Merton
Health and Care
Together

Merton Local Health and Care Plan

2022-2024

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.

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

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

Our updated vision

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"

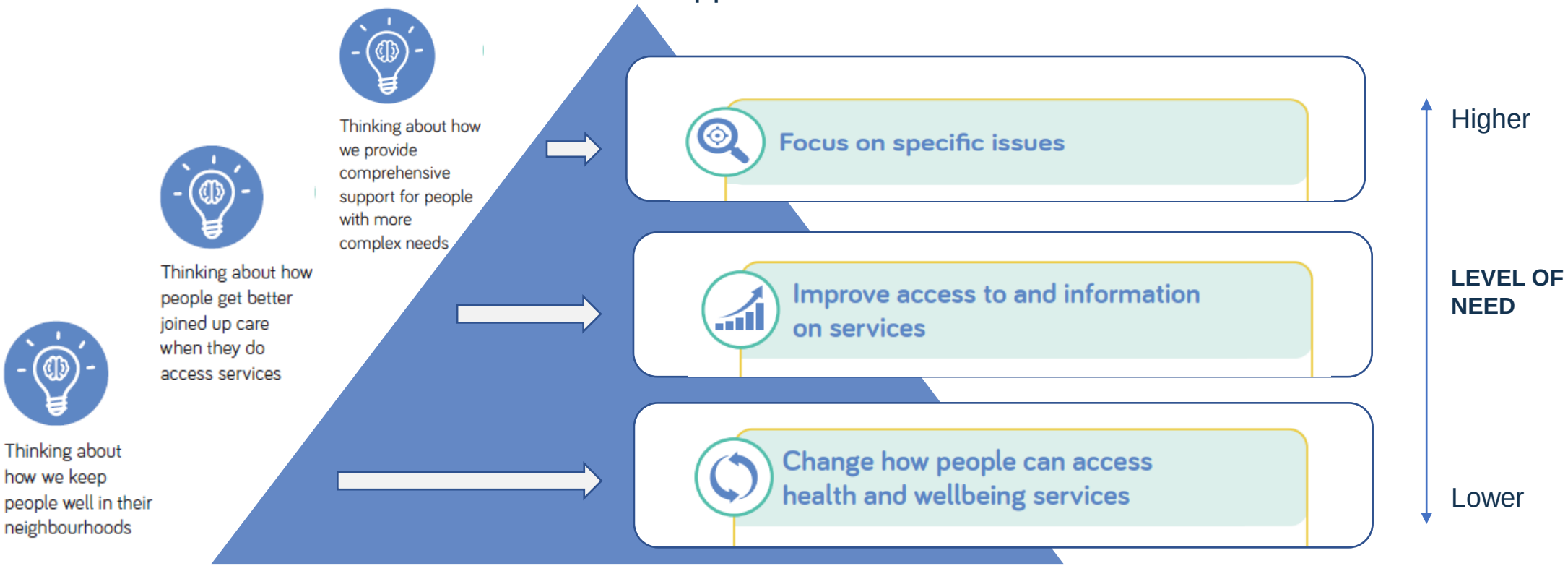
We want all children in Merton, regardless of their background or circumstances, to have the support and care they need to grow and thrive. We will work to change the way young people access health and wellbeing services, continuing to develop support in the places they already go, such as schools and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

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

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	• Scoping a CYP emotional health and wellbeing hub in a community/ high street space	- Improved access to services - Improved information and signposting and support to carers and families	- Increased numbers of people accessing services - Increased range of services
Improve integration of children's community services	• Building on development work done around the family hub bid, scope 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)	- All children and their families are supported to flourish and achieve their potential with appropriate support and care they need.	
	• Connecting staff who work with children and young people across the borough from different organisation by developing a community of practice for CYP staff across Merton		
	• 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 and reduce the gap between east and west by levelling up.	- Reduction in BMI - Increase in hours of physical activity - Changes in family diet
	• Autism – collaborative approach to supporting people with autism in Merton	- Improved access, experience and outcomes for people living with and supporting someone with Autism.	
Be focused on mental health and wellbeing	• 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 20	- Improved health and wellbeing of children and young people - Improved access to mental health services for young people.	- Increases in service utilization, particularly increase in number of children accessing early intervention and prevention services. - Through co-production work and feedback from children and young people

Live 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?
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	- Developing partnerships and enabling and empowering communities to tackle health inequalities and long term conditions using a prevention approach and a prevention framework - Improved access, experience and outcomes for those from Black, Asian and other. minority ethnic groups in the borough	- Questionnaires/surveys will measure the experience of those using the hub and enhanced therapeutic benefits and wellbeing from community care can be measured via community experience surveys.
	• We will work together to develop and expand community health checks and health clinics, enabling people at risk of diabetes or cardiovascular disease to be identified in a safe space in their community, empowering them to take control of their own health.	- Early identification, improvement in treatment of and prevention of the complications of diabetes and cardiovascular disease - Improved access as patients can access support closer to home, in the right place and at the right time.	- Improved patient experience and outcomes - Year in year increase in attendance at structured education courses and improvement in patient reported confidence to self-manage
Improve and optimise access to and information on primary care	• Developing profiles/ communications materials for all new ARRS roles and promoting these with health and care partners and the wider public		
	• 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		
	• Work to promote "Information Equality" by developing information on services in a range of preferred formats and language	- Reduction in digital inequalities	
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		
	• 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		

Age Well - programme of work

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.		
	• Implementing South West Merton PCN "Tackling Neighbourhood Health Inequalities" project working with Wimbledon Guild	- Improvements in quality of life and experience	
Improve access to and information on integrated services	• Expansion of the Integrated Locality team model into lower risk cohorts	- More people able to live independently and for as long as possible, including people with dementia and other mental health conditions - More people providing unpaid care can balance their caring role with a life outside caring	
	• 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	
	• Integrated approach to improving rapid discharge and admission avoidance initiatives such as 'D2A' or Virtual ward	- Improved access into intermediate care /reablement services, and better coordination of services - Increased resource and activity provided closer to home, reduction of unnecessary admissions in hospital and shorter length of stay	- Reducing unnecessary admissions to secondary care or premature entry to institutional care

Be focused on frailty	• Implementing the core components of the local authority led frailty service model development (2 PCNs East Merton and Morden):
	  • Physical activity programme - this will include training community groups in strength and balance activity and a "train the trainer" approach working with community groups
	  • Small grants programme - this will be available to resident, community and voluntary sector partners to run activities with older adults in the targeted areas
		- 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.	