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Merton Council

Health and Wellbeing Board

Date: **28 January 2020**

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

1	Apologies for absence	
2	Declarations of pecuniary interest	
3	Minutes of the previous meeting	1 - 4
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7	South West London CCG Merger - Verbal Update	

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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

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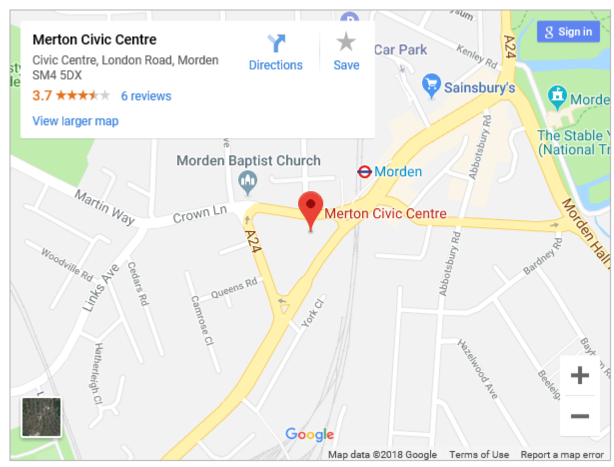

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Health and Wellbeing Board Membership

Merton Councillors

- Tobin Byers (Chair)
- Kelly Braund
- Oonagh Moulton

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

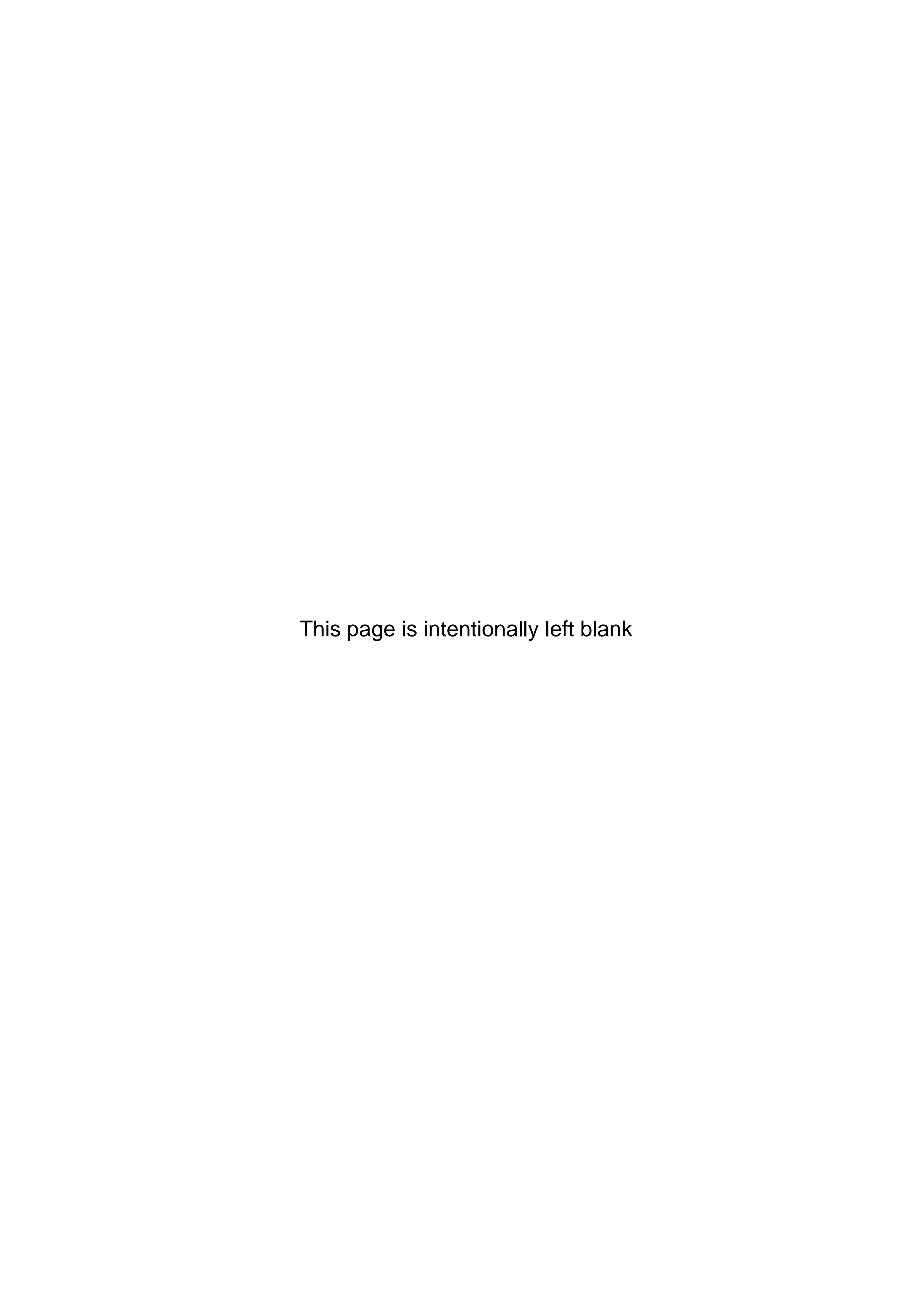
- One representative of Merton Voluntary Services Council
- One representative of the Community Engagement Network

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



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HEALTH AND WELLBEING BOARD
8 OCTOBER 2019

(6.15 pm - 7.22 pm)

PRESENT
Councillor Tobin Byers – Chair
Dr Andrew Murray - Vice Chair and Chair of Merton CCG
Councillor Kelly Braund – Cabinet Member for Children's Services
Councillor Oonagh Moulton,
Hannah Doody - Director of Community and Housing
Rachael Wardell - Director of Children, Schools and Families
Chris Lee - Director of Environment and Regeneration
Dr Dagmar Zeuner - Director of Public Health
James Blyth - Managing Director, Merton and Wandsworth CCGs
Dr Doug Hing - Merton CCG
Brian Dillon - Chair HealthWatch Merton

ALSO PRESENT
Josh Potter – Head of Commissioning Merton CCG
Louise Inman - Programme Director of Merton Health and Care Together
Annette Bunka - Head of Older People and Integrated Care at Merton and Wandsworth LDU
Jennifer Nolan – Head of Communications Merton and Wandsworth CCG
Sunita Patel – Head of Communications Merton Council

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for absence were received from:
Dr Andrew Otley – Merton CCG
Barbara Price – Merton Voluntary Services
Rob Clarke – Health and Social Care Forum
Dave Curtis –Healthwatch Merton

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

No declarations of Pecuniary Interest were received

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The minutes of the meeting on 25 June 2019 were agreed as an accurate record

4 LOCAL HEALTH AND CARE PLAN (Agenda Item 4)

Jennifer Nolan and Sunita Patel presented their report on the public communications of the final Merton Health and Care Plan. It was confirmed that amendments would

be made to the plan before publication including an update on the Merton Story. Board members requested that amendments should include a change to the East Merton Model of Health and Wellbeing, and some changes in accuracy to the children's section.

The Chair asked the Board to approve publication of the final version, taking into account the amendments specified. He also noted that there would need to be consideration of communications in relation to the Improving Health and Care Together consultation.

RESOLVED: The Board approved plans for public communications of the final Merton Health and Care Plan document

5 HEALTH AND WELLBEING STRATEGY PRIORITY ACTIONS (Agenda Item 5)

The Director of Public Health presented her report on Priority Actions for the Merton Health and Wellbeing Strategy. Board members supported the priorities and gave examples of how they are already being promoted:

- Merton Council are encouraging staff to use more active travel
- There is interest from local businesses, and there was a Healthy Workplace award at the recent Business Awards
- The CCG will support the Healthy Workplace and Mental Health initiatives
- There was support for the engagement of Children and Young People, in particular a Young People's HWBB and asking young people to help set next year's priorities.

The Board considered further promotion of the plan and suggested that there should be more involvement from MVSC. It was also suggested that partner organisations could promote the plan, for example the Veolia, the Waste Contractors.

The Director of Public Health spoke about ensuring that the outcomes are measurable and that what we measure must have a plausible and relevant link to an outcome so that there is a logical way of influencing outcomes

RESOLVED:
That the Health and Wellbeing Board consider, agree and champion the first of the rolling programme of priority actions for Merton Health and Wellbeing Strategy 2019 – 2024 as:

A. The new priority of Healthy Workplace, adopting the London Healthy Workplace Award as a framework for developing work places as healthy settings, with an initial focus on mental health and active travel.
B. Keeping the momentum on tackling diabetes, with a continued focus on tackling diabetes, through a whole systems approach.
C. To continue to self-develop and improve as a Board to be fit for the future and to consider how to involve children and young people as part of this development.

6 MERTON HEALTH AND CARE TOGETHER (Agenda Item 6)

The Programme Director of Merton Health and Care Together (MHCT) presented her report on The Merton Health and Care Together programme and asked the Board to note that relationships are maturing, work streams progressing with communications plans in place to staff and residents.

The Director of Public Health said that it is important that Merton Health and Care Together and the Health and Wellbeing Board (HWB) work together. It is helpful for the HWB to understand the workplace of MHCT so we can cross check and complement rather than working in parallel.

A discussion about how to fully engage teams within partner organisations took place and the Managing Director of Merton and Wandsworth CCG commented that there is a need to work across south west London to develop the workforce.

Reference was made to a recent MHCT workshop with Chris Ham and the need for every member of MHCT to think about how they can embed the Local Health and Care Plan into their work. Primary Care Networks will also be invited to join MHCT

The Director of Commissioning said that MHCT has helped day-to-day issues get resolved more quickly. MHCT needs to celebrate its successes more e.g. Independent Locality Teams work this year has led to a significant reduction in hospital referrals.

The Chair asked if MHCT becomes a Committee in Common how does this impact on the relationship with the Health and Wellbeing Board? The Managing Director of Merton and Wandsworth CCG replied that this supports the need for a good relationship between MHCT and the HWB. The work of the Local Health and Care Plan will be overseen by the HWB. The HWB will ensure join up with the Health and Wellbeing Strategy and other strategies at borough level. It is very important to have strong partnership at borough level and he is glad we have this established in Merton.

The Chair congratulated MHCT on its work to date and looked forward to an update in due course.

RESOLVED
The Board considered and approved Merton Health and Care Together programme update on progress to date and ambitions for 2019-2021

7 BETTER CARE FUND (Agenda Item 7)

Annette Bunka, Head of Older People and Integrated Care at Merton and Wandsworth LDU, presented her report on the Better Care Fund (BCF) – Plan for 2019/20. She thanked the Chair and Vice Chair for signing off this plan on behalf of the HWB ahead of this meeting so that it could be submitted on time.

The Director of Community and Housing explained that a lot of work goes into these plans and that there had been significant partnership work towards the BCF Plan being signed off in partnership. She thanked the CCG and LBM officers for this plan especially work the disabled facilities grant which was really impressive.

The Chair of Healthwatch Merton asked about monetary efficiencies – The Director of Communities and Housing explained that historically Merton had not performed well but that targets were now met. The Board noted that it is difficult to 'monetarize' such targets

James Blythe explained that much of this work keeps Merton sustainable, reducing demand reducing length of stays, which does link to cash savings and also improves quality and flow. There is a move away from tariff based costs instead looking at using staff and stock most efficiently.

RESOLVED
The Board noted the BCF Plan

8 SOUTH WEST LONDON CCGS MERGER PROPOSAL (Agenda Item 8)

The Managing Director of Merton CCG presented his report on the South West London CCGs merger proposals. He explained that all CCgs involved are currently going through the process of voting on the merger. Extensive work has been done preparing draft governance documents. When the merger is approved it will require an update of the Membership and Terms of reference of the Merton HWBB, to reflect the change in statutory body and roles and job titles of CCG representatives. It is likely that the Managing Directors role will become the Locality Director and Director of transformation, and there would be Chair of the Borough Committee

The Chair asked what would happen if not all CCGs did elect to join the SWLondon CCG, and the Managing Director explained that if this happened the first action would be to establish why they had voted in this way and how this could be addressed. He stressed that the plan was for all 6 CCGs to join.

RESOLVED: The Board noted the report

Committee: Health and Wellbeing Board

Date: 28th January 2020

Wards: All

Subject: Emotional Health and Wellbeing update

Lead officer: Dr Dagmar Zeuner, Director of Public Health

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

Contact officer: Barry Causer, Head of Strategic Commissioning (Public Health).

Recommendations:

A. HWB to agree to further develop the relationship with Thrive London to explore opportunities for further engagement, promote anti-stigma campaigns and seek opportunities for meaningful activity that compliments local work.

B. HWB members to agree to participate in the re-fresh of the Suicide Prevention action plan and promote evidence-based resources and training to residents and their staff.

C. HWB to discuss their experiences of workplace health programmes and the approach to supporting the mental health and wellbeing of their staff, to inform the approach to healthy workplaces in Merton.

D. HWB to note the holistic pilot programme taking place in East Merton around Health and Work.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report, requested by the Health and Wellbeing Board, is an update on a number of areas of existing and new work related to emotional health and wellbeing in Merton. The update focusses on the wellbeing aspect of mental health and does not cover clinical services.

2 INTRODUCTION

2.1. The Health and Wellbeing Board (HWB) received an overview of recent successes, developments and opportunities for future action on mental health and wellbeing at their meeting in January 2019. Since then the HWB has agreed the Health and Well-being Strategy (HWBS), which takes a whole life course approach so that all Merton residents can Start Well, Live Well and Age Well. The HWBS includes mental health and wellbeing as one of the three attributes of a healthy place and sets key mental health related outcomes of: less self-harm; better relationships; less depression, anxiety and stress; less loneliness; and, better social connectedness.

3 THRIVE LONDON MENTAL HEALTH FAIR

3.1. The HWB agreed at their meeting in January 2019 to work in partnership with Thrive London to develop an event that celebrates local mental health

and wellbeing services and engage with people who live and work in Merton about what matters to them around their mental health and wellbeing.

3.2. The Merton Mental Health Fair was held on Monday 4th November 2019 and with an estimate of over 300 people attending, was seen as a success. The Fair celebrated over 25 local organisations, covering mental health and wellbeing across the life-course, and there were contributions from the Leader of the Council Councillor Stephen Alambritis, Director of Public Health Dr Dagmar Zeuner and James Ludley from Thrive London.

3.3. Positive feedback has been received from services that attended who, as well as connecting with residents about the services that they provide, were also able to connect with other services, many of whom they were not aware of.

3.4. Feedback from those who attended the fair was wide ranging but had key themes around (1) communications (residents use a wide range of channels to access information e.g. word of mouth and the internet and the on-going need for wider promotion of Merton services e.g. a single place to access information), (2) the importance of delivery in key settings (a desire for support in key settings such as schools and workplaces and the importance of local assets for social support e.g. libraries and leisure centres) and (3) holistic care (the need to align mental and physical health services).

3.5. In line with the HWB's key principles and ways of working, including community engagement and empowerment, agreed as part of the Health and Wellbeing strategy, we would ask that the HWB develops the relationship with Thrive London to explore opportunities for further community engagement, the promotion of anti-stigma campaigns and pan-London services e.g. www.good-thinking.uk and actively seeks opportunities for meaningful activity that complements local work.

4 SUICIDE PREVENTION

4.1. Approved by the HWB in November 2018, the Merton Suicide Prevention Framework and Action Plan aims to support the vision for London to become a zero suicide City and for Merton to be a place where our residents know where to get help when they need it, where those supporting people at greater risk of suicide are well trained and where our communities encourage people to talk about mental health and wellbeing. There has been good progress in delivery of the plan, particularly on training and awareness, and we ask that the HWB notes the following successes and they provide support for their on-going delivery

- Merton Public Health and South West London STP Team has been successful in attracting £161,000 funding from the NHS/PHE 'Suicide Prevention Trailblazer Fund' for two suicide prevention projects. The first targets middle aged men and raises awareness about risk, encouraging people to talk, intervene and signpost to services. The second funds a bereavement co-ordinator who will work with the police and other emergency services to ensure people bereaved by suicide are connected to specialist and universal bereavement support services.

- We have delivered two tranches of 'Suicide Explained' training across Merton, promoting it to partners, community organisations and most recently

Council staff in Children, Schools and Families (CSF) and Adult Social Care staff working with at risk groups. The programme has trained 160 people so far and additional courses are being re-commissioned for delivery over the next year.

- Delivery of suicide awareness training programmes for schools, including a training event for CSF staff, run by Papyrus, where 16 CSF representatives were trained in suicide awareness.

- Delivery of Mental Health First Aid courses (two-day first aider and one-day champion) for partners and organisations across Merton including Merton CCG, SWLSTG, Metropolitan Police and a number of VCS organisations (including Commonside Trust, Faith in Action, Carers Support Merton, Jigsaw4U and Roots2Grow). In total 164 people have been trained to have greater awareness of mental health issues, reduce stigma around mental health and understand how to signpost to appropriate services. Additional courses are being re-commissioned, in partnership with MCCG, for delivery over the next year.

- Partners have supported Thrive London's campaign for a zero suicide city and have promoted the zero suicide alliance on-line training, found at www.zerosuicidealliance.com/training. The HWB's continued support by promoting the training and encouraging their staff and volunteers to complete the training would be welcome.

- Merton Public Health are working with the South West London STP Team on the Greater London Authority (GLA) pan-London data hub. This will provide data on suicides locally, with data being more time sensitive, as well as allowing greater data analysis functions which will be useful for prevention activity.

4.2. Over the next few months Merton Public Health will refresh the Suicide Prevention Framework Action Plan; choosing five key actions to progress in 2020/21. Proposals for action over the coming year include setting up a Suicide Prevention Forum, the development of a Community Action Plan which provides a framework when faced with clustering[1] or the risk of contagion[2], a short review of high risk buildings (such as multi storey car parks) and infrastructure in the borough (such as flyovers) to check for suicide risk and participation in a Suicide Prevention Sector Led Improvement programme; which includes webinars and case-studies that will guide our approach to the refresh of the Merton action plan.

The HWB members are asked to agree to participate in the re-fresh of the Suicide Prevention action plan and promote evidence based self-care resources e.g. www.good-thinking.uk and the suicide prevention training available at www.zerosuicidealliance.com/training.

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[1] A series of three or more closely grouped deaths which are linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are required to define a cluster. In the presence of a strong demonstrated social connection, only time linkage is required

[2] Contagion refers to the spread of suicidal behaviour, whereby one (or more than one) person's suicide influences another person to engage in suicidal behaviour.

5 MENTAL HEALTH AND WELLBEING IN THE WORKPLACE

5.1. The HWB agreed in October 2019 as their priority action for the delivery of the Health and Wellbeing Strategy the expansion of healthy workplaces across Merton.

5.2. As one of the three pillars of the London Healthy Workplace Award, Mental Health and Wellbeing is a critical component of the action plan that is being developed for consideration by the HWB in June 2020. In advance of this, we would like to present three case studies to the HWB, as examples of action focussed on mental health in the workplace. These are shared with the HWB to stimulate discussion around existing approaches taken by HWB members and to inform future action.

a) Merton CCG have supported their workforce in a healthy workplace programme by providing free fruit every week, encouraging participation in charity events that bring staff together and supporting physical activity through a global physical activity challenge. Due to the unsettling time for staff due to the restructure of the NHS across South West London, three of their senior managers have also been trained as Mental Health First Aiders so that they can have a greater awareness of mental health issues and be able to support colleagues and signpost to appropriate services. This has been well received by staff and managers and more staff will be trained as mental health first aiders and champions in the coming months.

b) Merton Council sent a survey to 60 Councillors to understand more about the pressure they are under whilst carrying out their duties and the effects on their mental health. Over half of the Councillors responded to the survey and initial results show

- Most Councillors have felt stressed, anxious or had sleeping difficulties caused by their role.
- The majority of Councillors are not aware of, and are not accessing, any resources for supporting their mental health and wellbeing.
- The majority of Councillors think they should receive support for mental health and wellbeing in the workplace.

The findings of the survey and the suggestions from Councillors e.g. highlighting self-care opportunities such as www.good-thinking.uk and exploring how Councillors can be supported at a pan-London level are being considered as part of the council approach to Healthy Workplaces which is led by the Workforce Strategy Board.

c) Merton Public Health commission Healthy Dialogues to support businesses in the three Business Improvement Districts to improve the health and wellbeing of their staff. Their monthly breakfast workshops are popular and upskill business leaders and employees to recognise the signs and symptoms of poor wellbeing, promote key health and wellbeing messages, use coaching strategies to support colleagues make positive behaviour changes and build resilience in the workplace. As a result of the training more than 80 business leaders and employees have set behaviour change goals and aspirations this year, including

- “This week I’m going to put aside some time to evaluate my stressors and what I will do differently”.
- “I’m going to bring TGROW [coaching model] to my meetings with my employees to have a clearer more focused discussion on time management and wellbeing issues”.
- “I’m going to get the team involved in setting wellbeing goals for the company”.
- “I’m going to be a better listener at work”.

5.3. We would ask that the HWB discusses their experiences of existing approaches to workplace health programmes that support the mental health and wellbeing of staff to inform the Merton healthy workplace action plan, which is being developed for consideration by the HWB in June 2020.

6 WORK AND HEALTH

6.1. A partnership from across Merton including Merton Council, Merton CCG, Department of Work and Pensions, (DWP) East Merton Primary Care Network and VCS organisations have been successful in securing £80k from Healthy London Partnership (HLP). This will fund a pilot programme to support people who have been signed off work by primary care with poor mental health and/or musculo-skeletal conditions back into work.

6.2. The pilot programme is still in design phase, but will include a holistic assessment and then signposting to a series of evidence based interventions e.g. yoga for healthy lower backs and an expansion of the art therapy offer in Merton. All activities will link to the roll out of Social Prescribing, be delivered in a community setting and will be available to practices in east Merton and for direct referrals from DWP.

6.3. The programme is being delivered in three pilot sites in London (Merton, Southwark and Camden) and is being evaluated centrally so that it can inform future planning by HLP and primary care.

7 ALTERNATIVE OPTIONS

7.1. NA.

8 CONSULTATION UNDERTAKEN OR PROPOSED

8.1. We have engaged with residents, in partnership with Thrive London, as part of the Mental Health Fair that took place on 4th November 2019. This was attended by over 25 local organisations and services and was attended by over 300 staff and residents from across Merton.

8.2. We have engaged with over 60 Councillors to understand more about the pressure they are under whilst carrying out their duties and the effects on their mental health.

9 TIMETABLE

9.1. NA.

10 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

10.1. NA.

11 LEGAL AND STATUTORY IMPLICATIONS

11.1. NA.

12 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

12.1. Improving mental health and wellbeing will contribute to reducing health inequalities.

13 CRIME AND DISORDER IMPLICATIONS

13.1. NA

14 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

14.1. NA

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

15.1. NA

BACKGROUND PAPERS

15.2. Suicide Prevention Framework 2018-2023

Committee: Health and Wellbeing Board

Date: 28 January 2020

Subject: Merton Story 2019/20

Lead officer: Dr Dagmar Zeuner, Director of Public Health

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

Contact officers: Mike Robinson, Consultant in Public Health; Samina Sheikh,

Principle Public Health Intelligence Specialist; Clarissa Larsen, Health and Wellbeing Board Partnership Manager

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Recommendations:

A. To approve the refreshed *Merton Story 2019/20*, and note its Key Messages, as part of the Joint Strategic Needs Assessment.

B. 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 and partnership working

C. To consider and comment on proposed direction of travel for Merton Story 2020/21

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1 PURPOSE OF THE REPORT AND EXECUTIVE SUMMARY

1.1 The *Merton Story* provides an overview of local needs identified through the Joint Strategic Needs Assessment (JSNA) process.

1.2 This paper presents the refreshed *Merton Story 2019/20* and infographic (see attached documents), and asks the Health and Wellbeing Board to support its dissemination and active use, to ensure key messages about the health and wellbeing of our local population inform strategic commissioning and partnership working.

1.3 The paper also outlines some proposed areas for development for the next Merton Story, The Board is asked to consider and comment on these proposals.

2 BACKGROUND

1.4 The Merton Story is the main component of a suite of products which together constitute the Merton Joint Strategic Needs Assessment (JSNA), which itself is a key part of Merton Data.

1.5 Production of the JSNA is a duty of the Health and Welllbeing Board. It is led by public health with contributions where appropriate from other council departments, the CCG and other partners.

3 DETAILS

1.6 The Joint Strategic Needs Assessment (JSNA) is a statutory assessment of population health and wellbeing needs for the Health and Wellbeing Board. In Merton we have re-named its main annual publication “The Merton Story” as a more accessible term.

1.7 The JSNA is more that the Merton Story alone. It also includes a number of other user-friendly products, e.g. Ward Health Profiles, Bulletins and in-depth Health Needs Assessments. These are issued periodically throughout the year, when relevant new data is published or more detailed analyses on particular topics have been completed. For some examples, please see Appendix

1.8 The Merton Story is intended to provide an overall summary. It consists of two main parts:

- The main document, in thematic sections, each headed by a number of Key Messages
- A 2-side infographic with the same main headings, providing an at-a-glance short summary

1.9 This structure is designed to meet the needs of a range of users, who vary in terms of the breadth and detail they require. The key messages are intended to summarise the most important points for decision makers and service leaders. The paragraphs which follow each key messages summary provide the detailed evidence upon which these are based.

1.10 This year’s version has been developed in line with feedback from the Board that there should be a greater focus on health promoting assets and population projections. In response, the section on the future demography of Merton has been expanded.

1.11 The Merton Story is explicitly limited to describing the risk and resilience factors that influence health and wellbeing, and the distribution of diseases and deaths, using mainly quantitative population data from national sources, supplemented where this is sparse with local and more qualitative insights. It is not the role of the Merton Story to cover performance of individual health and care services.

1.12 The main headlines and structure of the *Merton Story 2019/20* are similar to those in the previous version presented to the Board in March 2018. These are

that Merton is a healthy and safe place to live, rich in assets; at the same time there are areas of concern which are covered by the main headings of the report i.e. Inequalities and the Health Divide; Healthy Lifestyles and Emotional Wellbeing; Child and Family vulnerability and resilience, Increasing Complex Needs and Multi-morbidity and Hidden Harms and Emerging Issues.

1.13 The Board is asked to note the Key Messages of each section, and consider their implications for ongoing strategic commissioning and partnership working

Proposals for Merton Story 2020/21

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1.14 As the Health and Wellbeing Board needs to adapt to the changes in both the structure of local organisations and policy context, such as the establishment of a single SWL CCG by April 2020 and the closer working with Merton Health and Care Together Board, so does the Merton Story.

1.15 Following on from discussions in the last board seminar and in congruence with the principles of the refreshed Health and Wellbeing Strategy, we are proposing two main areas for development in the next version of the Merton Story: i) working closer with Health Watch Merton to present our population data side-by-side with what local people are telling us about their health experience for a deeper understanding of local need as well as assets; ii) using available population health and care data more explicitly to mirror them with data on wider determinants to strengthen our understanding of the link between healthy place, health and care services and health outcomes. As a potential focus to try out this approach, we are proposing to look at climate change as a system challenge.

1.16 For the longer-term, as the relationship and reciprocal roles of HWBB and MHCT board evolve and the SWL ICS develops, we need to review the most effective local and regional arrangements to bring together JSNA and population health management processes, capacity and capability to provide the health and care intelligence required for the whole system.

4 ALTERNATIVE OPTIONS

Not applicable – JSNA is a statutory requirement

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1 An informal survey of last year's users to discover how content was used; what had duplicated other information sources and could be omitted; what areas should be expanded

5.2 Draft key messages were sense checked with the CCG Executive Management Team, and other council departments

6 TIMETABLE

It is planned that the next version of the Merton Story will be presented to the Board in January 2021

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

No direct financial or resource implications. The Merton Story presents a summary narrative of population needs, to inform health and wellbeing partnership working, strategies and commissioning agendas. However, the Merton Story does not include recommendations how health and care needs should be met. This is picked up to through existing strategies and governance arrangements.

8 LEGAL AND STATUTORY IMPLICATIONS

As noted above, production of a JSNA is part of statutory guidance for Health and Wellbeing Boards

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Merton Story describes differences in health and care needs between different parts of the Merton population in particular between East and West; it does not explicitly reference human rights or community cohesion

10 CRIME AND DISORDER IMPLICATIONS

No direct implications. Fear of violence and knife crime have been identified as emerging issues

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

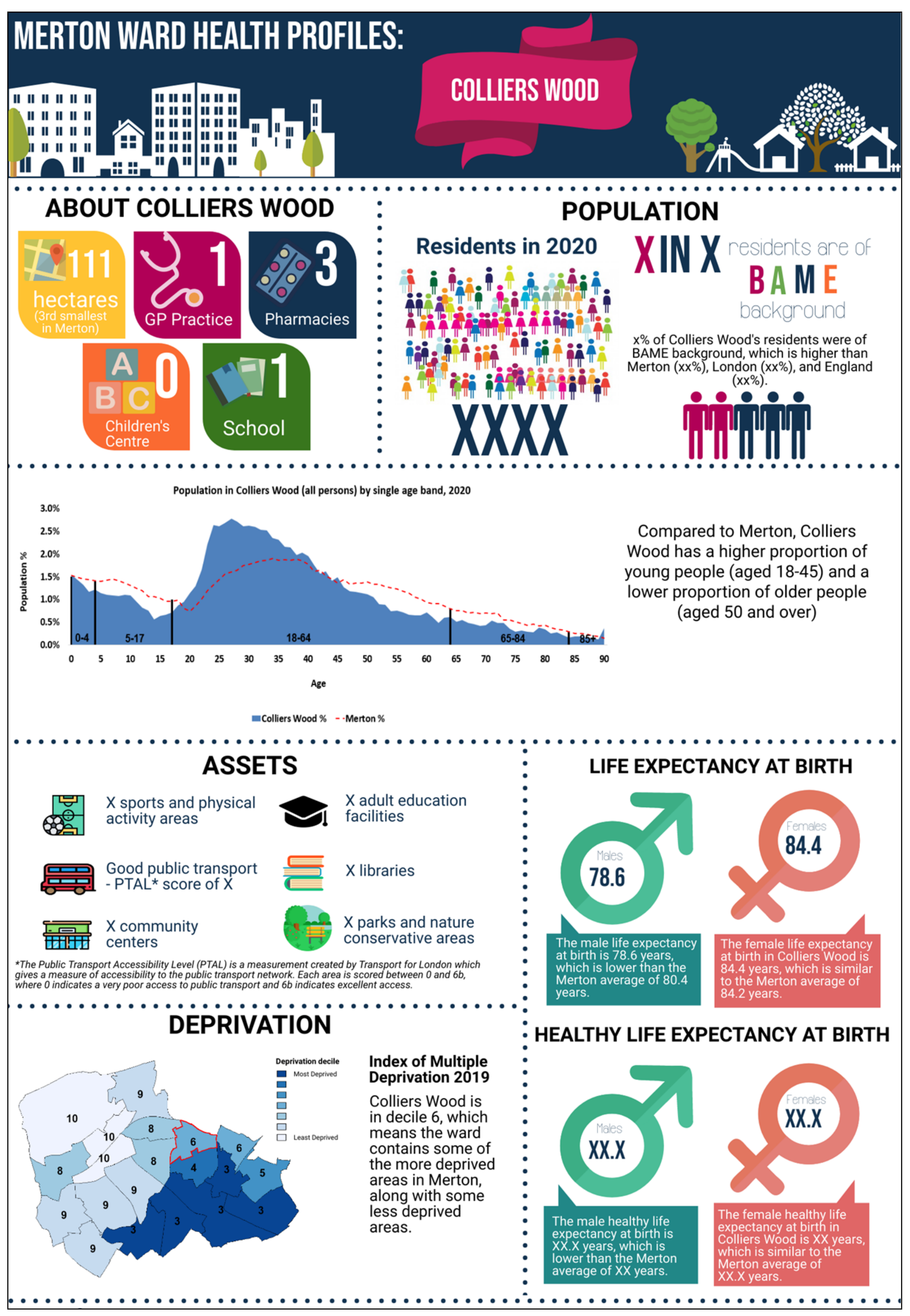
- The *Merton Story 2019/20* main report - see separate fie
- The *Merton Story 2019/20* infographic - see separate file
- Examples of other JSNA components – see below

Appendix: Examples of other JSNA components

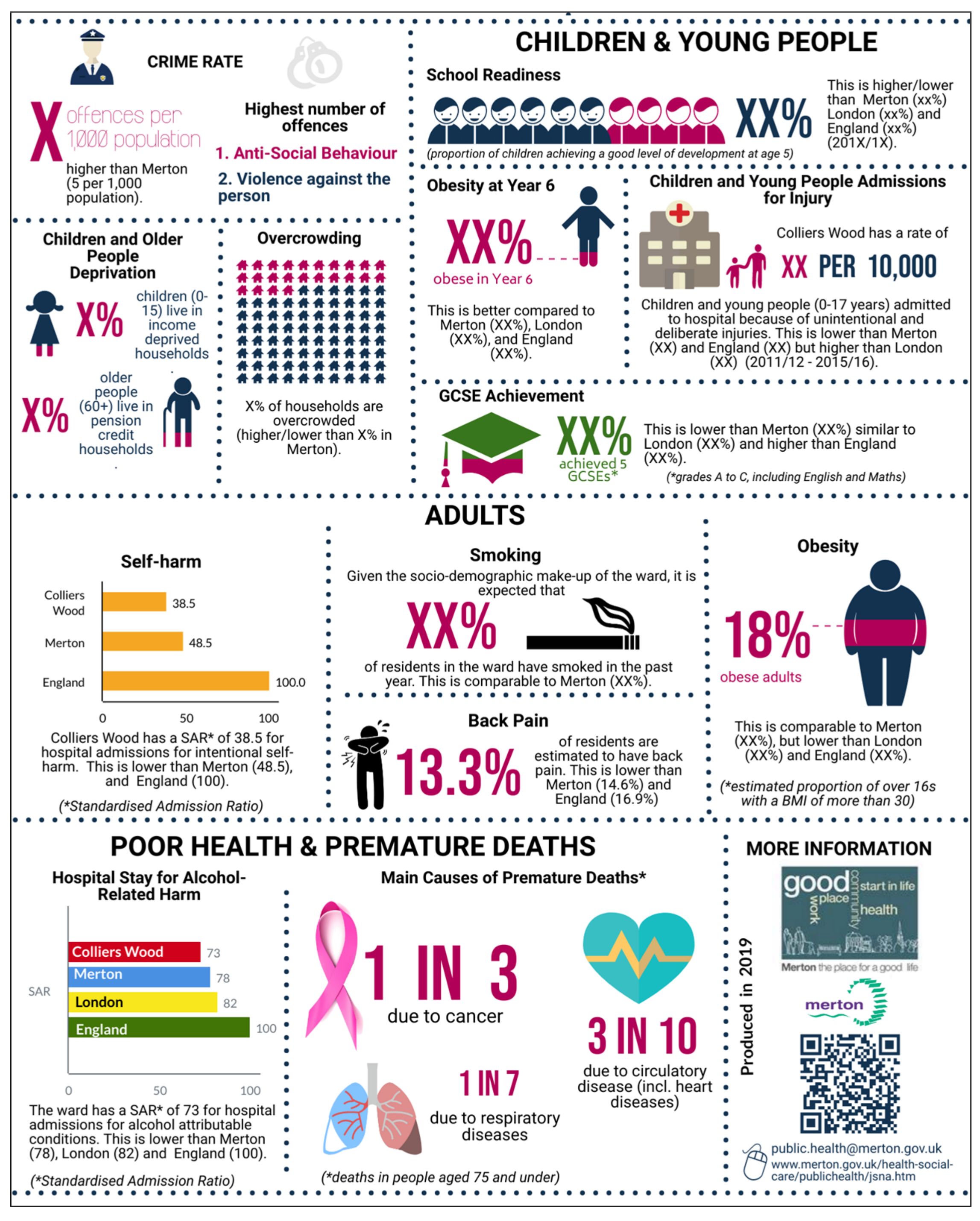
- Ward health profile – front page
- Ward health profile – back page
- Health needs assessment – table of contents

Ward Health Profile –front page

NB under construction; competed profiles to be published later in 2020



Ward Health Profile back page



Example Health profile – Autism - table of contents

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The Merton Story – Health and Wellbeing in Merton in 2019

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1 PURPOSE AND SCOPE

1.1 The Joint Strategic Needs Assessment (JSNA) is a statutory assessment of population health and wellbeing needs for the Health and Wellbeing Board. In Merton we have re-named its main annual publication “The Merton Story” as a more accessible term.

1.2 The JSNA is more than the Merton Story alone. It also includes a number of other user-friendly products, e.g. Ward Health Profiles, Bulletins and Health Needs Assessments on priority areas. These are issued periodically throughout the year, when relevant new data is published or more detailed analyses on particular topics have been completed.

1.3 The JSNA suite of products as a whole aim to describe the risk and resilience factors that influence health and wellbeing, and the distribution of diseases, both the current pattern and the forecast future trend. The purpose is to provide common evidence for all relevant partners and decision makers to help inform policy, strategy, commissioning and service delivery.

1.4 The Merton Story gives an overall summary, updated on an annual basis. It is a snapshot of what Merton is like as a place to live, the key risk factors for health and wellbeing through the life course, and the important health outcomes and health inequalities that exist between different population groups. Besides this main document, there is a 2-side infographic version which summarises its key messages.

1.5 This year’s version has a particular focus on the demographics of Merton, as this has not been covered in particular detail in past versions, and is a fundamental driver of need.

1.6 See the ‘Further Resources’ section on page 60 for the current range of other complementary JSNA products.

2 STRUCTURE AND CONTENT

2.1 This document consists of a number of sections, one for each of the main themes as shown in figure 1 below. Each section begins with a summary of the key messages for that theme, and is followed by a description of the underlying evidence from which the key messages have been distilled, supplemented where appropriate by maps and tables.

2.2 The first section is about the demographics of the Merton population, both now and as it is forecast to be in the future. Since demographics are fundamental to the interpretation of most of the detail that follows, this section also describes some of the uncertainties in the prediction process, and the different approaches that have been taken to address these. Subsequent sections are less discursive.

2.3 The Merton Story is not a comprehensive collection of all possible data on a given topic of interest. Priority has been given to evidence which meets the one or more of the following criteria:

a. Nationally published data, which allows comparison with London and England averages, other London Boroughs and statistical neighbours.

b. Part of a time series of data, meaning the recent trend over time can be ascertained and a forecast made for future years.

c. Available at smaller population size than the Borough as a whole, meaning that inequalities between East and West or between different population groups can be described.

2.4 Data from service delivery, which in past versions of the Merton Story has been included alongside population based data, has in general not been included in this 2019 version. The rationale for this change is:

a. Fluctuations in activity data may be due to changes in the availability of funding and human resources rather than the underlying population need

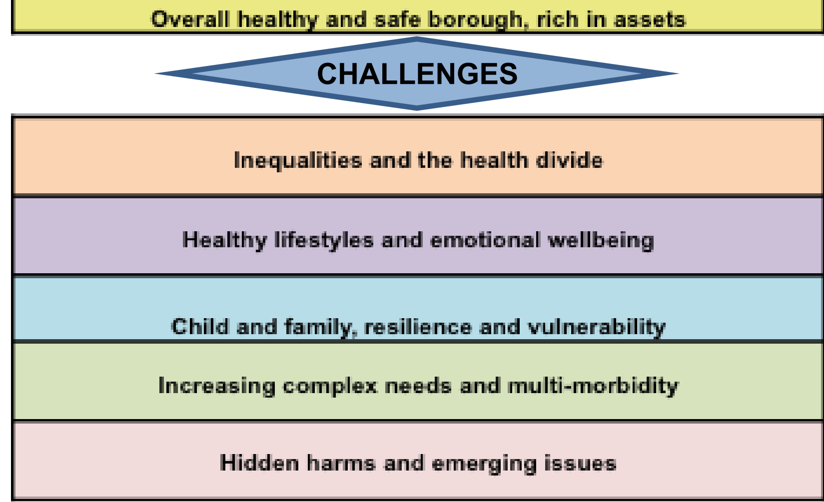
b. The detailed definition and collection method for activity data varies between areas making comparisons with other Boroughs difficult to interpret

c. Organisations which commission or provide services are better placed to report on such data

2.5 Exceptions to the principle that service data is excluded have been made for an important topic where there is none or only limited population data, or where there it is widely accepted that service data is a safe proxy for population need, eg hospital admissions for fractured neck of femur.

2.6 Policy recommendations based on the key messages and supporting data are not included in the Merton Story. It is for the Health and Wellbeing Board and other decision makers to refine and/or develop policy in response to the evidence presented. The exception to this general approach is where it seems appropriate to make recommendations about further data collection or analysis in order to better define population needs and outcomes.

Figure 1: Key Themes of Merton Story 2019



3 DEMOGRAPHICS OF OUR LOCAL POPULATION

Key messages

- The fundamental driver of population need and outcomes is the future size of the population, categorised by age, sex and other attributes.
- There are different types of Merton population eg school, resident and GP registered, and different ways for estimating current and likely future numbers. The best approach depends on the purpose for which the estimate or forecast is being made.
- The best estimate of Merton's current population is 210,400. It is predicted to grow by about 1750 (0.83%) each year for the next 15 years.
- This growth rate is not the same in all age groups. It is more than 2% per year in the 65+ group and less than 1% in the 0-4s.
- Merton's GP-registered and resident populations differ. In only 12 wards out of 20, 80% or more of the resident population are registered with a Merton GP. In total there is approximately 52,700 residents registered outside of the borough.
- The current proportion of Black Asian and minority ethnic groups in the resident population (1 in 5) is not predicted to significantly change over the next 15 years.
- Turnover (or "churn") in Merton is greater than similar Boroughs. In 2016, it is estimated a total of 38,000 people either moved in or moved out of Merton.

Introduction to Merton Demographics

3.1 The demographics of the population are the fundamental driver for its needs and outcomes. There is always a degree of uncertainty in the estimation of the total size of Merton's population, which planners and all stakeholders need to take into account

3.2 The reasons for this uncertainty are as follows:

- Even in the census year, when a precise count of residents is recorded, there is a degree of under-enumeration, which has to be estimated. Under-enumeration may be greater in some groups with higher needs such as asylum seekers and the homeless.
- People are continuously moving in and out of Merton. The rates of internal and external migration may be quite different and may vary by age, sex and other important characteristics such as ethnicity and income level.
- New housing is planned and is accounted for in some forecasts. However, actual delivery may differ from plans, some of which are made years in advance.

3.3 The risk of inaccurate population estimates is that this leads to services and funding being either under or over provided. To mitigate this risk, different agencies use different definitions of the Merton population and may project this forward using differing assumptions and methods. More information about the different types of projections and their strengths and weaknesses is an important part of the Merton Story and is provided in paras 3.5 below.

3.4 Demographics is not just about individuals, but also the families and groups in which they combine. This section also includes information about numbers and types of households, now and as predicted in 15-20 years. This is a new part of the Merton Story for 2019. See para 3.91 - 3.115.

Strengths and weaknesses of the different population definitions and projections

3.5 Given the inherent uncertainties in demographics described above, and because projections are used for quite different purposes by different users, a variety of sources and forecasting methods have been adopted.

3.6 Although 'resident' population is most often used, NHS bodies such as the CCG often use 'Merton GP-registered' population; Council education teams use the school registered population; those dealing with skills and employment may use the population who work in the borough etc.

3.7 A full description of all the sources and methods used across the public and private sectors in Merton beyond the scope of the Merton Story. What is given here is a summary of the most important sources and methods, and some discussion of their relative strengths and weaknesses.

3.8 Forecasting methods are often technically complex and not always well documented. Where publically available sources of information have gaps, clarifications have been requested from the relevant data supplier, usually GLA (Greater London Authority) or ONS. However, some questions remain unanswered. Given the necessary staff capacity, more work could be undertaken during the forthcoming year and published either as a supplementary bulletin or in the Merton Story 2020.

3.9 The main sources and methods which are described in the rest of this section are as follows

- ONS population projections
- GLA population projections
- NHS projections of the GP-registered population
- School rolls and projections
- Bespoke tabulations of ONS data combined with national surveys of social care needs and other research for social services planning (PANSI and POPPI)

3.10 The table below summarises the headline differences in population projections in Merton using these different sources. The differences are largest when considering future population numbers,are relatively small for their estimations of current numbers.

Figure 2 Comparison between different population projections, all ages

Persons (nearest 100)	2011	2019	2035
ONS 2016 based	-	210,400	225,100
GLA 2016 Housing Led	201,200	210,400	236,700
GLA Central trend Population	201,200	211,000	236,700
GLA Short-term Population	201,200	209,100	227,000
GLA Long-term Population	201,200	210,700	234,300
GP Registered in Merton		251,400	
POPPI (65+)/ONS 2016 based		26,400	37,200
PANSI (18-64)/ONS 2016 based		135,800	140,000

ONS population estimates

3.11 ONS population figures are the standard national reference and so considered first, although GLA projections (see below) are the source of first choice for most purposes locally.

3.12 The England & Wales Census occurs every 10 years, most recently in 2011. ONS uses information from the most recent Census, together with a set of assumptions about future fertility, mortality and migration, to produce "mid-year population estimates". Whilst a new Census count is only available every 10 years, there is a more contemporary information available about the other parameters, so population estimates are updated more frequently than the Census itself, usually every 3-5 years.

3.13 The changes from one set of mid-year population estimates to the next are usually of marginal significance; for example the ONS estimate of the 2019 mid-year population was 215,900 in the 2014 based projections and only changed by 5,400 in the subsequent and most recent set produced in 2016. However, when used to estimate mid-year population with a more distant time horizons, these changes are magnified; the most recent mid-year estimate for Merton in 2035 changed by 20,200 between the same two publications.

3.14 The strengths of the ONS mid year population estimates are that they use a consistent method across England as a whole; they estimate the age and sex distribution at local authority level not just the total size; they are widely used across sectors and agencies and so provide "a single version of the truth".[1]

3.15 The weakness of the ONS projections is that the assumptions about births, deaths and migration are those that are optimal across England as a whole, and are not necessarily the most sensible for London. In addition, ONS does not include information on planned

[1] ONS Data Principles.
https://www.ons.gov.uk/aboutus/transparencyandgovernance/lookingafterandusingdataforpublicbenefit/dataandsecurityprinciples/dataprinciples accessed 29.9.2019

housing developments. In response, the GLA has produced its own projections as described below.

3.16 The most recent ONS mid-year estimates are 2016 based. These have projections for each year up to 2041 by males and females in single and 5 year age bands, for regions and local authorities.[2] The next set of estimates are due to be published in autumn 2019, and the first set based on the 2021 census in September 2022.

GLA population projections

3.17 The GLA produces a series of population estimates and projections for use by London Boroughs. In 2018, LBM Analysts' Network produced a guide for council departments summarising the differences between the different GLA projections, and made recommendations for their use. See "A Guide to Population Projections" listed under further resources at the end of this document.

3.18 The GLA projections base is the first ONS mid-year estimate (MYE) following the decennial census. Projections are available by borough, ward and ethnicity. The borough level projections are produced in three versions that all use historic observations of migration but measured over variable length of time. The central trend uses observed migration over the last 10 years for which data is available; the short term trend uses the last 5 years of data and the long term trend the last 15 years. In addition, the GLA produces a housing-led projection, which incorporates data from the most recent Strategic Housing Land Availability Assessment (SHLAA). This housing-led projection is recommended as the default for LBM use.

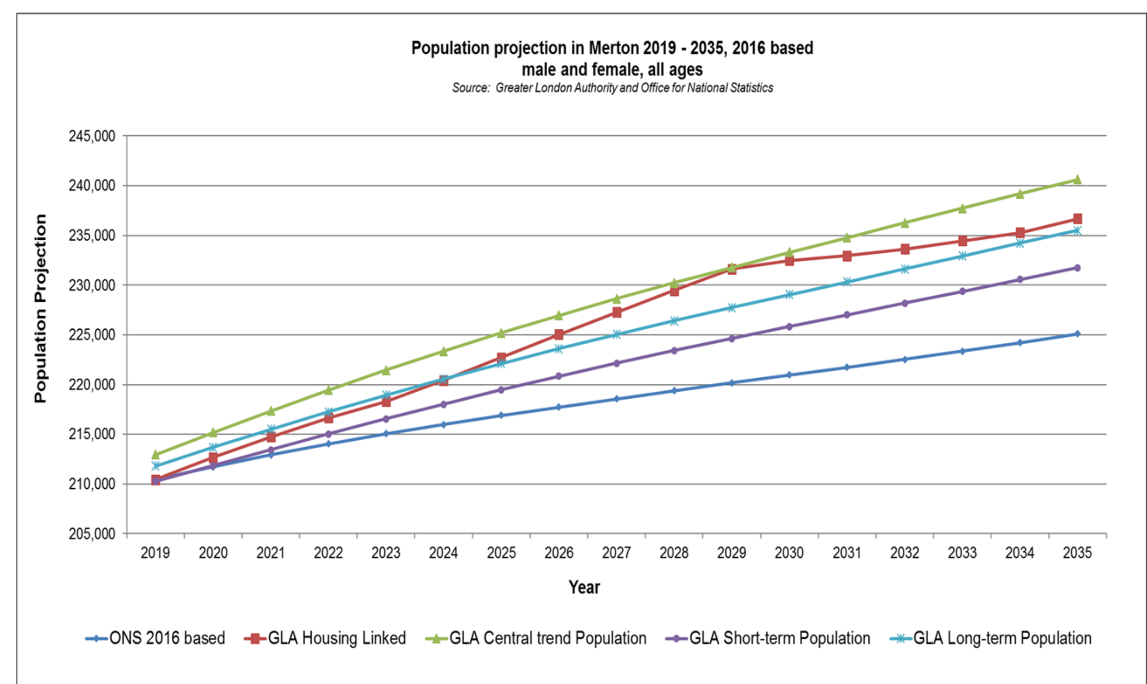
3.19 The advantage of the GLA projections is that they account for differences in population dynamics between London and England as a whole, in particular regarding national and international migration. This results in greater predicted rates of population growth. For example the Merton total population for 2035 is 225,100 based on ONS projections compared to 236,700 based on the GLA ones.

3.20 The most recent set of GLA projections were produced in 2017 based on the 2016 SHLAA. These are the set shown in Figure 3. The next full update of the GLA's projections will be the 2018-based projections, which are scheduled for release in autumn 2019.

3.21 Figure 3 shows how the latest ONS mid-year estimates and latest GLA set compare. Their divergence increases with time. By 2035, the fastest growing of the GLA predications exceeds the ONS estimates by about 20,000 people, nearly 10% of the baseline population.

[2] GLA 2016 based housing led ethnic group projections

Figure 3: Comparison of different population projections 2019 -2035



3.22 There are unanswered questions about the GLA estimates, for example the validation process for the migration scenarios from which they are derived; the detail of the SHLAA; the extent to which this matches the new Local Plan currently being produced by Future Merton. This is another area where more work could be done during the next year.

NHS projections of the GP-registered population

3.23 The GP registered population include all people that are registered with a GP within a given CCG, whether they are resident within the equivalent borough or not.

3.24 The NHS provides projections for a couple of years ahead and is available by ward, single year and gender. More information about how the resident and registered populations compare for Merton follows below in paragraphs 3.25 to 3.26.

3.25 The advantages of the GP registered population are that it is derived from a national database that is updated whenever individual patients move from one GP to another. It can potentially track movement into new housing developments and other local population changes. It is used as the basis for CCG funding allocations.

3.26 The weakness of the GP registration population figures are that they often suggest a population significantly higher than ONS or GLA. GP registration figures will almost always be inflated compared to the actual population size. One of the primary reasons for this difference particularly in London is due to failures to register/re-register promptly and the tendency for overseas movers to remain on the register. Areas which have a high churn rate and large student populations are likely to see highly distorted figures, whereas areas with more stable populations tend to show figures closer to the true population size.

School rolls and projections

3.27 The school census is a termly statutory data collection of details of pupils in every maintained (state-funded) school in England required by the Department of Education. For every pupil, it provides a detailed set of personal information including, date-of-birth, gender, ethnicity, entry date, whether they are part-time or full-time, their first language, enrolment status, Special Educational Needs provision, whether they are a service child or not, if they are entitled to free school meals and how long for, the number of absences they have taken with the reason for the absence(s)and their full home address.

3.28 This data set is used for reporting, particularly when pupil-based reporting requires some sort of contextual analysis. When combined centrally with results from other authorities, it is used for quality assurance of schools.

PANSI and POPPI : Bespoke tabulations of ONS data for social services planning

3.29 PANSI (Projecting Adult Needs and Service Information) and POPPI (Projecting Older People Population Information) are population projections that were originally developed for the Department of Health, which provide population data by age band, gender, and ethnic group. They are programmes designed to help explore the possible impact that demography and certain conditions may have on populations aged 18 to 64, and over 65 respectively.

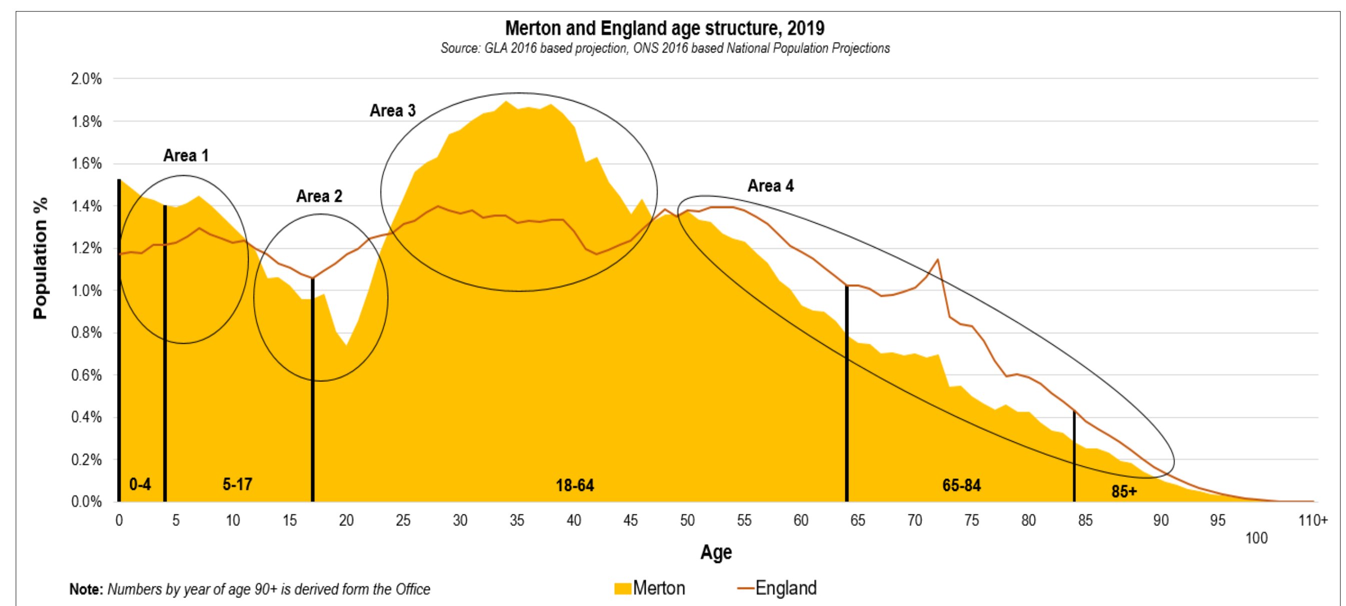
3.30 Prevalence rates from research have been used to estimate the impact of: learning disability, including living with a parent, Down's syndrome, challenging behaviour, autistic spectrum disorders; moderate or serious physical disability including personal care, stroke, diabetes, visual impairment and hearing impairment; mental health problems including depression, neurotic, personality and psychotic disorders, drugs and alcohol, suicide, adult survivors of childhood sexual abuse and early onset dementia.

Merton and England age distribution comparison

3.31 The greatest driver of funding allocations for individual areas is the overall size of the population. However, people at different ages have very different needs for services, so age distribution matters as well as size.

3.32 Whilst most allocations are adjusted to some extent for variations in age distribution, the default is that the local population will be similar to that for England overall. Understanding where this is not the case may be important. Figure 4 compares the estimated current age distributions for Merton and England as a whole.

Figure 4: Population by age groups in Merton 2019 compared to 2035



3.33 The figure shows that there are noticeable differences throughout the life-course. Merton has a relatively greater proportion of people in 2 ages groups: children aged 0-11 years old (see area 1 in figure 4), and younger adults aged from 24-47 years (see area 3 in figure 4). Conversely, Merton has a relatively smaller proportion of young people and young adults aged from 12-23 year olds and people 50 years and older (areas 2 and 4 in figure 4).

3.34 Besides understanding how the population now compares to England and other areas, it is important to understand what changes are predicted in future.

3.35 Key changes expected in Merton's resident population, 2019 to 2035, overall size, age distribution and ethnicity.

3.36 The Merton Story is focused on best estimates of the current population in 2019, and how this is forecast to change over the next 15 years, to 2035. This is an arbitrary time point, sufficiently far in the future that public health initiatives have time for long term impact yet still within current planning horizons for land use and climate change.

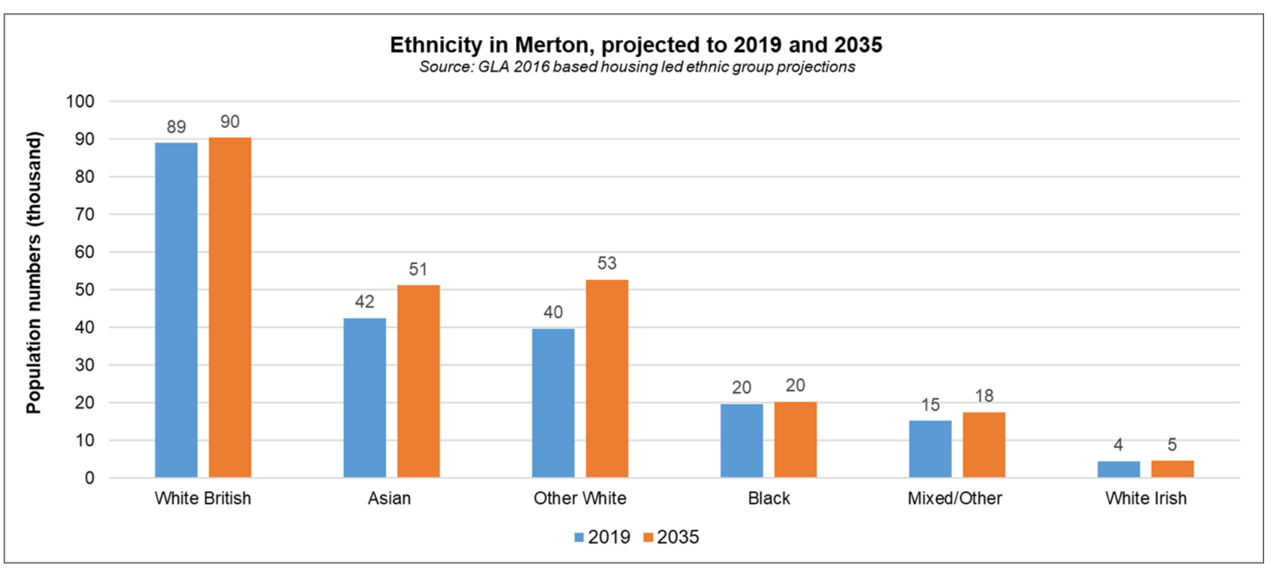
3.37 Based on the GLA housing led projections, Merton has an estimated resident population in 2019 of 210,400. This is projected to increase by about 12.5% to 236,700 by 2035.

3.38 GLA predicts that the growth to 2035 of about 26,200 people will consist of 53,600 births, 20,100 deaths and net outward migration of 7,300.

Ethnicity

3.39 Figure 5 shows how the resident population is expected to change in terms of its ethnicity.

Figure 5: Ethnicity in Merton



3.40 Currently, about 77,400 people (37% of Merton's population) are from a Black, Asian, or Minority Ethnic (BAME) group; this is expected to increase in line with overall population growth to about 89,000 people, meaning no significant change in the overall proportion (38% in 2035 compared to the current 37%).[2]

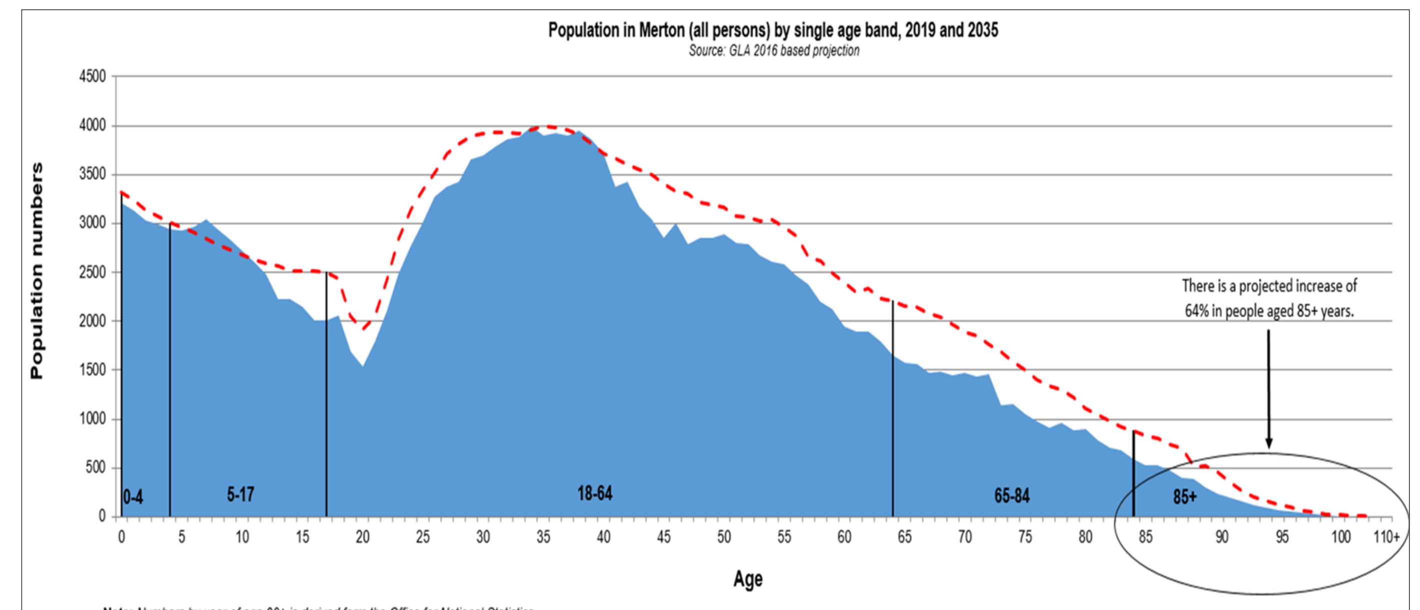
3.41 Within the BAME population, two-thirds of the 12,000 absolute growth is predicted to occur in the 'Asian' group, in contrast to little overall change in the 'Black' group.

3.42 Similarly, little change is expected is in the 'White British' or 'White Irish' groups.

Age distribution

3.43 The expected rate of population growth is not the same in all ages. Figure 6 shows numbers by age, now and as predicted in 2035.

Figure 6: Merton estimated population by age, 2019 and 2035



3.44 This shows that there is predicted to be more people at all ages, except for children aged 5-11 where a small decrease is expected.[3] Apart from in children, the absolute increase of individuals in each year of life is roughly constant (in 4 out of 5 cases there are on average 350-450 people at each age), this means a higher relative rate of growth in older people, whose absolute numbers are smaller. The average age of the population is rising.

3.45 More detailed information about how population will change in different age groups, comparing East and West Merton, is provided at para 3.73 below.

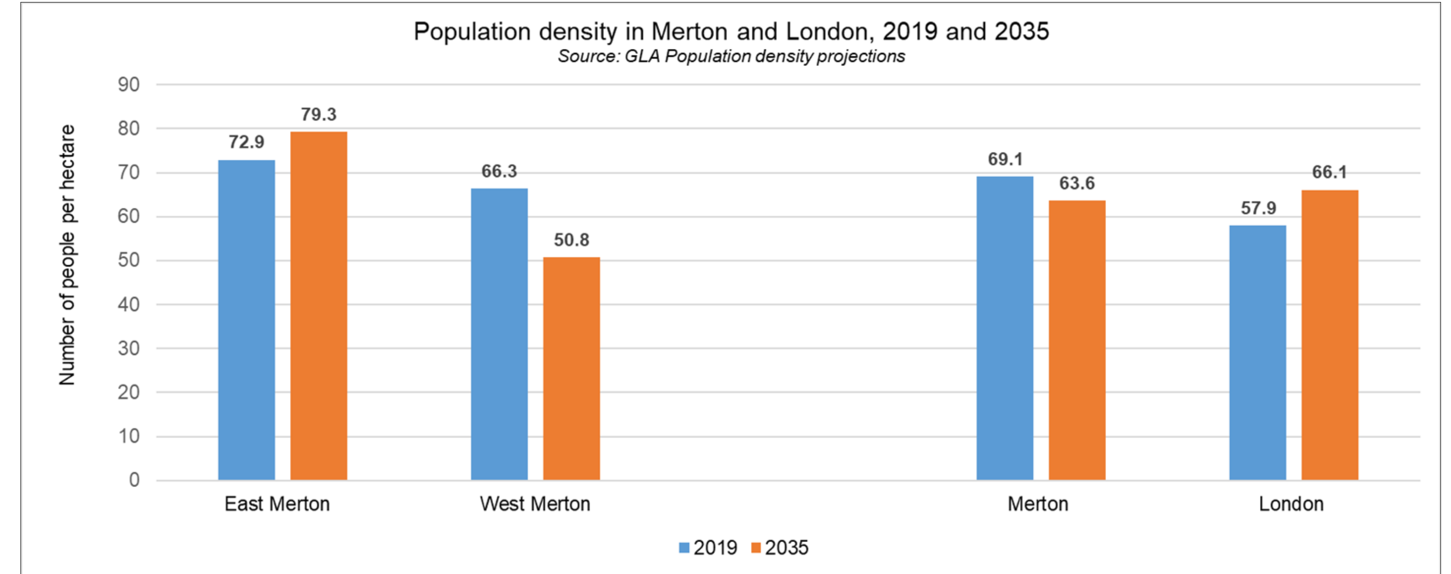
Population density and overcrowding

3.46 Population density is a measure of the average outdoor space per resident; all else being equal, higher population density will mean more overcrowding.

3.47 Population density can be estimated and forecast in the same way as age distribution and ethnicity, whereas overcrowding depends on housing conditions. Overcrowding is derived from the Census every 10 years, with little information available between Censuses, so it not amenable to forecasting in the same way.

[3] GLA 2016-based Demographic projections round, housing led model

Figure 7: Population density in Merton and London, 2019 and 2035



3.48 Figure 7 shows population density figures for east and west Merton, now and predicted for 2035. Population density is currently greater in the east of Merton than the west, 72.9 and 66.3 people per hectare respectively. There are 69.1 people per hectare in Merton overall, which is greater than London's 57.9 per hectare. By 2035 it is predicted there will be over 79.3 people per hectare in the east compared to 50.8 people per hectare in the west and 63.6 per hectare in Merton overall compared to 66.1 per hectare in London.[4]

3.49 A household is considered overcrowded when there are at least 1 bedroom too few as defined by the ONS. 'Bedroom standard' is used as an indicator of occupation density. A standard number of bedrooms is allocated to each household in accordance with its age/sex/marital status composition and the relationship of each of the members to one another.[5] In Census 2011, the rates in east and west Merton were 20% and 11% respectively, compared to 22% for London and 9% for England as a whole.

Population turnover

3.50 Population turnover (sometimes referred to as churn) is a measure of the rate at which people are moving into and out of an area. ONS who produce estimates every 2-3 years defines it as the sum of the numbers estimated to have moved in and those estimated to have moved out per 1000 total population.

3.51 Turnover may be an indicator of unmet need, as people with poor housing or debt seem more likely to move than people without such issues.

3.52 In 2019, Merton has a turnover rate of 178 per 1,000 residents, higher than its statistical neighbours (Redbridge, Ealing, Enfield and Barnet) whose rates varied from 125

[4] GLA Population density projections
[5] Overcrowded Households by Borough. ONS. 2014

to 151 per 1000. This suggests about 38,000 people either moved in or moved out of Merton in that year.

3.53 Turnover varies significantly by age. The 20-24 year age group has the highest rate of 461 per 1,000 and the 75-79 year age group the lowest at 35 per 1,000.

3.54 Predictions of how turnover will change at local level between 2019 and 2035 are not available.

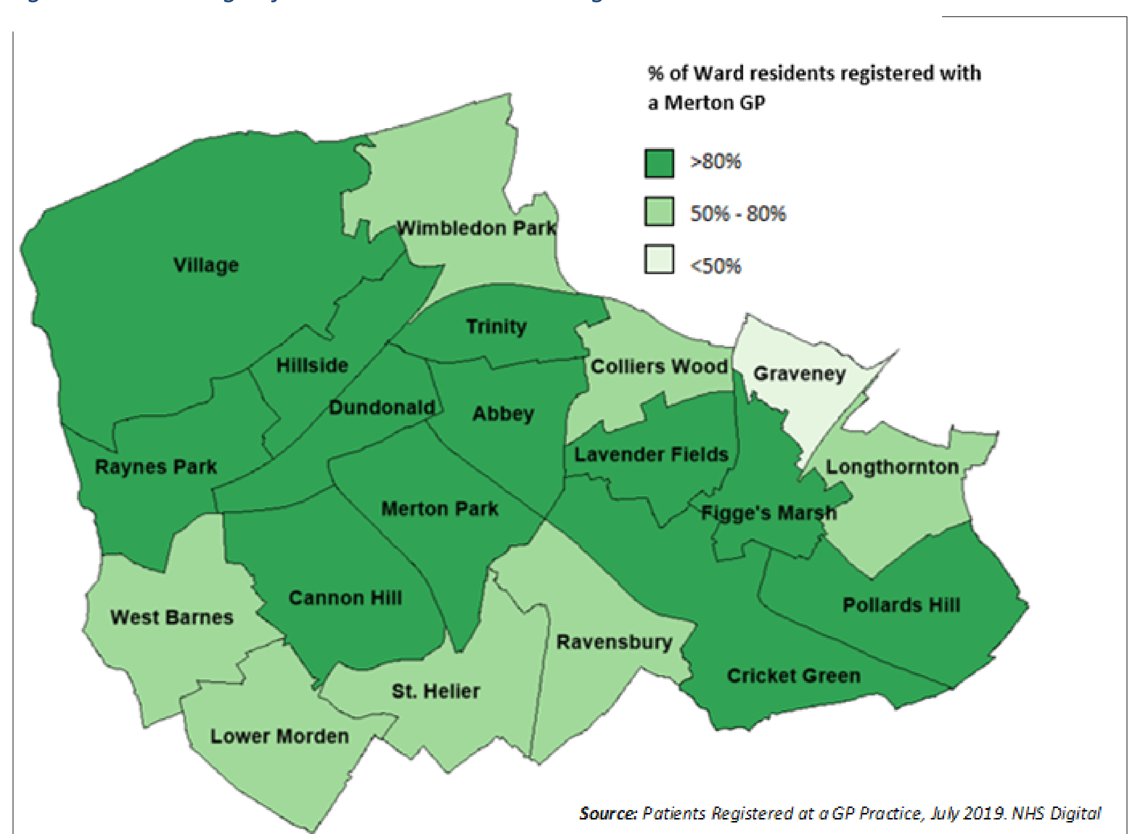
3.55 Population Turnover is an aspect of the Merton Story which could be developed further in future if capacity allowed, and there was agreement how the analysis would be used, for example to target homelessness prevention.

Key features of the GP-resident population and its conformity to residence

3.56 Merton CCG currently has a GP registered population of approximately 224,300, of which 90% are Merton residents.[6]

3.57 GP-registered and resident populations differ. It is estimated that 198,800 people are both resident and registered with a GP in Merton which is 90% of all those registered, and 80% of those resident. The proportion of the ward resident population of each ward who are registered with a Merton GP varies from 24% in Graveney ward at its least, to 98% in Dundonald ward at its most. Figure 8 shows the pattern across the borough as a whole. More than half the wards have at least 80% of residents registered with a Merton GP.[6]

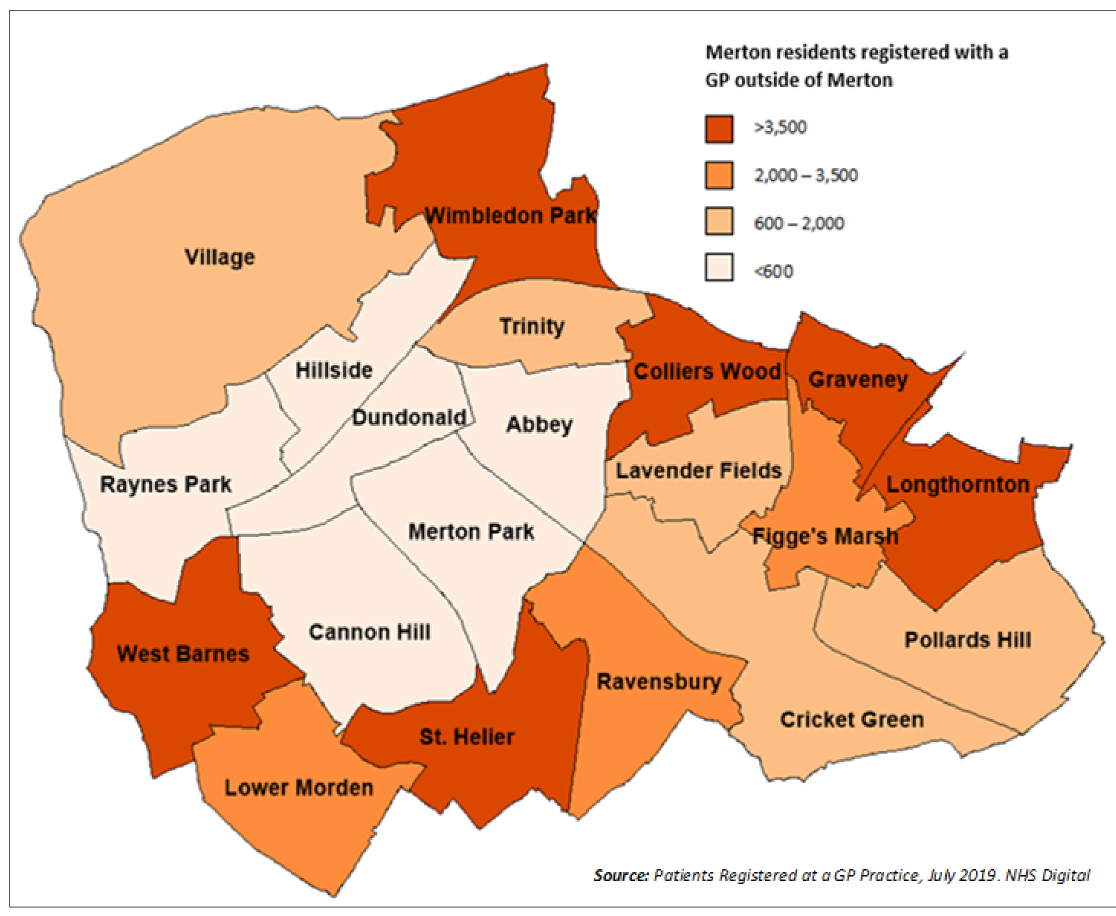
Figure 8: Percentage of Merton ward residents registered with a Merton GP



[6] Patients Registered at a GP Practice, July 2019. NHS Digital

3.58 On the other hand, about 52,700 Merton residents are registered with GPs outside Merton, in various other CCGs. Figure 9 shows how these people are distributed by ward. Those wards which are at the boundary tend to have more residents registered elsewhere, the most being Graveney ward with 9,600 residents.[6]

Figure 9: Number of Merton residents registered outside of Merton



3.59 Just over 50% of those with a GP elsewhere (28,000) go to Wandsworth followed by Sutton (9,000), Kingston (7,000), Lambeth (5,000) and Croydon (2,000).[6]

3.60 Conversely, there are residents of other boroughs whose NHS care is commissioned by Merton CCG. Of the total of 25,600 such people just over 40% (10,800) are residents of Sutton followed by Wandsworth (6,300), Kingston (2,600), Lambeth (2,400) and Croydon (2,200).[6]

3.61 The incomplete alignment of registered and resident populations is important in the context of working towards greater integration of health and social care. For example, hospital discharge planning requires co-operation between adult social care and primary care.

School population

3.62 Separate estimates and forecasts of the Merton school population are necessary, as children who live in Merton do not necessarily go to school in Merton; conversely Merton

schools have many students who come from elsewhere. Movement of children to and from school is a health and active transport issue.

3.63 A census of students at taxpayer-funded Merton schools is undertaken once per school term. More details have been provided at para 3.5 above in the section comparing different types of population estimate.

3.64 In 2019, there were 16,679 primary school children attending state funded schools within Merton from which nearly 90% were residents of Merton.

3.65 7,900 young people attended state funded secondary schools within Merton at statutory school age and a further 1,414 after 2016. Just over 70% of the statutory age secondary school pupils were residents of Merton.

3.66 Approximately 2,000 young people attending state funded secondary schools within Merton lived in another borough.

3.67 About 4,000 young people were living in Merton but attending secondary schools elsewhere.

3.68 The council's official roll projections for 2019 predict there will be a decrease to 15,721 primary school children by 2023/24 and an predicted increase to 9,469 statutory age secondary school children.

3.69 These and other projections are used to make planning decisions on school provision, for example creating additional school places where there is an identified shortage. The school roll in Merton state primary schools increased by 33% in the years from 2008 to 2017 and required a major expansion programme. As detailed at paragraph 3.68 above, primary school numbers are now reducing. The increase in the years up to 2017 is now flowing into secondary schools, with the new Harris Academy Wimbledon secondary school providing most of the extra capacity.

3.70 There has also been a significant increase in the number of children with SEND (Special Educational Needs and Disabilities) over the past 5 years requiring an increase in specialist provision.

3.71 School populations are also relevant to the provision of public health nursing and related services that aim to improve young people's mental health. As further discussed in paragraph 7.46 later in the report, this is an area of concern.

3.72 School population is an aspect of the Merton Story which could be developed further in future if capacity allowed and there was agreement how the analysis would be used, e.g. for planning new active travel initiatives which crossed Boroughs, or ensuring integration of young people's mental health support across Borough boundaries.

Further details of the expected population changes, by age group and locality

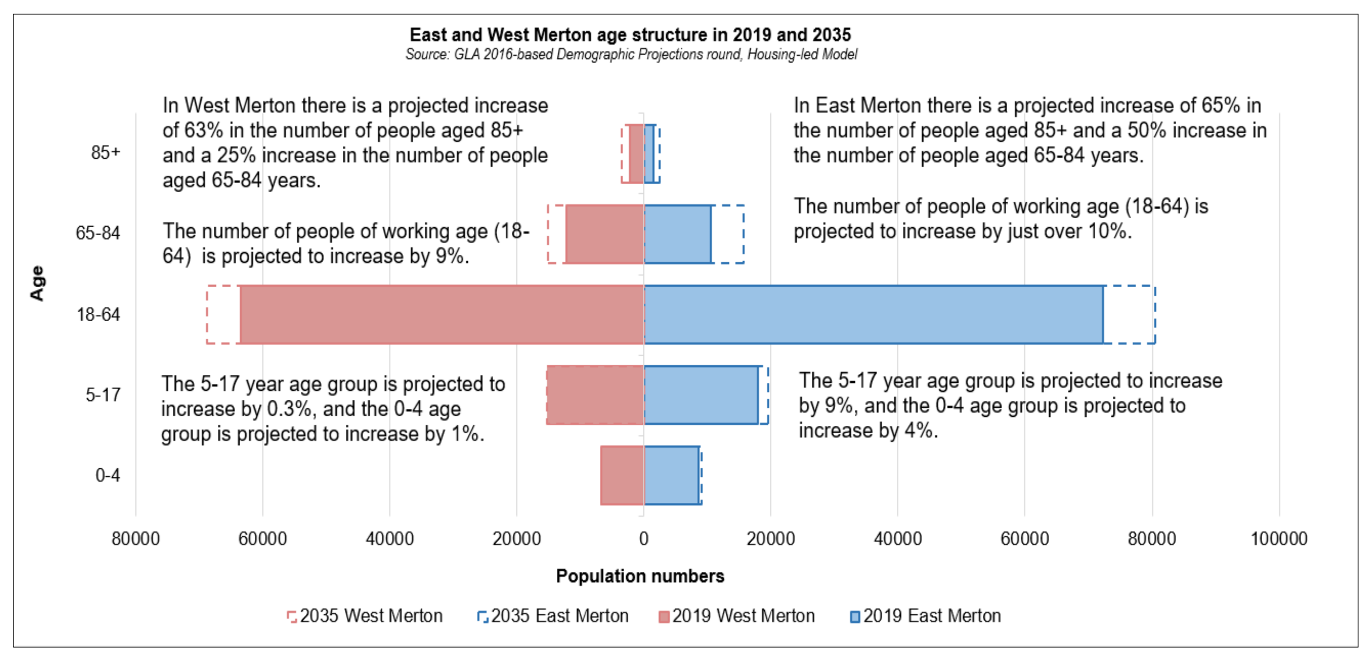
3.73 Health need is not uniform across the life course, so it is important to understand how overall population growth varies in different age groups. Needs also vary by locality. In general needs are greater at the extremes of life (infancy and old age) and in more deprived localities.

3.74 The approach adopted in the Merton Story 2019 has been to tabulate a set of population estimates using the following variables.

Year	2019 and 2035
Age group	Pre-schoolers (0-4 years); School age (5-17 years); Working Age Adults (18-64 years); Younger Elderly (65-84 years); Older Elderly (85+ years)
Locality	West and East [7]

3.75 A summary of the results is shown in Figure 10. In 2019, east Merton has an estimated resident population of 110,800 which is projected to increase to 127,100 by 2035 (a 14.7% increase). West Merton, has an estimated resident population of 99,600 which is projected to increase to 109,500 by 2035 (a 10.0% increase).

Figure 10: Projected population change 2019 to 2035 by age group and locality



Births

3.76 ONS projections are that the number of live births in Merton in 2019 will be 3,250. There is expected to be a decrease in number of births in Merton over the next 16 years, to 3,070 in 2035. ONS estimate there will be 50,000 births in total over this period.[8]

[7] For a definition of East and West localities see Annual Public Health Report 2017-18
[8] Births and Fertility Rates, Borough. Office for National Statistics. 2017

3.77 Merton had a smaller rate of decline between 2019 than 2018 than all other 29 London boroughs where births also declined. Only two London Boroughs showed an increase in births in this period.[9]

3.78 As explained in the introduction to the demographics at para 3.1, different agencies use different methods for their population projections. The number of births is one of the areas where differences are most noticeable. The GLA predicts there will be 32 more live births in Merton in 2019 than the Office of National Statistics, 3,282 rather than 3,250. Whilst for this single year this is only a 1% difference, if repeated every year, it becomes substantial.

3.79 The number of births is an important driver of the immediate need for health visiting services and in the medium term for school places. This is an area where more detailed work could be undertaken if it was considered a priority, for example to correlate counts of actual births in preceding years with the estimates used in funding and planning.

Pre-schoolers

3.80 In 2019, there were estimated to be 15,300 0-4 year olds making up 7.3% of the total population. By 2035 this is predicted to increase to 15,800 (7%) which is an extra 500 0-4 year olds in Merton.

3.81 A higher number of 0-4 year olds are estimated to be resident in east than in west Merton (8,600 and 6,700 respectively). Both are predicted to show an increase by 2035, to 9,000 in the east and 6,800 in the west.[3] The predicted increase is four times greater in east than west.

School age

3.82 There are currently estimated to be 33,200 5-17 year olds in Merton, which makes up 15.8% of the total population in 2019 and this is predicted to increase to 34,700 by 2035 (14.7% of the total population). Note that this is a small increase in the absolute numbers, but a fall in the proportion of the population overall.

3.83 East Merton currently has almost 18,000 5-17 year olds compared to only 15,200 in west Merton. Both east and west Merton are predicted to show an increase in this age group by 2035 to 19,500 in the east and 15,200 in the west.[3]

Working age adults

3.84 Merton's working age population is the largest of the tabulated age groups, currently estimated as 135,700 people making up 64.5% of the total population. By 2035 this is predicted to increase in absolute terms to almost 149,300 but to decrease slightly as a proportion of the total population, to 63.1%.

3.85 Almost 72,300 of this age group currently reside in east Merton compared to 63,400 in west Merton. There is expected to be an increase by 2035 to 80,500 in east Merton and 68,800 in west Merton.[3]

[9] Population Statistics User Group, Census Information Scheme, GLA

Younger elderly

3.86 Merton has 22,600 younger elderly people comprising 10.8% of the total population. By 2035 this is predicted to increase to 30,900 (13%).

3.87 Currently, 10,500 younger elderly live in east Merton compared to 12,200 in west Merton. By 2035 there is expected to be an increase to 15,700 in east Merton and almost 15,200 in west Merton.[3]

Older elderly

3.88 An estimated 3,600 people aged 85 years and over (1.7% of the total population) currently live in Merton. By 2035, this is predicted to increase to almost 6,000 (2.5%).

3.89 In 2019, 1,400 older elderly live in east Merton compared to almost 2,200 in west Merton. By 2035 there is expected to be an increase to 2,400 in the east compared to 3,600 in the west of Merton, meaning a 65% and 63% increase respectively.[4]

3.90 This rate of growth for the older elderly population is the greatest of any of the tabulated age groups, and has substantial cost implications. The Office or Budget Responsibility estimates that by 2020/21 the average annual spending on 85 and 90 year olds is projected to be five times and almost eight times respectively greater than the spending on 30 year olds.[10]

Households in Merton

Introduction, and what this section contains

3.91 Population projections are usually considered for individuals, divided by attributes, which drive need such as age, ethnicity and geographical location.

3.92 For some service planning, the types of household in which people live may be another important driver, for example older people living alone are more likely to need social care support.

3.93 Family structure is another potential driver of need, in particular for adult social care. Older people who have no children are more likely to need state-funded support.

3.94 The purpose of this section is to describe the information which is available about these factors, as estimated now and predicted in the future. For many of the questions that planners might want explored, there is no locally available data. Where possible national data has been scaled to the size of the Merton population. As described elsewhere, the Merton population is not typical of England in all respects so the interpretation of such scaled values is difficult.

[10] Office for Budget Responsibility Fiscal Sustainability Report: January 2017 (http://budgetresponsibility.org.uk/fsr/fiscal-sustainability-report-january-2017/).

3.95 This is another area where further work could be undertaken if it were clear how the results would influence decision-making. ONS have confirmed they would be willing to undertake additional analyses to assist this process for a fee.

Total numbers of households in Merton, comparison with other London Boroughs

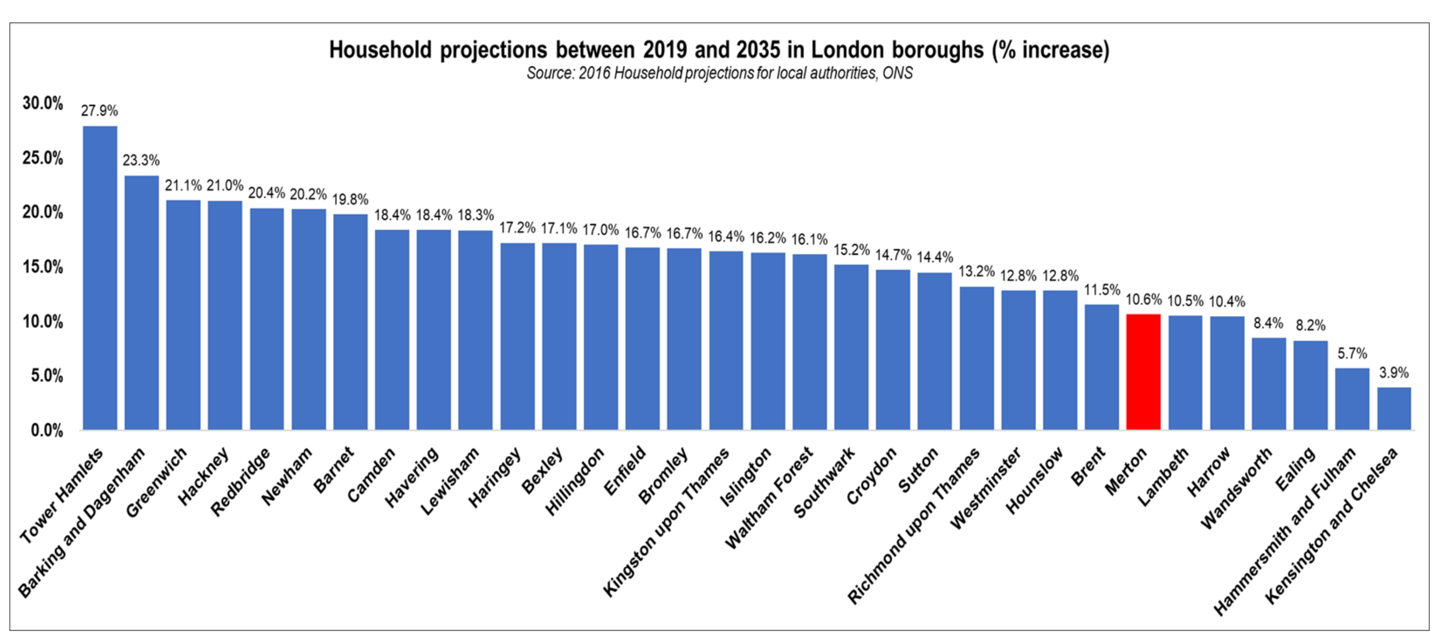
3.96 The total number of households in Merton in 2019 is estimated to be 80,400, and ONS predicts that this will grow by 10.6% to 88,900 by 2035. Equivalent values for other London Boroughs are shown in Figure 11, and shows that Merton is not an outlier.

3.97 ONS estimate that 99% of the resident population in 2019 were household-based, and that this will fall to 97% in 2041.[11] The difference is due to the small numbers of people living in care homes and other institutions.

3.98 Looking back, Merton's rate of growth in the total number of households has been smaller than now predicted, and less than in other places. From 2001 to 2018,[12] Merton has only had 7.3% increase in household growth[13], lower than in London (14.4%) and England as a whole (15.7%).

3.99 The reasons why the historic rate of growth in the number of households has been considerably smaller than elsewhere, and less than expected over the next 15 years, are unclear.

Figure 11: Projected increase in numbers of households 2019-2035, Merton compared to other LBs



Age distribution of principal householders – now and 2041

3.100 As described at paragraph 3.15, Merton's population is ageing. Projections of the age distribution of the principle householder show a similar trend. The number of households

[11] 2016 based household projections for local authorities, ONS
[12] Census, 2001
[13] Valuation Office Agency - Council Tax: Stock of Properties, Merton Data

where the principle householder is less than 45 is predicted to fall from about 33,900 in 2019 to 29,700 in 2041, a 12% fall.[12]

3.101 By contrast, the number of households where the principle householder is older than 65 is predicted to rise from about 16,600 in 2019 to 26,700 in 2041, which is a 60.6% increase.[12]

Types of household – now and 2041

3.102 Households are classified by whether or not they contain children; number of children (one, two or more); in the case of childless households whether or not they are a single person.

3.103 Figure 12 shows the numbers of each of these types of households in Merton in 2019, and for households without children, the age of the principle householder.

3.104 By 2041, it is expected that the numbers will have changed in the following ways

- An additional 735 (6.3%) households with one dependent child. This is the biggest percentage increase in types of family households consisting of children, reflecting the increasing tendency to have fewer children.
- An increase in single person households with an additional 1,995 male households and 2,753 female households by 2041.
- An additional 7,173 (22.5%) households with two or more adults.

Figure 12: Estimates of households by type and age of principal householder, 2019

Household projections by household type and age in Merton, 2019
Source: Office for National Statistics

Number of Households
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-

11,800
10,100
4,200
13,700
23,500

Households with one dependent child
Households with two dependent children
Households with three or more dependent children
One person households
Other households with two or more adults

Household type

Note: The age of household is based on the household reference person. This is the individual that represents the houshold for statistical purposes and is defined as the eldest economically active person in the household.

16-19 20-64 65-84 85+

3.105 The overall effect of these changes in household type is that the average household size is due to decrease from 2.61 in 2021 to 2.48 in 2041.

Households by tenure – now and 2041

3.106 There have been substantial changes in the numbers of people of different ages living in particular housing tenures. Nationally, the average age of first time buyers has risen considerably, with younger people consequently spending longer living with their parents or within the private rented sector.

3.107 Merton-specific information about the scale of this phenomenon is not currently available, and neither are projections about how the age distribution within the private rented sector will change in the medium term. The 2021 census will enable this, as it will provide a description of age of householder by household type by tenure in each small area. Work could be undertaken to compare this to equivalent results in 2011, although it may require fees being paid to ONS for extraction of the necessary data from individual census returns.

3.108 A particular driver for need and services will be the number of single person households in the private rented sector where the householder is retired and does not have children. The numbers of such individuals in Merton in 2019, and how and the likely growth rate in this group are unknown.

Other demographic changes which will affect need for state-funded social care

3.109 The need for social and personal care for older people is growing. The average lifetime expenses for social care faced by people aged 65+ exceeds £30,000. The cost of long-term care provision expenses have increased since 2000 and are projected to continue rising in the future.[14]

3.110 These estimates do not include informal care provided by family, friends and neighbours. The proportion of all care provided in this way is expected to fall.

3.111 The ageing of the population and changes in household type are not the only demographic changes affecting this. Most of these changes are tending to reduce the supply of family carers. Some of these are listed below, together with Merton values now and at other time points if known.

3.112 Reduced fertility: The total fertility rate in Merton is currently 1.8 and nationally the completed family size is 2.85. Both are expected to fall in the medium term. Childlessness is increasing which reduces the care-giving capacity of families.

3.113 Female employment rate. In 2018/19, 63% of women in Merton are employed compared to 57% 10 years ago.[15]

3.114 Young adults on average are leaving the parental home later, forming their first stable adult unions later, getting married later and postponing the birth of their first child. Whereas rising life expectancy increases the number of generations within the family network, postponement of births reduces it. This is known as the 'beanpole family' with increasing

[14] Current and future challenges of family care in the UK, Government Office for Science
[15] NOMIS. ONS annual population survey.
https://www.nomisweb.co.uk/reports/lmp/la/1946157274/subreports/ea_time_series/report.aspx

numbers of generations within the same family but with fewer members per generation. Therefore, people will grow older with more vertical than horizontal linkages in the family.

3.115 A summary measure of the demographic pressure is the age dependency ratio. The World Bank defines this as the ratio between senior dependents and the working adult population. Merton currently has 18.5 senior dependents for every 100 people of working age. By 2035 this is predicted to increase to 23.5.

4 OVERALL MERTON IS HEALTHY, SAFE AND HAS STRONG PUBLIC AND COMMUNITY ASSETS

Key messages

- Health in Merton is in general better than in London and England as a whole. Life expectancy is better than in 75% of other local authorities. Educational attainment is high, with the 4th highest rate of attainment of 5 good GCSEs of all London Boroughs
- Overall deprivation is lower than average. In terms of rank of average scores in IMD 2019, Merton is the 213th least deprived local authority district (out of a total of 317)
- There is a good range of public and community assets which support good health such as green spaces, schools, libraries and voluntary sector activity
- Merton is well served by public transport, more so in the west of the borough than the east, and has a road and path infrastructure to support cycling and walking. However cycling rates are lower than some neighbouring boroughs.
- The voluntary and community sector in Merton is very active. There are approximately 917 voluntary, community, faith and social enterprise organisations providing a wide range of services and activities for residents across the borough

4.1 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.

4.2 Educational attainment is high, with the 4th highest rate of attainment of 5 good GCSEs of all London Boroughs.

4.3 In the most recent calculation of the Index of Multiple Deprivation, Merton was found to be the 213th least deprived local authority district (out of a total of 317).

4.4 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.

4.5 We have good transport hubs, particularly in the west of the Borough, and a significant proportion of people who live in Merton work in the borough (over 82% of people in 2016).[16]

[16] Borough Profiles, Greater London Authority (GLA)

4.6 There are a total of 11 children's centres in Merton with 8 centres located in the east of the borough and 3 located in the west[17] and a total of 7 libraries in Merton.[18] Merton has 43 schools registered on the Healthy Schools London Programme of which 15 schools have achieved bronze status whilst 6 have achieved silver.[19]

4.7 Merton has a Public Transport Accessibility Level (PTAL) score of 2.6 where a PTAL score of 0 indicates very poor access to public transport and 6b indicates excellent access. Merton's PTAL score is similar to neighbouring London Boroughs. The west of the borough has a higher level of accessibility to public transport than the east, with a PTAL score of 2.8 compared to 2.3 respectively.[20]

4.8 Merton has 9 community centres of which 8 are in east Merton. There are also 5 sports and leisure centres. The largest employers include Merton council, which employs 5,400 people including school staff followed by Tesco's, Sainsbury's, Metropolitan Police and London General Transport Services which each employ between 800-900 people. Merton also has 12,000 small businesses.

4.9 Compared to other outer London Boroughs Merton has very high cycle ownership with a high proportion of shorter cycling trips. There is a wealth of green space for cycling including the Wandle Trail and Morden Park. However, there are barriers to overcome in changing people's attitude towards cycling and reallocating road space for cycling. Cycling schemes often face opposition from other road users, and the proportion of adults cycling regularly is lower than in some neighbouring boroughs.

4.10 There are 67 parks and nature conservative areas in Merton. 57.8% of households have good access to open spaces whilst 38.8% have good access to local parks.

4.11 The voluntary and community sector in Merton is very active. There are 917 voluntary, community, faith and social enterprise organisations providing a wide range of services and activities for residents across the borough. The sector is a vital part of the social capital of the borough and can be crucial in its ability to reach parts of the community that statutory service providers struggle to serve.[21]

4.12 More information about how health in Merton compares to London and England as a whole is available in the Merton Health Profile published by PHE. See further resources at the end of the document.

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[17] Young Merton https://directories.merton.gov.uk/kb5/merton/directory/youth.page?youthchannel=0

[18] Merton Council website, https://libraries.merton.gov.uk/client/en_GB/merton/?rm=BRANCHES2%7C%7C%7C1%7C%7C%7C0%7C%7C%7Ctrue

[19] Healthy schools London, https://www.london.gov.uk/what-we-do/health/healthy-schools-london/awards/get-award/schools-taking-part?borough=00BA

[20] Public Transport Accessibility Levels. Transport for London.

[21] Merton Voluntary Service Council. Strategic Review 2015-18

5 INEQUALITIES AND THE HEALTH DIVIDE

Key messages

- Significant social inequalities exist within Merton. The eastern half has a younger, poorer and more ethnically mixed population, with more areas of high deprivation. The western half is whiter, older and richer.
- East Merton had an average IMD 2015 score of 21.1 compared to west Merton of 8.2. A recent update (IMD 2019) shows broadly similar patterns.
- The gap in life expectancy at birth between the 30% most and 30% least deprived wards is 3.8 years for men and 2.4 years for women; for healthy life expectancy it is larger, 9.4 and 9.3 years for respectively.
- Economic activity, housing conditions, fuel poverty and crime are some of the other broader determinants of health, which are more challenging in the east than in west.

Introduction to the Inequalities section

5.1 Inequalities in health are longstanding and resistant to change, throughout England and more widely.

5.2 The 2018 Director of Public Health Annual Report reviewed what is known about inequalities in Merton and made recommendations for action and future monitoring. This section of the Merton Story 2019 contains some updates on that report. It is not a comprehensive refresh as for some indicators more recent data has not yet become available; for others whilst there is new data there has not been capacity to undertake the necessary computations. This is a potential area for more work during the forthcoming year or in next year's version.

5.3 There are many population attributes that are associated with health inequalities, such as age, ethnicity and income. The Merton Story 2019 focuses on the inequality that is seen between east and west Merton. More work could be done during the next 12 months or for next year's version on inequalities associated with other attributes, presuming that it was clear how such information would be used.

Life expectancy, healthy life expectancy and premature mortality

5.4 Life expectancy is the average age to which the population is expected to live, given current age-specific death rates. Healthy life expectancy modifies this to count only those years which can be expected to be lived in good health.

5.5 Life Expectancy at birth in Merton is 80.7 years for males and 84.4 years for females.[22] Men tend to have shorter life expectancy than females due to biological, hormonal,

[22] Public Health Outcomes Framework (PHOF)

behavioural, physiological and environmental influences in health behaviours. East Merton has shorter life expectancies both for men (79.3 years in the east compared to 82.2 years in the west), and women (83.5 years and 85.3 years respectively).

5.6 If the comparison is restricted to the 30% most deprived and 30% least deprived wards in Merton, the gap is larger: 3.8 years for men, and 2.4 years for women.[23]

5.7 Healthy life expectancy for Merton as a whole at birth is 64.1 years for men and 65.3 years for women, so many residents are living a considerable proportion of their lives with ill health. Data from ONS suggests that in 2009-13 only 43.5% in east Merton and 54.4% in west Merton of people aged 65 and over considered their life spent in good health.[29]

5.8 The gap between the 30% most and 30% least deprived wards is larger than for total life expectancy: 9.4 years for men and 9.3 for women. Therefore, someone living in a deprived ward in the east of the borough will on average spend at least 9 more years in poor health than someone in a more affluent part of the borough. This may impact on the last years of working life, family life and on a healthy and fulfilling retirement.[23]

5.9 Premature mortality (deaths under 75 years) is also strongly associated with deprivation. While overall rates of premature death have improved, premature deaths are linked to risk factors including tobacco use, unhealthy diet, alcohol and drug use, obesity, and high blood pressure, suggesting more should be done to make healthy choices easy throughout Merton.[24]

5.10 All wards in east Merton are more deprived and have higher rates of premature mortality than those in west Merton. Of all deaths in Merton between 2014-2018, 32% were premature. In the 30% least deprived wards, 26% of deaths were premature, compared to 38% in the 30% most deprived wards. Comparing this data to the last release (2013-2017), premature deaths have risen in the 30% least deprived wards by 1% but have remained the same in the most deprived wards.[25]

5.11 Years lived with disability (YLDs) are the number of years of life lived with any short term or long term health loss. In 2006 (2,780 per 100,000) and 2016 (2,814 per 100,000) musculoskeletal disorders were the largest cause of YLDs in Merton with low back and neck pain (1,815 per 100,000) being the top cause of YLDs in Merton in 2016.[26]

Index of multiple deprivation

5.12 Health is determined by complex interactions between individual genetics and other characteristics such as age and sex, lifestyle factors, and the physical, social and economic environment. These 'broader determinants of health' are the key drivers of healthy life expectancy and a healthy population.[27] Marked social inequalities are important drivers of the health divide in Merton.

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[23] Local Health, Public Health England
[24] Rates of premature mortality, IHME, www.healthdata.org
[25] Primary Care Mortality Database, 2014-2018
[26] The Global burden of disease study. https://vizhub.healthdata.org/gbd-compare/
[27] Kings Fund 2012/13 - Broader determinants of health: Future trends https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

5.13 The Indices of Deprivation provide scores for seven different domains of deprivation, across 32,844 neighborhoods within England, each with an average population of 1,500. These can be aggregated to give scores and rankings for wards and local authorities. The seven indices can also be combined into a singe Index of Multiple Deprivation (IMD).

5.14 The IMD2019 was published on 26th September 2019, too late for its detail to be incorporated in the Merton Story; this will be included next year. The detail below is derived from IMD2015; most differences between 2015 and 2019 are expected to be small.

5.15 The 2015 IMD score showed that Merton as a whole was less deprived (14.9) than London (23.9) and England (21.8). However, east Merton had an average IMD score of 21.1 compared to west Merton which was 8.2.[28] This highlights the difference in deprivation between the east and west of the borough.

Benefit claims and employment

5.16 Lower incomes and lower employment are bad for health. Being in work is generally good for health, although good working environments are important.

5.17 In 2018, 2% of the working age population (16-64) claimed out of work benefits in Merton, which equates to 2,771 people; however rates are higher in the east of the borough (3%), compared to west Merton (1%).[29]

5.18 The Merton average is similar to London (2.2%) and England (2.1%), but the east Merton rate is higher than the London and England average.[29]

5.19 In 2015 in Merton the employment rate was 78.8%, which is higher than London (72.9%), England (73.9%) and all statistical and geographical neighbours with the exception of Richmond.[29]

5.20 Between 2010 and 2017 there has been a 35% rise in the number of jobs available in Merton, from 78,000 to 105,000 jobs.[29] Job density is the number of jobs available per resident of working age and is also rising in Merton; however residents can and do travel out of Merton for work.

Housing conditions and homelessness

5.21 The most complete picture of housing is that obtained through the decennial census, but this becomes out-dated as time elapses before the next census takes place.

5.22 The 2011 Census showed that Merton's social housing stock is the fifth lowest in London at 14%. The London average is 20% with the proportion being much higher in some Boroughs, eg. in Hackney and Southwark.

5.23 The type of housing reported in 2011 differed significantly between owner occupied and social housing sectors. 58% of social housing and 63% of private rented homes were flats, compared to only 24% in the owner-occupied sector.[30]

[28] English indices of deprivation, HMG
[29] ONS via NOMIS 2018
[30] Census, 2011

5.24 More recent research undertaken by Shelter in 2018 showed a 1% increase of social housing stock to 15% of all housing stock in Merton since 2011. The private rented sector is estimated to have increased from 25% to 34%, with owner occupation decreasing from 61% of total stock to 51%.

5.25 Average house prices in the borough rose 33% between March 2014 and February 2019, from £392,126 to £520,262, although since then prices have dropped. However, prices are still unaffordable to households on an average income, with one-bed flats in the cheapest areas in Merton costing an average of £237,000, requiring an income of over £50,000 to obtain a mortgage (4 times income multiples) for the purchase, along with a 10% deposit. For a 3-bed family home in Mitcham averaging £424,518, an annual income of £95,500 is required for first-time buyers without any equity.

5.26 Renting can be also be unaffordable. Average weekly rents in all parts of Merton are above the Local Housing Allowance (LHA) rate, which means that households on benefits have to cover the shortfall with other benefit income. Private rented sector tenancies can also be insecure. The termination of Assured Shorthold Tenancies by landlords is the biggest cause of homelessness in Merton.

5.27 Although Merton has the lowest number of homelessness acceptances amongst all London boroughs, homelessness in the borough has been on the increase. In 2018 there were 165 households in temporary accommodation. With the introduction of the Homelessness Reduction Act which places a duty on local authorities to prevent and to relief homelessness, the number of residents seeking advice and assistance has increased significantly.

5.28 The number of people rough sleeping in Merton has also seen a substantial increase, increasing from 5 in 2017 to 23 in 2018 on a typical night. Many rough sleepers suffer from poor health, with support needs for substance misuse and/or mental health issues.

Fuel poverty

5.29 Low income combined with high energy costs is strongly linked to living in homes that are not heated sufficiently. A household is considered to be fuel poor if the required fuel costs of the household is above average (the national median level) and, were they to spend that amount, they would be left with a residual income below the official poverty line. Fuel poverty is more prevalent in inner London boroughs and lessens in outer London. [31]

5.30 In 2015, an estimated 10.2% of household (8,151) were fuel poor in Merton, which is similar to London and England. Between 2012 and 2014 levels of fuel poverty in Merton increased, although 2015 shows a slight fall. A similar trend is evident across London.

[31] Sub regional fuel poverty England, 2015 data, Department for Business, Energy & Industrial Strategy, published 2017.

Crime

5.31 The Metropolitan police states that Merton’s crime rate overall in 2018/19 was 68.4 per 1000 population. The east of the borough showed a higher rate at 72.9 compared to the west at 63.3. The rates are much lower than London as a whole (98.3 per 1000). [32]

5.32 The figures show a rise in crime rates from 2017/18, where rates for Merton were 67.9 and London 95.2 per 1000. Part of this rise is likely to be due to increased reporting and/or improved recording of data.[32]

5.33 Much more detailed information on the numbers of different types of crimes and the difference between east and west is available on Merton Data

[32] data.police.uk via Merton data

6 HEALTHY LIFESTYLES AND EMOTIONAL WELLBEING

Key messages

- The main causes of ill health and premature deaths in Merton are cancer and circulatory disease (including coronary heart disease and stroke). Unhealthy diet, smoking, lack of physical activity, and alcohol are attributable for around 40% of these deaths.
- The numbers of people in Merton with unhealthy behaviours are substantial. This is despite some positive rankings against London and England. Making healthy choices easy and preferred, which is the goal of the new Health and Wellbeing Strategy, can have major impact.
- Most risk factors are inversely associated with socio-economic conditions.
- Overall levels of sexually transmitted infections are fairly stable although high compared to England. There has been a rise in acute infections including gonorrhoea and syphilis, which are markers of risky sexual behaviour.
- 26,000 people in Merton are estimated to suffer from a common mental disorder such as anxiety or depression.
- Common mental disorders are often hidden. Only about half of Merton's cases are recorded on GP registers.

Introduction to Healthy Lifestyles and Emotional Wellbeing

6.1 The numbers of people in Merton who demonstrate unhealthy behaviours are substantial. This is despite some positive rankings against London and England for these primary risk factors.

6.2 The recently refreshed Merton Health and Wellbeing Strategy 2019-2024 "A Healthy Place for Healthy Lives" proposes a focus on healthy settings, such as healthy streets, healthy schools and healthy workplace. The strategy also defines a number of key outcomes, with indicators that can be used to track progress towards their achievement.

6.3 The Merton Story does not attempt to duplicate the Health and Wellbeing Strategy. Instead it describes in more detail some of the lifestyle behaviours that the strategy aims to influence, focusing on how Merton compares with London and England as a whole, and where data allows, how this varies within Merton.

Physical activity

6.4 Physical activity benefits health by helping to maintain a healthy weight, manage stress, and improve sleep and overall quality of life. Most physical activity also brings people together and so improves mental health. It reduces the risk of type II diabetes,

cardiovascular disease, falls, depression, dementia, joint and back pain, cancers of the colon and breast and helps in the management of Long Term Conditions.[33]

6.5 The most recent results from the Active Lives survey suggest that in Merton around 1 in 5 (19.6%) adults aged 19+ are physically inactive; doing less than 30 minutes of moderate intensity physical activity a week. This is worse than the previous results, which showed that 17.3% of adults were inactive.

6.6 Although this prevalence of inactivity (19.6%) is better than London (22%) and England as a whole (22.2%), it still equates to around 31,200 people.[34]

6.7 On the positive side of physical activity, the latest survey suggested that 68.3% or residents were complying with the Chief Medical Officers recommendation of at least 150 to 300 minutes of moderate intensity physical activity per week. This is slightly higher than London (66.4%) and England as a whole (66.3%), but has remained static over the last few years.

6.8 Only about 34,000 people (16.5% of the overall population) are estimated to use outdoor space for exercise/health reasons in Merton (2015/16) which is a lower rate than London (18%) and England as a whole (17.9%).[35] This is despite Merton being one of the greenest boroughs in London with 677ha of public open spaces, including more than 65 parks. Green spaces make up 18% of the borough, compared to the London average of 10%.[36]

6.9 A new Public Health Outcomes Framework indicator on people's access to woodland (within 500 metres of where they live) shows Merton's has good access at 25.1% (5th best of London boroughs). This is also better than England as a whole at 16.8%.

Tobacco dependence

6.10 Smoking tobacco is responsible for 70% of lung cancer deaths, and also causes cancer in other parts of the body including mouth and throat. There is also an increased risk of developing coronary heart disease, peripheral vascular disease, COPD, heart attacks and Stroke.

6.11 The percentage of adults in Merton aged 18 and over who smoke is 11.5% (2017). This level of smoking is lower than London (14.6%) and England (14.9%), but still equates to just over 18,280 people. Of the Routine and Manual workers group (aged 18-64, 2017), 22.9% of adults in Merton (an estimated 31,000 people) smoke compared to 24.7% in London and 25.7% in England.[35]

6.12 Comparison of smoking rates in East and West Merton is possible using GP data. In 2017/18, the latest year for which results are currently available, the recorded rates in registered patients aged 15 years and older were 12.4% in the west and 18.8% in the east, a gap of 6.4%. This has widened since 2014/15 by 1%.[37]

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[33] UK Chief Medical Officers Guidelines, 2011 Start Active, Stay Active
[34] Physical activity profile, Public Health England
[35] Public Health Profiles, Public Health England
[36] Future Merton, The London Borough of Merton
[37] Tobacco profiles, Public Health England

Diet

6.13 In 2016/17, only 56.2% of adults (over 16 years) were estimated to consume 5 or more portions of fruit and vegetables every day.[35]

6.14 Local data on diet is not routinely available and the last survey data is several years old. However, the healthiness of the diet in Merton is not likely to be significantly different to the national picture.

Adult obesity

6.15 94,000 people (58.4%) of adults in Merton aged 18 and over are estimated to be overweight or obese (2017/18). This has risen slightly from 2016/17, and is a higher proportion of the population than London (55.9%) but lower than England (62%).[35]

Alcohol and drug misuse

6.16 The scale of alcohol related harm in Merton is significant. Approximately 42,000 people are estimated to be drinking at harmful levels,[38] and there is estimated to be 83% unmet need in those with alcohol dependence.

6.17 In 2017/18 there were 3,254 admission episodes to hospital for alcohol related conditions. While the number is substantial, this represents a lower rate of admissions (2,020 per 100,000 population) compared to London (2,324) and England (2,224).[39]

6.18 There is a significant variation between the east and west of the borough, with a higher rate of alcohol-related admissions in the east compared to the west.[39]

6.19 Although drug and alcohol treatment outcomes are generally better than the London and national averages, and with consistently lower rates of drug related deaths, Merton also has a significant population of people with substance misuse problems other than alcohol who are not accessing treatment: an estimated 62% unmet need in the population of opiate and crack users (compared to 52% nationally).[40]

Sexual health.

6.20 The past decade has seen great improvements in the quality and scope of sexual and reproductive health promotion and HIV prevention. Merton has seen one of the highest reductions in teenage conceptions in London and overall the rate of new sexually transmitted infection (STI) diagnoses has remained stable. However, like the rest of London, Merton is experiencing a continuing rise in acute STIs, particularly syphilis and gonorrhoea. This has led to a higher demand for services in London than any other area of the country, and as a result, a rising cost to public services.[41]

6.21 The number of all new Sexually Transmitted Infection (STI) diagnoses (excluding Chlamydia aged <25) per 100,000 of the population aged 15-64 years was 1,070 in 2018.

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[38] Substance Misuse Profile, January 2018
[39] Local Alcohol Profiles for England (LAPE)
[40] PHE Drug and Alcohol team, Feb 2019
[41] Sexual Health strategy 2019, Merton

The prevalence of STIs is lower than London (1,490 per 100,000) but higher than England (784 per 100,000).[42] The Merton rate has changed little in recent years.

6.22 Numbers for gonorrhea and syphilis have increased in recent years. Both acute infections are markers of risky sexual behavior.[42]

6.23 The rank for gonorrhoea diagnoses in Merton was 23rd highest (out of 147 upper tier local authorities) in 2018. The rate per 100,000 was 178, worse than England but significantly better than the rate of 279/100,000 in London. Rates in Merton have been increasing since 2012 in line with London and England. This increase is particularly concerning due to the emergence of extensively drug resistant gonorrhoea (XDR-NG) in England.[42]

6.24 The rank for syphilis diagnoses in Merton was 23rd highest (out of 147 upper tier local authorities in England) in 2018. The rate per 100,000 was 29.1, worse than the rate of 13.1 in England but better than the London rate of 39.9.[41]

6.25 The percentage of repeat abortions in women under 25 living in Merton was 32.3% in 2017. This is higher than England (26.7%) and London (30.7%).[42]

6.26 The prevalence of diagnosed HIV per 1,000 people aged 15-59 years in 2018 was 4.2, worse than the rate of 2.4 in England. The rank for HIV prevalence in Merton was 23rd highest (out of 147 upper tier local authorities).[42]

6.27 Improving HIV test uptake will help to diagnose people before they become unwell, enabling access to treatment and reducing onward HIV transmission. Late diagnosis (2016-18) in Merton was high at 49.3% compared to London at 35.2% and slightly higher than England (42.5%). Late diagnosis is linked with a much higher risk of mortality than those diagnosed early.[42] Heterosexual Black Africans and gay men are disproportionately affected. In this same period, 70.6% of HIV in heterosexuals in Merton was diagnosed late as opposed to 31.3% in men who have sex with men.[42]

6.28 Evidence from across London indicates that boroughs with high rates of HIV amongst the heterosexual population have had less success reducing late diagnosis, which it is believed is primarily due to stigma and fear about being diagnosed with HIV and getting tested later. HIV prevention services in Merton have made great strides engaging with BME groups, gaining access to faith groups that it is very difficult to achieve, however more needs to be done to dispel myths and to encourage testing.[42]

Cancer

6.29 It is estimated that up to 38% of cancers are preventable[43] with smoking being the biggest cause of cancer, followed by obesity. Other preventable causes include poor diet, alcohol and lack of physical activity.

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[42] Sexual and Reproductive Health Profiles, Public Health England

[43] Cancer Research UK website at https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading-Two, referencing Brown K et al (2015).

6.30 In 2017/18, across all ages, 4,505 Merton residents (2% of the registered population) had a cancer diagnosis recorded on the GP practice disease register. This is a slightly higher than London (1.8%) but lower than England (2.7%).[44]

6.31 Cancer screening levels in Merton appear similar or slightly higher than London but lower than England, with most recent data showing 52.4% (bowel), 66.4% (cervical) and 69.3% (breast) of the eligible populations that were screened.[44]

Mental wellbeing

6.32 In terms of self-reported wellbeing and emotional resilience, 8% of the Merton population aged 16 and over reported a low happiness score compared to 8.3% in London and 8.8% in England (2015/16) and 20.6% of people aged 16 and over reported a high anxiety score compared to 21.2% in London and 20% in England.[45]

6.33 ONS has subsequently released further analysis on groups who score poorly on wellbeing indicators used in the Annual Population survey.[46] Over half (58%) of people with 'poor personal wellbeing' had rated their health as 'bad' or 'very bad'. Health is the strongest factor associated with poor wellbeing with people who report their health as bad or very bad being 13.6 times more likely to have poor personal wellbeing.

6.34 Self-reported disability was also associated with poor wellbeing but not as strongly as for bad health. People with a disability were 1.9 times more likely to report poor personal wellbeing. Other factors include age (mid-life), economic inactivity (unemployment or not working due to health/disability) and marital separation.

6.35 Based on population estimates, there were 1,368 Merton adults (aged 16+) with autism in 2019. During 2018-19 around 145 adults (aged 18+) with a reported autism health condition received adult social care support. As the population grows older, the number of adults with autism is anticipated to rise, with associated increase in the need for care and support for independent living.

6.36 In 2017, there were an estimated 25,300 adults in Merton (over 16 years) with common mental health disorders such as depression and anxiety, representing 15.5% of the total population.[47] This compares with London at 19.3% and England at 16.9%.12% (19,000) of adults aged over 18 years were identified with depression or anxiety by Merton GPs on their disease registers.[47] This suggests that a substantial proportion of adults in Merton experiencing common mental health conditions remain undetected. This is likely to affect physical as well as mental health outcomes, as both are often found together.

6.37 To tackle the large numbers of people with common mental health disorders, the NHS has established Improving Access to Psychological Treatment (IAPT). In the first half of 2018/19, Merton IAPT services received an average of 415 referrals per month; in the

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[44] Cancer services profile, Public Health England

[45] Annual Population Survey, Office for National Statistics, 2016

[46] Understanding well-being inequalities: Who has the poorest personal well-being?" (2018), ONS. This uses data from the Annual Population survey (2014-2016), reviewing questions of life satisfaction, worthwhileness, happiness and anxiety. Those scoring 4 (out of 10) or less for the first three questions or 6 out of 10 for anxiety had a poor personal wellbeing score. For the survey only those who had poor wellbeing scores across all four questions had a poor wellbeing score overall.

[47] Common Mental Health Profiles, Public Health England

second half of this increased to 568 patients per month. At this rate of referral, it would take the services about 3 years to receive a referral from all those affected.

6.38 In 2017/18, (0.9%) 2,048 people in Merton were recorded by their GP to have severe mental illness. This is lower than London (1.1%) and similar to England (0.9%). There has been a gradual increase since 2012/13.[48]

6.39 There is a gap in GP-recorded prevalence of severe mental illness between East and West Merton, with rates of 1.1% and 0.80% respectively. This gap has widened slightly since 2012/13, when the rates were 0.95% and 0.69% respectively.[48]

6.40 People with severe mental health have a higher likelihood of poorer physical health. For example, compared to the general population, people under 75 years of age in contact with mental health services in England have death rates that are 5 times higher for liver disease.[48]

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[48] Severe Mental Illness profile, Public Health England

7 CHILD AND FAMILY VULNERABILITY AND RESILIENCE

Key messages

- Most children and young people living in Merton are healthy and have a good start in life. Most experience better health and related outcomes than the London and England average.
- However not all children enjoy similar positive outcomes. Nationally 3% of children are subject to a Child Protection Plan lasting for 2 years or more, and Merton rates are similar.
- 73.5% of children starting school in 2017 (most recent year for which data is published) achieved the school readiness standard, similar to London and higher than England.
- About one in eight or 5,000 children aged under 16 are estimated to live in poverty.
- The numbers of Merton resident children and young people with an Education and Health Care plan are increasing at a faster rate than elsewhere.
- There are big differences in the rates of healthy weight, by age and location. The increase in the proportion of children who have excess weight between reception and year 6 is 17.7%, and the gap in obesity between east and west in year 6 is 11.5%.

Introduction to the Child and Family section

7.1 Children and families are the foundation of Merton's health and wellbeing in the long term, as well as being central to the assets of communities here and now.

7.2 Merton's Children's and Young People's Plan 2019-23 "My Family, My Future, My Merton" (the CYPP) was adopted by the Council in September 2019. The plan was directed and co-produced by young people themselves, and was based on extensive consultations. It sets out an ambitious programme to enable Merton to be a place where children and young people feel they belong, stay safe, and can thrive.

7.3 This section of the Merton Story should be considered alongside the CYPP. It does not replicate the statement of need that the CYPP contains, instead it focuses on numerical data about the population of children and their families, how Merton compares to London and England as a whole, and where data allows, the extent of variation within Merton.

7.4 The section is structured around 12 particular aspects of child and family vulnerability and resilience as follows:

- Poverty and poor social circumstances
- School readiness

- School quality
- Educational attainment
- Dental health
- Children with learning disabilities
- Healthy weight
- Teenage conception
- Substance misuse
- Youth offending
- Young people's mental health
- Accidents and non-accidental injuries

Poverty and poor social circumstances

7.5 Family context has a profound influence on a child's healthy development and life chances. Children living in poor social circumstances are most at risk of poor health outcomes.

7.6 A person's experiences during childhood lays down a foundation for the whole of their life, including physical and mental wellbeing. While Merton has generally lower rates of children living in deprived circumstances and generally better health and well-being outcomes, numbers with poor outcomes remain substantial.

7.7 Around 5,195 (13.1%) children under 16 years in Merton are living in poverty (2016) which is lower than both London (18.8%) and England (17%).[49] The rates are 20% in the 6 most deprived wards and 6% in the 6 least deprived wards. However this gap has narrowed since 2010, when it was 21%.[50]

7.8 Numbers of child protection cases in Merton have grown in recent years, but remain within the broad range seen across London Boroughs as a whole. In 2017/18 there were 404 children on the child protection register at some point in the year, including 183 as at end of the year. This represented a rate of 38.9 per 10,000, lower that than for London as a whole (39.6 per 10,000).[51]

7.9 In 2017/18 Merton numbers were similar to the previous year when there were 387 children on the child protection register at some point in the year, including 201 as at end of the year. The rate tends to vary in a cyclical nature and further analysis of the factors contributing to this is underway.[51]

7.10 On 31st March 2018, there were 155 children in care. This continues the trend of gradual increase since 2014, although the number typically lies within the range of around 140-160 at any given time. This rate of children in care (33 per 10,000 children) is significantly lower compared with London (49 per 10,000 children) and England (64 per 10,000 children).52

7.11 Parental mental health problems, parental misuse of alcohol and drugs and domestic violence are the most significant risk factors that impact on a child's health and wellbeing.

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[49] Public Health Profiles, Public Health England
[50] Children in Poverty, Borough and Ward, GLA 2016
[51] Research and Information Team, Children, Schools & Families. Unpublished data
[52] Children looked after in England 2016-2017, Department for Education September 2017

In 2017, the rate of children under 18 who started to be looked after due to family stress, dysfunction or absent parenting was 11.8 per 10,000. This was higher than London at 11.6 per 10,000 and England at 9.3 per 10,000.[49]

7.12 In 2018, the rate of children under 18 who started to be looked after due to abuse or neglect was 7 per 10,000. This was lower than London at 13.1 per 10,000 and England at 16.4 per 10,000.[49]

School readiness

7.13 'School readiness' is a key measure of a child's development - the percentage of children achieving a good level of development at the end of reception. In 2017/18, 73.5% of children living in Merton achieved this standard, similar to London (73.8%) but higher than England (71.5%).[49]

7.14 Children with free school meal (FSM) status do less well. In 2017/18, 64.1% of children with FSM status achieved a good level of development, representing a trend of significant and continuous improvement over the past five years from 32.9% in 2012/13. The most recent 2017/18 figure is similar to London (63.9%) but higher than England (56.6%). The gap in school readiness between children with FSM status and their peers has reduced to 9.4% (nationally the gap is 14.8%).[49]

7.15 The number of 2 year olds benefiting from funded early years education is 61%, which is lower than outer London (63%) and England (72%). It has increased from 2017 (55%). More recent local data (Jan 2019) continues to show a small increase in the percentage of 2 year olds that take up their funded place.[53]

7.16 For 3 and 4 year olds, the percentage of children benefiting from universally funded early years places is 84% which is the same as London but lower than England (94%).[53]

7.17 Ofsted has rated 93% of early education settings in Merton as 'Good' or 'Outstanding' which lower than the average for England (96%) but in line with the average for London boroughs (93%).[54]

School quality

7.18 Overall 91% of Merton schools are judged good or better as at April 2019; this maintains the good performance by Merton schools with regard to Ofsted inspections and is a strong improvement from 81% in 2014. 91% is above the national average and just below the London average.[54]

7.19 All secondary schools are now judged at least good with 50% as outstanding; all special schools are also judged at least good.[54]

[53] Statistics: childcare and early years: https://www.gov.uk/government/collections/statistics-childcare-and-early-years

[54] The Department for Education (DfE) (Pupil Outcomes) – Local calculation for Ofsted outcomes

Educational attainment

7.20 In 2018, the gap between disadvantaged pupils and their peers narrowed at the end of Key Stage 2 with regard to progress and attainment in all three of the core subjects of reading, writing and mathematics.[49]

7.21 2017 data for GCSE outcomes (the most recent data available) shows a gap of 12.9 between the average Attainment 8 score at GCSE for disadvantaged pupils (41.2) and all other pupils groups (54.1). This is higher than the London gap (9.8), and in line with the national gap (12.8).[49]

7.22 Merton has a low rate of 16-17 year olds Not in Education, Employment or Training (NEET) or whose activity is unknown at 2.6%, which is lower than London (5.0%) and England (6%) and is the 10th lowest in London.[49]

Dental health

7.23 In 2016/17, 22.5% of children aged 5 had one or more decayed, missing or filled teeth which is lower than London (25.7%) and England (23.3%).[49]

7.24 Between 2015/16 and 2017/18, 339.8 per 100,000 children aged 0-5 years were admitted to hospital for dental caries in Merton which is lower than London (455.7 per 100,000) but higher than England (325.1 per 100,000).[49]

Children with Special Educational Needs and disability

7.25 A child or young person has special educational needs and disabilities (SEND) if they have a learning difficulty and/or a disability that means they need special health and education support. Such children and young people will have greater difficulty learning than others of the same age; their disability may prevent them making use of facilities. Disabilities can include: problems seeing/hearing; communication and interaction difficulties; autism, including Asperger's syndrome; emotional and mental health; learning difficulties; physical development.[56]

7.26 Locally collected data shows that as of December 2019, there were just under 2,000 Merton resident children and young people with an Education Health and Care Plan, which is a higher number than previously.[55] There were about a further 4,200 pupils in Merton schools in 2019 with SEN support, also a larger number than previously.[56]

7.27 National data from The Department for Education SEN2 return (2019) recorded 1,712 children and young people with an EHC plan in Merton. This is a 63% increase between 2015 and 2019. For London the increase was 45% and for England it was 47%.[57]

7.28 There are a number of reasons for this increase in Merton (and nationally). Legislative changes introduced by the Children and Families Act 2014 significantly and rightly raised expectations and aspirations of parents for children with SEND. The age range increased from statutory school age to include children under the age of 5 years and young people

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[55] CSF, LBM. 2019

[56] National statistics - SEN - published 4 July 2019

[57] National statistics - Statements of SEN and EHCP Plans - published 30 May 2019

up to the age of 25 years. In addition, the test as to whether a child or young person should be assessed for an Education Health and Care Plan became a lower threshold.

7.29 In Merton (and nationally), this has led to an increase in the number of referrals for assessment by education settings but most significantly from parents who do not think their child's needs are being addressed at SEN Support.

7.30 Separately, there has been a growth in the school age population, advances in life-expectancy for children, increasing poverty and improved identification and diagnoses all of which are also contributing to the growing number of children and young people with SEND in Merton.[55]

Healthy Weight

7.31 438 reception children (4-5 years) and 785 year 6 children (10-11 years) were recorded as overweight or obese (excess weight) in 2017/18. 1 in 5 children entering reception are overweight or obese and this increases to 1 in 3 children leaving primary school in Year 6.[60] In terms of percentages this means that 35.9% children aged 10-11 years have excess weight; an increase of 1.9% from 2016/17. For children aged 4-5 years the equivalent figure is 18.5%, this being a decrease of 2.6% from 2016/17.[58]

7.32 The gap in levels of obesity in 10-11 year olds between the east and the west of the borough is currently 11.5% (2015/16-2017/18), and has increased in recent years. This is due to obesity levels reducing in the west and increasing in the east.[59]

7.33 More positive news for the future is that the gap in levels of obesity in 4-5 year olds between east and the west of the borough is about half that in Year 6, at 5.1% (2015/16-2017/18), and has decreased in recent years.[59]

7.34 There are also ethnic variations in obesity prevalence; nationally, evidence indicates that a child is more likely to have excess weight if they are from a BAME background. However, there is no straightforward relationship between obesity and ethnicity, with a complex interplay of factors.[60] Local analysis of excess weight (overweight and obese) in Year 6 by high level ethnic groups shows that that the Black ethnic group had the highest proportion of excess weight children at 43.4%, followed by the Asian ethnic group at 41.5% (2017/18). This is based on 90% recording of ethnicity of children measured in year 6.

Teenage conception

7.35 Since 2006 there has been a decline in under 18s conceptions from 41.1 per 1000 to 12.8 per 1000 in 2017. This is lower than London (16.4) and England (17.8).[42]

7.36 Merton had 38 under 18 conceptions recorded in 2017, 74% of which resulted in abortion.[42]

[58] Child and Maternity Health Profile, Public Health England
[59] National Child Measurement Programme, Prevalence of overweight and obesity by area of child residence. Modelled data: estimated from suppressed MSOA data. Electoral Ward (2018). Public Health England
[60] Annual Public Health Report 2016 – Childhood Obesity

7.37 Overall since the 1998 baseline when the drive to reduce teenage conceptions began, there has been a fall of 75%. This is the highest fall of all the outer London boroughs and the 10th highest reduction of all Local Authorities in England.[42]

7.38 Wards in east Merton have higher rates of under 18 conceptions compared to the west of Merton. The most recent figures for 2013-2015 show 21.9 in the east and 6.7 in the west, per 1000 women aged 15-17.[42]

Substance misuse

7.39 Alcohol and drug misuse are markers of risky behaviours and vulnerability among young people. A review of substance misuse need and provision was carried out in March 2019.[61] The review indicated that cannabis use remains of concern in Merton. Substance misuse (including cannabis) is of particular concern for those living in wards with higher levels of deprivation, among those who are NEET; have been excluded from mainstream school; or are in contact with youth justice services.

7.40 Young people in Merton have a lower usage of tobacco (6.2%) than national levels (8.2%).[62]

7.41 There is a clear link between use of substances and poor sexual health and child sexual exploitation and a clear link between young people who go missing and those involved in substance misuse and/or supply. There is some suggestion that there may be an increasing trend in children and young people (aged 13 and under) becoming involved in substance misuse, although this may be due to greater awareness amongst professionals than an actual change in prevalence.

Youth offending

7.42 Local data shows that the numbers of first time entrants into the criminal justice system continue to reduce. In 2018/19, the number of first time entrants dropped by 37% from 54 to 34 compared to the previous year.[63]

7.43 The small caseload of young people remaining on court orders present with a combination of complex needs, and the rate of reoffending is high compared to similar authorities.[63]

7.44 Violence against the person was the main type of offence committed by first time entrants and has had a drop in numbers from 21 in the previous year to only 10 in 2018/19.[63]

7.45 National data confirms the decline in rates is a long term trend: from 1,375 per 100,000 in 2009 to only 285 per 100,000 in 2017 (first time entrants to the youth justice system aged 10-17 years).[63]

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[61] Substance misuse service review, 2019

[62] Youth Survey WAY, 2015

[63] Merton Youth justice and Crime Prevention Plan. Children Schools and Families. 2019-2022

Young people's mental health and self-harm

7.46 Young people's mental health is a matter of widespread concern, with highly publicised individual stories and commentary in social and traditional media. 2,380 children and young people in Merton aged 5-16 are estimated to have a mental health disorder.[64]

7.47 Self-harm in young people is a particular concern. For a combination of reasons Merton-specific data is not available: young people or their families may be reluctant to seek help; schools do not routinely collect such data; referrals to CAMHS and counselling may not explicitly coded as self-harm; small numbers which do reach the NHS need special treatment to ensure confidentiality.

7.48 In the absence of Merton-specific data, regional and national data can be applied to the Merton population.

7.49 A national study of GP research practices showed a rise in the incidence of self –harm in girls aged 13-16 from 45/100,000 in 2011 to 77/100,000 in 2014. Applying these rates to Merton suggests a rise from roughly 3 cases per year to 5 per year. It is likely that only a small proportion of all cases present to their GPs, for the reasons noted above.

7.50 Another route to help from the NHS is through Accident and Emergency departments. The number of A&E admissions for self-harm in young people in South West London as a whole rose from 270 in 2014/15 to 460 in 2017/18. Numbers for Merton alone do not show this increase, but the numbers are small, around 40 per year, so interpretation is uncertain.

7.51 Nationally, the best measure of the prevalence of self-harm in the population at large comes from research based on the Adult Psychiatric Morbidity Survey and related national surveys. Nationally, the overall prevalence of self-harm in adults aged 16-74 increased from 2.4% in 2000 to 6.4% in 2014. The increase was seen in all sex and age groups, and was largest in young women aged 16-24 years, rising from 6.5% to 19.7%.

7.52 Applying these rates to the local population suggests that the number of young people aged 15-19 years affected in Merton may have risen from roughly 300 to 1,000.

7.53 Another source of data is feedback from parents and young people themselves, schools and other partners who seek to promote good mental health and wellbeing in young people.

7.54 In preparation for the CYPP, the Children's Trust led a large-scale consultation with over 1300 children and young people throughout Merton. A Young Residents survey and a Coram survey of children in care have also been completed recently.

7.55 The key findings of these surveys are as follows: The Young residents' survey asked "Thinking of yourself, which of these are you personally most concerned about" Mental health was selected from a drop down list in 23% of those aged 16-17years; and 6% of those aged 11-15years.

7.56 In the Children and young people's survey 2019, 32% (370/1158) agreed with the statement "I worry about the mental health of my friends".

[64] Children and young people's mental health and wellbeing profile, Public Health England

7.57 In the Merton Coram Voice: Your Life, Your Care survey (2018), 54% (28) of looked after children (aged -18) said - They are 'sometimes' or 'all or most of the time' worried about their feelings or behaviour.

7.58 These survey findings suggest that the scale of the problem is much larger than service data suggests.

Accidents and non-accidental injuries

7.59 In 2017/18 there were 636.4 per 1,000 A&E attendances in children aged 0-4 years which is statistically higher than the England average (619 per 1,000) but lower than the London average (730.7 per 1,000).[65]

7.60 Hospital admissions caused by unintentional and deliberate injuries in children and young people were higher in Merton compared to other London boroughs (2017/18). For 0-4 year olds it was 136 per 10,000 equal to 209 admissions, 0-14 years it was 111.6 per 10,000 equal to 456 admissions and 15-24 years it was 137.7 per 10,000 equal to 278 admissions.[65]

7.61 Local data analysis of SUS (Secondary User Services) showed the top 3 reasons for hospital admissions for unintentional and deliberate injuries in 0-24 year olds were injuries of appendages (e.g. arms and legs), injuries of the head and neck and poisoning and toxic effects of substances. The admissions were highest in those living in the East of the borough at 58%, compared to the West at 42%, rising to 65% of 15-24 age group from the east of the borough.

[65] Child and Maternal Health, Public Health England

8 INCREASING COMPLEX NEED AND MULTI-MORBIDITY

Key messages

- The population is ageing and increasing numbers of people are living longer into older age with multiple long-term conditions (LTCs).
- There are about 20,000 people of working age with a disability, and 3,900 with learning disabilities. Merton council spends around £22m per year supporting the latter group.
- About 40,000 people are estimated to have two or more LTCs, with greater numbers and rates in the east of the borough.
- Musculoskeletal conditions are often a component of complex needs. One in seven Merton residents has a long-term musculoskeletal problem, with one in six people over the age of 45 having knee osteoarthritis.
- Currently 6% of people in Merton has diabetes, with the number increasing by about 200 per year. Diabetes is frequently associated with multiple physical and mental conditions and is often preventable.
- The number of people with dementia is predicted to increase from 2,050 to 3,300 by 2035. Only 70% of the expected numbers are currently diagnosed. Early diagnosis improves quality of life and can slow disease progression.
- Social isolation and loneliness is an important health factor, comparable to smoking 15 cigarettes per day. Numbers of lonely older people are likely to rise in Merton if present trends continue.
- Unpaid carers have substantial needs. There are about 3,300 adults and 30 children and young people regularly providing more than 50 hours care per week
- Housing is often another component of complex needs. 100 people with learning difficulties supported by the council are recorded as living in unsettled accommodation.

Introduction to complex need and multi-morbidity

8.1 As the population in Merton ages, it would be expected that more people would have complex health and care needs, due to long term conditions which cannot be reversed

8.2 There are other factors besides the ageing of the population which have contributed to this trend for example:

- Higher expectations of care, meaning less under-diagnosis.

- More successful medical treatment, meaning people stay alive who might previously have died.

- A less healthy lifestyle, such as greater obesity and alcohol consumption

8.3 The purpose of this section is to highlight the main problems of complex need in Merton, how they compare to London and England as a whole, and where data allows, variations between different parts of the Borough

8.4 This section unashamedly draws on health and care activity data, as there is no separate population based data to be used as an alternative.

8.5 The findings are divided into a number of sub-sections as follows:

- Multi-morbidity
- Musculoskeletal conditions
- Osteoporosis
- Diabetes
- Coronary Heart Disease and Chronic Obstructive Pulmonary Disease
- Mental Health Disorders
- Self-harm and suicide
- Dementia
- Social care and housing
- Learning and Physical Disabilities
- Carers
- Social Isolation and Loneliness
- Falls

Multi-morbidity

8.6 Multi-morbidity can be defined as where a person has two or more LTCs. This can include having a long-term physical problem and a long-term mental health problem such as severe depression. Common LTCs include diabetes, chronic obstructive pulmonary disease, chronic heart failure, osteoporosis and dementia.

8.7 Multi-morbidity is associated with premature mortality; functional impairment/disability; a negative impact on the ability to work; an increased risk of hospital admission with an increased length of stay; poor quality of life; and a greater risk of adverse drug events.[66]

8.8 In 2011, the most recent year for which LA-specific data has been published, 10% (40,600) 20,200 per 100,000 people in Merton were estimated to have two or more long term conditions. 20,400 per 100,000 people were from east Merton compared to only 19,900 per 100,000 people in west Merton. 2,500 people living with multi-morbidity were from Cricket Green ward in east Merton which has the highest numbers in Merton compared to 1,700 in Trinity ward in West Merton which have the lowest rate of multi-morbidity.[67] On average in Merton there were 2,000 people living with two or more multi-

[66] Musculoskeletal conditions profile, Public Health England

[67] Prevalence of multi-morbidity by local areas in England (derived from observed prevalence estimates provided by Barnett and colleagues). South West Local Knowledge and Intelligence Service, Public Health England. 2018

morbidity, which is lower than the London average (2,700) but higher than the England average (1,800).[66]

8.9 The distribution of multi-morbidity varies by age. The proportion of people with two or more long-term conditions increased from 15% in those under 45, to 33% in those 45-64 years, to 70% in those over 65 years. This is approximately 14,400 people of the 45-64 year age group with higher numbers in east Merton (8,000). However, higher numbers of two or more multi-morbidity can be found in west Merton in the 65-84 and 85+ age groups compared to east Merton.[66]

8.10 Multi-morbidity is more common in women than men. It was estimated that 23,000 per 100,000 females have two or more LTCs compared to only 17,300) males per 100,000.[66]

8.11 The distribution of people with three or more LTCs was similar to that for two or more, but rates are lower. 11,600 per 100,000 of people in Merton had three or more LTCs, the numbers and rates being 11,900 per 100,000 (12,560) in the east and 11,300 per 100,000 (10,830) in west.[66,67]

8.12 About one in three people with multi-morbidity were estimated to have both physical and mental LTCs. The proportions were similar in east and west, 8,800 and 7,200 per 100,000 respectively.[66]

Musculoskeletal conditions

8.13 Musculoskeletal conditions, such as osteoarthritis and back pain, are the leading cause of disability in adults in England. People with a musculoskeletal condition are also likely to have another long-term condition. Among people living with multiple conditions, musculoskeletal conditions have been reported to cause the greatest impact on overall wellness, independence and quality of life due to increased pain and limited movement.[68]

8.14 In 2017/18, 13.6% (50,105) of people in Merton had a long-term musculoskeletal problem which is higher than London (12.7%) but lower than England (17%). Almost one in four of these people also reported having depression and anxiety. 8.9% (35,818), while in the same survey people reported having at least two LTC of which one was a musculoskeletal disease.[68]

8.15 A regression model based on the Health Survey for England and ONS 2012 population estimates for Merton calculated that 29,600 people of all ages had back pain which had lasted for 3 months or longer. Representing 14.6% of the total population. 2,500 (8.2%) had severe back pain.

8.16 A related model which included GP diagnoses as well as self-reports, suggested that 17.4% (11,855) of people over 45 years had knee osteoarthritis which is similar to London (17%) but lower than England (18.2%).

Osteoporosis

8.17 Osteoporosis is a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes, deficiency of calcium or vitamin

[68] Musculoskeletal Conditions Profile, Public Health England

D. Osteoporotic fragility fractures can cause substantial pain and severe disability and are associated with decreased life expectancy. Osteoporotic fragility fractures occur most commonly in the spine, hip and wrist (distal radius).

8.18 GP disease registers show 217 people with osteoporosis are over 50 years, representing 0.2% of the population. This is a lower rate than for London and England as a whole and it is likely that many cases are not being diagnosed.

8.19 The suspicion that osteoporosis is under-diagnosed in Merton is supported by data on hip fractures. As explained above, these are usually related to osteoporosis and are mostly common in people aged 65 and over. In 2016/17, 146 people in Merton over 65 suffered a hip fracture, a rate of 557 per 100,000. This is higher than London (499 per 100,000).[69]

Diabetes

8.20 Diabetes is one of the most important and most common LTC with many serious complications, of which many are preventable. The Merton Health and Wellbeing Board has accordingly identified diabetes one of its top priorities for action.

8.21 The DPH Annual Report 2019 focused on diabetes, and includes local and national data applied to Merton. Below is an update on that data, for more information see the further resources section below.

8.22 11,160 people were recorded with Type 1 or 2 diabetes in Merton practice disease registers in 2017/18. This equates to 6.2% of the population and is similar to London (6.5%) and England overall (6.8%). 70

8.23 There has been a steady increase in diabetes prevalence from 5.4% since 2012/13 to the current 6.2%, representing an additional 1,726 prevalent cases over 5 years. [70]

8.24 Type 2 diabetes is more than six times more common in people of South Asian descent and up to three times more common among those of African and African-Caribbean origin, and affects people from BAME backgrounds at a younger age. In 2017/18 53% of people in Merton with Type 2 diabetes were from a Black and Minority ethnic group, and 39% from a White ethnic background.[70]

8.25 The probability of both Type 1 and Type 2 diabetes also varies by age. In general children and young people are more likely to have Type 1 diabetes and older people Type 2.[70] In 2017/18, 77.3% of Type 1 diabetic patients achieved good blood pressure control (London 78.4%, England 74.8%) with 70.2% in Type 2 diabetics (London 75.2%, England 73.8%).[71] These are some of the reasons, but not the whole story, why the prevalence of diabetes in Merton varies in different localities. The overall gap between East and West is 2.6%. Prevalence is 7.8% in the east and 5.2% in the west based on GP practice data. The environment in Merton has unhealthy features which make it easy for children and adults to become overweight. Overweight or obese adults are 50% more likely to develop Type 2 diabetes.

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[69] Musculoskeletal Diseases profile, Public Health England
[70] Annual Public Health report 2019, Diabetes
[71] Diabetes Profile, Public Health England

8.26 Population outcomes as well as individual outcomes for diabetes are clearly related to the quality of care. NICE Clinical Guidelines recommend nine care processes that every person over 12 years old with diabetes should receive annually. Performance in Merton is variable compared to London and England as a whole. For example, in 2017/18, 77.3% of Type 1 diabetes patients were recorded as achieving good blood pressure control (London 78.4%, England 74.8%) and 70.2% in Type 2 diabetics (London 75.2%, England 73.8%).[72] Much more detailed information is available in publications from the National Diabetes Audit, see the final section on further resources.

Coronary Heart Disease and Chronic Obstructive Pulmonary Disease

8.27 Both Coronary Heart Disease (CHD) and Chronic Obstructive Pulmonary Disease (COPD) are very important LTC, both in terms of the numbers affected and the potential for prevention. In 2017/18, 4,500 people were recorded by Merton GPs with CHD and 2,500 with COPD. Both are likely to be underestimates of the true population prevalence.[73]

8.28 Information about the rates of these conditions in Merton, and their distribution by age, ethnicity and place is derived from NHS activity data. Comparisons with statistical neighbours and London and England averages are published by PHE on Fingertips. See final section on further resources.

Mental health disorders

8.29 As described above, common mental health disorders often co-exist with physical LTCs. Serious mental illnesses such as schizophrenia, bipolar disorder and other psychoses constitutes as complex needs in themselves

8.30 Rates of serious mental illness are lower in Merton than London or England as a whole. In 2017/18, 2,048 (0.91%) people of all ages in Merton were recorded on their GPs disease register with such conditions, lower than London (1.1%) and England (0.94%).[73]

8.31 Mental disorders are often associated with other threats to good health, such as unemployment and substance misuse, both as a cause and a consequence.

8.32 People in contact with secondary mental health services are much more likely to be unemployed than other working age adults. The gap in employment [74] is estimated to be 67.8% (2017/18) similar to that for London (68.2%) and England (68.2%).[49]

8.33 Substance misuse is also associated with mental health disorders. In Merton in 2016/17, a quarter (25.1%) of patients using mental health services were also recorded to have substance misuse issues, this is lower than London (28.5%) but higher than England (24.3%).[75]

[72] Diabetes Profile, Public Health England
[73] The National General Practice Profiles, Public Health England
[74] The gap in employment is defined as the percentage point gap between the percentage of working age adults who are receiving secondary mental health services and who are on the Care Programme Approach recorded as being employed (aged 18 to 69) and the percentage of all respondents in the Labour Force Survey classed as employed (aged 16 to 64).
[75] Mental Health & Wellbeing JSNA, Public Health England

8.34 National data shows approximately 68% of women and 57% of men with mental health problems are parents, highlighting the importance of taking a 'Think Family' approach across partners to mental health and other issues within the borough.[76]

8.35 88% of adults in contact with secondary mental health services are able to live independently or without support, compared to the London average of 61% and England average of 57%.[76]

Self-harm and suicide

8.36 Self-harm and suicide may be the result of mental illness, but may also occur through mental distress alone.[77]

8.37 Self-harm is an area of concern particularly in young people – see para 7.47 for more information about this.

8.38 In 2017/18 Merton had a rate of emergency hospital admission for intentional self-harm of 94.5 per 100,000 population (approximately 188 people) which is lower than England (185.5 per 100,000) but higher than London (83.6 per 100,000).[78]

8.39 There were 9.7 per 100,000 population suicides in Merton in 2016-18, an average of 16 suicides per year. Suicide rates are similar to England (9.6 per 100,000) and higher than London (8.1 per 100,000).[78] The Health and Wellbeing Board has recently adopted a Suicide Prevention Strategy. For more information, see further resources at the end of the report.

8.40 Suicide in young people may be rising, in line with the increase in rates of self-harm described above. An analysis of national data published in the Lancet suggested that between 2010 and 2017, suicide rates in adolescents increased by 7.9% per year, and this was of statistical significance.[79]

8.41 Merton specific data for suicide in young people is aggregated before publication due to the small numbers involved. Between 2013 and 2017, there were 24 suicides recorded in residents aged 10-34 years. This was a higher rate than in the previous time period (2011-2015), and a higher rate than in London and England as a whole. Small numbers mean that variations could be due to chance.

Dementia

8.42 Dementia is a progressive disorder of the mental processes caused by brain disease or injury and marked by memory loss, personality changes, and impaired reasoning. Dementia is now the most common cause of death in the UK, overtaking coronary heart disease.[80] Recent evidence suggests that healthy behaviors such as avoidance of tobacco

[76] Fundamental Facts About Mental Health 2016 – Mental Health Foundation
[77] https://www.rcpsych.ac.uk/mental-health/problems-disorders/self-harm
[78] Suicide prevention profile, Public Health England
[79] Bould H, Mars B, Moran P, Biddle L, Gunnell D. Rising suicide rates among adolescents in England and Wales. The Lancet (Online). 2019; S0140-6736(19)31102. Available from: https://guides.library.uwa.edu.au/c.php?g=324981&p=2177244
[80] https://www.dementiastatistics.org/statistics/deaths-due-to-dementia/

and alcohol, a good diet and regular physical activity can reduce the risk of dementia, so it is an important matter for public health.[81]

8.43 Dementia may develop gradually and diagnosis may be delayed. In 2018, 5% (1,258) of people aged 65 years and over were recorded with the condition in Merton, but this is only 69% of the total predicted from national research, and a lower diagnostic rate than London (70.5%), and England as a whole (67.5%).[82]

8.44 Overall numbers of people with dementia are forecast to rise substantially over the next 15 years. National estimates are that in 2019 there are 954,000 people living with dementia in the UK and this will rise to 1,531,000 by 2035.[83] Applying these projections to the Merton population, suggests the total number of residents with dementia will increase from 2,050 to 3,300 over the same period.[84]

8.45 Merton has a Dementia Action Alliance and is seeking to become a dementia-friendly community. For more information, see further resources at the end of the report.

Social care and housing

8.46 People with complex needs and multiple morbidities often need help with activities of daily living such as shopping, cooking, cleaning and personal care. Family, friends and neighbours provide the majority of this care, and carers themselves have needs, as described at para 8.57 below.

8.47 In some cases the need to provide social care falls to the council and its partners in the voluntary sector. Merton currently supports 3,200 adults aged 18 and over with social care needs and around 1,300 carers.[85] More details of the services which are provided and feedback from users are provided in the Local Account, see further resources.

8.48 Housing is another common component of complex needs. Latest figures (2018) suggest that 23% of supported people with learning disabilities (100 in total) and 12% of those in contact with secondary mental health services are not living in settled accommodation.

Learning and physical disabilities

8.49 Disability can be defined as a physical or mental impairment that has a substantial and long-term negative effect on the ability to do normal daily activities. A learning disability is a reduced intellectual ability and difficulty with everyday activities. Social deprivation and LTC's are more common in disabled people than others, and often give rise to complex needs.

8.50 The Merton Public Health team published a Disability Healthcare Profile in 2018. This section of the Merton Story contains only some of the highlights. For more information, on

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[81] Health Matters: midlife approach to reduce dementia risk. Public Health England, 2016

[82] Dementia Profile, Public Health England

[83] https://www.dementiastatistics.org/statistics/prevalence-projections-in-the-uk/

[84] https://app.polimapper.co.uk/?dataSetKey=41a8db966f6446b8803d0a33094f61b1#_=&con_over=Merton

[85] Merton Council Adult social care local account. 2016/17

the numbers of people with different types of disability at different ages and how rates compare to London and England, see the further resources section below.

8.51 It is estimated that 10.1% of Merton's working age population (16-64 years) population have a physical disability (14,000 people) which is slightly higher than London (9.9%) but lower than England (11.1%).[86]

8.52 In 2017/18, 708 (0.3%) Merton residents were registered as having learning disabilities by their GP. This is lower than England (0.5%), London (0.4%) and other comparator boroughs with the exception of Kingston Upon Thames.[87]

8.53 Not all people with learning disabilities are registered by their GPs as such. The estimated is 3,900, meaning only 18% are registered.

8.54 Social services also keep a register of people with learning disabilities. These tend to be people with more serious disabilities. There were just over 400 such adults recorded by the Council in 2016/17, 313 of whom lived in their own home or with their parents. This is three quarters (75.2%) of LBM's caseload and is higher than London (71.3%) but slightly lower than England (76.2%).[88]

8.55 Despite the relatively small number of people with learning disabilities supported by the council, compared to other types of service user, their share of the total spend on social care is significant, being 39% nationally.[88] LBM spend in 2018/19 was £21.7m, in line with the national proportion.[89]

8.56 The difference in employment rates between residents of working age compared with residents with learning disabilities was 76.3%, the rates being 80.8% in the general working age population, and 4.5% in those with learning disabilities. The gap has increased since 2011/12.[86]

Carers

8.57 In Merton there are thought to be approximately 17,000 carers, estimated to be making an economic contribution of over £200 million per year.[85] Caring can also provide life satisfaction/purpose and improve connections with loved ones. However, it can also have a negative impact on physical and mental health, and affect education and employment. 3,300 are estimated to provide more than 50 hours care per week.

8.58 Assessments and services were provided by the Council to 1,095 carers in Merton during 2017-18, only about 1 in 15 of the estimated total.

8.59 The 2016/17 carers' survey showed that Merton is performing better than our comparator group on "Overall satisfaction of carers with social services" Further detail is available in the Local Account referenced under further resources.

8.60 It is not just adults who are carers but children and young people too. In Merton, the 2011 Census suggested that there were about 1500 young people and adults in an unpaid

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[86] Public Health Profile, Public Health England
[87] Adult Social Care Profile, Public Health England
[88] https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf
[89] https://democracy.merton.gov.uk/documents/s21097/Budget%20Summaries%20Consolidated.pdf

caring role with 400 aged 15 or under.[90] Of these, 80% (330) provided up to 19 hours of care each week; 13% (53 young people) provided 20 to 49 hours of care each week and 7% (29 young people) over 50 hours of care each week.[91]

8.61 Less than 20 young carers are registered with the Council. If the research from the BBC is correct there could be as many as 4 times the number of young carers living in Merton than are currently identified.

Social isolation and loneliness

8.62 Social isolation and loneliness may be both a cause and an effect of complex needs and multi-morbidity. Research has shown that loneliness is as a serious a risk to health as smoking 15 cigarettes per day.[92]

8.63 Figures on the amount of loneliness in Merton specifically are not available. Nationally just over 14% of older people aged 65 to 74 report being lonely at least 'some of the time' whilst this increases to just under 20% for those aged 75+.[93] Rates in Merton are likely to be similar.

8.64 The amount of loneliness in older people is likely to increase if nothing is done. There are currently about 7,000 people aged 65-84 living alone and 1,000 over the age of 85. As detailed in para 3.88, the total numbers of older people are predicted to rise by about 10% of those aged 65-84, and 65% in those aged 85+.

8.65 Loneliness is frequently reported by people who receive social care from the Council. In the most recent survey of users of adult social services, only 40.6% reported that they had as much social contact as they would like (2017/18). This is significantly lower than the average for England (46%), although similar to the average for London (41.4%).[94]

Falls

8.66 Falls are more common in people with multiple morbidities and the underlying causes are often a complex mixture of social and health care needs.

8.67 Population measures of the size of the issue in Merton and elsewhere are not available. A proxy measure is the number and rate of people admitted to hospital after a fall. Rates may differ over time and between local authority areas because of variations in coding and service configuration.

8.68 In 2017/18 in Merton there were 876 emergency admissions for injuries due to falls among people 65 years & over. This represented a rate of 3,329 per 100,000, significantly higher than for London (2,319) and England (2,170).[95]

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[90] Merton Young carers Multi-agency strategy 2019-2022: https://www.mertonscp.org.uk/wp-content/uploads/2019/02/MSCP-Young-Carers-Strategy-2019-2022-Final-1.pdf

[91] ONS

[92] Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Perspect Psychol Sci. 2015 Mar;10(2):227-37.

[93] Loneliness - What characteristics and circumstances are associated with feeling lonely? ONS, available at www.ons.gov.uk

[94] Adult Social Care Outcomes Framework (ASCOF), 2018

[95] Public Health Profiles, Public Health England

9 EMERGING ISSUES AND HIDDEN HARMS

Key messages

Part of the pattern of health and wellbeing need in Merton is not visible, and it is not static. Some important issues are difficult to quantify; others are emergent and monitoring processes are still developing. Examples include:

- Parent and carer mental health and substance misuse. 15% of referrals to the safeguarding hub in a recent audit were related to this
- Poor Air Quality. Whilst this has not got worse, the evidence of harm to health has become clearer
- Excess winter mortality. This is worse in Merton than other Boroughs and there are likely to be variations within Merton itself
- Children and young people with complex need transitioning to adult services
- Adult social care pressures and workforce uncertainties from Brexit
- Knife crime and fear of violence
- Drug dealing/county lines
- Climate change

Introduction to emerging issues and hidden harms

9.1 The pattern of health and wellbeing in Merton, and the contributory protective factors and risks, is not all visible and it is not static.

9.2 Some of the assets that protect health, and the drivers of need for prevention and care are relatively easy to quantify and to predict, for example the demography of the population, which is the focus of Section 3. Other factors that may be equally important are by their nature more difficult to measure, or are newly emerging meaning monitoring and forecasting is not yet in place. This section highlights some of these factors.

9.3 The selection of topics for this section is not as data-driven as other parts of the Merton Story and requires judgment regarding priorities. Feedback is welcomed as to whether the topics outlined in this section are the most appropriate set for Merton in 2019 (see section 10 further resources below for how to provide feedback).

Parents and carers with mental health/substance misuse issues

9.4 There are likely to be significant numbers of children in Merton living with parents who misuse drugs or alcohol, and as we know from data presented earlier in paragraph 6.16 on unmet need, a substantial proportion of those parents will not be accessing treatment. Parental substance misuse can cause serious harm to children at every age from

conception through to adulthood. The same is true for other issues such as parental mental health.

9.5 In a survey of referrals between December 2017- January 2018, 14.5% of cases to the Merton Multi-Agency Safeguarding Hub were related to parental Mental Health.[96]

9.6 In 2011/12, Public Health England estimated that 102 parents per 100,000 children aged 0-15 were in drug treatment and 133/100,000 children in alcohol treatment in Merton. This equates to about 40 and 53 parents respectively. This is likely to be a small fraction of all parents misusing substances as many will not be accessing any treatment.

9.7 Reducing this 'hidden harm' to children in Merton requires better understanding of these cohorts, and a 'Think Family' approach to partnership data and intelligence sharing. This is an area where more work could be undertaken during the next 12 months if it were clear how decision makers would use the products.

9.8 The same risks of unrecognised and untreated mental health and substance misuse issues apply to carers of adults. Cases where substance misuse is an issue for carers often emerge through adult safeguarding concerns, however there are likely too many unidentified cases.

Air quality

9.9 Data collected locally shows that air quality has not worsened in the last year, although there is still an issue with poor air quality in the borough and it is a growing public concern. Scientific evidence on poor air quality has grown, and shows that it is a cause of damage to health at all ages, from early childhood through to old age. For example, there is emerging evidence that poor air quality is associated with dementia and diabetes.

9.10 Merton has declared the whole Borough an Air Quality Management Area and published an Air Quality Action Plan in 2018. The problem is most severe around the major transport routes. Annual Status Reports are published on the Council's website in accordance with the statutory process (see section 10 further resources).

9.11 There is emerging evidence that schools in London which are worst affected by air pollution are in the most deprived areas, meaning that poor children and their families are disproportionately exposed to the multiple health risks which follow.[97]

9.12 Air quality is now carefully monitored so it is no longer a hidden harm, but the severity of the associated health impacts are still emerging. More modelling of the impact of poor air quality on Merton residents could be undertaken for the Merton Story 2020.

Excess winter mortality

9.13 Mortality is seasonal, and more people die in the winter than the summer. The level of 'excess' winter deaths (as shown by the Excess Winter Mortality Index)[98] in Merton is

[96] Hilina Asrress, presentation to parental mental health conference. 21 March 2018

[97] London's Polluted Schools: The Social Context. Brook R, Smith H, Pridmore A, King K, Williamson T; Aether. Commissioned by the FIA Foundation. 2017

[98] The EWM index is calculated as the number of excess winter deaths divided by the average non-winter deaths x 100. The EWM index shows the *percentage of extra deaths* that occurred in the winter.

noticeably higher than the London and England average (27.7% in 2016/17, compared to 22.9% and 21.6% respectively).[99] The majority of these excess deaths occur in people aged 75 and over. The main causes are respiratory and cardiovascular diseases, exacerbated by inefficient heating, insulation and substandard housing.

9.14 It is likely that excess winter deaths are more significant in the more deprived parts of Merton. This is an area suitable for further analysis in the next year, if more targeted action might follow.

Children and young people with complex need transitioning to adult services

9.15 Driven in part by increases in quality and safety of maternity and early years care, more children are surviving into childhood and adolescence with complex health, care and education needs. As this is likely to mean an increasing number of complex packages, the local picture in Merton needs to be quantified and explored further.

9.16 This is an important issue for the young people, their families and service commissioners and providers. Forecasting of how this need will change could be included in the Merton Story 2020.

Adult social care pressures

9.17 The demographic trends of an aging and growing population will lead to increased demand for older people's health services and Adult Social Care. At the same time, there is increasing pressure on budgets for these services.

9.18 Due to the scarcity of resource, social care packages are increasingly targeted to those with higher need. More work needs to be done to fully understand the impact of both demographic trends and constrained finances across the whole health and care system.

9.19 The Merton Health and Care Partnership which reports to the Health and Wellbeing Board is leading on this work. Several parts of the Merton Story form the backdrop. More detailed work can be undertaken and published in-year as Bulletins under the JSNA suite of products, or included in the Merton Story 2020.

Workforce shortages.

9.20 Merton's population projections identify a 10.5% increase in the working age population by 2035, which is much smaller than the 64% increase expected in those aged 85+. We are also likely to see an increase in "beanpole" families (see paragraph 3.114). This means there is likely to be a rise in the proportion of middle aged people coping with the competing demands of looking after both young children and older parents.

9.21 As a result of both these factors, there may be relatively fewer people available to join the health and care workforce. Merton has a generally high employment rate and therefore attracting people into this field may be challenging given generally higher rates of pay in alternative sectors such as hospitality and retail. Brexit is a further unknown factor.

[99] Public Health Profiles, Public Health England

Community safety and knife crime

9.22 Whilst the actual number of knife crime offences in Merton is low in absolute and relative terms compared to other London boroughs, fear of violence affects a much larger segment of the Merton population. This in turn changes people's behaviour and leads to lower levels of physical activity and more social isolation.

9.23 Results from the 2017 residents survey show that almost 96% of people in Merton feel safe when outside in their local area during the day, in line with LGA benchmarking.

9.24 After dark, the results are not so positive. 85% reported feeling safe, although most of these feel fairly safe (63%) as opposed to very safe (22%).

9.25 There is a significant difference in feeling of safety after dark between east and west Merton (82% compared to 88% respectively).

9.26 Female residents and those aged 65+ are also significantly less likely to feel safe after dark.

9.27 Disabled residents are significantly less likely to feel safe after dark compared to nondisabled residents (72% cf. 86%).

9.28 In 2018/19, 220 knife crime offences were recorded in Merton, a 17.7% increase from 2017/18. 52 of these offences resulted in some form of injury. Within the overall knife crime figures, approximately 20% of the offences are also flagged as being domestic abuse related. In 2018/19 Merton had the third lowest borough total for 'violence with injury' offences in London and saw a 1.0% reduction from the previous financial year.[100] For more information see further resources.

Drug dealing/county lines

9.29 The borough has seen an emergence of open drug dealing in some areas since the last Merton Story. The dealing, of predominantly Class B drugs is affecting all ages; however, it is mainly young people and young adults who are being drawn to sell items. This is occurring in various locations across the borough with Mitcham Town Centre as a particular area of concern.

9.30 Drug dealing, as with drug use, is intrinsically linked to violence. With the rise of serious violence across the country, tackling the supply of drugs is an essential element of work for the Community Safety Partnership.

9.31 Anti-social behaviour within the borough may be used to understand the impact of drug use on the community. The Merton Anti-social Behavioural Unit reported 131 (11.2%) out of 1166 calls related to drug use in the year form April 2018 to March 2019.

9.32 An increase in "county lines" drug dealing involving young people from Merton has also been recognised.[101]

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[100] MPS FY 2018/19 Crime Statistics. Available at https://www.met.police.uk/sd/stats-and-data/met/year-end-crime-statistics/

[101] https://www.local.gov.uk/sites/default/files/documents/4.%20Merton%20Youth%20Justice%20-%20Josh%20Talbot%20and%20Emma%20Bradley.pdf

Climate Change

9.33 Climate change is a change in global and regional climate patterns apparent from the 1990s onwards, attributed largely to increased levels of atmospheric carbon dioxide produced by the use of fossil fuels.

9.34 Merton Council in line with many other local authorities has declared a “Climate Change Emergency” and a plan for addressing this is being prepared for approval by the Council in spring 2020.

9.35 Climate change will have widespread effects on health and wellbeing. Many of the changes which are being recommended as necessary to minimise the change may have a positive effect on people’s health, such as more active travel and dietary changes.

9.36 As the choices facing decision makers in Merton become clearer, it will be possible to undertake a health impact assessment on proposed interventions. More information about this will be included in the Merton Story 2020, or published separately sooner if required.

10 FURTHER RESOURCES

Merton Joint Strategic Needs Assessment

The Merton Story is part of the Merton Joint Strategic Needs Assessment (JSNA). Other JSNA products include:

Merton Data – https://data.merton.gov.uk/

Ward Health Profiles for each of Merton's electoral wards – https://www2.merton.gov.uk/health-social-care/publichealth/jsna/ward-health-profiles.htm

Topic Health Profiles and Health Needs Assessments – a range of more in-depth assessments on priority topic areas – https://www2.merton.gov.uk/health-social-care/publichealth/health-needs-assessments.htm

Tackling health inequalities – progress in closing the gap within Merton. Annual Public Health Report 2018. https://www2.merton.gov.uk/Annual-Health-Report2018.pdf

Tackling Diabetes in Merton: Learning from a whole system approach. Annual Public Health Report 2019. https://www2.merton.gov.uk/APHR_2019_Diabetes_In_Merton_FINAL_WEB.pdf

Adult social care performance. https://www.merton.gov.uk/social-care/adult-social-care/plans-and-performance/performance

Merton Dementia Action Alliance Annual Report 2018-19. https://www.merton.gov.uk/assets/Documents/Merton%20DAA%20Report%202018-19%20Final.pdf

Local air quality management: Annual Status Reports https://www.merton.gov.uk/communities-and-neighbourhoods/pollution/air-quality-and-air-pollution/local-air-quality-management

Suicide Prevention Strategy (draft version) https://democracy.merton.gov.uk/documents/s25559/6.Suicide%20Prevention%20Framework%20Annexe.pdf

Metropolitan Police https://www.met.police.uk/sd/stats-and-data/met/crime-data-dashboard/

Wider resources

There are a vast amount of data sources and information located on the web relating to the content of this report and similar related information. Some of this information can be located by anyone with an interest by accessing the following websites:

PHE Public Health Profiles https://fingertips.phe.org.uk/

PHE Data and Analysis Tools hub https://www.gov.uk/guidance/phe-data-and-analysis-tools

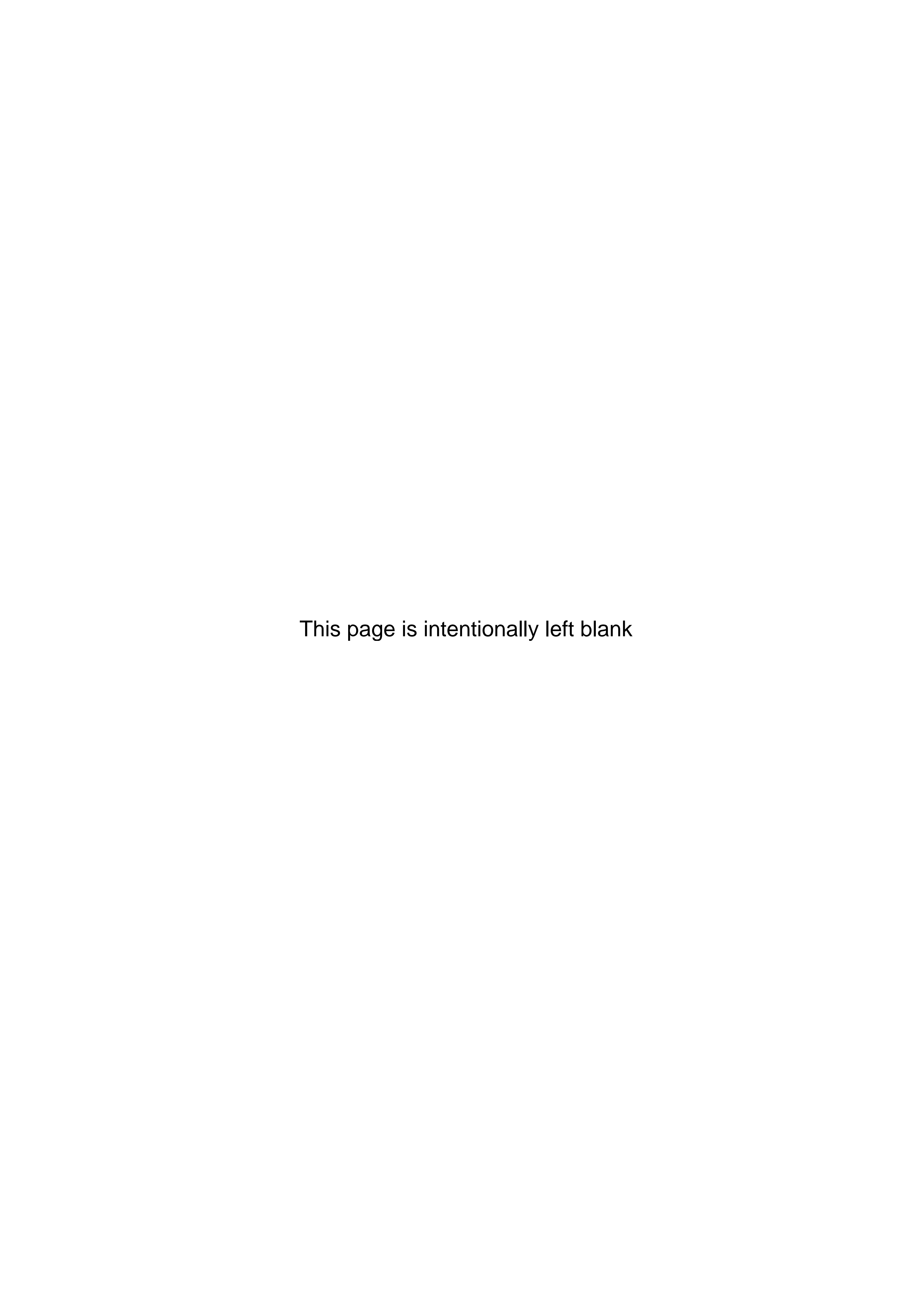
PHE Local Health http://www.localhealth.org.uk/

National diabetes audit: https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit

Public Health profiles: https://fingertips.phe.org.uk/

Other commonly used Public Health data sources: https://www2.merton.gov.uk/data_sources_commonly_used_in_public_health_intelligence.pdf

How to give feedback
Please email mertonjsna@merton.gov.uk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The Merton Story 2019

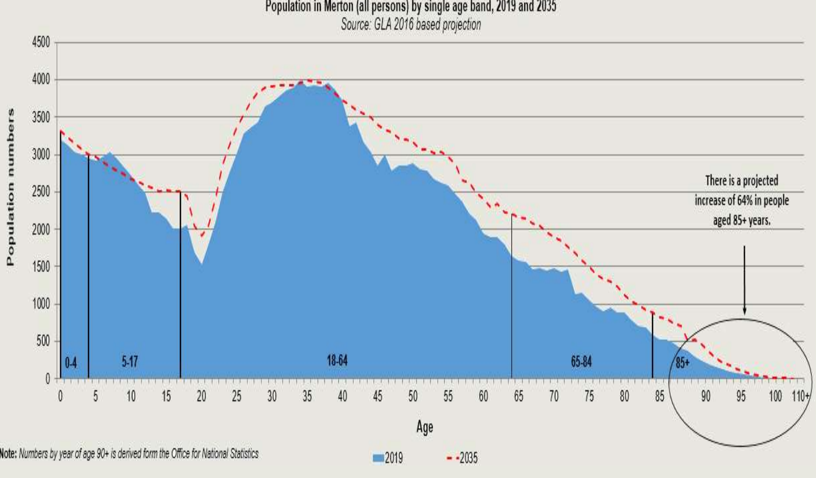
Version 3. 17/1/2020

Overall healthy and safe borough, rich in assets

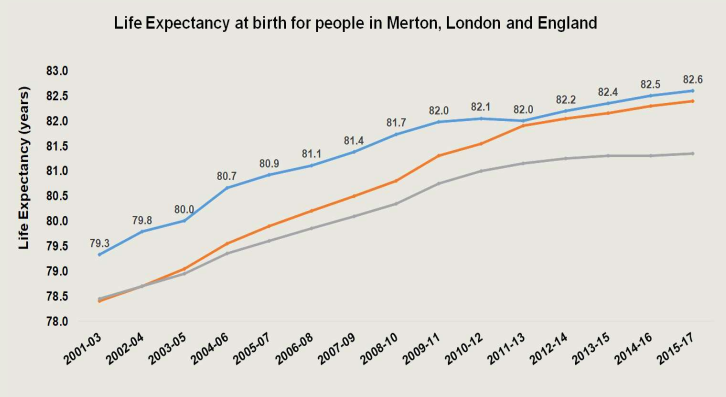
CHALLENGES

- Inequalities and the health divide
- Healthy lifestyles and emotional wellbeing
- Child and family, resilience and vulnerability
- Increasing complex needs and multi-morbidity
- Hidden harms and emerging issues

Population in Merton (all persons) by single age band, 2019 and 2035



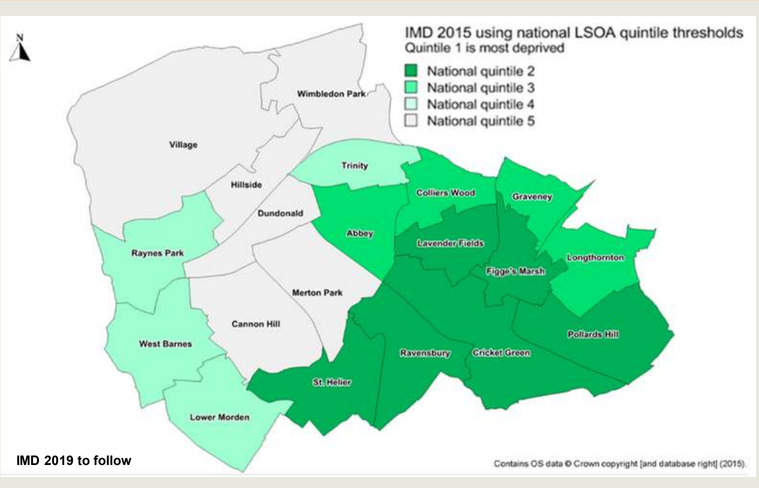
Overall healthy and safe borough



Rich in Assets

- Many green spaces
- Active voluntary and community sector
- Good transport connections (especially in west Merton)
- Resourceful libraries
- Good schools
- Cycling infrastructure

Inequalities and the health divide



Significant social inequalities between east and west.

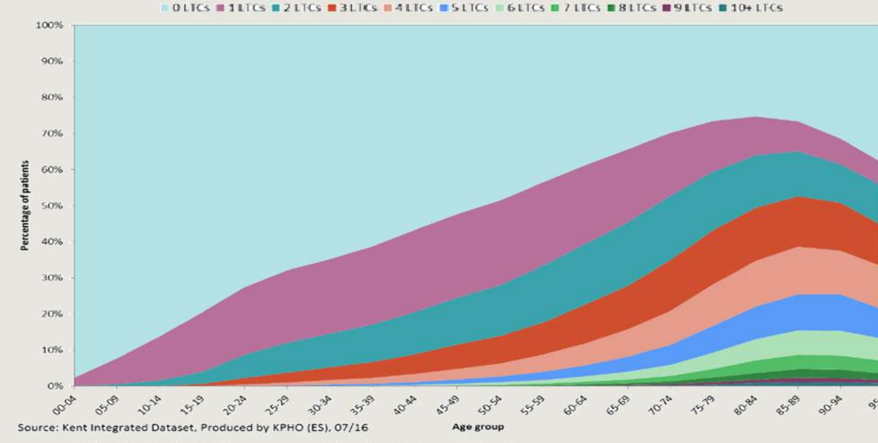
Similar patterns for:

- Life expectancy
- Unemployment
- Long term conditions
- Educational attainment
- Overcrowding

Healthy lifestyles and emotional wellbeing

	Number of adults in Merton (% of adult population)	Risk Factors
	31,000 (20%)	**Exercise** - Adults doing less than 30 minutes of moderate intensity physical activity per week
	68,200 (43%)	**Healthy eating** - Adults not meeting the recommended '5-a-day' on a 'usual day'
	40,700 (26%)	**Alcohol** - Adults drinking above the recommended limit of alcohol a week
	17,600 (11%)	**Smoking** - Adults who smoke
	19,000 (12%)	**Mental Wellbeing** - Adults with depression or anxiety recorded by GPs

Increasing complex needs and multi-morbidity



N.B. This is illustrative data – pattern in Merton will be similar

Total number of long term conditions increases with age e.g. 75% of people aged 80-84 years have at least 1 long term condition; 50% have 3 or more.

Child and family vulnerability and resilience

Good things happening…

- School readiness
- Reduced teenage pregnancy
- 16-17 year olds not in education, employment or training (NEET)
- Dental health

Keeping an eye on…

- Increasing childhood obesity gaps
- Substance misuse
- Poverty and poor social circumstances

Worrying about…

- Mental health and self-harm
- Rise in number of children and young people with Education and Health Care Plans
- Safety outside of home

Hidden harms and emerging issues

Hidden harms

Excess winter deaths

Parents and carers with mental health/substance misuse issues

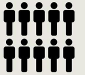
Knife crime

Emerging issues

Air pollution

County lines

Increase in Special Educational Needs and Disability (SEND)



Workforce shortages

Committee: Health and Wellbeing Board

Date: 28th January 2020

Subject: Merton Joint Sexual Health Strategy and implementation plan

Lead officer: Dr Dagmar Zeuner, Director of Public Health

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

Contact officer: Julia Groom, Consultant in Public Health /Kate Milsted, Sexual Health Commissioning Manager

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Recommendations:

That the Health and Wellbeing Board members:

A. ***approve and endorse the final borough wide sexual health strategy and implementation plan;***

B. ***note the work completed in response to their earlier comments on the draft strategy.***

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report sets out the steps followed in the development of the final local authority and CCG sexual health strategy (2020-2025) for Merton, which have been made since the proposed vision and priorities were presented at a previous board meeting on 28th June 2019.

1.2. When the strategy was brought to the board meeting on 28th June, members requested that the final version of the strategy along with the implementation plan be brought to a subsequent meeting for approval.

1.3. Board members are requested to approve and endorse the final version of the strategy and the associated implementation plan.

2 BACKGROUND

2.1. A sexual health strategy for Merton has been developed to provide a joined up response to sexual health, by detailing how partners will collaboratively respond to increasing STI and HIV rates and the subsequent pressure on services. The long-term goal is to improve outcomes in sexual health and sexual well-being and access to services in the borough, which should in turn reduce the cost to the broader health and social economy.

2.2. The public health team undertook a comprehensive sexual health needs assessment, which has informed the vision, strategies and actions in the strategy.

2.3. A strategy development steering group was set up to oversee the development of the sexual health needs assessment, strategy and implementation plan. The group was co-chaired by Dr Tim Hodgson (GP

lead for sexual health, Merton CCG) and Julia Groom (Public Health Consultant lead for sexual health). All key partners were represented on this group.

2.4. Face-to-face consultation with over 300 professionals working in the borough has taken place as well as 123 focus groups held with young people. 1,283 people also provided feedback into the process via online surveys.

3 DETAILS

3.1 The draft vision and priorities for the joint sexual health strategy were presented to the Health and Well-Being board meeting held on 28th June 2019. The recommendations were agreed and it was requested that the final strategy and implementation plan were brought back to the board for agreement and endorsement.

3.2 At the meeting on the 28th June board members asked for further consideration of how:

- older people are supported with their sexual health needs;
- Merton are working together with other local authorities;
- the principles that applied to successful work on the teenage pregnancy strategy can be utilised;
- links with other services, including mental health can be made.

3.3 The strategy steering group reviewed these areas and have addressed them within the strategy priorities and implementation plan. Actions include:

- a review of how services meet the needs of older people and engagement with those aged 50+ to further understand their needs;
- desk top research into good practice examples of how to meet the needs of those ageing with HIV;
- joint working with commissioners in South West London to standardise and re-commission pharmacy sexual health services across the sector;
- referral pathways developed and adopted between the integrated sexual health service and mental health and substance misuse service.
- development of a multi-agency steering group to oversee the actions identified in the sexual health implementation plan, ensuring a senior level champion is identified;

3.4 On the 5th November, the Healthier Communities and Older People Overview and Scrutiny Group considered and commented on the draft sexual health strategy. They did not propose any changes, but had a helpful discussion about how much cross cutting and intersectionality exists between groups most affected by sexual health issues. The Director of Public Health informed

that there is some overlap but that the strategy seeks to strengthen this under priority three, a comprehensive approach. They were informed that focus groups with those who do not traditionally engage with services has been undertaken, to ensure actions to destigmatise sexual health issues amongst certain groups have been included in the implementation plan.

3.5 Since the board meeting on 28th June, the draft strategy and implementation plan has been presented to the following meetings and any feedback received has been incorporated. All these groups have supported the final version of the strategy and implementation plan:

1. Merton CCG Patient Engagement Group
2. Merton Local Medical Committee
3. Merton Children's Trust Board
4. Merton CCG Clinical Oversight Group
5. London Borough of Merton Corporate Management Team
6. Merton CCG Executive Management Team

3.6 In September, the draft version of the strategy and the implementation plan were sent to all groups who were initially consulted on the proposed vision and priorities, allowing them another opportunity to comment. Only a few minor changes were requested and these have been made.

4 ALTERNATIVE OPTIONS

Not applicable

5 CONSULTATION UNDERTAKEN OR PROPOSED

Extensive consultation has been undertaken with residents, professionals who work in Merton, and those studying or looked after in the borough.

6 TIMETABLE

Please see below some key milestones in the next steps for strategy progress:

Feb 2020: Membership of the strategy development steering group will be reviewed, and a new strategy implementation steering group formed. This group will oversee the strategy implementation plan.

March 2020: First meeting of the strategy implementation group and work on the implementation plan commences.

March 2020: Strategy is published on the London borough of Merton website, and distributed to stakeholders.

Sept 2020: Six month review meeting of implementation plan progress.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

There has been no cost incurred whilst developing the strategy except staff time. The implementation plan will be delivered within existing budgets and staff resources.

8 LEGAL AND STATUTORY IMPLICATIONS

The strategy will have oversight of the following areas, which are the legal and statutory responsibility of local authorities:

- The statutory duty to secure the provision, for their residents, of open access services for contraception and for testing and treatment of sexually transmitted infections (STIs).
- Statutory Relationships and Sex Education (RSE), which will come into effect in September 2020.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1 Assessment of need, research and consultation conducted indicates that there is recognised disparity and inequality of sexual health between different population groups. Young people, gay men, and black and minority ethnic groups are disproportionately affected by poor sexual health.

9.2 The strategy and corresponding implementation plan aim to address this disparity, and ensure equality and equity of access to education and sexual health services in the borough, with particular emphasis on these most vulnerable groups.

9.3 A equality impact assessment has been carried out and the results fed into the strategy and implementation plan.

10 CRIME AND DISORDER IMPLICATIONS

There are strong links between sexual health and wellbeing and domestic violence, sexual exploitation and abuse. The police and Sexual Assault and Referral Centres (SARC) are key partners in the strategy.

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

Appendix 1: Merton joint sexual health strategy 2020-25

Appendix 2: Merton implementation plan: 2020-2025

13 BACKGROUND PAPERS - None

Merton Sexual Health Strategy 2020-2025

January 2020

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2. Foreword

Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health, London Borough of Merton.

As the Cabinet Member responsible for Public Health, I commend this joint Merton Sexual Health Strategy. Relationships affect everyone at some stage of their lives, therefore it is laudable that this strategy takes a whole life-course approach and adopts a holistic view in its aim to improve sexual health in Merton.

Merton has seen excellent progress in some areas such as the decline in teenage pregnancy rates which are now lower than England or London averages. However this strategy recognises that there is still work to do. It proposes aspirational yet achievable solutions for responding to increasing sexually transmitted infections and HIV, as well as ensuring people in Merton are equipped with the knowledge and skills needed to have happy healthy relationships. Delivery of the strategy will require working with partners and people living, working and studying in Merton to ensure its ambitious aims are achieved.

Dr Tim Hodgson, Clinical Lead for West Merton, Merton Clinical Commissioning Group

As Clinical Lead for West Merton and a local GP, I experience first-hand some of the relationship and sexual health issues people in Merton encounter. Residents access GP services for contraception, STI testing and reproductive health as well as a whole range of related matters, and it isn't always easy to know what services are available and where they should be directed. I am therefore pleased to see the joined up approach which has been adopted in this strategy, which recognises that sexual health often goes hand in hand with other issues such as drugs & alcohol use, exploitation, abuse and emotional health and well-being.

I have enjoyed being part of the development of this strategy which has brought together all the key partners in Merton to discuss this topical subject. Close partnership working between Merton Local Authority and Merton NHS CCG has been fundamental in the development of this comprehensive, joint sexual health strategy and will be imperative moving forwards.

The strategy sets out clear objectives and a positive direction of travel for tackling sexual health in Merton. It is a useful resource for anyone working in this field, as well as all residents in the borough.

3. Executive summary

This 2020-2025 joint Sexual Health Strategy recognises that healthy relationships, sexuality and sexual health affects everyone at some point in their lives. The strategy sets out how London Borough of Merton (LBM) and NHS Merton Clinical Commissioning Group (MCCG), along with their partners and the residents of Merton, plan to improve sexual health in the borough. It sets out plans to respond to increasing sexually transmitted infections (STI) and HIV rates, and prevent long lasting impacts of poor sexual health and well-being.

The strategy and associated implementation plan recognise that sexual health and well-being impact on and are affected by wider determinants of health (such as social, economic and environmental issues which shape daily life and impact on people's health), and so partnership working with all relevant organisations nationally, regionally and locally is crucial.

Prevention is a priority and although a universal approach is identified it is also recognised that certain groups, such as under 25s, men who have sex with men (MSM) and black and minority ethnic (BME) groups, are disproportionately affected and so targeted interventions are required.

Our vision is to improve the sexual health and wellbeing of those who live, work and learn in Merton by:

- providing people with the information and skills they need to make informed choices about their sexual health and wellbeing;
- providing confidential, easily accessible and comprehensive services; and
- promoting healthy fulfilling sexual relationships and reducing stigma, exploitation, violence and inequalities.

To achieve this three key priorities have been identified:

Priority One: Education & Training - increase training and education with the community and frontline workforce to build their confidence to discuss sexual health and wellbeing, empowering people in Merton to manage their own sexual health and develop fulfilling and healthy relationships.

Priority Two: Easy access to sexual health & well-being services - ensuring sexual health and well-being services are free, confidential, comprehensive and available to all, at times and locations which meet the need.

Priority Three: Comprehensive sexual health and wellbeing - enabling people to consider their sexual health and wellbeing in the context of their whole life, by ensuring services are joined up and address the wider determinants.

This vision and key priorities were informed by a local sexual health needs assessment, which highlighted that although sexual health need in Merton is similar to much of London, there are areas which require focus. These include but are not limited to: reducing the rate of new diagnoses of gonorrhoea and syphilis,

(which are markers of risky sexual behaviour); tackling high repeat termination of pregnancies in under 25 year olds; ensuring those at risk of HIV get tested earlier; and providing protection against sexual violence and exploitation.

The sexual health landscape is continually changing with emerging issues such as the threat of antibiotic resistance to gonorrhoea and new medical interventions, and Pre-exposure prophylaxis (PrEP) causing challenges to already reduced public budgets. Demand for sexual health services remain high, and in response commissioners and providers have had to be innovative. In London partners have worked together to introduce a standardised integrated service model, a more effective pricing mechanism and an online STI service.

The development of this strategy has been overseen by a multi-agency steering group with representation from all key partners. Extensive stakeholder engagement with over 1,500 people living, working and studying in Merton has been undertaken which has been invaluable in ensuring the vision, priorities and actions respond to local views and need.

The implementation plan for the borough sets out how partners will work together to achieve the strategy's priorities, with the top six actions being to:

- Provide support and training to schools to implement the new national guidance for Relationship and Sex Education (RSE) and meet the new Ofsted framework on promoting personal development.

- Enable those with special educational needs and disabilities, to develop safe and sexually healthy lives by strengthening education and training for parents, carers and professionals.

- Work in partnership with South West London commissioners to review the provision of sexual health services in pharmacies, with the view to ensuring a standard model across the sector and widening access, particularly in the east of the borough.

- Explore opportunities to engage with those identified as needing further support, including but not limited to those: aged over 25; aged 50 +; identifying as lesbian, gay, bisexual, transgender, or questioning (LGBTQ+); with physical and learning disabilities; experiencing or at risk of child sexual exploitation (CSE) and; MSM.

- Continue to develop and improve pathways between services in the sexual health system working to address commissioning issues where needed. This includes but is not limited to:
    - termination and contraceptive services so that LARC is offered and provided more consistently;
    - cervical screening in the integrated sexual health service;
    - antenatal and postnatal support to prevent second conceptions in under 25s and;

- HIV support providers and the community nurse outreach to ensure joined up care for those living with HIV

- Strengthen and embed sexual health knowledge and support into inter-linked services, particularly for those: experiencing poor mental health; living and ageing with HIV; experiencing domestic violence or dealing with previous past abuse; who are the victim of child sexual exploitation and who are using substances.

4. Introduction

4.1. What is sexual health and well-being?

Sexual health and wellbeing is a fundamental aspect of the human identity and life experience. The World Health Organisation (WHO) definition of sexual health is:

"…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006)

Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease (DoH, 2001). It is a key public health issue and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

4.2. The case for change

The past decade has seen great improvements in the quality and scope of sexual and reproductive health promotion and HIV prevention. In 2013 the Government published a framework for sexual health improvement setting out its ambitions to improve sexual health outcomes. Merton has seen one of the highest reductions in teenage conceptions in London and overall the rate of new STI diagnoses has remained stable. However, alike the rest of London, Merton is experiencing a continuing rise in acute STIs, particularly syphilis and gonorrhoea. This has led to a higher demand for services in London than any other area of the country, and as a result, a rising cost to public services.

A focus on sexual health and well-being is required as:

- **Sexual health inequalities remain**
  Sexual ill health disproportionately affects young people, men who have sex with men (MSM) and people from black and minority ethnic (BME) groups adding to existing health inequalities. Services need to continue to be targeted to these groups and integrated pathways to support are clear.

- **Commissioning responsibilities are complex and fragmented**
  Greater partnership working is required to ensure the best outcomes and value from combined assets: London Borough of Merton (LBM); NHS Merton Clinical Commissioning Group (MCCG); and NHS England, and third sector partners.

- **Sexually transmitted infections (STIs) and unintended pregnancies can have a long lasting economic impact**
  Preventing STIs, HIV and unwanted pregnancies is cost effective and evidence of return on investment is strong. For every pound spent on sexual health services, £86 could be saved on future public spending (Lucas, 2015) and every pound spent on contraception saves £11 in reduced healthcare costs (Kings Fund, 2014).

- **Sexual health clinics are open access services**
  While most residents choose to access services in South West London and Central London residents can choose to access services in any part of the country. This creates challenge to financial planning, making it difficult to predict and control budgets. Collaboration with commissioners across the whole sexual health system is therefore imperative.

- **Sexual health is compounded by the wider determinants of health**
  Socio-economic deprivation, alcohol/substance misuse, mental health, domestic violence, coercion, exploitation and abuse all impact on sexual health outcomes. A clear strategic direction and collaborative approach is required for organisations and departments to address cross cutting agendas together and create greater efficiency and effectiveness.

- **Almost everyone will have a sexual relationship at some point in their life**
  Stigma, myths and embarrassment about sexual health however, remain and disproportionately affect certain groups including young people, those at risk of HIV, those with learning disabilities and LGBTQ+ groups.

- **Local need is changing**
  The local sexual health picture is set out in our accompanying needs assessment, however, key needs are identified as:
    - low teenage conception rates, but high percentage of those leading to abortion and high repeat abortion rates;
    - low uptake of long acting reversible contraception (LARC);
    - high rates of STIs in comparison with the rest of the country and disproportionately affecting MSM, BME groups and young people;
    - low chlamydia detection rates;
    - increasing rates of new diagnosis of HIV alongside high late diagnosis of HIV.

4.3. Purpose and scope of the strategy

This is a joint strategy between London Borough of Merton (LBM) and NHS Merton Clinical Commissioning Group (MCCG) and partners. It sets out how organisations plan to achieve their collective vision for Merton. It recognises that healthy relationships, sexuality and good sexual health affects everyone at some point in their lives, and so takes a life course approach (Marmot 2010).

This strategy for Merton sets out a vision and priorities which will shape how LBM, MCCG and their partners will collaboratively work to improve sexual health and wellbeing and respond to increasing STI and HIV rates as well as the other determinants linked to sexual health.

The overall aim is to work in partnership to address the wide range of areas and issues which have an impact on relationships and sexual health, including health services, education, preparing for adulthood, employment and the criminal justice system. By working together it is hoped that Merton can reach the long-term goal of improving outcomes in sexual health and sexual well-being. This in turn should lead to a more effective patient pathway that allows people to manage their own sexual health and wellbeing and to seek help earlier, thus reducing the cost of treatment and care.

The scope of this strategy includes all sexual health services and interventions which are commissioned by LBM or MCCG. MCCG have delegated responsibility from NHS England to commission primary care services so these will be included. Other sexual health services commissioned by NHS England fall outside the scope of this strategy.

An integrated sexual health service for Merton was recently recommissioned in line with the London sexual health programme and this contract is not due to end until September 2022 at the earliest. In light of this, the strategy will focus on the development, rather than procurement, of the services covered under the contract. Consideration will also be given to future service models, and the potential to move towards a more integrated approach as part of holistic services, in line with other community health services.

5. Our vision for Merton

The vision and priorities for this strategy have been developed with key stakeholders including professionals who work in the borough, residents, and young people who are educated in Merton. Time has been taken to ensure engagement of priority groups and the professionals who work with these groups including; under 25 year olds; men who have sex with men; black Africans; and those with learning and physical disabilities and young people experiencing or at risk of CSE.

5.1. Vision

To improve the sexual health and wellbeing of those who live[1], work and learn in Merton by:

- providing people with the information and skills they need to make informed choices about their sexual health and wellbeing;
- providing confidential, easily accessible and comprehensive services; and
- promoting healthy fulfilling sexual relationships and reducing stigma, exploitation, violence and inequalities.

5.2. Principles

The strategy adopts the following principles to ensure quality of impact and achievement of outcomes:

People centred: sexual health pathways and services will be focussed on the individual and not on organisational or commissioning boundaries. Service user's views and experiences will be used to improve existing services and inform the commissioning of new services.

Equity: services will be available to all residents, but proportionate to needs. This includes offering universal services but also targeting the most deprived areas and the groups with the highest risk of poor sexual health.

Life-course approach: a life-course approach to sexual health and reproductive health will be taken, ensuring opportunities for health promotion at all stages but particularly at transitions.

Evidence based: all sexual health and well-being services will be commissioned using the latest national evidence and standards including National Institute of Clinical Excellence (NICE), British HIV Association (BHIVA) and British Association of Sexual Health and HIV (BASHH) and will be informed by local needs assessments.

Partnership working: provision of sexual health services is complex and sexual health has many cross cutting themes. Continued partnership working at a local, London and national level is crucial to ensuring a whole systems approach.

[1] This includes young people who are looked after by Merton, but may live elsewhere.

Prevention focussed: it is recognised that prevention work underpins public health. This will be a core part of all interventions and services provided.

5.3. Proposed approach

Promoting sexual health across the life-course

Under 16s Knowledge & Resilience	16 to 24 Choices and Outcomes	24 to 49 Information and access	50+ Remaining sexually healthy

5.4. Outcomes

The strategy aims to achieve the following outcomes:

Rates of infections: reduce the prevalence of undiagnosed STIs and HIV by encouraging early diagnosis and treatment.

Unwanted pregnancies: maintain reductions in under 18 conceptions, reduce repeat abortions and continue to support young parents through early years strategies.

Sexual health and well-being of vulnerable groups: to identify a set of outcome indicators to measure wider determinants of sexual health and well-being in relation to vulnerable groups, and achieve improvements in relation to priority areas.

Living with HIV: provide support for those living with HIV to ensure they are living well with zero HIV related stigma, HIV transmissions or HIV related deaths.

Sexual violence and exploitation: decrease the rate of sexual offences (outcome indicators for further development).

6. Our Priorities

This section should be read in conjunction with the implementation plan which provides the detail about how we plan to achieve each of the priorities.

6.1. Priority 1: Education and Training

6.1.1. Definition
Increase training and education with the community and frontline workforce to build their confidence to discuss sexual health and wellbeing, empowering people in Merton to manage their own sexual health and develop fulfilling and healthy relationships.

6.1.2. Why is this a priority?
Education and training about sexual health for individuals, communities and the workforce forms a vital component of improving sexual health and wellbeing while reducing reliance on specialist services. The sexual health workforce is diverse and includes both specialists and non-specialists in sexual health. Prevention strategies rely heavily on the knowledge, skills and confidence of professionals providing up-to-date and evidence-based interventions that promote sexual health. Yet, our workforce told us that they often felt poorly supported to deliver expected teaching and patients felt staff would merit from more training to understand the needs associated with sexual wellbeing.

6.1.3. What did people say?

- Over 80% of residents who responded to our online survey told us their top priority was improving Relationships and Sex Education (RSE). This was echoed by the workforce, who asked for support implementing the new national guidance on RSE.

- The workforce asked for support to develop their knowledge and skills, particularly in relation to:
  - the specific issues facing LGBTQ+ communities and those with disabilities;
  - supporting people living with HIV particularly those who are aging;
  - supporting those who disclose sexual abuse, violence and/or exploitation and;
  - sexual wellbeing, such as the changing nature of relationships due to technological advances, pornography and on-line sexual bullying.
  - Understanding the relationship between religion, belief and sexual health.

- Parents asked for support to build their skills and confidence to talk to their children about sex and relationships and the associated issues.

- Young people wanted information that didn't just focus on sexually transmitted infections and pregnancy but also sexual pleasure, consent and what to do if you have a concern.

6.1.4. Where are we now?

- Providers support the delivery of universal Personal Social Health Education (PSHE) including:
  - a support network for PSHE practitioners;
  - sexual health education sessions in schools including nurse provision;
  - theatre in education programmes which promote knowledge, skills and confidence;
  - programmes targeting the specific needs of children with special educational needs (including grooming, consent).

- Specialist HIV providers deliver training to professionals on HIV awareness, recognising and addressing stigma and normalising testing.

- The integrated sexual health service provides training on sexual health to primary care, pharmacies, school nurses and other healthcare professionals.

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6.1.5. What do we plan we do?

The top four areas of development are to:

1. Provide support and training to schools to implement the new national guidance for Relationship and Sex Education (RSE) and meet the new Ofsted framework on promoting personal development.
2. Enable children, young people and adults with special educational needs and disabilities, to have safe and sexually healthy lives by strengthening education and training for parents, carers and professionals.
3. Ensure sexual health information is embedded into existing training for professionals, adopting Making Every Contact Count (MECC) principles to enable the workforce to opportunistically promote sexual health and wellbeing in all conversations.
4. Provide information on how to most effectively support people who disclose sexual abuse, violence and/or exploitation.

6.2. Priority 2: Easy access to sexual health and well-being services

6.2.1. Definition

Ensuring sexual health and well-being services are free, confidential, comprehensive and available to all, at times and locations which meet the need.

6.2.2. Why is this a priority?

Improving access to sexual health and wellbeing services was a key recurring theme within our engagement work. In order for people to achieve good sexual health they require age appropriate education on how to protect their sexual health so they can make informed decisions, and information on how to access appropriate services and interventions when they need them.

6.2.3. What did people say?

- 72% of residents who responded to our online survey felt access to free, confidential contraception and STI screening was a priority, with many stipulating that this could be improved by increasing provision in GP practices, pharmacies and online.
- Only 42% of young people reported that they would know which services to go to if they had a concern about sexual health, with young people in wards with higher levels of deprivation feeling less able to talk to an adult about sexual health.
- Residents felt over 25 year olds, particularly the 50+ age group, were often overlooked so wanted a greater understanding of their needs, how to reach them and how to ensure they have the required skills and knowledge.
- Stakeholders specifically felt there is a need for improved:
  - outreach services and out of hours access to sexual health services, particularly in the east of the borough;
  - use of technology to inform people about sexual health services and to improve access e.g. booking appointments online;
  - fast track access to specialist sexual health services for those who are vulnerable and at risk and;
  - 'consideration' for the needs of vulnerable groups such as young people experiencing or at risk of CSE, those with physical or learning disabilities, LGBTQ communities and MSM.

6.2.4. Where are we now?

The provision of core sexual health services are constantly under review to ensure access to services is equitable and meets the needs of Merton's diverse population. Over the last few years Merton has:

- Commissioned a new integrated sexual health service with a single point of access which allows early triage to the right service so simplifying the patient journey.
- Supported the roll out of the London e-service which provides online STI testing for those with no symptoms.

- Provided ongoing funding for community sexual health services for 13-24 year olds including pharmacy provision of emergency contraception, chlamydia screening programme, and condom distribution scheme.
- Provided targeted outreach services and testing to those most at risk including in schools and the local college, and to MSM and BME groups in their communities.
- Continued to promote awareness of the www.gettingiton.org website for young people which provides information on local sexual health services.

6.2.5. What do we plan to do?

The top four areas of development are to:

1. Work in partnership with South West London commissioners to review the provision of sexual health services in pharmacies, with the view to ensuring a standard model across the sector and widening access particularly in the east of the borough.

2. Explore opportunities to engage with those identified as needing further support, including but not limited to those: aged over 25; aged 50 +; identifying as lesbian, gay, bisexual, transgender, or questioning (LGBTQ+); with physical and learning disabilities; experiencing or at risk of child sexual exploitation (CSE) and; MSM.

3. Ensure a robust communications strategy is developed for the integrated sexual health service to ensure services are well publicised to all groups and promote positive messages about sexual wellbeing and health.

4. Continue to support the roll out of the London e-service with a particular focus on channel shift from clinic to online in order to free up capacity in the integrated sexual health service.

6.3. Priority 3: Comprehensive sexual health and well-being

6.3.1. Definition

Enabling people to consider their sexual health and wellbeing in the context of their whole life, by ensuring services are joined up and address the wider determinants.

6.3.2. Why is this a priority?

Sexual wellbeing focuses on the more than just health and considers an individual's sexual life in its entirety. National and local evidence demonstrates there are strong links between sexual health and other key determinants of health and wellbeing, such as alcohol and substance misuse, smoking, obesity, mental and emotional health, and violence (particularly violence against women and girls), which exacerbate existing health inequalities. Delivering care that focuses on both sexual health and sexual wellbeing requires services and interventions to be developed and delivered to tackle these determinants in a joined-up way.

6.3.3. What did people say?

- The majority of respondents to our engagement work were clear in their view that sexual health and wellbeing across the borough needed to be more equitable, and that a joined up approach is needed. In particular stakeholders felt there is a need for:

    - The needs of vulnerable groups to be prioritised with a specific mention of those who have been in the care system, young parents, those experiencing or at risk of violence, those with poor mental health or using substances, BME and LGBTQ+ communities and those with disabilities.
    - Easier to navigate pathways between sexual health services and other related services such as substance misuse organisations, voluntary sector support, mental health services, social services, and the police.
    - A joined up approach with clear pathways between the whole sexual health related system including: GP and pharmacy services; integrated sexual health services; termination providers; HIV prevention and support; antenatal and maternity services; cervical screening; psychosexual services; and sexual health referral centres.
    - Education and promotion that focusses on sexual wellbeing and portrays relationships and sex positively, with a skilled and confident workforce able to address inter-related complex issues sensitively.

6.3.4. Where are we now?

Many of the services in Merton are already integrated or have successfully embedded sexual health into their work. These include:

- Risk and resilience service for young people which combines substance misuse interventions with sexual health promotion.
- Sexual health interventions with young parents as part of the Family Nurse Partnership.

- HIV testing and testing for blood borne viruses which is offered in the substance misuse service.
- Routine health reviews with looked after children include a discussion on sexual health and relationships.
- Improved local identification and response to people's emotional and mental health and wellbeing.

6.3.5. What do we plan to do?

The top four areas of development are to:

1. Continue to develop and improve pathways between services in the sexual health system working to address commissioning issues where needed. This includes but is not limited to:
    - termination and contraceptive services so that LARC is offered and provided more consistently;
    - cervical screening in the integrated sexual health service;
    - antenatal and postnatal support to prevent second conceptions in under 25s and;
    - HIV support providers and the community nurse outreach to ensure joined up care for those living with HIV.

2. Strengthen and embed sexual health knowledge and support into inter-linked services, particularly for those: experiencing poor mental health; living and ageing with HIV; experiencing domestic violence or dealing with previous past abuse; who are the victim of child sexual exploitation and who are using substances.

3. Improve sexual wellbeing for our most vulnerable communities and those where sexual health inequalities are greatest through strengthening conversations and reducing stigma in respect of sexual health and HIV.

4. Develop a greater understanding of the inter-relationship between emotional well-being and sexual health within both children and adults mental health service provision.

7. How will the strategy be delivered?

7.1. How has this strategy been developed?

7.1.1. <u>Multi agency steering group</u>

A steering group has been set up to oversee the development of the strategy, which is co-chaired by the LBM Public Health Consultant leading on sexual health, and the Clinical Lead for West Merton, MCCG. Members of this group include managers and commissioners from MCCG and LBM, the local pharmaceutical committee, voluntary sector organisations, the integrated sexual health service provider and Merton Healthwatch. The final strategy and implementation plan has been through the relevant governance processes of LBM and MCCG, and has been endorsed by Merton's Children's Trust and Health and Well-Being Board.

7.1.2. <u>Sexual health needs assessment</u>

The strategy has been informed by a comprehensive sexual health needs assessment. This provides an overview of sexual health in Merton and the services currently available. A summary is set out in the supporting information (see section 7). The full needs assessment **(link to be added when put online)** includes national guidance and evidence, local population data, service mapping and stakeholder engagement. This data was used alongside stakeholder feedback to develop the strategy vision and priorities and so should be read in conjunction with this document.

7.1.3. <u>Stakeholder engagement</u>

Extensive engagement work has been undertaken on the strategic vision and priorities. This includes:

- Feedback from over 300 professionals from attendance at a wide range of staff meetings which included:
    - Local Pharmaceutical Committee
    - MCCG Patient Engagement Group
    - CSF Health Commissioning Group
    - Promote and Protect Forum
    - MVSC Involve Forum
    - Preparation for Adulthood Board
    - 0-19 community health services
    - Secondary school curriculum & PSHE leads
    - Violence Against Women & Girls strategy group
    - Children's Trust Board
    - Primary & secondary head teachers meetings
    - School governors
    - Health & Well-Being Board
    - GP practice leads
    - Substance Misuse Partnership Board
    - Young People's Health Reference Group

- Focus groups and workshops held with over 120 young people aged 24 and under including those with learning disabilities, BME groups, those excluded from school and LGBTQ+.
- Over 1,200 children and young people provided feedback on sexual health questions in the Children and Young People's School Survey.
- Public consultation published on the local authority website which received above average coverage with over 115 responses.

This feedback has been used to shape the strategy vision and priorities and the implementation plan.

7.2. Governance

The membership and terms of reference of the current sexual health strategy group will be reviewed within two months of the strategy being signed off. Once reviewed this will become the sexual health implementation group which will hold responsibility for the strategy.

The group will report to the Director of Public Health at LBM and the Director of Commissioning at MCCG. The group will meet regularly to oversee the strategy implementation plan and ensure that tasks are completed within the timeline. The plan will be reviewed for these meetings and updated to track progress. Regular updates will be communicated to key stakeholders via existing clinical networks and practitioner meetings. Annual reports will be provided to the Children's Trust Board and the Health and Wellbeing Board.

7.3. Implementation plan and partners

The strategy is supported by a comprehensive implementation plan which details how LBM and MCCG plan to achieve the strategy priorities. The actions within this plan will be delivered within existing resources. Progress will be regularly reviewed and assessed by the strategy implementation group, to ensure it remains fit for purpose and that milestones are met.

7.4. Measuring success

The key indicators to assess whether this strategy has been successful are those reported in the PHE Sexual and Reproductive Health profiles. This will be alongside the development of a local dashboard which will measure the outcomes in the implementation plan.

8. Supporting information

8.1. The evidence base for sexual health

Many organisations including National Institute for health and Care Excellence (NICE) and the Department of Health have published guidance on the reasons why there should be a focus on sexual health. These include:

- Use of condoms, regular testing and reducing the number of sexual partners reduces the risk of Sexually Transmitted Infections (STIs).
- Comprehensive, open access sexual health services where people can be treated quickly and confidentially encourages people to attend for testing, treatment and partner notification, ensuring prompt diagnosis and treatment and preventing onward transmission (DoH, 2013).
- Effective partner notification protects against re-infection, consequences of untreated infection and onward transmission (DoH, 2013).
- The main cause of unintended pregnancies is the incorrect and inconsistent use of contraception.
- Long acting reversible contraception (LARC) is the most effective form of contraception.
- Improving HIV test uptake will help to diagnose people before they become unwell, enabling access to treatment and reducing onward HIV transmission.
- Relationships and sex education (RSE) results in young people choosing to wait until they are older to have sex for the first time, and being less likely to be involved in abusive relationships.

8.2. National Context

<u>8.2.1 Policy and Responsibilities</u>

Following the Health & Social Care Act 2012 and the subsequent transfer of public health responsibilities to local authorities in 2013, LBM has had a statutory duty to commission open access, demand-led sexual health services, including contraception and testing and treatment of STIs.

In 2013, the Government published *A Framework for Sexual Health Improvement in England* setting out its ambition to improve the sexual health of individuals and populations within the context of a changing commissioning landscape. This sets out the commissioning responsibilities shared between NHS England, Local Authorities and Clinical Commissioning Groups (CCGs).

Diagram 1. Sexual Health Services and who commissions them

Local Authority
- Contraceptive services
- STI testing and treatment incl. HIV
- Specialist services: YP services, outreach, HIV prevention, services in schools/colleges

Schools / Colleges
Relationships and Sex Education in schools

Clinical Commissioning Groups (CCGs)
- Termination services
- Sterilisation / Vasectomy
- Psychosexual health services (non sexual health)
- Gynaecology services incl. contraception for non contraceptive purposes

NHS England
- Contraception under GP contract
- HIV treatment & care
- Opportunistic testing and treatment
- Prison sexual health services
- Sexual Assault and Referral Services
- Cervical Screening
- Foetal medicine services

**to note – in Merton the CCG have delegated responsibility from NHS England to commission primary care services which would include contraception under GP contract*

A supporting document *'Commissioning Sexual Health Services and Interventions – Best Practice Guidance for Local Authorities'* (DoH, 2013) outlines best practice and practical steps for local authorities to commission sexual health services. As well as these there are many other guidance and support documents which have been published including national policy and NICE guidance.

A number of national public health outcome framework indicators are in place in order to provide oversight of sexual health improvement, including:

- Reduction in under 18 conceptions
- Increases in Chlamydia screening
- Late diagnosis of HIV

These are supplemented by further indicators in Public Health England's Sexual and Reproductive Health Profiles including:

- Diagnostic rates for syphilis, gonorrhoea and chlamydia
- HIV testing, coverage and diagnosis
- Abortion rates
- HPV vaccine take up rates
- Long acting reversible contraception (LARC)

8.2.2. Emerging issues

Sexual health is a rapidly developing area of public health. Some of the key areas of focus in 2019 and onwards are:

Fast track cities

In January 2018, London signed up as a 'Fast Track City' to reduce HIV infection. London has already exceeded the initial UNAIDS targets and aims to reach zero new infections, preventable deaths or stigma by 2030. Merton is committed to working with partners across London to address the challenges to achieving this target, in particular: tackling stigma and fear in BME groups; supporting an ageing population living with HIV; and modernising the model of care to recognise HIV as a long term condition.

PrEP impact trial

Pre-exposure prophylaxis (PrEP) has proven highly effective in reducing the risk of HIV transmission. NHS England are currently running a trial to establish the 'realities' of rolling out PrEP as standard across the NHS. Uptake has been high and has caused immediate pressure on local authority budgets as those on the trial are required to undertake more frequent STI testing. Discussions are ongoing with the trial impact board to establish who would have responsibility for commissioning PrEP in the long term.

Global issue of antibiotic resistance to gonorrhoea

The first case of multi-drug resistant gonorrhoea was identified in the UK in March 2018, which has led to the WHO warning this infection may soon become untreatable. LBM and MCCG, along with other local authorities and CCGs in the country, must work with Public Health England to report on any resistant strains and ensure timely and effective treatment.

Mandatory relationship and sex education (RSE)

Following amendments made to the Children and Social Work Bill (Department of Education 2017) from September 2020 schools will have to teach RSE. The local authority will need to support schools to deliver comprehensive lessons which are inclusive to all and tackle topical issues such as healthy relationships, consent, the increasing role of social media and the internet in sexual assault and abuse, and the difficulties faced by vulnerable groups.

Introduction of Human papillomavirus (HPV) vaccination for boys

Vaccination of school aged girls was rolled out in 2008 and roll out to all boys in year 8, 12 and 13 started in September 2019. This is an important step in eliminating cervical cancer and other associated cancers. Delivery of this in Merton will be through the school immunisation service commissioned by NHS England.

Increased diagnosis of Mycoplasma Genitalium (Mgen)

Mgen is a bacterial STI which often has no symptoms but can cause serious health problems if left untreated. Although in existence since 1981 a reliable test only

became available in 2017 and since then more cases have been diagnosed across the Capital. A treatment pathway for this STI was not included in the original London sexual health tariff so clinics are not currently receiving payment. A new tariff is now proposed which will increase pressure on local authority budgets. In the longer term there is concern this STI will become resistant to some antibiotics and so will require a more expensive drug to treat it effectively, increasing cost.

Youth violence across the capital

Levels and rates of serious youth violence have been increasing across the Capital as reported by the police, ambulance service and hospitals (Greater London Authority, 2018). There is a strong correlation between those who are victims of serious youth violence and a number of public health factors, including conception to a mother aged under 18, children living in poverty, deprivation and emotional and mental health.

7.3. Regional context

Over the last five years the sexual health commissioning landscape and financial context have changed dramatically. In response to this local authorities in London, including Merton, have been working in partnership under the London Sexual Health Programme (LSHTP).

The objective is for all London boroughs to work together to transform and commission services, ensuring continued good practice whilst responding to current and future financial challenges by making the best use of resources.

To date the programme has achieved the;

- introduction of a standardised integrated service model and a more effective pricing mechanism;
- co-commissioning of integrated sexual health services in clusters rather than by boroughs individually;
- procurement of an e-service for those who are asymptomatic and;
- co-ordination of London wide approaches to commissioning challenges.

In line with the LSHTP objectives Merton have recently co-commissioned a local integrated sexual health service with the London Borough of Wandsworth and the Royal Borough of Richmond upon Thames.

Moving forwards, the programme will continue to ensure the new integrated service models and governance are embedded, and will have continued oversight of the development of the London e-service. Longer term sustainable funding models are being considered with the recognition that tariff can only go so far at containing cost pressures, and that sexual health services need to become part of capitated budgets.

As well as LSHTP, Merton partners with other London local authorities to commission HIV services for the Capital. The aim is to reduce new HIV infections and increase earlier diagnosis of HIV by: increasing the uptake of HIV testing;

promoting condom use; and promoting safer sexual behaviours. To date it has delivered a highly successful HIV prevention campaign called ‘Do It London’.

7.4. Local Partners

Several consortia arrangements for the co-commissioning of services are in place with neighbouring boroughs. These include the integrated sexual health service, HIV services and termination services. Working together allows for better access to services across a larger footprint recognising that people do not just stay within one borough, as well as ensuring economies of scale for local authorities.

Within Merton there are links between public health and MCCG, as well as between LBM directorates, to ensure a joined up approach to ongoing national issues such as sexual exploitation, trafficking, domestic violence, knife crime and failure to support those with mental health issues.

7.5. Sexual health need in Merton

A full analysis of the needs relating to sexual health is detailed in *Merton’s sexual health needs assessment (2019).* The sexual health needs in Merton are similar when compared with the London average, but alike the rest of London need is high when compared to England averages. A review of the Merton data shows that there are specific key areas which require focus.

Reducing the percentage of under 18 conceptions which lead to abortion
Merton has achieved great success in reducing teenage conceptions, with the rate per 1,000 15-17 year old girls being 12.8, which is lower the London or England average. However, 74% of conceptions to under 18s in Merton in 2017, led to abortion, which is higher than both England (52%) and London (64.4%).

Tackling STIs amongst vulnerable groups
Since 2013 the rate of all new STI diagnoses in Merton has remained fairly stable. However Merton still has the 24th highest rate of new STI diagnoses in the country and certain STIs such as gonorrhoea and syphilis are rapidly increasing. Young people (particularly 25-34 year olds), MSM and BME groups are disproportionately affected and so must be targeted.

Reducing rates of gonorrhoea and syphilis
Merton, alike the rest of London and England is experiencing increasing rates of syphilis and gonorrhoea. These STIs are a marker for risky sexual behaviour. Rates in Merton are higher than the England average but lower than the London average. The rate of syphilis in Merton is 29.1 per 100,000 as compared to 13.1 per 100,000 in England and 38.9 per 100,000 in London. The rate of gonorrhoea is 178.1 per 100,000 as compared to 98.5 per 100,000 in England and 279.4 per 100,000 in London. In line with national data, the number of diagnoses of these STIs are higher in gay men compared to heterosexual men.

Increasing chlamydia screening amongst 15-24 year olds
When the National Chlamydia Screening Programme (NCSP) was established in 2003, DoH set a target of achieving a detection rate of 2,300 per 100,000 of

15-24 year olds. Although the chlamydia detection rate in Merton has increased over the period 2012-2018 which shows progress, this target is not being met. In 2018, there were 428 chlamydia diagnoses in this age group, which is a rate of 2,119 per 100,000. This is lower than the London average of 2,610 but higher than the England average of 1,975.

Reducing repeat abortions amongst under 25 year olds
In 2017, 32.3% of abortions in Merton women under the age of 25 were repeat abortions. Although similar to the proportion in London (30.7%) this is significantly higher than the proportion nationally (26.7%).

Increasing access to long acting reversible contraception (LARC)
In 2017, the rate of LARC prescribed by GPs and sexual and reproductive health services to women aged 15-49 years in Merton was 26.6 per 1,000. This was significantly lower than the England rate (47.4) and slightly lower than the London rate (34.0). This low uptake alongside a high repeat abortion rate for under 25s indicates that more work needs to be undertaken to ensure that young, vulnerable women in particular can access contraceptive services and are encouraged to use LARC.

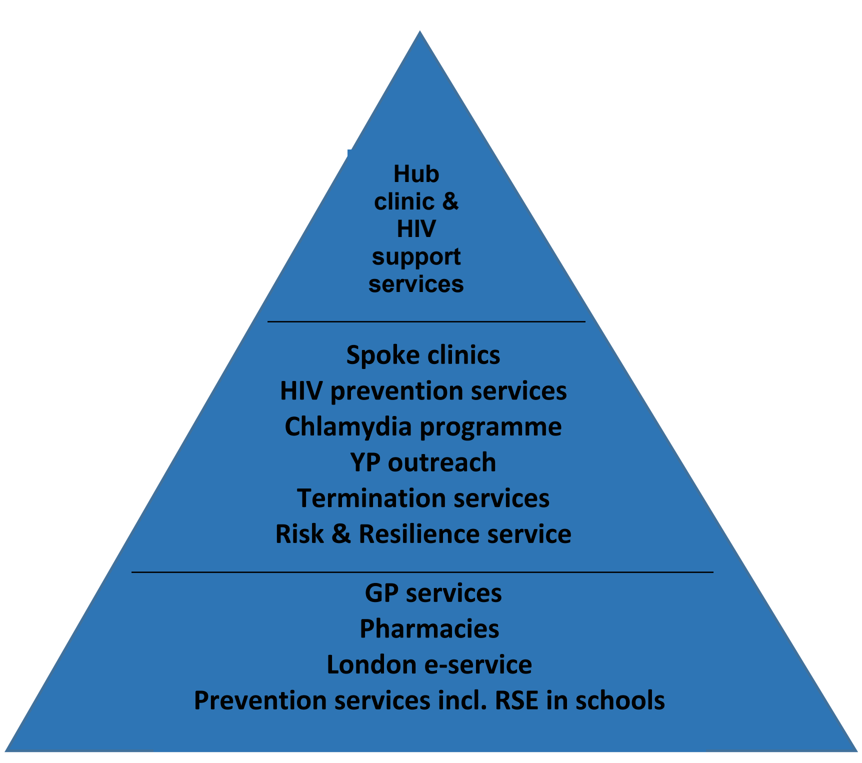
Reducing new incidences of HIV
Between 2011 and 2017 the rate of new HIV diagnoses in Merton has risen by 10.3%. In 2017, 30 new diagnoses of HIV were seen in Merton in those aged 15 and over. This equates to a rate of 18.2 per 100,000, which is significantly higher than the England average (8.7 per 100,000) but lower than the London value (21.7 per 100,000).

Assisting those living with HIV to live well and reducing onward transmission
Merton along with all other boroughs in London continues to be a HIV high prevalence area. In 2017, 558 people in Merton were known to be living with HIV. This equates to a prevalence rate of 4.27 per 1,000 of the population aged 15-59 years, which is significantly higher than the England average (2.32 per 1,000) but lower than the London average (5.69 per 1,000). Merton ranks 20 (with 1 being the highest) out of 33 London boroughs.

Reducing late diagnosis of HIV
Between 2015 and 2017, 43.2% of HIV diagnoses in Merton were made at a late stage (CD4 count was less than 350 cells/mm^3 within 3 months of diagnosis). This is higher than both the England (41.1%) and London (35.2%) figures. Heterosexual Black Africans and gay men are disproportionately affected. In this same period, 61% of late HIV diagnoses in Merton were heterosexuals as opposed to 26% being gay and bisexual men. Evidence from across London indicates that boroughs with high rates of HIV amongst the heterosexual population have had less success reducing late diagnosis, which it is believed is primarily due to stigma and fear about being diagnosed with HIV and getting tested later. HIV prevention services in Merton have made great strides engaging with BME groups, gaining access to faith groups which it is very difficult to achieve, however more needs to be done to dispel myths and to encourage testing.

7.6. Merton sexual health services

The diagram below shows the sexual health services, as set out in the national commissioning responsibilities, commissioned by either LBM or MCCG. Those commissioned by NHS England are mentioned to give context but are not included on the diagram. The bottom of the triangle shows universal services and the top complex care. The aim is for people to be seen at the most appropriate service for their need.



Integrated sexual health (ISH) service

The service model is 'hub and spoke' with the hub located in Clapham Junction and the spoke clinics in Merton located in Wimbledon and Mitcham. Clients contact the service via a single point of access phone number and are triaged accordingly.

Clinic/service	Services provided	Clients
Hub clinic	Testing for those with symptoms, STI treatment, complex contraception, psychosexual counselling, specialist gay men's clinic sessions, walk in sessions for young people.	Symptomatic patients All gay men
Spoke clinics	Testing for asymptomatic patients, treatment for chlamydia and	Asymptomatic patients

	gonorrhoea, contraception, advice, walk in session for YP.	
London e-service	Option to be referred to register for a kit to be delivered to home or picked up from clinic.	Asymptomatic patients
Chlamydia programme	Chlamydia screening in pharmacies, GP & community settings	All 15-24 year olds
YP outreach	Mentoring programme, clinic in a box (15 hours a week) in schools & college, education sessions.	All under 21 year olds

It is an open access, high demand and high volume service. In 2018/19 there were approximately 9,000 patients attending the ISH service with an average of 1.75 interventions per patient, which totals approximately 16,000 interventions. Of these interventions about two thirds were for contraception.

In addition to accessing services at the local ISH service, Merton residents can choose to access a sexual health service anywhere in the country, attendance at which is then charged back to LBM. Latest data shows 52% of Merton residents access the local ISH service, 38% access other clinics in South West London and 10% access services elsewhere in the country, but mainly central London.

GP and Pharmacy led services
Provision of GP and Pharmacy sexual health services are complicated due to different commissioning organisations holding responsibility for the funding of different services. In order to ensure a smooth patient pathway all commissioners must work together.

Service	**Responsible commissioner**
GP Core contract - routine contraception & EHC	Delegated responsibility from NHS England to MCCG
GP - LARC for contraceptive reasons and chlamydia screening services	LBM
GP - LARC for non-contraceptive reasons	MCCG
National cervical screening programme (mainly delivered via GPs)	NHS England
Non sexual health related community pharmacy services	NHS England
Prescribing services – GPs	MCCG
Prescribing services – community pharmacies	NHS England
Pharmacy sexual health services – EHC and chlamydia screening	LBM

HIV prevention and support services
LBM commissions HIV prevention and support services which offer HIV testing and health promotion advice in the community, as well as support services (counselling, advice and advocacy and family support) for those living with HIV. MCCG commission a community nurse lead for HIV who provides care, particularly on adherence to medication, for those diagnosed with HIV and their carers. Merton residents living with HIV will usually access specialist HIV clinics (mainly to receive medication) at one of the surrounding acute hospitals – St Georges, St Helier or Kingston. These clinics are commissioned by NHS England.

Termination of Pregnancy (ToPs) services
Merton and Wandsworth CCGs along with Sutton, Richmond and Kingston have jointly commissioned an Any Qualified Provider (AQP) Framework for the provision of ToPs. The service provides support, advice, assessment and appointment for any person suspected of pregnancy and/or wanting to discuss termination. As part of the assessment free non-LARC contraceptives (pill and condoms) are offered and also screening, treatment and partner notification (where required) for HIV, chlamydia, gonorrhoea and syphilis infection. Post abortion counselling is also offered.

Risk & resilience service
LBM public health and Children, Schools and Families (CSF) teams jointly commission a young peoples' risk and resilience service that incorporates substance misuse, detached youth and sexual health promotion including condom distribution. This service is currently being extended to incorporate missing from home and care and exploitation interventions. The service is delivered in a range of venues including youth clubs, schools, college and community outreach.

Online sexual health services
These are particularly popular with certain groups including under 25 year olds and gay men. LBM commission a well-established information website (www.gettingiton.org) aimed at under 21 year olds which covers sexual health, substance misuse, emotional & mental health and related issues. Both service users and professionals routinely use this to find out about local services in South West London. Merton also participate in the London e-service which provides online ordering of postal kits for a range of STIs, and the local Chlamydia Screening Programme offers an online testing option for 15-24 year olds.

Support schools to deliver Personal, Social & Health Education (PSHE)
A number of agencies support the provision of PSHE in schools, some of which are purchased by schools directly and others which are commissioned by the borough. For example, theatre in education sessions on sex and relationships are delivered in Merton educational settings to support pupils with the knowledge, skills and confidence they require to make informed decisions about their sexual health & well-being.

9. Glossary

AIDS	Acquired immunodeficiency syndrome
BASHH	British Association for Sexual Health & HIV
BHIVA	British HIV Association
BME	Black and minority Ethnic
CCG	Clinical Commissioning Group
CLCH	Central London Community Healthcare Trust
CSE	Child sexual exploitation
CSF	Children, schools and families
DoH	Department of Health
EHC	Emergency hormonal contraception
GUM	Genito-urinary medicine
GPs	General Practitioners
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
ISH	Integrated sexual health
LA	Local Authority
LARC	Long acting reversible contraception
LBM	London Borough of Merton
LGBTQ+	Lesbian, gay, bisexual, transgender and questioning
LSHTP	London Sexual Health Transformation Programme
MSM	Men who have sex with men
MCCG	Merton Clinical Commissioning Group
NCSP	National Chlamydia Screening Programme
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
PrEP	Pre-Exposure Prophylactic
PSHE	Personal and social health education
RSE	Relationships and sex education
SHNA	Sexual health needs assessment
STIs	Sexually Transmitted Infections
UNAIDS	United Nations AIDS targets
WHO	World Health Organisation

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Sexual Health Strategy Implementation Plan: 2020 – 2025

It should be noted that detailed actions are included for the first two years of the strategy (2020-2022) and longer term goals are included for 2022-2025. These longer term goals will become more detailed actions at a later date under the review of the sexual health strategy implementation group. The shorter term actions for 2020-2022 will be reviewed regularly by this group who will meet regularly to monitor progress.

Priority One: Education and Training					
Areas for Development	**Action**	**Measure of Success**	**Timescale**	**Lead/s**	**Progress (RAG) and comment**
1. Provide support and training to schools to implement the new national guidance for Relationships and Sex Education (RSE) and meet the new Ofsted framework on promoting personal development.	a) Continue to strengthen the existing PSHE support network ensuring regular attendance of providers.	90% of education providers who are members of the network attend at least once a year.	Ongoing	Head Teachers/ Borough PSHE network lead	
	b) Share learning from Merton RSE Early Adopter schools.	Learning shared with all schools in the borough	July 2020	Borough PSHE network lead	
	c) Provide support to schools to write comprehensive RSE policies and to ensure the involvement of pupils and parents in the development of RSE programmes.	Workshops commissioned and delivered. Ongoing support provided through PSHE support network.	July 2020	CSF Commissioning team/Borough PSHE network lead	
	d) Support the training of school staff to deliver the new RSE guidance and Ofsted framework.	Training provider identified and training provided.	Sept 2020	CSF School Improvement team/ CSF commissioning team	

	e) Support schools to take up borough offer of interactive RSE Theatre in Education Workshops.	Annual TiE workshops offered and built into curriculum.	Ongoing	CSF commissioning team/ PSHE Network/ Head Teachers	
2. Enable those with special educational needs and disabilities, to develop safe and sexually healthy lives by strengthening education and training for parents, carers and professionals.	a) Share learning from the RSE programme at Cricket Green school, to all other secondary mainstream SEND schools.	Presentation to PSHE network.	Dec 2020	CSF commissioning team/Borough PSHE network lead/ Cricket Green school representative	
	b) Offer training on sexual health to parents/carers of young people with SEND through Kids First programme.	2 training sessions provided by Kids First.	March 2022	CSF commissioning Team/Kids First	
	c) Gain greater understanding of the training needed for professionals working in specialist sexual health services for engaging with those with SEND/disabilities.	Conduct a training needs analysis and explore training options.	April 2021	ISH service/Public Health & CSF commissioning teams	
3. Ensure sexual health information is embedded into existing training for professionals, adopting Making Every Contact	a) Support provided to those who organise training to ensure information on sexual health and well-being is included in training programmes for key professionals[1].	Training opportunities reviewed and standard information for inclusion agreed.	April 2021	Public Health & CSF Commissioning teams/ISH Service/R&R service/HIV service	

[1] Key professionals include: *Children Schools and Families & Adult Social workers; youth workers; substance misuse service workers, mental health service workers, school health teams, Looked after children nurses, health visitors, GPs, Pharmacists, maternity service teams, IDVAs, Rough Sleeping Assessors.*

Count (MECC) principles, to enable the workforce to opportunistically promote sexual health and wellbeing in all conversations.					
	b) Review of training needs of GPs, Pharmacists and professionals working in young people services.	Training needs analysis completed and training programme developed.	Sept 2020	Public Health & CSF Commissioning teams/ISH Service	
	c) Provide LARC training to GP practices to ensure they can continue to maintain their letters of competencies.	One LARC training session is offered per year & all GP practices are invited to attend.	Ongoing	ISH Service	
	d) Provide training to those working with BME groups to help them address fear and stigma associated with HIV and increase acceptability of HIV & STI testing and contraception.	Provide 2 workshops/training sessions per year	Ongoing	ISH Service/HIV service	
	e) Training provided to Pharmacists, GP practices and professionals in the community to provide chlamydia testing to young people and to promote online testing services.	Increase in the number of tests returned to the laboratory which were undertaken in GPs and Pharmacies.	March 2021	ISH Service/Chlamydia screening programme	

	f) Support and train youth workers to provide information on sexual health & well-being as a core part of the youth work curriculum (including c-card).	In-house youth services provide planned youth work session on RSE at least 3 x per year and actively promoting c-card.	Ongoing	ISH service/Youth service/R&R service	
4. Provide information on how to most effectively support people who disclose sexual abuse, violence and/or exploitation.	a) Enable professionals working with those displaying harmful sexual behaviour to appropriately identify their needs & signpost them accordingly.	Identify evidence-based local/national support pathways including funding options. Criteria and pathways developed & distributed for inward and outward referral to the ISH service..	March 2021	Children/adults Social Care teams ISH service	
	b) Gain greater understanding of the training needed for professionals to identify issues in relation to disclosure /support of current or past sexual abuse.	Conduct a training needs analysis and explore training options.	Dec 2020	Public Health & CSF Commissioning teams/VAWG group/Safer Merton team/ISH service	

Priority One - Education and Training: Longer term goals 2022-2025

- *Develop ongoing plan for supporting schools to adopt RSE guidance and new Ofsted Framework for personal development.*
- *Annual programme of training on sexual health & well-being (including LARC and Chlamydia) developed and offered by the ISH service to a wide variety of professionals with different knowledge and skill needs. This should include training on wider issues such as chemsex, impact of sexual health issues on mental and emotional health, undertaking difficult conversations about sexual health with vulnerable community groups.*
- *Explore further opportunities for accessing support from expert organisations to ensure RSE programmes and services offered in Merton are appropriate to those with SEND.*
- *Expand RSE support and training offer to childrens social care teams, voluntary youth workers and school health teams (including c-card distribution).*

- *Explore and deliver training options/plan for increasing workforce knowledge and skills in relation to addressing and improving the sexual health needs of those with disabilities, older people and those who are at risk of sexual exploitation .*
- *Conduct costed feasibility study to identify development of a harmful sexual behaviour service/programme for those identified with or potential to develop harmful sexual behaviour.*

Priority Two: Easy access to sexual health and wellbeing services.					
Area for Development	**Action**	**Measure of Success**	**Timescale**	**Lead/s**	**Progress (RAG) and comment**
5. Work in partnership with South West London (SWL) commissioners to review the provision of sexual health services offered by pharmacies and General Practice, with the view to ensuring a standard model across the sector and widening access particularly in the east of the	a) Map sexual health services offered in pharmacies across SWL to gain further understanding of what services are available, including current activity levels and finances.	Services mapped	Jan 2020	Public Health team working with SWL commissioners & SWL Local Pharmaceutical Committees	
	b) SWL service specification for pharmacies developed and rolled out to commissioned services in line with standardising payment for services offered.	Service specification issued to pharmacies offering EHC and Chlamydia.	March 2020	Public health team	

borough.	c) Review the pharmacies providing sexual health services in East Merton and uptake over the last 3 years.	Review undertaken	May 2020	Public Health team	
	d) Support pharmacies to increase the number of EHC and Chlamydia screening interventions and to offer condoms. .	Training and support provided to Pharmacists.	Ongoing	Public Health team/ISH service/R&R service	
	e) Agree an approach for delivery of sexual health services in pharmacies across SWL including potential procurement options.	Options paper developed & possible procurement (if agreed).	March 2021	Public Health working with SWL commissioners & the LPCs	
6. Explore opportunities to engage with those identified as needing further support, including but not limited to: over 25's; those aged 50 +; LGBTQ+; those with physical and learning disabilities; those experiencing or at risk of CSE and; MSM.	a) Explore options for including sexual health services & outreach in the Wilson Hospital development plans, to improve access in the east of the Borough.	Sexual health discussed with the lead for the Wilson development and included in consultation/plans (if agreed)	Dec 2020	Public Health team/CCG lead for Wilson site	
	b) Improve fast track access to the ISH service for those who are vulnerable and at risk (including CSE).	Fast track pathway developed, agreed & communicated to stakeholders.	Sept 2020	ISH service	
	c) Finalise venues and begin delivery of clinical outreach for under 25s in Merton.	3 sessions per week delivered.	Jan 2020	ISH service	

	d) Work with Merton's LGBTQ+ forum to explore how best to engage this community and ensure services meet their needs.	Opportunities explored and support from sexual health services provided where necessary.	Ongoing	LGBTQ+ forum/ Public Health team/ISH service	
	e) Establish links with agencies working with older people, including Age Concern's Silver Rainbows group, to explore how to meet the needs of 50+ more effectively and provide information and advice on sexual health & well-being and HIV.	Links made with appropriate agencies/groups and options to engage with 50+ identified. Sexual health session delivered to Silver Rainbows group & ongoing support identified.	Dec 2020 July 2020	Public Health team ISH service/HIV service/Age Concern	
	f) Ensure the ISH service is accessible and meets the needs of those with SEND or disabilities.	Equality impact assessment of ISH service conducted and any issues identified are addressed. Inclusion of service users with SEND and disabilities on the service user forum.	March 2021 Sept 2020	ISH service ISH service	
7. Ensure a robust communications strategy is developed for the integrated sexual health service to ensure services are well publicised to all groups and promote positive messages about	a) Support the ISH service to develop and implement a successful communications strategy.	Communications strategy developed and agreed with commissioners.	March 2020	ISH service/ Public Health team	
	b) Ensure the strategy addresses how the service will inform and engage with vulnerable groups including YP, BAME, LGBTQ+, SEND,	These groups are identified and their needs addressed within the ISH communications strategy.	March 2020 Sept 2020	ISH service/ Public Health team	

sexual wellbeing and health.	50+, LAC and care leavers and MSM.	Service user forum has representation of these vulnerable groups.		ISH service	
	c) Ensure all stakeholders are aware of what the ISH service provides and how to refer into it when needed.	Referral pathways developed and service information provided to all relevant stakeholders.	July 2020	ISH service	
	d) Utilise a range of different media channels (including social media) to reach potential service users to advertise/promote the ISH service.	Channels and marketing activities identified in the communications strategy. ISH service website is kept up to date including clinic information, referral to e-service, working appointment booking system.	March 2020 Ongoing	ISH service	
	e) Continue to expand, update and publicise services to under 25 year olds through www.gettingiton.org.uk.	Annual increase in landing clicks to GIO Merton services pages/ Ensuring the website is accessible for those with SEND.	Ongoing	Public Health & CSF Commissioning teams	
8. Continue to support the roll out of the London e-service with a particular focus on channel shift from clinic to online in order to free	a) Support the ISH service to strengthen triage processes to the e-service for those who are eligible. e.g. referral via SPA, self-check in screens in clinics.	Year on year increase in numbers of eligible service users accessing the e-service (ISH service KPI).	Ongoing	ISH service/Public Health team	

up capacity in the integrated sexual health service.	b) Support the ISH service to increase access to self-testing kits in clinics and support to comply with test procedures e.g. support from a worker to do the test for the first time.	Year on year increase in the number of kits completed in clinic (self- sampling tariff applies)	Ongojng	ISH service/Public Health team	
	c) Support the promotion of the e-service website, particularly to vulnerable groups.	Actions identified in ISH service communications strategy and e-service website included on publicity.	Ongoing	ISH service	
	d) Ensure links between the ISH service, London Sexual Health programme & Public Health, ensuring open lines of communication.	ISH service representative attends London SH e-service meetings. Public Health commissioner from SWL attends e-service strategic group.	Ongoing	ISH service/Public Health team	
	e) Provide regular training for all ISH service staff (including SPA team) on the e-service & what needs to be communicated to service users.	Training takes place quarterly and all staff are invited to attend.	Ongoing	ISH service working with London sexual health programme	

Priority Two - Easy Access: Longer term goals 2022-2025
• *Continue to update and oversee the ISH Communications Strategy ensuring that service users and other stakeholders are aware of the services provided and how to access them, and are included in service development.* • *Review outcome of SWL pharmacy work and undertake procurement of SWL pharmacy sexual health services (if identified as a viable option)* • *Review Merton’s ‘You’re Welcome’ guidelines/framework and explore whether Young Inspectors have the capacity to undertake assessment of sexual health services.*

- *Undertake a review of how existing services provide support to older people and consult with those aged 50+ to further understand their needs and ensure services meet these needs, ensuring links with organisations who work with older people*
- *Explore opportunities to re-configure and increase sexual health services in GP practices, linking in with Primary Care Networks, including the development of practice based sexual health governance and communications strategies.*
- *Explore how technological solutions such as 'Digital First' and online sexual health services can be utilised to ensure easy access for service users.*
- *Engage with providers of services in the borough who work with those with SEND and disabilities, to better understand how information on sexual health & well-being and sexual health services can best be provided and any barriers to access or engagement.*
- *Explore evidence-based approaches through which vulnerable groups can access sexual health provision in the community thus reducing the costs of expensive treatment e.g. provision of condoms, LARC and contraception within outreach settings for those who are homeless, rough sleepers, disabled, sex workers or using substances.*

Priority Three: Comprehensive sexual health and wellbeing					
Area for Development	**Action**	**Measure of Success**	**Time scale**	**Lead/s**	**Progress (RAG) and comment**
9. Continue to develop and improve pathways between services in the sexual health system working to address commissioning issues where needed. This includes but is not limited to: ○ Termination and contraceptive	a) Develop pathways between termination and ISH services so that those who are not eligible for LARC at the time of their termination are followed up.	Clear written pathways agreed and adopted.	Dec 2020	ISH service/termination providers/CCG commissioner	
	b) Ensure STI testing is offered to all those undertaking an assessment for a termination and referral pathways are in place for quick treatment.	Increase in STI testing in termination services. Referral pathway in place for STI treatment.	March 2021	Termination providers/CCG commissioner/ISH service/Public Health team	

services so that LARC is offered and provided more consistently; ○ Cervical screening in the integrated sexual health service; ○ Antenatal/postnatal support to prevent second conceptions in under 25s; ○ Providers of HIV support services and the community nurse outreach to ensure joined up care for those living with HIV.	c) Strengthen antenatal and postnatal support (beyond Family Nurse Partnership programme) to ensure advice and information on second pregnancies including LARC is provided to those under 25.	Map out current support offered to under 25s who are pregnant and agree actions to address any issues.	March 2022	CCG commissioner/ Public Health team/ISH service	
	d) Establish links between the HIV support services and the community nurse for HIV to ensure clients are referred appropriately and there is no duplication of provision.	Clear referral pathways developed and adopted.	March 2021	HIV service/ CCG commissioner/HIV nurse	
	e) Establish links with the commissioner responsible for cervical screening at NHS England to establish how can work together to ensure easy access to screening, particularly for those already attending the ISH service for STI testing.	Referral pathways established for those attending ISH service who need a smear test but do not wish to access their GP.	March 2022	Public Health team along with NHS England/ISH service	
10. Strengthen and embed sexual health knowledge and support into inter-linked services, particularly for those: experiencing poor mental health; living and ageing with HIV; experiencing domestic violence or	a) Ensure sexual health & wellbeing is considered within development of the new mental health Uplift and IAPT services.	Mental Health representative attends sexual health implementation group. Referral pathways established between these services and the ISH service.	March 2020 Dec 2020	St George's Mental Health Trust/Public Health team/ISH service	

dealing with previous past abuse; victims of child sexual exploitation and; those using substances.	b) Encourage GPs to undertake MSCP training.	GPs attendance at MSCP training increases.	Ongoing	CCG commissioner/Public health team/MSCP	
	c) Enable fast-track access to the ISH service for those experiencing or in recovery from domestic violence.	Fast track pathway developed, agreed & communicated to stakeholders.	April 2020	ISH service	
	d) Undertake research into good practice and models of care for those ageing with HIV recognising that it is now a long-term condition.	Desk top research exercise conducted and informs ongoing commissioning plans.	March 2022	Public Health & CSF Commissioning teams	
	g) Roll-out c-card to mental health and substance misuse services as well as other inter-linked services.	At least 2-3 inter-linked services are trained in c-card distribution.	March 2021	R&R service	
	h) Ensure there are close links between sexual health and substance misuse services so staff are trained in offering advice and information on the other subject area and there are clear referral pathways.	Referral pathways are in place and each service has provided training to staff in the other service.	March 2022	ISH service/R&R service/adult substance misuse service	
	i) Ensure sexual health & wellbeing information is embedded into the new mental health assessment pilot for young people entering care.	Sexual health questions considered (and included if appropriate) in the assessment framework.	March 2021	Childrens Social Care team/CAMHS/ISH services	

11. Improve sexual wellbeing for our most vulnerable communities and those where sexual health inequalities are greatest through strengthening conversations and reducing stigma in respect of sexual health and HIV.	a) Re-commission HIV prevention and support services, targeted to at risk groups.	Services re-commissioned and provided.	April 2020	Public Health team along with SWL commissioners.	
	b) Continue to provide STI & HIV testing to MSM and BME groups in community settings such as libraries, barbershops and faith groups.	HIV testing provided regularly in at least 3 community settings.	Ongoing	HIV service	
	c) Ensure sexual health is included in adult and children with disabilities Health & Care Plans.	Care plans include reference to sexual health.	March 2021	CSF Education team/Adult Social Care	
	d) Consider approaches to ensuring frontline workers are aware of and able to discuss chemsex with those who are affected.	Further understanding of evidence based approaches to tackling chemsex in particular staff training options.	March 2022	Public Health team/ISH service/substance misuse service	
	e) Consider approaches to raising awareness of and destigmatising communities where Female Genital Mutilation (FGM) is a concern.	MSCP FGM policy developed & promoted.	March 2022	MSCP/PSHE Network	
12. Develop a greater understanding of the relationship between emotional wellbeing	a) Ensure representation from children's and adult mental health services at the strategy implementation group.	Representation from services on the group.	March 2020	Children and adults mental health services	

and sexual health in both children and adults mental health service provision.	b) Undertake an analysis of what support is provided within children and adults mental health services. b) Develop closer links between mental health and sexual health services ensuring referral pathways are in place. c)Ensure staff working in mental health services feel confident talking to clients about sexual health and wellbeing or whether training is required.	Analysis work undertaken and training needs identified. Referral pathways developed & adopted.	March 2022 March 2021	Children and adults mental health services ISH service/ Children and adults mental health services	

Priority Three - Comprehensive sexual health & well-being: Longer term goals 2022-2025
• Gain further understanding of the issues Merton faces in relation to 'pop up brothels' and sex workers to ensure that there are resources in place (if needed) to support sex workers to protect themselves from STI's, get regular check-ups and protect themselves against sexual violence. • Explore opportunities for further community based approaches to increasing HIV testing amongst targeted groups and reducing the stigma of testing and accessing sexual health services. • Explore the viability and cost of programmes such as 'Pause' programme which works with women who have experienced, or are at risk of, repeat removals of children from their care. • Explore the extent of sexual harassment experienced in schools/community and develop a longer term plan as to how to challenge and support those who have experienced this. • Consider the findings & commissioning implications from HIV desk-top research into those ageing with HIV and ensure any actions are considered in future action plans, working with care homes and other services aimed at older people. • Ensure key priorities for addressing sexual health & well-being in Merton are included in other borough strategies e.g. homelessness, violence against women & girls. • Consider how schools can be supported to take up initiatives linked to sexual health and well-being such as the Red Box Scheme which aims to tackle period poverty.

- Consider sexual health needs and access for children who are looked after and placed outside of Merton as well as transition services for care leavers who are no longer in children's services but still vulnerable adults.

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