieu of ward data for Marmot/ Equity indicators); await new UC metrics
	Determinant	**Employment & Support Allowance (ESA)**	ONS NOMIS (2017)	Medium to long term	3.4 % points			Stable	N	N	--	Ward; Borough	Y	Y but depends on new UC metrics	Y (as above); but await new UC metrics
	Determinant	*Incapacity benefit*	NOMIS (2017)	Medium to long term	Not calculated as numbers too small			Numbers too small to make robust conclusions	N	N	HWBS	Ward; Borough	Y but numbers too small for robust trend	Y but numbers too small for robust trend	Await new UC metrics
	Determinant	*Severe disablement allowance*	NOMIS (2017)	Medium to long term	Not calculated as numbers too small			Numbers too small to make robust conclusions	N	N	-	Ward; Borough	Y but numbers too small to make robust conclusions	Y but numbers too small to make robust conclusions	Await new UC metrics

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[31] According to NOMIS: JSA "is not an official measure of unemployment, but is the only indicative statistic available for areas smaller than Local Authorities."

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap 30/30	Merton Gap E/W	Merton Gap Other	Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
Chapter 5: Healthy standard of living	Determinant	**Deprivation IMD 2015**	IMD (2015)	Long term	17.01 point difference in average score			N/A	N	N	-	LSOA; Ward	N	N	Y (trend not available, but can look at relative change over time)
	Determinant	**Deprivation IMD 2015**	IMD GP Profiles (2015) DCLG	Long term		11.74 point difference in score		N/A	N	N	-	GP; Borough	N	N	N (use IMD 2015 by ward as above)
	Determinant	**Deprivation IMD 2015- IDACI - Children (GP profiles)**	IMD GP Profiles (2015) DCLG	Long term		13.33 % point difference in score		N/A	N	N	-	GP; Borough	N	N	N – difficult to interpret, direct trend not available, Child Poverty is a better indicator
	Determinant	**Deprivation IMD 2015- Deprivation in Older People**	IMD GP Profiles (2015) DCLG	Long term		8.63 % point difference in score		N/A	N	N	-	GP; Borough	N	N	N – difficult to interpret, direct trend not available
	Determinant	**Household overcrowding**	ONS Census (2011)	Medium to long term	10.2 % points			N/A	N	N	-	Ward; Borough	N	N	N (lack of both recent data and trend until next Census in 2021)
	Determinant	**Fuel poverty for high cost fuel households**	PHE Local Health (ONS 2015)	Medium to long term	1.4 % points			N/A	Y	N	-	Ward; Borough	N	Maybe via Local Health in future – to monitor	M if sufficient trend data available in future
	Determinant	*Homelessness*	PHOF	Medium to long term					N	Y	-	Borough	N	N	Y (borough, not E/W or 30/30 gap), as a good measure of equity in itself)

Chapter	Type of indicator	Indicator	Data source (year)	Timescale for change?	Merton Gap 30/30	Merton Gap E/W	Merton Gap Other	Trend in gap	PHE Marmot indicator	PHE Health Equity Indicator	Current Merton indicator?	Geography level for data availability	Inequality trend to date? (Y/N)	Inequality trend in future? (Y/N/Maybe)	Consider as HWBS 2019+ indicator?
CHAPTER 6: Healthy, sustainable communities	Determinant	Burglary	*Metropolitan Police Data (2017)*	Medium to long term	-3.4 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	N
	Determinant	Theft	*Metropolitan Police Data (2017)*	Medium to long term	-8.5 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	N
	Determinant	Criminal damage	*Metropolitan Police Data (2017)*	Medium to long term	4.2 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	N
	Determinant	Antisocial behaviour	*Metropolitan Police Data (2017)*	Medium to long term	7.0 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	Y
	Determinant	Violence against the person	*Metropolitan Police Data (2017)*	Medium to long term	14.5 per 1000 rate difference			N/A	N	N	-	Ward; Borough	Y but not calculated for this report	Y	M
	Determinant (Psychosocial risk factor)	Older people (65+) living alone	ONS Census (2011)	Medium to long term	0.5 % points			N/A	N	N	-	Ward, Borough	N	N	N as not a measure of social isolation in itself, and lack of timely trend data (Census)
	Determinant	Utilisation of outdoor space for exercise/health reasons	PHOF	Short to medium term	/////	/////		Y	N	HWBS	Borough	N	N	Y (borough not gap)

Annual Public Health Report 2018: Health inequalities in Merton
SUPPLEMENTARY DATA REPORT

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Supplementary data: graphs to support text

1. CHAPTER 1: Overarching indicators

1.1.1. Life expectancy from birth in males, 2005 to 2015

Male Life Expectancy from birth in Merton 2011-2015
Source: Public Health England - Local Health

— Most deprived average   — Least deprived average

Trend in life expectancy from birth in males in Merton
Source: Public Health England - Local Health

— Most deprived   — Least deprived   — Merton
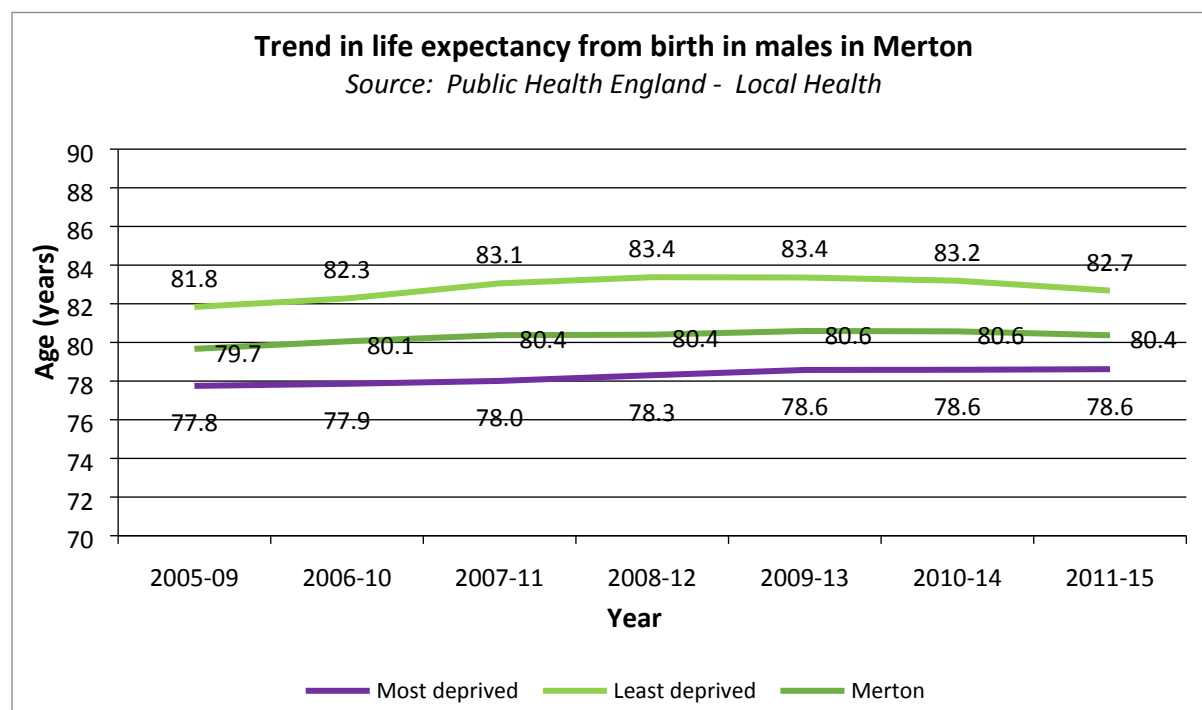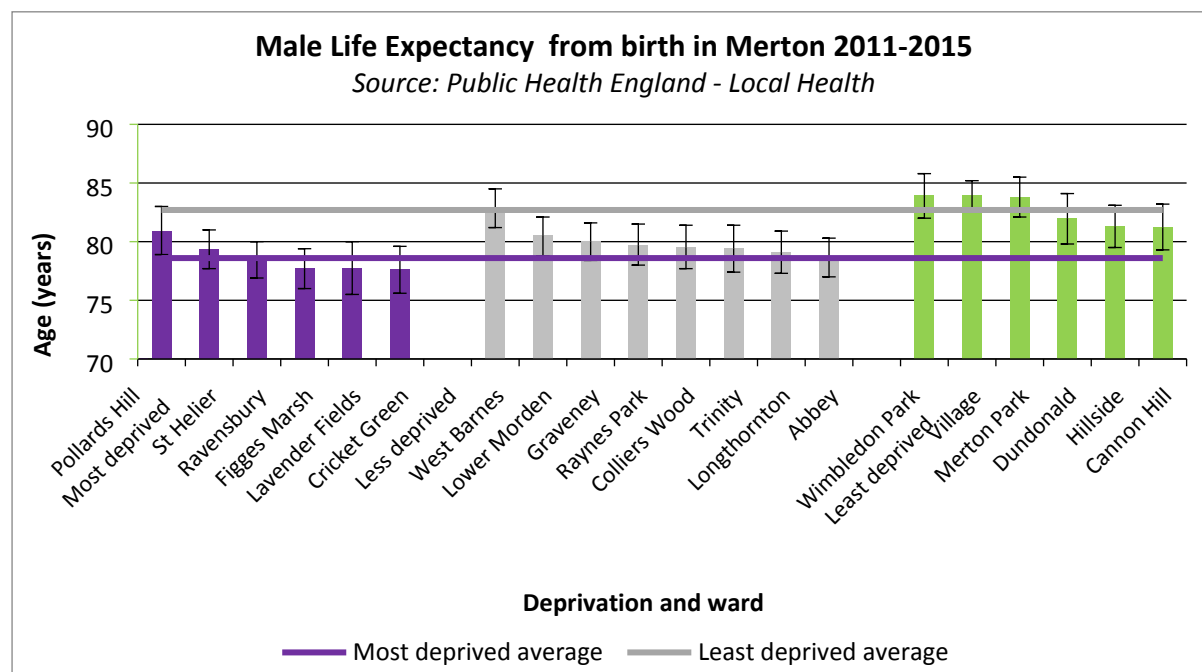
INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 4.1 years (2011-2015 data)
TREND IN INEQUALITY GAP	Between 2005 and 2015, the difference in male life expectancy between the most and least deprived wards remained the same

1.1.2.Life expectancy from birth in females, 2005 to 2015

Female Life Expectancy from birth in Merton 2011-2015
Source: Local Health, Public Health England

Trend in life expectancy from birth in females in Merton
Source: Public Health England - Local Health
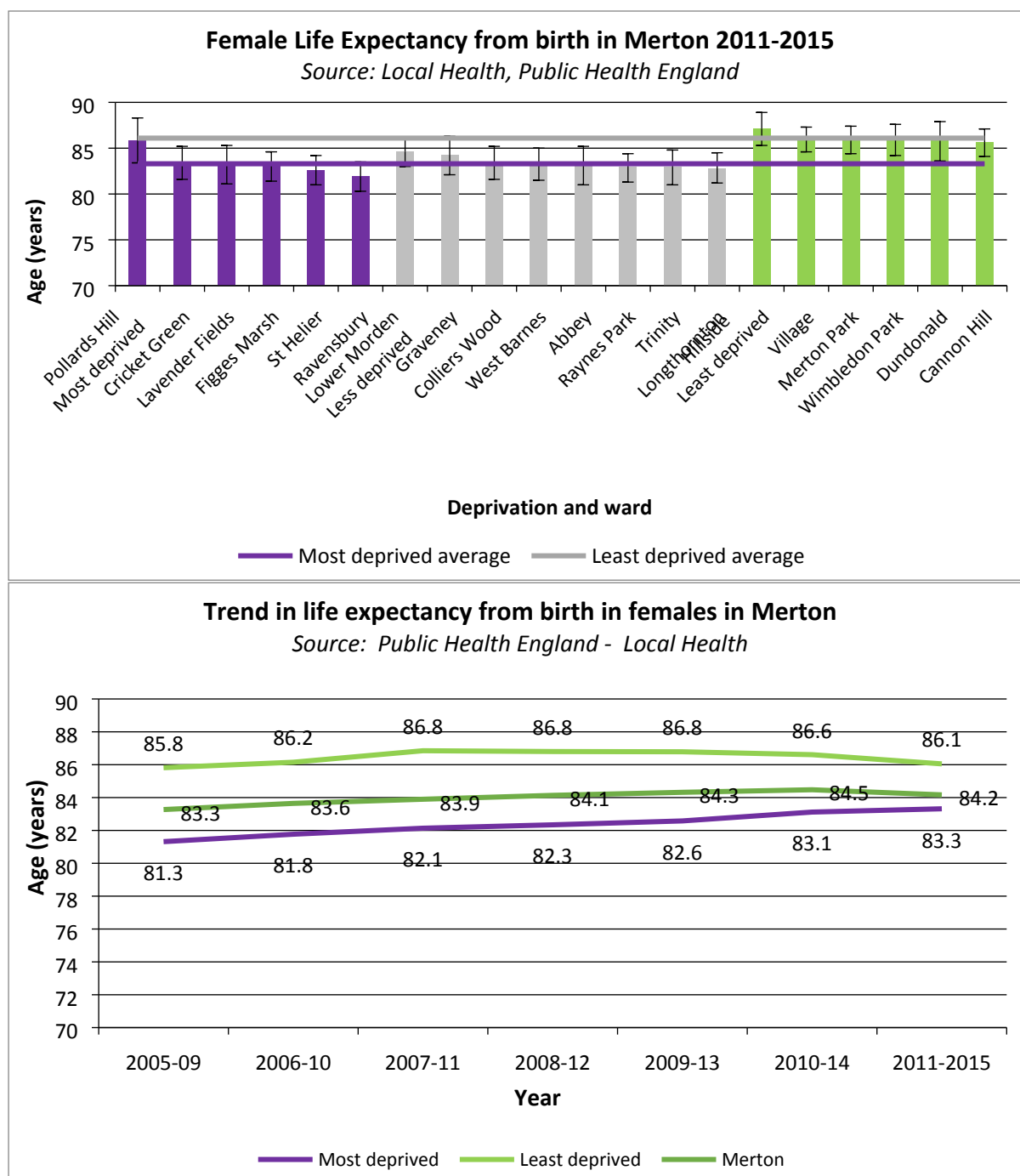
INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 2.7 years (2011-2015 data)
TREND IN INEQUALITY GAP	Between 2005 and 2015, the difference in female life expectancy between the most deprived and least deprived wards reduced (from 4.5 to 2.7).

1.1.3. Slope index of inequality in males, 2005-07 to 2014-16

Life expectancy and slope index of inequality in Males in Merton

Source: Office for National Statistics
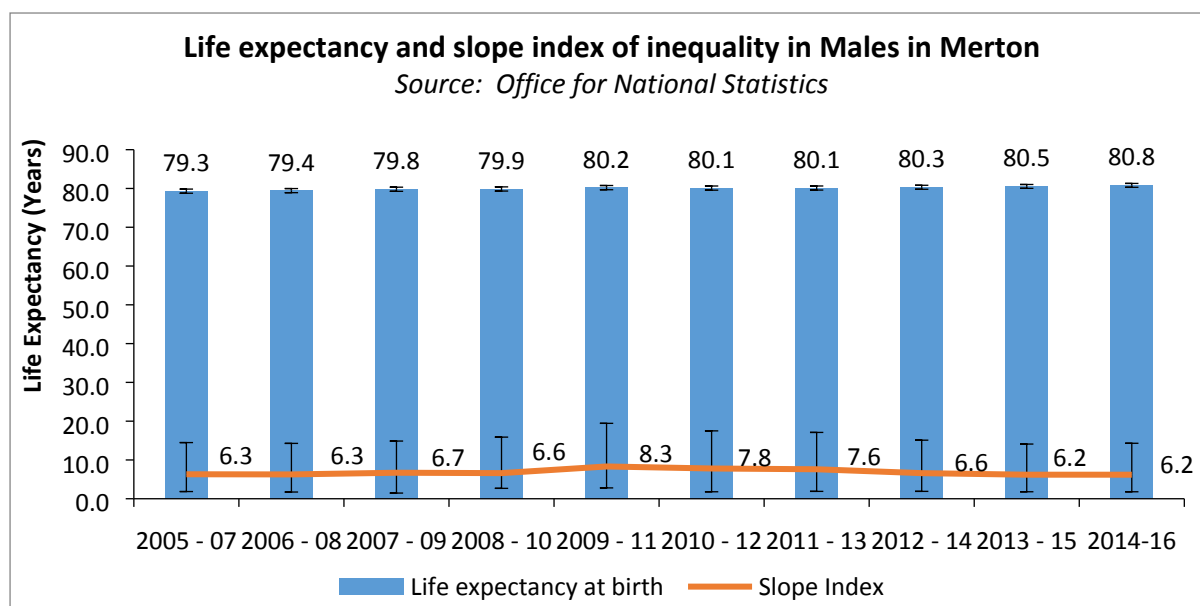
INEQUALITY GAP	Current gap between 10% most and 10% least deprived: 6.2 years (2014-16 data)
TREND IN INEQUALITY GAP	Between 2005-07 and 2014-16, the difference in male life expectancy between the most and least deprived wards remained the same

1.1.4. Slope Index of inequality in females, 2005-07 to 2014-16

Life expectancy and slope index of inequality in females in Merton

Source: Office for National Statistics
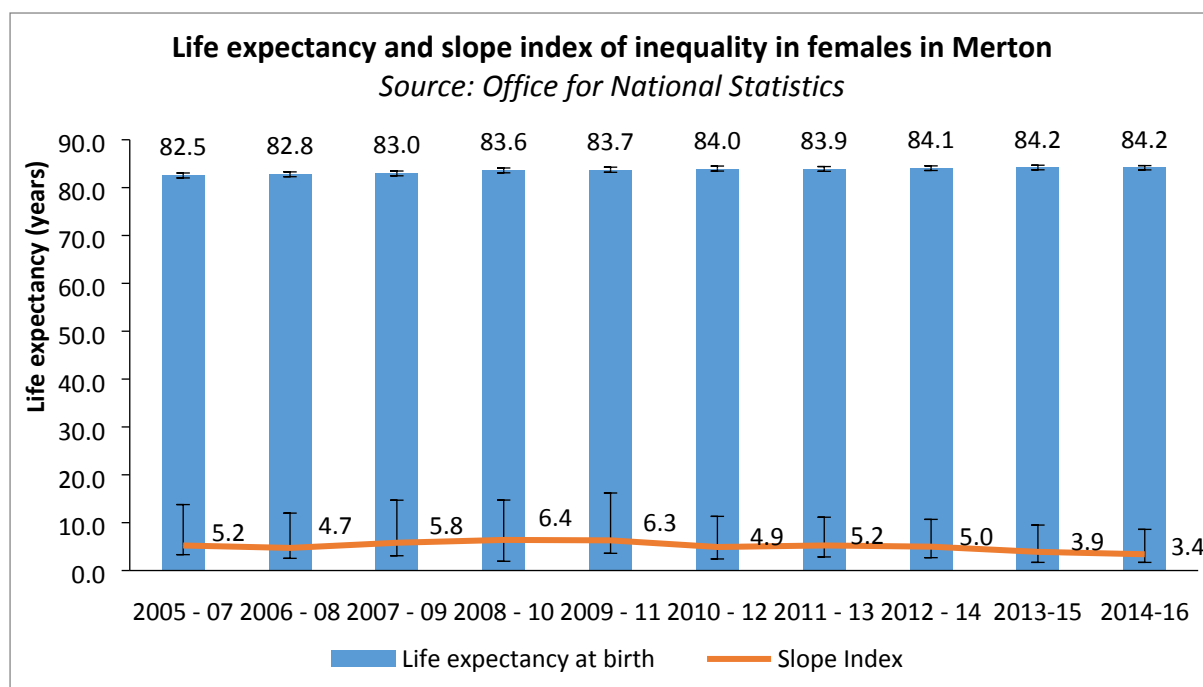
INEQUALITY GAP	Current gap between 10% most and 10% least deprived: 3.4 years (2014-16 data)
TREND IN INEQUALITY GAP	Between 2005-07 and 2014-16, the difference in female life expectancy between the most deprived and least deprived wards reduced (from 5.2 to 3.4). However, it is not yet a statistically significant reduction.

1.1.5.Healthy Life Expectancy (males), 2009-2013

Healthy life expectancy from birth by ward, Merton wards
Males, 2009-2013
Source: Office for National Statistics
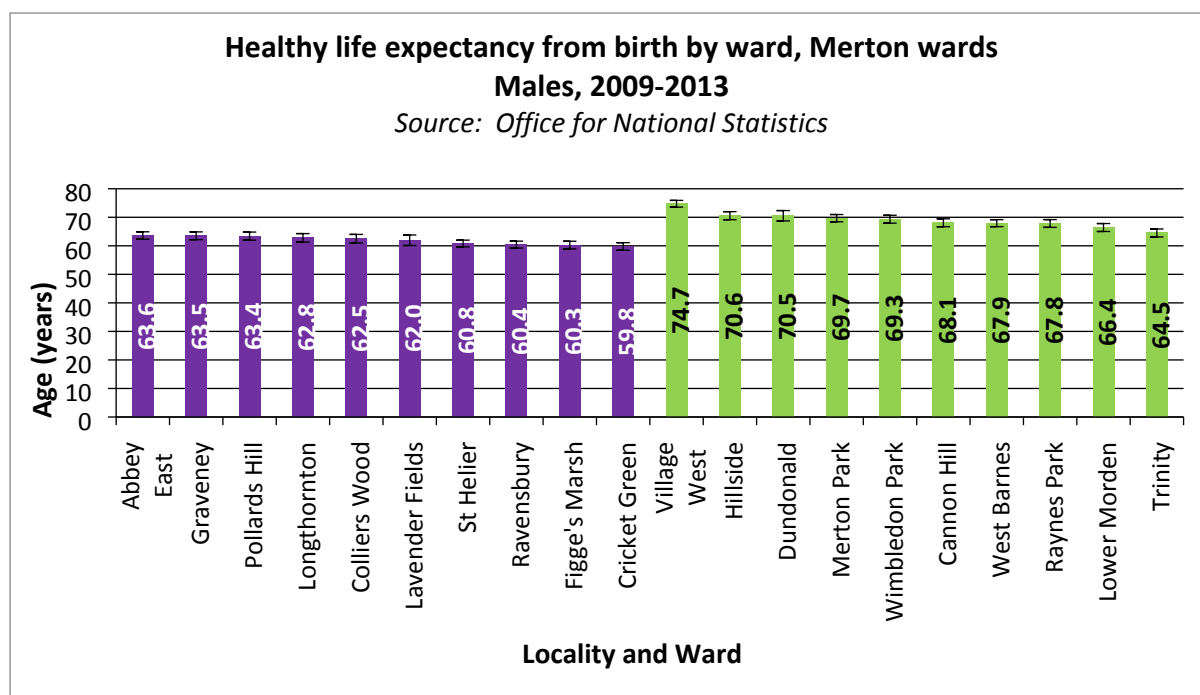
Males Healthy LE from birth 2009-2013	Years
Average for East of borough	61.9
Average for West of borough	69
Merton	65.3

Males Healthy LE from birth 2009-2013	Years
Least deprived	70.5
Most deprived	61.1
Merton	65.4

INEQUALITY GAP	Difference in healthy life expectancy between the 30% most and least deprived is 9.4 years (61.1 years in the 30% most deprived compared to 70.5 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.6.Healthy Life Expectancy (females), 2009-2013

Healthy life expectancy from birth by ward, Merton
Females, 2009-2013
Source: Office for National Statistics
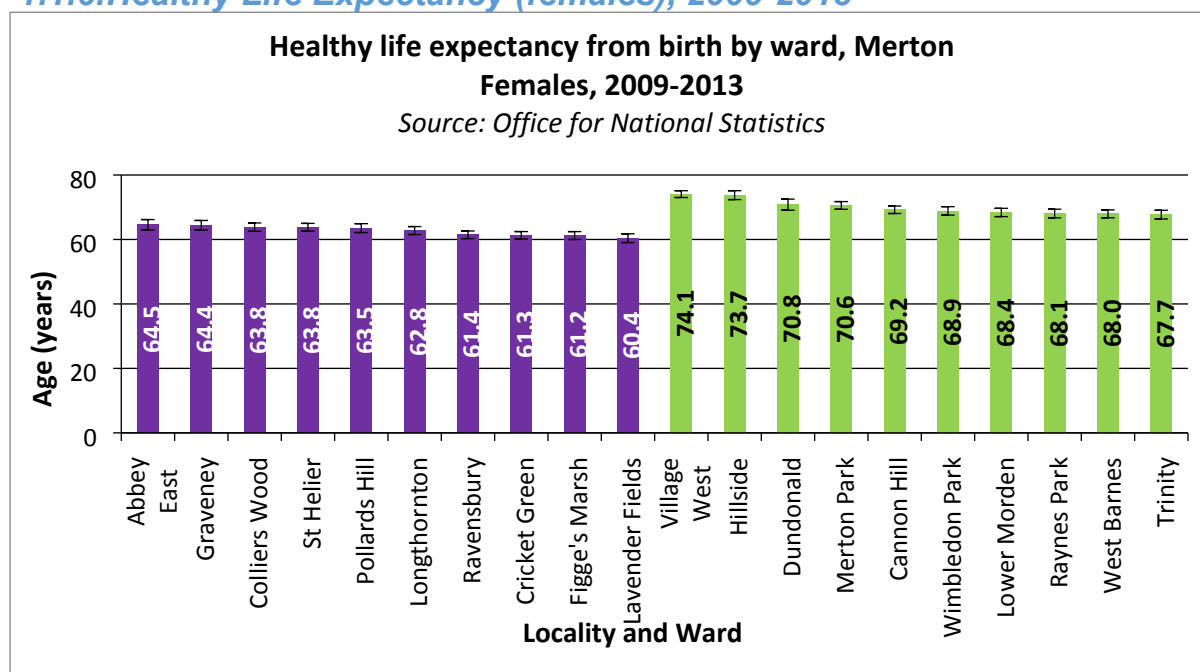
Females Healthy LE from birth 2009-2013	Years
Average for East of borough	62.7
Average for West of borough	69.9
Merton	66.3

Females Healthy LE from birth 2009-2013	Years
Least deprived	71.2
Most deprived	61.9
Merton	66.3

INEQUALITY GAP	Difference in healthy life expectancy (females) between the 30% most and least deprived is 9.3 years (61.9 years in the 30% most deprived compared to 71.2 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.7.Disability Free Life Expectancy at birth, 2009-2013
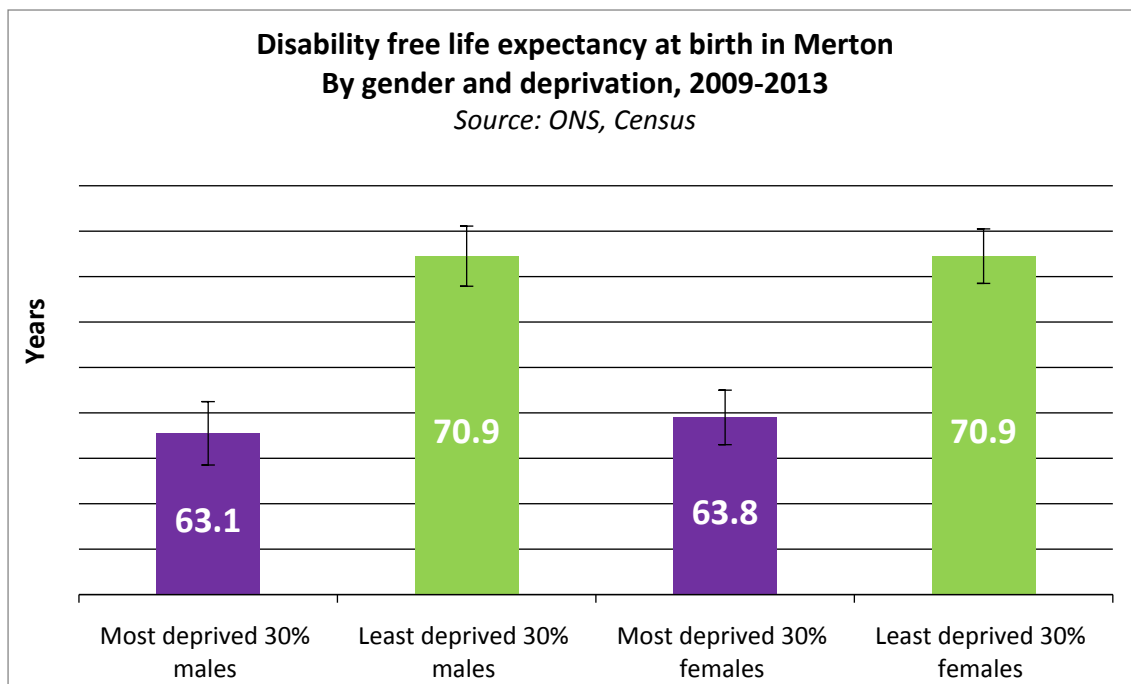
Disability free life expectancy at birth in Merton
By gender and deprivation, 2009-2013
Source: ONS, Census

INEQUALITY GAP	Difference in disability free life expectancy at birth between the 30% most and least deprived is 7.8 years in males and 7.1 years in females (2009-2013 data). Confidence intervals show that these differences are statistically significant.
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.8.Disability Free Life Expectancy at age 65, 2009-2013

Disability free life expectancy at 65 in Merton
By gender and deprivation, 2009-2013
Source: ONS, Census
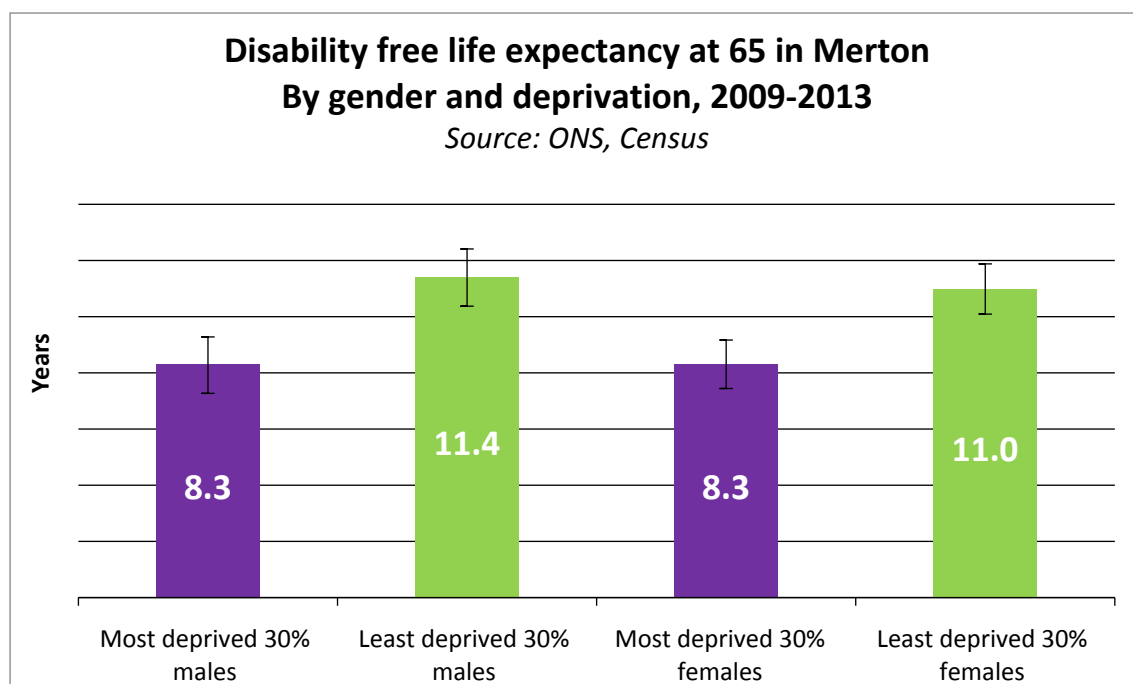
INEQUALITY GAP	Difference in disability free life expectancy at age 65 between the 30% most and least deprived is 3.1 years in males and 2.7 years in females (2009-2013 data). Confidence intervals show that these differences are statistically significant.
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.9.Proportion of life spent without a disability at birth, 2009-2013

Proportion of life spent without a disability at birth in Merton
By gender and deprivation, 2009-2013
Source: ONS , Census

INEQUALITY GAP	Difference in proportion of life spent without a disability at birth between the 30% most and least deprived is 4.7 percentage points in males and 4.5 percentage points in females (2009-2013 data). Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.10.   Proportion of life spent without a disability at age 65, 2009-2013

Proportion of life spent without a disability at age 65 in Merton
By gender and deprivation , 2009-2013
Source: ONS, Census

INEQUALITY GAP	Difference in proportion of life spent without a disability at age 65 between the 30% most and least deprived is 8.7 percentage points in males and 7.0 percentage points in females (2009-2013 data). *Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)*
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.11. *Proportion of life spent in good health at birth, 2009-2013*

**Proportion of life spent in good health at birth in Merton
By gender and deprivation, 2009-2013**
Source: ONS, Census

	Value
Most deprived 30% males	77.8
Least deprived 30% males	84.5
Most deprived 30% females	74.9
Least deprived 30% females	82.1

INEQUALITY GAP	Difference in proportion of life spent in good health between the 30% most and least deprived is 6.7 percentage points in males and 7.2 percentage points in females (2009-2013 data). *Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)*
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.12.   Proportion of life spent in good health at age 65, 2009-2013

Proportion of life spent in good health at age 65 in Merton
By gender and deprivation, 2009-2013
Source: ONS, Census

INEQUALITY GAP	Difference in proportion of life spent in good health at age 65 between the 30% most and least deprived is 13.4 percentage points in males and 11.8 percentage points in females (2009-2013 data). *Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)*
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE*

1.1.13. Premature mortality (under 75), 2011-2015 to 2013-2017

Premature mortality (under 75) by 30% most and least deprived wards in Merton, as a % of all deaths in the respective 30%
Source: Primary Care Mortality Data

pp=percentage point difference between two values

INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 12.5 percentage points (2013-17 data)
TREND IN INEQUALITY GAP	There appears to be is a widening gap between the most and least deprived 30% in Merton, increasing from 11.5 percentage points in the 2011-2015 data to 12.5 percentage points in the 2013-2017 data. The percentage of premature deaths in the most deprived 30% have remained relatively stable, however premature deaths in the least deprived 30% show a drop in percentages from 27% in 2011-2015 to 25.9% in 2013-2017. However, there are only 3 data points, and it is unlikely that this is statistically significant.

2. CHAPTER 2: Best start in life

2.1.1. Child poverty, 2010 to 2015

Child Poverty indicator definition: "Proportion of children aged 0–15 years living in income deprived households as a proportion of all children aged 0–15 years"

Child Poverty in Merton showing 30% most and least deprived wards
Source: Her Majesty's Revenue & Customs via Greater London Authority

Child Poverty in Merton showing the most and least deprived 30% 2010-2015 with projection to 2018
Source: Her Majesty's Revenue & Customs via Greater London Authority

pp = percentage points, the difference between two values

INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 21 percentage points (27% of children living in low income households in the most deprived 30% of wards compared to 6% of children in the least deprived, 2015 data) Statistically extrapolated data suggests that the current 2018 gap is likely to be smaller than this, at 6 percentage points (19% v 13%).
TREND IN INEQUALITY GAP	Although most recent 2015 data appears to show that gap has remained the same as 2010, extrapolated regression analysis suggests the gap is reducing, from 21 % points in 2010 to 6 % points in 2018.However, the underlying picture is mixed: the trend in child poverty in the most deprived areas appears to be downwards (27% in 2015 to an estimated 19% in 2018) which is positive, where as child poverty in least deprived areas appears to be increasing (from 6% to an estimated 13% in 2018) which is worrying, and accounts for some of the narrowing inequality gap. This needs to be monitored over time.

2.1.2. Child development at age 5: school readiness, 2012/13 to 2016/17

There is a lack of ward level data over a number of years that would enable us to show trend, but we can make some comparisons between the total data set, and the subset of those who have Free School Meal status.

School readiness - all pupils and those with Free School Meal status
Source: Fingertips, Public Health England
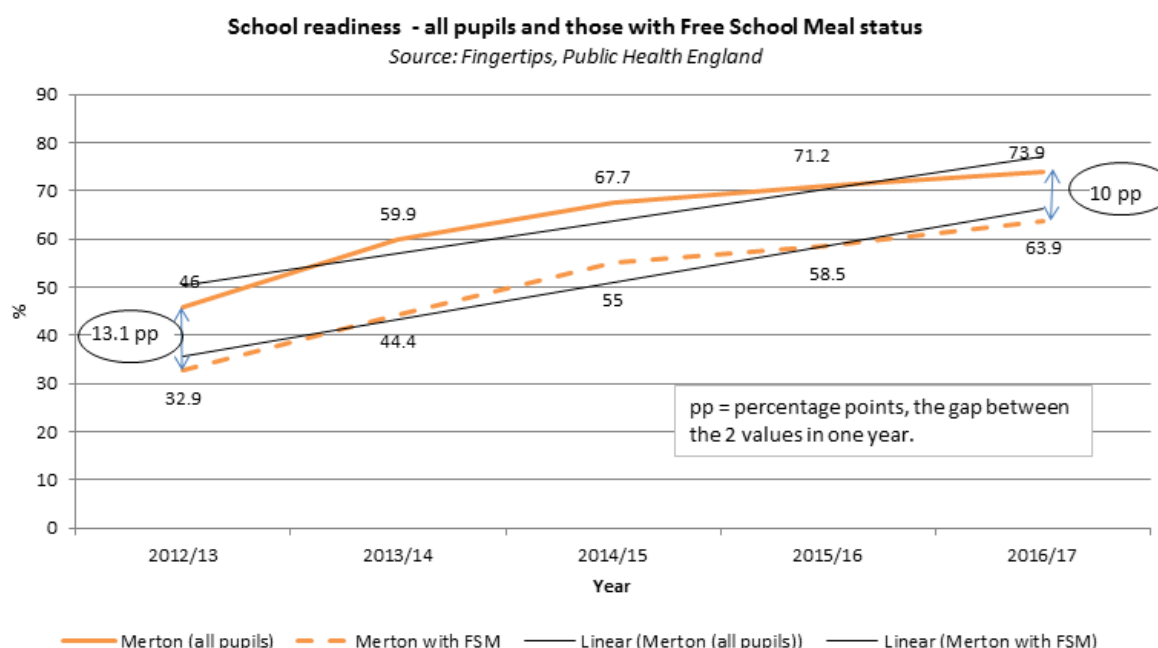
The gap between all children and those with free school meal status for school readiness in **London** between 2012/13 and 2016/17 **rises from 9.7 pp to 10.3 pp** whereas Merton values reduce from 13.1 pp to 10 pp.

INEQUALITY GAP	Current gap between all children and those with FSM status: 10.0 percentage points (73.9% of all children in Merton achieve a good level of development, where as only 63.9% of children with FSM status achieve a good level of development) (2016/17 data)
TREND IN INEQUALITY GAP	Between 2012/13 and 2016/17, the difference in school readiness between all children and those with FSM status reduced (from 13.1 percentage points to 10.0 percentage points).

2.1.3. Child excess weight: Reception age, 2010/11-2012/13 to 2014/15-2016/17

Excess weight in Reception Children (aged 4-5 years) in Merton
Source: Gov.UK
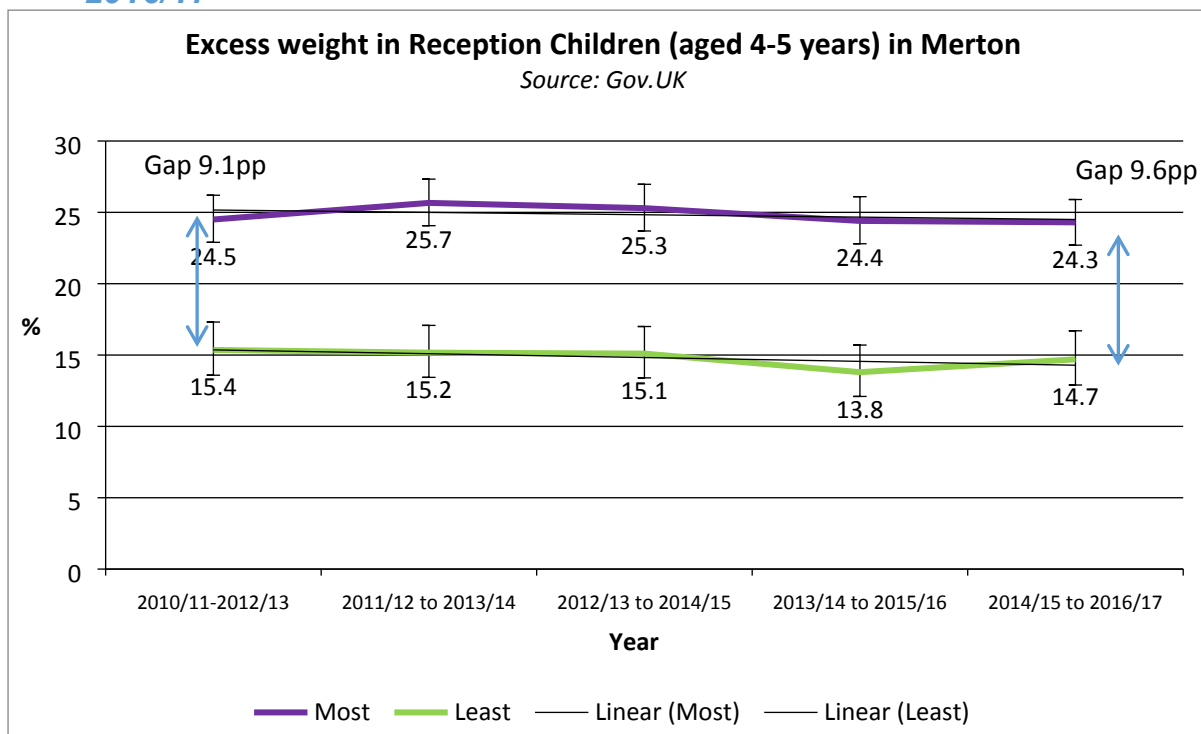
INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 9.6 percentage points (24.3% compared to 14.7%), 14/15 – 16/17 data. The difference is statistically significant.
TREND IN INEQUALITY GAP	Between 10/11-12/13 and 14/15-16/17, the difference between the most deprived and least deprived wards increased (from 9.1 to 9.6 percentage points).

2.1.4. Child excess weight: Year 6 (age 10-11), 2010/11-2012/13 to 2014/15-2016/17

Excess weight in Year 6 Children (aged 10-11 years) in Merton
Source: Gov.UK

Gap 11.5 percentage points

Gap 14.5 pp

| Most values | 39.0 | 39.6 | 39.8 | 40.2 | 40.2 |
| Least values | 27.5 | 26.0 | 27.2 | 27.7 | 25.7 |

Years: 2010/11-2012/13, 2011/12 to 2013/14, 2012/13 to 2014/15, 2013/14 to 2015/16, 2014/15 to 2016/17

Legend: Most — Least — Linear (Most) — Linear (Least)
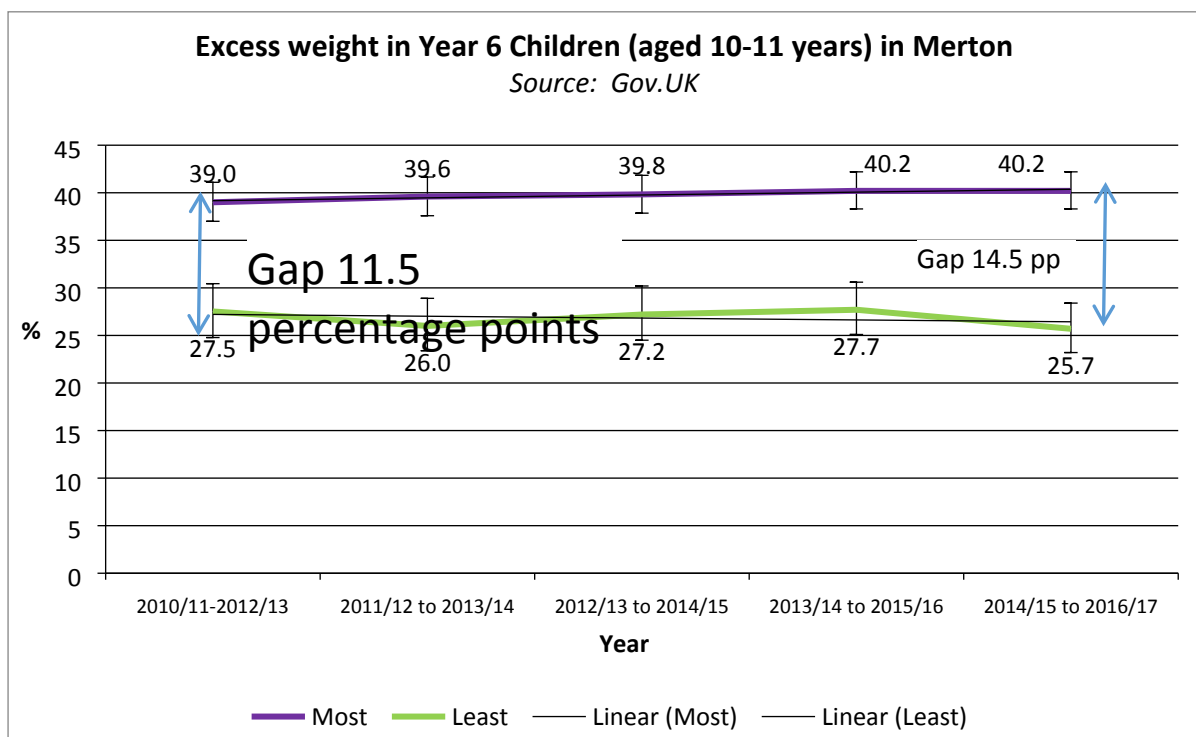
INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 14.5 percentage points (40.2% compared to 25.7%), 14/15 – 16/17 data. The difference is statistically significant.
TREND IN INEQUALITY GAP	Between 10/11-12/13and 14/15-16/17, the difference between the most deprived and least deprived wards increased (from 11.5 to 14.5 percentage points).

2.1.5. Childhood obesity, 2013/14 – 2015/16

PHE's recent Health Inequalities Briefing, based on the Global Burden of Disease study, highlights the social gradient in childhood obesity in Merton (N.B. this shows obese children, not those with excess weight (='overweight + obese') as the previous graphs):

Percentage of children classified as obese (Year 6) for Merton wards by percentage income deprived (2013/14 – 2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)
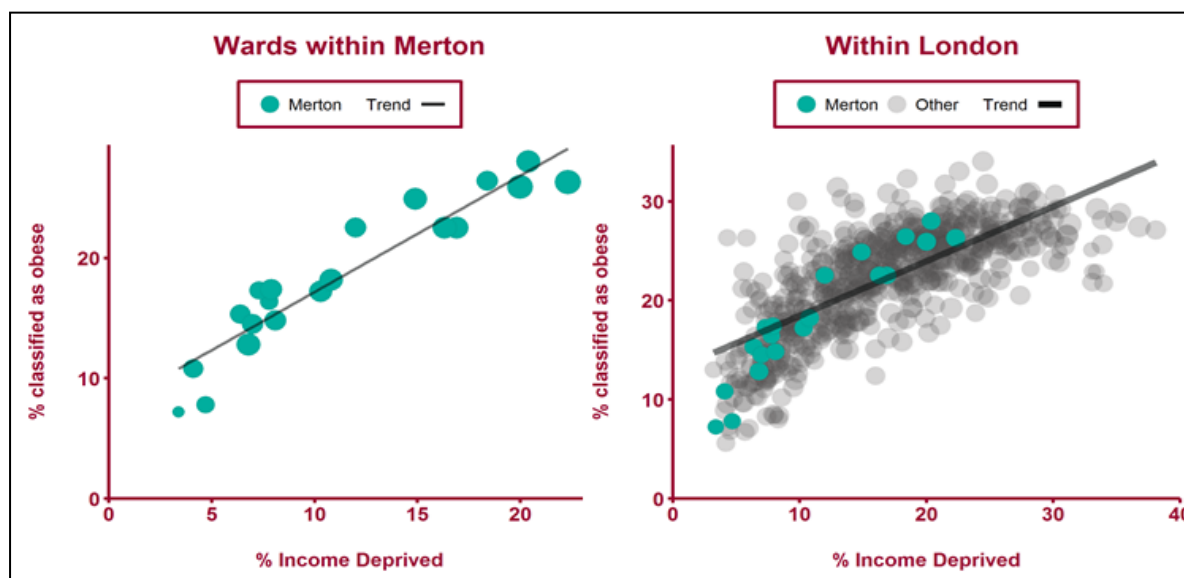
Percentage of children classified as obese (Year 6) for Merton (2013/14 – 2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)
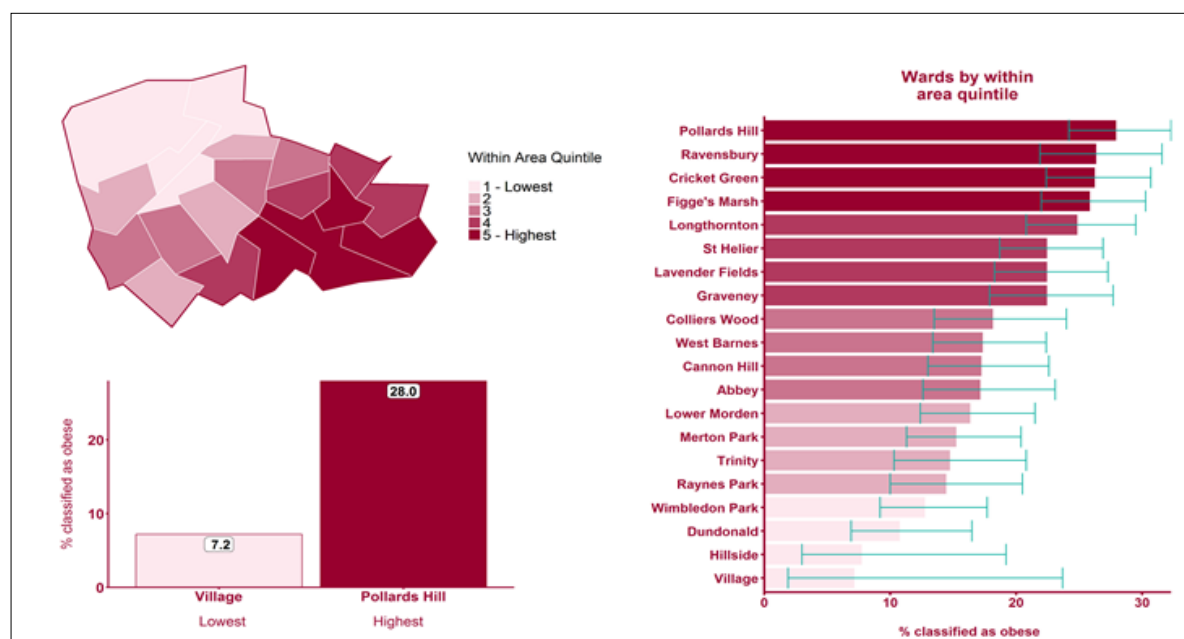
2.1.6. GCSE attainment, 2013/14

Percentage of GCSE (5A*-C including English and Maths) 2013/14
Source: Department for Education

Purple bars represent most deprived
Green bars represent least deprived

INEQUALITY GAP	Difference in GCSE attainment (% young people achieving 5A*-C including English & Maths) between the 30% most and least deprived is 15.4 percentage points (2013/14 data). 30% most deprived wards: 61.1%; 30% least deprived wards: 76.5%. *Confidence intervals cannot be calculated to look at statistical significance, as the metric provided is 'percentage' (numerator and denominator not available)*
TREND IN INEQUALITY GAP	Trend data not available due to change in indicator definition, but future trend should be possible to track.

3. CHAPTER 3: Prevention of ill health

3.1.1. Smoking prevalence from GP QOF, 2012/13 to 2015-16

Recent trends in smoking prevalence and the gap between East and West Merton
Source: GP Profiles

East Merton values: 15.35, 20.81, 19.56, 19.36
West Merton values: 13.40, 15.70, 10.48, 13.12

1.9 pp

6.2 pp

pp=percentage point difference between two values
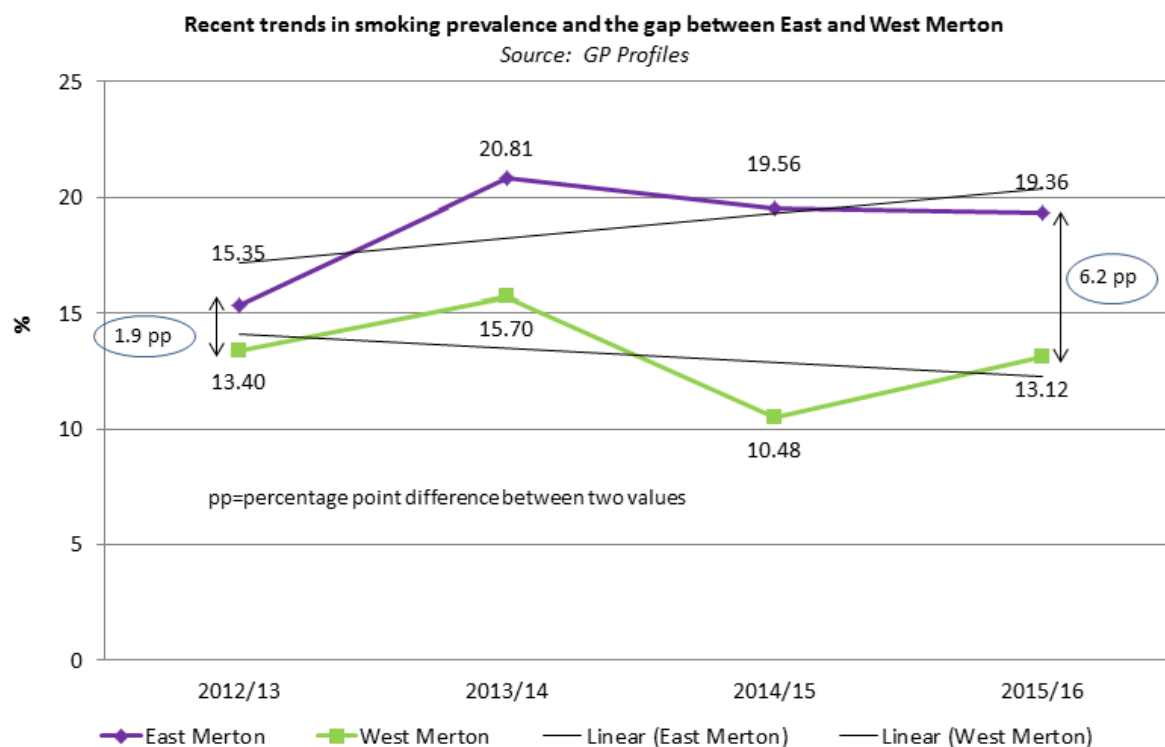
INEQUALITY GAP	Current gap between East Merton and West Merton: 6.2 percentage points (2015/16 data).
TREND IN INEQUALITY GAP	Between 2012/13 and 2015/16, the difference between the most deprived and least deprived wards increased (from 1.9 percentage points to 6.2 percentage points).

3.1.2. Alcohol-related harm (hospital admissions), 2011/12-2015/16

The PHE Marmot indicator for alcohol related harm is directly standardised rate per 100,000 (e.g. the 2016/17 figure for Merton is 495); however, this is only available at borough level whereas PHE Local Health shows standardised admission ratios at ward level, enabling us to look at the difference between the 30% most and 30% least deprived wards.

Hospital stays due to alcohol related harm 2011/12 to 2015/16
Source: Hospital Episode Statistics, Local Health

Purple bars represent 30% most deprived wards
Green bars represent 30% least deprived wards
Red line represents average comparator score (100)

Ward	SAR
Merton Park	74.5
West Cannon Hill	73.4
Hillside	59.9
Dundonald	58.9
Wimbledon Park	52.9
Village	47.8
Trinity	73.9
Lower Morden	71.4
West Barnes	61.2
Raynes Park	56.2
Cricket Green	105.8
East Ravensbury	102.0
Figge's Marsh	99.4
Lavender Fields	98.1
St Helier	96.7
Pollards Hill	94.3
Longthornton	89.5
Graveney	85.3
Abbey	73.8
Colliers Wood	73.1

N.B. These are standardised admission ratios SAR and cannot be compared to each other, only the comparator, in this case England. Therefore benchmark data not included in the chart.

INEQUALITY GAP	Difference in ward scores for Standardised Admission Ratios (SAR) between the 30% most and least deprived is 38.2 SAR points (2011/12 to 2015/16) – 99.4 SAR in the 30% most deprived and 61.2 SAR in the 30% least deprived). An SAR of 100 is the average for England (the comparator).
TREND IN INEQUALITY GAP	*TREND DATA NOT ROBUST (For indicators such as this, PHE Local Health amalgamate years together to provide robust figures when data is at ward level, therefore no yearly trend data available, only two data points: 2010/11-2014/15 and 2011/12-2015/16)*

PHE's recent Health Inequalities Briefing, based on the Global Burden of Disease study, demonstrates this social gradient in alcohol related harm in Merton further:

Hospital stays for alcohol related harm for Merton wards by percentage income deprived (2011/12-2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)
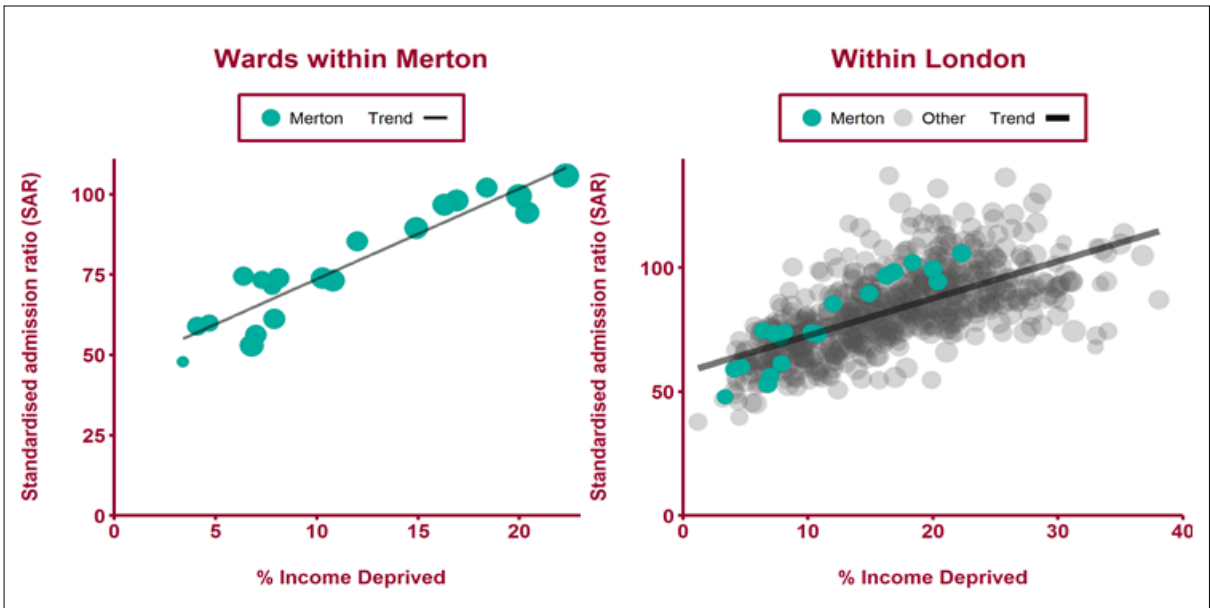
Hospital stays for alcohol related harm for Merton wards (2011/12-2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)
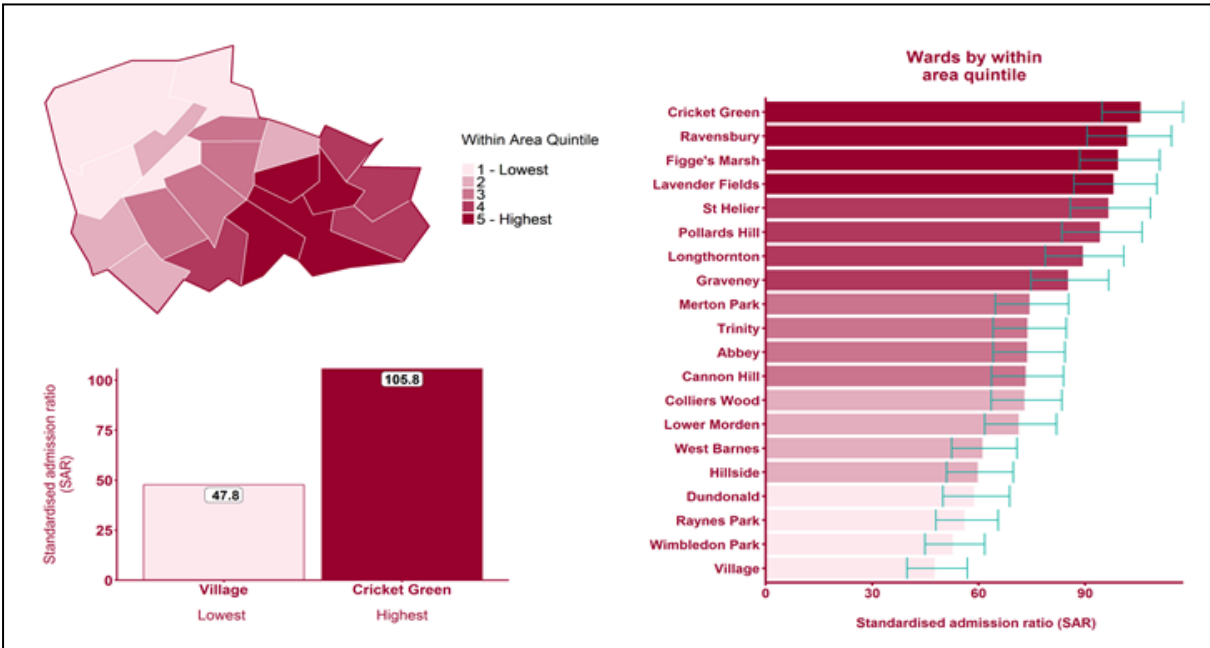
3.1.3.Hypertension prevalence (all ages) from GP QOF, 2011/12 to 16/17

Hypertension prevalence in Merton, all ages 2016/17
Source: Quality and Outcomes Framework

Bar chart showing hypertension prevalence by locality:
- Stonecot Surgery: 16.71
- Grand Drive Surgery: 13.25
- Wimbledon Village Practice: 11.88
- The Nelson Medical Practice: 10.77
- Lambton Road Medical Practice: 9.71
- The Vineyard Hill Road Surgery: 9.46
- (next): 9.21
- (next): 7.99
- (next): 7.60
- (next): 7.05
- (next): 6.98
- Wide Way Medical Centre: 14.69
- Ravensbury Park Medical Centre: 14.59
- Tamworth House Medical Centre: 14.50
- Cricket Green Medical Centre: 14.10
- Colliers Wood Surgery: 13.29
- Riverhouse Medical Practice: 12.92
- GP Led Health Centre: 12.72
- (next): 12.38
- (next): 11.29
- (next): 10.86
- (next): 7.90
- (next): 6.14
- (next): 5.25
- West Merton: 10.06
- (next): 11.59
- Merton: 10.89

Locality

Recent trends in hypertension prevalence and the gap between East and West Merton
Source: Quality and Outcomes Framework

East Merton: 11.22 (2011/12), 11.23 (2012/13), 11.42 (2013/14), 11.65 (2014/15), 11.64 (2015/16), 11.59 (2016/17)

West Merton: 9.95 (2011/12), 9.82 (2012/13), 10.00 (2013/14), 10.51 (2014/15), 10.18 (2015/16), 10.06 (2016/17)

Gap: 1.3 pp (2011/12), 1.5 pp (2016/17)

pp=percentage points difference between two values

Legend: East Merton, West Merton, Linear (East Merton), Linear (West Merton)

INEQUALITY GAP	Current gap between East and West: 1.5 percentage points (11.59 compared to 10.06) in 2016/17. This difference appears statistically significant.
TREND IN INEQUALITY GAP	Between 2011/12 and 2016/17 there was a slight increase in the gap (1.3 to 1.5). However, the increase is not likely to be statistically significant.

Diabetes prevalence age 17 and over 2016/17
Source: Quality and Outcomes Framework

Locality

Recent trends in diabetes prevalence and the gap between East and West Merton
Source: Quality and Outcomes Framework

pp=percentage point difference between 2 values

— East Merton — West Merton — Linear (East Merton) — Linear (West Merton)

INEQUALITY GAP	Current gap between East and West: 3.1 percentage points (8.0 compared to 4.85) in 2016/17. This difference is statistically significant.
TREND IN INEQUALITY GAP	Between 2011/12 and 2016/17, the difference between East and West increased (from 2.5 to 3.1); this increase appears statistically significant.

Gap =
25.6

INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 25.6 (35.0 per 100,000 in the 30% most deprived compared to 9.4 per 100,000 in the 30% least deprived) (2014-16 data)
TREND IN INEQUALITY GAP	Between 2011-13 and 2014-16, the difference between the most deprived and least deprived wards increased (from 23.7 to 25.6). This is unlikely to be a statistically significant increase at this point as numbers are small and confidence intervals are wide.

3.1.6. Mental health prevalence (all ages) from GP QOF, 2012/13 to 2016/17

Mental Health prevalence all ages 2016/17
Source: Quality and Outcomes Framework

Recent trends in mental health prevalence and the gap between East and West Merton
Source: Quality and Outcomes Framework

pp=percentage point difference between two values
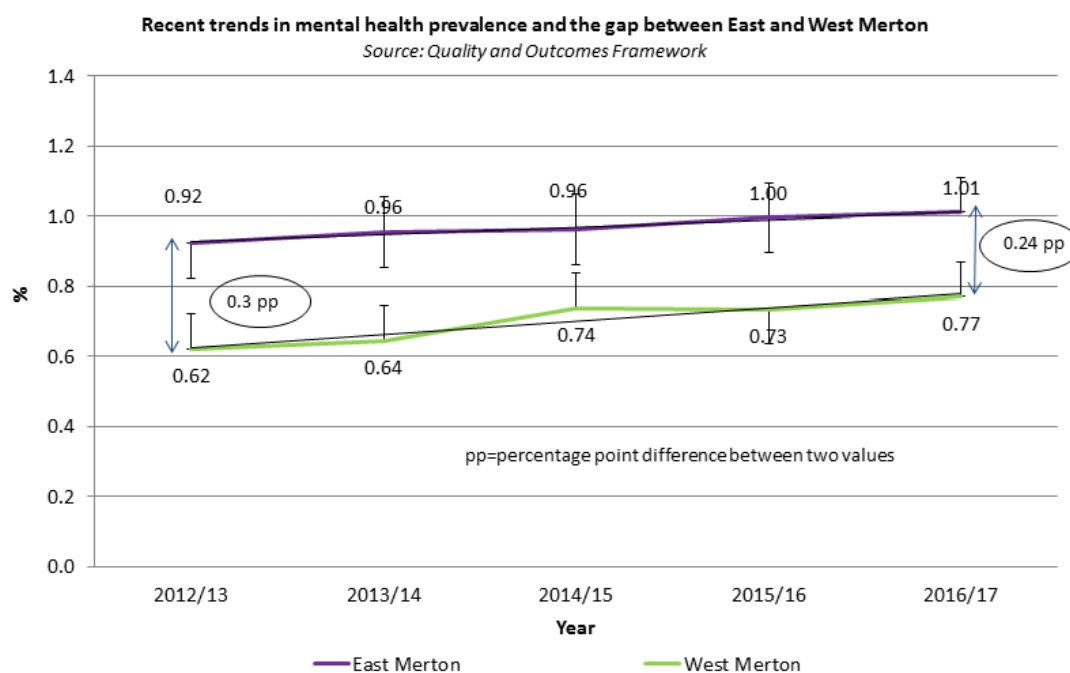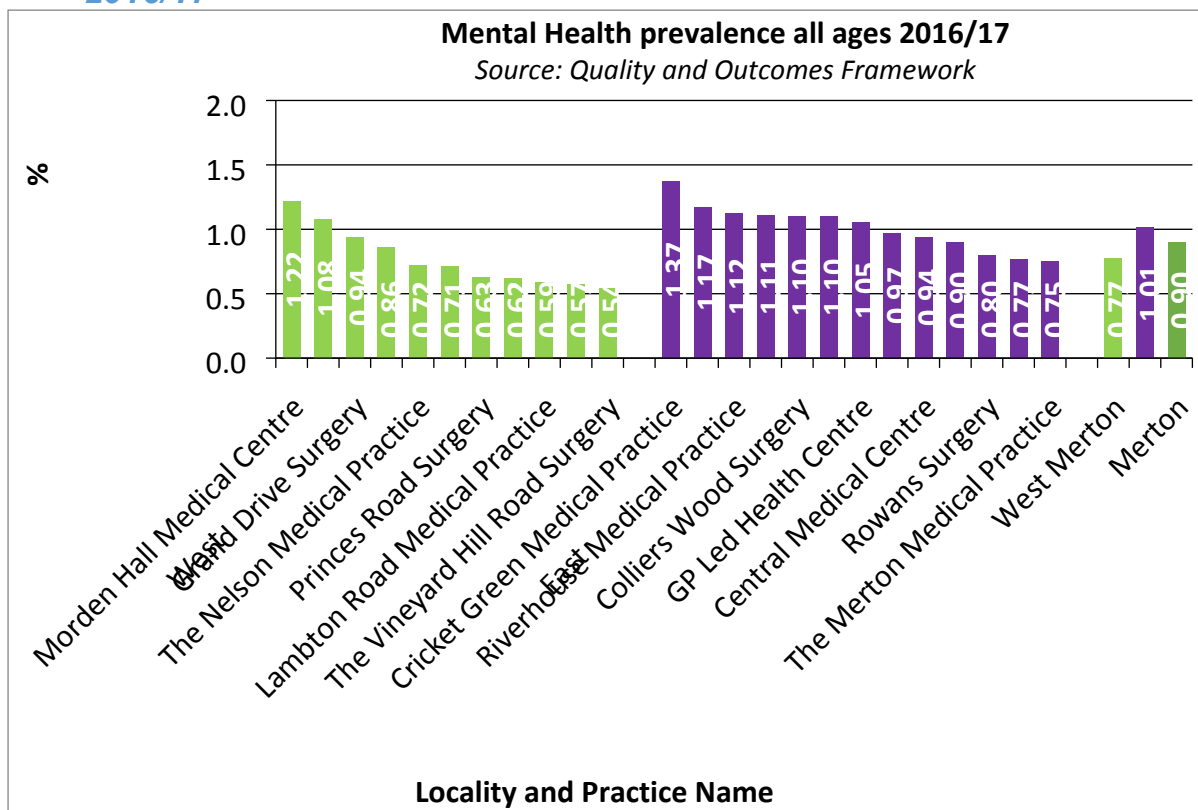
INEQUALITY GAP	Current gap between East and West: 0.24 percentage points (1.01% compared to 0.77%) in 2016/7. This difference is statistically significant.
TREND IN INEQUALITY GAP	Between 2012/13 and 2016/17 there was a slight decrease in the gap (from 0.30 to 0.24), driven by a faster increasing prevalence in west Merton compared to east).

3.1.7. Depression prevalence (age 18+), from GP QOF, 2011/12 to 2016/17

Recent trends in depression prevalence (18+) and the gap between East and West Merton
Source: Quality and Outcomes Framework

pp=percentage point difference between two values

Legend: East Merton · West Merton · Linear (East Merton) · Linear (West Merton)
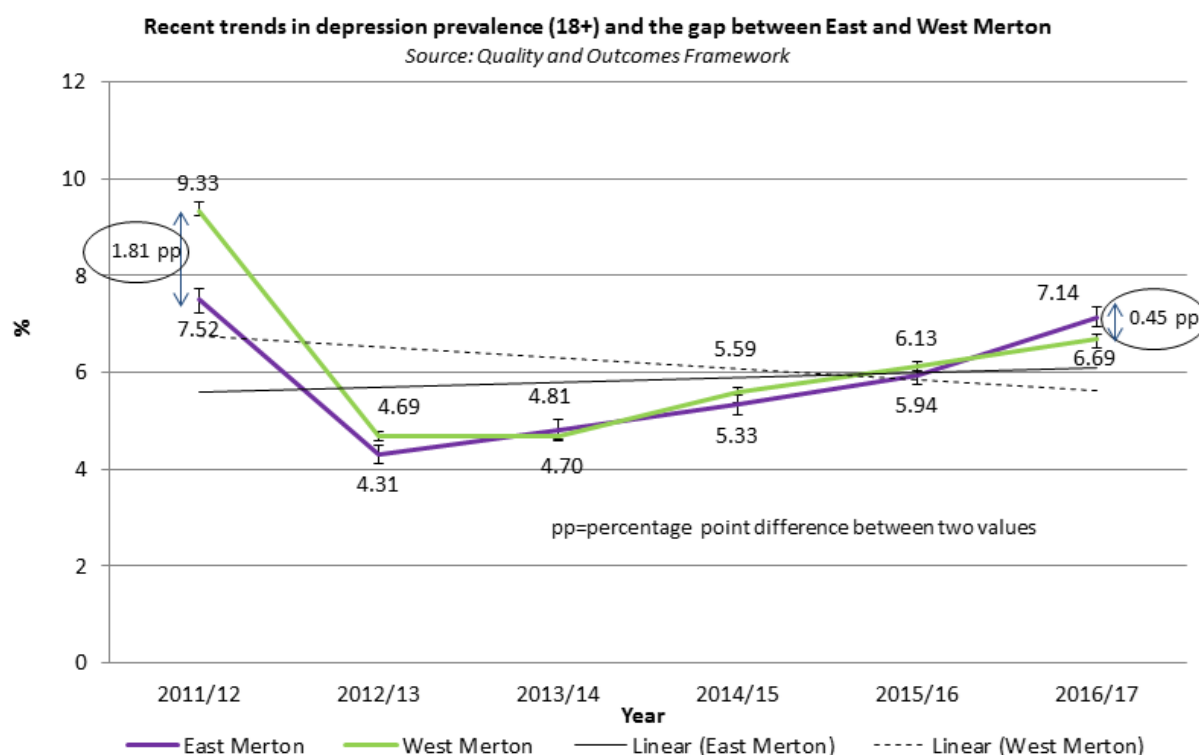
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Gap between east and west localities	-1.81	-0.38	0.12	-0.25	-0.19	0.45

INEQUALITY GAP	Current gap between East and West Merton: 0.45 percentage points (7.14 in East Merton compared to 6.69 in West Merton, 2016/17 data). The difference is statistically significant.
TREND IN INEQUALITY GAP	Between 2011/12 and 2016/17 the inequality gap appears to have flipped, from higher rates of depression in West Merton (difference of -1.81 percentage points) to higher rates in East Merton in 2016/17 (0.45 percentage points). This is one of the only indicators we looked at where the rate of a disease or risk factor was higher in less deprived areas than more deprived areas at any point in the historical trend data.

3.1.8. Self reported wellbeing scores (low life satisfaction), 2009 to 2013

Well-being scores for the 30% most and least deprived areas in Merton, 2009-2013
Source: Greater London Authority
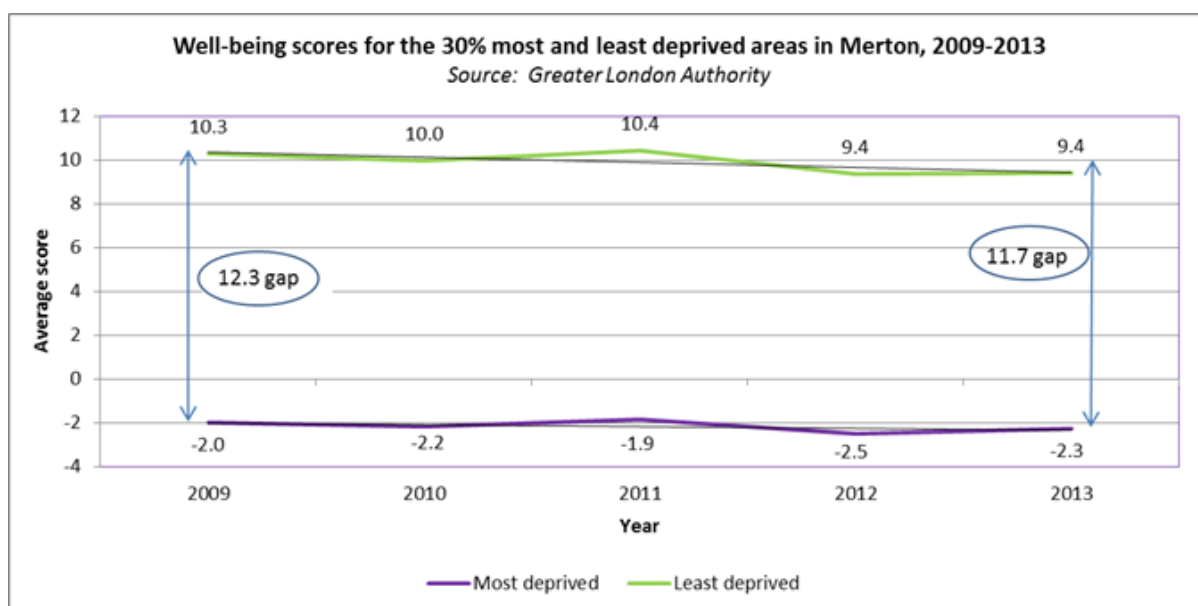
These ward level well-being scores present a combined measure of well-being indicators based on 12 different measures. Where possible each indicator score is compared with the England and Wales average, which is zero. Scores over 0 indicate a higher probability that the population on average experiences positive well-being according to these measures.

INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 11.7 points (a score of -2.3 in the 30% most deprived wards compared to a score of 9.4 in the 30% least deprived), 2013 data
TREND IN INEQUALITY GAP	Between 2009 and 2013, the difference between the most deprived and least deprived wards reduced (from 12.3 to 11.7). However, the wellbeing scores got worse in both the most and least deprived areas, but with a steeper gradient in the least deprived areas, so this does not represent a positive direction of travel.

3.1.9. Emergency hospital admissions, 2011/12-2015/16

PHE's recent Health Inequalities Briefing, based on the Global Burden of Disease study, highlights the social gradient in emergency hospital admissions in Merton:
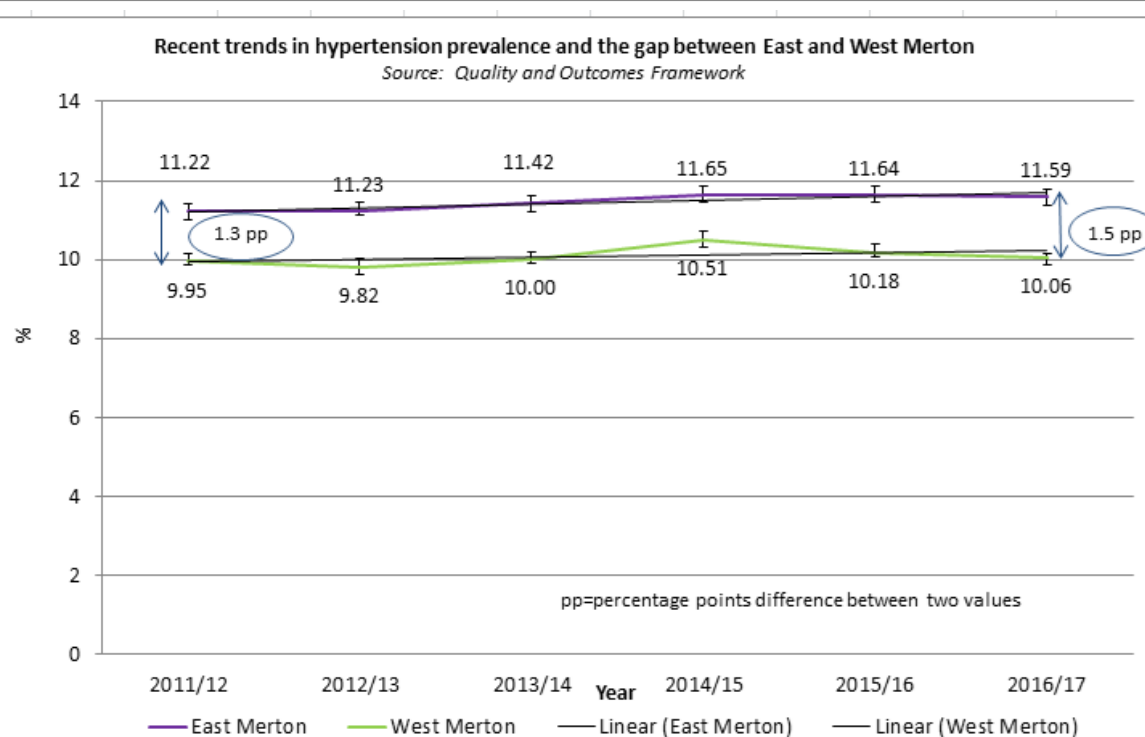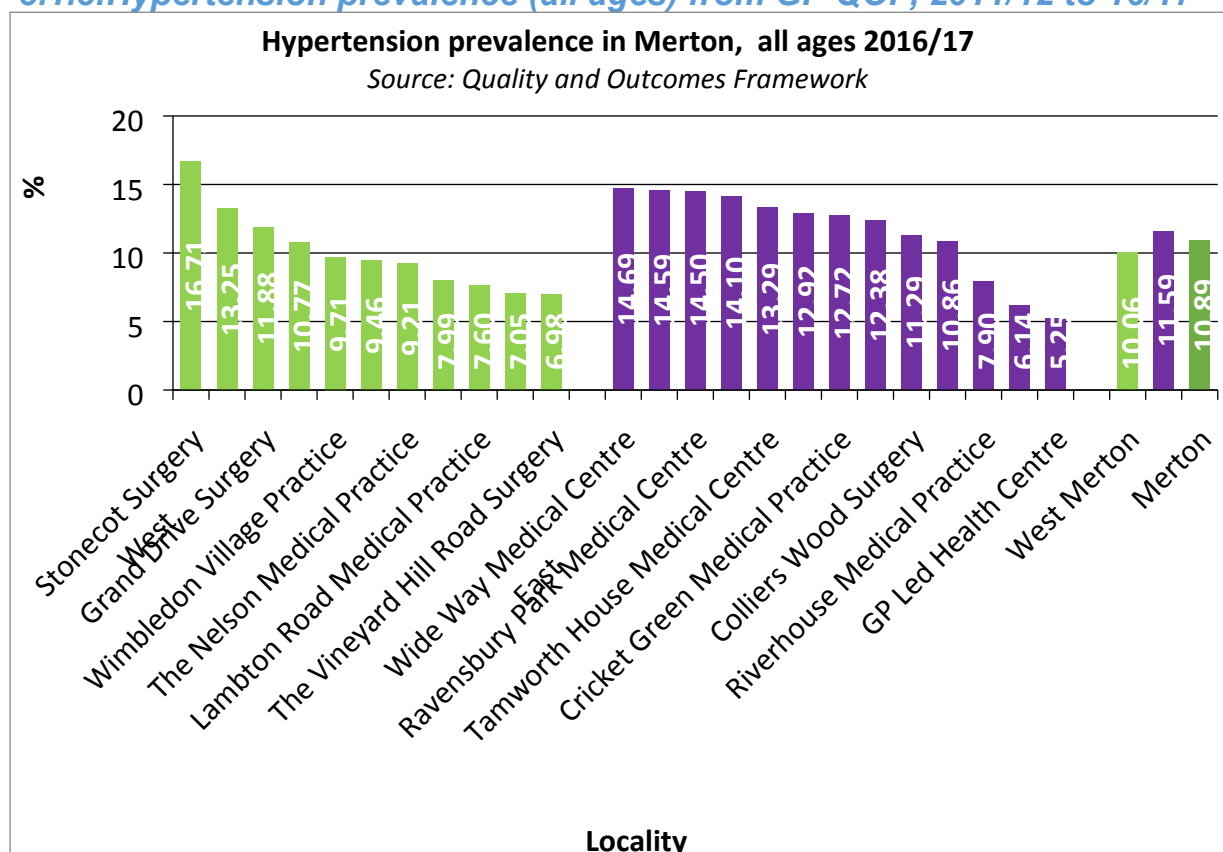
Emergency hospital admissions for all causes for Merton wards by percentage income deprived (2011/12-2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)
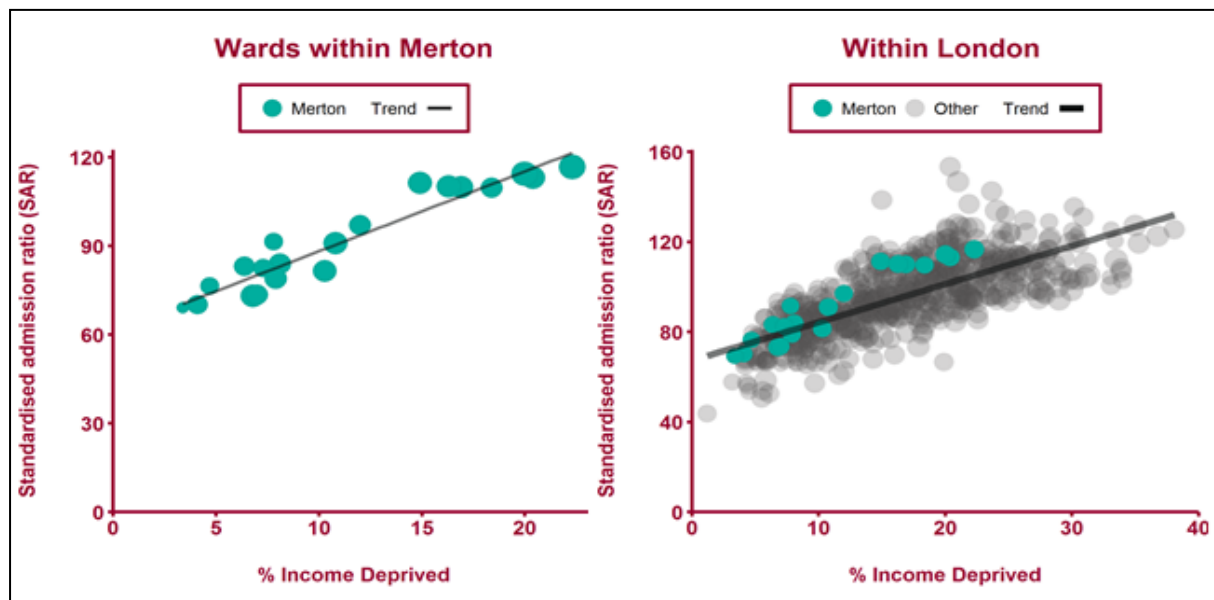
Emergency hospital admissions for all causes for Merton wards (2011/12-2015/16) (Source: PHE Health Inequalities Briefing Merton, 2018)
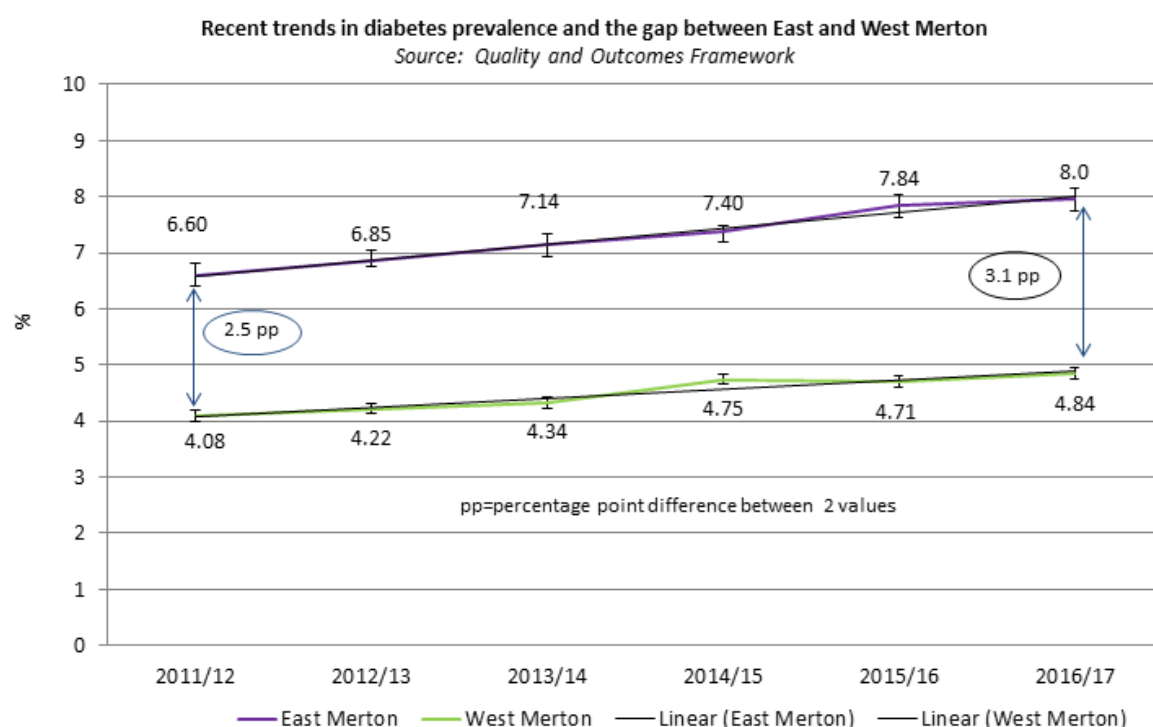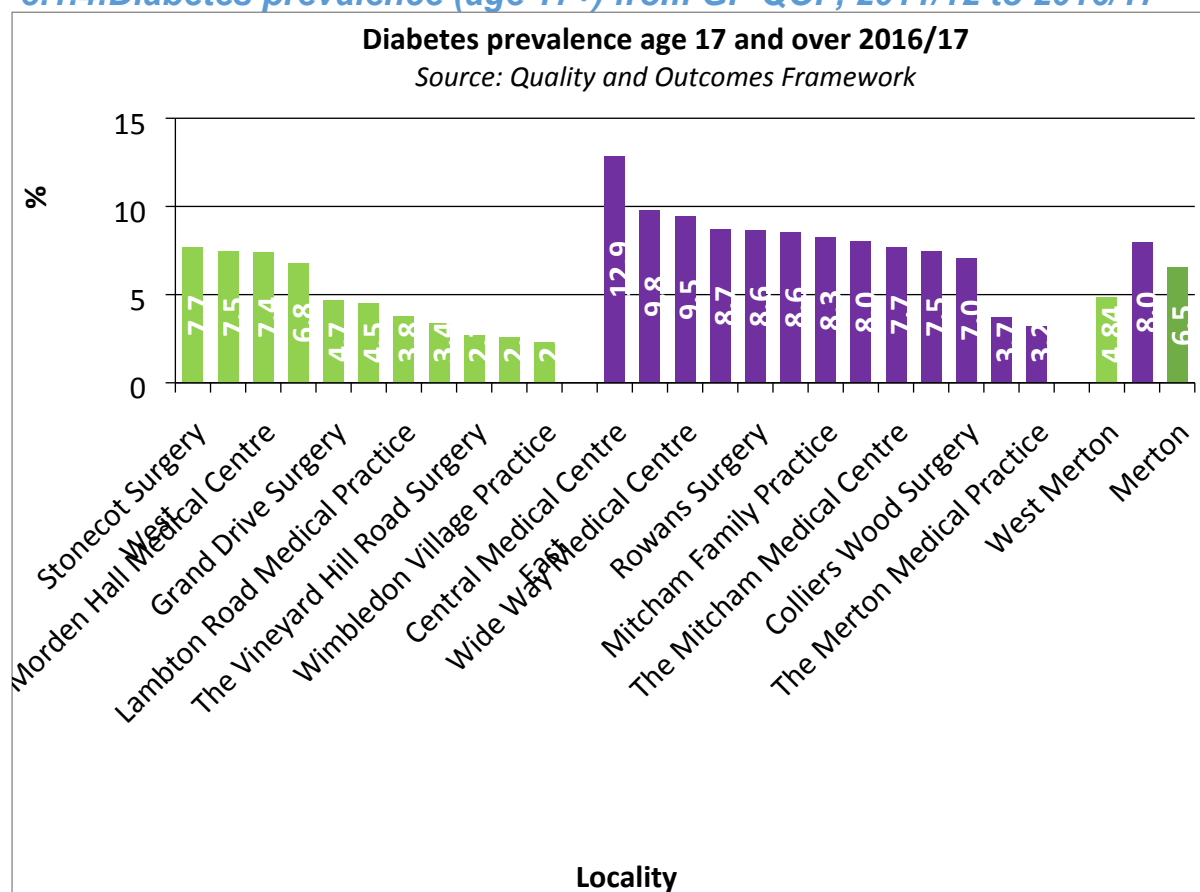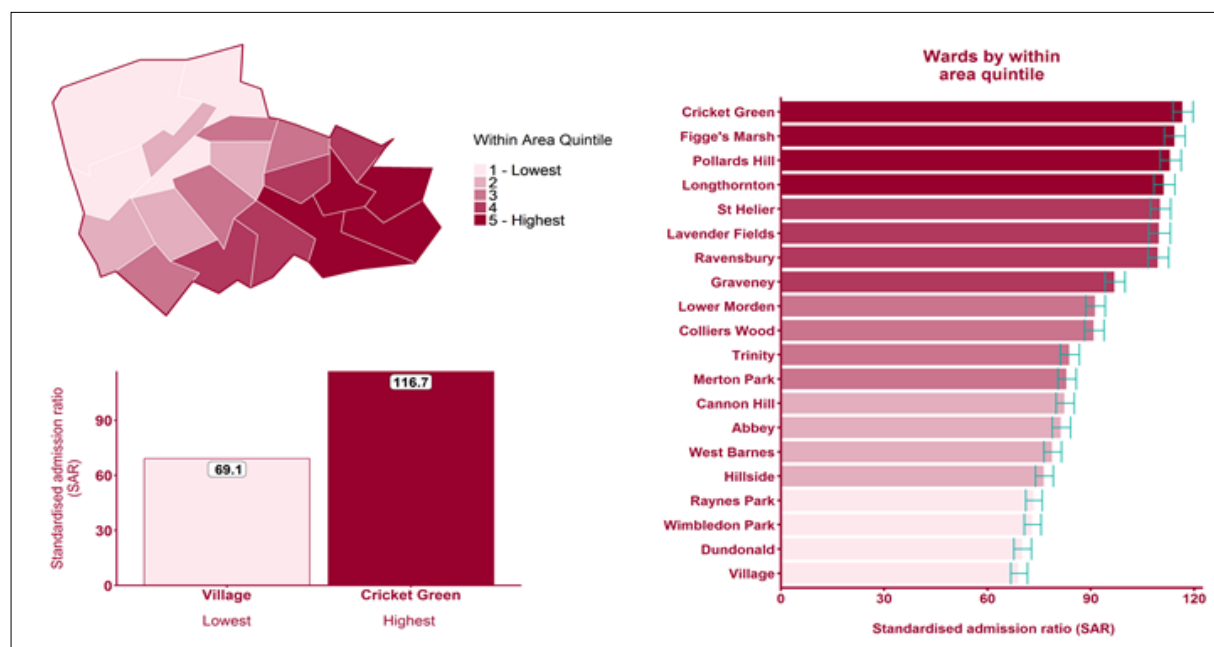
4. CHAPTER 4: Fair employment, good work

4.1.1.Economically active population claiming Job Seekers Allowance, 2011 to 2015
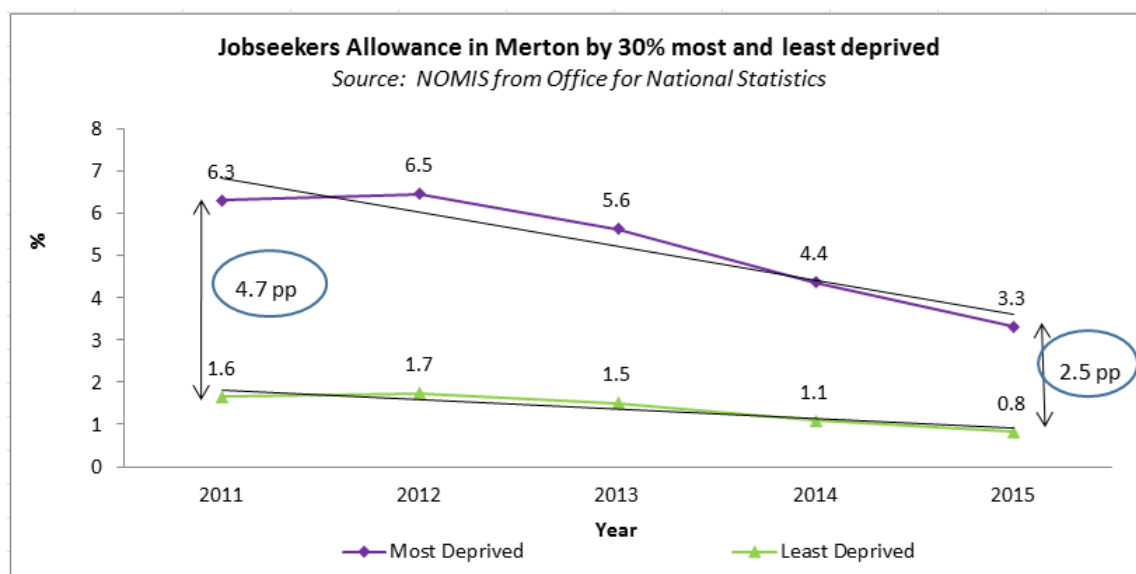
INEQUALITY GAP	Current gap between 30% most and 30% least deprived: 2.5 percentage points (2015 data)
TREND IN INEQUALITY GAP	Between 2011 and 2015, the difference in those claiming JSA between the most deprived and least deprived wards reduced (from 4.7 to 2.5), driven by general decrease across the borough and faster decrease in the most deprived wards

Regression analysis appears to show that gap in 2018 likely to be just under 1 percentage point difference between the most deprived wards (1.2%) compared to the least deprived (0.2%):
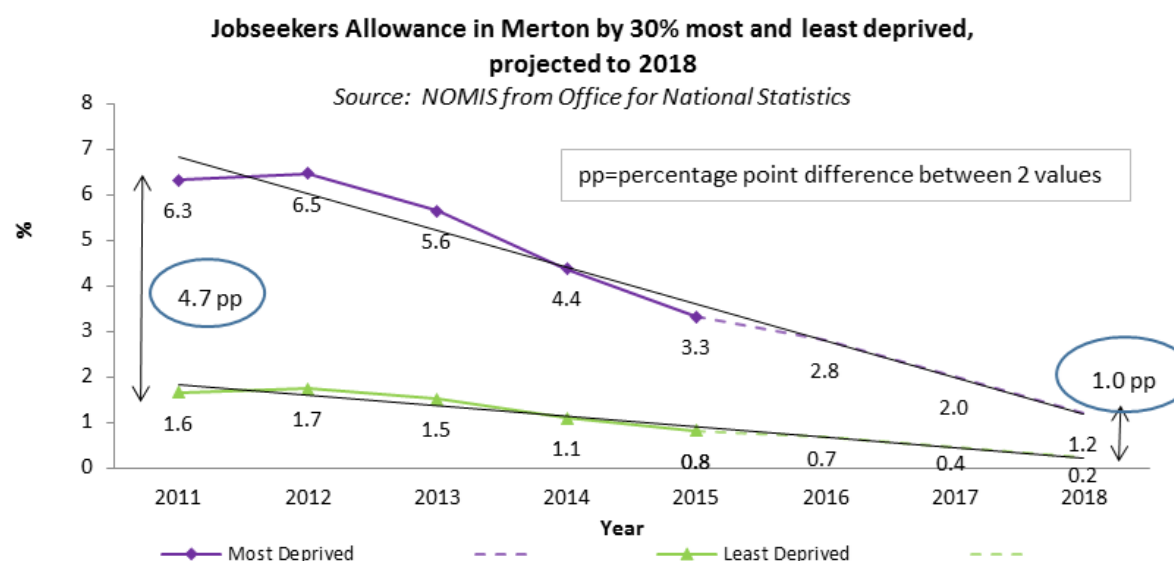
4.1.2. Benefit claimants - employment and support allowance (ESA), 2014 to 2017

Recent trends in recipients of employment and support benefit (ill or disabled)
Source: NOMIS from Office for National Statistics
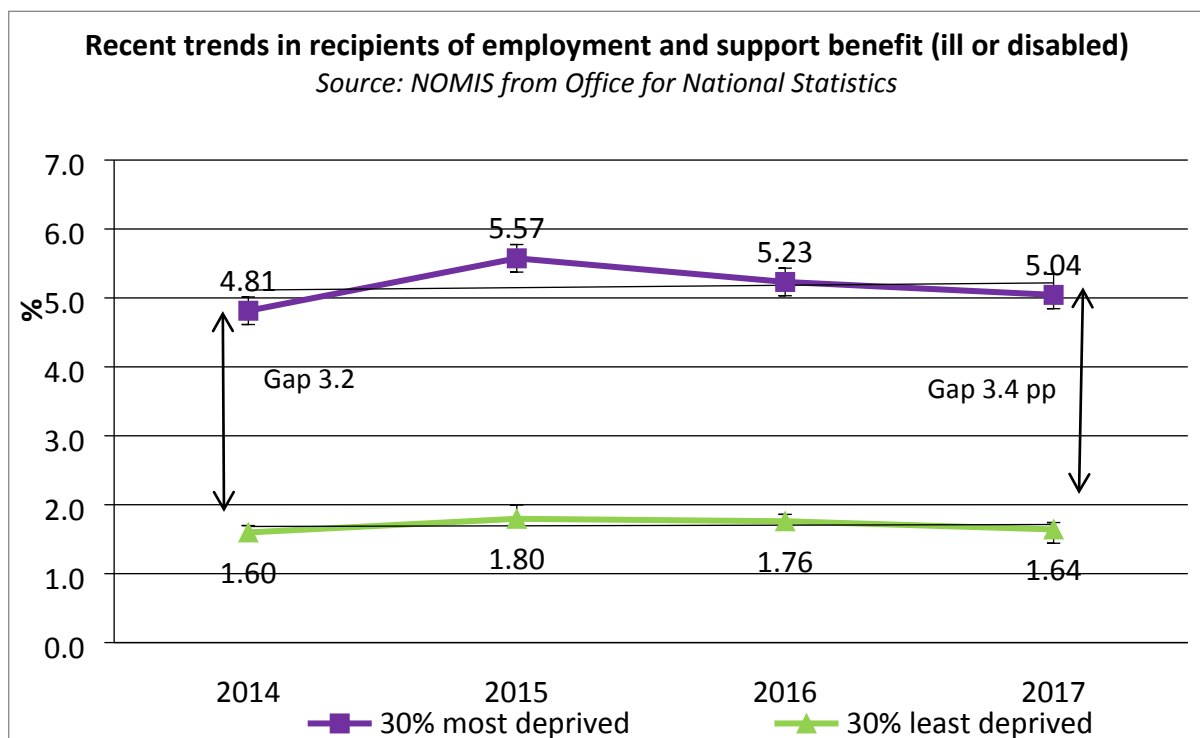
INEQUALITY GAP	Current gap between 30% most and 30% least deprived:3.4 percentage points (2017). This gap is statistically significant.
TREND IN INEQUALITY GAP	Between 2014 and 2017, the difference in ESA claimants between the most and least deprived wards remained similar.

5. CHAPTER 5: Ensure healthy standard of living for all

5.1.1. Index of Deprivation 2015: ward scores

Index of multiple deprivation 2015 ward scores

Purple bars represent 30% most deprived wards

Green bars represent 30% least deprived wards

IMD score

27.59 | 26.17 | 24.81 | 23.75 | 21.70 | 21.43 | 19.57 | 16.27 | 15.24 | 12.83 | 10.08 | 9.86 | 9.64 | 8.39 | 8.28 | 8.22 | 8.12 | 6.94 | 6.28 | 5.54

Cricket Green, East Merton, Figge's Marsh, Pollards Hill, Ravensbury, St Helier, Lavender Fields, Longthornton, Colliers Wood, Graveney, Abbey, Raynes Park, West Merton, Trinity, Lower Morden, West Barnes, Cannon Hill, Wimbledon Park, Merton Park, Hillside, Dundonald, Village

Locality and Wards

INEQUALITY GAP	Difference in ward scores between the 30% most and least deprived is 17.01 (24.24 in the 30% most deprived compared to 7.23 in the 30% least deprived wards). The higher the score the more deprived the area
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE (Year on year comparisons not possible as the weighting of indicators has been changed over time)*

5.1.2.Index of Deprivation 2015: GP practice scores
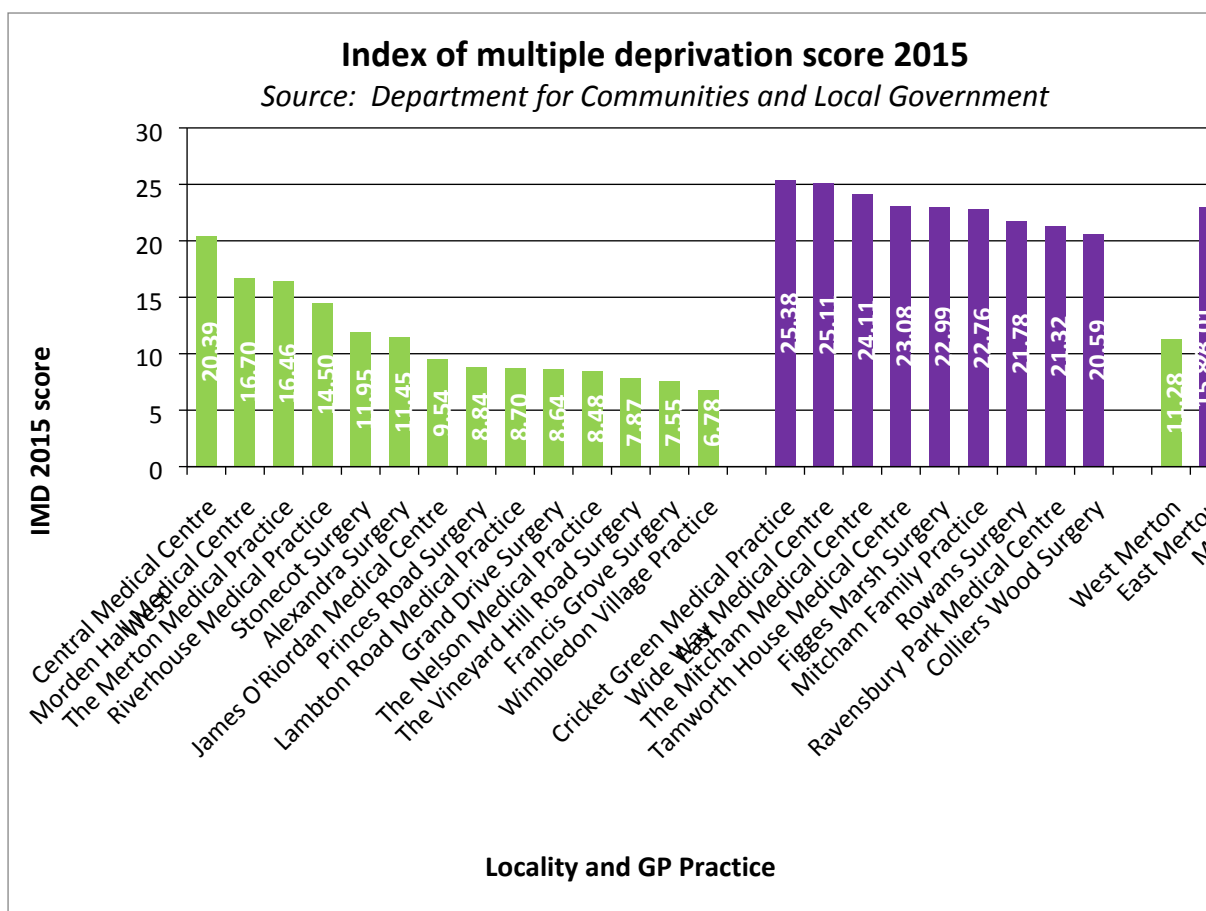
Index of multiple deprivation score 2015

Source: Department for Communities and Local Government

INEQUALITY GAP	Difference between the average score of GP practices in east and those in west Merton is11.74 (23.01 compared to 11.28). The higher the score the more deprived the area.
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE (Year on year comparisons not possible as the weighting of indicators has been changed over time)*

5.1.3.Overcrowded households, 2011

Overcrowded households%
Source: Census 2011

Purple bars represent 30% most deprived wards

Green bars represent 30% least deprived wards

West										East										Benchmark				
Wimbledon Park	Hillside	Dundonald	Merton Park	Cannon Hill	Village	Trinity	Raynes Park	West Barnes	Lower Morden	Figge's Marsh	Lavender Fields	Cricket Green	Pollards Hill	Ravensbury	St Helier	Colliers Wood	Graveney	Abbey	Longthornton	30% least deprived	30% most deprived	West	Merton	East
17.3	15.4	10.6	9.5	7.3	5.6	15.6	12.6	9.5	8.0	26.3	24.1	23.6	18.8	18.1	16.1	23.5	19.3	18.1	16.2	11.0	21.2	11.1	16.1	20.4

INEQUALITY GAP	Current gap in proportion of overcrowded households between 30% most and 30% least deprived: 10.2 percentage points (21.2% compared to 11.0%, with a borough average of 16.1%)
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE (Census data)*

5.1.4.Fuel poverty, 2015

Fuel Poverty in Merton, 2015
Source : GOV.UK

Green bars represent least deprived 30%
Purple bars represent most deprived 30%

Ward	%
Dundonald	11.5
Merton Park	10.1
Wimbledon Park	9.7
Hillside	8.8
Cannon Hill	8.5
Village	5.5
Trinity	8.8
West Barnes	8.6
Raynes Park	7.8
Lower Morden	7.3
Ravensbury	11.7
St Helier	11.2
Figge's Marsh	10.7
Pollards Hill	10.0
Lavender Fields	10.0
Cricket Green	9.4
Graveney	15.6
Colliers Wood	14.5
Abbey	11.8
Longthornton	10.7

West Merton — East Merton

Locality and ward

— Most deprived average   — Least deprived average

INEQUALITY GAP	Difference between the 30% most deprived and 30% least deprived wards is 1.4 percentage points (10.5% compared to 9.1%). This difference appears to be statistically significant
TREND IN INEQUALITY GAP	HISTORIC TREND DATA NOT AVAILABLE AT WARD LEVEL. This is a new indicator on PHE Local Health, and trend data may be available going forward in future years.

6. CHAPTER 6: Healthy, sustainable communities

6.1.1.Burglary in Merton, 2017

Burglary in Merton, 2017
Source: Metropolitan Police Data

Purple bars represent 30% most deprived wards
Green bars represent 30% least deprived wards
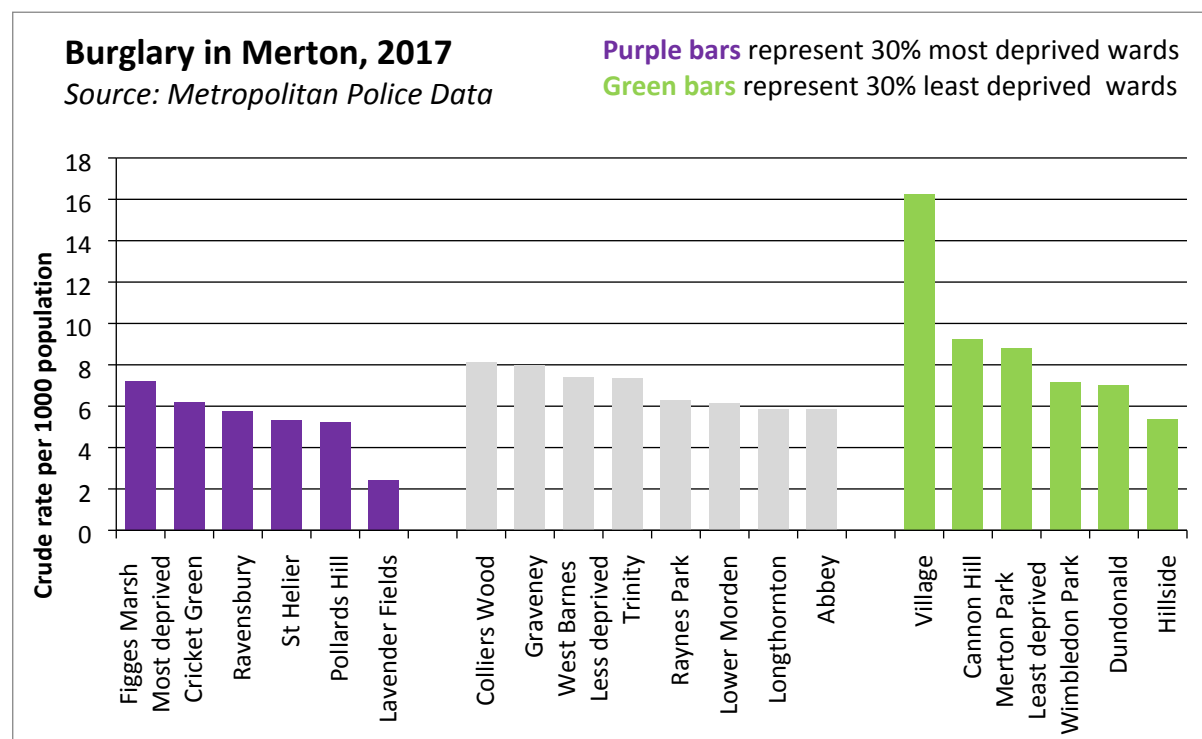
INEQUALITY GAP	Difference in ward scores for burglary between the 30% most and least deprived is -3.4 per 1000 population rate difference (5.3 per 1000 in the 30% most deprived compared to 8.7 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

Theft in Merton, 2017

Source: Metropolitan Police Data

Purple bars represent 30% most deprived wards
Green bars represent 30% least deprived wards
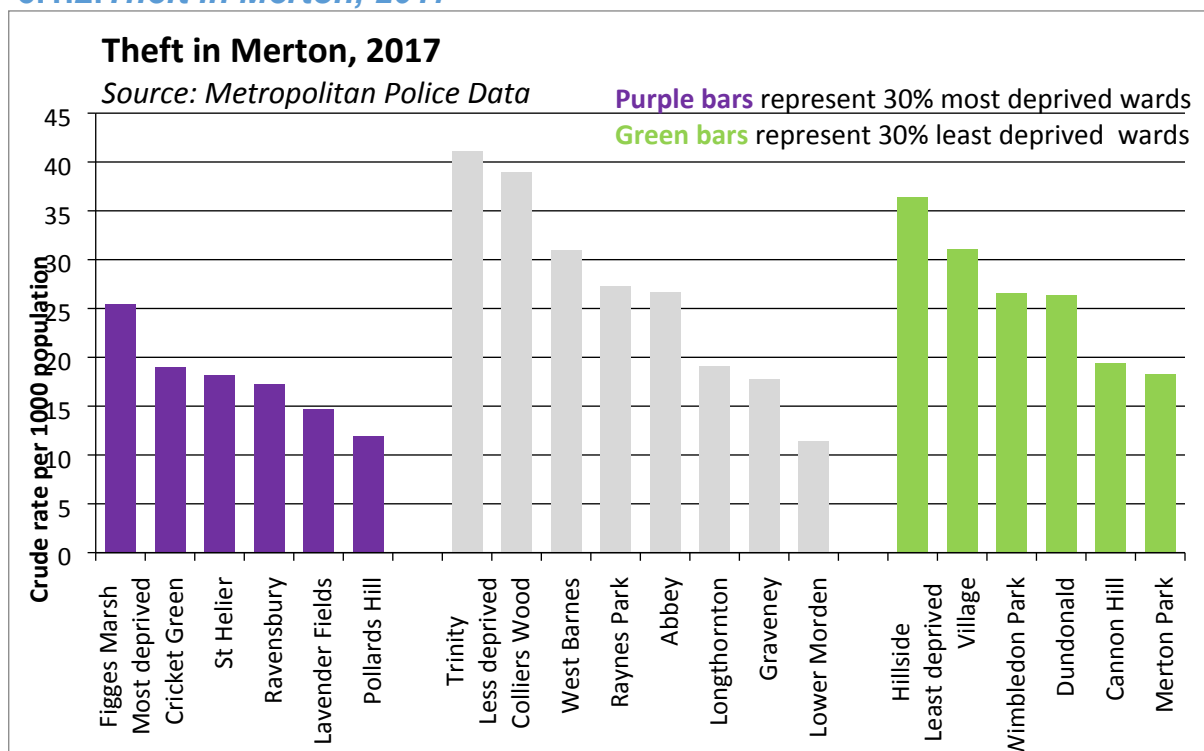
INEQUALITY GAP	Difference in ward scores for theft between the 30% most and least deprived is -8.5 per 1000 population rate difference (18.0 per 100,000 in the 30% most deprived compared to 26.5 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.3. *Criminal damage in Merton, 2017*

Criminal damage in Merton, 2017
Source: Metropolitan Police Data
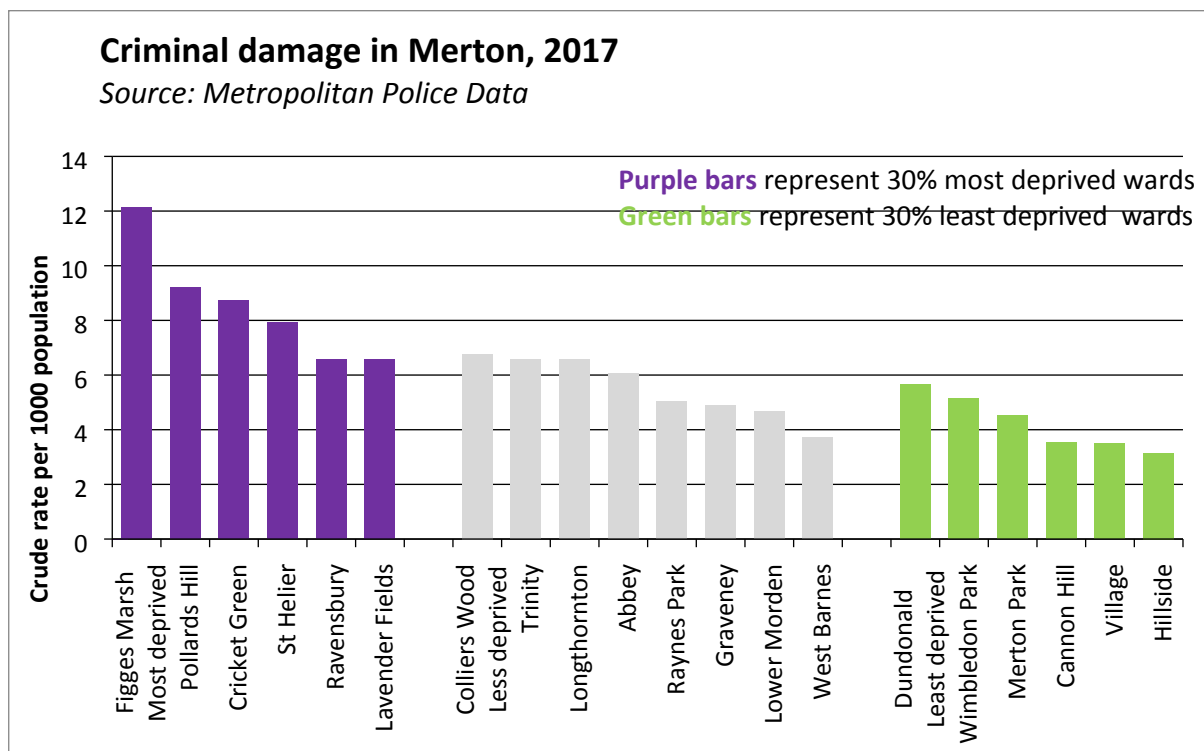
INEQUALITY GAP	Difference in ward scores for criminal damage between the 30% most and least deprived is 4.2 per 1000 population rate difference (8.5 per 100,000 in the 30% most deprived compared to 4.3 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.4. Antisocial behaviour in Merton, 2017

Antisocial Behaviour in Merton, 2017

Source: Metropolitan Police Data

Purple bars represent 30% most deprived wards
Green bars represent 30% least deprived wards
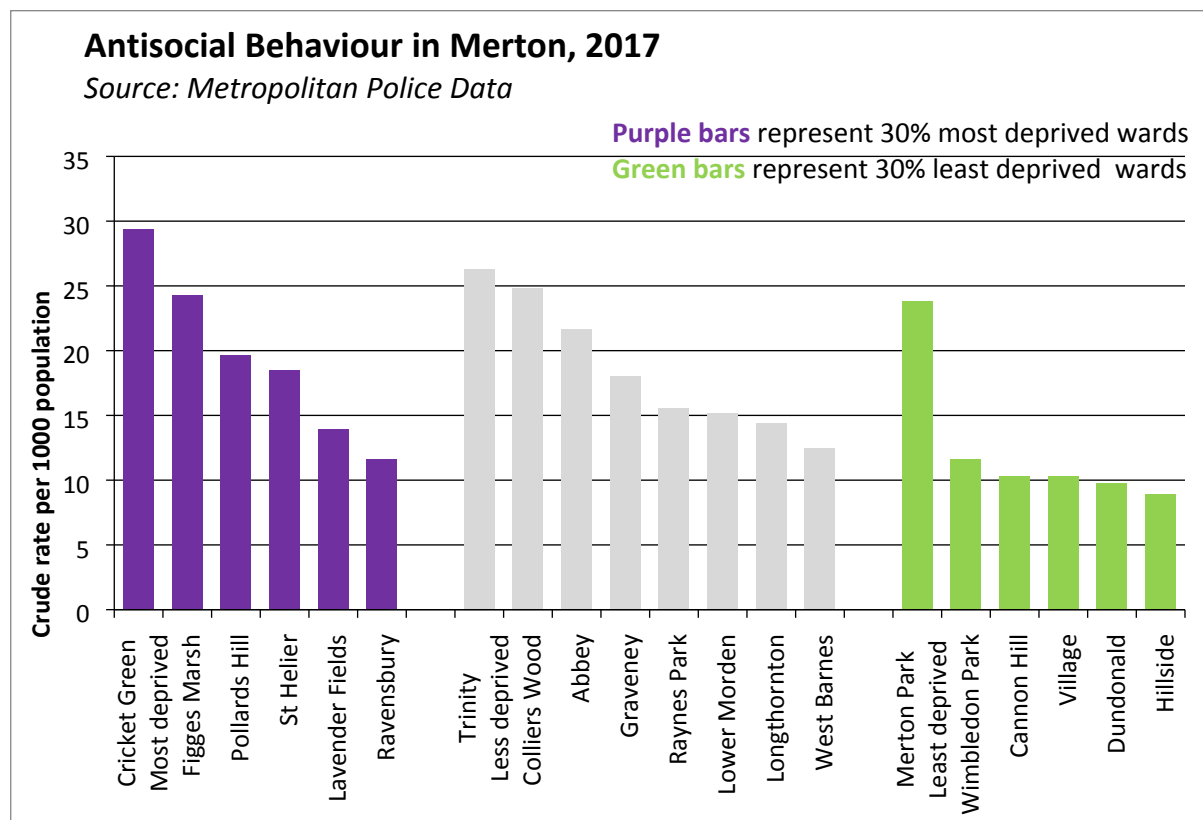
INEQUALITY GAP	Difference in ward scores for antisocial behaviour between the 30% most and least deprived is 7.0 per 1000 population rate difference (19.5 per 100,000 in the 30% most deprived compared to 12.5 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.5. Violence against the person in Merton, 2017

Violence against the person in Merton, 2017

Source: Metropolitan Police Data
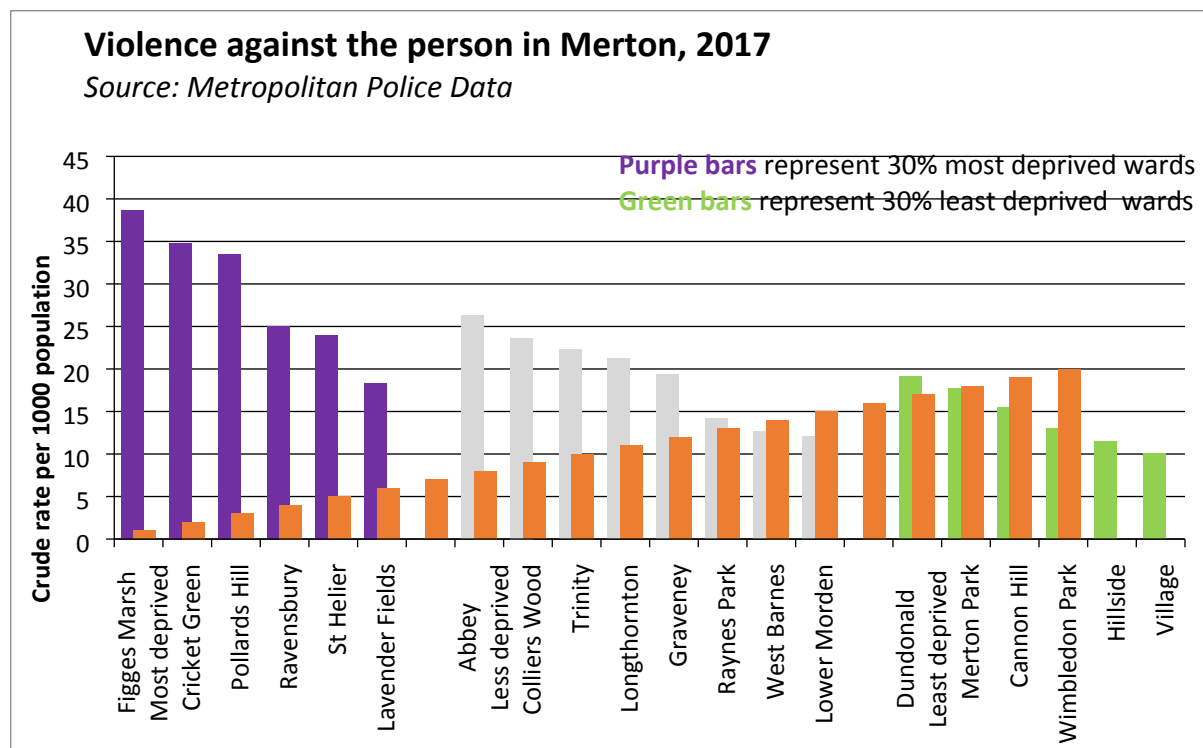
INEQUALITY GAP	Difference in ward scores for violence against the person between the 30% most and least deprived is 14.5 per 1000 population rate difference (28.9 per 100,000 in the 30% most deprived compared to 14.5 in the 30% least deprived wards).
TREND IN INEQUALITY GAP	*Both historic and future trend data is available, but has not been calculated for this report as it is available by month and so amalgamating the data is time consuming but possible.*

6.1.6. Older people (65+) living alone, 2011

People aged 65 and over living alone, 2011

Source: ONS Census 2011

Green bars represent 30% least deprived
Purple bars represent 30% most deprived

Ward	%
Hillside	48.5
Dundonald	38.1
Merton Park	30.5
Wimbledon Park	28.6
Cannon Hill	28.4
Village	28.1
Abbey	45.9
Trinity	38.9
Raynes Park	33.9
Longthornton	32.9
Graveney	29.4
Colliers Wood	28.3
Lower Morden	28.3
West Barnes	27.8
Cricket Green	39.1
St Helier	36.2
Figges Marsh	35.3
Lavender Fields	32.4
Ravensbury	31.7
Pollards Hill	30.3
West Merton	33.1
MERTON	33.3
East Merton	34.2

West | East | Comparators

Locality and Ward

INEQUALITY GAP	Current gap in proportion of older people living alone, between 30% most and 30% least deprived: 0.5 percentage points (34.2% compared to 33.7%
TREND IN INEQUALITY GAP	*TREND DATA NOT AVAILABLE (Census data)*

Overview of PHE Marmot indicators for Merton

NB these are at borough level not looking at inequality gap.

Compared to England

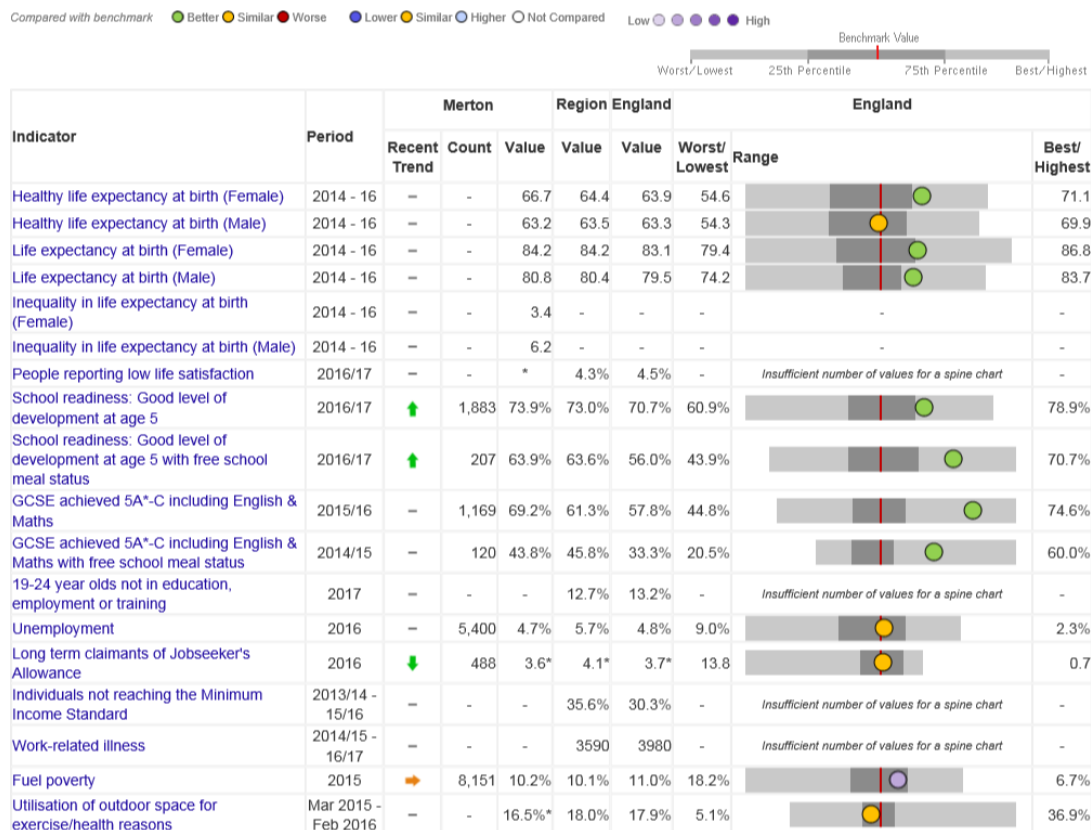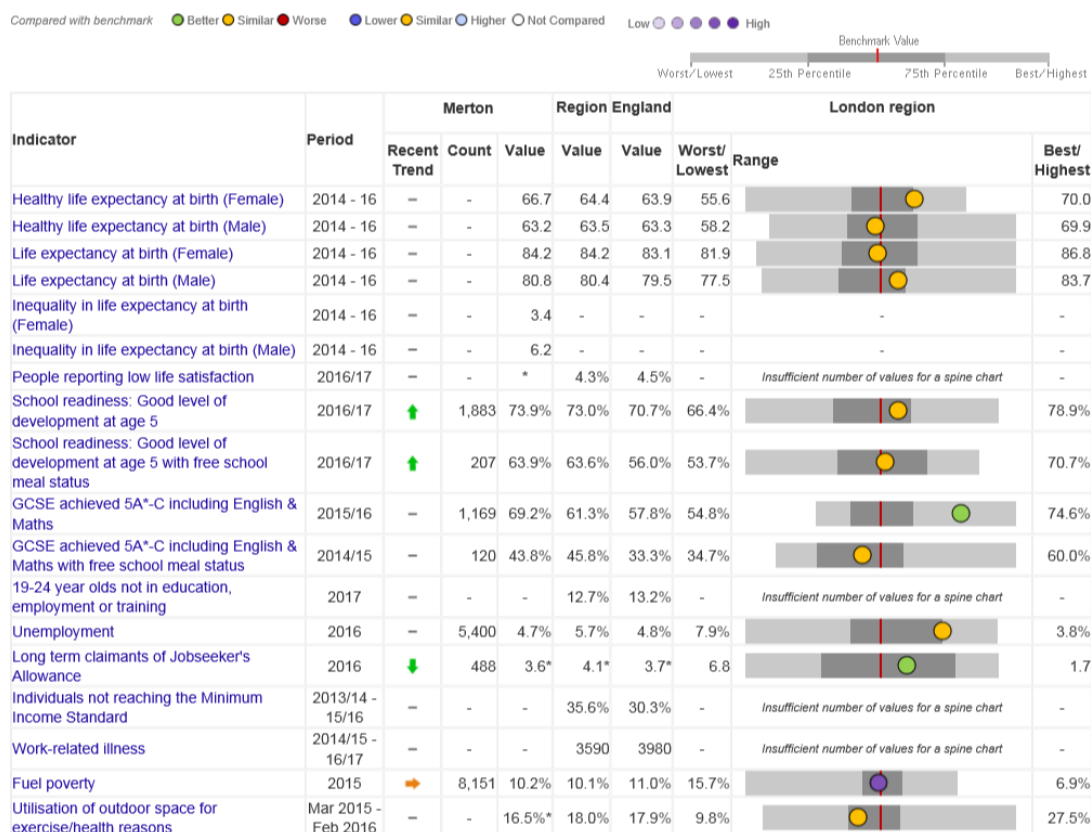| Indicator	Period	Merton Recent Trend	Count	Value	Region Value	England Value	Worst/ Lowest	England Range	Best/ Highest
Healthy life expectancy at birth (Female)	2014 - 16	–	-	66.7	64.4	63.9	54.6		71.1
Healthy life expectancy at birth (Male)	2014 - 16	–	-	63.2	63.5	63.3	54.3		69.9
Life expectancy at birth (Female)	2014 - 16	–	-	84.2	84.2	83.1	79.4		86.8
Life expectancy at birth (Male)	2014 - 16	–	-	80.8	80.4	79.5	74.2		83.7
Inequality in life expectancy at birth (Female)	2014 - 16	–	-	3.4	-	-	-	-	-
Inequality in life expectancy at birth (Male)	2014 - 16	–	-	6.2	-	-	-	-	-
People reporting low life satisfaction	2016/17	–	-	*	4.3%	4.5%	-	Insufficient number of values for a spine chart	-
School readiness: Good level of development at age 5	2016/17	↑	1,883	73.9%	73.0%	70.7%	60.9%		78.9%
School readiness: Good level of development at age 5 with free school meal status	2016/17	↑	207	63.9%	63.6%	56.0%	43.9%		70.7%
GCSE achieved 5A*-C including English & Maths	2015/16	–	1,169	69.2%	61.3%	57.8%	44.8%		74.6%
GCSE achieved 5A*-C including English & Maths with free school meal status	2014/15	–	120	43.8%	45.8%	33.3%	20.5%		60.0%
19-24 year olds not in education, employment or training	2017	–	-	-	12.7%	13.2%	-	Insufficient number of values for a spine chart	-
Unemployment	2016	–	5,400	4.7%	5.7%	4.8%	9.0%		2.3%
Long term claimants of Jobseeker's Allowance	2016	↓	488	3.6*	4.1*	3.7*	13.8		0.7
Individuals not reaching the Minimum Income Standard	2013/14 - 15/16	–	-	-	35.6%	30.3%	-	Insufficient number of values for a spine chart	-
Work-related illness	2014/15 - 16/17	–	-	-	3590	3980	-	Insufficient number of values for a spine chart	-
Fuel poverty	2015	→	8,151	10.2%	10.1%	11.0%	18.2%		6.7%
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	–	-	16.5%*	18.0%	17.9%	5.1%		36.9%

Compared to London

Indicator	Period	Merton Recent Trend	Count	Value	Region Value	England Value	Worst/ Lowest	London region Range	Best/ Highest
Healthy life expectancy at birth (Female)	2014 - 16	–	-	66.7	64.4	63.9	55.6		70.0
Healthy life expectancy at birth (Male)	2014 - 16	–	-	63.2	63.5	63.3	58.2		69.9
Life expectancy at birth (Female)	2014 - 16	–	-	84.2	84.2	83.1	81.9		86.8
Life expectancy at birth (Male)	2014 - 16	–	-	80.8	80.4	79.5	77.5		83.7
Inequality in life expectancy at birth (Female)	2014 - 16	–	-	3.4	-	-	-	-	-
Inequality in life expectancy at birth (Male)	2014 - 16	–	-	6.2	-	-	-	-	-
People reporting low life satisfaction	2016/17	–	-	*	4.3%	4.5%	-	Insufficient number of values for a spine chart	-
School readiness: Good level of development at age 5	2016/17	↑	1,883	73.9%	73.0%	70.7%	66.4%		78.9%
School readiness: Good level of development at age 5 with free school meal status	2016/17	↑	207	63.9%	63.6%	56.0%	53.7%		70.7%
GCSE achieved 5A*-C including English & Maths	2015/16	–	1,169	69.2%	61.3%	57.8%	54.8%		74.6%
GCSE achieved 5A*-C including English & Maths with free school meal status	2014/15	–	120	43.8%	45.8%	33.3%	34.7%		60.0%
19-24 year olds not in education, employment or training	2017	–	-	-	12.7%	13.2%	-	Insufficient number of values for a spine chart	-
Unemployment	2016	–	5,400	4.7%	5.7%	4.8%	7.9%		3.8%
Long term claimants of Jobseeker's Allowance	2016	↓	488	3.6*	4.1*	3.7*	6.8		1.7
Individuals not reaching the Minimum Income Standard	2013/14 - 15/16	–	-	-	35.6%	30.3%	-	Insufficient number of values for a spine chart	-
Work-related illness	2014/15 - 16/17	–	-	-	3590	3980	-	Insufficient number of values for a spine chart	-
Fuel poverty	2015	→	8,151	10.2%	10.1%	11.0%	15.7%		6.9%
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	–	-	16.5%*	18.0%	17.9%	9.8%		27.5%

Committee: Health and Wellbeing Board

Date: 26 June 2018

Agenda item:

Wards: All

Subject: Merton Autism Strategy 2018-2023 and Action Plan

Lead officer: Dr Dagmar Zeuner, Director of Public Health

Lead members: Cllr Tobin Byers, Cllr Kelly Braund

Forward Plan reference number:

Contact officer: Julia Groom, Consultant in Public Health; Dr Sally O'Brien, Public Health Registrar

Recommendations:

A. To approve the Autism Strategy 2018-2023.

B. To endorse the Strategy Action Plan.

C. To agree to champion the ambition to make Merton an autism-friendly borough, and in particular to support the objective to improve autism awareness in the wider population which was highlighted as a priority in engagement on the Autism Strategy.

D. To agree the proposed governance arrangements for the Strategy.

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to inform the Board about the development of the Merton Autism Strategy 2018-2023. It is also to seek approval for the final Strategy and Action Plan and request that members of the Board champion opportunities promote awareness of autism and work towards Merton becoming an 'autism-friendly' borough.

1.2 The report sets out drivers for the development of the Strategy; outlines the six priority themes of the strategy and summarises the findings of a public engagement period. It highlights key deliverables set out in the strategy action plan; updates on progress of the redesign of the 0-19 support and diagnosis pathway; and sets out proposed governance arrangements and next steps.

A summary of the strategy is on p.5-8 set out in Appendix A.

2. BACKGROUND

2.1 Autism is a life-long condition affecting about 1 in every 100 people. It affects how people see, hear and feel the world. Everyone with autism will experience it differently. Autism is a spectrum of different needs, which means people with autism are on different points on the spectrum and affected in different ways.

2.2 It is estimated based on prevalence figures that there are about 540 children and young people and 1,200 adults with autism in the borough. Demographic data suggests that the number of people with autism is increasing. In Merton there has been an increase in children with autism recorded as their primary type of educational need; 407 CYP in 2017, an increase of 60% from 2013. As the population grows older the number of adults with autism is projected to rise, increasing by 14% to reach approximately 1,570 adults in 2030, although

local trends indicate this may be higher. This implies there will be an associated increase in need for care and support for adults with autism in Merton over time.

2.3   Feedback from stakeholders including service providers, voluntary organisations, people with autism and families and carers have told us they want to see improvements in support and services locally.

2.4   There are statutory guidance and legal duties for local authorities and the NHS, along with evidence based quality standards. Public sector services are all facing financial pressures and need to work in partnership to ensure that resources are used effectively.

2.5   In response to these factors, the London Borough of Merton (LBM) and Merton NHS Clinical Commissioning Group (MCCG) have developed an Autism Strategy, working in collaboration with a range of partners. The strategy takes a life-course approach and encompasses children, young people and adults, taking into account the needs of families and carers.

3.   DETAILS

3.1   The Merton Autism Strategy sets out a vision to 'develop an autism-friendly borough in which people with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them'.

The strategy document sets out the following background: drivers for change (p.10), national policy and guidance (p.13-14), information on our population (p.14-16), a detailed description of our current services and access to support (p.17-25), and summary of stakeholder feedback (p.25-26).

Strategy Priorities

3.2   The Strategy includes six priorities and for each sets out evidence for change, where we are now, where we want to be and how we will get there (p.30-46):

- *Awareness training and support for staff and services*: this priority includes the general population as well as those working with people with autism having a better awareness and understanding. This means understanding the specific strengths of people with autism as well as having an awareness of challenges they may face and counteracting unhelpful stereotypes and prejudices.

- *Recognition, support, referral and assessment*: we know that the earlier autism is identified the better the outcomes. Early support, diagnosis and assessment of needs can offer an understanding of why a child or adult is different from their peers. Improving the support and diagnosis pathway for 0-19 year olds as well as having clear protocols for adult diagnosis is a priority.

- *Involving and supporting people with autism*: people with autism will have different needs at different times of life and key to this strategy is having access to the right support at the right time. We want people with autism to be fully involved in their care and able to participate equally, including in education, employment and leisure.

- *Preparing for adulthood*: this priority is a recognised challenge. Although the majority of young people with autism will not need specialist services as an adult, they may need support as in developing independence, such as

learning additional life skills, seeking opportunities for further education, apprenticeships and employment.

- *Think family –involving and supporting families and carers*: families and carers value existing support but felt strongly that there should be a better continuum of support and more parenting programmes, particularly for those with children over 8 years.

- *Access to information*: Access to comprehensive information about local services is important to support making informed choices. Building on and strengthening the' local offer' for children, young people and adults is important.

The Strategy is attached as Appendix A and an easy read version at Appendix B.

Public engagement

3.3 Initial stakeholder engagement in 2017 included a survey of stakeholders; a workshop involving 35 partners; presentations and discussions at community and voluntary sector groups and forums involving people with autism; parents and carers. This helped shape the draft strategy and agree the six priorities.

3.3 In February–March 2018 a public engagement on the draft strategy took place. This comprised of an on-line survey and paper easy-read survey; engagement through facilitated feedback sessions including adults and young people with autism; parents and carers; and professionals.

A total of 146 participants engaged in the feedback process as individuals and/or part of group feedback, including 19 people with autism and 45 parents/carers.

Key issues from the engagement which have been incorporated in the final strategy include:

- Strong support for the vision, aims and priorities within the strategy. However there were also significant concerns that there was not strong enough commitment to achieving the aims and no additional resources, which meant a risk that it would not result in tangible improvements for people with autism.

- Strong feedback that awareness training for staff and other residents was fundamental to achieving the aim of becoming an 'autism-friendly' borough and should be given higher priority.

- Consistent feedback that improvements were needed to improve early intervention and support, access to diagnostic services and availability of post-diagnostic support, and support for parents and carers.

- The need to prioritise services which are inclusive for people with autism and enable social participation and independent living.

- The need to listen to parents and carers, whilst ensuring that the voice of people with autism is at the forefront of decision-making.

  Further details of the public engagement are set out in Appendix D.

Action Plan

3.4 An outline action plan has been developed for the life of the strategy. This has aimed to respond to concerns that the draft strategy did not give strong

enough commitments by highlighting which actions will be prioritised for delivery in the first year. These include:

- Action 1.1: Improve the local training and awareness offer, including delivering a training programme for CYP workforce.
- Action 2.1: Redesign and improve the assessment, diagnosis and support pathway for 0-18 year olds.
- Action 2.2: Raise awareness of the diagnostic pathway for adults.
- Action 2.3: Promote autism champions in all education settings.
- Action 3.1: Improve customer journey in adult health and social care for adults with autism.
- Action 3.2: Ensure people with autism are actively involved in co-designing and delivering services.
- Action 3.3: Improve employment opportunities for people with autism.
- Action 3.4: Improve opportunities for people with autism to participate socially.
- Action 3.5: Increase the number of places within specialist and additionally resources educational provision.
- Action 4.1: Improve the quality of transition assessments.
- Action 5.1: Identify resources to increase provision of parenting programmes.
- Action 5.2: Ensure families and carers are involved in the co-design and delivery of services.
- Action 6.1: Improve quality and accessibility of information available to people with autism and their families/carers.

3.5   Other actions set out in the plan will be developed over the life of the strategy and this action plan will be reviewed and updated on an annual basis.

3.6   Lead officers for each priority will develop milestones and relevant partnership groups with monitor delivery. It is important that delivery of the Action Plan builds on existing infrastructure and resources, and identifies all opportunities to lever in additional resources in order to scale up or enhance services.

The Action Plan is attached as Appendix C.

0-18 Assessment support and diagnosis pathway

3.7   A key priority in the strategy is redesigning and improving the assessment, diagnosis and support pathway for 0-18 year olds. It is widely recognised that the current diagnosis pathways do not meet the needs of residents and this was a consistent theme in the public engagement on the strategy.

3.8   The CCG has invested short term funding to reduce waiting times within current services. The CCG are leading on the co-production of a new pathway in the short and longer term. There is a commitment to retain open access for diagnostic assessment, provide help and support earlier in the pathway, and reduce waiting times for children and young people.

3.9   As part of this we will continue to engage children and young people, parents and carers and professional stakeholders, including community paediatrics and CAMHS, who deliver the current 0-5 and 5-18 diagnostic services respectively.

Governance

3.7   It is proposed that:

- Progress on delivering this action plan is be monitored through existing partnerships (including the CAMHS Partnership and Preparing for Adulthood Partnership and Adult Mental Health Programme Board.

- In the first year an Autism Partnership steering group will be established to provide leadership and oversight, this will report to the Children's Trust Board and Health and Wellbeing Board.

- There is a commitment in the strategy to engaging people with autism and parents/carers in the steering group and delivery of the strategy which will require support. Talk Autism/Kids First have already identified parents/carers who may wish to participate and people with autism who participated in discussion groups have expressed an interest in continuing to be involved.

Fig.1: Proposed governance:
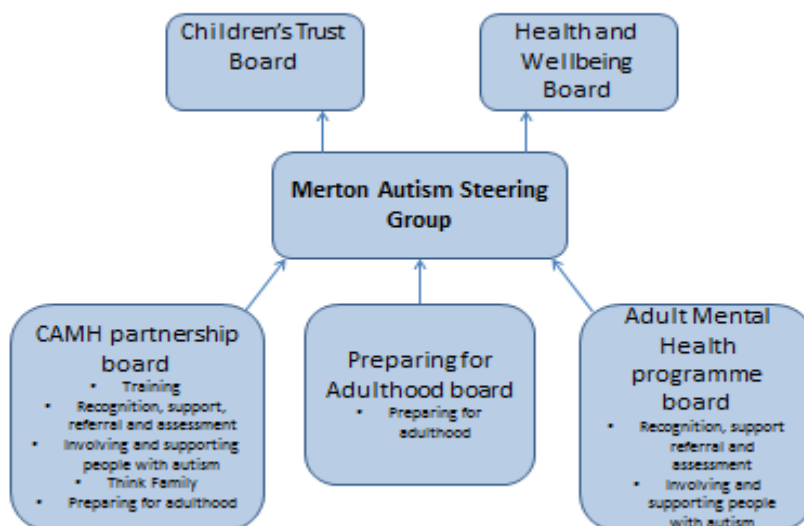
Next Steps

- Work is already underway to deliver priority objectives in the action plan, including children and young people assessment and diagnosis pathway redesign.

- It is proposed that the first Steering Group takes place in September 2018.

- Members are asked to champion the commitment to making Merton an autism-friendly borough and in particular to support the objective to improve autism awareness in the wider population which was highlighted as a priority in public engagement.

4.   **ALTERNATIVE OPTIONS**

None

5.   **CONSULTATION UNDERTAKEN OR PROPOSED**

Significant public engagement has been undertaken in the development of the strategy including pre-strategy stakeholder engagement and public engagement on the draft strategy.

A summary is set out in the Strategy document p.25-26. Further details are set out in Appendix D. Merton Autism Strategy Public Engagement Feedback report.

6.   **TIMETABLE**

The strategy is for 2018-2023. The action plan will be reviewed annually.

7.   **FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS**

The strategy recognises the financial constraints of both NHS and local authority partners and has been developed on the basis that it will be delivered within existing resources and the expectation is for better use of existing resources aligned to need through better collaboration between partners.

It is important that the delivery of the action plan builds on existing infrastructure. It also includes commitments for partners to enhance or scale up delivery by seeking opportunities to lever additional resources to the borough.

8.   **LEGAL AND STATUTORY IMPLICATIONS**

In 2014 an updated national strategy for adults 'Think Autism' was published. Statutory guidance from the Department of Health was published in 2015. This contains a number of duties on local authorities and the NHS. Further details: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/422338/autism-guidance.pdf

The Merton Autism Strategy and action plan contributes to supporting implementation of the national strategy for adults.

9.   **HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS**

Based on the evidence that many people with autism are socially and economically disadvantages, the strategy is likely to have a positive impact on equality through seeking to address the needs of residents with autism.

An equality analysis detailed opportunities to further promote equality. A summary is set out in the strategy document p.28.

10.   **CRIME AND DISORDER IMPLICATIONS**

People with autism may be witnesses or victims of crime and at risk of bullying and intimidation. People with autism also appear to be over-represented in the

criminal justice system nationally and guidance highlights the importance of ensuring the needs of people with autism are met in all custodial settings.

The strategy includes theme 1: awareness training and support for staff and services, which was highlighted in the public engagement as a priority for public services and includes an action to work with the Police and work with partners to deliver awareness training to relevant staff groups.

11.   RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A

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

a. Merton Autism Strategy 2018-23

b. Merton Autism Strategy –Easy Read

c. Merton Autism Strategy Action Plan

d. Merton Autism Strategy Public Engagement report

13.   BACKGROUND PAPERS

None

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Merton Autism Strategy
2018-2023

June 2018
(Version 11.8: 26/06/2018)

Contents

Foreword

Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health and Councillor Kelly Braund, Cabinet Member for Children's Services

As the Cabinet Members responsible for public health and children, we commend this joint Merton Autism Strategy. Autism touches the lives of many people in our Borough and affects all aspects of life, from school to healthcare to employment and social lives. As such, this strategy covers the whole life-course including children, young people, adults and families and carers.

Making Merton an autism friendly borough in which people with autism are able to live fulfilling and rewarding lives is an important priority for us. We recognise that raising awareness of autism in the wider community and increasing knowledge and understanding is key to succeeding in this. Councillors have an important role to play in this too, which is why we will ensure all elected members are given training about autism.

In developing this strategy we have engaged with, and heard the views of, people with autism, families, carers and partners from across Merton and we want this to continue as the strategy is delivered. The strategy proposes aspirational yet achievable solutions to make Merton a better place to live for people with autism. Delivery of the strategy will require that we work in partnership for and with our communities to ensure its positive ambitions are achieved.

Dr Andrew Murray, Chair of Merton NHS Clinical Commissioning Group

As the chair of NHS Merton CCG and a local GP, I see first hand some of the challenges facing people with autism in Merton. I am therefore pleased that Merton Council has been working closely with NHS Merton CCG and other partners to develop this comprehensive, joint autism strategy.

Autism is a condition which affects someone for their whole life. We want to build on what people can do and where they want to get in life rather than just focusing on what people may find challenging. It is commendable that this strategy considers the whole life-course and takes positive steps to address wide-ranging issues, including the important role of the NHS in supporting people with autism.

The strategy sets out clear objectives and constructive actions to achieve the aim of making Merton an autism friendly borough. It is a useful resource for anyone working with people with autism, as well as residents with autism themselves and their families and carers.

About this document

This document begins with summary of our overall plans (p.5); it then provides an overview of our vision for an autism-friendly Merton and what this might mean for people with autism living in the borough. Section 2 (p.13) gathers facts and figures about autism along with guidance and evidence. It also provides details of services and support currently available to people with autism and their families and carers in Merton and a summary of what stakeholders have said could be improved in the borough.

Section 3 (p.27) sets out details of the six priority themes in our strategy and for each covers: the evidence for change; where we are now; where we want to be and how we will get there – our plans for improvement. Section 4 (p.47) briefly sets out how we will implement the strategy. A detailed action plan is also available.

Note on language

The terms 'autism', 'autistic spectrum disorder' (ASD) and 'autistic spectrum condition' (ASC) are often used interchangeably and refer to the same spectrum of conditions which includes autism and Asperger syndrome. Asperger syndrome is sometimes referred to as 'high functioning' autism (1). For consistency, we will use the terms 'autism' and 'person with autism' throughout this document.

4

Executive Summary

We want Merton to be an autism-friendly borough in which people with autism are able to live fulfilling and rewarding lives within a society that accepts and understand them and reach their full potential at all stages of their lives. With this in mind, we have developed a strategy for the next five years which takes a whole life course approach, encompassing children, young people and adults with autism and taking into consideration the needs of families and carers.

We know that autism touches the lives of many people in Merton and demographic data suggests that the number of people with autism is increasing. It is therefore important that we have a strategy which enables us to work in partnership to support people with autism in the most effective way possible. This includes raising awareness and understanding of autism in the wider community, ensuring that people with autism reach their educational potential, gain employment and can access the right support at the right time to be as independent as possible. Additionally, there is a need to ensure our local services are compliant with statutory duties and guidance for local authorities and the NHS in relation to autism.

This is a joint strategy between the London Borough of Merton and Merton NHS Clinical Commissioning Group (CCG) in collaboration with a range of partners, including NHS providers, Merton JobCentre Plus, Schools and the voluntary sector. Public sector services are all facing financial pressures and we need to work in partnership to ensure we use local resources most effectively.

In preparing this strategy we have engaged with a wide range of stakeholders, including people with autism and parents and carers, people working in education, housing, employment and health services to seek their views on what is working well and what needs to improve for people with autism. We have also collected and evaluated a wealth of local and national data and evidence. Through this process we have identified six key themes that we need to address in order to achieve our ambition of making Merton an autism-friendly borough:
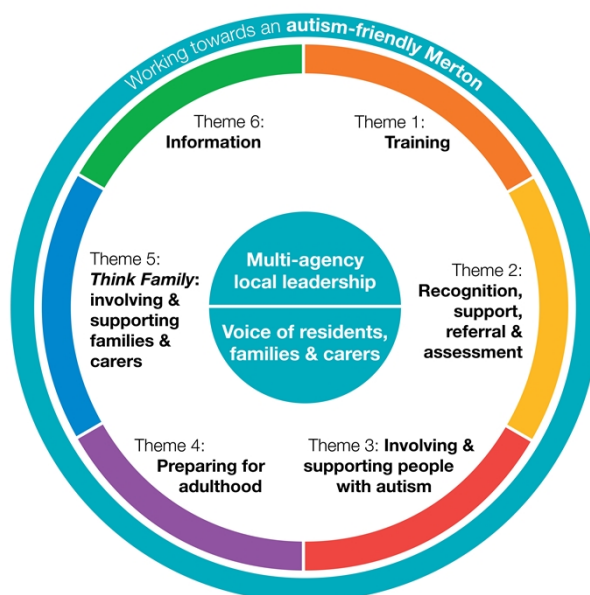
Theme 1: Awareness training and support for staff and services

Increasing awareness and understanding of autism is at the heart of this strategy and is fundamental to achieving our ambition of making Merton an autism-friendly borough, in which the general population are aware of autism and have a better understanding of the condition. This means understanding the specific strengths of people with autism, as well as having an awareness of the core social difficulties that those with autism may face. By improving autism awareness in the general population, and not just those who are working directly with people with autism, we hope to counteract unhelpful stereotypes and prejudices.

Summary of actions:

- We will deliver a new autism awareness training programme aimed at the wider CYP workforce.

- We will develop and deliver training to SENCO's and key staff to ensure that CYP in mainstream settings receive appropriate support and access to the curriculum.

- We will work towards all NHS and Merton Council staff undertaking autism awareness training as part of general induction and equality training.

- We will involve people with autism in the development of training.

Theme 2: Recognition, support, referral & assessment

We know that the earlier autism is identified, the better the outcomes and we therefore need to ensure that the wider community as well as those working with people with autism are aware of the signs of autism and the local pathways for assessment and diagnosis for people of all ages. We recognise that an autism diagnosis and assessment of needs can offer an understanding of why a child or young person is different from their peers. It can open doors to support and services in education, health and social care, and be a route into voluntary organisations and contact with other children and families with similar experiences. Access to support should however, be guided by need and should not be dependent on a diagnosis.

Summary of actions:

- CCG and Local Authority commissioners, in consultation with residents, will work together to redesign local referral, assessment and support services to meet the needs of children and young people (and their parents or carers) who may need diagnosis of an autistic spectrum disorder.

- We will design services such that access to assessment and diagnosis is available to those who need it, but not a requirement to accessing support.

- We will raise awareness of the diagnostic pathway for adults with autism through a published pathway and training of professionals.

- We will promote 'Autism Champions' in all early years and education settings to raise awareness of autism among staff and support early identification and referral.

Theme 3: Involving and supporting people with autism

No two people with autism are the same and they will have different needs at different times of life, it is therefore key to this strategy that people with autism of all ages in Merton are able to access the right support at the right time. We want Merton to be a borough in which people with autism are fully involved in their care and can participate equally in society, including in their education setting, the world of work and in leisure activities. It is essential we work with people with autism to ensure the

design and delivery of services which are of a high quality, well joined up and available to everyone equally when they need them. We will seek to ensure that there is always opportunity for people with autism to be involved in service developments and delivery.

Summary of actions:

- We will actively involve people with autism, families and carers in co-designing services and take steps to promote equality.

- We will develop a plan for communication and engagement with people with autism over the life-course of the strategy.

- We will work to better support those with lower level needs as well as those with complex needs, including publishing a protocol outlining social care needs assessments for adults with 'high functioning' autism.

- We will develop a support offer for people with autism and complex needs, with early co-ordinated multi-disciplinary support, including transition from children to adult services.

- Work with the voluntary sector to develop a support offer for adults with autism with intermittent, lower level needs. This may include advocacy and advice services, peer support, volunteering programmes, social prescribing etc.

- We will increase the number of places within Specialist Maintained schools and schools with additionally resourced provisions so that CYP with Autism can be educated locally.

- We will promote the South London partnership 'Better Working Futures' programme, Project Search and the government's 'Disability Confident' scheme.

Theme 4: Preparing for adulthood

Preparing for adulthood is a recognised challenge. Although the majority of young people with autism will not need specialist services as an adult e.g. adult social care, they will need support as they move towards adulthood in developing independence. This includes learning additional life skills such as travelling independently and seeking opportunities for further education, employment and independent living.

Summary of actions:

- We will ensure transition assessments are structured and use a framework such as the national Preparing for Adulthood framework

- We will work with schools, libraries and adult education to explore their potential for providing more life skills training for young people with autism

- We will work with FE Colleges to increase understanding of the needs of CYP with autism in further education and to improve their access to support within colleges.

Theme 5: Think Family: involving & supporting families & carers

Families and carers in Merton have expressed that they would like to be more involved in decision-making about the care and support their loved ones receive. In Merton, families and carers value the existing support services available such as parenting programmes and short breaks, but felt they would benefit from a better continuum of support. In addition, access to clear, comprehensive, up-to-date information about local services has been highlighted as a priority for families and carers.

Summary of actions:

- As part of the development of the CYP 0-19 assessment, diagnosis and support pathway, we will work with partners to identify resources to increase the availability of parenting programmes on offer in the borough-particularly for those with children over 8 years old.

- We will produce clear information about local parenting support as part of the 'local offer'.

- We will promote co-production amongst organisations re-commissioning or delivering new services that support families and carers of people with autism.

Theme 6: Access to Information

Access to comprehensive information about local services is essential in empowering people with autism to make informed choices. High quality information is also crucial to support families and carers of those with autism and staff working in organisations who may be in contact with people with autism. Merton Local Authority publishes a 'local offer' for children and young people with special education needs and disabilities, an online resource containing information about local services, however feedback has identified that this could be improved.

Summary of actions:

- Develop an all-services information hub to provide a single place for information about local services and resources relevant to autism, including the local SEN offer.

- When producing information, stakeholders will consider its accessibility in terms of clarity (easy-read), whether translations into non-English languages are required, and whether cultural factors have been taken into account, seeking to ensure information is widely accessible.

Delivering the Strategy

A time-limited, Merton Autism Steering Group, or similar, will be set up to lead and oversee delivery of this strategy, which is based on working in partnership to use our resources most effectively and seeking opportunities to bring additional resources to the Borough. An Action plan has been produced setting out how and when the actions will be implemented. Progress will be reported to the Health and Wellbeing Board and Children's Trust Board.

1. Introduction

Our vision & aims

1. We want Merton to be an autism-friendly borough. In line with the Government's vision (2), we want Merton to be a place in which people with autism are able to live '*fulfilling and rewarding lives within a society that accepts and understands them. This means they can get a diagnosis if they choose and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them to make the most of their talents*.'

2. It is estimated that there are more than half a million people with autism in England. This is equivalent to more than 1% of the population, similar to the number of people that have dementia (3) and in Merton there are an increasing number of children and young people with a recorded diagnosis of autism. The National Autistic Society (NAS) estimates autism touches the lives of 2.8 million people in the UK every day (1) (4) and evidence shows that autism is a source of social, economic, and health inequality across England (2).

3. This strategy sets out our plan to achieve our vision for Merton and takes a life-course approach, encompassing children, young people and adults with autism, and taking into consideration the needs of families and carers. It recognises autism affects people in different ways and touches many aspects of their lives. Our ambition is to work in partnership to address the wide range of areas in which residents with autism might be supported, including in health services, education, preparing for adulthood, employment, independent living and the criminal justice system.

4. In implementing the strategy over the next 5 years, our intention is that Merton residents with autism and their families and carers feel more involved in the development and delivery of local services. Residents should expect to:

    *   encounter a society which takes a strengths-based view of autism. We will build on what people can do, and where they want to get to in life, rather than a focus on what people may find challenging;

    *   participate in decisions about assessment and diagnosis and receive support, information, and advice as early as possible after needs have been identified;

    *   understand your diagnosis, if you choose to have one, and what this means to you and your parents/carers on a daily basis;

    *   encounter a range of high-quality services that are joined-up, easy to navigate and appropriate for your needs;

    *   be able to access clear, comprehensive and up-to-date information about where to go for support, and have a means of sharing knowledge and experiences with others;

    *   find staff in relevant services have a clear understanding of autism and are knowledgeable about where to go for more information or help;

    *   feel that Merton is a place where you can participate socially and lead an independent life, including reaching your educational potential, gaining and maintaining employment, living close to family and social networks, and have the opportunity to take part in leisure and social activities.

    This strategy will act as the roadmap for commissioning intentions and service re-design and improvement initiatives going forward over the next five years.

Drivers for change

5. The need for an Autism Strategy for Merton has been informed by a number of drivers:

- There has been an increase in the number of children in Merton with autism recorded as their primary type of educational need, which indicates an increasing need for local education, health and other resources.

- As the population grows older, the number of adults with autism is projected to rise, with an associated increase in the need for care and support for independent living.

- Recognition that we need to understand better and improve our diagnosis pathway, as we know that our current 0-18 years pathway is not NICE compliant.

- Stakeholders including service providers, voluntary organisations, people with autism and families and carers have told us they want to see improvements in support and services locally.

- Preparation for adulthood has been identified as an important transition point for young people with autism, and ensuring this is well planned can have a significant impact on future wellbeing.

- There are statutory guidance and legal duties for local authorities and the NHS, along with evidence-based quality standards.

- Public sector services are all facing financial pressures and we need to work in partnership to ensure we use local resources most effectively.

Developing Merton's Autism Strategy

6. This is a joint strategy between the London Borough of Merton and NHS Merton Clinical Commissioning Group. A multi-agency steering group, comprising commissioners and managers from Merton Local Authority, NHS Merton Clinical Commissioning Group (CCG), South West London and St George's Mental Health NHS Trust, and Merton JobCentre Plus, has led its development, with overview provided by senior level boards within Merton Council and NHS Merton CCG.

7. As part of the preparation of this strategy we engaged with a range of stakeholders including people with autism, parents/carers and professionals, through face-to-face meetings, multi-agency workshops, e-mail and on-line questionnaires and sessions with parents and carers.

8. A range of needs assessment information underpins the strategy, including national guidance and evidence, local population data, service mapping information and stakeholder feedback.

9. Through this process the following Merton priorities have been identified;

Figure 1: Strategy themes

What is autism?

10. We all have differences that affect how we live in the world and relate to our environment. Autism can affect the way a person communicates with, and relates to, other people throughout their life. It affects how a person makes sense of the world around them. It has been stated that autism is neither a learning disability nor a mental health problem, although mental health problems can be more common among people with autism and it is estimated that one in three adults with a learning disability also have autism.

11. Autism is a spectrum of different needs, which means all people with autism are on a different point of the spectrum and affected in different ways. Some people with autism will have good language and communication skills and will be able to live independently, whilst others may have very limited language skills and will require specialist support throughout their lives. Asperger syndrome is on the autism spectrum and is often referred to as 'high functioning' autism, due to the fact that people with Asperger syndrome often have good verbal/language skills, however this can also mask a range of needs.

12. Over the past 40 years the prevalence of autism has increased substantially; greater awareness and diagnosis is thought to have contributed to this rise (5). Autism is more commonly diagnosed in males than females, with most recent estimates suggesting almost eight males have a diagnosis for every one female (6). It has however been suggested the 'true' ratio is narrower and there is under-diagnosis in females (6) (1).

Features of autism

13. Autism affects how a person understands and interacts with others and the world around them. People with autism can find it more difficult to understand, relate to and communicate with others, and can find the world overwhelming, leading to anxiety and isolation. This can also have a profound effect on their families.

14. Autism is also associated with a range of positive attributes and advantages. People with autism may be better able to understand numbers and patterns than others, giving them an advantage in problem-solving (7). Some studies suggest, compared to the average person, those with autism think more creatively and have better memories (8). These characteristics convey a clear benefit for certain types of work; indeed, case studies show some businesses specifically seek to employ people with autism for the skills they bring.

Difficulties associated with autism

15. People with autism more commonly experience certain health conditions, including generalised anxiety disorder, depression, obsessive compulsive disorder (OCD) and bipolar disorder (9). NAS estimates at least one third of people with autism are experiencing severe mental health difficulties (1). Epilepsy and sleep problems are more common (9), and people with autism can have sensory and motor difficulties including sensitivity to light, sound, touch, balance and pain, which can lead to distressing sensations and behaviours (3).

16. Learning disabilities are more common among those with autism than in the general population. NAS estimates between 44% and 52% of people with autism also have a learning disability (1).

17. Such difficulties, combined with the core features of autism, can result in people having a complex set of needs that may require specialist assessment and support and coordinated care that integrates a range of different services.

Social participation

18. The difficulty people with autism face interacting with others can result in everyday life being confusing and frightening, and leave them feeling isolated (3). The right support can have an enormous impact on the lives of people with autism and their families, and NAS report that, when asked, 70% of people with autism said they would feel less isolated with greater social support (1).

A source of inequality

19. People with autism may face inequality in society; indeed, the Autism Act 2009 was created in response to evidence that many people with autism are socially and economically excluded. People with autism can be stigmatised and the object of discrimination (3) and nationally, many pupils with autism report bullying.

20. National data from January 2016 shows that around 4% of pupils with a diagnosis of autism received at least one fixed period exclusion and about 0.1% were permanently excluded (10). In Merton in 2016, 22% of all permanent exclusions were amongst CYP with autism, however a third of these CYP were only diagnosed with autism after the exclusion.

21. NAS estimates only 15% of adults are in full time, paid work (1).

22. While autism is more commonly identified in males than females, it has been suggested this disparity may in part be due to under-diagnosis of autism in females (6) (1), which can result in unmet need among these individuals and their families. People with autism from Black, Asian and Minority Ethnic (BAME) communities may face additional challenges related to discrimination, engagement and accessing help and support. This may result in some people with autism from BAME communities being particularly disadvantaged.

2. National and Local context

The National picture: policy & guidance

The Autism Act 2009 & national strategy

23. The Autism Act 2009 was created in response to evidence that many people with autism are excluded, both socially and economically (11). This act required the Government to create a national Autism Strategy; *Fulfilling and Rewarding Lives*, *the strategy for adults with autism in England*, which was published in 2010 (2).

24. An updated strategy, *Think Autism* (3) was published in 2014 reflecting progress made and changes in the organisation of public services. Statutory guidance from the Department of Health was then produced in 2015 to assist local authorities and NHS agencies turn the strategy into action (12) . This guidance detailed nine priority areas;

    • Training of staff who provide services to adults with autism.
    • Identification and diagnosis of autism in adults, leading to assessment of needs for relevant services.
    • Planning in relation to the provision of services for people with autism as they move from being children to adults.
    • Local planning and leadership in relation to the provision of services for adults with autism.
    • Preventative support and safeguarding in line with the Care Act 2014 from April 2015.
    • Reasonable Adjustments and Equality.
    • Supporting people with complex needs, whose behaviour may challenge or who may lack capacity.
    • Employment for adults with autism.
    • Working with the criminal justice system.

25. The 2015 statutory guidance contains a number of legal duties on local authorities and NHS agencies.

National Institute of Health & Care Excellence (NICE) guidance

26. The National Institute of Health and Care Excellence (NICE) provides national guidance on health and care, including advice, information, and quality standards to guide the development of best practice in service delivery.

27. The NICE autism pathway brings together all NICE evidence, guidance, quality statements, and other information relating to health and care support for children, young people and adults with autism (13). It recommends the following:

    • service organisation and delivery of care should be led by a multi-agency strategy group;

    • care, assessment and support should be delivered by specialised children and young people and adult autism teams, which consist of professionals from a range of disciplines;

    • partnership working for delivering high-quality and comprehensive local services and support.

28. The NICE guidance contains general principles of care for children and young people and adults including: access for all; fully informed decisions made jointly between professionals, patients, and their families and carers; care delivered by skilled and trained staff; and physical environments designed or adapted to minimise their negative impact. It highlights how smooth transition from young people's to adult services requires advanced planning and a coordinated approach between the two services.

29. NICE quality statements are concise, prioritised statements designed to drive measurable improvements. The NICE autism quality standard (QS51), comprises eight quality statements relevant to the care of CYP and adults with autism. The quality statements are not mandatory (required by law), but are designed to form the basis of local audit criteria to support continuous quality improvement, and should be measured using locally collected data. Table 1 details the quality statements.

30. In Merton it is recognised that we have not yet achieved all the quality statements set out in national guidance and this is challenging. Partners are working towards achieving standards and this strategy identifies priority areas where this will be strengthened.

Table 1: NICE autism quality statements for CYP and adult autism services [QS51]
Quality statement 1: People with possible autism who are referred to an autism team for a diagnostic assessment have the diagnostic assessment started within 3 months of their referral.
Quality statement 2: People having a diagnostic assessment for autism are also assessed for coexisting physical health conditions and mental health problems.
Quality statement 3: People with autism have a personalised plan that is developed and implemented in a partnership between them and their family and carers (if appropriate) and the autism team.
Quality statement 4: People with autism are offered a named keyworker to coordinate the care and support detailed in their personalised plan.
Quality statement 5: People with autism have a documented discussion with a member of the autism team about opportunities to take part in age-appropriate psychosocial interventions to help address the core features of autism.
Quality statement 6: People with autism are not prescribed medication to address the core features of autism.
Quality statement 7: People with autism who develop behaviour that challenges are assessed for possible triggers, including physical health conditions, mental health problems and environmental factors.
Quality statement 8: People with autism and behaviour that challenges are not offered antipsychotic medication for the behaviour unless it is considered because psychosocial or other interventions are insufficient or cannot be delivered because of the severity of the behaviour.

Our population

Estimated numbers of Children and Young People (CYP) with autism

31. The most recent prevalence estimates for adults in England come from the combined Adult Psychiatric Morbidity Surveys (APMS) 2007 and 2014. This research suggested around 0.8% of adults (1.5% of men and 0.2% of women) have autism (6). Since autism is a life-long condition, APMS estimates may be applied to all populations.

14

32. Based on APMS, there were an estimated 541 children and young people aged 0 to 25 with autism resident in Merton in 2017 (14). We need to evaluate the data further within Merton to ensure that we are capturing the CYP who have received a diagnosis 0-5 years, 5-18 years and in adulthood.

## *Resident Merton CYP with an Education, Health and Care Plan (EHCP) & autism*

33. Merton has an increasing number of resident children and young people with an Education, Health and Care Plan (EHCP) or SEN Statement, with autism recorded as their primary type of special educational need. Of the 1500 CYP who had an EHCP in January 2017, 407 CYP (aged 0 to 25 years) were in this group (15). It is important to note CYP with autism are only captured in this data if they have an Education, Health and Care Plan (EHCP) or SEN Statement, and autism is recorded as their primary, and not a secondary, need.

> **Note:** An education, health and care (EHC) plan is for children and young people aged up to 25 who need additional special educational provision to meet their special educational needs than is from SEN support.
>
> EHCPs replaced SEN Statements under the Children and Families' Act 2014. All Merton CYP with SEN Statements will be moved to EHCPs by the end of March 2018. Throughout this document, the term 'CYP with an EHCP' will be used to encompass those with an EHCP or SEN Statement.

34. Between 2013 and 2017, the number of CYP with an EHCP and autism as their primary need rose by roughly 60%, from 255 to 407 individuals. This may be due to greater awareness and diagnosis in the region, as well as an overall increase in the 0-19 population (5). In addition, changes implemented following the Children's and Families Act 2014, in which the age range for SEN provision was extended to include young people aged 19 to 25, contributed to additional young people being captured in the data after 2015.

35. Chart 1 displays the rise in Merton CYP with an EHCP and recorded autism between 2013 and 2017.

Chart 1: number of Merton CYP with ASD recorded as primary type of need, 2013 - 2017
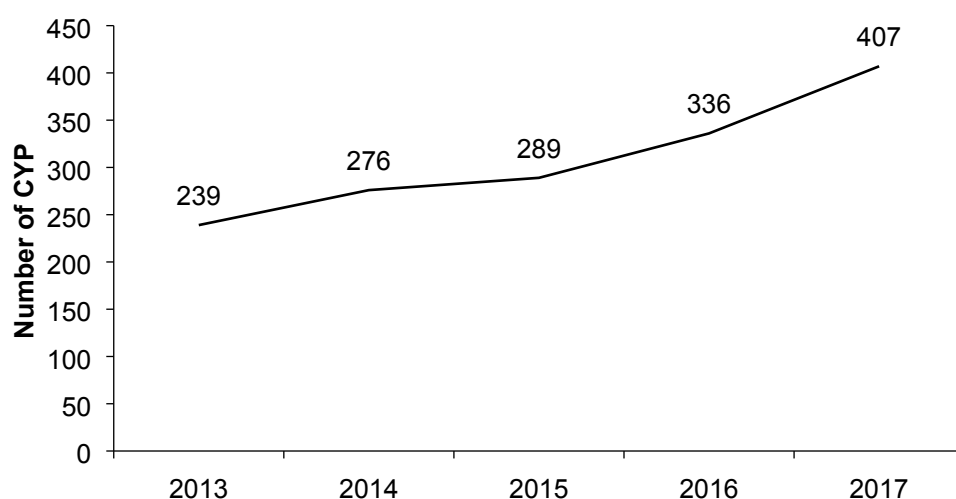
Diversity among Merton's CYP with an EHCP & autism

36. Similar to the national picture, there is a difference in prevalence between males and females in Merton; in 2017 85% of CYP recorded with autism were male. It has however been suggested this difference may in part represent under-diagnosis and unmet need among females (6) (1).

37. In 2017, among Merton's CYP with an EHCP and a primary need of autism, and in whom ethnicity was recorded, around half were in a white ethnic group. CYP of Black or Black British origin represented the second largest group, making up 19%. One in seven was Asian or Asian British, just over one in ten was of mixed ethnicity, and 3% were of other ethnic origins. This is comparable to school ethnicity in Merton indicating that ethnic groups are represented equally in terms of autism diagnoses.

Estimated numbers of adults with autism

38. Among adult residents (aged 16+), based on the APMS estimates, in 2017 there were around 1,202 Merton adults with autism, including roughly 1,050 men and 150 women. As the population grows, the number is projected to rise, increasing by 14% to reach approximately 1,570 adults in 2030. This implies there will be an associated increase in need for care and support for adults with autism in Merton over time.

Merton children, young people and family wellbeing model

39. This strategy has been developed in the context of the Merton children, young people and family wellbeing model, which was refreshed in 2017 (see figure 2. below). This sets out our local framework for working with children, young people and families and supports organisations to have a shared understanding of levels of need and work in partnership to address risk and vulnerability.

Figure 2:
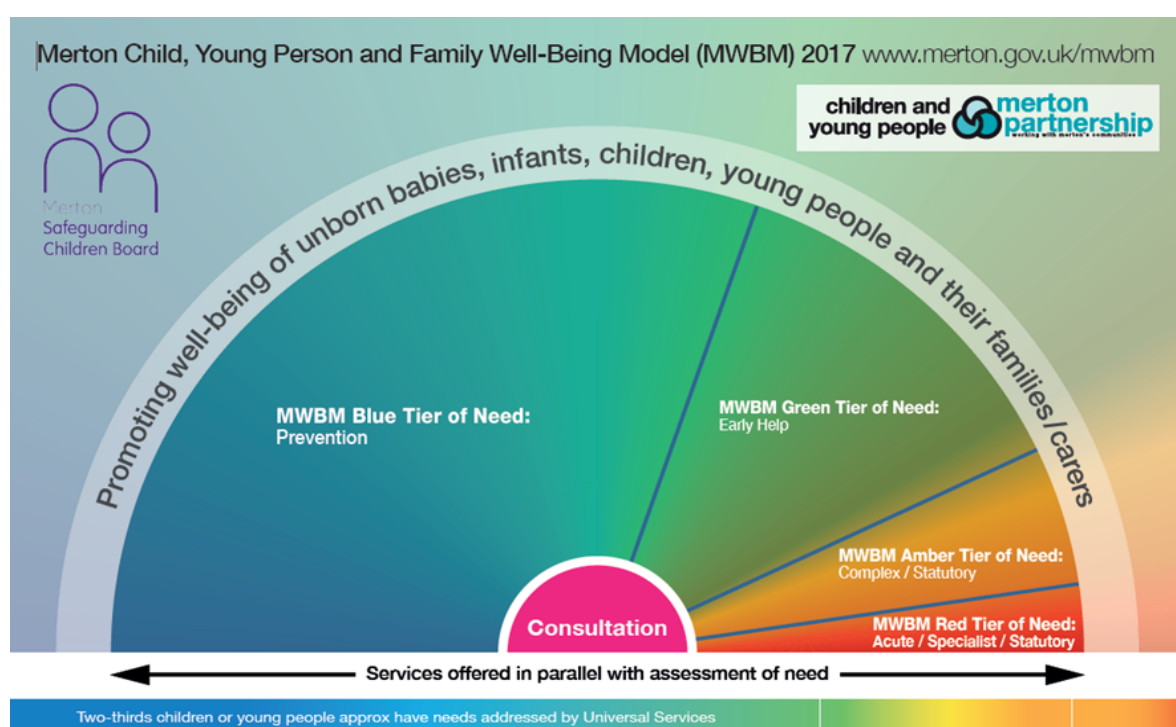
Our current services and access to support

40. This section provides details of the current service provision and support available to people with autism in Merton. An assessment of the strengths and weaknesses of the current services on offer has informed the priorities set out in this strategy. This section provides useful context, however if you would like to read about the strategy priorities please go straight to section 3 (page 27).

41. Further information about resources and accessing services are set out in the Merton 'Local Offer' https://fsd.merton.gov.uk/kb5/merton/directory/site.page?id=ncO0A9s4RpY

Recognition, referral & assessment

42. Identification, assessment and diagnosis are important for enabling people with autism and their families to understand their condition and access care and support where needed. Table 2 details current providers and sources of referral for diagnosis.

43. Early Years practitioners including community health, care and education, teachers and GP's are often the first professionals a family will see when investigating assessment/diagnosis for a child who may have delayed language or social skill development. Education settings (e.g. early years, school and colleges) and Primary Care can therefore play a vital role in diagnosis and support pathways for autism. Autism awareness, understanding of referral pathways and sources of support and information are all important for education providers and GP practices to consider.

Table 2: Merton diagnostic services				
	Commissioner	**Provider**	**Service**	**Sources of referrals**
Under five years				
	Merton NHS CCG	Epsom and St Helier University Hospitals NHS Trust	Sutton and Merton Community Paediatrics	Direct from health or education professionals
Five to 17 years				
	Merton NHS CCG	South West London and St George's Mental Health NHS Trust (SWLStG)	CAMHS Neurodevelopmental Service, a dedicated autism and attention deficit hyperactivity disorder (ADHD) service within the Child and Adolescent Mental Health Service	Health or education professionals via CAMHS Single Point of Access
18+				
	Merton NHS CCG	SWLStG	Adult autism team: for adults without a learning disability	Direct from GPs
	Merton Local Authority	Merton Local Authority	Team for People with Learning Disabilities: for resident adults with a learning disability	Health or social care professionals

Specialist services for children and young people
Educational provision & support

44. Appropriate, high-quality support in education settings (e.g. early years, schools and colleges) is crucial for CYP with autism, supporting them to participate, progress and reach their potential. CYP with autism have differing educational needs, and this is reflected in the range of educational provision and services offered in Merton.

45. Many Merton CYP with autism are most suited to mainstream education. In 2017, approximately 40% of Merton CYP with an EHCP and autism attended a mainstream school, representing the largest group. Of those not in mainstream schools, roughly equal proportions attended state-maintained special schools and independent schools, with the lowest proportion attending additional resourced provision (ARP) bases. This distribution of CYP across the different school types indicates a diversity of needs among Merton's CYP with autism, with different settings most appropriate for different needs.

46. The majority of mainstream, ARP, and state-funded special school placements are in-borough, whereas around 82% of those attending independent schools are placed out-of-borough. Chart 2. displays the numbers of CYP in different types of school, in- and out-of-borough, in 2017.

Chart 2: Number of CYP with ASD placed in- and out-of borough , by educational establishment, 2017
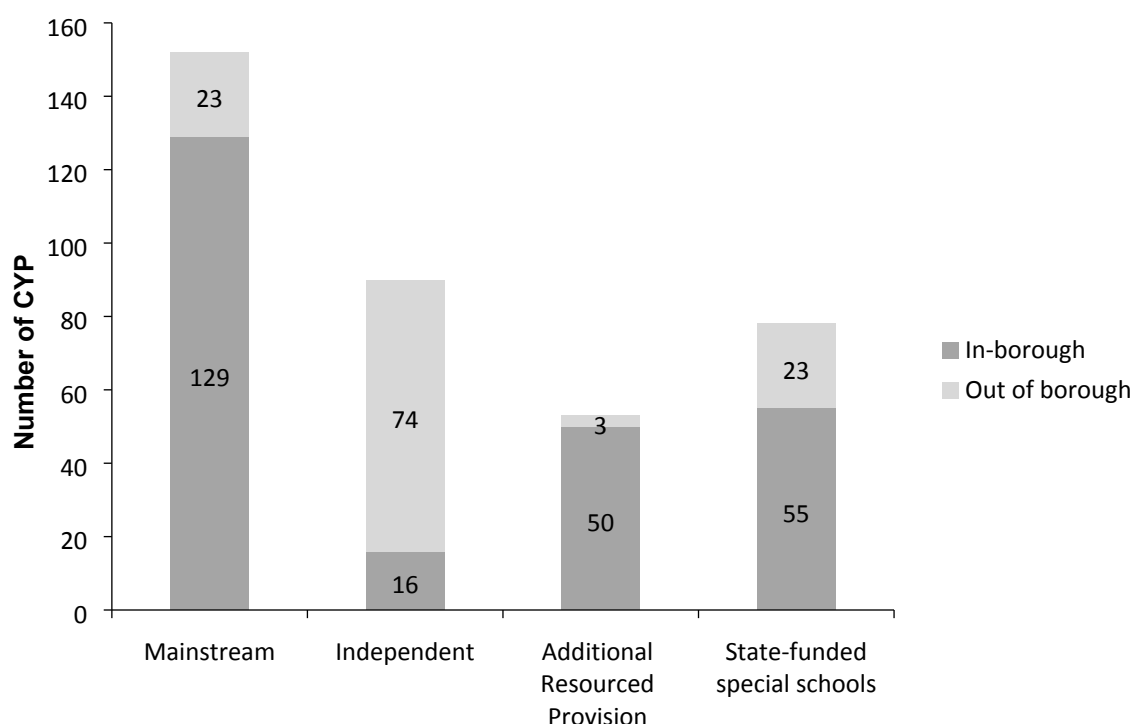
47. In recent years small numbers of CYP with autism have been in residential schools. This small yet significant group of CYP is likely to have some of the most complex needs. Almost all residential placements were independent schools out-of-borough, and tended to be high-cost.

48. Support within education provision varies depending on the type and the needs of individual pupils. Merton's four autism Additional Resourced Provision (ARP's) including three primary and one secondary school, provide specialist educational, social and emotional support tailored

specifically to CYP with autism. Speech and Language Therapists (SaLT), educational psychologists and Merton Autism Outreach Service (MAOS) work with Merton ARPs to provide additional specialist input, as outlined in EHCP's.

49. Cricket Green and Perseid schools are Merton's two state-maintained special schools, both taking CYP of all schools ages, including a substantial number with autism. Perseid is for CYP with severe and profound learning difficulties, including learners with an additional diagnosis of autism and/or additional physical and/or sensory disabilities. Cricket Green School is for CYP with diverse learning needs. Cricket Green school is involved in leading a number of additional services, including Merton Autism Outreach Service (MAOS) and Project SEARCH.

50. SaLT work with CYP in all schools to help them develop speech and language skills. SaLT can also offer information to parents and teach them specialist techniques to help develop their child's communication skills at home.

51. Merton Educational Psychology Service provides psychological consultation to all Merton schools concerning CYP with special educational needs, including autism. Educational psychologists can also offer training to school staff and deliver evidence-based interventions to support individual pupils, including video interactive guidance (VIG) and cognitive behavioural therapy (CBT). In addition, the service is commissioned by Merton Local Authority to provide psychological advice for EHCPs. This ensures EHCPs best identify and meet the pupils' needs.

52. MAOS helps school staff effectively support pupils with autism. MAOS staff work with head teachers, Special Educational Needs Coordinators (SENCos), classroom teachers and teaching assistants, in their own school setting, to advise on new strategies tailored to supporting individual pupils. The service mainly works in primary schools although expansion into secondary schools is underway. In order to receive support, schools are required to directly contact MAOS.

53. Merton Sensory Support Service work with CYP in school settings and in the home. Specialist Teachers provide support and advice for CYP with a visual, hearing or multi-sensory impairment to access the curriculum and environment and offer information to teaching staff and families.

54. Children's social care provide support and services to a smaller number of children and young people with autism who have been identified with very complex needs, or who may be children in need, looked after or care leavers. There is a dedicated Children with Disabilities social care team, however children with autism may also be known to other parts of the social care system and wider Children, Schools and Families department including the 0-25s Early Intervention and 'Shortbreaks' service.

55. For children in the early years there are a range of support services available including health visiting, specialist therapists, advisory inclusion work in the child's setting and specialist programmes supporting children's social and communication. Families can be supported through home based specialist family support and have access to specialist parenting and child development programmes.

56. Merton has a specialist 'Shortbreaks' Centre which provides high quality, out of school provision for children and young people with specific needs, including Autism. The Brightwell Specialist Out of School Provision is open after school during term time, and during the day at weekends and school holidays (closed for a maximum of 2 closure weeks and bank holidays) and works with children and young people aged 6 – 18 and their families, in partnership with other specialist agencies.

Child and Adolescent Mental Health Services

57. Merton CCG commission child and adolescent mental health services (CAMHS) from South West London and St Georges NHS trust (SWLStG). This delivers assessment, diagnosis and management of mental health conditions and services may be accessed by CYP with autism, as well as specialist services including the neurodevelopmental pathway for diagnosis of ASD and ADHD. Services are accessed via a single point of access.

Parenting programmes

58. Parenting programmes can help parents understand and communicate with their child, and support children with autism to develop social and communication skills. Merton Local Authority and Merton CCG deliver and commission a number of parenting programmes, including autism-specific programmes, such as the NAS 'Early Bird Plus' programme, programmes that are suitable for children with disabilities and/or autism such as the 'Triple P Stepping Stones' programme and general programmes aimed at parents of children with communication or behavioural difficulties, such as 'Social Butterflies' and 'Incredible Years'. Programmes vary in their approaches and aims, and are designed for children of different age groups, ranging from one to eight. Depending on the programme, referrals may come from education, health and social care staff or educational psychologists working in schools, including MAOS.

59. Our ambition in Merton is to ensure there is a full range of parenting programmes to meet diverse needs of local families. In addition, we want to work towards easier access to these programmes.

Preparing for adulthood

60. People who have received support with autism in childhood may not automatically need support from adult services. This includes a small number of our Looked After Children who will not meet the threshold for adult social care, but who the council may need to continue to support as their corporate parent. Young people sometimes see adulthood as a time to progress to greater independence and may not want an assumption of lifelong need for services, their needs are also likely to change as they move into adulthood and they may need less or more support, particularly if they have secondary diagnoses. Where there is a need for ongoing support, it is essential that the focus of this support is on developing independence and fulfilling their potential.

61. CYP with autism and an EHCP are supported in education provision on the basis of educational needs, whereas adults with autism receive state-funded support on the basis of social care needs under the Care Act 2014, or are supported as Care Leavers under a range of legislation. The majority of CYP with an EHCP and autism will have needs that do not reach the threshold for adult social care, albeit some not reaching that threshold, including Care Leavers, will have significant support needs as young adults in achieving independence.

62. In educational provision, young people with autism and an EHCP receive an annual review. From year nine this review includes 'Preparing for Adulthood', a framework which aims to ensure young people with special educational needs and disabilities (SEND) can reach their full potential as they move into adulthood, including paid employment and higher education, housing options and independent living, good health, friends, relationships, community inclusion and choice and control over their lives and support (16). EHCP outcomes are based on the national 'Preparing for Adulthood' framework.

63. For CYP supported by the council's Children with Disabilities (CWD) Social Care team, a transition meeting is held at age 14 to consider whether the young person is likely to be eligible for adult social care. For those identified, the council's CWD and Transitions teams co-work with the young person and their family/ carers from age 16 to plan for transition to adult social care. Young adults transfer to adult social care services at age 18. Care leavers not held in CWD and not meeting the threshold for adult social care will be supported through to independence as Care Leavers by the council's Children, schools and families department.

64. Merton Council offers a wide range of courses in partnership with South Thames College which have specialist teaching, and a support team to work with young people and adults with a wide range of disabilities. It also runs Merton-specific 'Towards Independence' courses which are daytime courses for adults (people over 18), who have a learning disability or difficulty and include life skills, looking after yourself, arts & crafts, etc.

65. The Aurora Centre is Merton College's specialist, non-residential centre for young adults aged 16-25 with autism and complex needs. It runs courses focusing on three key areas: living, work and community. Students are also able to take part in supervised work experience.

66. Project SEARCH, an initiative originally developed in the USA, is provided in Merton, led by Cricket Green School. This programme provides practical work experience and prepares a cohort of young people with learning disabilities, including those with autism, for the world of work. The programme places roughly 6 students per year within an organisation where they gain on-the-job training and additional employment support. The current host organisation is St Georges Hospital. Although numbers of participants are relatively low, the success rates are high with 76% of participants gaining on-going employment after the project.

Specialist Services for adults

Adult social care & support

67. Merton Council's Team for People with Learning Disabilities and Transition is a multi-disciplinary health and social care team working with adult residents. Where eligible, the team supports adults with autism through professional health services and social care, including conducting needs assessments under the Care Act 2014 and commissioning support to meet individuals' social care needs.

68. In January 2017, 178 adults (aged 16+) with a diagnosis of autism were receiving adult social care and support. The number of adults with autism receiving adult social care has gradually increased year on year since 2012, as chart 3 depicts.

Chart 3: Number of adults with autism receiving adult social care
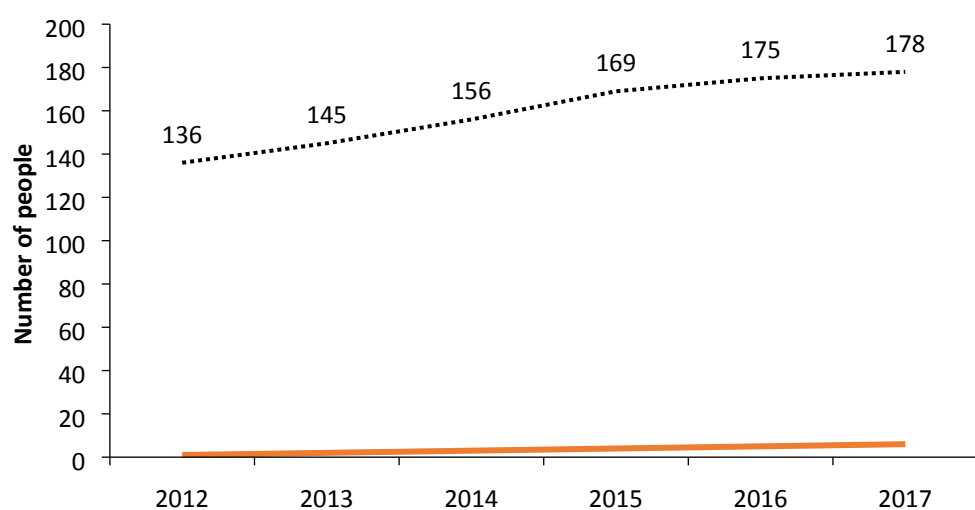
69. The number of care agreements in place ranged from one to nine per person, demonstrating varied levels of need among the group. Approximately 75% of service users were receiving at least one professional service, which may be support from social workers or health professionals. 30% were being supported in residential care, and around one quarter were receiving home care. Chart 4 displays the total numbers and types of services being delivered to service users with autism in January 2017.

Chart 4: number of care agreements among adult social care users with autism, by service type, Jan 2017
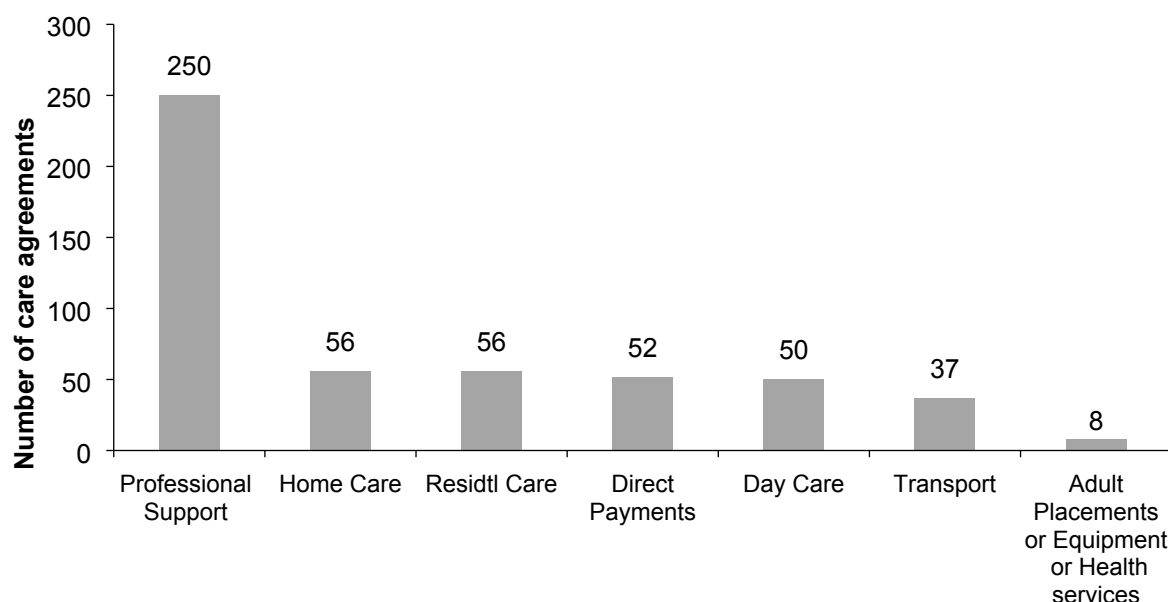
Adult mental health services

70. Merton CCG commissions South West London St Georges NHS Mental Health Trust (SWLStG) to provide adult mental health services, which deliver assessment, diagnosis and management of adults with mental health conditions. This is a universal service, and routinely cares for residents with autism and co-existing mental health needs.

71. Social workers work within SWLStG adult mental health services fulfilling adult social care functions under the Care Act 2014, for example carrying out social care needs assessments. This allows a multi-disciplinary approach to supporting people with mental health needs, including those with autism.

Support for training, employment & independent living

72. At Mitcham JobCentre Plus, a Disability Employment Advisor and work coach support people with disabilities, including those with autism, into training and employment. Merton Local Authority Employment Team for People with Learning Disabilities also offers support to adults with autism who have a learning disability.

73. The London Borough of Merton is aiming to support young people with a learning disability to be able to travel independently between home and their place of education or training. The aim is to provide young people with the skills they need to confidently travel on their own, removing the need for transport to be provided for them and supporting their greater independence. Merton Mencap currently provides this service to students attending schools and colleges in Merton (and some surrounding areas), including Cricket Green School, Raynes Park High, Ricards Lodge High, Rutlish, South Thames Crossroads and Carshalton College.

74. A new South London partnership 'Better Working Futures' programme, which is being jointly commissioned by 5 councils across South London started in Spring 2018. The programme aims to help people who have been unemployed for longer than two years, or who have struggled to get into work due to health problems or disability, into jobs. Furthermore it will also address other difficulties including a lack of basic education, debt and homelessness.

75. Merton Local Authority Library and Heritage Service provides opportunities for people with autism to participate in activities and programmes in these facilities. Library staff are trained to understand the basics of many common conditions, including autism, in order to support service users.

Services relevant to residents of all ages

Access to mainstream health services

76. As well as specialist services, people with autism need to be able to access universal services such as GP practices and hospitals. Using these services can be more difficult for people with autism. A lack of awareness amongst staff of the features of autism, and inappropriate or stressful environments are likely to be contributing factors. For example, waiting areas in hospital A&E departments are often loud, brightly lit and some staff working in these departments may be unaware of how best to communicate with people with autism. GP practice reception areas may be crowded and appointments may not run to time. Such environments may deter people with autism from using these services. Putting in place reasonable adjustments (such as booking a person with autism for the first morning appointment or booking with the same doctor) and raising awareness can ensure that people with autism are able to benefit fully from mainstream public services and live independently and healthily.

Respite & short breaks services

77. Merton's children and young people special educational needs and disabilities integrated service co-ordinate short breaks services for children and young people. The adult social care team co-ordinates short breaks services for adults and their families/carers. Eligible carers can have a break from their caring role for a few hours each week by having someone support their loved one either in a community provision or at home, or could receive an allocation of

day/overnight respite stays throughout the year. The carer can organise this support as and when they need this. Carers looking after an adult could also be entitled to a grant (of up to £100 per annum) to support their caring role, which they could use for a short break. Families with children and young people up to the age of 18, could be eligible for a short break with a focus on supporting the child's development through a recreational activity as well as providing the parent with a short break.

78. Merton Shared Lives Scheme offers an accommodation based service for adults with a learning disability or mental health issue that need some support in their everyday lives. The Shared Lives Carer provides help and support, either by sharing their own home with the client, or by offering 'floating support' by regularly visiting a service user who resides in another property.

Social prescribing

79. In 2017, Merton Partnership, the CCG and Merton Public Health jointly commissioned a pilot for social prescribing. Social prescribing is a mechanism for linking patients in primary care with non-medical sources of support within the community. The pilot is currently active in two GP practices in the east of the borough and is due to be rolled out across the rest of Merton in 2018.

80. For people with autism and their families and carers, social prescribing could help to reduce social isolation and support people with autism to access a wide range of community organisations, including sports and leisure clubs, befriending services and adult learning. Social prescribing co-ordinators are also trained to provide information and advice on housing, employment, debt and benefits, and support people with low to moderate mental health issues, including those with autism.

Voluntary sector services

81. The voluntary sector plays a key role in Merton, providing opportunities for people with autism to participate socially, particularly outside the school day, and fostering networks of local families and carers through which information and support can be shared. Merton Mencap runs Talk Autism, which provides monthly information and support sessions for parents of people with autism. Merton National Autistic Society holds monthly coffee mornings for families and carers, and is in the process of setting up regular social groups for CYP and adults with autism. Carers Support Merton, Carers Partnership Group and Merton Centre for Independent Living support residents concerning a range of needs, including autism. Merton Voluntary Service Council provides supported volunteering, befriending and training placements for young people in the borough, including those with autism.

Services in the criminal justice service

82. People with autism may be witnesses or victims of crime. They may also commit crimes and be detained. People with autism appear to be over-represented in the criminal justice system (17) (18) nationally, and national guidance highlights the importance of ensuring the needs of people with autism are met in all custodial settings and as they move between settings.

83. Merton CCG commissions SWLStG to provide assessment and support for detained young people. A CAMHS worker screens all young people receiving a youth court order, and fully assesses individuals who may have care and support needs, including due to autism.

Social, Leisure and Community Resources

84. This strategy adopts an approach that expects children and adults with autism to be able to take advantage and enjoy all that their local communities have to offer. Some local organisations are already taking steps to promote inclusion for all and reduce barriers. There are also local facilities that people with autism will be able to use along with everyone else, and this strategy will work to promote the development of community assets.

85. Examples of existing leisure activities which are autism friendly include Wimbledon Theatre's creative learning programmes and Uptown Youth Services which is run from the High Path community centre and hosts activities 3 nights a week for children with and without learning difficulties.

What stakeholders say

86. Stakeholders provide a unique and valuable insight into local challenges, priorities, and potential solutions. Information provided by local stakeholders has been critical to developing this Autism Strategy and identifying themes and priorities.

87. Initial engagement included a survey of stakeholders; a workshop involving 35 partners; presentations and discussion at community and voluntary sector groups and forums involving people with autism, parents and carers; engagement with young people with autism about the assessment and diagnosis process; presentations and discussion at health and partnership groups.

88. Stakeholder views were incorporated in the sections on priority themes that follow. Key themes that were identified from initial engagement included:

    * the need for better multi-agency collaboration;

    * the need to involve people with autism and families and carers better;

    * the need for clearer support pathways and information;

    * the need to increase staff awareness;

    * the need to create appropriate environments that enable people with autism to participate socially;

    * the need to strengthen training and employment opportunities and support;

    * the need to recognise the needs of people with autism from Black and minority ethnic groups and the needs of girls and women with autism.

89. Following the development of a draft strategy, wider public engagement took place over 6 weeks to seek stakeholders' views on the draft, identify any issues which had not been addressed and ascertain priorities for action. This engagement period involved two strands; written engagement via a structured on-line survey and paper easy-read survey; verbal engagement through facilitated feedback sessions with stakeholders including people with autism, parents and carers and professionals. 146 participants engaged in this process.

90. The feedback received was used to inform the final version of the strategy. Key issues from engagement on the draft strategy that have been incorporated in the final strategy include;

    * the need to increase awareness of autism in the wider community and promote inclusion;

    * the need to ensure our aims are achievable and set clear priorities for action;

    * the need for further emphasis on early intervention and training for front-line staff;

- the need for improved access to diagnostic services and availability of post-diagnostic support;

- the need to prioritise services which are inclusive for people with autism and enable social participation and independent living;

- the need to listen to parents and carers, whilst ensuring the voice of people with autism is still at the forefront of decision-making.

3. Priority Themes

91. The following section considers our priority themes in turn, for each describing the evidence for change, current situation in Merton, our aspirations for where we want to be and what we will do to achieve our ambitions. These are all underpinned by multi-agency local leadership and working with our resident children, young people, adults and their parents/carers.
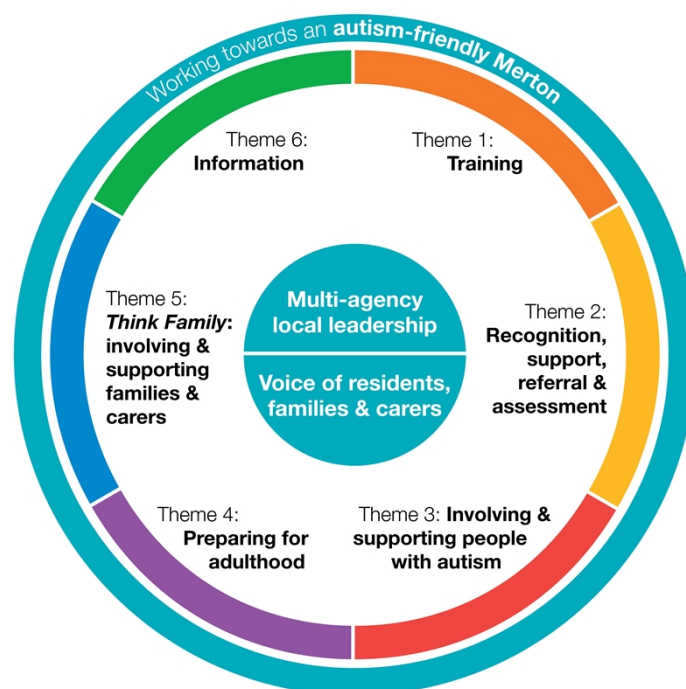
Multi-agency local leadership & the voice of residents with autism, families & carers

92. Multi-agency local leadership underpins the planning and delivery of support for people with autism in Merton. A range of services and organisations have important roles to play in making Merton an autism-friendly borough, and should therefore be involved in designing and delivering local services as well as being accountable for their commitments.

93. The voice of residents with autism and their families and carers should be central to the delivering and monitoring the strategy. In seeking the views of service users, families and carers, local organisations should be willing and able to take these views into account in designing and delivering services in line with the strategy.

Governance

94. We will establish a time-limited, multi-agency Merton Autism Steering Group, or similar, to lead implementation of the strategy and monitor progress against an action plan. The Group will include representation from the local authority, NHS, education, voluntary sector, Job Centre and engage people with autism and families and carers.

95. We will develop effective and sustainable methods for engaging with, and collecting the views of, people with autism to ensure user voice is heard and taken into account and helps drive continuous improvement.

96. Methods used to collect the views of people with autism need to take into account their specific needs. For example, some people with autism may not wish to attend meetings or focus groups and may prefer to provide their feedback via email or online questionnaire. We will therefore use a range of ways to engage people with autism and ensure we feedback to them on how their views are used to influence local plans.

Promoting equality

97. Based on evidence that many people with autism are socially and economically disadvantaged, this strategy is likely to have a positive impact on equality through seeking to address the needs of residents with autism.

98. In addition, an equality analysis detailed a number of specific opportunities to further promote equality. Table 3 summarises these opportunities and where they are addressed in the strategy.

Table 3: opportunities to promote equality		
Equality issue	**Themes where addressed**	
Age		
Early years: awareness, diagnosis and intervention in early childhood may improve long-term outcomes. Without early diagnosis, children may miss the opportunity to benefit from intervention and support.	Theme 2	Recognition, support, referral & diagnosis
	Theme 1	Training
Young adults: transition from children to adulthood is a recognised challenge and, without appropriate planning and support, young adults can face particular difficulties after they enter adult life.	Theme 4	Preparing for adulthood
Sex		
Although autism is more common in males, it has been suggested there may be under-diagnosis in females, which may lead to unidentified and unmet needs in this group.	Theme 2	Recognition, support, referral & diagnosis
	Theme 1	Training
Race		
People affected by autism from BAME communities may face additional challenges related to different cultural perspectives, varying levels of knowledge and understanding about the condition, and difficulty accessing services and information due to language or other barriers (19). This may result in some people with autism from BAME communities being particularly disadvantaged.	Theme 2	Recognition, support referral & diagnosis
	Theme 3	Involving & supporting people with autism
	Theme 4	*Think Family:* involving & supporting families and carers

	Theme 6	Information
	Theme 1	Training

99. The Steering Group and its member organisations should take joint responsibility for promoting equality by collecting data on protected characteristics of service users, interpreting the data and acting upon the findings.

Theme 1: Awareness training and support for staff and services

Evidence for change

100. Improving training around autism is at the heart of the national autism strategy '*Think Autism'*, for all public service staff but particularly for those working in education, health and social care. This includes not only general autism awareness training, but also different levels of specialist training for staff in a range of roles.

101. Staff autism training can bring wider benefits to residents with autism through increasing awareness and understanding of the condition throughout society, leading to an autism-friendly population. This applies to staff from a range of settings having access to training, including education, health and social care, transport, criminal justice and local businesses.

102. This means understanding the specific strengths of people with autism, as well as having an awareness of the core social difficulties that those with autism may face, thereby counteracting unhelpful stereotypes and prejudices.

103. Finding employment can be a challenge for people with autism, and lack of awareness among local employers about the value employees with autism can bring to the workplace may contribute to this. In addition, employers may not be aware of their duty to make reasonable adjustments for people with autism under the Equality Act 2010 (22). Autism training and education for local employers can improve the employment prospects of people with autism.

Where we are now

104. Stakeholders passionately expressed that training and raising awareness of autism is fundamental to achieving the strategy's aims of making Merton an autism-friendly borough.

105. A substantial number of education, social care and health staff across Merton regularly interact with CYP and adults with autism. Many have received training to raise their awareness and understanding of the condition.

106. Merton Local Authority offers free autism awareness training to all education, health and social care employees. In addition, the council has delivered training to other local practitioners including providers of adult social care services and GPs. Local NHS Mental Health Services (SWLStG) have established 'Autism Champions' throughout the trust to increase awareness among staff.

107. Training helps increase staff knowledge of local services available and how to refer, enabling them to seek timely, appropriate support for service users. Stakeholder feedback has highlighted the need for more routine training for relevant education, health and social care staff to increase autism awareness and knowledge of local support available. This could lead to earlier diagnosis and intervention, reduced risk of under-diagnosis in females, improved equality, and higher quality support provided more consistently across Merton.

108. Many stakeholders feel training should be co-developed with people with autism, quality-assured and evaluated to measure its impact and enable improvement over time.

109. Stakeholders identified the following key groups for autism training; employers, children and young people and front line staff in schools and health settings.

Where we want to be

Merton is committed to being an autism-friendly borough in which:

110. The general population are aware of autism and have a basic level of understanding of the condition. This contributes to people with autism feeling understood, accepted, having equal opportunity to live independently and participate socially.

111. All education, health and social care staff are aware of autism, understand the importance of recognition and referral, and know where to go for more information.

112. Staff working with CYP or adults with autism have a more in-depth understanding of the condition, its related equality issues, and local services available. This enables them to provide high-quality support.

113. Local employers understand the value people with autism can bring to the workplace and ensure residents with autism have equal opportunity to gain and stay in fulfilling employment.

114. People with autism interacting with the criminal justice system are treated appropriately by staff who understand the condition and know how to access additional support where necessary.

How we will get there

In the first year we will:

115. Deliver a new programme of autism training for CYP workforce. This will include targeted training for Early Years workforce on recognising the signs of autism, including recognition in girls, to enable early intervention.

116. Deliver general awareness training for wider CYP workforce, including education, health, social care and third sector. This will include anxiety and sensory training.

117. Develop and deliver training to SENCO's and key staff to ensure that CYP in mainstream settings receive appropriate support and access to the curriculum.

118. Utilise the existing early-years accredited SENCO training programme

119. Utilise training packages which have been co-developed with people with autism and their families and carers e.g. NAS accredited training.

120. Review opportunities and seek funding to educate children and young people about autism and identify champions.

Over the life of the strategy we aim to:

121. Work towards all NHS and Merton Local Authority staff undertaking autism awareness training as part of general induction and equality training.

122. Seek opportunities to deliver training to GP's and health professionals in recognising and managing co-existing mental health issues in people with autism e.g. ADHD/anxiety.

123. Promote uptake of autism awareness training among local employers. This training should include information about employers' duty to make reasonable adjustments for people with autism under the Equality Act 2010.

124. Explore how social care staff can be better supported when working with people with autism with very complex needs.

125. Work with the Police and encourage work with partners to deliver training to relevant staff groups.

Theme 2: Recognition, support, referral & assessment

Evidence for change

126. We know that the earlier autism is identified, the better the outcomes. We therefore need to ensure that the wider community as well as those working with people with autism are aware of the signs of autism and the local pathways for diagnosis and assessment for people of all ages.

127. NICE highlight that an autism diagnosis and assessment of needs can offer an understanding of why a child or young person is different from their peers. It can open doors to support and services in education, health and social care, and a route into voluntary organisations and contact with other children and families with similar experiences (20). All of these can improve the lives of the child or young person and their family. Access to support should not however, be dependent on a diagnosis and should be guided by need.

128. NICE publish guidelines for recognition, referral and assessment for 0-19's and for adults. The guidelines include the following recommendations;

- Improving early recognition of autism by raising awareness of the signs and symptoms of autism through multi-agency training.

- Making sure the relevant professionals (healthcare, social care, education and voluntary sector) are aware of the local autism pathway and how to access diagnostic services.

- Formation of a multi-disciplinary 'local autism team' who have the skills and capabilities to carry out an autism diagnostic assessment, and communicate with children and young people and adults with suspected or known autism, and with their parents and carers, and sensitively share the diagnosis with them.

- People having a diagnostic assessment for autism should also be assessed for coexisting physical health conditions and mental health problems.

129. Additionally, the guidelines for recognition, referral and assessment for 0-19's recommend;

- An autism diagnostic assessment should be started within 3 months of the referral to the autism team.

Where we are now

130. Earlier identification and diagnosis among CYP has been highlighted by stakeholders as a local priority, since early intervention may improve long-term outcomes (21).

131. Demand currently exceeds capacity and waiting times have been lengthening inappropriately. Added to this, the current process is not currently NICE compliant so the pathway needs significant revision.

132. This position has led to a number of workshops and 'listening events' with parents and commissioners about how the needs of CYP, particularly those seeking an assessment and diagnosis without specific mental health needs, can best be met.

133. Some local stakeholders are concerned that there is a lack of awareness among local staff and residents around the routes to diagnostic assessment for adults. This may prevent adults receiving appropriate assessment and support. A lack of post-diagnostic support was also raised during stakeholder engagement.

134. Stakeholders have fed back that access to support should be on the basis of need and there should be wider awareness that you do not have to wait until a diagnosis has been made to access support.

135. Additional opportunities to promote equality in recognition, referral and diagnostic services include taking steps to reduce the risk of under-diagnosis in females and considering the needs of people from BAME backgrounds.

Where we want to be

Merton is committed to being an autism-friendly borough in which:

136. All people are treated with sensitivity and respect by staff with the right skills and understanding and are able to access universal and other services appropriately.

137. Assessment takes place in a timely manner, particularly for children, where effective early intervention may improve long-term outcomes.

138. Pathways to autism assessment, diagnosis and support are clear, published and equally accessible to all residents where needed.

139. Assessments are efficient and high-quality, conducted by multi-disciplinary teams, build on assessments which have already been conducted and meet NICE quality standards (QS51).

How we will get there

In the first year we will:

140. Work together to redesign local referral, assessment and support services to meet the needs of children and young people (and their parents or carers) who may need a diagnosis of autism.

141. Create an assessment, diagnosis and support pathway for CYP 0-18 year olds, which is easily understood by referrers, parents, and (as appropriate) by children and young people, where assessment and diagnosis is available to those who need it but not a requirement to accessing support.

142. Promote autism champions in all education settings to raise awareness amongst staff, enable early identification of autism and ensure that staff provide appropriate support.

143. Raise awareness of the diagnostic pathways for adults with autism through a published pathway and training of professionals.

Over the life of the strategy we aim to:

144. Ensure the newly designed pathway for CYP 0-18 is fully embedded, has sufficient capacity to meet demand and work towards quality that complies with NICE guidelines.

145. Audit the new pathway against NICE autism quality standard (QS51), using this as a tool for continuous quality improvement.

146. Use the SEN Quality Assurance framework to ensure that staff provide appropriate support.

147. Engage staff and clients of adult services to explore options for post-diagnostic support

Theme 3: Involving & supporting people with autism

Evidence for change

149. Autism is a spectrum disorder, meaning that different people will be affected in different ways, and therefore will require differing levels of support throughout life. For example, some CYP may only need help to understand a diagnosis, others may need a one-off service, whereas others will need more enhanced support at various ages, stages, transitions or life events. A small number will need on-going intensive education, health and social care support.

150. The 2014 Care Act states that local authorities must involve individuals (including those with autism and their carers) when carrying out certain care and support functions in respect of them, such as when conducting needs or carers assessments, preparing care and support, or support plans.

151. Employment among adults with autism is low nationally (1), and supporting adults with autism into training and employment is a key priority highlighted in statutory guidance and NICE guidelines. In 2017, fewer than one in twelve Merton adult social care users with autism were recorded as being in any type of work, including unpaid and paid work.

Where we are now

Supporting CYP through education, health & social care

152. Merton's CYP with autism attend different types of education provision as appropriate for their needs. Certain types of specialist provision are only available out of borough. For example, a small yet significant group of CYP are in residential placements, which may be for education, health and social care needs, these provisions are out of borough and are often independent establishments. In line with Merton Council's Special Educational Needs and Disabilities (SEND) place planning, keeping CYP closer to home is a key priority for the borough.

153. The current SEND Placement Planning is taking into account the increase in autism and we are expanding capacity in both Cricket Green and Perseid schools and reviewing our ARP's with the view of expansion.

154. The importance of life skills training for CYP with autism is recognised. Such training can help people with autism manage unknown situations, in turn enabling them to live more independently, particularly after they transition into adulthood.

155. Some CYP with autism will meet the criteria for a Short Break. There are different levels of Short Breaks to meet the different needs of CYP with a disability and their families/carers which include Universal, Targeted and Specialist Services. Merton's Short Breaks Services Statement can be found on the Local Offer.

Supporting adults through education, health & social care

156. The majority of adults with autism in Merton will have needs that do not reach the threshold to receive adult social care support. Stakeholder engagement identified the need to consider

opportunities to support all adults with autism to live independently and participate in society, regardless of their eligibility for adult social care. This includes wider aspects of life such as employment services, social and leisure activities, peer support and advocacy, and appropriate physical environments. Support in these areas also contributes to a preventative approach, increasing resilience and independence, with the aim to reduce demand for social care and crisis intervention.

157. Stakeholder engagement has highlighted the need to improve the social care needs assessment pathway for adults with high functioning autism, in order to improve the experience of those waiting for assessments and strengthen efficiencies in the referral and assessment process. Stakeholders have identified the need to clarify responsibilities of different teams.

158. Merton Council Adult Social Care service supports a number of adults with autism in residential care. Concerns have been expressed that there may be an over-reliance on residential support, which may limit the individual's ability to live independently and participate in social and family life. In January 2017 this represented the largest social care cost among service users with autism (excluding the cost of professional support).

159. An Autism Trust Lead at SWLStG works to ensure CYP and adult mental health services are autism-friendly. Every clinical team in the trust has an 'Autism Champion' with responsibility for raising awareness of autism among staff and ensuring the individual needs of people with autism are taken into account during their care. In addition, the Trust has a system for making staff aware when a person with autism is under their care to ensure reasonable adjustments are made.

Supporting adults into employment

160. A key challenge for people with autism seeking employment has been identified as a lack of understanding among employers of the positive impact people with autism can have in the workplace. Suggested approaches to address this include engaging local employers and promoting autism awareness training, utilising the new Better Working Futures programme and promoting the government's Disability Confident scheme among local businesses.

Wider settings that support CYP & adults

161. Merton's libraries and voluntary sector provide wider social and educational opportunities that can support people with autism to live independently and participate socially. Many stakeholders have suggested it would be valuable to build on or expand existing services to increase the breadth and capacity of support available for CYP and adults with autism. Suggestions include expanding peer support and advocacy networks such as Autism First, leisure activities, traineeships and volunteering schemes, alert-card schemes and social prescribing, which is currently being developed more widely in Merton.

Joined-up services

162. A number of local services across a range of organisations support residents with autism. Local stakeholders have suggested more joined-up working between relevant organisations could help to improve awareness and access the range of services in a coordinated and timely way (see also Theme 6: Access to Information).

Where we want to be

Merton is committed to being an autism-friendly borough in which:

163. Merton CYP with autism are able to access appropriate, effective interventions in a timely manner, including in, and out of, school support.

164. All residents with autism (diagnosed or undiagnosed) can access appropriate support to participate socially and live independently. This includes ensuring autism-friendly leisure and social opportunities are available, supporting adults into training and employment, and preventing people going into residential care where possible.

165. Residents with autism are involved in the planning of their own support and care, and actively involved in co-creating local services.

How we will get there

In the first year we will:

166. Develop a plan for communication and engagement with people with autism over the life-course of the strategy, which links with existing forums e.g. the SEN user voice forum.

167. Regularly engage and seek feedback from people with autism on the priorities within this strategy, and its implementation to frontline services.

168. Finalise and publish a protocol outlining social care needs assessments of adults with 'high-functioning' autism.

169. Develop a support offer for people with autism and complex needs, with early co-ordinated multi-disciplinary support, including transition from children to adult services.

170. Promote the new South London partnership 'Better Working Futures' programme, which helps people with a disability or those who have been out of work for a period of time to find and maintain work.

171. Promote the government's Disability Confident scheme among local organisations and businesses.

172. Work with the voluntary sector to develop a support offer for adults with autism with intermittent, lower level needs. This may include advocacy and advice services, peer support, volunteering programmes, social prescribing etc.

173. Increase the number of places within Specialist Maintained schools and additionally resourced provisions so that CYP with Autism can be educated locally.

174. Evaluate costs of additional life skills training in schools for CYP with autism.

Over the life of the strategy we aim to:

175. Promote co-production amongst organisations re-commissioning or delivering new services that support people with autism, and take steps to promote equality.

176. Encourage relevant services, including health services, education settings, libraries and transport providers, to consider how their physical environments may be improved to better meet the needs of people with autism.

177. Ensure there is equal access to housing options for people with autism.

Theme 4: Preparing for adulthood

Evidence for change

178. Supporting young people as they prepare for adulthood, including those who transition between children's and adult services is a key priority nationally and locally. Preparing for adulthood is however a recognised challenge. Differing eligibility criteria between children's and adult services is believed to contribute to some of the difficulties that can arise.

179. Advanced planning and coordination of care, is a means of ensuring young people's needs are identified and, where appropriate, plans are put in place to meet these needs as young people move into adult life. However, the majority of CYP with autism in Merton will not be eligible for adult social care services, and transition planning needs to focus on the development of independence as young people move towards adulthood.

180. NICE set out a number of key recommendations in relation to those young people who are eligible for transition to adult services. These include:

- Local autism teams should ensure that young people with autism who are receiving treatment and care from child and adolescent mental health services (CAMHS) or child health services are reassessed at around 14 years to establish the need for continuing treatment into adulthood.

- If continuing treatment is necessary, make arrangements for a smooth transition to adult services and give information to the young person about the treatment and services they may need.

- As part of the preparation for the transition to adult services, health and social care professionals should carry out a comprehensive assessment of the young person with autism.

- Involve the young person in the planning and, where appropriate, their parents or carers and provide information about adult services.

Where we are now

181. The current provision of transition assessments for young people with an EHCP, or CYP known to the council's Children with Disabilities (CWD) Social Care team are detailed in the 'current services and access to support' section of this document.

182. Most young people with autism will not be eligible for adult social care services. As such, stakeholders feel that a key role of transition planning needs to be to enable people with autism to make informed choices as they move from children's to adults services.

183. Local stakeholders have identified that transition planning needs to have more of a focus on developing independence, through post-16 education opportunities, life skills training, travel training and housing support. Some examples of this kind of support already exist in Merton and are detailed in section 2, page 20.

184. Engagement identified that young people felt that it is easy to pigeon-hole young people with autism into specific courses or programs designed for SEND and this is sometimes limited in its offer. They felt more should be done to either increase the offer of subjects available in SEND provisions or further enable inclusion into mainstream courses.

Where we want to be

Merton is committed to being an autism friendly borough in which:

185. Preparing for adulthood is a priority, and there are systems in place to ensure young people's needs are met as they move into adulthood. This should be the case whether or not the person with autism has social care needs.

186. There will also be a focus on supporting independent living, maintaining good health in adult life, and participation in society.

187. CYP with autism and their families and carers feel well informed regarding the transition from children's services to adulthood including the difference in eligibility criteria between children's and adult services, and are given advice on where to go to access further information about services available to them.

188. There are a range of services available and published in our 'local offer', to support CYP as they prepare for adulthood, and these services are easily accessible. Examples include life skills development, housing support and support with employment.

189. The expectation is that the EHCP will serve as the coordinating plan for young people with the highest levels of SEN up to the age of 19, by which time planning for their adulthood in terms of employment, care, health and community involvement should be secure. Between the ages of 16 and 19 the SEN team will identify education and training outcomes that support employability. Some of these outcomes may need to continue after the young person reaches the age of 19.

190. As young people with an EHCP move into adulthood it will be important to support their aims for employment and training, for independent living, for good health and community involvement.

How we will get there

In the first year we will:

191. Maintain our ambition for all CYP with special educational needs and disability and recognise the importance of ensuring a smooth transition to adulthood for such children and young people.

192. For those with the most complex needs, we will continue our commitment to providing an integrated approach across education, social care and health to ensure a smooth transition into adult services.

193. Ensure transition assessments are structured and use a framework such as the national *Preparing for Adulthood* framework.

194. Ensure assessments involve the CYP and their families, and provide clear and comprehensive information to enable CYP and their families and carers to make informed choices as they move from children's services to adulthood.

Over the life of the strategy we aim to:

195. Develop a new programme of work experience within the council for vulnerable cohorts, including those with autism.

196. Work with further education colleges to increase understanding of the needs of CYP with autism in further education and to improve their access to support.

197. Work with schools, libraries and adult education to explore their potential for providing more life skills training for young people with autism e.g. interview training, extended work experience opportunities, financial management training and cooking classes.

Theme 5: Think Family: involving & supporting families & carers

Evidence for change

198. *Think Autism* highlights that 'Local Authorities should ensure that their local Autism Strategies are linked to local carer's strategies (or equivalent). Involvement of self-advocates and family carers directly is essential to support a joined up approach across the strategies.'

199. The availability of in-home support that complements parenting programmes and in-school services is a priority area for local families and carers and other key stakeholders. Interventions such as video interaction guidance (VIG) and outreach services can support people with autism and families and carers in their home and outside of the school day, thus widening support.

200. Merton CCG, in partnership with Merton Mencap, has recently undertaken a review of the views of parents and carers of CYP with autism on family support needs. The results of this work will inform future commissioning.

Where we are now

201. Local engagement has highlighted that families and carers would like to be more involved in decision-making about the care and support their loved ones receive, and contribute to shaping local services. This would enable them to feel reassured that their relatives will receive high-quality long-term support and mean local services are designed with the needs of people with autism, and their families and carers, at the centre.

202. In Merton several parenting programmes and child development programmes help parents and children with autism to interact and develop communication and social skills. This includes universal, targeted and specialist support services delivered in a range of settings (Children's Centres, childcare, early education provision and the family home). Parents and carers did however feel that parenting programmes need to be more widely available, recognising that parental understanding is key to improving outcomes for children with autism.

203. Stakeholders felt there is a need to recognise the emotional challenges associated with being a parent/carer of someone with autism, and the impact on the wider family. It was suggested that counselling or peer-support should be promoted and utilised to address these needs.

204. Families and carers value the opportunity for short breaks, and feel there is a need locally for a better continuum for support.

205. A number of voluntary sector services support families and carers by fostering peer networks through which members can support and learn from each other. Family and carer representatives have emphasised the value these peer networks offer, and have suggested families and carers would benefit from greater access to peer support and advocacy.

206. Families and carers also feel a key priority is having access to clear, comprehensive, up-to-date information about the local services and resources available. This is addressed in Theme 6: Information.

207. Stakeholders also noted that some families and carers from BAME backgrounds may face additional challenges due to varying levels of knowledge and understanding of the condition, stigma and difficulties accessing services and information.

Where we want to be

Merton is committed to being an autism-friendly borough in which:

208. Families and carers of people with autism are informed and involved in making decisions about the care and support of their loved ones and contribute to designing local pathways and services.

209. Families and carers have ready access to information, advice, advocacy and peer support networks.

210. Safe and high-quality support services for carers and families are available (subject to assessed needs) and parents are guided to those that best meet their needs.

211. Wherever possible interventions/programmes are evidence based to ensure effectiveness of the support offered to parents.

How we will get there

In the first year we will:

212. Produce clear information about local parenting support as part of the 'local offer'.

213. As part of the development of the CYP 0-19 assessment, diagnosis and support pathway, we will work with partners to identify resources to increase the availability of parenting programmes on offer in the borough-particularly for those with children over 8 years old.

214. Promote support available to carers of adults with autism and the 'Thinking Ahead' plan.

215. Promote co-production amongst organisations re-commissioning or delivering new services that support families and carers of people with autism.

Over the life of the strategy we aim to:

216. Explore opportunities for improving the availability of counselling and emotional support for parents and carers of people with autism. This could include raising awareness of the Merton IAPT service or supporting autism champions to facilitate peer support groups for parents.

217. Look for opportunities to increase training for staff in evidence based interventions, such as 'video interaction guidance' (VIG).

Theme 6: Access to information

Evidence for change

218. Statutory guidance states; 'It is important that parents, young people and adults with autism can access information that is relevant to them to help them make choices about the type of support they can receive.' (12)

219. In addition, Section 4 of the Care Act 2014 states that 'it is important that all people with autism, whatever their level of need, can easily access information in their local area about what support from peers, charities or other community groups is available.'

220. For staff working in local services, better information may assist them to make appropriate referrals and more effectively support people with autism. This applies to professionals working in health, education, social care and the criminal justice service, who cite access to information as a key priority, as well as staff who may interact with people with autism in wider settings, such as transport and local businesses.

Where we are now

221. Following SEND reforms resulting from the Children and Families Act 2014 and changes to the SEND code of practice 2015, Merton Local Authority provides the 'local offer', an online resource containing information for residents, families, carers and key stakeholders about the local services available for CYP with special educational needs and disabilities.

222. A wealth of local knowledge exists among Merton staff and residents, and facilitating information sharing could benefit many people affected by autism in the borough, particularly parents of children newly diagnosed.

223. There are a number of valuable services and resources available for people with autism and their families and carers in Merton. However, stakeholders have identified the need to improve access to clear, comprehensive information about these services and how they can be accessed.

224. It is possible to search for autism-specific services on the 'local offer' website, however there is a need to ensure the information in the 'local offer' is easy to understand, up-to-date and that local people know it exists and how to find it.

Where we want to be

Merton is committed to being an autism-friendly borough in which:

225. Merton staff and residents can access easy to understand, comprehensive, up-to-date information that is available via a single location online (as well as other formats where appropriate).

226. Relevant staff and residents know where to go for information.

227. Key groups, including people with autism and family/ carer organisations, can share their local knowledge and resources with the community.

How we will get there

In the first year we will:

228. Develop an all-services, electronic information hub to provide a single place for information about local services and resources relevant to autism, including the local SEN offer.

229. When producing information, stakeholders will consider its accessibility in terms of clarity (easy-read), whether translations into non-English languages are required, and whether cultural factors have been taken into account, seeking to ensure information is widely accessible.

Over the life of the strategy we aim to:

230. Hold an 'autism fair' to promote autism-friendly services and activities in the borough and increase wider awareness.

231. Explore opportunities for a system to enable key groups, including people with autism and their families/ carers, to share local information with the community. This may involve partnership working with local voluntary sector organisations.

4. Governance and delivering the strategy

232. A time-limited Merton Autism Steering Group, or similar, will be established to oversee the strategy and implementation of an action plan. A range of agencies will be represented on the Steering Group including senior commissioners, managers and practitioners, as well as people with autism and families/ carers.

233. An action plan has been developed for the life of the strategy and reviewed annually. This sets out timescales and leads for implementing actions and expected benefits and outcomes.

234. The Steering Group will monitor progress against the action plan, and report to Merton Children's Trust Board and the Health and Wellbeing Board.

235. The delivery of the strategy is based on working in partnership to use resources within the system more effectively in order to achieve our ambitions to develop '*an Autism friendly borough, where people with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them*'. We will also look to enhance delivery by seeking opportunities to lever in additional resources to the borough.

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Glossary

ARP	Additional Resourced Provision	School which has been given extra funding to support children who have additional learning needs, including speech, language and communication difficulties.
ASC	Autism Spectrum Condition	
ASD	Autism Spectrum Disorder	
Autism Champion		Staff member or person who has been given autism training and can cascade this learning to a wider group.
BAME	Black, Asian and Minority ethnic	used to refer to members of non-white communities in the UK
CAMHS	Child and Adolescent Mental Health Services	CAMHS are the NHS services that assesses and treat young people with emotional, behavioural or mental health difficulties.
Care pathway		A 'Care Pathway' describes the process of best practice to be followed in the care and support of a patient or group of people with a particular condition.
CBT	Cognitive Behavioural Therapy	Cognitive behavioural therapy (CBT) is a talking therapy that can help manage problems by changing the way people think and behave. It is most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems
CCG	Clinical Commissioning Group	Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
CWD team	Children with Disabilities team	The Children with Disabilities service supports children up to the age of 18 who have learning disabilities, a physical or sensory impairment or who have particular mental health difficulties
CYP	Children and Young People	
Diagnosis		Identification or recognition of a disease or condition

EHCP	Education, Health and Care Plan	An education, health and care plan (EHCP) is for children and young people aged up to 25 who need additional special educational provision to meet their special educational needs than is from SEN support.
High-functioning autism		High-functioning autism (HFA) is a term sometimes applied to people with autism who are deemed to be cognitively "higher functioning" (with an IQ of 70 or greater) than other people with autism. High-functioning autism and Asperger syndrome are often used interchangeably.
Life course		A person's whole life
Local offer		Information about support and services for children and young people with Special Educational Needs and disabilities and their families
MAOS	Merton Autism Outreach Service	Merton Autism Outreach Service (MAOS) supports the inclusion of pupils with Autism Spectrum Disorder (ASD) and Social Communication Difficulties in mainstream settings.
NAS	National Autistic Society	The leading UK charity for autistic people (including those with Asperger syndrome) and their families.
NICE	National Institute of Health and Care Excellence	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care
Reasonable adjustments		Employers have a duty to change their procedures and remove barriers that people with disabilities could face. The Equality Act 2010 calls this the duty to make reasonable adjustments
SaLT	Speech and Language Therapy	The care, support and treatment for children and adults who have difficulties with communicating, eating, drinking and swallowing.
SEND	Special Educational Needs and Disabilities	
SWLStG	South West London St Georges Mental Health Trust	NHS mental health trust
VIG	Video Interactive Guidance	A tool to enhance communication and relationships by recording interactions and reflecting on the positive attributes.

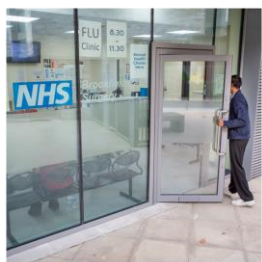This page is intentionally left blank

Merton Autism Strategy Easy Read

This is a plan to make life better for people with autism in Merton. This plan is for children, young people and adults with autism and Asperger syndrome

Why do we need a plan?

We want Merton to be a friendly place to live for people with autism and Asperger syndrome.

We want to make it easier to find out if you have autism, and easier to get help and support if you want it.

We want all people with autism to feel included.

We want everyone in Merton to know about the things that people with autism are good at, as well as the things people with autism might find difficult.

We want to make things better at school for children with autism, and make it easier for people with autism to get a job and live where they want to live.

What is autism

Autism is a condition that lasts your whole lifetime. It affects how you understand other people and how you make sense of the world.

Everyone with autism is different. Some people with autism find these things difficult:
- understanding other people and telling people how they feel
- meeting new people and making friends
- being in loud places or where there are bright lights and lots of people

Some people with autism will be very good at these things
- understanding numbers and patterns
- thinking creatively and solving problems
- remembering things

About one out of every 100 people has autism.

Part 1: Teaching people about autism

Teaching people about autism helps them to understand the problems that some people with autism might have. It also helps them understand the good things about autism.

What we plan to do

Train doctors, nurses, social workers, teachers and children about autism, so they can help support people with autism in a better way.

Offer autism training to employers (owners of businesses), so that they know about the things that people with autism are good at and make it easier for people with autism to get a job.

Encourage autism 'champions' in all schools to help other teachers when they are working with people with autism.

Part 2: Finding out if you have autism

Finding out if you have autism can be helpful for some people. You can have an assessment to check if you have autism and this can help you to get the right support.

We want to make it quicker and easier for children and adults to find out if they have autism.

We want to make sure everyone can get help if they are having problems with autism, even if they don't know that they have autism yet.

What we plan to do

Make a new 'pathway' for children who want to find out if they have autism.

Make sure this new pathway is clear, and makes it quicker for children to find out if they have autism, with help and support along the way

Make it clearer for adults to find out if they have autism

Make sure doctors, social workers and teachers know about autism and how people can find out if they have autism.

Part 3: Involving and supporting people with autism

Everyone with autism is different. We want to make sure that people with autism get the right help at the right time.

We want people with autism to be involved in decisions about the help they get.

We want to make it easier for people with autism to join in with social activities and get a job if they want one.

What we plan to do

Ask people with autism to help us to make services that will work better for them

Make it easier for adults to find out if they have autism and get help from social services if they need it

Teach more people about autism, so that they know about the things people with autism are very good at, and the things they might find difficult.

Work with charities to make it easier for people with autism to take part in social activities

Part 4: Helping young people with autism as they grow up

Growing up can be difficult for young people with autism

What we plan to do

Make sure that children's services and adult services share information so that people with autism can move easily from one service to the other if they need.

Make sure young people with autism are involved in decisions about what happens as they get older

Make sure that young people with autism have the option to continue learning if they choose to, get a job or live on their own as they get older.

Make sure that children with autism and their families and carers know about the services that will be available to them as they grow up.

Part 5: Supporting the carers and families of people with autism

We want to make things better for the carers and families of people with autism

What we plan to do

Make sure there is clear information for carers and families about where they can get support

Ask carers and families to help design new services for people with autism

Increase the number of services which help parents and carers in the borough and make it easier for parents to use them

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Part 6: Information

We want to make it easier for people with autism to find out what help and support they can get.

We also want doctors, social workers and teachers to know more about where people with autism can go to get help.

What we plan to do

Make the 'local offer' better and keep it more up-to-date. The 'local offer' is a website which tells you what services there are in Merton for people with special needs, including autism.

Make sure that information for people with autism is easy for people with autism to understand, including people with autism who do not speak English.

Find a way for people with autism to share their knowledge with other people in the local community.

Next steps

We will make a group of people, including people with autism, who will be in charge of making sure that this plan happens over the next 5 years.

Get in touch

Public health team
3rd floor
Civic Centre
London Road
SM4 5DX

0208 5454 396

Public.health@merton.gov.uk

This easy read booklet about your information was made by the London Borough of Merton.

Merton Autism Strategy 2018-2023

Action Plan

June 2018

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Introduction

This Action Plan sets out priorities over the life of the Merton Autism Strategy 2018-2023. This has been shaped by the responses to the public engagement on the strategy and should be read in conjunction with the Autism Strategy document.

In the first year of the Strategy 2018/19 the focus is on starting to deliver the priorities which have been highlighted in the plan, these include:

- Action 1.1: Improve the local training and awareness offer, including delivering a training programme for CYP workforce
- Action 2.1: Redesign and improve the assessment, diagnosis and support pathway for 0-18 year olds
- Action 2.2: Raise awareness of the diagnostic pathway for adults
- Action 2.3: Promote autism champions in all education settings
- Action 3.1: Improve customer journey in adult health and social care for adults with autism
- Action 3.2: Ensure people with autism and parents/carers are actively involved in co-designing and delivering services
- Action 3.3: Improve employment opportunities for people with autism
- Action 3.4: Improve opportunities for people with autism to participate socially
- Action 3.5: Increase the number of places within specialist and additionally resources educational provision
- Action 4.1: Improve the quality of transition assessments
- Action 5.1: Identify resources to increase provision of parenting programmes
- Action 5.2: Ensure families and carers are involved in the co-design and delivery of services
- Action 6.1: Improve quality and accessibility of information available to people with autism and their families/carers

Other actions set out in the plan will be developed over the life of the strategy and this action plan will be reviewed and updated on an annual basis.

Progress on delivering this action plan will be monitored through existing partnerships (including the CAMHS Partnership, Preparing for Adulthood Partnership and Adult Mental Health Programme Board). In the first year an Autism Partnership steering group will be established to provide leadership and oversight, this will report to the Children's Trust Board and Health and Wellbeing Board.

Theme 1: Awareness training and support for staff and services

No.	Objective	Action	Timescale/When completed	Organisation/ lead	Expected Outcome/benefit

1.1	Improve local awareness and training offer.	**2018-19 Priority:**
		
		• Deliver new autism awareness training programme aimed at wider CYP workforce, including:
		
		   • Early Years workforce – early recognition and response
		   • General awareness: wider CYP Workforce including health, education, social care and third sector professionals, with a specific focus on social workers
		   • understanding parent experience and strategies to support CYP workforce
			July 2019	LBM/MCCG
				
				Claudia Tomlinson/ CAMHS programme officer
					Staff working with people with autism are better equipped to carry out their roles.
					
					Improved quality of care for people with autism.
					
					Reduction in anxiety/poor outcomes/crisis intervention.

		• Develop and deliver training to SENCO's and key staff to ensure that CYP in mainstream settings receive appropriate support and access to the curriculum	December 2019	Karla Finikin/Keith Shipman	Increase understanding of autism and inclusion of CYP with autism in schools
		• Utilise the existing early-years accredited SENCO training programme	December 2018	Allison Jones	
		• Review opportunities and seek funding to educate children and young people about autism.	December 2019	Karla Finikin/Elizabeth Fitzpatrick/Keith Shipman	

		• Explore how social care staff can be better supported when working with people with autism with very complex needs.	April 2019	Paul Angeli/Phil Howell	Ensure people who come into contact with autism, including elected members, are properly trained to understand it.
		• Deliver a training session for LBM elected Members on autism.	December 2019	LBM C&H & CSF	
1.2	Improve autism awareness in the wider population.	• Promote uptake of autism awareness training among local employers.	December 2018	DWP Ayda Al-Deweiny	Increase in employment opportunities and financial independence.
		• Seek opportunities to deliver training to GP's and health professionals in recognising and managing co-existing mental health issues in people with autism e.g. ADHD/anxiety.	April 2019	MCCG Patrice Beveney	Improve recognition and management of mental health issues.
		• Work towards all NHS and Merton Council staff undertaking autism awareness training as part of general induction and equality training.	April 2020	Learning and development teams	Improved every day experiences and quality of life for people with autism.
		• Work with the Police and encourage work with partners to offer training to relevant staff groups.	April 2019	LBM E&R Neil Thurlow	
1.3	Involve people with autism in the development of training	• Utilise training packages which have been co-developed with people with autism and their families and carers e.g. NAS accredited training	Ongoing	All	

Theme 2: Recognition, support, referral and assessment

No.	Objective	Action	Timescale/When completed	Organisation/ Lead	Expected outcome/benefit
2.1	Improve the assessment, diagnosis and support pathway for 0-18 year olds, ensuring there is capacity to meet demand. Ensure service users and families/carers are involved in service re-design.	**2018/19 Priority:** • Redesign local referral, assessment and support services to meet the needs of children and young people (and their parents or carers) who may need diagnosis of autism. • Develop 5 Year milestones plan for achieving NICE guidelines compliance. • Incorporate findings from 'Exploring the diagnostic experiences of Merton young people who have ASD' paper and additional engagement exercises in diagnostic pathway re-design. • Ensure there is awareness that support begins when need identified and patients do not need to wait for diagnosis to access support.	April 2019	MCCG/ LBM Claudia Tomlinson CAMHS Partnership	Improved experiences for service users in accessing assessment and diagnostic services. Increased support for those waiting for diagnosis, or those who chose not to have a diagnosis.
2.2.	Raise awareness of diagnostic pathway for adults.	**2018/19 Priority:** • Publish and promote awareness of diagnostic pathway for adults with a learning disability.	April 2019	Learning Disability Health Team and SWLSTG diagnostic ASD Team/CCG	Improve experience of adults seeking diagnosis. Improve awareness of adults with autism amongst professionals and wider society.

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		• Publish and promote awareness of diagnostic pathway for adults that have no prior diagnosis.		SWLSTG & MCCG Patrice Beveney	
2.3.	Raise awareness of autism amongst staff in educational provision Support earlier identification of autism	**2018/19 Priority:** • Promote autism champions, who may be pupils, in all education settings to raise awareness amongst staff and enable early identification of autism. • Use the SEN quality assurance framework to ensure that staff provide appropriate support.	April 2019 On-going	LBM CSF Karla Finikin Allison Jones Elizabeth Fitzpatrick	Earlier identification of autism leading to improved outcomes for CYP Staff are adequately trained to identify and support CYP in education settings.
2.4	Ensure new pathway is NICE compliant by 2022.	• Ensure the newly designed pathway for CYP 0-19 is fully embedded, has sufficient capacity to meet demand and work towards quality that complies with NICE guidelines. • Audit the new pathway against NICE autism quality standard (QS51), using this as a tool for continuous quality improvement.	December 2022 Annually	MCCG/LBM Claudia Tomlinson CAMHS Partnership	0-19 Pathway meets quality standards.
2.5	Improve post-diagnostic support for adults.	• Engage staff and clients of adult services to explore options for post-diagnostic support.	December 2021	MCCG Patrice Beveney	

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Theme 3: Involving and supporting people with autism

No.	Objective	Action	Timescale/When completed	Organisation/lead	Expected Outcome/benefit
3.1	Improve customer journey in adult health and social care for adults with autism.	**2018/19 Priority** • Finalise and publish a protocol outlining social care needs assessments for adults with 'high-functioning' autism and support pathways available through services including the voluntary sector. • Improve service development by mapping customer journey through health, adult social care and SWLSTG. • Develop a support offer for people with autism and complex needs, with early co-ordinated multi-disciplinary support, including transition from children to adult services.	December 2018 April 2019	LBM C&H David Cafferty/Phil Howell David Cafferty, Phil Howell, SWLSTG Jennifer Lewis-Anthony Paul Angeli/Phil Howell	Increase numbers of adults with autism accessing support services. Improvement in preventative/holistic support and reduction in crisis intervention.
3.2.	Ensure people with autism are actively involved in co-designing and delivering services.	**2018/19 Priority** • Engage people with autism in co-production of redesign of the 0-19 assessment and diagnostic pathway	December 2018	MCCG Claudia Tomlinson	Maximise use of resources to provide services which meet the needs of users.
3.3	Ensure people with autism are involved in the	**2018/19 Priority** • Develop a plan for communication and	December	Chair -Merton	Increase involvement and inclusion for

			2018	Autism Partnership Steering Group	people with autism.
	implementation of this strategy.	engagement with people with autism over the life course of the strategy which links with exiting forums, for example the SEN user voice forum			
		• Establish a time limited Autism Partnership Steering Group or similar, which regularly engages and seeks feedback from people with autism and parents/carers..	September 2018		
3.3	Improve employment opportunities for people with autism.	**2018/19 Priority** • Promote the South London partnership 'Better Working Futures' programme and Project Search. • Promote the Government's Disability Confident scheme among local businesses/organisations.	April 2019 Ongoing	DWP/LBM E&R Ayda El-Deweiny & Mo Yartley	Increase numbers of people with autism in paid work. Increase independence. Reduce social isolation. Increase financial resilience and quality of life.
3.4	Improve opportunities for people with autism to participate socially.	**2018/19 Priority** • Work with the voluntary sector to develop a support offer for adults with autism with intermittent, lower level needs. This may include advocacy and advice services, peer support, volunteering programmes, social prescribing etc.	April 2019	LBM C&H: Richard Ellis/Heather Begg, Andy Ottoway-Searle,Steve Langley MertonMencap	Increase in social participation. Increase access to mainstream services Reduction in isolation and mental health problems.

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3.5	Improve inclusion and support for all CYP with autism in education provision	**2018/19 Priority** • Increase the number of places within Specialist Maintained schools and additionally resourced provisions so that CYP with Autism can be educated locally. • Evaluate costs of additional life skills training in schools for CYP with autism.	December 2019 December 2018	LBM C&H Karla Finikin/Tom Procter Karla Finikin/Kids First	Increase local provision to prevent CYP with autism being educated out of the Borough CYP with autism are better equipped for adulthood. Improvement in preventative/holistic support and reduction in crisis intervention.
3.6	Ensure equal access to housing options for adults with autism.	• Include autism in the council's new Housing and Homelessness Strategies. • Work in partnership with colleagues from the Learning Disabilities team to develop a housing offer for people with Autism.	April 2019	LBM C&H Steve Langley	Minimise numbers of homelessness episodes in people with autism. Reduction in need for residential placements. Increased independence and quality of life.
3.7	Improve local infrastructure to meet the needs of those with autism.	• Health services, education settings and libraries will consider how their physical environments may be improved to better meet the needs of those with autism and take steps to achieve this.	December 2022	LBM/MCCG Primary Care Schools and colleges - Elizabeth Fitzpatrick/Tom Proctor Libraries - Anthony Hopkins	Local services more accessible for those with autism Increased autism awareness throughout the borough, making Merton a more autism-friendly borough.

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Theme 4: Preparing for adulthood

No.	Objective	Action	Timescale/When completed	Organisation/lead	Expected Outcome/benefit
4.1	Improve the quality of transition assessments.	**2018/19 Priority** • Ensure transition assessments are structured and use a framework such as the national Preparing for Adulthood framework. • Ensure assessments are multi-disciplinary, involving health, social care and educational professional as necessary. • Involve the young person and their families and carers in transition assessments. • For those receiving treatment or care from CAMH's, audit transition process against NICE guidelines (NICE clinical guidelines 170).	December 2018 Annually	LBM/MCCG Karla Finikin John Morgan Claudia Tomlinson/Ian Davis	Better continuum of support for young people as they reach adulthood and increased involvement of young people in decision making. Reduction in 'fall off a cliff effect' in accessing services as CYP move towards adulthood. Improved quality of care for those receiving care or treatment from CAMHS.
4.2	Support young people to reach their potential and develop independence as they move towards adulthood.	• Develop a new programme of work experience within the council for vulnerable cohorts, including those with autism. • Work with FE colleges to increase understanding of the needs of CYP with autism in further education and to improve their access to support within colleges.	December 2018 December 2018	LBM E&R LBM HR LBM CSF Karla Finikin	Increase independence and resilience of CYP with autism as they move towards adulthood. Increase access to appropriate curriculum and support for CYP in colleges.

| | | • Work with schools, libraries and adult education to explore their potential for providing more life skills training for young people with autism e.g. interview training, extended work experience opportunities, financial management training and cooking classes. | April 2020 | Schools/Libraries/Voluntary sector/ Karla Finikin | |

Theme 5: Think Family					
No.	Objective	Action	Timescale/When completed	Organisation/ lead	Expected Outcome/benefit
5.1	Improve the 'local offer' of support for families.	**2018/19 priority** • As part of the development of the CYP 0-19 assessment, diagnosis and support pathway, we will work with partners to identify resources to increase the availability of parenting programmes on offer in the borough-particularly for those with children over 8 years old. • Produce clear information about local parenting support as part of the 'local offer'. • Promote support available to carers of adults with autism and the 'Thinking Ahead' plan.	December 2019 On-going	MCCG Claudia Tomlinson LBM/Voluntary Sector Karla Finikin/Talk Autism LBM C&H Gemma Blunt	Improved sense of support, knowledge and quality of life for families/carers of people with autism. Improved communication and interaction between families/carers and people with autism.
5.2	Ensure families and carers are involved in the co-design and delivery of services.	**2018/19 priority** • Promote co-production amongst organisations re-commissioning or delivering new services that support families and carers of people with autism.	Ongoing	Merton Autism Partnership Steering Group	Increased opportunities for families/carers to feedback their experiences and use this to shape future services, leading to improved quality of services.
5.3	Improve wider support for families	• Explore opportunities for improving the availability of counselling and emotional support for parents and carers of people	December 2020	LBM/MCCG/Voluntary sector	Improved sense of support, knowledge and quality of life for families/carers of people with

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			Patrice Beveney	autism.
and carers.	with autism. This could include raising awareness of the Merton IAPT service or supporting autism champions to facilitate peer support groups for parents. • Look for opportunities to increase training for staff in evidence based interventions, such as 'video interaction guidance' (VIG).			

Theme 6: Access to information

No.	Objective	Action	Timescale/When completed	Organisation/lead	Expected Outcome/benefit
6.1	Improve quality and accessibility of information available to people with autism and their families/carers.	**2018/19 Priority** • Develop an all-services, electronic information hub to provide a single place for information about local services and resources relevant to autism, including the local SEN offer. • When producing information, stakeholders will consider its accessibility in terms of clarity (easy-read), whether translations into non-English languages are required, and whether cultural factors have been taken into account, seeking to ensure information is widely accessible.	April 2019 Ongoing	LBM CSF Allison Jones All	People with autism and their families/carers are empowered to make more informed choices about the care and services available to them. Reduction in information inequalities.
6.2	Ensure people with autism are able to provide and share information.	• Hold an 'autism fair' to promote autism-friendly services and activities in the borough and increase wider awareness. • Explore opportunities for a system to enable key groups, including people with autism and their families/ carers, to share local information with the community. This may involve partnership working with local voluntary sector organisations.	April 2020	LBM/Voluntary sector Karla Finikin/David Cafferty/Merton Mencap	People with autism and their families/carers are empowered to make more informed choices about the care and services available to them.

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Merton Autism Strategy 2018-2023 Public Engagement Feedback Report

Introduction

The London Borough of Merton and Merton NHS Clinical Commissioning Group (CCG) have developed a draft Autism Strategy working in collaboration with a range of partners. The draft strategy encompasses children, young people and adults, taking into account the needs of families and carers. The draft strategy set out plans to work in partnership towards an autism-friendly borough and address the wide range of areas to improve the lives of residents with autism. The draft strategy was developed in response to increasing numbers of children and adults with autism in the borough and awareness that there is a need to make improvements in support and services currently provided. National policy and statutory guidance has also informed development of the strategy.

The strategy sets out a framework for action over the next 5 years and identifies priorities for commissioning and service re-design and improvement for people with autism in Merton.

This report analyses responses to recent public engagement on the draft strategy and provides a detailed overview of the respondents' comments and suggestions.

The report is split into 3 main sections:

1. Methods
2. Findings
3. Conclusions

Section 1: Methods

A public engagement period took place from the 5th of February to the 19th March 2018 (6 weeks).

The engagement was comprised of 2 main strands:

- written engagement via a structured on-line survey and paper easy-read survey
- verbal engagement through facilitated feedback sessions with stakeholders including people with autism; parents and carers; and professionals.

Engagement questionnaire

The on-line questionnaire was made up of 21 questions and focused on the 6 main themes within the strategy. There was a mix of closed, ranking questions and free-text questions. The intention of the questionnaire was to ascertain stakeholders' priorities for actions and identify any issues which have not been addressed.

The engagement questionnaire was available online, either to be filled in via the council's consultation website or downloaded and emailed to a member of the public health team. It was also available as a hard copy on request. An easy-read survey was also available to down-load. The questionnaire was disseminated via stakeholders and networks from the

Local Authority, NHS partners, MVSC and local voluntary sector organisations, schools and individuals on the Merton Autism Strategy reference group (see appendix 1).

Engagement sessions

Engagement sessions were organised for a range of groups to enable individuals to offer their views on the strategy. Sessions were facilitated by members of the autism strategy steering group in collaboration with local group leaders. A total of 7 sessions were held over the 6 week period and were attended by stakeholders including young people and adults with autism, parents/ carers and professionals working in health, education, social care and voluntary sector organisations (see appendix 2).

Additional feedback

A small number of respondents emailed their comments directly to the public health team. These responses were logged and analysed alongside those from the questionnaire and engagement sessions.

Responses

A total of 146 participants were engaged in the feedback process as individuals and/or part of group feedback. 42 respondents completed the online questionnaire and a further 5 questionnaires were received by post. Engagement sessions were attended by a total of 90 individuals across 7 sessions. 9 respondents submitted individual feedback via email.

Additionally, the draft strategy was presented at two GP locality meetings which were a attended by a total of 35 health professionals across east and west Merton.

Not all respondents provided demographic data, but of those who did we have categorised respondents as per table 1 below.

Table 1. Respondents by category

Category	Number of respondents
People with autism	19
Parents/carers	45
Health professional	4
Education professional	56
Local authority employee (non-education)	3

Analysis

Following the closing date, all responses were collated and analysed. Responses from the online questionnaire were downloaded into an excel spreadsheet. Paper copy responses were input into the spreadsheet as well as information from engagement sessions which responded to specific questions. For example, where stakeholders had ranked priorities in a feedback session this data was included in the spreadsheet. Where groups of individuals had responded e.g. in group work through engagement sessions this was logged as an individual response on the spreadsheet.

Additional comments and suggestions were analysed and grouped into themes; the 6 priority themes within the strategy and cross-cutting themes.

This report reflects the views of those who responded to the engagement but may not necessarily be representative of all views across the Borough.

Acknowlegments

Many thanks to all those who responded to the public engagement and to partners who contributed and co-ordinated feedback sessions including: Talk Autism/Merton Mencap and the Hearts and Minds Group; LBM CSF engagement team; LBM Adult social care; Merton NHS CCG Patient and Public engagement team.

Section 2: Findings

Vision and aims

1. The vast majority of respondents to the questionnaire (78%) agreed with the vision and aims set out in the draft strategy. A number of people commented that the aims were positive and comprehensive.

2. However, there was significant feedback that the language used in the strategy did not give strong enough commitment to achieving the aims of the strategy and there was a risk that the strategy would be aspirational and not result in tangible improvements for people with autism and their families.

3. It was noted that the proposals within the strategy are to be delivered within existing resources, however many respondents commented that without additional resources it would be very difficult to achieve the aims set out in the strategy.

Current services and access to support

4. This question relates to the section on 'our current services and access to support' (p.16 in the draft strategy). The questionnaire asked respondents if there were any other local services or support that was not included. Respondents listed the following services which were not included in the draft strategy.
   - ACES youth club for high functioning autism (Merton Mencap)
   - Merton Sensory Support Service
   - Mencap 0-5 supporting families team

   Additional comments relating to services and support will be detailed in the analysis of theme 2.

Priority themes

5. Most respondents to the questionnaire (81%) agreed with the 6 key themes around which the strategy is framed. It was suggested that education could be a separate theme. It was also suggested that there could be separate themes for children and adults as this would make the strategy easier to navigate. Another suggestion was that theme 6 (awareness training and support for staff and services) should be earlier

on in the strategy as this was thought to be one of the most important areas to address.

Theme 1: Recognition, support, referral and assessment.

6. There was consistent feedback that the current referral and assessment process takes too long and there is no support available to those who are awaiting assessment. Ensuring the new diagnostic pathway is NICE compliant was highlighted as an essential priority, in particular the points around a 3 month minimum waiting time and assignation of a key-worker.

7. Most respondents agreed with the proposal that support should begin as soon as a need is identified and should not be dependent on having a diagnosis. However, some respondents were sceptical about how this could be implemented, believing that many services require a diagnosis in order to access them at present. Many respondents also felt strongly that whilst a diagnosis should not be a requirement for support, this does not mean that receiving a diagnosis is less important to people with autism or their families and carers, and certainly should not be a reason for limiting access to diagnosis.

8. Some respondents felt that there should be more emphasis on early intervention in the strategy; they felt that currently many front line staff are not properly trained to recognise the signs of autism and therefore the opportunity for early intervention is being missed. There was also a view that more should be done to address the under-diagnosis of autism in girls.

9. Strong feedback was received that establishing autism champions in schools should be a priority. It was suggested by some respondents that the autism champions could be people with autism themselves, or that people with autism were involved in the training of autism champions.

10. A lack of recognition of co-morbidities associated with autism e.g. ADHD, anxiety and depression was highlighted. Some respondents felt that at present these co-morbidities are often ignored or 'bundled together' with autism and therefore not treated appropriately by health professionals. In addition, it was noted that some people are only diagnosed with autism when being assessed for co-morbid mental health problems i.e they have to wait until they require intervention or assessment from mental health services in order for autism to be recognised. Furthermore, if the autism was recognised and managed at an earlier stage they may not have gone on to develop these problems e.g. anxiety, depression etc.

11. There was significant feedback that the diagnostic pathway for adults is unclear and this prevents many adults from accessing assessments.

12. For both children and adults, there was a consistent feedback that there is a lack of support following diagnosis. In particular, where to go for help/advice in the future and counselling on how to come to terms with a diagnosis (especially for adults) were identified as priorities.
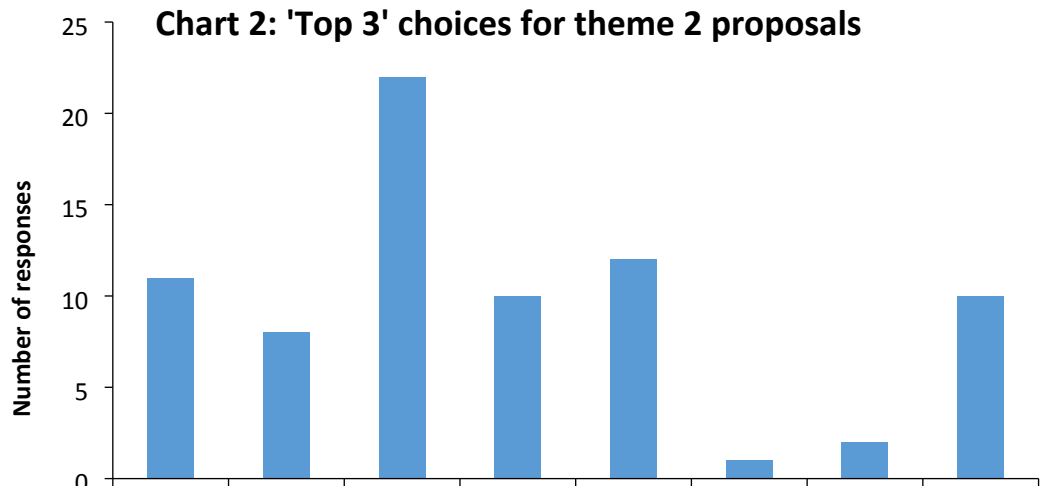
Chart 1: 'Top 2' choices for theme 1 proposals
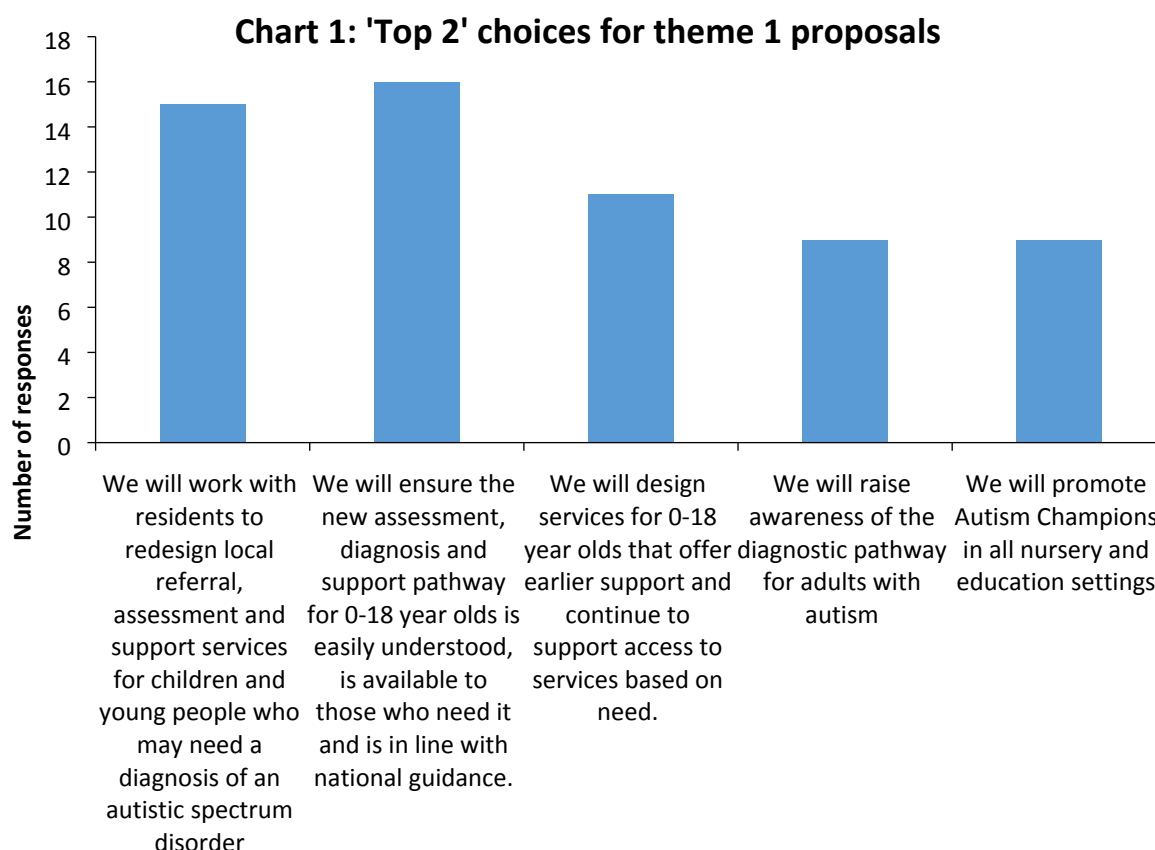
Theme 2: Involving and supporting people with autism

13. It was highlighted that there is currently no register for people with autism in Merton, and a lack of data on adults with autism (diagnosed or undiagnosed). As a result, services are planned on estimates rather than true figures. To overcome this it was suggested that the voluntary disability register, which currently exists for children aged up to 19 years old should be extended to include adults. In addition, the M-Card scheme which you can apply for through the disability register should be extended to include adults.

14. There was wide feedback that there is a lack of social activities for both children and adults with autism in the borough. In particular, the young people with autism who participated in the engagement felt there was a particular lack of social activities for teenagers. They suggested well organised, small group activities, i.e. in the same place, at the same time each week/month would be a good start. They were in agreement that activities should be autism-friendly, but not necessarily autism-specific.

15. There was feedback that services need to be better co-ordinated, and it was suggested that an autism team within London Borough of Merton be established to address this. This team should include representatives from housing, benefits, social care and education who are trained in autism, and there should be a named 'autism lead' to oversee the team.

16. There was a consensus that support needs to be individualised, and available throughout a persons life i.e.it should be accessible on an ad-hoc basis. By providing

a better continuum of support this would lead to a reduction in crisis intervention whereby people are only accessing support at a critical point.

17. Young people passionately expressed the importance of involving people with autism in the design of services and in particular the recruitment and selection of staff who will work with those with autism.

Chart 2: 'Top 3' choices for theme 2 proposals

Theme 3: Preparing for adulthood

18. There was widespread feedback that the proposal to focus on developing independence as young people move towards adulthood was important.

19. Young people felt that there should be more opportunities for apprenticeships and training e.g. extended work experience and interview training. One respondent had recently completed travel training and valued this extremely highly as a means of increasing independence.

20. Young people felt that it is easy to pigeon-hole young people with autism into specific courses or programs designed for SEND and this is sometimes limited in its offer. They felt more should be done to either increase the offer of subjects available in SEND provisions or further enable inclusion into mainstream courses.

21. Young people felt more should be done to support the basic independent living skills including financial management, understanding employment, transport and living skills such as using kitchen appliances, cooking, planning their own timetables etc.

22. It was suggested that an event such as an 'autism fair', which advertises opportunities for young adults with autism in education/work/social activities would be beneficial.

Chart 3: 'Top 2' choices for theme 3 proposals

| Transition assessments will be timely, structured and involve the young person and their families or carers. | Assessments will equip people with autism with realistic expectations of services available to them as they move towards adulthood, and have a focus on developing independence. | We will review opportunities for supporting students with autism in further education, with a specific focus on preparing for employment and independent living. |

(Number of responses — chart values: 19, 20, 17)

Theme 4: Supporting families and carers

23. There was consistent feedback that there is currently a lack of support for parents of children and adults with autism in the borough. It was noted that parenting programmes are not available to those with children over 8 years and the current 'Early Bird' parenting programmes are only available to parents with children under 8.

24. It was acknowledged that parental understanding is key to improving outcomes for children with autism and that training for parents following a diagnosis of ASD should be a priority (see also theme 6).

25. In addition, it was highlighted that there was no recognition in the strategy that families and carers of people with ASD are often under extreme pressure which can lead to family breakdown and mental or physical health issues for the parents/carers themselves. It was suggested that post-diagnosis counselling is offered to parents/carers, and that GP's and social workers need to be better trained in recognising, and acting on signs of stress or mental health issues amongst the families/carers of those with autism.

26. There was also feedback that there needs to be more training for parents and carers as children with autism grow up and their needs change, such as how to help their

children with issues related to puberty, friends and whether or not to disclose their diagnosis as they get older.

Chart 4: 'Top 2' choices for theme 4 proposals

Number of responses

25	
20	
15	
10	
5	
0	

We will review opportunities to improve support for families and carers of people with autism, such as strengthening signposting, peer support networks, advocacy services and short breaks

We will produce clear information about local parenting support

We will actively involve carers and families in the co-designing and delivery of services that support them.

Theme 5: Information

27. There was a majority view that the 'local offer' which currently details information on services for people with autism needs to be improved in order to be useful. It was suggested that a role is created within the council for a local offer lead, who would ensure the information provided is comprehensive and up to date. It was stated that the council should be proactive in finding out about services available and should not be dependent on organisations or parents informing them about services. It was also suggested that the local offer be clearly laid out with headings of 'Childrens ASD' and 'Adults ASD' to make it easier to navigate.

28. Young people fed back that not enough was done to promote access to mainstream extra curricular activities such as youth clubs and that they don't always want to go to 'special clubs'. They felt staff running mainstream extra-curricular activities need to be autism aware. The lack of support available for young females with autism and how there are few opportunities to learn from positive female role models with autism was noted.

Chart 5: 'Top 2' choices for theme 5 proposals

Number of responses

| We will build on and strengthen the local offer for children, young people and adults to provide a single point of access to clear, comprehensive information about local services relevant to autism | When producing information, we will consider its clarity (easy-read), whether translations are required, and whether cultural factors have been taken into account | We will explore opportunities to enable people with autism and their families/carers to share local information with the community. |

Theme 6: Awareness training and support for staff and services

29. There was an overwhelming consensus in the engagement feedback that training for staff and other residents is fundamental to achieving the strategy's aims of making Merton an autism-friendly borough.

30. It was suggested that autism awareness training should be mandatory for all NHS and local authority staff, should include anxiety and sensory training and should be co-developed by people with autism.

31. People with autism who fed back views were mainly very enthusiastic about providing, or being involved in the development of, training for key staff groups. Similarly, respondents to the engagement (in particular those working in health services) were very positive about receiving training.

32. It was suggested in the feedback from people with autism that children need to be educated about autism as a priority, as well as teachers, employers and other professionals. They expressed that children and young people in school are one of the groups who understand autism the least, and this lack of understanding leads to bullying and people with autism feeling intimidated when out and about e.g. on public transport. It was proposed by young people with autism that older, non-autistic students could act as autism champions in school. They felt that this would help with acceptance and inclusion in schools.

Chart 6: 'Top 2' choices for theme 6 proposals

Bar chart showing number of responses (y-axis 0–18) for six proposals:

- We will work towards all NHS and Merton Local Authority staff undertaking autism awareness training. — 14
- Within available resources, staff working directly with children, young people and adults with autism will be offered more in-depth autism training — 17
- We will seek to offer autism awareness training to a wider range of staff, including local employers and those working in the criminal justice system. — 7
- People with autism will be involved in the development of training, for example;experts by experience; training sessions could be delivered to those working directly with CYP and adults with autism. — 7
- We will explore how social care staff can be better supported when working with people with autism with very complex needs. — 6
- We will work with the criminal justice system and encourage work with partners to offer training to relevant staff groups. — 3

Nmber of responses

Cross-cutting themes

33. Responses to the public engagement from people with autism, parents and carers in particular provided powerful feedback on the challenges facing individuals and families in the borough and many suggestions as to how these could be addressed.

34. There was a widespread agreement that strategy was comprehensive, the aims were endorsed and that it was a positive step towards making Merton a better place to live for people with autism.

35. There was also widespread feedback that whilst the proposals are generally positive and cover most of the important points, there was frustration that the language used in the strategy needed to give more positive commitment to delivering actions and offer more assurance that they will be achieved.

36. A recurrent theme across the feedback was that the strategy does not provide details of resources or costings that will be used to implement the proposals, which is needed to provide assurance.

37. It was noted that there is an emphasis on 'support' throughout the strategy but very little mention of 'inclusion' and removing barriers to participation, which would align with educational legislation. It was suggested that the language is revised to reflect this legislation more closely.

38. Feedback on the easy-read document was very positive, with respondents commenting that it is clear, well set out and of a high quality.

Section 3: Conclusions/recommendations

Priority Themes

39. It is proposed that the actions set out in the 'how we will get there' sections of the priority themes are prioritised in light of the public engagement feedback and aligned with the strategy action plan under the headings: 'In the first year we will..' and 'Over the life of the strategy we aim to..'

40. It has been agreed that the action plan is published alongside the final version of this strategy. It is proposed that this should identify priority actions for the first 1-2 years of the strategy, alongside priorities over the life of the strategy. This would offer assurance to stakeholders that progress is being made and accountability for delivery of the strategy.

41. It is proposed that theme 6 (awareness training and support for staff and services) is moved to Theme 1 to reflect the strength of feeling that training and awareness-raising is one of the most important themes in the strategy and fundamental to improving outcomes.

Theme 1: Recognition, support, referral and assessment.

42. Merton NHS CCG, LB Merton and partners are currently working in partnership to re-design the diagnostic pathway for 0-19 year olds and are undertaking separate co-production engagement on this. Detailed responses which relate to the diagnostic pathway will be fed back to the relevant commissioners to ensure these views are taken into account.

43. It is recommended that the new diagnostic pathway for children and existing pathway for adults includes a post-diagnosis appointment. This appointment would allow people with autism and their parents/carers the opportunity to ask questions about the future and be referred to post-diagnostic counselling/training if needed.

44. We received strong feedback that establishing autism champions is a top priority for stakeholders. It is recommended that this action is prioritised for the first year of the strategy and that people with autism are involved in the training and/or selection of autism champions in schools.

Theme 2: Involving and supporting people with autism

45. It is recommended that increasing social activities for children and adults with autism is a priority in the action plan, with identified specific leads who will implement this action.

46. We received feedback that we should consider establishing an 'autism team' within the London Borough of Merton and that this should include trained representatives from housing, social care and education and be over-seen by a named autism lead. We recommend that this is considered going forward, but recognise that more information gathering is required around the function and feasibility of such a team.

Theme 3: Preparing for adulthood

47. It is recommended that schools, libraries and adult education explore their potential for providing more life skills training for young people with autism. This could include interview training, extended work experience opportunities, financial management, cooking etc.

48. It is recommended that further education providers consider how they can promote inclusion for people with autism in existing 'mainstream' programmes, or expand the variety of programmes on offer for SEND pupils.

Theme 4: Think family

49. It is recommended that LBM works with partners, including Merton NAS, to identify resources to increase the availability of parenting programmes on offer in the borough –particularly for those with children over 8 years.

50. It is suggested that LBM explores opportunities to offer counselling and peer support to parents/carers of people with autism. For example, ensuring that existing counselling services (e.g. new IAPT service) are promoted; trained professionals or autism champions are supported to facilitate peer support groups for parents.

Theme 5: Information

51. It is recommended that Merton holds an annual autism fair to promote autism friendly services and activities in the borough and increase wider awareness of autism.

Theme 6: Training and awareness

52. It is suggested the existing proposal on 'working towards all NHS and Local Authority staff undertaking autism awareness training as part of general equality and diversity training' should be made mandatory and include anxiety and sensory training.

53. For health care professionals, including GPs, it is strongly proposed that training is delivered which includes the importance of recognising and managing co-existing mental health issues in people with autism.

54. It is proposed that an action is included that people with autism are involved in the development of autism training in schools and that schools are encouraged to provide autism training to all pupils, as well as staff.

Next Steps

55. The findings from the public engagement have provided valuable insight into local challenges, priorities and solutions. Information will be used to update the draft Autism Strategy and Action Plan, and feed into the governance of strategy going forward.

Appendix 1. Questionnaire dissemination list

London Borough of Merton
- Community and Housing: - Adult social care, Libraries and heritage, Housing needs, Public Health   - Children, Schools and Families: - Education, Children's Social care, Youth offending team   - Environment and Regeneration: - Public protection   - Safer Merton   - Elected Members
Health services
- Merton NHS CCG   - NHS Providers including South west London and St Georges NHS Trust   - London Ambulance Service   - Healthwatch
Voluntary services
- KidsFirst   - Talk Autism   - Merton Mencap   - NAS Merton   - Carers Support Merton   - Hearts and Minds   - Citizens Advice Bureau   - Merton Voluntary Service Council   - Age UK Merton   - Merton Centre for Independent Living
Community services
- Schools: Head teachers and SENCOs   - Lifeways   - Ability Housing   - United Response   - Vibrance   - Choice Support   - Merton Fire brigade   - Circle / Clarion Housing   - Merton Job Centre Plus
Other
Individuals on the Merton Autism Strategy Reference Group

DRAFT

Appendix 2. Engagement sessions and meetings

  i.   Engagement Sessions with people with autism and parents/carers:

Session	Date
TalkAutism/KidsFirst	07/02/18
NAS Merton	08/03/18
London Borough of Merton Learning Disability team	12/03/18
Hearts and Minds	14/03/18
Youth engagement team	March 2018

  ii.   Engagement sessions and meetings with professionals and partners:

Session/meeting	Date
Merton CCG Patient Engagement Group	24/01/18
Merton CCG Clinical Reference Group	10/10/18
London Borough of Merton Education Team	05/02/18
Merton SENCO Forum	28/02/18
Merton NHS CCG GP locality meetings (East and West Merton)	21/03/18 22/03/18
Merton Children's Trust Board	21/02/18
Merton Preparing for Adulthood Partnership	05/03/18

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Committee: Health and Wellbeing Board

Date: 26ᵗʰ June 2018

Wards: All

Subject: Plans for developing the Health and Wellbeing Strategy (HWS) 2019-2024

Lead officer: Dagmar Zeuner, Director of Public Health

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

Contact officers: Clarissa Larsen (Health and Wellbeing Board Partnership Manager) Clarissa.Larsen@merton.gov.uk and Natalie Lovell (Health Improvement Officer, Healthy Places) Natalie.lovell@merton.gov.uk

Recommendations:

A. To review and clear the proposed plans for developing the Health and Wellbeing Strategy (HWS) 2019-2024

B. To provide feedback on the proposed task and finish workshops; the proposed themes: proposed agenda: and to discuss whom from the HWBB would like to attend the workshops

C. To note the synergies between the Health and Wellbeing Strategy and the Merton Local Health and Care Plan

1   PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1.   It is a statutory duty for the Health and Wellbeing Board (HWB) to produce a joint Health and Wellbeing Strategy, based on the Joint Strategic Needs Assessment (JSNA).

1.2.   The Health and Wellbeing strategy sets out how the Health and Wellbeing Board will work in partnership to ensure a fair share of opportunities for Merton residents to live healthy lives, to take early action* to improve their health and wellbeing, and to reduce health inequalities.

1.3.   The current Merton Health and Wellbeing Strategy 2015-2018 is coming to an end this year, and this paper outlines plans for its refresh, led by the Public Health team on behalf of the Health and Wellbeing Board.

1.4.   The HWS will be based around 4 key themes:

- Start Well

- Live well

- Age well

- …in Healthy Places

*People use different language when referring to early action/prevention/early intervention etc. We will consider this carefully when deciding the language to use in the final health and wellbeing strategy

2   DETAILS

Plans for developing the Health and Wellbeing Strategy 2019-2024

2.1.   Data sources to inform the HWS refresh:

- The HWS refresh will be informed by the Joint Strategic Needs Assessment, including analysis from the Annual Public Health Report 2018 on monitoring health inequalities in Merton, the Merton Story, and Merton Data. It will fit with the direction of council TOMS.

2.2.   Context within which the HWS fits:

- Multiple pieces of work currently underway will link closely with the HWS refresh. These include:
  - Local health and care plan, focusing on health and social care integration
  - 2018 annual public health report on health inequalities
  - Prevention framework refresh
  - Health in all policies (HiAP) action plan
  - Merton's local plan
  - Mayor of London's draft health inequalities strategy

2.3.   Proposed content of the HWS 2019-2024:

Please see annex 1 for the draft outline of the health and wellbeing strategy 2019-2024.

- We will build on the existing work of the council to help shape the HWS, including but not limited to the Local Health and Care Plan and council TOMS.
- Given that the HWS refresh will build on the ongoing work of the Health and Wellbeing Board, we welcome the HWBB's thoughts and suggestions on the draft outline, in particular their views on the 'how will we get to our goal' and 'key themes' sections.

2.4.   Process to develop the HWS 2019-2024

- **Task and finish workshops**: We are considering engagement with key stakeholders through a series of task and finish workshops, based on the key themes of the health and wellbeing strategy. We suggest that HWBB members would chair these workshops, which will be facilitated by the Public Health team.

  Please see annex 2 for the proposed themes and agenda for the task and finish workshops.

- **Community engagement and communications**: We will pursue a mixed engagement programme to ensure Merton residents have an opportunity to shape and comment on the HWS refresh. Firstly, we will use the community engagement research that has already taken place over the past 18 months, including but not limited to the diabetes truth conversations, community conversations, Wilson workshops, and prevention offer discussions, as well as relevant community engagement undertaken by other council departments. During our analysis of this research we will be particularly mindful of health inequalities and its root causes. Secondly, we will make best use of opportunities that arise regarding upcoming engagement, such as the 2018 resident's survey, local democracy week and Local Plan 2019 autumn consultations. Lastly, we will consider an online survey that covers the 4 key themes of the health and wellbeing strategy, making best use of our stakeholders' networks to ensure a high response rate, in particular by people who live in the most deprived parts of Merton.

- **Synergy with the Merton Local Health and Care plan**: A key part of the process will be to develop the HWS refresh in tandem with the Merton local health and care plan. We anticipate that this will involve joint working with local health and care plan leads and the Merton Health and Care together board, sharing timelines and content, and making joint use of engagement opportunities.

2.5.   Governance:

- Although governance of the HWS refresh sits with the Health and Wellbeing Board, the refresh process will include all thematic partnerships; Children's Trust board; Safer and Stronger Partnership; and Sustainable Communities and Transport Partnership. It will also include the Merton Health and Care Together board.

2.6.   Indicators:

- The indicators in the HWS refresh will be both quantitative (for example, Index of Multiple Deprivation (IMD) ward scores to indicate healthy standard of living) and qualitative (for example, GLA data on self-reported wellbeing at ward level) and they will cover change over both the short and longer term.

- The choice of indicators will be informed by applying the learning from previous strategies which highlights the importance of ensuring indicators fit with the vision of the strategy. They will also be informed by:
  - Analysis set out in the Annual Public Health Report 2018 on health inequalities (see paper presented to HWB alongside this paper) which recommends the use of logic models and proxies
  - Wellbeing indicators (for example, wellbeing scores can be calculated based on public transport accessibility scores, crime rates, access to nature, unemployment rates etc). Wellbeing indicators could also be selected from the Annual Residents Survey (latest 2017)
  - Desk top research which will distil what is already measured in terms of health and wellbeing, and relevant literature.

- We anticipate a small number of indicators relating to each of the key themes in the strategy. A discussion about indicators and how to measure their progress could take place at each of the task and finish workshops, to help inform the HWS.

- We envisage the indicators used for the HWS to complement those used in the Local Health and Care Plan; so that the totality of what is measured is meaningful to the people we serve.

- We welcome the HWBB's thoughts and suggestions regarding indicators that will help us understand if change relating to health and wellbeing is occurring in the right direction.

3   RECOMMENDATIONS

HWBB Members are therefore asked to:

- Review and clear the proposed plans for developing the Health and Wellbeing Strategy (HWS) 2019-2024

- Provide feedback on the proposed task and finish workshops; the proposed themes: proposed agenda: and to discuss whom from the HWBB would like to attend the workshops

- Note the synergies between the Health and Wellbeing Strategy and the Merton Local Health and Care Plan

4   ALTERNATIVE OPTIONS

N/A

5   CONSULTATION UNDERTAKEN OR PROPOSED

N/A

6   TIMETABLE

The plans for developing the health and wellbeing strategy 2019-2024 have been taken to Communities and Housing (C&H) DMT, and further action will be taken according to the timetable below.

Date	Action
Spring/summer 2018	Scoping and initial engagement
31 May 2018	DMT meeting
12 Jun 2018	One Merton meeting
26 Jun 2018	HWBB meeting- Outline HWS
10 Jul 2018	CMT meeting
Jul-Oct 2018	Task and finish workshops on key themes
3 Oct 2018	HWBB meeting- Development session
Autumn 2018	Drafting/continued engagement
27 Nov 2018	HWBB meeting
29 Jan 2019	HWBB draft HWBS
Feb-Mar 2019	Consultation on draft
26 Mar 2019	HWBB sign off of HWBS

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report.

8 LEGAL AND STATUTORY IMPLICATIONS

It is a statutory duty for the Health and Wellbeing Board (HWBB) to produce a joint Health and Wellbeing Strategy (HWS), based on the Joint Strategic Needs Assessment (JSNA).

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The HWS is directly concerned with improving health equity.

10 CRIME AND DISORDER IMPLICATIONS

N/A

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A

12 APPENDICES –

Appendix 1: Health and wellbeing strategy 2019-2024 draft outline

Appendix 2: Proposed themes and agenda for the task and finish workshops

13 BACKGROUND PAPERS

None

Appendix 1: Health and wellbeing strategy 2019-2024 draft outline

NB: We will ensure the HWS refresh is written in a way that is accessible to the public; by avoiding jargon and making it as relatable as possible. This will involve thinking about how specific sections of the HWS, such as the 'Start Well' section, can be presented in a way that is engaging to the people it is for, in this case children, young people and families.

Section headings & sub headings	What the section will include
Foreword	0.5 page foreword (HWBB chair and vice-chair)
1 page summary of the strategy	1 page to visually summarise the strategy, possibly through use of infographics (this could also be a separate document)
Introduction/welcome	1 page to: • Welcome the reader and outline the aim of the strategy • Describe: what the health and wellbeing strategy is; that it's the duty of the HWB as system leaders to produce it; who the health and wellbeing board are (locally elected councillors, local GPs and voluntary sector reps); and what they do • Summarise what the strategy will tell the readers and how they can use it. This could include a diagram showing how the HWS links with other strategies, plans & systems in South West London • Highlight in particular the link with the Local Health and Care Plan
Our vision	1 page to: • Summarise the main challenges and opportunities Merton faces (eg increased need for health and care services and the importance of preventing and intervening early) • State the overall vision of the health and wellbeing strategy (to protect and improve the wellbeing and health for the population of Merton, taking early action, throughout their lives, with a particular focus on reducing the health inequalities that exists between the West and East of the borough)

|	
What makes us healthy?	1 page to: • Explain what makes and keeps us healthy ie explain what the social determinants of health are and why they are relevant, highlighting the importance of prevention and early intervention. • Brief description of what causes health inequalities and why it's important to tackle them • Summary of the evidence of what works to tackle inequalities
Where are we now?	1 page to: • Explain (in more detail than is outlined in the 'our vision' section) where we are at regarding health and wellbeing in Merton • Do this by summarising the Merton Story 2018 (a snapshot of the local needs which have been identified through the JSNA process)- overall Merton is healthy, safe and has strong community assets, but there are areas of concern and ambition- explain what these are and what causes them • Include the life expectancy/healthy life expectancy gap in Merton – could be a map/visual way to represent health inequalities • Stress these issues are why the health and wellbeing strategy is so important
How will we get to our goal?	1-2 pages to describe how the health and wellbeing board will work together to achieve their vision: • Brief description of the following proposed principles: -health in all policies -integrated health and care provision for seamless service experience - intelligent use of data and evidence -Think Family

	-build on what work already exists -partnership work across sectors including mobilising wider resources -co-create solutions with the community & empower them -whole systems approach • Summarise 4 key themes start well-live well-age well…in healthy places • Explain that more detail on these themes is covered in the next section
4 key themes	• 4-8 pages to cover 4 key themes: o Start well o Live well o Age well o Healthy places • For each of these themes, outline -why is it important -what is being done already -what we will focus on -what we will achieve/outcomes broken down by short term and longer term • Explain that we will tackle each of these themes by considering individual, community and population level action and intervention
DELIVERY PLAN –to underpin the strategy outlined above	This will be a document that outlines in more detail the delivery plan through which the vision of the health and wellbeing board will be achieved. The delivery plan will: • Be delivered by other teams within existing governance structures • Include short and longer term indicators that could be reported on annually • Include breakdown of activities relating to: o HiAP action plan o Personal prevention offer o Measurement of outcomes • Clarify that the health and wellbeing strategy will focus on the wider determinants of health and

	Merton residents, whilst the local health and care plan will focus on health and care for Merton patients

Annex 2: **Proposed themes and agenda for the task and finish workshops**

Between July-October 2018, we propose 4 task and finish workshops (one for each theme), to last approximately half a day each (3 hours). We propose that HWBB members will chair these workshops, which will be facilitated by the Public Health team.

1. **Proposed themes:**
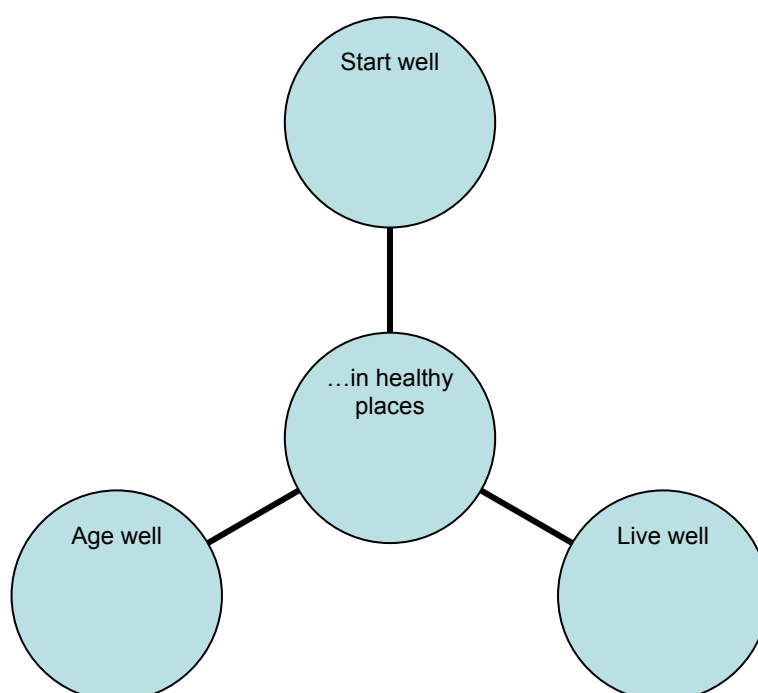
2. **Template agenda for each theme:**

Agenda item	Purpose	Timings
Welcome/Introduction	To explain: why we're here; provide background to the HWS and the journey to produce it; introduce the social determinants of health & importance of whole systems approach; outline key health challenges in	10 mins

	Merton; outline what we hope to achieve today and what we hope others will gain from the event.	
Key note speakers/presentations	2 presentations to provide different perspectives on the theme	10 mins each
Deep dive	Ask ourselves the questions (wrt theme): Why is this important? What is being done already? What do we want to focus on? What do we want to achieve (ST & LT) *(Breakout into groups for each question and then have a wider discussion)*	2 hours? *(with break in the middle)*
Indicators/measurement	Discussion around how we measure success –*to help inform which indicators to include in the HWS/Delivery Plan*	20 minutes
Next, steps, thank you, and close	Explain the next steps for the HWS, find out how people want to be informed of progress	10 minutes

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Committee: Health and Wellbeing Board

Date: 26 June 2018

Wards: All

Contact Officer : Josh Potter, Director of Commissioning, MCCG

Recommendations:

A. To note the background to, and development of, the Merton Health and Care Together programme, and the Merton Local Health and Care Plan

B. To approve the priorities contained within the Health and Care Plan

1   PURPOSE OF REPORT AND EXECUTIVE SUMMARY
1.1.   To outline why the Merton Health and Care Together programme has been established
1.2.   To outline what the approach will be, and what priority areas it will focus on via the Merton Health and Care Plan

2   DETAILS – please see attached presentation

3   ALTERNATIVE OPTIONS – N/A

4   CONSULTATION UNDERTAKEN OR PROPOSED – N/A

5   TIMETABLE – N/A

6   FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS – N/A

7   LEGAL AND STATUTORY IMPLICATIONS –N/A

8   HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS – N/A

9   CRIME AND DISORDER IMPLICATIONS – N/A

10   RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS – N/A

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

12   BACKGROUND PAPERS – N/A

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Merton Health and Care Together, and the Merton Health and Care Plan

Presentation to the Merton Health and Wellbeing Board (June 2018)

Josh Potter

Director of Commissioning

NHS Merton Clinical Commissioning Group

Merton Health and Care Together: Why? What?

We know that the Merton health and care systems faces a number of public health, demographic, and financial challenges

We know that organisations and services do not always work well together, or with the user at the centre. This results in poorer experience, outcomes and efficiency than we aspire to

Formed in December 2017, Merton Health and Care Together is a collaboration of all providers and commissioners of health and care services for Merton, with the aim of working on these issues together via a Merton Health and Care Plan

How does it work?

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

- True collaboration between all partners, including voluntary sector and HealthWatch from the start

- Development of a new relationship between providers of services for Merton residents

- Focusing on delivering significant improvements to services in Merton

- Looking at how the system can change to encourage further improvements, and achieve sustainable change

- This is articulated within a Merton Health and Care Plan

St George's University Hospitals **NHS**
NHS Foundation Trust

NHS Merton
Clinical Commissioning Group

South West London and St George's
Mental Health NHS Trust **NHS**

merton

Central London **NHS**
Community Healthcare
NHS Trust

healthwatch
Merton

Epsom and St Helier **NHS**
University Hospitals
NHS Trust

merton health

mvsc
inspiring excellence

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Merton Health and Care Plan:
What is it for, and how does it fit?

Geography	Plan	Purpose
National	National Policy - Five Year Forward View, Care Act, etc	National policy direction, sets out the government's agenda for health and care
Regional	South West London Partnership: Sustainability and Transformation Plan	A requirement of the Five Year Forward View - articulates the sustainability challenge for the NHS in South West London, and to outline the main ways this could be addressed
Local	Health and Wellbeing Strategy	Focuses on health inequalities and on the influences that contribute to health. Brings together the most important influences on health, such as the early years, education, income and the environment in which people live to maximise health and wellbeing (www.merton.gov.uk).
	Joint Strategic Needs Assessment (JSNA)	An overview of the health and wellbeing of Merton residents, it highlights trends and key insights gained from research and health needs assessments about our population and how best to improve health and wellbeing
	Merton Health and Care Plan	**In response to the sustainability challenge, health and wellbeing strategy and JSNA, this plan will articulate the priority areas of work to be undertaken jointly between all partners in the Health and Care System**

Excellent Outcomes for People in Merton

"working together, to provide truly joined up, high quality, sustainable, modern and accessible health and care services"

Start well

Childhood Obesity

Children and Young Peoples' Mental Health

Live Well

Primary Care Development

East Merton Model of Health and Wellbeing

Primary Mental Healthcare

Diabetes

Age Well

Health and Social Care Integration

Dementia Friendly Merton

Continuous improvement of existing services

Creating the Right Environment

| Workforce | Outcomes & Engagement | Data and Analysis | Person Centred Approach | Incentives & Payment | Technology | Provider Development | Market Management |

What's next?

- Merton Health and Care Together Board meet on a monthly basis

- Development of a Case for Change – to identify the resources needed to make this work

- Project team in place – ensuring that plans are robust and deliverable

- Launch of new work stream, particularly in "Creating the Right Environment". Initial priorities are Outcomes Framework Development and Provider Development

- Merton Health and Care Plan to be finalised in the Autumn

- Deliver