# Merton Council
# Healthier Communities and Older People Overview and Scrutiny Panel

Date: 20 June 2022
Time: 7.15 pm
Venue: Council chamber - Merton Civic Centre, London Road, Morden SM4 5DX

**AGENDA**



**This is a public meeting – members of the public are very welcome to attend. The meeting room will be open to members of the public from 7.00 p.m.**

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## Healthier Communities and Older People Overview and Scrutiny Panel membership

**Councillors:**
Agatha Mary Akyigyina OBE (Chair)
Jenifer Gould (Vice-Chair)
Laxmi Attawar
Max Austin
Caroline Charles
Eleanor Cox
Simon McGrath
Slawek Szczepanski
Martin Whelton

**Substitute Members:**
Mike Brunt
Michael Paterson
Dennis Pearce
Tony Reiss
Matthew Willis

**Co-opted Representatives**
Saleem Sheikh (Co-opted member, non-voting)
Diane Griffin (Co-opted member, non-voting)

**Note on declarations of interest**

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**What is Overview and Scrutiny?**

Overview and Scrutiny describes the way Merton's scrutiny councillors hold the Council's Executive (the Cabinet) to account to make sure that they take the right decisions for the Borough. Scrutiny panels also carry out reviews of Council services or issues to identify ways the Council can improve or develop new policy to meet the needs of local people. From May 2008, the Overview & Scrutiny Commission and Panels have been restructured and the Panels renamed to reflect the Local Area Agreement strategic themes.

Scrutiny's work falls into four broad areas:

⇒ **Call-in**: If three (non-executive) councillors feel that a decision made by the Cabinet is inappropriate they can 'call the decision in' after it has been made to prevent the decision taking immediate effect. They can then interview the Cabinet Member or Council Officers and make recommendations to the decision-maker suggesting improvements.
⇒ **Policy Reviews**: The panels carry out detailed, evidence-based assessments of Council services or issues that affect the lives of local people. At the end of the review the panels issue a report setting out their findings and recommendations for improvement and present it to Cabinet and other partner agencies. During the reviews, panels will gather information, evidence and opinions from Council officers, external bodies and organisations and members of the public to help them understand the key issues relating to the review topic.
⇒ **One-Off Reviews**: Panels often want to have a quick, one-off review of a topic and will ask Council officers to come and speak to them about a particular service or issue before making recommendations to the Cabinet.
⇒ **Scrutiny of Council Documents**: Panels also examine key Council documents, such as the budget, the Business Plan and the Best Value Performance Plan.

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HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL
14 MARCH 2022

(7.15 pm - 8.33 pm)

PRESENT Councillors Councillor Peter McCabe (in the Chair), Councillor Janice Howard, Councillor Nigel Benbow, Councillor Pauline Cowper, Councillor Mary Curtin, Councillor Helena Dollimore, Councillor Jenifer Gould and Di Griffin

Stella Akintan (Scrutiny Officer), Keith Burns, Head of Commissioning and Market Development, Mark Creelman Executive Director Merton and Wandsworth, SW London CCG and Dr Dagmar Zeuner (Director, Public Health)

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for absence were received from Councillor Linda Kirby and Co-opted Member Saleem Sheikh

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

Councillor Dollimore declared she is a vaccinator with St John's Ambulance

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

Councillor Dollimore expressed concern that the Panel had not been provided with the latest immunisations data. The Chair said the Panel cannot compel organisations to attend and he is disappointed that this information has not been provided. The Scrutiny officer said the report was slightly delayed due to pressures on resources caused by the impact of the pandemic. In the past NHS colleagues have always provided timely reports to this Panel.

4 IMPACT OF COVID-19 ON CARE HOMES IN MERTON (Agenda Item 4)

The Director of Public Health gave an overview of the report.

A panel member said that the Department of Health praised Merton for their response to the pandemic. The Director of Public Health reported that a Government Minister had visited care homes in Merton and found that the council has established a close relationship with care homes during the pandemic.

A panel member asked about the source of funding for Temporary Alternative Discharge Destination Facilities. (TADD) . The Head of Commissioning and Market Development said Merton has two TADS which enabled the department to secure beds quite quickly.

A panel member extended congratulations to officers for their work with care homes during the pandemic and asked if we are preparing for a potential outbreak of a new variant. The Director of Public Health said funding is available for infection control and preparedness is being maintained within the system.
The care home manager said care homes have a named person on covid preparedness.

A panel member asked about pressures within the system. It was reported that these are reducing, a small number of staff resigned due to covid mandate, the impact of the reversal of the mandate remains to be seen.

A Panel member asked about the number of unvaccinated Merton staff. The Head of Commissioning and Marketing Development said there are over 1000 staff in Merton 32 are unvaccinated and have exemptions. There are 93 exemptions amongst agency staff. Over 50% of staff have had the booster. Merton data compares well with London and England averages.

RESOLVED
The panel agreed to send a letter to all care homes thanking them for their hard work during the pandemic.

5 UPDATE ON COVID RATES IN MERTON (Agenda Item 5)

The Director of Public Health gave an update on the latest position covid and reported that rates of covid and hospital admissions are in decline.

Universal testing will end on April 1st, vulnerable people will still be able to access tests and anti-viral medication.

Local councils will rely on national survey data for the latest covid rates and will apply national estimates to local situations.

The Director highlighted that vaccinations are an important plank post pandemic

6 REPORT OF THE HEALTH AND WELLBEING BOARD 2021 (Agenda Item 6)

The Director of Public Health gave an overview of the report.

The Chair thanked the Director for her work.

7 TOPIC SUGGESTION REQUESTS FOR 2022-23 (Agenda Item 7)

The Panel agreed to send topic suggestions to the scrutiny officer

# NHS London region Breast Screening Recovery Programme



Merton OSC

Monday 20th of June 2022

**Author**: Sanjeet Johal, Programme Director for Breast Screening Recovery Programme
**Senior Responsible Officer (SRO)**: Dr Chris Streather

NHS | NHS England and NHS Improvement

# Background

- All women aged 50 up to their 71st birthday are invited for breast screening every 3 years. Women receive their first invitations to screening some time between their 50th and 53rd birthdays.
- Breast screening uses an X-ray test called a mammogram to check the breast for signs of cancer. It can spot cancers that are too small to see or feel

- There are 6 Breast Screening Services (BSS) In London:
    - West of London BSS (WOLBSS) – Imperial College NHS Healthcare Trust;
    - **South West London BSS (SWLBSS) – St George's University Hospitals NHS FT**
    - South East London BSS (SELBSS) – Kings College Hospital NHS Foundation Trust;
    - North London BSS (NLBSS) – Royal Free London NHS FT;
    - Central and East London BSS (CELBSS) – Royal Free London NHS FT;
    - Outer North East London BSS (ONEL) – InHealth Group

- All six services are supported by The London Administration Hub (the Hub) which has numerous administrative functions, including (but not exhaustive) patient data collation and reporting, appointment scheduling and a call centre to manage appointment cancellations and rebooks.
- Together the six services and the Hub are responsible for supporting 1,300,000 eligible clients over their 3 yearly screening round, throughout the London region, aged 50-70.

- There are a total of seven locations across SWL which deliver breast screening: Edridge Road Community Health Centre (Croydon), Purley War Memorial Hospital (Purley), Queen Mary Hospital (Roehampton), Rose Centre, St George's Hospital (Tooting), Surbiton Health Centre (Surbiton), Robin Hood Lane Health Centre (Sutton) and Teddington Memorial Hospital (Teddington). There are currently no mobile units operating within South West London.

- All routine breast screening was paused in the week commencing 24th March 2020 and restarted in June 2020. Providers maintained services only for those with positive screens and those at high risk.

- All healthcare systems and services have faced significant challenges as a result of the pandemic. While other cancer screening programmes recovered, Breast Screening services in London have continued to struggle. The pandemic has exacerbated deep-rooted historical issues leading to capacity constraints across services and a further deterioration in coverage and uptake rates.

- National Operational Planning Guidance gives June 2022 as a target date for restoration of Breast Screening Services.Full recovery and restoration of breast screening services has been defined by National as:
    - **Backlog recovery:** Clear the longest waiters and Very High Risk women which ensures the reduction of the backlog and screening of the highest priority women
    - **Round length restoration**: Invite 90% of women for a screen within 36 months of their last one
    - **Increase screening uptake**: Ensures detection of cancers in invited women, a high uptake is important in detecting cancers in invited women

# Programme update

# Key programme updates

- Since January 2022, the Breast Screening Recovery Programme has been reshaped in London and both a new SRO (Dr Chris Streather) and Programme Director (Sanjeet Johal) are in post to lead and drive the recovery and improvement of Breast Screening Services in London.

- The first meeting of the Regional Improvement Board for the Breast Screening Programme was held on 25th of January 2022 (replacing the Strategy, Oversight and Risk Group (SORG)). The Board comprises of two ICS representatives (*e.g. Clinical Directors and/or Senior Operational leads of Breast Screening Services and/or Managing Directors of Cancer Alliances*) and Senior Regional representatives. The Board is now the key governance mechanism for overseeing recovery and transformation of Breast Screening Services. The key objectives agreed via the Board are:
    - To ensure capacity is available across screening services to meet demand
    - To create a sustainable workforce in London
    - Understanding and addressing health inequalities to improve uptake



London has been impacted inadvertently by the national mandate to transition from timed appointments to open invites (OI) during the pandemic. Due to the relaxation of covid restrictions, clients who did not respond to their invitation earlier in the year are now engaging with screening services which has resulted in an unprecedented surge in demand, however there have been limited appointment slots due to capacity constraints (e.g. workforce shortages IPC requirements). The transition to OI has left some services struggling to manage demand and capacity effectively, while The Hub struggled to cope with increased call volumes and administrative burden associated with OI. NHSEI has declared a Serious Incident (SI) with a formal investigation underway into the root causes of this problem.

- To date, three of London's six services have recovered their screening backlog (NL, ONEL and CEL) with the remaining three services expected to recover after June 2022. The impact of the SI and severe capacity constraints (e.g. workforce sickness) have impacted some services more than others (SWL, WOL and SEL). We are working closely with services to assess the impact on recovery trajectories.

- Recovery and restoration of breast screening services in London back to pre covid levels is not acceptable and the level of ambition through this reshaped programme over the coming months will be greater to achieve equitable and accessible services for eligible women in London.

# Immediate areas of focus for the programme

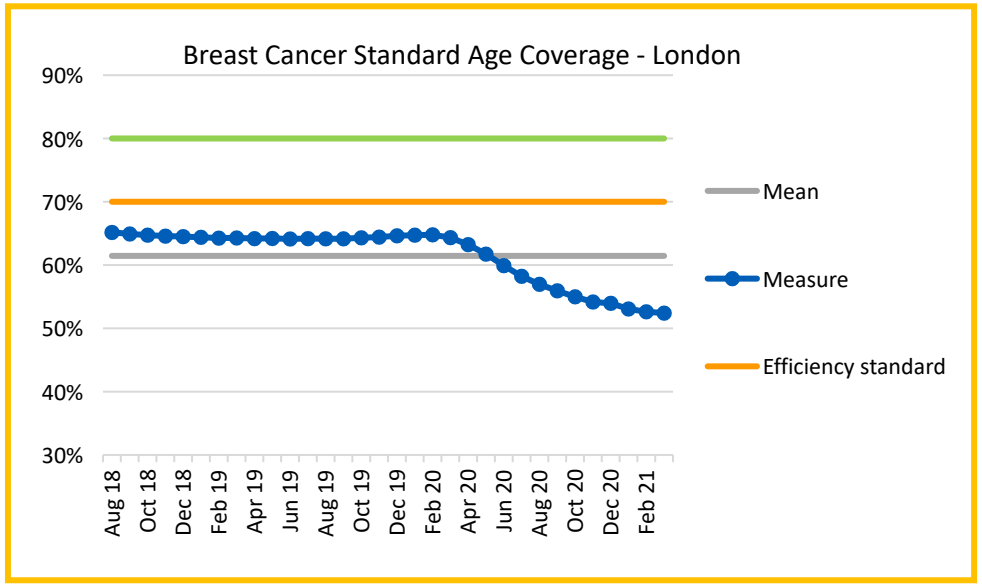
- Finalise Root Cause Analysis (RCA) from the Serious Incident Investigation, recommendations and lessons learned
- Provide targeted support for services in London to recover their backlog, uptake and round length position
- Work with services to create capacity across London to meet demand
- Stabilise and expand the breast screening front-line workforce to ensure future sustainability of services
- Establishing a new workstream within the recovery programme with system partners to drive improvements in uptake and address health inequalities challenge (see slides 12 and 13)
- Implementing recommendations from the lessons learned session from the pandemic and recovery period, held in early April,  with breast screening service providers in London

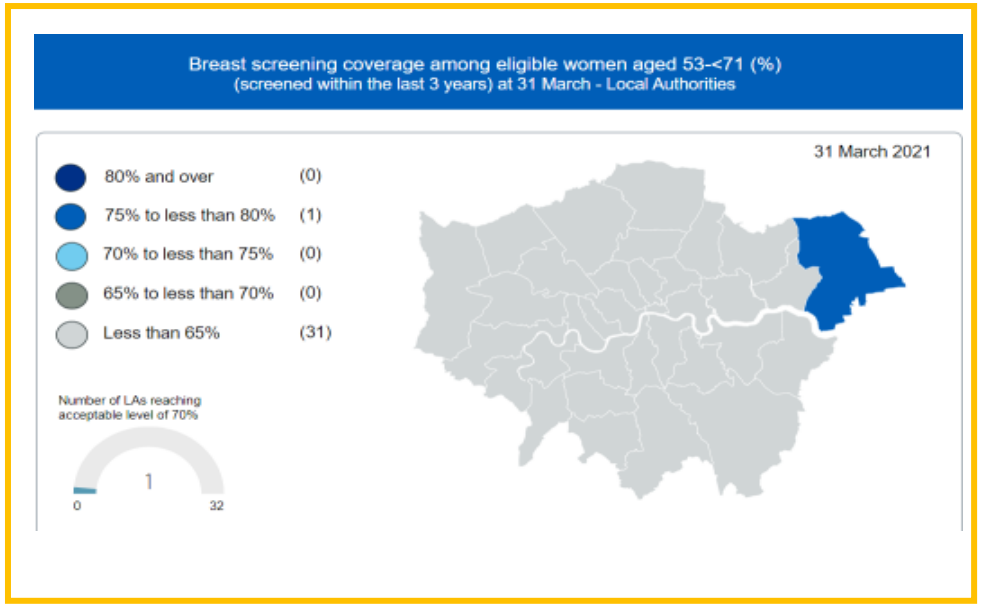
# Improving uptake and reducing health inequalities

# Breast Screening coverage at London Borough level

| Region | 31 March 2014 | 31 March 2015 | 31 March 2016 | 31 March 2017 | 31 March 2018 | 31 March 2019 | 31 March 2020 | 31 March 2021 |
|---|---|---|---|---|---|---|---|---|
| **London** | | | | | | | | |
| Barking and Dagenham | 71.2 | 64.3 | 66.6 | 67.7 | 67.0 | 65.8 | 66.4 | 54.5 |
| Barnet | 71.3 | 70.5 | 69.9 | 68.9 | 69.5 | 68.9 | 68.3 | 57.1 |
| Bexley | 78.2 | 77.9 | 78.7 | 78.8 | 78.8 | 78.4 | 78.1 | 54.6 |
| Brent | 68.7 | 66.7 | 65.8 | 64.5 | 64.5 | 64.4 | 64.3 | 53.0 |
| Bromley | 77.0 | 75.9 | 77.2 | 77.9 | 77.9 | 77.5 | 77.2 | 64.1 |
| Camden | 61.2 | 56.3 | 61.4 | 61.8 | 60.9 | 44.7 | 54.1 | 45.6 |
| Croydon | 66.7 | 68.6 | 70.0 | 70.4 | 71.7 | 72.5 | 71.5 | 57.9 |
| Ealing | 69.2 | 68.2 | 69.2 | 69.7 | 69.3 | 69.8 | 68.7 | 53.8 |
| Enfield | 73.9 | 73.4 | 72.3 | 71.7 | 72.1 | 72.2 | 68.3 | 52.9 |
| Greenwich | 70.3 | 67.3 | 69.0 | 67.6 | 69.5 | 69.0 | 66.5 | 61.7 |
| Hackney and City of London | 61.5 | 58.7 | 63.6 | 66.5 | 65.4 | 41.3 | 58.1 | 55.0 |
| Hammersmith and Fulham | 61.4 | 61.1 | 62.8 | 63.1 | 62.8 | 64.0 | 62.4 | 51.0 |
| Haringey | 67.6 | 66.9 | 66.4 | 64.3 | 65.2 | 64.7 | 61.4 | 48.8 |
| Harrow | 75.6 | 74.4 | 72.9 | 73.1 | 72.7 | 71.9 | 71.8 | 55.3 |
| Havering | 79.0 | 78.7 | 76.4 | 77.7 | 78.4 | 78.7 | 78.7 | 75.9 |
| Hillingdon | 71.3 | 70.9 | 72.4 | 73.4 | 73.5 | 73.7 | 72.8 | 55.9 |
| Hounslow | 69.0 | 69.4 | 70.5 | 70.5 | 69.6 | 70.8 | 70.6 | 57.0 |
| Islington | 57.4 | 62.6 | 63.5 | 64.9 | 63.8 | 62.6 | 57.4 | 45.1 |
| Kensington and Chelsea | 59.2 | 57.3 | 57.4 | 57.0 | 56.3 | 55.9 | 55.4 | 42.7 |
| Kingston Upon Thames | 64.2 | 71.7 | 72.0 | 70.0 | 73.5 | 74.2 | 74.3 | 52.8 |
| Lambeth | 63.1 | 63.0 | 63.6 | 64.4 | 65.4 | 64.9 | 64.3 | 54.7 |
| Lewisham | 65.0 | 65.7 | 66.4 | 67.8 | 69.3 | 68.6 | 66.4 | 61.1 |
| Merton | 66.2 | 68.5 | 70.1 | 71.0 | 71.1 | 70.5 | 70.4 | 59.9 |
| Newham | 67.4 | 61.7 | 65.1 | 64.9 | 63.1 | 52.7 | 57.3 | 50.2 |
| Redbridge | 74.0 | 72.1 | 73.4 | 71.6 | 70.7 | 71.8 | 71.9 | 61.7 |
| Richmond Upon Thames | 70.6 | 72.6 | 73.0 | 72.5 | 72.4 | 74.0 | 73.7 | 52.5 |
| Southwark | 64.1 | 64.3 | 65.3 | 67.2 | 66.5 | 65.6 | 64.9 | 47.6 |
| Sutton | 73.0 | 74.5 | 75.8 | 74.0 | 75.6 | 75.8 | 74.5 | 59.7 |
| Tower Hamlets | 61.5 | 59.6 | 62.6 | 68.7 | 63.3 | 62.6 | 56.0 | 48.6 |
| Waltham Forest | 71.3 | 67.1 | 73.3 | 73.3 | 70.5 | 55.4 | 59.6 | 59.9 |
| Wandsworth | 64.5 | 65.7 | 66.9 | 67.3 | 67.0 | 66.7 | 66.4 | 52.6 |
| Westminster | 60.7 | 60.2 | 60.0 | 60.0 | 59.4 | 58.1 | 57.0 | 41.8 |






**Definition of coverage:** Coverage is defined as the percentage of women in the population who are eligible for screening at a particular point in time, who have had a test with a recorded result within the last three years. The latest validated data published indicates in London only 53% (and SWL: 53%) of eligible women had a recorded test result with the last three years (range across the seven regions is 52-66% based on the latest Oct 21 data)

# What are we currently doing to address health inequalities in London?

- **Strategic priorities** for Breast Cancer recovery
- **Where are we and what are we currently doing** to support health inequalities in London?
  - London Breast Screening Health Equity Audit 2019
  - London Breast Screening Health Equity Audit 2022
  - Breast Cancer Screening stocktake
  - After Action Review: Breast Screening
- Women's health strategy
- Next steps for the BCS Health Inequalities workstream – identifying evidence, understanding and action

- To ensure capacity is available across screening services to meet demand
- To create a sustainable workforce in London
- **Understanding and addressing health inequalities to improve uptake**
- **Lessons learned from recovery of breast screening services**

# Breast Cancer Screening Health Equity Audit 2019

- Controlling for the other characteristics, the odds of being screened within 6 months of invitation for younger women (aged 59 or lower) is **85%** and the odds of being screened for women aged 60 and above is **78%**.
- **Therefore, women in the lower age bracket are 4% more likely to attend screening than women in the higher age bracket.**

- Ethnicity data was not 100% complete for any of the London Breast Screening Centres. Controlling for the other characteristics, the odds of being screened for those from a White background is 84% and the odds of being screened for the BME group is 82%.
- **Therefore, there is a 9% decrease in the likelihood of uptake when women are from a BME background compared to a white background.**
- Within white ethnic background groups, the 'White British' group has a significantly higher uptake than other white backgrounds. **Women from a non-British white background are 32% less likely to be screened compared to white British.**
- Within BME backgrounds, the 'Black or Black British' group has the highest uptake; **women from the other BME categories are 5% less likely to be screened compared to 'Black or Black British' women** - with 'Mixed White and Black' women having the lowest odds, 24% less likely to be screened than 'Black or Black British'.

- Controlling for the other characteristics, the odds of being screened (within 180 days of invitation) for women from more deprived areas (IMD deciles 1 to 5) is **81%** and the odds of being screened for the less deprived areas (IMD deciles 6 to 10) is **84%**.
- **Therefore, women who live in a more deprived area are 25% less likely to be screened within 180 days of invitation than those from a less deprived area**
- At IMD quintile level, the biggest jump is seen between quintile 4 to quintile 5: **there is a 22% increase in the odds of a woman being screened if they are in the 5th IMD quartile (least deprived), compared to the 4th quartile.**

# London Breast Screening Health Equity Audit 2022

**Aimed to:**

- Compare patterns of uptake ‘pre’ and ‘post’ service suspension
- Assess impact of Open Invitation methodology on screening participation
- Identify demographic factors which may be key to better understanding low uptake
- Identify groups of women who have been most disadvantaged and where most can be gained by special uptake initiatives

**Outcomes suggested that:**

London has some of the poorest breast screening uptake in the country and it has got worse ~10% drop from 62% to 51%

Open invitations have made the situation worse ~-10% compared to Timed Invitations

The post-covid pattern is similar to historical patterns but the least deprived have generally suffered least.

Marmot’s conclusion that the pandemic amplifies inequalities holds true for breast screening (with caveats)

Deprivation alone does not explain more than 20% of variation in uptake e.g. country of birth is more strongly associated with uptake

The audit can identify groups who need to be targeted most and to whom resources are most needed

# Breast screening inequalities stocktake 2022

- NHSEI and the Transforming Care Service Team have undertaken a survey of partners to determine current interventions to improve breast screening uptake and reduce inequalities across London
- the survey included the regional Cancer Alliances, who provided information on the initiatives they are taking to support targeted groups.
- Key questions include detail of the intervention, target group, monitoring and evaluation plans/outcomes
- Three out of four Cancer Alliances have provided feedback to date
- Survey responses have been collated and will be shared with the Improvement Board in June 2022
- This stocktake provides a baseline gap analysis - what interventions are taking place / planned and gaps
- It will be used in conjunction with the breast screening equity data to inform the priorities and delivery plan for the pan-London Breast Screening Inequalities workstream

# Next steps (1/2)

- Setting up a **London region BCS Health Inequalities advisory group** followed by a wider forum to include all providers and cancer alliances
  - A national Breast Screening T&F group is being established; suggestion for London to sit on this group and for National to sit on the London region group
- **Identifying and aligning to national and regional strategies and policies** that support to levelling up of women's health
- **Identifying and learning from research and development** regionally and nationally across screening areas to address inequalities in uptake E.g., To increase cervical screening uptake rates among women with SMI
  - An informed choice tool (information leaflet) to offer some extra support with the testing.
  - Tips for during the appointment and a checklist of things to share
  - Text message reminders
- **Data and evidence** – consideration for digital and data including inequalities data can support
  - Triangulate provider, health equity and uptake data by borough, in order to evidence need – normative and felt
  - Identify where targeted approaches are required
  - Identify appropriate interventions that improve uptake.
  - Identifying measurable outcomes
  - Review how we can measure the impact of interventions to ensure they are efficient
  - Roll-out of a new shape mapping tool commissioned in London for breast screening
- **Gap analysis** to identify what data we need, where it is and how we can get it.

# Next steps (2/2)

- **Partnership working** to understand how best to gather women's experiences and to embed their voices within strategies.
  - Inclusive and integrated working with and learning from the London Covid legacy and equity partnership
  - Working with Systems and partners including Local authorities and the Office for Health Improvement and Disparities (OHID) and others to support local systems to explore innovative models of care that improve women's access to health services.
  - Working with local authorities, communities and the third sector, to identify target audience and implement appropriate interventions at a local level.
- **Alignment & integration with other BCS workstreams** - consideration for how the BCS workstream links with other work streams in the BCS programme to avoid duplication and maximise opportunities
  - consideration for how we share information with patients and the public, communities & health and social care
- **Oversight and planning for funded HI programmes and identifying gaps and priorities**
  - Currently includes language support, support for people with learning and physical disabilities, increasing population awareness and identifying community assets/champions
  - Gaps identified by the stocktake including homeless and Gypsy traveller communities
- **Formulating priorities** for the workstream leading to a **strategy** and **action plan** and Identification of additional funding

# Breast Screening Performance

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# Merton Overview & Scrutiny Committee

## Cervical & Bowel Cancer Screening Update



NHS England/Improvement (London Region)
June 2022

# Cervical Screening Programme

NHS England and NHS Improvement

# Background

- Cervical screening is for women and people with a cervix. Screening is offered every 3 years from age 25 to 49 and every 5 years from age 50 to 64. This is because most cervical cancers develop between these ages. First invitations arrive a few months before people turn 25. Individuals are required to book a screening appointment in primary care.
- The NHS Cervical Screening Programme saves thousands of lives from cervical cancer each year in the UK . In England cervical screening currently prevents 70% of cervical cancer deaths. If everyone attended screening regularly, 83% could be prevented.

## HPV and cervical cancer

- Nearly all cervical cancers are caused by a virus called human papillomavirus (HPV).
- HPV is very common. Most people will get the virus at some point in their life. It is spread through close skin to skin contact during any type of sexual activity with a man or woman. HPV can stay in the body for many years. It can stay at very low or undetectable levels and not cause any problems. This means an HPV infection may have come from a partner a long time ago.
- There are many different types of HPV, but only some high-risk types can lead to cancer. The types of HPV that cause cervical cancer do not cause any symptoms. In most cases, your immune system can get rid of the virus without you ever knowing you had it. But sometimes, HPV can cause cells in the cervix to become abnormal.
- The body can usually get rid of the abnormal cells and the cervix returns to normal. But sometimes this doesn't happen, and the abnormal cells can go on to develop into cancer.



## How cervical screening works

- Cervical screening is not a test for cancer. It looks for abnormal cells in the cervix. Abnormal cells can develop into cancer if left untreated.
- The test involves using a soft brush to take a small sample of cells from the surface of your cervix. The sample is put into a small plastic container and sent to a laboratory. It is tested for the types of HPV that can cause cervical cancer. If the result is negative for the most common types of HPV that cause cervical cancer, the risk of cervical cancer is very low and there is no need to check for abnormal cells.
- If the result is positive for HPV the laboratory will check the sample for abnormal cells. Abnormal cells are not cancer, but they could develop into cancer if left untreated.
- As a next step, individuals may be another examination (called a colposcopy) to look at the cervix more closely. If abnormal cells during colposcopy treatment may be required to remove the cells. This is how screening can prevent cervical cancer.


1. https://www.gov.uk/government/publications/cervical-screening-description-in-brief/cervical-screening-helping-you-decide--2#fn:1
2. Peto, J and others (2004). The cervical cancer epidemic that screening has prevented in the UK. Lancet 35, 249 to 256.
3. Castanon, A and others (2017). By how much could screening by primary human papillomavirus testing reduce cervical cancer incidence in England? Journal of Medical Screening vol. 24, (2) 110 to 112.

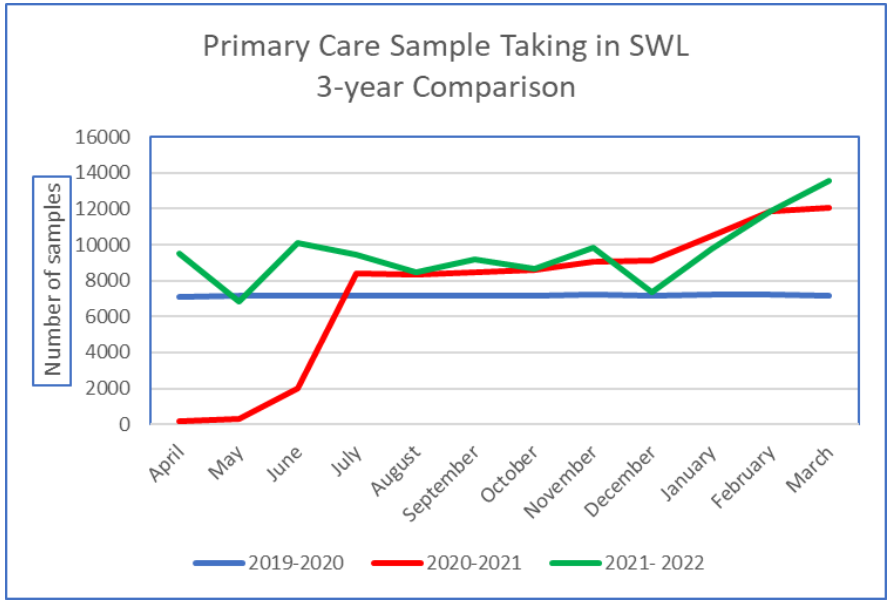
# Cervical Screening – Primary Care

In 2019/20 (pre-COVID) a total of 86,170 cervical screening samples were taken in primary care across London. In 2020/21, despite a two month pause in screening, activity at 88,824 was 3.1% higher than in the previous year; during 2021/22 there was a 29% increase in primary care activity on the previous year, giving a total of 114,415 samples taken. March 2022 has seen the highest number of samples taken in a month in Primary Care in London.

Across SWL an additional 25 sample takers have attended the Sample Taker Foundation Course run by the London Regional Cytology Training Centre since September 2021 when training recommenced after the pandemic

**SWL: Samples taken by Month**

| Year | April | May | June | July | August | September | October | November | December | January | February | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019-2020 | 7121 | 7147 | 7172 | 7179 | 7178 | 7178 | 7182 | 7193 | 7192 | 7214 | 7241 | 7173 | 86170 |
| 2020-2021 | 150 | 298 | 2037 | 8417 | 8355 | 8455 | 8570 | 9069 | 9111 | 10455 | 11829 | 12078 | 88824 |
| 2021- 2022 | 9505 | 6809 | 10084 | 9447 | 8459 | 9157 | 8644 | 9811 | 7326 | 9771 | 11827 | 13575 | 114415 |




Source: NHSE/I Screening GptoLab Data and NHSD coverage and uptake reports

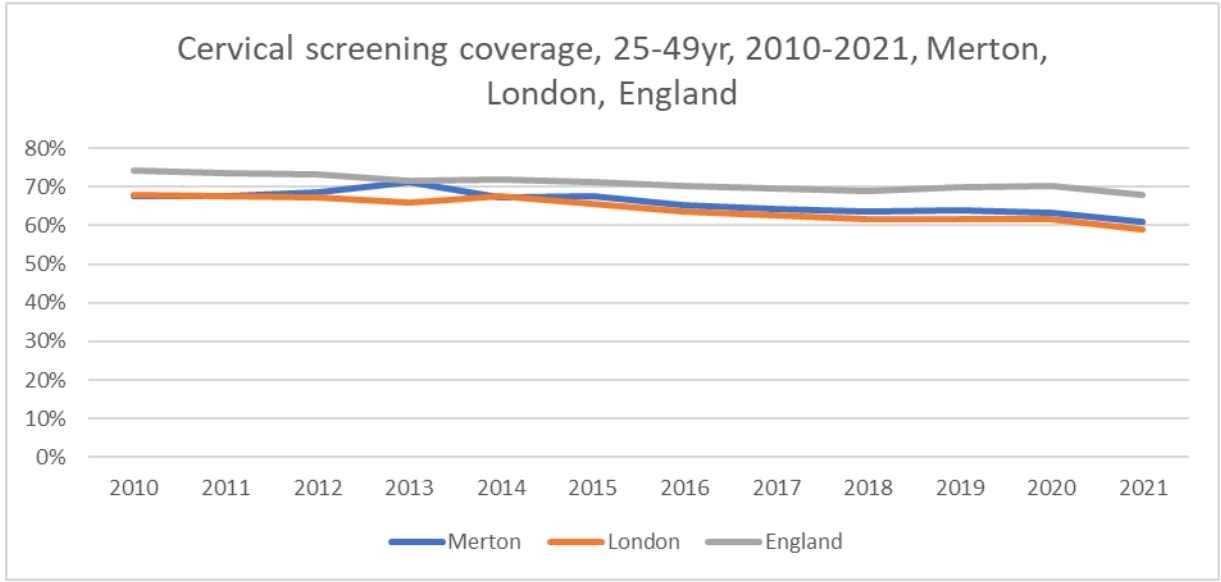
# Trends in cervical screening coverage, 25-49 yr

C24b - Cancer screening coverage - cervical cancer (aged 25 to 49 years old) 2021

Proportion - %

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | → | 7,089,096 | 68.0* | 68.0 | 68.0 |
| London region | ↓ | 1,346,971 | 59.1* | 59.1 | 59.2 |
| Bexley | → | 33,009 | 72.2 | 71.8 | 72.6 |
| Havering | ↑ | 34,306 | 71.4 | 71.0 | 71.8 |
| Bromley | → | 46,247 | 71.1 | 70.7 | 71.4 |
| Sutton | → | 29,458 | 70.0 | 69.5 | 70.4 |
| Richmond upon Thames | ↓ | 28,553 | 65.8 | 65.4 | 66.3 |
| Croydon | → | 55,272 | 65.0 | 64.6 | 65.3 |
| Enfield | → | 45,172 | 64.0 | 63.7 | 64.4 |
| Lewisham | → | 51,060 | 64.0 | 63.7 | 64.3 |
| Hillingdon | ↑ | 41,227 | 63.2 | 62.8 | 63.6 |
| Greenwich | ↓ | 43,680 | 62.5 | 62.1 | 62.8 |
| Kingston upon Thames | ↓ | 24,191 | 62.3 | 61.9 | 62.8 |
| Waltham Forest | → | 44,308 | 62.2 | 61.9 | 62.6 |
| Barking and Dagenham | → | 30,257 | 62.0 | 61.5 | 62.4 |
| Wandsworth | ↓ | 65,984 | 61.2 | 60.9 | 61.5 |
| Merton | ↓ | 33,439 | 61.1 | 60.7 | 61.5 |
| Lambeth | ↓ | 62,003 | 61.0 | 60.7 | 61.3 |
| Hackney | ↓ | 51,090 | 60.3 | 60.0 | 60.7 |
| Southwark | ↓ | 54,830 | 59.5 | 59.2 | 59.8 |
| Ealing | ↑ | 54,541 | 59.4 | 59.1 | 59.7 |
| Hounslow | → | 41,985 | 59.1 | 58.7 | 59.4 |
| Haringey | ↓ | 44,335 | 59.1 | 58.7 | 59.4 |
| Redbridge | → | 41,265 | 58.6 | 58.2 | 58.9 |
| Barnet | → | 53,327 | 58.5 | 58.1 | 58.8 |
| Harrow | → | 32,527 | 56.5 | 56.1 | 56.9 |
| Newham | ↓ | 53,859 | 56.5 | 56.1 | 56.8 |
| Brent | ↓ | 47,760 | 54.2 | 53.8 | 54.5 |
| Islington | ↓ | 39,769 | 52.8 | 52.4 | 53.2 |
| Tower Hamlets | ↓ | 50,685 | 50.3 | 50.0 | 50.6 |
| Hammersmith and Fulham | ↓ | 30,825 | 49.1 | 48.7 | 49.5 |
| Camden | ↓ | 32,607 | 46.6 | 46.2 | 47.0 |
| City of London | ↓ | 1,050 | 45.2 | 43.2 | 47.2 |
| Westminster | ↓ | 29,434 | 43.7 | 43.3 | 44.1 |
| Kensington and Chelsea | ↓ | 18,916 | 42.9 | 42.5 | 43.4 |

**Definition:** The proportion of women in the resident population eligible for cervical screening aged 25 to 49 years at end of period reported who were screened adequately within the previous 3.5 years.
Acceptable std: 80%




Cervical screening coverage in women aged 25-49 years, has been steadily declining across the country since 2010. In 2021, the coverage for women in Merton (61%) was the lowest in SWL, but above the rate for London (59%) and below the national rate (68%).

The reasons behind the national decline are unclear. In London however, lower participation rates are associated with list inflation and population mobility, ethnic diversity and deprivation.

Access to screening appointments remains a challenge in some parts London, with limited availability out of hours and during weekends, combined with a shortage of practice nurse sample takers.

Working with the London Regional Cytology Training School, NHSEI and RMP Cancer Alliance have trained additional sample takers, mentors and assessors to further increase cervical screening capacity in primary care

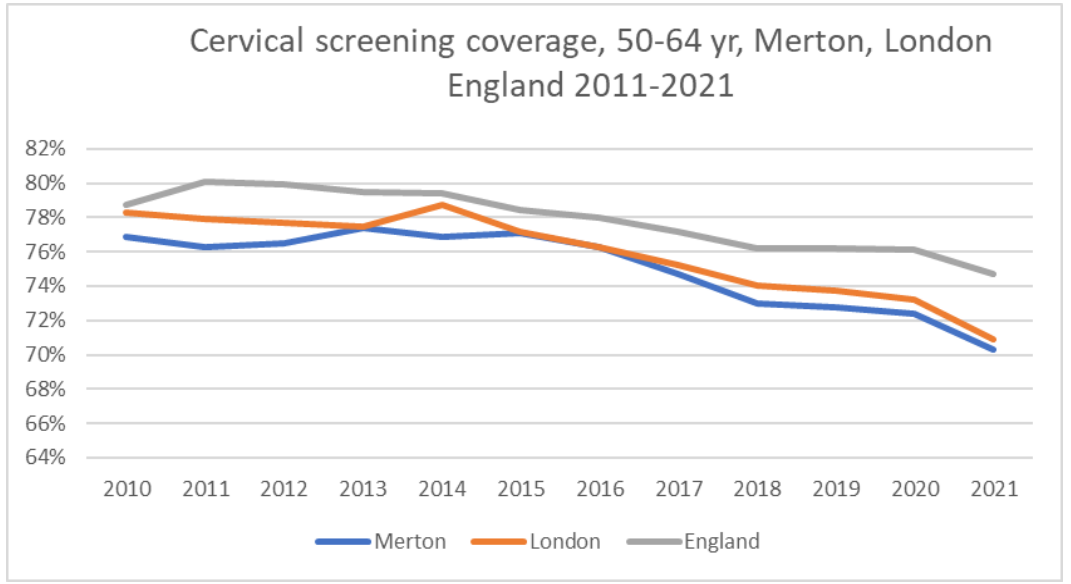
Source: NHS Digital (Open Exeter) / Office for Health Improvement and Disparities

# Trends in cervical screening coverage, 50-64 yr

C24c - Cancer screening coverage - cervical cancer (aged 50 to 64 years old) 2021

Proportion - %

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | ↓ | 3,903,086 | 74.7* | 74.6 | 74.7 |
| London region | ↓ | 559,548 | 70.9* | 70.8 | 71.0 |
| Havering | ↓ | 18,356 | 76.3 | 75.7 | 76.8 |
| Bromley | ↓ | 24,515 | 75.3 | 74.8 | 75.7 |
| Bexley | ↓ | 17,461 | 75.2 | 74.7 | 75.8 |
| Croydon | ↓ | 28,374 | 74.3 | 73.9 | 74.8 |
| Sutton | ↓ | 14,301 | 74.2 | 73.6 | 74.8 |
| Enfield | ↓ | 23,859 | 74.0 | 73.5 | 74.4 |
| Hillingdon | ↓ | 19,584 | 73.9 | 73.4 | 74.4 |
| Waltham Forest | ↓ | 17,713 | 73.6 | 73.0 | 74.1 |
| Lewisham | ↓ | 20,298 | 73.1 | 72.5 | 73.6 |
| Redbridge | ↓ | 18,594 | 72.5 | 72.0 | 73.1 |
| Richmond upon Thames | ↓ | 15,028 | 72.1 | 71.5 | 72.8 |
| Newham | ↓ | 19,038 | 71.9 | 71.3 | 72.4 |
| Hackney | ↓ | 15,605 | 71.6 | 71.0 | 72.2 |
| Haringey | ↓ | 18,645 | 71.4 | 70.9 | 71.9 |
| Greenwich | ↓ | 16,965 | 71.2 | 70.6 | 71.8 |
| Hounslow | ↓ | 18,298 | 71.2 | 70.6 | 71.7 |
| Barking and Dagenham | ↓ | 12,148 | 71.2 | 70.5 | 71.9 |
| Southwark | ↓ | 19,825 | 71.0 | 70.5 | 71.6 |
| Ealing | ↓ | 24,049 | 71.0 | 70.5 | 71.5 |
| Kingston upon Thames | ↓ | 11,054 | 71.0 | 70.3 | 71.7 |
| Lambeth | ↓ | 20,350 | 70.9 | 70.3 | 71.4 |
| Islington | ↓ | 12,935 | 70.7 | 70.0 | 71.4 |
| Brent | ↓ | 22,763 | 70.7 | 70.2 | 71.2 |
| Harrow | ↓ | 16,800 | 70.6 | 70.1 | 71.2 |
| Merton | ↓ | 14,070 | 70.3 | 69.6 | 70.9 |
| Barnet | ↓ | 25,496 | 69.7 | 69.3 | 70.2 |
| Tower Hamlets | ↓ | 11,171 | 69.4 | 68.7 | 70.1 |
| Wandsworth | ↓ | 17,815 | 68.7 | 68.1 | 69.3 |
| City of London | → | 452 | 65.7 | 62.1 | 69.1 |
| Camden | ↓ | 12,414 | 63.9 | 63.2 | 64.6 |
| Hammersmith and Fulham | ↓ | 10,878 | 63.0 | 62.2 | 63.7 |
| Westminster | ↓ | 11,800 | 57.3 | 56.6 | 58.0 |
| Kensington and Chelsea | ↓ | 8,894 | 53.5 | 52.8 | 54.3 |




Cervical screening coverage in women aged 50-64 years, has been steadily declining across the country since 2010. In 2021, the coverage for women in Merton (70.3%) was similar to the rate for London (71%) but below the national rate (75%). In SWL, only Wandsworth has a lower coverage in this age group (69%)

Source: NHS Digital (Open Exeter) / Office for Health Improvement and Disparities

**Definition:** The proportion of women in the resident population eligible for cervical screening aged 50 to 64 years at end of period reported who were screened adequately within the previous 5.5 years. Acceptable std: 80%

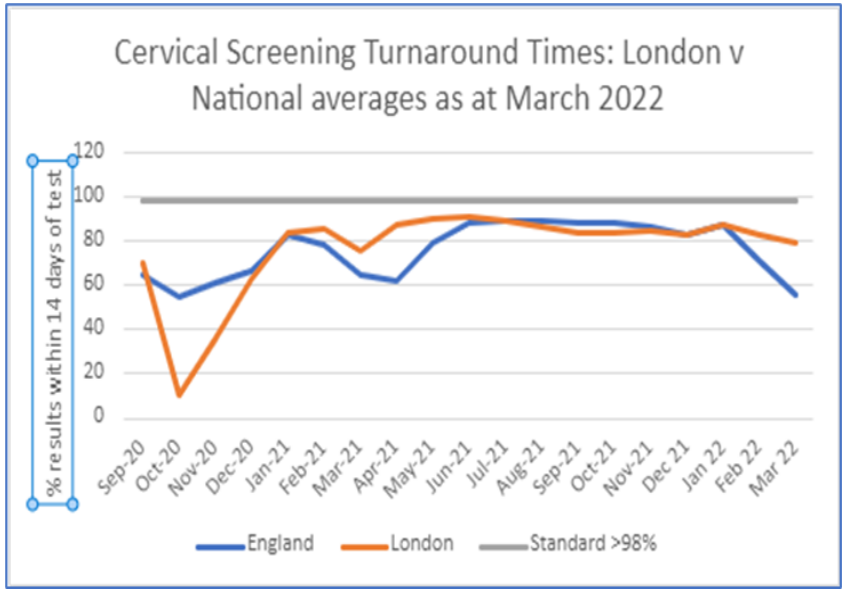
# Cervical Screening – Laboratory (CSL) Performance

The Cervical Screening Laboratory tests all cervical screening samples across London.

A key performance indicator for the cervical screening programme is that women receive accurate screening results in a timely manner. The national policy is that all women should receive their cervical screening test results within two weeks of the sample being taken. The acceptable standard is that 98% of letters should be delivered within 14 days.
In March 2022, the London turnaround time (TAT) for % of letters delivered within 14 days was 79.3% compared to the England TAT of 56.1% (see graph below). The table below shows CSL data specific to SWL ICS. In March 22, the 14 day TAT for SWL was 90.4% (figure to be validated).

In March 2022, the laboratory built up a backlog of 630 reporting cases due to supply issues (national supply of platform test kits) and increased COVID-related staff sickness amongst screening and reporting staff. Overtime has been reintroduced and the backlog has been reduced to 360. Due to Easter Bank Holidays, HPV+ve samples are being reported in 3 weeks; HPV-ve samples reported within 7 days. The laboratory aims to clear the backlog of cases for reporting by end of June 2022

| | Jan 22 | Feb 22 | March 22 |
|---|---|---|---|
| **Activity** Received | 9708 | 11243 | 12631 |
| Authorised | 8946 | 10700 | 12414 |
| **TAT's 12 day (taken to authorise)** | 89.5% | 80.7% | 90.4% |
| **Number of direct referrals to Colp** | 7.3% | 7.1% | 3.6% |
| **HPV positivity rate** | 10.7% | 13% | 12.7% |




NHSEI Screening via Open Exeter and Laboratory Performance Reports

## Cervical Screening – Histology Performance

**Histology**

A key performance indicator for the cervical screening programme is that 80% of specimens should be reported within 7 days of the cervical sample having been taken; 90% within 10 days.

The laboratory at Epsom St Helier (which services the Merton population) is meeting national standards

| Measure | Reporting timeframe 2021/22 | Epsom | Kingston | SWLP* |
|---|---|---|---|---|
| Workload | Q3 | 2,915 | 1,554 | Not submitted |
| | Q2 | 2,817 | 1,482 | 1,265 |
| 7 day turnaround time | Q3 | 85% | 65% | Not submitted |
| | Q2 | 81.10% | 66.30% | 83% |
| 10 day turnaround time | Q3 | 94% | 85% | Not submitted |
| | Q2 | 92.40% | 85.70% | 91% |

SWLP- South West London Pathology (Partnership between St George's University Hospitals NHS Foundation Trust, Croydon Health Services NHS Trust and Kingston Hospital NHS Foundation Trust)

Source: NHSEI Screening – Quarterly Histology Report

## Cervical Screening – Colposcopy Performance

Despite an increase in colposcopy referrals due to HPV Primary Screening and an increase in samples taken as part of the NHSCSP, The colposcopy service at St Helier (which serves the Merton population) is achieving waiting times standards for all screening referrals.

Between April and December 2019 and December 2021, low grade referrals increased by 98% from 447 to 884, while referrals for high grade abnormalities increased by 149% from 104 to 259 over the 9 month period

| Measure | Standard | Reporting timeframe | Kingston | Croydon | St George's | St Helier |
|---|---|---|---|---|---|---|
| Women offered appointment within 6 weeks of referral | Acceptable ≥99% | Q3 2021/22 | 33.6 | 58.6 | 83.5 | 91.9 |
| | | Q2 2021/22 | 43.3 | 87.5 | 93.4 | 92.6 |
| | | Q1 2021/22 | 44.7 | 93.4 | 95.4 | 90.9 |
| | | Q4 2020/21 | 45.1 | 93.8 | 85.2 | 97.0 |
| Women offered appointment within 6 weeks of referral of low grade referral | Acceptable ≥99% | Q3 2021/22 | 6.1 | 49.4 | 87.7 | 100.0 |
| | | Q2 2021/22 | 14.8 | 89.3 | 100.0 | 100.0 |
| | | Q1 2021/22 | 23.7 | 100.0 | 99.7 | 93.7 |
| | | Q4 2020/21 | 24.5 | 99.7 | 95.3 | 99.3 |
| Offered appointment within 2 weeks of invasive referral | Acceptable ≥93% | Q3 2021/22 | 100.0 | 100.0 | 100.0 | 100.0 |
| | | Q2 2021/22 | 100.0 | 100.0 | 100.0 | 100.0 |
| | | Q1 2021/22 | 100.0 | 100.0 | 100.0 | 100.0 |
| | | Q4 2020/21 | 100.0 | 100.0 | 100.0 | 100.0 |
| Offered appointment within 2 weeks of severe or worse referral | Acceptable ≥93% | Q3 2021/22 | 100.0 | 100.0 | 100.0 | 100.0 |
| | | Q2 2021/22 | 100.0 | 100.0 | 100.0 | 100.0 |
| | | Q1 2021/22 | 98.0 | 100.0 | 97.0 | 100.0 |
| | | Q4 2020/21 | 100.0 | 100.0 | 100.0 | 100.0 |
| Offered appointment within 2 weeks of moderate referral | Acceptable ≥93% | Q3 2021/22 | 97.4 | 100.0 | 100.0 | 100.0 |
| | | Q2 2021/22 | 97.9 | 100.0 | 98.8 | 100.0 |
| | | Q1 2021/22 | 98.6 | 100.0 | 100.0 | 100.0 |
| | | Q4 2020/21 | 100.0 | 100.0 | 100.0 | 94.5 |

NHSEI – KC65 Returns

| | |
|---|---|
| | Meeting std |
| | Below std |

## Cervical Screening – FDS Performance

Standard: 75% of patients to be informed whether or not they have cancer within 28 days.

St Helier achieved the FDS target in Q3 of 2021/22

There is a discrepancy between national FDS data and locally reported data which is currently being investigated.

| SWL | | Croydon | St George's | St Helier | Kingston |
|---|---|---|---|---|---|
| Measure | Reporting timeframe | Achievement % | Achievement % | Achievement % | Achievement % |
| **FDS Target:** Patients informed if cancer is either ruled out or confirmed within 28 days | Q3 2021/22 | 92% | 85.00% | 89.00% | 100.00% |
| | Q2 2021/22 | 96% | 94.80% | 70.20% | 93.40% |
| | Q1 2021/22 | 98.70% | 100% | 46.00% | Not provided |
| | Q4 2020/20 | 34% | Not provided | 73% | 96% |

# Reducing inequalities and improving cervical screening coverage

- GP-endorsed text messages sent to all women after the invitation and reminder letters
- Cervical screening social marketing campaign (February to April 2022)- multi-channel including social media, out of home marketing, community radio and community engagement in low coverage boroughs. The evaluation is underway
- Commissioned cervical screening specialist service for victims of sexual violence including FGM (pan-London service) https://mybodybackproject.com/
- Funding Primary Care Network Pilot initiatives to assess the feasibility of interventions to tackle barriers to engagement for targeted communities which include:
    - People with learning disabilities
    - People from the Orthodox Jewish community
    - People from Romanian and Bengali communities
    - People who have never attended for a cervical screen
    - People who are at least 6 months overdue a screen

Cervical Screening Pilot Improvement Projects - Healthy London Partnership

RMP Cancer Alliance is delivering the following interventions across SWL and Merton:

- Produced awareness and promotional videos for all 6 boroughs in SWL encouraging attendance to cervical screening clinics
- Training for non clinical staff on cervical screening call/recall
- "Cervical Screening in Trans Men and Non-binary People with a Cervix - written document and cascaded to Primary Care teams Guidance for Primary Care "
- Extended Hours Screening delivered by PCNs and GP Federations
- Training of sample takers and assessors/mentors
- Training for primary care clinical staff in screening and inequalities modules.
- Commission No Barriers Cervical screening clinic for trans men and non-binary people– this service is open to all https://rmpartners.nhs.uk/no-barriers-cervical-screening-for-trans-and-non-binary-people/
- Planned training on LGBTQ+ for primary care

# Bowel Cancer Screening Programme

NHS England and NHS Improvement

# Bowel Cancer Screening

## Background

Bowel cancer screening is offered every two years to people aged 56 to 74 years old in London. A faeco-immunochemical test (FIT) kit is sent to the individual's home address. Once completed, the test is returned by post to the NHS London Bowel Screening Hub in a pre-paid envelop.

### How bowel screening works

The faecal immunochemical test detects microscopic levels of blood in faeces. We look for blood because polyps and bowel cancers sometimes bleed. Finding blood does not diagnose bowel cancer but it means that further tests may be needed. (usually a bowel examination/colonoscopy).



## Bowel Screening Providers in SWL (Merton Population)

- The London Bowel Cancer Screening Hub, hosted by London North West University NHS Trust, sends screening kits, invitation and results letters and processes/tests returned kits.
- South West London Bowel Screening Centre, hosted by St Georges Hospital NHS Trust provides:
  - Specialist screening practitioner (SSP) assessment for people with a positive screen result
  - Colonoscopy and treatment
  - Health promotion

# Bowel cancer screening –uptake and coverage

In 2019, the NHS Bowel Screening Programme replaced the faecal occult blood test (FOBT) kit with the faecal immunochemical test (FIT) kit. FIT has a higher acceptability than FOBT and its introduction has resulted in an a 7% increase in uptake across London with the largest increases among groups with low participation rates, such as men, people from ethnic minority backgrounds, and people in more deprived areas.

**Improving Uptake and reducing inequalities**

NHSEI London, the London Hub and RMP Cancer Alliance have implemented a variety of interventions to improve uptake:

- Phone calls to first time invitees to encourage attendance and address barriers to screening, particularly targeting ethnic minority non-English speakers(RMP & Community Links)
- Multi-lingual phone call reminders to people who have not returned their bowel screening kit (to be relaunched in 2022/23)
- SMS reminders sent to non-responders (NHSEI, London Hub, UCL Centre for Behavioural Science)
- Multi-channel social marketing campaign planned for late summer 2022 to include social media, radio, out of home advertising and community engagement in lowest-uptake boroughs

St Georges/SWL Bowel Screening Centre Health Promotion Team is responsible for primary care engagement and support, targeted health promotion in low uptake communities/areas and regular equity audits and has delivered the following:

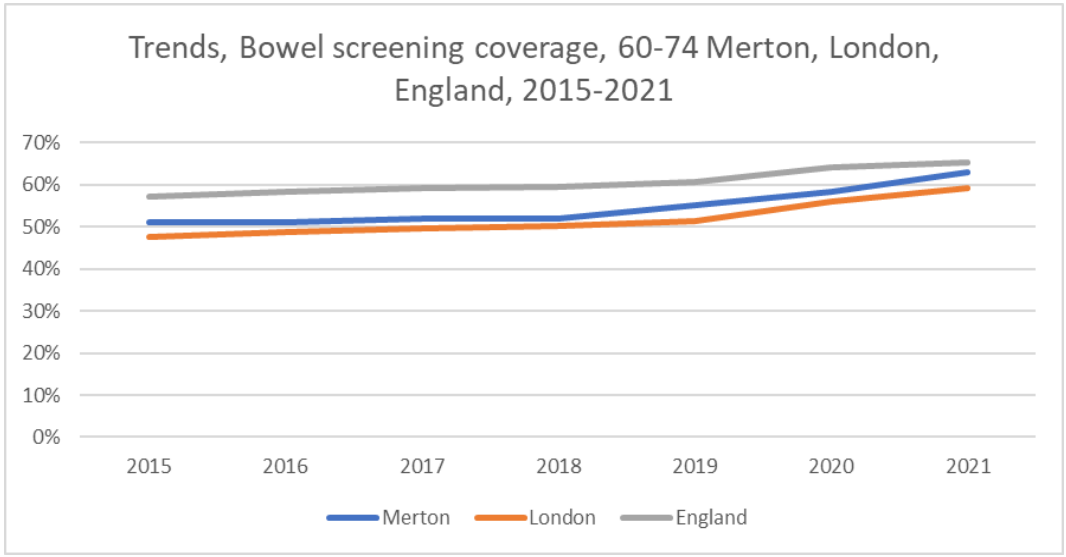
- Health Equity Audit (HEA) to inform Trust Health Promotion Work Plan and to prioritize activities for improving uptake in the 'Hardly Reach' groups. The Health Promotion Work Plan is delivered in collaboration with key Trust Partners with joint actions and deliverables to improve uptake
- PCN & GP Engagement - currently working closely with the Cancer Lead to provide tailored support to PCNs and Practices. Includes providing real-time data for Bowel screening uptake and support to increase screening uptake and raising awareness. Includes training of practice staff members on following up non-responders
- Development of Merton-specific Bowel Screening Script pack for general practice- containing key guidance and resources to support practices improve uptake, including use practice social media platforms to promote bowel screening
- In Practice Community Awareness Events- drop-in sessions provided by Health Improvement Specialist in various practices where members of the public can come and discuss bowel screening
- Working closely with Dr Zaitun, Cancer Screening Lead for SWL CCG to deliver targeted screening for the following groups across SWL CCG: A) 70 – 74 year olds, B) Patients with Learning disabilities, C) Patients with serious mental Illness, D) Patients from BME Communities
- Stakeholder Engagement – including working with RMP Cancer Alliance, the cancer clinical leads, Macmillan GP, charities including such as Cancer Research UK, Macmillan and Bowel Cancer UK and Community Links
- Community Engagement - Working with local communities to raise awareness of screening in the area and establish champions within the community and delivering awareness sessions for local charities Age UK, Mencap, ARCC, BME Forum etc.
- Bowel screening training for SWL CCG volunteer Health coaches and supporting development of community cancer champions
- Care Home Engagement- training of staff and residents on bowel screening and use of the FIT kit

# Trends in bowel screening coverage, 60-74 yr

C24d - Cancer screening coverage - bowel cancer 2021

Proportion - %

| Area | Recent Trend | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | ↑ | 5,933,716 | 65.2* | 65.1 | 65.2 |
| London region | ↑ | 636,957 | 59.3* | 59.2 | 59.4 |
| Sutton | ↑ | 19,474 | 67.8 | 67.3 | 68.4 |
| Bromley | ↑ | 33,969 | 67.6 | 67.2 | 68.0 |
| Havering | ↑ | 26,641 | 66.5 | 66.0 | 66.9 |
| Kingston upon Thames | ↑ | 15,460 | 66.2 | 65.6 | 66.8 |
| Richmond upon Thames | ↑ | 19,736 | 66.0 | 65.5 | 66.6 |
| Bexley | ↑ | 23,370 | 65.1 | 64.6 | 65.5 |
| City of London | ↑ | 749 | 63.7 | 60.9 | 66.4 |
| Merton | ↑ | 17,461 | 62.9 | 62.3 | 63.4 |
| Croydon | ↑ | 33,545 | 62.7 | 62.3 | 63.1 |
| Harrow | ↑ | 23,163 | 61.4 | 60.9 | 61.9 |
| Hillingdon | ↑ | 24,260 | 61.0 | 60.5 | 61.5 |
| Enfield | ↑ | 26,643 | 60.4 | 59.9 | 60.8 |
| Wandsworth | ↑ | 19,955 | 60.1 | 59.5 | 60.6 |
| Hounslow | ↑ | 21,411 | 59.4 | 58.9 | 59.9 |
| Barnet | ↑ | 31,336 | 59.3 | 58.9 | 59.7 |
| Redbridge | ↑ | 22,252 | 59.0 | 58.5 | 59.5 |
| Waltham Forest | ↑ | 18,056 | 59.0 | 58.4 | 59.5 |
| Ealing | ↑ | 27,601 | 58.7 | 58.3 | 59.2 |
| Greenwich | ↑ | 18,551 | 58.4 | 57.8 | 58.9 |
| Southwark | ↑ | 18,244 | 56.9 | 56.4 | 57.5 |
| Haringey | ↑ | 17,622 | 56.3 | 55.8 | 56.9 |
| Lewisham | ↑ | 18,250 | 56.2 | 55.7 | 56.7 |
| Islington | ↑ | 12,809 | 55.8 | 55.2 | 56.5 |
| Lambeth | ↑ | 18,821 | 55.7 | 55.2 | 56.3 |
| Brent | ↑ | 24,093 | 55.7 | 55.2 | 56.2 |
| Hackney | ↑ | 14,094 | 55.2 | 54.6 | 55.8 |
| Newham | ↑ | 17,507 | 55.2 | 54.6 | 55.7 |
| Barking and Dagenham | ↑ | 11,440 | 54.3 | 53.6 | 54.9 |
| Camden | ↑ | 14,108 | 54.0 | 53.4 | 54.7 |
| Tower Hamlets | ↑ | 11,139 | 53.7 | 53.0 | 54.4 |
| Hammersmith and Fulham | ↑ | 11,057 | 52.3 | 51.6 | 53.0 |
| Westminster | ↑ | 13,462 | 47.8 | 47.3 | 48.4 |
| Kensington and Chelsea | ↑ | 10,678 | 47.4 | 46.8 | 48.1 |




Bowel screening coverage has been increasing steadily across the country. The most significant increase is evident from 2019 due to the introduction of FIT kit (see previous slide). In 2021, the coverage in Merton was 63%, which was higher than London (59%) but lower than England (65%).

Acceptable std: 52%
Achievable std: 60%

**Definitions**

**Uptake:** The proportion of men and women aged 60 to 74 invited to participate in bowel cancer screening who adequately participate.

**Coverage:** The proportion of eligible men and women aged 60 to 74 invited for screening who had an adequate faecal occult blood test (FOBt) screening result in the previous 30 months.

Source: NHS Digital (Open Exeter) / Office for Health Improvement and Disparities

# Bowel screening KPI's- April 2022

Bowel cancer screening performance at St Georges meets or exceeds national minimum standards.

All bowel screening services in London cleared the patient backlogs resulting from COVID in September 2021

| | Monthly | Monthly | Monthly | Monthly | Monthly |
|---|---|---|---|---|---|
| | **Invitations Sent** | **Kits Sent** | **Kits Returned** | **Reaching SSP waiting time target (%)** | **Reaching diagnostic test waiting time target (%)** |
| Barking, Havering And Redbridge | 3,901 | 4,489 | 2,969 | 100% | 94% |
| Kings | 2,924 | 3,451 | 2,010 | 100% | 100% |
| North East London | 5,221 | 6,149 | 3,359 | 100% | 98% |
| South East London | 6,352 | 7,230 | 4,892 | 100% | 99% |
| St Georges | 7,696 | 8,867 | 6,094 | 100% | 100% |
| St Marks | 5,369 | 6,223 | 3,846 | 100% | 97% |
| University College London | 7,604 | 8,762 | 5,416 | 100% | 98% |
| West London | 6,252 | 7,301 | 4,262 | 100% | 97% |

Bowel Screening KPIs, April 2022 (Source:OBIEE/NHS Future)

# Age extension

- In April 2021, NHS England and NHS Improvement (NHSE/I) commenced a four-year plan to expand the eligibility of the NHS Bowel Screening Programme to 50-59-year olds. This age extension will meet a key commitment of the NHS Long Term Plan to modernise the programme and ensure alignment with the government commitments to improve earlier diagnosis of cancer.

- Last year (2021/22) was Year 1 of the expansion of the programme in which 56-year olds were invited for bowel cancer screening. In May 2022, London started inviting 58-year olds. The age extension to the remaining age groups will be gradually rolled out across the country in a phased approach over the next three years:
  - Year 1 (2021/22) 56-year olds
  - Year 2 (2022/23) 58-year olds
  - Year 3 (2023/24) 54-year olds
  - Year 4 (2024/25) 52 & 50-year olds

| | Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|---|
| Age | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
| 60-74 | Invite | Invite | Invite | Invite |
| 58 | | Invite | Invite | Invite |
| 56 | Invite | Invite | Invite | Invite |
| 54 | | | Invite | Invite |
| 52 | | | | Invite |
| 50 | | | | Invite |

# NHSE/I funded research to improve uptake

- *Development and Testing of Novel Behavioural Science Informed Reminder SMS Content and Video Intervention in Breast Cancer Screening* **Lead Investigator Dr Gaby Judah Lecturer in Behavioural Science Imperial College**

  **Aim** This study will test the impact on screening uptake in London, of SMS reminders informed by behavioural science, and the impact of including a video (incorporating multiple Behavioural Change Techniques) within the intervention SMS. We will also investigate the optimal timing of the messages.

- *Exploring the effectiveness and cost-effectiveness of text-message reminders and telephone patient navigation to improve the uptake of faecal immunochemical test screening among non-responders in London* **Lead Investigator Dr Rob Kerrison Lecturer Surrey University/University College London**

  **Objectives** The objectives of this study are to: 1) test the effectiveness of text-message reminders to improve participation among bowel cancer screening non-responders and, 2) test whether a combination of text-message reminders and PN is more effective and cost-effective than using text-message reminders alone.

- *Generate evidence about whether and how cancer screening programmes can be used to enhance uptake of screening for other cancers* **Lead investigator Christian von Wagner Reader in Behavioural Science and Health UCL**

  Evidence from health records in England and Scotland suggests that only around 35% of women who are eligible for all three cancer screening programmes attend for all three. In London, where screening uptake is lower than the national average, it is likely that large numbers of women take part in just one or two programmes, providing potential opportunities to increase screening uptake via cross-programme promotion activities.

  To inform potential cross-programme interventions, the study will explore: 1) the differential barriers to screening for different programmes; 2) acceptability of screening in one context being used as a 'teachable moment' to discuss other types of screening; and 3) stakeholder views on the feasibility and acceptability of cross-programme promotion activities.

# Healthier Communities and Older People Overview and Scrutiny Panel

## Date: 20th June 2022

## Subject: Merton Local Health and Care Plan

Lead officer: Mark Creelman, Executive Locality Director

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

**Recommendations:**

A. To note the refreshed local health and care plan in Merton.

### 1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. To provide an overview of the Merton Local Health and Care Plan, outlining the key priorities and our approach to collaborative working.

### 2 DETAILS

2.1. The Local Health and Care (LCHP) plan identifies health issues (through existing programmes and initiatives) which require health, social care and the voluntary and community sector to work in partnership to improve the health and wellbeing of residents, particularly addressing inequalities.

2.2. The LHCP is one element of work being undertaken by health, social care and community partners in Merton and across South West London to improve health and wellbeing. The priorities identified are focused on the areas where, over the next two years (2022-24) the greatest impact can be made by working collectively to prevent ill health, keep people well and support them to stay independent.

### 3 SUMMARY OF THE PLAN

3.1. The Health and Care Plan 2022-2024 is focused on achieving the vision ‘Working together to reduce inequalities and provide truly joined up health and care services with and for all people in Merton, so they start, live and age well in a healthy place”

3.2. In ‘Start well’ the plan aims to develop partnership projects that are focused on improving how children and young people access health and wellbeing services, improving the integration of children’s community services and a renewed focus on mental health and wellbeing.

3.3. In ‘Live Well’ the plan aims to develop partnership projects to improve how people access health and wellbeing services through exploring new and innovative approaches. For example, Health on the high street and expanding community led health initiatives. The focus is to take a renewed focus on prevention and improve access to and into primary care.

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

3.5. Across all our work we aim to:

(i) Reduce health inequalities and embed equity.

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

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

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

3.6. The LHCP will remain dynamic, ensuring emerging priorities can be incorporated as required.

3.7. The priorities in the Local health and care plan will be implemented collaboratively through the Merton Health and Care Board. The Board has strong representation from partners across the Merton system and has a strong history of collaborative working.

3.8. This plan is informed by the experience of a previous LHCP that was developed in 2018 and expired in April 2021.

3.9. The plan was developed collaboratively and is informed by:

(i) the updated Joint Strategic Needs Assessment 2021 ensuring that the plan is evidenced based and responding to the needs of residents.

(ii) Review and progress made on the previous plan objectives and progress made by the Merton Health and Care Together partnership.

(iii) Engagement with wide range of partners and stakeholders; health and care professionals, voluntary and community leaders and service users, carers and their families to ensure that the plan reflects the key health and wellbeing priorities. Engagement followed a process of reminding people what was in the original local health and care plan 2019-2021 including what had been delivered; reviewing the impact of Covid-19, and refreshing the future direction for Merton based upon collective feedback and the data.

(iv) Existing strategies and policy directives, such as the national white paper on integration, the Health and Wellbeing Strategy in Merton and Merton 2030 ambitions.

## 4 ALTERNATIVE OPTIONS

Not applicable at this time.

## 5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. In line with point in 3.9 (iii)

## 6 TIMETABLE

6.1. The plan was endorsed by the Health and Wellbeing Board at their meeting in March 2022. The plan is now being implemented through the Merton Health and Care Together Partnership overseen by Merton Place Committee.

## 7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1.

## 8 LEGAL AND STATUTORY IMPLICATIONS

8.1.

## 9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1.

## 10 CRIME AND DISORDER IMPLICATIONS

10.1.

## 11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1.

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

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## 13 BACKGROUND PAPERS

13.1. Merton Local Health and Care Plan full document attached.

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Merton
Health and Care
Together



# Merton Local Health and Care Plan

## 2022-2024

# Contents

Merton Health and Care Together



# 1) Introduction

# Introduction


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

Merton Health and Care Together



# 2) Vision for health and care in Merton

# Our updated vision

Merton Health and Care Together

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

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




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


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


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

Merton Health and Care Together



# 3) Merton in context

# Our community in Merton

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

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

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

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

# Our challenges

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

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

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

# Our challenges

Merton Health and Care Together


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




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

# Our challenges


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



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

Merton Health and Care Together



# 4) Developing our plan with our local people and partners

# Approach to refresh our plan

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

Merton Health and Care Together



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

# How was the original local health and care plan developed?

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

# What has been delivered?

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

# Start Well – you said, we did

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

# Live Well – you said, we did

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

# Live Well – you said, we did cont.

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

# Age Well – you said, we did

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

Merton Health and Care Together



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

# Listening to our community and understanding our needs together

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

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

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

# The Merton Story 2021

Merton Health and Care Together

## Merton Story 2021 – at a glance

### Start Well

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

**Staying safe, enjoying & achieving**

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

**Being healthy**

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

### Age Well

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

**Frailty & dementia**

- Deconditioning
- ↓ Dementia diag.
- ↑ Falls

**Disability**

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

**Cancer**

*Delays in:

- Diagnosis
- Treatment
- Screening

### Live Well

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

**Obesity**

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

**Smoking**

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

**Mental health**

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

**Alcohol / drugs**

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

**Sexual health**

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

Please note: * refers to likely based on national data

### Merton as a Healthy Place

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

**Assets**

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

**! Challenges**

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

# General feedback themes

Some consistent themes were found across all feedback:

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

# General feedback themes (cont.)

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

# Impact of Covid

The following negative impacts of Covid were identified:

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



However there have also been reported positives:

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

Merton Health and Care Together

# *Refresh* - what do we want to do next?

# Developing the plan

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

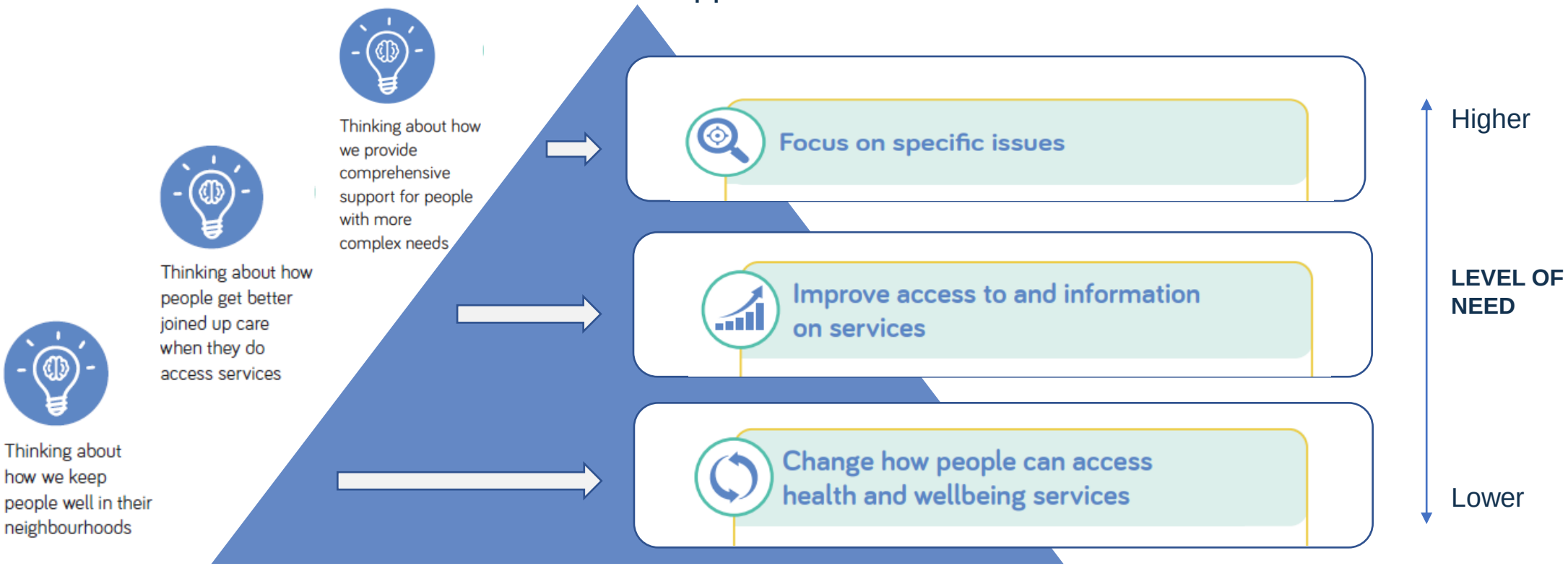
Merton Health and Care Together



# 6) Our refreshed plan – 2022-2024

# Principles of the plan

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



# For Start Well we will:

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

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

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

# For Live Well we will:

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

# For Age Well we will:

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

# What will help make our plan happen?

## Enablers/ other developments

### 1) Primary Care Network (PCN) Development

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

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

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

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

### 3) Estates

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

# What will help make our plan happen?

## Enablers/ other developments

### 3) Merton as a healthy place & developing social anchors

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

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



### 4) Digital

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

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

### 5) Workforce

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

# Start Well - programme of work

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

# Live Well - programme of work

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

# Age Well - programme of work

Merton Health and Care

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

# How will we measure success?

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

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

Merton Health and Care Together



# Ongoing engagement and delivery

# A new approach to engagement

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

# Delivery - programme management framework and measuring success

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

Merton Health and Care Together



# Appendices

Merton Health and Care Together



# Appendix 1 – feedback by life course area

# Start Well – feedback summary

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

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

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

# Live Well – feedback summary

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

# Age Well – feedback summary

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

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# Healthier Communities and Older People Overview and Scrutiny Panel

## Date: 20 June 2022

## Subject: Joint Strategic Needs Assessment (JSNA) plans

Lead officer: Dagmar Zeuner, Director of Public Health

Lead member: Cllr Peter McCabe, Cabinet Member for Health and Social Care

Contact officer: Yannish Naik, Consultant in Public Health

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**Recommendations:**

A. That the scrutiny panel notes the purpose and scope of the Joint Strategic Needs Assessment, and the changes to the process for developing the JSNA in 2022

B. That the panel reviews the key issues that have been identified for the Merton Story 2022, using their local experience and taking into consideration the methodology applied to focus on a small number of strategic issues

C. That the panel provides any comments on future developments around the JSNA, to support the steering group in planning for 2023.

### 1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of this report is to present current plans around Merton's Joint Strategic Needs Assessment to the scrutiny committee. The report provides an opportunity for the scrutiny committee to review the key issues identified and feed into longer term plans for the JSNA.

1.2. The report sets out the remit of the JSNA, considers the current strengths and challenges of the JSNA, then discusses some of the changes made for 2022. These include

1.2.1 Being more collaborative in developing the JSNA (including through the steering group which brings together partners, and the identification of key stakeholders for each chapter)

1.2.2 Aiming to separate the Merton Story into separate web pages, following a standard structure to ensure that these are more accessible

1.2.3 Focusing on identification of a smaller number of key issues for the borough to ensure the JSNA serves its purpose to be strategic and remains manageable.

1.3. The report outlines some longer-term areas to explore for the JSNA in the future.

### 2 DETAILS

2.1. The Joint Strategic Needs Assessment (JSNA) is a statutory assessment of population health and wellbeing needs for the Health and Wellbeing Board. In Merton its main annual publication is named "The Merton Story".

2.2. The JSNA is more than the Merton Story. It includes a number of other products such as ward health profiles and in-depth Health Needs Assessments. These are issued throughout the year where relevant new data is published and to support redesign and commissioning of specific services.

2.3. The Merton Story has consisted of two sections:

2.3.1 The main document, in thematic sections, each with a number of key messages

2.3.2 A 2-side infographic with the main headings, providing an at a glance summary.

2.4. Since its original idea, the Merton Story main document has grown to include a range of health topics.

2.5. 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, as previously agreed with the Health and Wellbeing Board.

2.6. The Merton Story also does not include recommendations around how health and care needs should be met as this is picked up through existing strategies and governance arrangements. That is, the Merton Story describes the current state of population health but does not prescribe solutions.

2.7. Main partners of the JSNA include the local authority, the NHS, and the voluntary sector. As of July 2022 the JSNA will need to cater for the new local partnership system which will include the local borough committee, MHCT board, and HWBB.

2.8. The current Merton Story covers a wide range of topics in detail, including health inequalities and local assets. Some strengths and challenges of the Merton Story 2021 are provided below.

2.8.1 <u>Strengths:</u>

(i) Risk factors for health conditions are identified and presented well throughout.

(ii) We use a range of data sources and tell the Merton story well.

(iii) We have received informal positive feedback about usefulness from council, VCS and NHS.

2.8.2 <u>Challenges:</u>

(i) The single large document is not very accessible for all stakeholders; it is hard to update this document every year and the chapters are quite different.

(ii) Communication with users and stakeholders needs to be stronger for frequent feedback, and to ensure data collated is being used.

(iii) Identifying the scope of the Merton Story clearly to manage expectations, resource requirement, and length of time for completion.

2.9. The following changes have been made for the Merton Story 2022:

2.9.1 Improving collaboration

(i) A steering group has been set up with representation across several council departments, health partners and the VCSE (see appendix 1).

(ii) Each chapter lead has been asked to identify key stakeholders to work with them on the chapters.

(iii) Ensuring key colleagues such as the members of Merton Council's analysts network are aware of the work undertaken for the JSNA.

2.9.2 Content and format

(i) Identifying a number of strategic key issues for the Merton Story 2022, as outlined in the table below. The key issues will be structured in several categories (Population, COVID Pandemic, Start Well, Live Well, Age Well and Healthy Place) to align with the Health and Wellbeing Strategy and the local Health and Care Plan. Methodology to identify key issues:

a) We reviewed the Public Health Outcomes Framework (a robust and comprehensive indicator set outlining population health at a local authority level, compiled by the Office for Health Improvement and Disparities), and the Merton Story 2021 to identify key issues.

b) These were considered by our steering group and chapter leads to further develop the list of key issues drawing on local knowledge. They are also being shared with DMTs and this scrutiny committee for review to ensure they are comprehensive.

c) The steering group will oversee the final agreement on key issues.

Table 1 – key issues for Merton Story 2022 for review

| Chapter Topic | Key issues |
|---|---|
| **Merton Population** | East / West population differences & characteristics |
| | Migration, population density and population turnover including life expectancy |
| | Inclusion and inequalities (ethnicity, age & sex LGBTQ+, socioeconomic status) |
| **COVID Pandemic** | The Pandemic in Merton |
| | Risk of severe disease – including vaccination |
| | Wider impacts – age specific covered in Start Well, Live Well and Age Well, and some specifics to cover e.g. long covid, therapeutics. |
| | Disproportionate impact on certain communities |
| **Start Well** | Mental health |
| | Healthy weight |
| | Childhood adversity / safeguarding (including poverty, offending, substance misuse) |
| | Maternal health / early years – including low birth weight |

| | |
|---|---|
| | Screening and immunisations |
| | Education including school readiness & Special Educational Needs and Disabilities |
| **Live Well** | Smoking and respiratory health |
| | Diabetes and other long term conditions (including cardiovascular disease) |
| | Obesity (including food / physical activity) |
| | Sexual health |
| | Adult mental health including suicide and self harm |
| | Substance misuse and alcohol - Broad overview, awaiting needs assessment |
| **Age Well** | Dementia |
| | Frailty and falls |
| | Loneliness and isolation (including digital exclusion) |
| | Screening and immunisations including cancer screening, Abdominal Aortic Aneurysm screening, flu |
| | Disabilities |
| | Carers |
| **Merton as a Healthy Place** | Financial pressures and cost of living, including employment of particular groups |
| | Housing |
| | Food |
| | Greenspace and climate change |
| | Community cohesion and crime |
| | Transport and air quality including injuries |

(ii) The Merton Story large document will be broken down into a web page per key issue, with a standard format to ensure it is accessible.

(iii) Taking into account the recent changes to the ward boundaries the East-West boundary for analysis has been redrawn. Lower Morden will be in West Merton, Abbey will remain in East Merton and Wandle will be in West Merton as it is mainly made up of wards previously in West Merton.

2.9.3 Data

(i) We are using automated data processes to support the analysis of the Merton Story, including an automated analysis of the Public Health Outcomes Framework data for Merton (see appendix 2).

(ii) The analysis for the Merton Story will be broad, identifying issues where more detailed analysis is required. For example, we have begun a needs assessment around substance misuse and alcohol.

(iii) Service data will only be used selectively where it provides a good proxy for population health.

2.10. There are several areas that we are keen to explore in the future

2.10.1 Demonstrating the use of evidence from the JSNA in decision making including by key governance mechanisms.

2.10.2 Strengthening the incorporation of resident voice and assets in a more systematic way.

2.10.3 Ensuring that we integrate the JSNA with other work undertaken around data including working across the council, linking with developments in the NHS such as population health management.

2.10.4 Building on existing analysis to include predictive modelling.

2.11. All options for future development will depend on securing capacity and capability to deliver the above.

## 3 ALTERNATIVE OPTIONS

3.1. Do nothing: This would leave us without important information and fail in delivering a statutory duty.

3.2. Retain the status quo: While we could attempt to retain the format and breadth of topics contained within the Merton Story 2021, it does not seem feasible and this would not address some of the points that our proposals are seeking to address in terms of making the JSNA more accessible.

## 4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. A steering group for this work has been established, bringing together key stakeholders including from the council, the NHS and the VCS (see appendix 1). This steering group is meeting monthly. The Merton Story 2022 will be presented to the Health and Wellbeing Board in September.

## 5 TIMETABLE

| **Merton Story/JSNA 2022 Actions** | **Timeline – By When to be completed** |
|---|---|
| Identify: key stakeholders, sub chapter leads, initial identification of key issues | 30th April 2022 (completed) |
| 1st Working Group meeting | Week beginning 18th April 2022 |
| 2nd Working Group meeting: update key issues to be included | Week ending May 2022 |
| Scrutiny meeting | June 2022 |
| To have updated chapters and sub sections & sign off by chapter leads & their managers for each section as a 1st draft | 30th June 2022 |
| To have 2nd draft and key messages signed off by chapter leads and their managers | 17th July 2022 |

| | |
|---|---|
| Sign off of key messages by PH SLT | 31st July 2022 |
| Analyst network meeting | Week beginning 1st August 2022 |
| Present/Circulate to HWBB, Other DMTs | September 2022 |
| Merton story publication | October 2022 |

## 6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. The JSNA will be delivered within existing capacity.

## 7 LEGAL AND STATUTORY IMPLICATIONS

7.1. The JSNA is a statutory duty as outlined above.

## 8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. The JSNA will consider equity throughout, including in the choice of key issues and in the structure of each topic.

## 9 CRIME AND DISORDER IMPLICATIONS

9.1. N/A

## 10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. Regular reporting on project progress is taking place through the C&H recovery and reset dashboard.

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

**Appendix 1 – JSNA 2022 Steering Group Members**

| Steering Group Member | Position |
|---|---|
| **Yannish Naik** | Public Health Consultant |
| **Clarissa Larsen** | Health and Wellbeing Board Partnership Manager |
| **Keith Burns** | Head of Commissioning and Market Development |
| **Shamal Vincent** | Business Intelligence Manager |
| **Catherine Dunn** | Policy, Strategy & Partnerships Officer |
| **Farah Ikram** | CSF Head of Policy, Performance & Partnerships |
| **Simon Shimmens** | VCS Representative |
| **Dave Curtis** | HealthWatch Representative |
| **Kate Symons** | Clinical Commissioning Group Representative |
| **Gemma Dawson** | Merton Health and Care Together Representative |
| **Ann Maria Clarke** | Planner, Environment and Regeneration |

**Appendix 2 (attached): Public Health Outcomes Framework for Merton**

## 12 BACKGROUND PAPERS

The Merton Story 2021

The Merton Story Summary 2021

Merton Story report to Health and Wellbeing Board, 2020

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# Merton Public Health Outcomes Framework Indicators

| Trend Icon | Definition |
|---|---|
| ⚪ | Cannot be calculated |
| ↓ | Decreasing and getting better |
| ↓ | Decreasing and getting worse |
| ↓ | Decreasing/Lower |
| ↑ | Increasing and getting better |
| ↑ | Increasing and getting worse |
| ↑ | Increasing/Higher |
| → | No significant change/Similar |

*Overall trend based on previous 5 data points.

| Background | Definition |
|---|---|
| | Better |
| | Cannot be calculated |
| | Higher |
| | Lower |
| | Similar |
| | Worse |

*Merton value background colour based on comparison to previous year.

**Summary Information:**
Source: Office for Health Improvement and Disparities.

The Overarching Indicators present outcomes for life expectancy and healthy life expectancy.
Accompanying indicators to the overarching indicators measure contributors to healthy life expectancy in the population, this includes:

- Wider Determinants of Health
- Health Improvement
- Health Protection
- Healthcare and Premature Mortality

**Please Note:**
**Merton value background colour** based on comparison to previous year Merton value.
**Comparison background colour** based on Merton comparison to London, or England.

- **Cannot be calculated:** No Merton value or confidence interval to compare to.
- **Similar to Merton:** London or England value and confidence intervals falls within the Merton value confidence intervals.
- **Merton is Better:** London or England value and confidence intervals do not fall within the Merton value confidence interval. In this case, Merton is performing better than London or England.
- **Merton is Worse:** London or England value and confidence intervals do not fall within the Merton value confidence interval. In this case, Merton is performing worse than London or England.
- **Merton is Possibly Better/Worse**: London or England value and confidence intervals overlap with Merton value confidence intervals.

# Overarching Indicators

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A01a - Healthy life expectancy at 65 | 65 | Female | 2018 - 20 | Years | 13.60 | 10.60 | 16.70 | | 11.20 | Merton is Possibly Better | 11.30 | Merton is Similar |
| A01a - Healthy life expectancy at 65 | 65 | Male | 2018 - 20 | Years | 9.20 | 6.40 | 12.00 | | 10.30 | Merton is Similar | 10.50 | Merton is Similar |
| A01a - Healthy life expectancy at birth | All ages | Female | 2018 - 20 | Years | 67.10 | 63.30 | 70.80 | | 65.00 | Merton is Similar | 63.90 | Merton is Similar |
| A01a - Healthy life expectancy at birth | All ages | Male | 2018 - 20 | Years | 66.60 | 63.60 | 69.70 | | 63.80 | Merton is Possibly Better | 63.10 | Merton is Better |
| A01b - Life expectancy at 65 | 65 | Female | 2018 - 20 | Years | 21.60 | 21.20 | 22.00 | | 22.00 | Merton is Possibly Worse | 21.10 | Merton is Possibly Better |
| A01b - Life expectancy at 65 | 65 | Female | 2020 | Years | 21.00 | 20.40 | 21.60 | | 21.30 | Merton is Similar | 20.70 | Merton is Similar |
| A01b - Life expectancy at 65 | 65 | Male | 2018 - 20 | Years | 18.80 | 18.40 | 19.20 | | 19.20 | Merton is Possibly Worse | 18.70 | Merton is Similar |
| A01b - Life expectancy at 65 | 65 | Male | 2020 | Years | 17.60 | 17.00 | 18.30 | | 18.30 | Merton is Possibly Worse | 18.10 | Merton is Similar |
| A01b - Life expectancy at birth | All ages | Female | 2018 - 20 | Years | 84.10 | 83.70 | 84.60 | | 84.30 | Merton is Similar | 83.10 | Merton is Better |
| A01b - Life expectancy at birth | All ages | Female | 2020 | Years | 83.50 | 82.80 | 84.20 | | 83.50 | Merton is Similar | 82.60 | Merton is Better |
| A01b - Life expectancy at birth | All ages | Male | 2018 - 20 | Years | 80.30 | 79.80 | 80.80 | | 80.30 | Merton is Similar | 79.40 | Merton is Better |
| A01b - Life expectancy at birth | All ages | Male | 2020 | Years | 78.60 | 77.80 | 79.50 | | 79.00 | Merton is Similar | 78.70 | Merton is Similar |
| A01c - Disability-free life expectancy at 65 | 65 | Female | 2018 - 20 | Years | 13.00 | 9.90 | 16.20 | | 10.20 | Merton is Possibly Better | 9.90 | Merton is Possibly Better |

# Overarching Indicators

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A01c - Disability-free life expectancy at 65 | 65 | Male | 2018 - 20 | Years | 9.50 | 6.80 | 12.10 | | 10.30 | Merton is Similar | 9.80 | Merton is Similar |
| A01c - Disability-free life expectancy at birth | All ages | Female | 2018 - 20 | Years | 65.80 | 61.90 | 69.70 | | 63.30 | Merton is Similar | 60.90 | Merton is Better |
| A01c - Disability-free life expectancy at birth | All ages | Male | 2018 - 20 | Years | 66.90 | 63.90 | 69.80 | | 64.40 | Merton is Possibly Better | 62.40 | Merton is Better |
| A02a - Inequality in life expectancy at 65 | 65 | Female | 2018 - 20 | Years | 3.80 | 2.40 | 5.20 | | 3.60 | Merton is Similar | 4.80 | Merton is Similar |
| A02a - Inequality in life expectancy at 65 | 65 | Male | 2018 - 20 | Years | 5.00 | 3.70 | 6.40 | | 4.80 | Merton is Similar | 5.20 | Merton is Similar |
| A02a - Inequality in life expectancy at birth | All ages | Female | 2018 - 20 | Years | 5.00 | 3.30 | 6.60 | | 5.40 | Merton is Similar | 7.90 | Merton is Better |
| A02a - Inequality in life expectancy at birth | All ages | Male | 2018 - 20 | Years | 7.70 | 6.00 | 9.40 | | 7.50 | Merton is Similar | 9.70 | Merton is Better |
| A02b - Inequality in healthy life expectancy at birth ENGLAND | All ages | Female | 2017 - 19 | Years | | | | | | Cannot be calculated | 19.30 | Cannot be calculated |
| A02b - Inequality in healthy life expectancy at birth ENGLAND | All ages | Male | 2017 - 19 | Years | | | | | | Cannot be calculated | 19.00 | Cannot be calculated |
| A02c - Inequality in healthy life expectancy at birth LA | All ages | Female | 2009 - 13 | Years | 13.60 | 11.60 | 15.60 | | | Cannot be calculated | | Cannot be calculated |
| A02c - Inequality in healthy life expectancy at birth LA | All ages | Male | 2009 - 13 | Years | 13.60 | 11.40 | 15.80 | | | Cannot be calculated | | Cannot be calculated |

# Wider Determinants of Health

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.01i - Children in low income families (all dependent children under 20) | 0-19 yrs | Persons | 2016 | % | 13.40 | 13.10 | 13.80 | ↓ | 19.30 | Merton is Better | 17.00 | Merton is Better |
| 1.10 - Killed and seriously injured (KSI) casualties on England's roads (historic data) | All ages | Persons | 2016 - 18 | per 100,000 | 29.40 | 25.30 | 34.00 | ○ | 39.50 | Merton is Better | 42.60 | Merton is Better |
| B01b - Children in absolute low income families (under 16s) | <16 yrs | Persons | 2019/20 | % | 13.20 | 12.90 | 13.60 | ↑ | 14.60 | Merton is Better | 15.60 | Merton is Better |
| B01b - Children in relative low income families (under 16s) | <16 yrs | Persons | 2019/20 | % | 16.30 | 16.00 | 16.70 | ↑ | 18.30 | Merton is Better | 19.10 | Merton is Better |
| B02a - School readiness: percentage of children achieving a good level of development at the end of Reception | 5 yrs | Persons | 2018/19 | % | 75.50 | 73.70 | 77.20 | ↑ | 74.10 | Merton is Similar | 71.80 | Merton is Better |
| B02a - School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception | 5 yrs | Persons | 2018/19 | % | 62.30 | 56.80 | 67.50 | → | 64.10 | Merton is Similar | 56.50 | Merton is Possibly Better |
| B02b - School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1 | 6 yrs | Persons | 2018/19 | % | 83.40 | 81.90 | 84.90 | ↑ | 84.20 | Merton is Similar | 81.80 | Merton is Possibly Better |
| B02b - School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1 | 6 yrs | Persons | 2018/19 | % | 72.40 | 67.60 | 76.70 | → | 76.20 | Merton is Possibly Worse | 70.10 | Merton is Similar |
| B02c - School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception | 5 yrs | Persons | 2018/19 | % | 86.40 | 85.00 | 87.80 | → | 82.60 | Merton is Better | 82.20 | Merton is Better |
| B02d - School readiness: percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception | 5 yrs | Persons | 2018/19 | % | 76.70 | 74.90 | 78.30 | ↑ | 74.80 | Merton is Possibly Better | 72.60 | Merton is Better |
| B03 - Pupil absence | 5-15 yrs | Persons | 2018/19 | % | 4.18 | 3.93 | 4.44 | → | 4.47 | Merton is Possibly Better | 4.73 | Merton is Better |
| B04 - First time entrants to the youth justice system | 10-17 yrs | Persons | 2020 | per 100,000 | 160.40 | 107.70 | 229.80 | → | 222.30 | Merton is Possibly Better | 169.20 | Merton is Similar |
| B05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known | 16-17 yrs | Persons | 2020 | % | 2.50 | 2.20 | 3.10 | → | 4.00 | Merton is Better | 5.50 | Merton is Better |
| B06a - Adults with a learning disability who live in stable and appropriate accommodation | 18-64 yrs | Persons | 2020/21 | % | 75.10 | 70.70 | 79.10 | → | 77.70 | Merton is Similar | 78.30 | Merton is Similar |

# Wider Determinants of Health

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B06b - Adults in contact with secondary mental health services who live in stable and appropriate accommodation | 18-69 yrs | Persons | 2020/21 | % | 86.00 | 82.80 | 88.70 | ○ | 61.00 | Merton is Better | 58.00 | Merton is Better |
| B07 - People in prison who have a mental illness or a significant mental illness | 18+ yrs | Persons | 2018/19 | % | | | | ○ | | Cannot be calculated | 7.35 | Cannot be calculated |
| B08a - Gap in the employment rate between those with a long-term health condition and the overall employment rate | 16-64 yrs | Persons | 2019/20 | Percentage points | 8.60 | 4.90 | 12.20 | ○ | 11.50 | Merton is Possibly Better | 10.60 | Merton is Similar |
| B08b - Gap in the employment rate between those with a learning disability and the overall employment rate | 18-64 yrs | Persons | 2019/20 | Percentage points | 77.80 | 73.80 | 81.80 | ○ | 68.10 | Merton is Worse | 70.60 | Merton is Worse |
| B08c - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate | 18-69 yrs | Persons | 2019/20 | Percentage points | 67.00 | 62.30 | 71.70 | ○ | 68.10 | Merton is Similar | 67.20 | Merton is Similar |
| B08d - Percentage of people in employment | 16-64 yrs | Persons | 2020/21 | % | 78.70 | 74.30 | 83.10 | → | 74.50 | Merton is Possibly Better | 75.10 | Merton is Similar |
| B09a - Sickness absence - the percentage of employees who had at least one day off in the previous week | 16+ yrs | Persons | 2018 - 20 | % | 1.80 | 1.00 | 3.30 | ○ | 1.90 | Merton is Similar | 1.90 | Merton is Similar |
| B09b - Sickness absence - the percentage of working days lost due to sickness absence | 16+ yrs | Persons | 2018 - 20 | % | 0.80 | 0.50 | 1.50 | ○ | 0.90 | Merton is Similar | 1.00 | Merton is Similar |
| B10 - Killed and seriously injured (KSI) casualties on England's roads | All ages | Persons | 2020 | per billion vehicle miles | 190.60 | 148.30 | 241.20 | ○ | 165.80 | Merton is Simlar | 86.10 | Merton is Worse |
| B11 - Domestic abuse-related incidents and crimes | 16+ yrs | Persons | 2020/21 | per 1,000 | 35.20 | | | ○ | 35.10 | Cannot be calculated | 30.30 | Cannot be calculated |
| B12a - Violent crime - hospital admissions for violence (including sexual violence) | All ages | Persons | 2018/19 - 20/21 | per 100,000 | 48.40 | 43.00 | 54.40 | ○ | 44.30 | Merton is Simlar | 41.90 | Merton is Worse |
| B12b - Violent crime - violence offences per 1,000 population | All ages | Persons | 2020/21 | per 1,000 | 20.40 | 19.70 | 21.00 | ↑ | 24.30 | Merton is Lower | 29.50 | Merton is Lower |
| B12c - Violent crime - sexual offences per 1,000 population | All ages | Persons | 2020/21 | per 1,000 | 1.30 | 1.10 | 1.40 | → | 1.80 | Merton is Lower | 2.30 | Merton is Lower |
| B13a - Re-offending levels - percentage of offenders who re-offend | All ages | Persons | 2018/19 | % | 24.90 | | | ○ | 27.40 | Cannot be calculated | 27.90 | Cannot be calculated |
| B13b - Re-offending levels - average number of re-offences per re-offender | All ages | Persons | 2018/19 | - | 2.90 | | | ○ | 3.42 | Cannot be calculated | 4.00 | Cannot be calculated |

# Wider Determinants of Health

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B13c - First time offenders | 10+ yrs | Persons | 2020 | per 100,000 | 166.00 | 148.00 | 187.00 | ↓ | 184.00 | Merton is Possibly Lower | 160.00 | Merton is Similar |
| B14a - The rate of complaints about noise | All ages | Persons | 2019/20 | per 1,000 | 10.50 | 10.00 | 10.90 | ○ | 16.80 | Merton is Better | 6.40 | Merton is Worse |
| B14b - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime | All ages | Persons | 2016 | % | 9.50 | | | ○ | 12.10 | Cannot be calculated | 5.50 | Cannot be calculated |
| B14c - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time | All ages | Persons | 2016 | % | 12.30 | | | ○ | 15.90 | Cannot be calculated | 8.50 | Cannot be calculated |
| B15a - Homelessness - households owed a duty under the Homelessness Reduction Act | Not applicable | Not applicable | 2020/21 | per 1,000 | 7.00 | 6.40 | 7.60 | ○ | 14.50 | Merton is Better | 11.30 | Merton is Better |
| B15c - Homelessness - households in temporary accommodation | Not applicable | Not applicable | 2020/21 | per 1,000 | 2.50 | 2.20 | 2.90 | ○ | 17.00 | Merton is Better | 4.00 | Merton is Better |
| B16 - Utilisation of outdoor space for exercise/health reasons | 16+ yrs | Persons | Mar 2015 - Feb 2016 | % | 16.50 | 8.10 | 24.80 | ○ | 18.00 | Merton is Similar | 17.90 | Merton is Similar |
| B17 - Fuel poverty (low income, high cost methodology) | Not applicable | Not applicable | 2018 | % | 11.20 | | | → | 11.40 | Cannot be calculated | 10.30 | Cannot be calculated |
| B17 - Fuel poverty (low income, low energy efficiency methodology) | Not applicable | Not applicable | 2019 | % | 14.70 | | | ○ | 15.20 | Cannot be calculated | 13.40 | Cannot be calculated |
| B18a - Social Isolation: percentage of adult social care users who have as much social contact as they would like | 18+ yrs | Persons | 2019/20 | % | 40.60 | 35.50 | 45.70 | ○ | 42.90 | Merton is Similar | 45.90 | Merton is Possibly Worse |
| B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like | 18+ yrs | Persons | 2018/19 | % | 24.90 | 20.50 | 29.30 | ○ | 33.20 | Merton is Worse | 32.50 | Merton is Worse |
| B19 - Loneliness: Percentage of adults who feel lonely often / always or some of the time | 16+ yrs | Persons | 2019/20 | % | 24.92 | 20.65 | 29.83 | ○ | 23.69 | Merton is Simlar | 22.26 | Merton is Simlar |

# Health Improvement

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method | 6-8 weeks | Persons | 2020/21 | % | 78.20 | 76.50 | 79.70 | ○ | | Cannot be calculated | 47.60 | Merton is Better |
| C01 - Total prescribed LARC excluding injections rate / 1,000 | All ages | Female | 2020 | per 1,000 | 29.90 | 28.30 | 31.50 | ↑ | 27.00 | Merton is Higher | 34.60 | Merton is Lower |
| C02a - Under 18s conception rate / 1,000 | <18 yrs | Female | 2020 | per 1,000 | 7.10 | 4.40 | 10.70 | ↓ | 9.80 | Merton is Similar | 13.00 | Merton is Better |
| C02b - Under 16s conception rate / 1,000 | <16 yrs | Female | 2020 | per 1,000 | | | | ○ | 1.40 | Cannot be calculated | 2.00 | Cannot be calculated |
| C03a - Obesity in early pregnancy | Not applicable | Female | 2018/19 | % | 15.60 | 14.10 | 17.10 | ○ | 17.80 | Merton is Better | 22.10 | Merton is Better |
| C03b - Drinking in early pregnancy | Not applicable | Female | 2018/19 | % | | | | ○ | | Cannot be calculated | 4.10 | Cannot be calculated |
| C03c - Smoking in early pregnancy | Not applicable | Female | 2018/19 | % | 5.70 | 4.90 | 6.50 | ○ | 6.00 | Merton is Similar | 12.80 | Merton is Better |
| C04 - Low birth weight of term babies | >=37 weeks gestational age at birth | Persons | 2020 | % | 3.29 | 2.67 | 4.06 | → | 3.29 | Merton is Similar | 2.86 | Merton is Simlar |
| C05a - Baby's first feed breastmilk | Newborn | Persons | 2018/19 | % | 83.80 | 80.30 | 87.30 | ○ | 76.30 | Merton is Better | 67.40 | Merton is Better |
| C06 - Smoking status at time of delivery | All ages | Female | 2020/21 | % | 4.80 | 4.10 | 5.70 | → | 4.60 | Merton is Simlar | 9.60 | Merton is Better |
| C07 - Proportion of New Birth Visits (NBVs) completed within 14 days | <14 days | Persons | 2020/21 | % | 95.90 | 95.10 | 96.60 | ○ | 94.30 | Merton is Better | 88.00 | Merton is Better |
| C08a - Child development: percentage of children achieving a good level of development at 2-2½ years | 2-2.5 yrs | Persons | 2020/21 | % | 85.00 | 83.20 | 86.60 | ○ | 79.60 | Merton is Better | 82.90 | Merton is Better |
| C08b - Child development: percentage of children achieving the expected level in communication skills at 2-2½ years | 2-2.5 yrs | Persons | 2020/21 | % | 90.60 | 89.10 | 91.90 | ○ | 84.80 | Merton is Better | 86.80 | Merton is Better |
| C08c - Child development: percentage of children achieving the expected level in personal-social skills at 2-2½ years | 2-2.5 yrs | Persons | 2020/21 | % | 94.10 | 92.80 | 95.10 | ○ | 91.50 | Merton is Better | 90.20 | Merton is Better |
| C09a - Reception: Prevalence of overweight (including obesity) | 4-5 yrs | Persons | 2019/20 | % | 18.40 | 16.80 | 20.00 | → | 21.60 | Merton is Better | 23.00 | Merton is Better |
| C09b - Year 6: Prevalence of overweight (including obesity) | 10-11 yrs | Persons | 2019/20 | % | 35.10 | 32.90 | 37.10 | → | 38.20 | Merton is Better | 35.20 | Merton is Similar |
| C10 - Percentage of physically active children and young people | 5-16 yrs | Persons | 2020/21 | % | | | | ○ | 44.40 | Cannot be calculated | 44.60 | Cannot be calculated |

# Health Improvement

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) | <15 yrs | Persons | 2020/21 | per 10,000 | 44.80 | 38.80 | 52.00 | ↓ | 55.10 | Merton is Better | 75.70 | Merton is Better |
| C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) | 0-4 yrs | Persons | 2020/21 | per 10,000 | 55.50 | 43.40 | 68.30 | ↓ | 75.90 | Merton is Better | 108.70 | Merton is Better |
| C11b - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years) | 15-24 yrs | Persons | 2020/21 | per 10,000 | 85.30 | 73.00 | 99.10 | ↓ | 80.70 | Merton is Similar | 112.40 | Merton is Better |
| C12 - Percentage of looked after children whose emotional wellbeing is a cause for concern | 5-16 yrs | Persons | 2020/21 | % | 43.80 | 32.30 | 55.90 | → | 30.50 | Merton is Worse | 36.80 | Merton is Similar |
| C13a - Smoking prevalence age 15 years - regular smokers (SDD survey) | 15 yrs | Persons | 2018 | % | | | | ○ | | Cannot be calculated | 5.00 | Cannot be calculated |
| C13b - Smoking prevalence age 15 years - occasional smokers (SDD survey) | 15 yrs | Persons | 2018 | % | | | | ○ | | Cannot be calculated | 6.00 | Cannot be calculated |
| C14b - Emergency Hospital Admissions for Intentional Self-Harm | All ages | Persons | 2020/21 | per 100,000 | 91.00 | 78.10 | 105.40 | → | 82.70 | Merton is Similar | 181.20 | Merton is Better |
| C15 - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) | 16+ yrs | Persons | 2019/20 | % | 53.30 | 48.90 | 57.60 | ○ | 55.80 | Merton is Similar | 55.40 | Merton is Similar |
| C16 - Percentage of adults (aged 18+) classified as overweight or obese | 18+ yrs | Persons | 2020/21 | % | 50.40 | 45.50 | 55.30 | ○ | 56.00 | Merton is Possibly Better | 63.50 | Merton is Better |
| C17a - Percentage of physically active adults | 19+ yrs | Persons | 2020/21 | % | 67.30 | 63.00 | 71.20 | ○ | 64.90 | Merton is Similar | 65.90 | Merton is Similar |
| C17b - Percentage of physically inactive adults | 19+ yrs | Persons | 2020/21 | % | 20.20 | 16.70 | 23.90 | ○ | 24.30 | Merton is Possibly Better | 23.40 | Merton is Similar |
| C18 - Smoking Prevalence in adults (18+) - current smokers (APS) | 18+ yrs | Persons | 2019 | % | 13.50 | 9.70 | 17.40 | ○ | 12.90 | Merton is Similar | 13.90 | Merton is Similar |
| C18 - Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition) | 18+ yrs | Persons | 2020 | % | 13.50 | 7.30 | 19.70 | ○ | 11.10 | Merton is Similar | 12.10 | Merton is Similar |
| C19a - Successful completion of drug treatment - opiate users | 18+ yrs | Persons | 2020 | % | 11.00 | 7.60 | 15.80 | → | 5.50 | Merton is Better | 4.70 | Merton is Better |
| C19b - Successful completion of drug treatment - non-opiate users | 18+ yrs | Persons | 2020 | % | 42.70 | 36.00 | 49.70 | ↓ | 32.10 | Merton is Better | 33.00 | Merton is Better |
| C19c - Successful completion of alcohol treatment | 18+ yrs | Persons | 2020 | % | 47.60 | 41.80 | 53.50 | → | 36.90 | Merton is Better | 35.30 | Merton is Better |

# Health Improvement

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C19d - Deaths from drug misuse | All ages | Persons | 2018 - 20 | per 100,000 | | | | | 3.50 | Cannot be calculated | 5.00 | Cannot be calculated |
| C20 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison | 18+ yrs | Persons | 2020/21 | % | | | | | 22.00 | Cannot be calculated | 38.10 | Cannot be calculated |
| C21 - Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. | All ages | Female | 2020/21 | per 100,000 | 220.00 | 191.00 | 253.00 | → | 348.00 | Merton is Better | 456.00 | Merton is Better |
| C21 - Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. | All ages | Male | 2020/21 | per 100,000 | 483.00 | 435.00 | 534.00 | → | 348.00 | Merton is Worse | 456.00 | Merton is Simlar |
| C21 - Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. | All ages | Persons | 2020/21 | per 100,000 | 343.00 | 316.00 | 372.00 | → | 348.00 | Merton is Similar | 456.00 | Merton is Better |
| C22 - Estimated diabetes diagnosis rate | 17+ yrs | Persons | 2018 | % | 75.10 | 71.50 | 78.20 | | 71.40 | Merton is Possibly Better | 78.00 | Merton is Possibly Worse |
| C23 - Percentage of cancers diagnosed at stages 1 and 2 | All ages | Persons | 2019 | % | | | | | | Cannot be calculated | 55.00 | Cannot be calculated |
| C24a - Cancer screening coverage - breast cancer | 53-70 yrs | Female | 2021 | % | 59.90 | 59.20 | 60.50 | ↓ | 55.20 | Merton is Better | 64.10 | Merton is Worse |
| C24b - Cancer screening coverage - cervical cancer (aged 25 to 49 years old) | 25-49 yrs | Female | 2021 | % | 61.10 | 60.70 | 61.50 | ↓ | 59.10 | Merton is Better | 68.00 | Merton is Worse |
| C24c - Cancer screening coverage - cervical cancer (aged 50 to 64 years old) | 50-64 yrs | Female | 2021 | % | 70.30 | 69.60 | 70.90 | ↓ | 70.90 | Merton is Possibly Worse | 74.70 | Merton is Worse |
| C24d - Cancer screening coverage - bowel cancer | 60-74 yrs | Persons | 2021 | % | 62.90 | 62.30 | 63.40 | ↑ | 59.30 | Merton is Better | 65.20 | Merton is Worse |
| C24e - Abdominal Aortic Aneurysm Screening - Coverage | 65 | Male | 2020/21 | % | 34.10 | 31.10 | 37.10 | ↓ | 42.50 | Merton is Worse | 55.00 | Merton is Worse |
| C24m - Newborn Hearing Screening - Coverage | <1 yr | Persons | 2020/21 | % | 97.90 | 97.30 | 98.40 | | 96.40 | Merton is Better | 97.50 | Merton is Similar |
| C24n - Newborn and Infant Physical Examination Screening - Coverage | <1 yr | Persons | 2020/21 | % | 97.80 | 97.10 | 98.30 | | 96.90 | Merton is Better | 97.30 | Merton is Similar |
| C26a - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check | 40-74 yrs | Persons | 2016/17 - 20/21 | % | 62.60 | 62.20 | 63.00 | | 73.40 | Merton is Worse | 71.80 | Merton is Worse |

# Health Improvement

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Check | | | | | | | | | | | | |
| C26b - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check | 40-74 yrs | Persons | 2016/17 - 20/21 | % | 33.70 | 33.20 | 34.30 | ○ | 49.90 | Merton is Worse | 46.50 | Merton is Worse |
| C26c - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check | 40-74 yrs | Persons | 2016/17 - 20/21 | % | 21.10 | 20.80 | 21.40 | ○ | 36.60 | Merton is Worse | 33.40 | Merton is Worse |
| C27 - Percentage reporting a long-term Musculoskeletal (MSK) problem | 16+ yrs | Persons | 2021 | % | 12.10 | 10.90 | 13.30 | ○ | 12.10 | Merton is Similar | 17.00 | Merton is Better |
| C28a - Self-reported wellbeing - people with a low satisfaction score | 16+ yrs | Persons | 2020/21 | % | | | | ○ | 5.70 | Cannot be calculated | 6.10 | Cannot be calculated |
| C28b - Self-reported wellbeing - people with a low worthwhile score | 16+ yrs | Persons | 2020/21 | % | | | | ○ | 3.60 | Cannot be calculated | 4.40 | Cannot be calculated |
| C28c - Self-reported wellbeing - people with a low happiness score | 16+ yrs | Persons | 2020/21 | % | | | | ○ | 8.30 | Cannot be calculated | 9.20 | Cannot be calculated |
| C28d - Self-reported wellbeing - people with a high anxiety score | 16+ yrs | Persons | 2020/21 | % | 27.80 | 20.70 | 34.90 | ○ | 23.80 | Merton is Similar | 24.20 | Merton is Similar |
| C29 - Emergency hospital admissions due to falls in people aged 65 and over | 65+ yrs | Persons | 2020/21 | per 100,000 | 2,127.00 | 1,956.00 | 2,308.00 | ↓ | 1,872.00 | Merton is Worse | 2,023.00 | Merton is Similar |
| C29 - Emergency hospital admissions due to falls in people aged 65-79 | 65-79 yrs | Persons | 2020/21 | per 100,000 | 1,024.00 | 884.00 | 1,180.00 | ↓ | 947.00 | Merton is Similar | 937.00 | Merton is Similar |
| C29 - Emergency hospital admissions due to falls in people aged 80+ | 80+ yrs | Persons | 2020/21 | per 100,000 | 5,324.00 | 4,803.00 | 5,885.00 | ↓ | 4,555.00 | Merton is Worse | 5,174.00 | Merton is Similar |

# Health Protection

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| D01 - Fraction of mortality attributable to particulate air pollution (new method) | 30+ yrs | Persons | 2020 | % | 7.20 | | | ○ | 7.10 | Cannot be calculated | 5.60 | Cannot be calculated |
| D01 - Fraction of mortality attributable to particulate air pollution (old method) | 30+ yrs | Persons | 2019 | % | 6.30 | | | ○ | 6.40 | Cannot be calculated | 5.10 | Cannot be calculated |
| D02a - Chlamydia detection rate / 100,000 aged 15 to 24 | 15-24 yrs | Female | 2020 | per 100,000 | 2,667.00 | 2,352.00 | 3,013.00 | → | 2,311.00 | Merton is Possibly Higher | 1,889.00 | Merton is Higher |
| D02a - Chlamydia detection rate / 100,000 aged 15 to 24 | 15-24 yrs | Male | 2020 | per 100,000 | 1,321.00 | 1,108.00 | 1,564.00 | → | 1,323.00 | Merton is Similar | 916.00 | Merton is Higher |
| D02a - Chlamydia detection rate / 100,000 aged 15 to 24 | 15-24 yrs | Persons | 2020 | per 100,000 | 2,012.00 | 1,820.00 | 2,219.00 | → | 1,819.00 | Merton is Possibly Better | 1,408.00 | Merton is Better |
| D02b - New STI diagnoses (exc chlamydia aged <25) / 100,000 | 15-64 yrs | Persons | 2020 | per 100,000 | 1,000.00 | 948.00 | 1,054.00 | → | 1,391.00 | Merton is Better | 619.00 | Merton is Worse |
| D03b - Population vaccination coverage - Hepatitis B (1 year old) | 1 yr | Persons | 2020/21 | % | 95.00 | 76.40 | 99.10 | ○ | | Cannot be calculated | | Cannot be calculated |
| D03c - Population vaccination coverage - Dtap / IPV / Hib (1 year old) | 1 yr | Persons | 2020/21 | % | 89.90 | 88.70 | 91.10 | ↓ | 86.70 | Merton is Better | 92.00 | Merton is Worse |
| D03d - Population vaccination coverage - MenB (1 year) | 1 yr | Persons | 2020/21 | % | 89.40 | 88.10 | 90.50 | ○ | 86.60 | Merton is Better | 92.10 | Merton is Worse |
| D03e - Population vaccination coverage - Rotavirus (Rota) (1 year) | 1 yr | Persons | 2020/21 | % | 88.80 | 87.50 | 90.00 | ↓ | 85.10 | Merton is Better | 90.20 | Merton is Worse |
| D03f - Population vaccination coverage - PCV | 1 yr | Persons | 2019/20 | % | 92.30 | 91.20 | 93.30 | ↓ | 89.10 | Merton is Better | 93.20 | Merton is Similar |
| D03g - Population vaccination coverage - Hepatitis B (2 years old) | 2 yrs | Persons | 2020/21 | % | 88.20 | 65.70 | 96.70 | ○ | | Cannot be calculated | | Cannot be calculated |
| D03h - Population vaccination coverage - Dtap / IPV / Hib (2 years old) | 2 yrs | Persons | 2020/21 | % | 92.20 | 91.00 | 93.10 | ↓ | 89.40 | Merton is Better | 93.80 | Merton is Worse |
| D03i - Population vaccination coverage - MenB booster (2 years) | 2 yrs | Persons | 2020/21 | % | 83.10 | 81.60 | 84.50 | ○ | 80.30 | Merton is Better | 89.00 | Merton is Worse |
| D03j - Population vaccination coverage - MMR for one dose (2 years old) | 2 yrs | Persons | 2020/21 | % | 85.70 | 84.20 | 87.00 | → | 82.40 | Merton is Better | 90.30 | Merton is Worse |
| D03k - Population vaccination coverage - PCV booster | 2 yrs | Persons | 2020/21 | % | 85.30 | 83.80 | 86.60 | ↓ | 81.10 | Merton is Better | 90.10 | Merton is Worse |
| D03l - Population vaccination coverage - Flu (2-3 years old) | 2-3 yrs | Persons | 2020/21 | % | 55.20 | 53.70 | 56.60 | ↑ | | Cannot be calculated | | Cannot be calculated |
| D03m - Population vaccination coverage - Hib / MenC booster (2 years old) | 2 yrs | Persons | 2020/21 | % | 85.50 | 84.00 | 86.80 | → | 82.20 | Merton is Better | 89.80 | Merton is Worse |

# Health Protection

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| D04a - Population vaccination coverage - DTaP/IPV booster (5 years) | 5 yrs | Persons | 2020/21 | % | 69.30 | 67.60 | 71.00 | → | 72.60 | Merton is Worse | 85.30 | Merton is Worse |
| D04b - Population vaccination coverage - MMR for one dose (5 years old) | 5 yrs | Persons | 2020/21 | % | 88.80 | 87.50 | 89.90 | → | 88.80 | Merton is Similar | 94.30 | Merton is Worse |
| D04c - Population vaccination coverage - MMR for two doses (5 years old) | 5 yrs | Persons | 2020/21 | % | 72.50 | 70.90 | 74.20 | → | 75.10 | Merton is Worse | 86.60 | Merton is Worse |
| D04d - Population vaccination coverage - Flu (primary school aged children) | 4-11 yrs | Persons | 2020 | % | 64.70 | 64.00 | 65.40 | ○ | 52.70 | Merton is Better | 62.50 | Merton is Better |
| D04e - Population vaccination coverage - HPV vaccination coverage for one dose (12-13 year old) | 12-13 yrs | Female | 2020/21 | % | 75.00 | 72.30 | 77.60 | ○ | 71.00 | Merton is Better | 76.70 | Merton is Similar |
| D04e - Population vaccination coverage - HPV vaccination coverage for one dose (12-13 year old) | 12-13 yrs | Male | 2020/21 | % | 73.80 | 71.20 | 76.20 | ○ | 67.00 | Merton is Better | 71.00 | Merton is Possibly Better |
| D04f - Population vaccination coverage - HPV vaccination coverage for two doses (13-14 years old) | 13-14 yrs | Female | 2020/21 | % | 0.00 | 0.00 | 0.40 | ↓ | 33.70 | Merton is Worse | 60.60 | Merton is Worse |
| D04g - Population vaccination coverage - Meningococcal ACWY conjugate vaccine (MenACWY) (14-15 years) | 14-15 yrs | Persons | 2020/21 | % | 84.70 | 83.10 | 86.30 | → | 78.60 | Merton is Better | 80.90 | Merton is Better |
| D05 - Population vaccination coverage - Flu (at risk individuals) | 6 months-64 yrs | Persons | 2020/21 | % | 48.20 | 47.50 | 48.80 | → | 45.00 | Merton is Better | 53.00 | Merton is Worse |
| D06a - Population vaccination coverage - Flu (aged 65+) | 65+ yrs | Persons | 2020/21 | % | 70.70 | 70.10 | 71.20 | → | 71.80 | Merton is Worse | 80.90 | Merton is Worse |
| D06b - Population vaccination coverage - PPV | 65+ yrs | Persons | 2020/21 | % | 64.30 | 63.70 | 64.90 | → | 66.10 | Merton is Worse | 70.60 | Merton is Worse |
| D06c - Population vaccination coverage – Shingles vaccination coverage (71 years) | 71 | Persons | 2019/20 | % | 43.00 | 40.30 | 45.70 | ○ | 44.80 | Merton is Similar | 48.20 | Merton is Worse |
| D07 - HIV late diagnosis (all CD4 less than 350) (%) | 15+ yrs | Persons | 2018 - 20 | % | 48.20 | 34.70 | 62.00 | ○ | 38.40 | Merton is Similar | 42.40 | Merton is Similar |
| D08a - Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months | All ages | Persons | 2019 | % | 92.60 | 76.60 | 97.90 | → | 84.80 | Merton is Similar | 82.00 | Merton is Similar |
| D08b - TB incidence (three year average) | All ages | Persons | 2018 - 20 | per 100,000 | 13.70 | 11.00 | 17.00 | ○ | 17.90 | Merton is Better | 8.00 | Merton is Worse |
| D09 - NHS organisations with a board approved sustainable development management plan | Not applicable | Not applicable | 2015/16 | % | 83.30 | 43.60 | 97.00 | → | 70.10 | Merton is Similar | 66.20 | Merton is Similar |
| D10 - Adjusted antibiotic prescribing in primary care by the NHS | All ages | Persons | 2020 | per STAR-PU | 0.53 | 0.53 | 0.53 | ○ | 0.56 | Merton is Better | 0.75 | Merton is Better |

# Healthcare and Premature Mortality

| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| E01 - Infant mortality rate | <1 yr | Persons | 2018 - 20 | per 1,000 | 2.50 | 1.60 | 3.80 | ○ | 3.40 | Merton is Similar | 3.90 | Merton is Possibly Better |
| E02 - Percentage of 5 year olds with experience of visually obvious dental decay | 5 yrs | Persons | 2018/19 | % | 27.70 | 21.90 | 34.30 | ○ | 27.00 | Merton is Similar | 23.40 | Merton is Similar |
| E03 - Under 75 mortality rate from causes considered preventable (2019 definition) | <75 yrs | Persons | 2017 - 19 | per 100,000 | 114.80 | 104.70 | 125.60 | ○ | 125.80 | Merton is Possibly Better | 142.20 | Merton is Better |
| E03 - Under 75 mortality rate from causes considered preventable (2019 definition) | <75 yrs | Persons | 2020 | per 100,000 | 118.20 | 101.10 | 137.30 | → | 122.70 | Merton is Similar | 140.50 | Merton is Better |
| E04a - Under 75 mortality rate from all cardiovascular diseases | <75 yrs | Persons | 2017 - 19 | per 100,000 | 62.30 | 54.90 | 70.50 | ○ | 69.10 | Merton is Similar | 70.40 | Merton is Possibly Better |
| E04a - Under 75 mortality rate from all cardiovascular diseases | <75 yrs | Persons | 2020 | per 100,000 | 53.20 | 41.80 | 66.70 | → | 72.30 | Merton is Better | 73.80 | Merton is Better |
| E04b - Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition) | <75 yrs | Persons | 2017 - 19 | per 100,000 | 25.50 | 20.80 | 30.90 | ○ | 27.50 | Merton is Similar | 28.10 | Merton is Similar |
| E04b - Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition) | <75 yrs | Persons | 2020 | per 100,000 | 19.90 | 13.20 | 28.70 | → | 28.40 | Merton is Possibly Better | 29.20 | Merton is Possibly Better |
| E05a - Under 75 mortality rate from cancer | <75 yrs | Persons | 2017 - 19 | per 100,000 | 114.60 | 104.40 | 125.50 | ○ | 117.40 | Merton is Similar | 129.20 | Merton is Better |
| E05a - Under 75 mortality rate from cancer | <75 yrs | Persons | 2020 | per 100,000 | 125.80 | 107.80 | 146.00 | → | 111.30 | Merton is Similar | 125.10 | Merton is Similar |
| E05b - Under 75 mortality rate from cancer considered preventable (2019 definition) | <75 yrs | Persons | 2017 - 19 | per 100,000 | 44.80 | 38.50 | 51.90 | ○ | 48.20 | Merton is Similar | 54.10 | Merton is Better |
| E05b - Under 75 mortality rate from cancer considered preventable (2019 definition) | <75 yrs | Persons | 2020 | per 100,000 | 46.30 | 35.60 | 59.20 | → | 45.10 | Merton is Similar | 51.50 | Merton is Similar |
| E06a - Under 75 mortality rate from liver disease | <75 yrs | Persons | 2017 - 19 | per 100,000 | 15.30 | 11.80 | 19.50 | ○ | 16.10 | Merton is Similar | 18.80 | Merton is Similar |
| E06a - Under 75 mortality rate from liver disease | <75 yrs | Persons | 2020 | per 100,000 | 23.00 | 15.80 | 32.20 | → | 17.80 | Merton is Similar | 20.60 | Merton is Similar |
| E06b - Under 75 mortality rate from liver disease considered preventable (2019 definition) | <75 yrs | Persons | 2017 - 19 | per 100,000 | 13.60 | 10.40 | 17.60 | ○ | 14.20 | Merton is Similar | 16.70 | Merton is Similar |
| E06b - Under 75 mortality rate from liver disease considered preventable (2019 definition) | <75 yrs | Persons | 2020 | per 100,000 | 22.40 | 15.30 | 31.60 | → | 15.70 | Merton is Possibly Worse | 18.20 | Merton is Similar |

# Healthcare and Premature Mortality



| Indicator | Age | Sex | Period | Unit | Merton | 95% LowCI | 95% UpCI | Overall Trend | London | London Comparison | England | England Comparison |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| E07a - Under 75 mortality rate from respiratory disease | <75 yrs | Persons | 2017 - 19 | per 100,000 | 27.40 | 22.30 | 33.10 | ● | 29.40 | Merton is Similar | 33.60 | Merton is Better |
| E07a - Under 75 mortality rate from respiratory disease | <75 yrs | Persons | 2020 | per 100,000 | 22.90 | 15.40 | 32.80 | → | 26.70 | Merton is Similar | 29.40 | Merton is Similar |
| E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition) | <75 yrs | Persons | 2017 - 19 | per 100,000 | 16.60 | 12.70 | 21.20 | ● | 17.50 | Merton is Similar | 20.20 | Merton is Similar |
| E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition) | <75 yrs | Persons | 2020 | per 100,000 | 12.80 | 7.40 | 20.50 | → | 15.40 | Merton is Similar | 17.10 | Merton is Similar |
| E08 - Mortality rate from a range of specified communicable diseases, including influenza | All ages | Persons | 2017 - 19 | per 100,000 | 9.40 | 6.70 | 12.80 | ● | 8.90 | Merton is Similar | 9.40 | Merton is Similar |
| E08 - Mortality rate from a range of specified communicable diseases, including influenza | All ages | Persons | 2020 | per 100,000 | | | | ● | 8.20 | Cannot be calculated | 8.30 | Cannot be calculated |
| E09a - Premature mortality in adults with severe mental illness (SMI) | 18-74 yrs | Persons | 2018 - 20 | per 100,000 | 74.70 | 65.60 | 84.60 | ● | 102.50 | Merton is Better | 103.60 | Merton is Better |
| E09b - Excess under 75 mortality rate in adults with severe mental illness (SMI) | 18-74 yrs | Persons | 2018 - 20 | % | 363.10 | 302.60 | 432.60 | ● | 389.10 | Merton is Similar | 389.90 | Merton is Similar |
| E10 - Suicide rate | 10+ yrs | Persons | 2018 - 20 | per 100,000 | 6.90 | 4.80 | 9.50 | ● | 8.00 | Merton is Similar | 10.40 | Merton is Better |
| E11 - Emergency readmissions within 30 days of discharge from hospital | All ages | Persons | 2020/21 | % | 16.30 | 15.70 | 16.90 | ● | 16.10 | Merton is Similar | 15.50 | Merton is Worse |
| E12a - Preventable sight loss - age related macular degeneration (AMD) | 65+ yrs | Persons | 2020/21 | per 100,000 | 52.60 | 28.70 | 88.20 | → | 64.20 | Merton is Similar | 82.00 | Merton is Similar |
| E12b - Preventable sight loss - glaucoma | 40+ yrs | Persons | 2020/21 | per 100,000 | 13.80 | 7.30 | 23.50 | → | 10.70 | Merton is Similar | 9.20 | Merton is Similar |
| E12c - Preventable sight loss - diabetic eye disease | 12+ yrs | Persons | 2020/21 | per 100,000 | | | | ● | 1.80 | Cannot be calculated | 0.90 | Cannot be calculated |
| E12d - Preventable sight loss - sight loss certifications | All ages | Persons | 2020/21 | per 100,000 | 22.80 | 16.70 | 30.30 | → | 20.60 | Merton is Similar | 29.20 | Merton is Similar |
| E13 - Hip fractures in people aged 65 and over | 65+ yrs | Persons | 2020/21 | per 100,000 | 429.00 | 355.00 | 515.00 | → | 428.00 | Merton is Similar | 529.00 | Merton is Better |
| E13 - Hip fractures in people aged 65-79 | 65-79 yrs | Persons | 2020/21 | per 100,000 | 160.00 | 108.00 | 228.00 | → | 188.00 | Merton is Similar | 219.00 | Merton is Similar |
| E13 - Hip fractures in people aged 80+ | 80+ yrs | Persons | 2020/21 | per 100,000 | 1,211.00 | 970.00 | 1,495.00 | → | 1,124.00 | Merton is Similar | 1,426.00 | Merton is Similar |
| E14 - Excess winter deaths index | All ages | Persons | Aug 2019 - Jul 2020 | % | 13.80 | 1.40 | 27.60 | ● | 18.80 | Merton is Similar | 17.40 | Merton is Similar |
| E14 - Excess winter deaths index (age 85+) | 85+ yrs | Persons | Aug 2019 - Jul 2020 | % | 25.20 | 5.10 | 49.10 | ● | 21.90 | Merton is Similar | 20.80 | Merton is Similar |
| E15 - Estimated dementia diagnosis rate (aged 65 and over) | 65+ yrs | Persons | 2021 | % | 63.20 | 56.00 | 69.60 | → | 65.60 | Merton is Possibly Worse | 61.60 | Merton is Possibly Better |

| | |
|---|---|
| **Committee:** | Healthier Communities and Older People Overview and Scrutiny Panel |
| **Date:** | 20 June 2022 |
| Wards: | All |
| Subject: | Healthier Communities and Older People Overview and Scrutiny Panel Work Programme 2022/23 |
| Lead officer: | Stella Akintan, Scrutiny Officer |
| Lead member: | Councillor Agatha Akyigyina, Chair of the Healthier Communities and Older People Overview and Scrutiny Panel |
| Contact officer: | Stella Akintan: stella.akintan@merton.gov.uk, 020 8545 3390 |

**Recommendations:**

That members of the Healthier Communities and Older People Overview and Scrutiny Panel:

i. Finalise the topics for work programme 2022/23 municipal year, and agree issues and items for inclusion (see draft in Appendix 1);

ii. Ask Scrutiny Officer to work with colleagues to draw up a draft work programme with a schedule for each topic and bring to the next meeting for agreement.

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to support and advise Panel members to determine their work programme for the 2022/23 municipal year.

This report sets out a summary of discussion by councillors and co-opted members at a topic selection workshop held on 07 June 2022

Panel Members to be aware that there is flexibility in the work programme and it can be revised throughout the year to respond to issues as they arise.

1.1 In order to gather items for the agenda, the Scrutiny Team has undertaken a campaign to gather suggestions for issues to scrutinise either as agenda items or task group reviews. Suggestions have been received from members of the public, councillors and partner organisations including the police, NHS and the voluntary and community sector. The Scrutiny Team has consulted with departmental management teams in order to identify forthcoming issues on which the Panel could contribute to the policymaking process.

1.2 The panel members who attended a “topic selection” workshop on 07 June 2022 discussed these suggestions. Suggestions were prioritised at the workshop. Participants sought to identify issues that related to the Council’s strategic priorities or where there was underperformance; issues of public interest or concern and issues where scrutiny could make a difference.

1.3 A note of the workshop discussion relating to the remit of the Panel is attached

## 2. Task group reviews

2.1 A review on Youth Provision has been put forward as a suggested in- depth task group review for this year.

## 3. ALTERNATIVE OPTIONS

3.1 The Healthier Communities and Older People Overview and Scrutiny Panel is free to determine its work programme as it sees fit. Members may therefore choose to identify a work programme that does not take into account these considerations. This is not advised as ignoring the issues raised would either conflict with good practice and/or principles endorsed in the Review of Scrutiny, or could mean that adequate support would not be available to carry out the work identified for the work programme.

3.2 A range of suggestions from the public, partner organisations, officers and Members for inclusion in the scrutiny work programme are set out in the appendices, together with a suggested approach to determining which to include in the work programme. Members may choose to respond differently. However, in doing so, Members should be clear about expected outcomes, how realistic expectations are and the impact of their decision on their wider work programme and support time. Members are also free to incorporate into their work programme any other issues they think should be subject to scrutiny over the course of the year, with the same considerations in mind.

## 4. CONSULTATION UNDERTAKEN OR PROPOSED

4.1 To assist Members to identify priorities for inclusion in the Panel's work programme, the Scrutiny Team has undertaken a campaign to gather suggestions for possible scrutiny reviews from a number of sources:

a. Members of the public have been approached using the following tools: request for suggestions from all councillors and co-opted members, letter to partner organisations and to a range of local voluntary and community organisations.

b. Councillors have put forward suggestions by raising issues in scrutiny meetings, via the Overview and Scrutiny Member Survey 2021, and by contacting the Scrutiny Team direct; and

c. Officers have been consulted via discussion at departmental management team meetings.

## 5. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

5.1 There are none specific to this report. Scrutiny work involves consideration of the financial, resource and property issues relating to the topic being scrutinised. Furthermore, scrutiny work will also need to assess the implications of any recommendations made to Cabinet, including specific financial, resource and property implications.

## 6. LEGAL AND STATUTORY IMPLICATIONS

6.1 Overview and scrutiny bodies operate within the provisions set out in the Local Government Act 2000, the Health and Social Care Act 2001& 2012 and the Local Government and Public Involvement in Health Act 2007.

6.2 Scrutiny work involves consideration of the legal and statutory issues relating to the topic being scrutinised. Furthermore, scrutiny work will also need to assess the implications of any recommendations made to Cabinet, including specific legal and statutory implications.

## 7. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

7.1 It is a fundamental aim of the scrutiny process to ensure that there is full and equal access to the democratic process through public involvement and engagement. The reviews will involve work to consult local residents, community and voluntary sector groups, businesses, hard to reach groups, partner organisations etc and the views gathered will be fed into the review.

7.2 Scrutiny work involves consideration of the human rights, equalities and community cohesion issues relating to the topic being scrutinised. Furthermore, scrutiny work will also need to assess the implications of any recommendations made to Cabinet, including specific human rights, equalities and community cohesion implications.

## 8. CRIME AND DISORDER IMPLICATIONS

8.1 In line with the requirements of the Crime and Disorder Act 1998 and the Police and Justice Act 2006, all Council departments must have regard to the impact of services on crime, including anti-social behaviour and drugs. Scrutiny review reports will therefore highlight any implications arising from the reviews relating to crime and disorder as necessary.

## 9. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

9.1 There are none specific to this report. Scrutiny work involves consideration of the risk management and health and safety issues relating to the topic being scrutinised. Furthermore, scrutiny work will also need to assess the implications of any recommendations made to Cabinet, including specific risk management and health and safety implications.

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

10.1 Appendix I – Selecting a Scrutiny Topic – criteria used at the workshop on 07 June 2022

## 11. BACKGROUND PAPERS

11.1 None

Note from the Healthier Communities and Older People Scrutiny Panel
Topic Selection discussion
07 June 2022

**Present**: Councillor Agatha Akyigyina (Chair), Councillor Jenifer Gould (Vice Chair), Councillor Susie Hicks, Dagmar Zeuner, Director of Public Health, John Morgan, Interim Director of Community and Housing, John Dimmer, Head of Strategy, Policy and Partnerships, Aadam Ahmed, Assistant Policy Officer.

Listed below are the topics which the Members in attendance at the topic selection workshop wanted to look at over the forthcoming year. This list does not include the statutory / long-standing items which appear at the Committee.

**Topics**

1. St Heliers Hospital

Comment: As the refurbishment is not planned to be completed until 2027 discussions focussed on scrutinising the provisions and services that are intended to run in the interim period. It was noted that this would fit well as part of a themed panel looking at Access to healthcare.

2. Wilson Development

Comment: The panel noted the comment on the initial summary document which cited delays to the project and thought that it would be beneficial to scrutinise this item. It was noted that this would fit well as part of a themed panel looking at access to healthcare.

3. Access to healthcare

Comment: The panel felt that it would be beneficial to look at this item given that it is wide-ranging and would allow for wide-ranging and constructive discussion on how residents are able to access different healthcare services. It was stated that Health on the High Street could be looked at within this topic. It was noted that this would fit well as part of a themed panel looking at access to healthcare.

4. Adult Social Care Reform

Comment: The panel agreed with the summary advice that it would be beneficial to receive an update on forthcoming legislation and its impact on policy direction. It was noted that elements of this could be linked to access.

5. Home Care redesign Recommissioning

Comment: The panel agreed with the summary advice that it would be beneficial to receive an update on the recommissioning process. Attention was drawn to the significant cost implications with recommissioning and the cross-cutting nature of the topic.

6. Discharge from acute settings

Comment: The panel felt that having a topic focussed on discharge arrangements would be useful, especially given the themed items on access.

7. Suicide prevention across all age groups

Comment: The panel decided that this item was best looked at as an item on the work programme as opposed to having a task group focus. The panel emphasised the importance of looking across all age groups, including children given that this was an area where not as much work has been done.

8. Mental Health Reforms

Comment: The panel agreed that it would be beneficial for Officers to present an overview of the reforms and the impact that this could have on Merton residents.

9. ICS Governance (SWL and Place) Arrangements

Comment: The panel agreed that this topic should be selected given the role and impact that Integrated Care Systems will have on services provided in Merton. In particular it was noted that it would be beneficial to see how the ICS links with the Health and Wellbeing Board.

10. Substance Misuse

Comment: The panel discussed the topic of substance misuse and agreed that it would be beneficial to see a report on the work being done around substance misuse in the borough.

11. Long-Covid and Post-Covid Support

Comment: The panel agreed that it would be beneficial for a report to be produced which looks at what is in place to support those living with Long-Covid and what support is there for residents who may need additional support with the transition to the post-covid world, particularly those who are considered vulnerable and those who are anxious about the impact of Covid-19.

Additional topic for consideration:

Air Quality

Comment: The panel noted that this was an item on the Sustainable Communities topic suggestion list and would welcome any collaboration on this item given that it cross-cuts between the two panels.

**Task Group Focus**

Topic: Support for People with Autism in the borough

Comment: The panel agreed that this was a topic of significant importance in the borough and officers noted that this work would be welcomed as there was acknowledgement that this was an area where further work was needed. It was noted that this topic could allow for collaboration with the Children and Young People Panel and the Healthcare Trust.

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