South West London
Merton Clinical Commissioning Group

Report to the Merton Clinical Commissioning Group Governing Body

Date of Meeting: Thursday 21st March 2013

Agenda No: 6.5 **ATTACHMENT: 07**

Report on Merton Health and Wellbeing Strategy
Appendix 1 – Final Draft Merton Health and Wellbeing Strategy
Appendix 2 – Health and Wellbeing Strategy Draft Delivery Plan 2013/14

Title of Document: Merton Health and Wellbeing Strategy	**Purpose of Report:** To approve the Merton Health and Wellbeing Strategy
Report Author: Julia Groom, Joint Consultant in Public Health / Clarissa Larsen, Partnership Manager Health and Wellbeing Board	**Lead Director:** Dr Val Day, Interim Director of Public Health
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Executive Summary: To present Merton Health and Wellbeing Strategy which has been finalised following the consultation and engagement programme. To set out the draft Delivery Plan 2013/14 for each of the four priorities of the Health and Wellbeing Strategy.	
Key sections for particular note (paragraph/page), areas of concern etc: Merton Health and Wellbeing Strategy (Appendix 1) - Section 8, Page 20 provides a single page summary of the four priority themes, outcomes and delivery leads.	
Recommendation(s): 1. The Merton Clinical Commissioning Group Governing Body is requested to: approve Merton Health and Wellbeing Strategy.	

Committees which have previously discussed/agreed the report: N/A
Financial Implications: N/A
Implications for the Sutton and Merton Board or Joint PCT Boards: N/A
Other Implications: (including patient and public involvement/Legal/Governance/ Risk/ Diversity/ Staffing) The Merton Health and Wellbeing Strategy has been finalised following a comprehensive consultation and engagement programme.
Equality Analysis: The vision of the Merton Health and Wellbeing Strategy is fundamentally concerned with addressing health inequalities.
Information Privacy Issues: N/A
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) N/A

MERTON HEALTH AND WELLBEING STRATEGY

Report to Merton Clinical Commissioning Group 21 March 2013

1. EXECUTIVE SUMMARY AND PURPOSE OF REPORT

1.1 This report presents the Merton Health and Wellbeing Strategy which has been finalised following the consultation and engagement programme

1.2 It provides feedback on the extensive consultation and engagement programme.

1.3 It sets out the draft Delivery Plan 2013/14 for each of the four priorities of the Health and Wellbeing Strategy.

2. DETAILS

2.1 Merton Health and Wellbeing Strategy

The final draft of the Merton Health and Wellbeing Strategy is included in Appendix 1 of this report. The Strategy has been finalised following a comprehensive consultation and engagement programme taking account of the comments made and views expressed.

The HWB Strategy was reported to the Shadow Health and Wellbeing Board on 5 February and was also taken to Merton Partnership and Merton Council's Cabinet for agreement. It is will also be reported to other Shadow Health and Wellbeing Board members' organisations including MVSC and Merton LINkS.

2.2 Evaluation of Consultation and Engagement Programme

2.2.1 A full consultation and engagement programme on the HWB Strategy took place from October to December 2012 across a range of activities, events and meetings. It involved a total of over 2,000 contacts with over 250 face to face contacts and over 100 documented responses received. Details of the programme and a summary of the comments and input received, and actions taken as a result, are included in Section 9 and Appendix 3 of the Health and Wellbeing Strategy.

2.2.2 A range of stakeholders, community and voluntary groups, local people and clinicians participated in the engagement programme including:

- **LINkS Community Event** - with over 50 delegates attending to hear presentations on the HWB Strategy and take part in discussion groups on each of the four Priority Themes.
- **Stakeholder meetings and presentations** - a special meeting of Healthier Communities and Older People Overview and Scrutiny was convened specifically to consider the Health and Wellbeing Strategy. The Strategy was also considered by other stakeholder groups including: Merton Partnership Executive Board and thematic groups, the Joint Consultative Committee and Merton GP Locality Meetings.
- **On-line Survey** – a survey was hosted on the Merton Consultation website asking for views but also encouraging those responding to think about how they and their organisation could get involved in delivering the Strategy. 55

responses were completed with many suggestions for involvement of a range of voluntary organisations. An article and link was also included in the Merton Connected newsletter and Merton CCG newsletter.

- **Health and Wellbeing in Annual Resident's Survey** For the first time a set of questions on wellbeing were included in the Merton Resident's Survey and Young People's Survey conducted annually on behalf of the Council.
- **Community Forum consultation jointly with Community Plan -** the opportunity was taken to link with engagement on the review of Merton Community Plan through health and wellbeing being discussed at the local Community Forum meetings organised by the Council.

2.2.3 The consultation programme closed in December 2012 and all comments and input has been analysed and considered and several changes have been made to the draft strategy to produce the final Merton Health and Wellbeing Strategy.

2.3 Delivery Plan 2013/14

The Delivery Plan is a working document that has been developed to set out how the Health and Wellbeing Strategy will be implemented by partners over the next two years and what outcomes will be achieved.

Each of the four priority themes has given a set of high level outcomes with further detailed plans for each outcome which will be managed by a lead delivery group. This includes milestones and indicators/success measures, frequency of reporting/by when and a specified a lead for each action.

The delivery plans have been prepared as working plans by the partners through the lead delivery group for priority themes as follows:

Priority 1	Children's Trust Board
Priority 2	Healthy Living Delivery Group
Priority 3	One Merton Group
Priority 4	Sustainable Communities Group

Each delivery group will have responsibility for performance monitoring the implementation of the Delivery Plan for their Priority, with each lead reporting to the Health and Wellbeing Board on an annual basis.

The Delivery Plan is included in Appendix 2. This is a working document and will be evaluated through the implementation period 2013/14

3. NEXT STEPS

3.1 The Merton Health and Wellbeing Strategy will be central to the influence of the statutory Health and Wellbeing Board (HWB) from 1 April 2013. It provides a focus for the integrated work which the HWB and its members are promoting and will inform commissioning strategies and NHS Commissioning Board commissioning plans from 2013.

3.2 The Merton Health and Wellbeing Strategy was agreed by the Shadow Health and Wellbeing Board on 5 February, it was reported to Merton Council Cabinet on 18 February and to Merton Partnership on 19 February. It will also be reported within other members' organisations of the HWB.

3.3 The production of a full Health and Wellbeing Strategy and JSNA (Joint Strategic Needs Assessment) is a statutory duty for the Health and Wellbeing Board from 1 April 2013. This first Strategy covers 2013/14 in light of the major

organisational change taking place. An updated long-term Strategy will then be prepared building on this one and learning from experience.

APPENDICES

Appendix 1 Merton Health and Wellbeing Strategy 2013/14
Attached separately

Appendix 2 Health and Wellbeing Strategy Delivery Plan 2013/14
Attached separately

Merton Health and Wellbeing Strategy 2013/14

Final Draft

'Working in partnership to increase opportunities for all to enjoy a healthy and fulfilling life and reduce health inequalities'

January 2013

Contents

Foreword

Councillor Linda Kirby, Chair of Merton Health and Wellbeing Board

Merton's first Health and Wellbeing Strategy has been developed at a time of substantial change, significant challenges and real opportunity.

From April 2013 our Health and Wellbeing Board will become a statutory body, Merton Clinical Commissioning Group will be commissioning the majority of NHS services for the people of Merton, public health responsibilities will transfer to Merton Council and a new local HealthWatch will be established. These changes provide new opportunities to tackle health inequalities and make a real difference to people's lives. The Merton Health and Wellbeing Strategy has been developed to take advantage of these opportunities and takes a broad view of health to address the wider determinants of good health and wellbeing.

These changes take place at a time of substantial financial pressure for both the organisations involved and for people living in Merton. Efficiency savings that health and social care are having to find together with the impact of the Welfare Reform Act will present challenges. We have worked in partnership and at pace to develop a Strategy which sets out a vision for health and wellbeing in Merton.

The work has involved the Council, Merton Clinical Commissioning Group, NHS SW London and the voluntary sector. It builds on our existing strategies and is informed specifically by the local needs identified in the Joint Strategic Needs Assessment mertonjsna.org.uk. The Health and Wellbeing Strategy also links closely to the Merton Community Plan and to thematic partnerships of the Merton Partnership.

The Health and Wellbeing Strategy is important in that it will inform the commissioning of health and social care services in Merton. It will provide the focus for the partnership work of our Health and Wellbeing Board and determine its core areas of influence. It will encourage integration, resources can go further and services will be better equipped to meet need if we all work together - share good practice, work collaboratively on agreed outcomes, and aim for quality

We need input from all key agencies to ensure we have a comprehensive approach. Good health and wellbeing is affected by a wide range of determinants - employment, housing, the environment in which we live, financial security, connectivity and resilience. A broad approach is necessary if we are going to make a real difference and the fantastic response to our consultation programme shows a willingness in Merton to work as a team. I believe that this, together with the experience we bring, will help us to achieve our vision.

Councillor Linda Kirby (signature)

Executive Summary

The Merton Health and Wellbeing Strategy central focus is to encourage a more joined up, integrated approach to health and wellbeing. At a time of change and significant financial pressure there is a both a real need and opportunity to work in an integrated, joined up way.

The Strategy sets out the challenges to health and wellbeing and details in the Delivery Plan a set of clear targets to address these challenges and deliver real change.

The vision of the strategy sets out our aim to work together to promote good health and wellbeing and tackle health inequalities in Merton.

By working with communities and residents, to increase the opportunities for all adults and children to enjoy a healthy and fulfilling life and reduce health inequalities.

The Health and Wellbeing Strategy is concerned with promoting the health of the whole population of Merton but the strategy also highlights significant inequalities which require targeted actions.

Our core principles reflect this and the broad need to support people to take greater responsibility for their health and wellbeing, encouraging everyone to make a personal contribution. They also recognise mental health as an issue that cuts across the strategy as a whole, concerned with each of the priorities.

The four priority themes have been developed with reference to research the; Joint Strategic Needs Assessment and existing strategic priorities:

Giving every child a healthy start in life- aims to ensure babies have the best start in life and to promote the personal, social and mental wellbeing of children and young people and their parents. It aims to promote and increase the proportion of healthy weight children and young people and to enable and increase the number of young people making healthy life choices.

Supporting people to improve their health and wellbeing- aims to promote and deliver an integrated approach to health and wellbeing. Increasing the proportion of people achieving a healthy weight and participating in physical activity, reducing smoking, promoting sensible drinking, reducing harm from substance misuse and improving sexual health and access to services.

Enabling people to manage their own health and wellbeing as independently as possible - aims to improve the quality of life for people with long term conditions and enable people with dementia and their carers to have access to good quality early diagnosis and support. It seeks to ensure people with mental health issues

have access to timely assessment, treatment and support and good access to treatment and care. It also seeks to enable people to stay and live well in their own home as long as possible and aims to increase the preferred pace of care and death for those who need end of life care services.

Improving wellbeing, resilience and connectedness – aims to address the wider determinants of health and wellbeing and links to wider actions. This includes work to reduce poverty and increase economic development, improve wellbeing through safer communities, increase volunteering and make best use of local assets, promote access to learning and skills, build a healthy environment and improve community connectedness.

Each of the priorities has a set of clear outcomes. The Strategy details what we are aiming for under each of the outcomes, what we need to do and our strategic intentions for 2013/14.

The draft Health and Wellbeing Strategy undertook a comprehensive consultation and engagement programme from October to December 2012 across a range of activities, events and meetings involving a total of over 2,000 contacts with nearly 250 face to face contacts and over 100 documented responses received. The consultation programme asked for views on the priorities but also asked how respondents could get involved in helping to deliver the Strategy which generated a very positive response.

The vision and priorities of the Health and Wellbeing Strategy have been broadly welcomed but people want to see details of how the planned outcomes are going to be delivered. Each priority theme lead has drafted a Deliver which sets out how the Health and Wellbeing Strategy will be implemented over the next two years.

Each of the four priority themes has given milestones, indicators and success measures, frequency of reporting and a specified lead for each action. The Delivery Plans will be managed by the lead delivery group for the priority theme reporting to the Health and Wellbeing Board on the high level outcomes.

It is a requirement from April 2013 that all Health and Wellbeing Boards produce a Joint Strategic Needs Assessment and a Health and Wellbeing Strategy. This first Merton draft strategy has been developed in partnership by Merton Council, Merton Clinical Commissioning Group, public health, NHS South West London and the voluntary sector. It is the joint responsibility of all members of the Health and Wellbeing Board and will provide the focus for the integrated approach to health and wellbeing which the Board is committed to promote.

1. Introduction

In Merton residents are generally healthy and health outcomes are largely in line with, or above, the England average. However there remain stark differences in health between areas. Most strikingly there is a gap in life expectancy of nearly nine years for men, and over eleven years for women, between the least and the most deprived wards of Merton.

Our draft strategy aims to help all local people improve their health and wellbeing by identifying key priorities for improvement. These are based on evidence in our Joint Strategic Needs Assessment, what can be done to address them and what outcomes are intended to achieve. These priorities will underpin commissioning plans and other agreements to undertake action together, in order to make the greatest impact across the health and social care system and wider Council and partner responsibilities.

The new Health and Wellbeing Strategy is the mechanism by which Merton Health and Wellbeing Board will establish preventative priorities, address identified needs and set out agreed outcomes for collective action by our commissioners.

Our shadow Health and Wellbeing Board is a partnership of local Councillors, officers of the Council, Merton Clinical Commissioning Group, HealthWatch and representatives of the health and voluntary sector. Through better integration of service planning and service provision the Health and Wellbeing Board will avoid duplication and increase efficiency and quality of services for residents, whilst maximising use of resources.

This draft strategy has been produced fairly rapidly in order to provide a framework for wider consultation and engagement. It will provide a foundation on which to base further developments in 2013/14 and beyond.

2. Vision and Principles

Our vision is:

By working with communities and residents, to increase the opportunities for all adults and children to enjoy a healthy and fulfilling life and reduce health inequalities.

What do we mean by 'Health and Wellbeing'?

The World Health Organisation defines 'health' as:

> 'a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity'

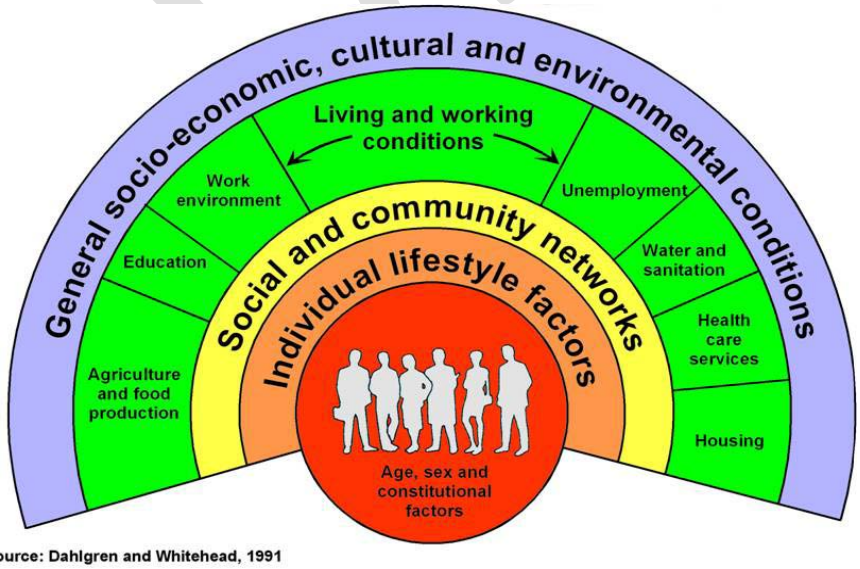
This definition implies that health is a positive concept to which government, public sector, community and voluntary groups, business and individuals can all contribute.

The Department of Health has defined 'wellbeing' as:

> 'a positive state of mind and body, feeling safe and ability to cope, with a sense of connection with people, communities and the wider environment'

Health is influenced strongly by our age, gender and genetic makeup, and our lifestyles. However other factors are also important. Education, housing, work, crime, the environment, income and access to resources all have a part to play in our health, so improvements in all of these factors are important to improve the heath of a population over time.

Diagram 1 illustrates the wider factors that impact on health and wellbeing.



Source: Dahlgren and Whitehead, 1991

Five Ways to Wellbeing

Individual wellbeing is about how people experience their quality of life, and includes family relationships, financial situation, work, community and friends, health, personal freedoms and personal values. Resilience is the ability of individuals and communities to cope positively with change, challenge and adversity. Five factors have been identified as key in achieving mental wellbeing and resilience:

- **Be active** - Participating in regular physical activity has been shown to improve both your mental and physical health.
- **Connect** - Building good relationships with those around you (friends, family, colleagues and community) will help to support you, improve your self-worth and enrich your life.
- **Give** - Helping others can make you feel good about yourself. This can be anything from a small act of kindness to volunteering at a local community centre or service.
- **Keep Learning** - Learning a new skill can build your confidence and enhance your sense of achievement. It can also be a great way to meet new people.
- **Take notice** - Taking the time out to think about yourself and what is going on around you can give you the opportunity to de-stress and recharge your batteries.

Core Principles

It is important that our Health and Wellbeing Strategy is underpinned by core principles that all partners on the Health and Wellbeing Board are signed up to. These have been agreed as:

- Supporting everyone to take greater responsibility for their health and wellbeing
- Encouraging everyone to make a personal contribution
- Raising aspirations
- Recognising mental health as a cross cutting issue integral to wellbeing
- Focusing on tackling the worst inequalities in health and wellbeing
- Promoting equalities and diversity
- Working in partnership and promoting integration to achieve more

3. Assets and Enablers

Merton shadow Health and Wellbeing Board recognises that only by working together and building on the resources we have locally we can work to make the changes needed to give residents a healthier Merton. Merton has a continuing commitment to its community based resources including libraries, children's centres, parks and open spaces, cycle ways and community centres. Assets we have in Merton which can help build a healthier population include:

- 26 General Practices with family doctors and practice nurses as well as pharmacies, dental practices and health centres
- 43 Primary schools, eight secondary schools, three special schools, one Pupil Referral Unit and 11 children's centres
- Seven Libraries
- Three Leisure Centres and a range of sports facilities
- Over 65 parks and open spaces (including Wimbledon and Mitcham commons), 28 conservation areas, 11 nature reserves and 17 allotment sites
- A strong and diverse voluntary sector supported by the Compact
- 7 Community centres and a wide range of places of worship
- Community groups and neighbourhood activity

These are just examples of the array of assets in Merton. Further information about assets and services in local neighbourhoods throughout Merton is available at

http://www.merton.gov.uk/community-living/areas-wards.htm

Enablers are the capabilities and resources that contribute to success. We have identified the following enablers to help ensure that this strategy is effective in delivering outcomes:

- Workforce development across all partners
- New technologies and IT infrastructure
- Information and intelligence
- Performance monitoring/metrics
- Communication

A key enabler to health and wellbeing in Merton is the effectiveness of access to information. The launch of the information portal Merton I will help support local people in finding the information they need.

http://merton-i.merton.gov.uk/kb5/merton/asch/home.page

4. Scope and Purpose

The Merton Health and Wellbeing Strategy sets out our approach to improving the health and wellbeing of children and adults in Merton and reducing health inequalities.

The strategy works along side a range of existing strategies and strategic plans including:

- Merton's Children and Young People's Plan
- Merton Community Plan
- Merton's Core Strategy
- Merton's BAME Strategic Plan
- Merton Clinical Commissioning Group Integrated Strategic Operating Plan (ISOP)
- LB Merton Commissioning Plans
- The Safer Merton Partnership plan
- Merton Partnership Community Cohesion Strategy
- Merton Partnership Volunteering and Community Action Strategy
- Merton Housing Strategy

For 2013 the strategy includes identified priorities based on the Joint Strategic Needs Assessment, performance management and those common to core partner organisations. It will provide a foundation on which to base further developments from 2013, incorporating feedback from wider consultation and engagement.

We will prioritise the issues requiring the greatest attention, not trying to do everything at once, and focusing on key areas that can make the biggest difference.

5. Context

National Context

The Health and Social Care Act 2012 fundamentally impacts on the way in which public health, health services and social care are delivered. It creates new organisations, structures and accountabilities with significant responsibilities moving from the Department of Health to the new NHS Commissioning Board.

Groups of GP practices and other professionals have formed Clinical Commissioning Groups (CCGs) which are seeking authorisation to commission health services - the Merton CCG has been a partner in developing the Health and Wellbeing Strategy. The legislation also creates a health specific economic regulator and moves all NHS trusts to foundation trust status

The Act creates Health and Wellbeing Boards (HWBs) which have a core role in encouraging integrated, joined-up commissioning across the NHS, social care, public health and other local partners. HWBs full statutory responsibilities will be in place by April 2013 but a Shadow Health and Wellbeing Board has been working in Merton since 2011 and has steered this strategy. The Act includes responsibility for public health transferring from the NHS to local authorities and Merton Council will have new statutory powers and a public health budget by 2013.

The changes link to Fair Society, Healthy Lives 2010 which reported Professor Sir Michael Marmot's analysis of health inequalities in the UK. The Marmot 'six priorities for action' offer a way of considering a total response to health needs. Social infrastructure impacts on deprivation which is the breeding ground for poor health; supporting community activity can improve people's confidence and resilience; positive behaviours keep people healthy. Appendix 2 sets out an illustration of the causal pathway of this relationship between social inequality and health inequality.

Wider Government legislation including the Welfare Reform Act 2012 will impact on factors which can determine health and wellbeing. The Department of Work and Pensions (DWP) estimates that 56,000 households in England will have their benefits reduced in 2013-14 losing on average £93 per week. London is expected to be hit hardest by Housing Benefit reform with an estimated 159,000 households due to lose out which DWP acknowledge will lead to a higher risk of homelessness. In Merton it has been estimated that 309 people will be affected by the total benefit income cap and 958 claimants by the changes to housing benefit under occupancy.

The common view is that absolute and relative poverty will increase over the coming decade. (Institute of Fiscal Studies (IFS) October 2011) which inevitably impacts on health and wellbeing.

Local Context

Merton Clinical Commissioning Group (MCCG) is operating in shadow form while it develops to full authorisation to commission health services. It has worked closely in the development of this strategy and its commissioning intentions as set out in their Integrated Strategic Operating Plan (ISOP) are closely aligned with this strategy.

Public health will become the responsibility of Merton Council in April 2013 and a Director of Public Health for Merton has been appointed. This is an opportunity to strengthen how Council services impact on the determinants of health and there is also scope for increasing community capacity to support health and wellbeing through prevention and self care initiatives. The Public Health team has worked in partnership with Merton Council for a number of years and the transfer of responsibilities to the local authority will help build a public health movement through engagement with a wider variety of organisations, professionals and decision makers

This approach also builds on the work of Merton Compact
http://www.merton.gov.uk/compact

a partnership agreement between local public bodies and the voluntary and community sector to improve their relationships and provide a framework within which the sectors can understand what to expect from each other. It also increases capacity and capability, addressing health knowledge and skills within local communities across the wider workforce, amongst public health practitioners and specialists, and in leadership of the Council, MCCG and other organisations.

Providing effective services which meet the needs of our community is challenging. Both the Council and the NHS are facing a highly challenging financial position in the short and medium term. This involves delivering significant savings, whilst demand for services, particularly from those most vulnerable in our society, continues to increase.

Partners are experiencing significant budgetary pressure while operating in an environment of rising expectations and demand for high quality services. Demand for health and social care services is expected to rise due to demographic changes and this increases the pressures on finite resources.

Better Services, Better Value is the review of health services in South West London in which doctors, nurses together with wider stakeholders and patients' representatives have been involved in clinical working groups looking at proposals the following areas:

- Planned care
- Urgent, unscheduled and emergency care
- Maternity and newborn care
- Children's services
- Long-term conditions

- End of life care

As well as health professionals looking at these areas, there has been a wider engagement programme involving partners, community groups, voluntary organisations and local people. However, the proposals of Better Services Better Value are the subject of an ongoing discussion and no decision has yet been made.

Better Healthcare Closer to Home (BHCH) is a programme that seeks to reshape health services in Sutton and Merton to provide healthcare designed around the needs of the local people by:

- Improving outcomes for patients
- Providing more care locally
- Tackling health inequalities
- Meeting changing demographic and healthcare needs
- Modernising estates
- Using resources more efficiently

BHCH proposes to meet its objectives through the development of local care centres (LCCs) at the old Nelson hospital site and in Mitcham to provide a wide range of improved outpatient, minor procedure and diagnostic services in a local setting. It also includes expansion of intermediate and post-acute care services, doubling of support for home-based intermediate and post-acute care services and development of a more flexible procurement model for intermediate care.

Local evidence and the direction of national policy highlights that partnership working between primary care, local authorities and the third sector to deliver effective prevention and early intervention services can bring important benefits including increasing quality and reducing costs.

We have achieved much together in partnership in Merton to deliver Merton's Healthier Communities strategy 2009-2012. The time is now right to take health and wellbeing forward to a new level. Based on existing work and seeking to fully engage with all those with a contribution to make, those in the public sector, voluntary and community sector and local businesses.

It also means involving local communities better in improving their own health. This approach will serve to develop the capability and capacity of the Merton Health and Wellbeing Board to provide a good foundation for Merton's future health.

6. Health and Wellbeing in Merton

The Joint Strategic Needs Assessment (JSNA) provides a picture of health and wellbeing for Merton. It provides a basis of sound evidence for the planning and commissioning of local services. It includes an overview of health and wellbeing needs and links to other in-depth needs assessments where available. It is accessible on line at: www.mertonjsna.org.uk. The JSNA draws out the most important challenges to our residents:

Population growth and changes to our population

Merton has a resident population of approximately 200,000 according to the results of the latest 2011 census, with a younger population profile than England. There have been significant changes to the demographics of the population in Merton over the past decade, most noticeably the increasing birth rate, which has increased by 40% since 2002. The population is set to increase by over 21% by 2021, including a projected increase in the number of over 65 year olds by nearly 21%. This has significant implications for the planning and delivery of local health and care services.

Health inequalities

Overall Merton health outcomes are among the best in London, and largely in line with the England average, for example life expectancy for men is 80.7 years and for women is 84.6 years. However, there are stark differences between different areas and life expectancy is nearly 9 years lower for men and 13 years lower for women in the most deprived areas (ward level) in east Merton than the least deprived areas in the west of the borough. Although overall deprivation has reduced across Merton, these health inequalities reflect the gap in multiple deprivation between east and west Merton.

Local communities have become more diverse over the last ten years, and it is estimated that overall 49% of the population are from Black and Asian Minority Ethnic groups and non-British White communities, with emerging new Polish and Tamil communities in the borough. It is important to understand the different needs of all our communities so that when help is needed, we can ensure people can access the right services at the right time to meet their needs.

People with a learning disability are 2.5 times more likely to have health problems than the general population, both physical and mental health (Disability Rights Commission report, ‘Equal Treatment – Closing the Gap’). In Merton prevalence information on people with learning disabilities suggests that they are tending to live longer than expected and as people with learning disabilities get older they will have increasingly complex health and social care needs.

Children and young people

Around 23.5% of the population of Merton are under the age of 20. Around 61% of school children are from a black or minority ethnic group. The health and wellbeing of children in Merton is generally better than the England average, however inequalities remain, for example although deprivation is lower than the England average, about 7,400 children still live in poverty.

What a child experiences during the early years lays the foundations for the whole of their lives. Merton has a significantly lower level of babies with low birth weight (6.5%) compared with the regional profile (7.5%), but again there is variation at ward level, ranging from 3.9% in Wimbledon Park to 8.8% in Longthornton.

Breastfeeding is an effective way of ensuring child health and in 2011-12 over 82% of mothers initiated breastfeeding when their baby was born, and by 6-8 weeks after birth 69% of mothers were continuing to breastfeed. Immunisation is a very effective means of preventing infectious disease with protective benefits both for individuals and the community. In Merton the uptake of childhood immunisations is below the 95% that would be ideal, and is also generally lower than the London and England rates, and measures are being implemented to address this locally.

Obesity continues to be a national and local challenge. The National Child Measurement Programme results for 2010/11 show that nearly 1 in 5 Reception Year children are categorised as overweight or obese, and this rises to over a third of Year 6 children. 58% of children and young people participate in 3 hours of sport or more, which is above the national average.

There are strong links between emotional wellbeing of children and young people and their personal and social development and educational performance. Through the TellUs 4 survey 52% of young people in Merton perceive that they are emotionally healthy compared to 56% nationally. Rates of mental health admissions to hospital among 0-17 year olds is below the national and London averages.

Teenage pregnancy rates remain relatively low; with a 40.4% reduction in under 18 conception rates since 1998. Work continues to emphasise prevention, for example through the development of a standardised condom distribution scheme and the provision of easily accessible sex and relationship advice.

Hospital admission rates (under 18 year olds) for alcohol specific conditions are well below national averages, and less young people reported having been drunk in Merton than nationally. Admissions specifically related to substance misuse for young people (15 – 24 years) are also well below regional and national rates and this was again reflected in what young people told us in the ‘Tellus4’ survey.

Lifestyle risks for adults

Lifestyle choices have a significant impact on current and future health and wellbeing of our residents and remain a significant challenge in Merton. It is estimated that nearly 1 in 5 adults are obese, but in some areas in the east of the borough this rises to nearly a third of adults. Overweight and obesity is associated with deprivation and costs the NHS in Merton about £50 million each year. Levels of physical activity in Merton are lower than regional and national averages, with less than 1 in 10 adults taking part in enough physical activity to benefit their health. Overall it is estimated that just over 16% of adults are smokers in Merton, however in some areas in the east of the borough up to 24% of adults are estimated to smoke.

Although the estimated level of binge drinking in Merton is lower than the London average, the estimated levels of drinking at 'increasing risk' is higher than the London average. Evidence suggests that higher risk drinking is evident across both deprived and affluent areas of Merton. The rate of alcohol specific hospital admissions increased between 2008 and 2010, but is still below the London average. It is estimated that overall 5,024 people aged 18 to 64 are dependent on drugs, with most dependence on cannabis (PANSI).It is estimated that there are 1,029 crack and opiate users in the borough (NDTMS).

Sexual health priorities in Merton include reducing the late diagnoses of HIV, which made up 36% of all diagnoses in 2009; increasing access to contraception and access to sexually transmitted infection testing and maintaining coverage of Chlamydia testing. Sexual health is a fundamental right for the whole population, but inequalities exist in Merton, which is consistent with national evidence which show that women, men who have sex with men (MSM), young people (aged 25 and under) and people from BME (black and minority ethnic) communities are disproportionately affected by poor sexual health.

Local research into attitudes to healthy living among adults in Merton, including residents in east Merton wards, told us that the most important health behaviour was 'keeping happy' followed by 'not feeling stressed'. This shows the importance of good mental well being to residents. Residents seem to 'know the what, but not the how' and wanted support to make lifestyle changes.

Main causes of poor health and death

The way we live our lives can have a very significant impact on future health and wellbeing. Cancer, circulatory diseases, diabetes and respiratory diseases are the main diseases present in Merton. Cancers and circulatory disease remain the main causes of death. Deaths from cancer and circulatory disease in people aged under 75, many of which are potentially preventable, have reduced over the past 10 years. However inequalities remain and in line with the gap in life expectancy and lifestyle

risks, there remains a gap in the rate of deaths from these causes between east and west Merton.

Mental ill-health includes conditions on a spectrum ranging from those almost entirely managed in Primary Care to conditions that are almost exclusively managed by specialists. Mental ill-health can be both the cause and the consequence of social exclusion leading to a cycle of homelessness, unemployment, and worsening physical and mental health. In Merton it is estimated that about 13,500 people of working age experience depression and/or anxiety, and Merton ranks 21 out 33 London boroughs for prevalence of depression/anxiety, where 1 is the highest.

Dementia is by far the biggest mental health issue for people over the age of 65 and this increases with age, with 68% of all people with dementia aged over 80 years. In Merton the prevalence of dementia in the older population is 5.2% for men and 7.3% for women (2007).

With an ageing population we are facing an increasing number of people needing support in their last days of life. For people approaching the end of their lives, as well as for carers, families and friends having a choice in where they receive care is important. A national survey indicated that 57% of respondents would prefer to die at home, for Merton just over 18% of deaths occurred in the home (2008-2010), however, this position is improving with 34% of deaths now occurring at home or in a care home.

Our Living Environment – the wider determinants of health

The quality of the physical environment, the services that people receive and the connections that they make with each other all contribute to community resilience and the ability of neighbourhoods to be inclusive and care for everyone who lives there. The Council and its partners have a strong influence over certain aspects of our immediate environment: the air we breathe; the condition of living accommodation; our economic circumstances; and our sense of personal security. Addressing the wider determinants of health will create an environment which maximises the potential for healthy choices.

Being in good employment is generally protective to health, and people who are unemployed have higher rates of limiting long term illness, cardiovascular disease and health problems. In Merton, 3,878 people claimed Jobseekers Allowance (October 2012), 2.7% of the resident population aged 16-64 years. The percentage of claimants is lower than the London (4.2%) and Great Britain (3.8%) levels, but is concentrated in east of the borough.

Merton has the lowest number of accepted homeless households amongst all London boroughs. However, there is high level of housing needs amongst Merton residents. Merton's Housing Needs Survey identified a need to develop an additional 1,848 affordable homes per year between 2005 and 2010 if all housing need in the

borough were to be met. The 2010 Merton Strategic Housing Market Assessment showed that across Merton, around 17.2% of households are unsuitably housed, equivalent to 13,860 households (including owner-occupiers), with much of the unsuitable housing being in the east of the borough.

Areas such as alcohol related disorder in town centres, anti-social behaviour, burglary and robbery are consistently highlighted by residents through survey activity as a cause for concern. Local consultation found that there has been an increase in residents believing that levels of anti social behaviour have not changed, although the residents survey showed an increase which may reflect the civic unrest of Summer 2011. There were 749 reported domestic violence offences in 2011, and there has been a reduction in Merton over the past three years, however, it should be noted that domestic violence is generally underreported.

7. Setting Priorities

Priorities have been set through a health and wellbeing prioritisation model that involves an explicit process.

Step One
A review of Joint Strategic Needs Assessment and wider evidence of health and wellbeing.

Step Two
A review of prioritised need against agreed criteria (this is widely used set from King's Fund framework):

- Is this an issue which affects a significant proportion of the population?
- Is this an issue which significantly affects vulnerable groups?
- Is this issue a significant contributor to inequalities in health and wellbeing?
- Is there evidence of unmet need?
- Is the need likely to increase if there is no intervention?

Step Three
Prioritisation results were reviewed and decisions made on the basis of the outcome of the process.

8. Our Priority Themes

Informed by our Joint Strategic Needs Assessment and the steps set out to establish key priorities we have identified four priority themes to achieve our vision:

By working with communities and residents, to increase the opportunities for all adults and children to enjoy a healthy and fulfilling life and reduce health inequalities

Priority 1	Giving every child a healthy start
Priority 2	Supporting people to improve their health and wellbeing
Priority 3	Enabling people to manage their own health and wellbeing as independently as possible
Priority 4	Improving wellbeing, resilience and connectedness

The diagram below sets out the four priority themes with key outcomes, delivery leads, core principles and enablers.

Merton Health and Wellbeing Strategy

Priority Themes

Giving every child a healthy start	Supporting people to improve their health and wellbeing	Enabling people to manage their own health and wellbeing as independently as possible	Improving wellbeing, resilience and connectedness

Outcomes

Ensure every baby has the best start in life. Promote and improve the personal, social and mental wellbeing of our children and young people and their parents. Promote and increase the proportion of healthy weight children and young people Enable and increase the number of young people making healthy life choices	Promote and deliver an integrated approach to health and wellbeing Increase the proportion of people achieving a healthy weight and participating in the recommended levels of physical activity Reduce the prevalence of people smoking Promote sensible drinking, reduce alcohol related harm and harm from drug misuse Improve sexual health and access to services	Improve health related quality of life for people with long term conditions. Enable people with dementia and their carers to have access to good quality, early diagnosis and support. Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location. Enable people to stay in their own home as long as possible. Increase the preferred place of care and death for those who need end of life care services.	Reduce poverty and increase income through economic development. Improve wellbeing through safer communities and community cohesion. Increase volunteering and make best use of local assets including parks, schools and leisure centres to promote wellbeing. More people make a positive contribution to their own wellbeing through access to learning and development of skills. Build a healthy environment including access to housing, local amenities and activities. Improve community connectedness, improve independence and resilience of local communities.

Priority Lead

Children's Trust	Healthy Living Delivery Group	One Merton Group	Sustainable Communities Partnership

Core Principles

Taking greater responsibility for personal health and wellbeing	Encouraging everyone to make a personal contribution	Recognising mental health as integral to wellbeing
Promoting equalities and diversity	Focus on tackling the worst inequalities in health and wellbeing	Working in partnership to achieve more

Enablers

Workforce development	New technologies and IT infrastructure	Performance monitoring /metrics
Communication	Information and intelligence	

Priority 1: Giving every child a healthy start

Why is this important?

We want to give every child the best start in life, as there is compelling and growing evidence that shows what a child experiences during the early years (including before birth), lays down a foundation for the whole of their life. (Marmot Review 2010, Centre for Excellence and Outcomes in Children and Young People's Services 'Grasping the Nettle' 2010). Birth weight is a good measure of infant health, and we know that disadvantaged mothers are more likely to have low birth weight babies. Low birth weight is associated with poor long-term health and educational outcomes. Two of the key factors for low birth weight are maternal smoking and poor nutrition.

Breastfeeding is one of the most effective ways to ensure child health and survival (World Health Organisation), with benefits to babies, (reduction in risk of infections, diabetes, eczema and asthma, obesity) and to mothers (reduction in risk of breast and ovarian cancers, and osteoporosis in later life), as well as helping create a special bond between mother and baby.

The ability to communicate underpins a child's social, emotional and educational development (The Bercow Report, 2008). It is therefore vital that children are given every opportunity to develop early communication skills through positive interactions through their parents or through prompt and early identification of delay, and age-appropriate targeted interventions.

Parents are the most significant influence on children, so it is important that parents can access the support they need to parent effectively. Support may take the shape of antenatal care, postnatal care, support to tackle alcohol and substance misuse, support for specific vulnerable groups (such as teenage parents) or support at specific ages and stages (such as transition from Primary to Secondary School). Evidence-based parenting programmes are a way to help parents better understand the needs and behaviours of their child; supporting them to be the best parents they can be and equipping the whole family with tools that will enable them to build resilience, and lead healthy lives.

Emotional difficulties and mental health problems in children and young people are associated with educational failure, family disruption, offending and anti-social behaviour. Untreated, emotional difficulties and mental health problems create distress, not only in children and young people, but also for their families, carers and the wider community. This can continue into adult life and affect the next generation. Healthy children with high self-esteem learn and behave better. School-based mental health promotion can help to improve self-esteem and reduce risky behaviours.

The teenage years are an important time for making significant life choices and decisions. Aspiration and attainment will frame these choices. Research shows that

in early adolescence young people become more sensitive to reward, but it takes much longer before they develop their ability to control impulses, make strategic decisions and develop the ability to understand another persons point of view. These changes in behaviour occur at a time when influence from friends and peers is increasing and reliance on parents and family decreasing. This may help explain why young people are more likely to undertake risky behaviours and demonstrate why young people continue to need support to make healthy life choices (Positive for Youth, 2011).

Where are we now?

Many indicators relating to health outcomes are improving in Merton. Levels of breastfeeding and immunisations are rising. This has been achieved in part through our developing positive partnership relationships, including, the integrated delivery of a range of health initiatives through our 11 Children's Centres, (involving midwives, health visitors, stop smoking service, speech and language therapists), and through the establishment of our integrated service for children with disabilities.

Rates of obesity remain challenging although there has been some reduction in the number of children overweight or obese, in reception year. Progress has also been made in promoting healthy lifestyles with increasing take up of healthy school meals and PE and sport. Merton's new adventure playground has attracted high levels of use.

Partners have been engaged in developing a new emotional well-being strategy, focusing on lower level interventions supported by the re-commissioning of specialist Child and Adolescent Mental Health (CAMH) services, and the development of Targeted Mental Health in Schools.

We have delivered a large number of parenting programmes in Merton, but we know there is scope for better coordination of delivery of these across partner agencies, further improvements in targeting parents, and improvements in the number of parents that complete programmes, ensuring that the right parents get the right support at the right time.

We have been a pilot site for provision of free provision for disadvantaged 2 yr olds, and have introduced early language and communication interventions such as 'Every Child a Talker' (ECAT) and 'Chitter Chatter' in our Early Years settings and Children's Centres. We have continued to narrow the gap in attainment at the end of the Early Years Foundation Stage.

Integrating the commissioning of youth, substance misuse and teenage pregnancy services has improved targeting and value for money of these services. Merton continues to perform well in reducing levels of teenage pregnancy. We now have the provision of accessible contraception advice, Chlamydia screening, and pregnancy testing for young people through the 'Check It Out' service.

Where do we want to get to?

We want to further strengthen our partnership approach to preventative strategies for health and well being, across all universal services and settings. We want to ensure the earliest identification of health and well being issues, (for example through the roll out of the complete 'Healthy Child Programme'), and through this, better targeting of services to those families that are in greatest need of support.

We want to ensure the workforce is equipped with the skills to:

- Promote healthy life choices
- Identify health issues at the earliest possible opportunity
- Intervene effectively when needed.

Priority 1 Giving Every Child a Healthy Start

Outcomes

1. ***All babies have the best start in life.***
2. ***Promoting the emotional wellbeing of our children and young people***
3. ***Promoting a healthy weight***
4. ***Helping young people to make healthy life choices***

Outcome 1.1: All babies have the best start in life

What we are aiming for:

We want to provide every child with the best start in life, setting a foundation that helps to reduce health inequalities across the life course.

What we need to do:

To achieve this, we need to ensure that parents are supported to give birth to healthy babies by ensuring:

- women (especially younger women) have access to good contraceptive and sexual health services so that pregnancies are planned, and more women choose to have their babies after their teenage years.

- parents-to-be can access good antenatal support that prepares them for parenthood, as well as ensuring the health of mother and baby throughout pregnancy.

We need to continue to work in partnership to ensure the promotion of health initiatives including:

- Breastfeeding,
- Childhood immunisations
- Parenting support including the promotion of our Children's Centre offer, delivery of accredited parenting programmes and targeted support for parent carers of children with disability.
- The Healthy Child Programme.

Strategic Intentions for 2013/14:

- Further develop our partnership approach to targeting services within Children's Centres
- Implement our new Early Intervention Strategy for our most vulnerable families.
- Reviewing our focus on health and well being in our parenting strategy.

Outcome 1.2: Promoting the emotional wellbeing of our children and young people

What we are aiming for

We want children in Merton to enjoy good mental health. We want to see a pro-active approach to child mental health, with provision of prompt support and early interventions to promote good mental health. We want problems addressed at the lowest possible tier of provision by offering a prompt response to service users, families and agencies concerned with children's well-being.

What we need to do:

To achieve this we need to ensure that we work in partnership to build relationships with our vulnerable parents, helping them to develop a warm and stimulating environment so that babies can form secure attachment, and families can become resilient. We need to identify early and provide the support needed for issues such as:

- Post Natal Depression
- Parental Alcohol and Drug Misuse
- Domestic Violence

We need to continue to promote emotional well being in our children through our Universal Settings such as Children's Centres and Schools through commissioned interventions and through universal delivery such as:

- PSHE (Personal, Social and Health Education)
- SEAL (Social and Emotional Aspects of Learning)

And we need to ensure that these settings are supported in this delivery, and have the skills to identify children that need additional emotional and mental health support.

We need to ensure that those children and young people that have a serious mental health issue/illness have prompt access to specialist assessment and treatment.

Strategic Intentions for 2013/14

- Review and refresh the CAMH Strategy.
- Maintain a sharp focus on the delivery of CAMH services as the lead responsibility for commissioning shifts to the Clinical Commissioning Group.

Outcome 1.3: Promoting a healthy weight

What we are aiming for

We want to tackle childhood obesity and help children and young people achieve a healthy weight as a key way to prevent future illness.

What we need to do:

We need to ensure that we work in partnership to deliver activities and messages that consistently promote and help our babies, toddlers and children to maintain a healthy weight. These may include:

- Children's Centre Activities that promote physical exercise
- The take up of Free School Meals
- Requiring all commissioned and directly provided activities and services to offer healthy food choices and promote healthy eating.

- Promoting and enhancing access to leisure and sport activities for children, young people and families.

We need to continue to monitor our levels of overweight and obesity through increased numbers of eligible children and young people taking part in the National Child Measurement Programme (NCMP), using this information to inform the development of support programmes which:

- Are age-specific
- Deliver a multi-faceted programme that includes healthy eating, exercise and behaviour change.
- Targets specific communities or geographical areas directly linked to the outcome of the NCMP
- Focus on completion and outcomes
- Review, enhance and promote the availability of leisure and sport activities for children, young people and families.

Strategic Intentions for 2013-14

- Close performance management of current commissioned interventions, to ensure continuity of service delivery during transition of public health responsibilities to the local authority.
- Review and re-commissioning of a children and young people's weight management programme to support the National Child Measurement Programme, for commencement in April 2014.

Outcome 1.4: Helping Young People to make Healthy Life Choices

What we are aiming for

We want young people to feel good about themselves, and feel confident and informed to make Healthy Lifestyle Choices as they move into adulthood.

What we need to do:

We need to ensure that our young people and their parents (carers) are fully informed during adolescence, encouraging and supporting them to make healthy life choices. At this time, many young people experiment, sometimes with risky behaviours. The areas of advice need to focus on:

- Sexual health advice including easy access to contraception, advice and information on sexually transmitted infections and pregnancy.

- Drug and Alcohol misuse including the dangers of binge drinking, recreational drugs, signs and symptoms of drug misuse.
- The hazards of smoking.

Alongside this, we need to have sufficient diversionary and positive activities for young people, including volunteering opportunities that will help them develop self-esteem and confidence, and increase their chance of future education and employment opportunities as they move into adulthood.

For those young people that already have issues associated with risk taking behaviours, we need to ensure that they have access to age-appropriate interventions and/or support such as:

- Pregnancy testing, termination advice and counselling, antenatal and postnatal support that includes access back into education, employment, or training (EET)
- 1:1, group work and parenting support for young people and their families to deal with substance and alcohol misuse.
- Smoking cessation services

Strategic Intentions for 2013/14

- Undertake an options appraisal for Young People smoking cessation services, and review future commissioning arrangements.
- Re-commission the substance misuse service.
- Explore the possibilities of commissioning a combined substance misuse, sexual health and smoking cessation service for young people.
- Establish volunteering opportunities for young people in cultural, sport and leisure activities.

Priority 2:

Supporting people to improve their health and wellbeing

Why is this important?

We want to support people in Merton to improve their health and wellbeing, to increase quality of life, enable people to make their own choices and have better life chances. In doing so, we want to reduce the gap in life expectancy and reduce the burden on public services.

Circulatory disease (including cardiovascular disease and stroke) and cancer are still the major killers in Merton and consequently these diseases along with diabetes are among the main causes of long term illness and disability. Key risk factors are smoking, being overweight and obese, lack of physical activity and risky drinking behaviour and therefore many of the resulting illnesses and conditions are potentially preventable. Mental Wellbeing is of vital importance for long-term physical health and there are links between long-term stress, isolation and lonliness and poorer physical health.

Lifestyle decisions have a very significant impact on future health and wellbeing, however, while individual lifestyle choices may seem most amenable to change through 'informed choice' in reality many apparently free choices are strongly influenced by socioeconomic, cultural and environmental factors. Tackling inequalities requires partnership work with communities and an integrated approach to prevention and health improvement.

Where are we now?

It is estimated that nearly 1 in 5 adults are obese but in some areas in the east of the borough this rises to 29%. Overweight and obesity is associated with deprivation and costs the NHS in Merton about £50 million each year. Levels of physical activity in Merton are lower than regional and national averages, with less than 1 in 10 residents taking part in enough physical activity to benefit their health. Tackling obesity is complex having behavioural, genetic, environmental and social factors and promoting healthy weight requires a multi-agency response, including a whole family approach, promotion of healthy food choices, building physical activity into our day to day lives, safe open spaces, promoting walking and cycling, promoting the role of employers and personalised advice and support for individuals. Locally progress has been made on these areas and support for people who are overweight and obese include the LiveWell service and weight management programmes.

Overall it is estimated that 16% of adults are smokers in Merton, however in some areas in the east of the borough up to 24% of adults are estimated to smoke. The impact of smoke free legislation has been positive in reducing exposure to second hand smoke and changing behaviour, with smokers cutting down tobacco

consumption. Tobacco control in Merton includes reducing illegal sales of tobacco to underage people and ensuring compliance with regulations on the display of tobacco products, as well as providing an NHS Stop Smoking Service for people wanting to quit, targeting areas and groups with higher levels of smoking.

Although the estimated level of binge drinking in Merton is lower than the London average, the estimated levels of drinking at 'increasing risk' is higher than the London average. Evidence suggests that higher risk drinking is evident across both deprived and affluent areas of Merton. The rate of alcohol specific hospital admissions increased between 2008-2010, but is still below the London average. It is estimated that overall 5,024 people aged 18-64 are dependent on drugs, with most dependence on cannabis. It is estimated that there are 1,029 crack and opiate users in the borough.

Sexual health priorities in Merton include reducing the late diagnoses of HIV, which made up 36% of all diagnoses in 2009; increasing access to contraception and access to sexually transmitted infection testing and maintaining coverage of Chlamydia testing. Sexual health is a fundamental right for the whole population, but inequalities exist in Merton and we know that women, men who have sex with men (MSM), young people (aged 25 and under) and people from BME (black and minority ethnic) communities are disproportionately affected by poor sexual health.

Local research into attitudes to healthy living among adults in Merton, including residents in east Merton wards, told us that:

The most important health behaviour was 'keeping happy' followed by 'not feeling stressed'. This shows the importance of good mental well being to residents.

- Walking and cycling, limiting alcohol intake and eating 5 a day were least important.
- 50+ residents perceived healthy weight, safe sex, regular exercise and not smoking as less important compared to the young age groups
- Residents seem to 'know the what, but not the how' and wanted support to make lifestyle changes.
- Residents wanted to build relationships with deliverers and wanted local activities delivered by local people.
- People with disabilities find it difficult to maintain a healthy lifestyle, but were very clear how important being healthy was for them

We know that people from Black Asian and Minority Ethnic groups are disproportionately affected by poor health because of a range of complex genetic, social, cultural and environmental factors. We need to ensure that support for health

improvement is accessible and appropriate for all Merton's diverse communities and consistent with priorities in Merton's BAME Strategic Plan.

Our ambition:

We want to:

- Strengthen self-esteem, confidence and personal responsibility
- Positively promote healthier behaviours and lifestyles
- Adapt the environment to make healthier choices easier
- Promote an integrated approach to healthy living

Priority 2: Supporting people to improve their health and wellbeing

Outcomes

2.1 ***Promote and deliver an integrated approach to healthy living***

2.2 Increase the proportion of people achieving a healthy weight and participating in the recommended levels of physical activity

2.3 Reduce the prevalence of people smoking

2.4 Promote sensible drinking and reduce alcohol related harm and harm from drug misuse

2.5 Improve sexual health and access to services

Outcome 2.1: Promote and deliver an integrated approach to healthy living

What we are aiming for:

We want to support people to improve their health and wellbeing through an integrated approach, this means that all local partners should be active in promoting health and wellbeing as part of their day to day work –including the NHS, Council, voluntary and community sector and local businesses. By working together towards shared priorities and improving communication we can make the greatest impact, reduce health inequalities and maximise the use of resources.

What do we need to do?

As well as promoting a healthier environment, we need to ensure that support is available at the right time and right level to help people lead healthier lives. We have developed a health improvement framework that sets out different levels of support enabling people to take care of themselves, access support to change, and access specialist help when needed.

We know that good mental wellbeing is important to residents and the links between physical and mental wellbeing are well established. We need to ensure that all health improvement services have an integrated approach to improving mental wellbeing.

In order to deliver an integrated approach to health improvement we need to:

- continue to commission effective integrated assessment and lifestyle services for the residents to improve physical and mental wellbeing.
- target resources towards the east of Merton where we know there are the biggest health inequalities.
- ensure health improvement support and services are appropriate for diverse communities across Merton.
- ensure that health and other professionals deliver consistent health improvement messages and support as part of their day to day work.
- engage businesses and employers to promote health through their services and support employees.

Strategic intentions for 2013/14

- Increase the number of residents receiving an NHS Health Check and increase the number of health improvement outcomes from residents supported by an integrated LiveWell/Stop Smoking service.
- Support communities to improve health through the East Merton Health and Wellbeing Community Fund.
- Support health and other professionals to promote health –make every contact count
- Engage business to improve health through the local Public Health Responsibility Deal
- Further develop our understanding of what motivates local people through social marketing research
- Ensure Mental Wellbeing is addressed in the development of all health improvement services and programmes

Outcome 2.2: Increase the proportion of people achieving a healthy weight and participating in the recommended levels of physical activity

What we are aiming for:

We want to support more people to achieve and maintain a healthy weight. It is a key health inequality issue in Merton, with a gap of nearly 18% between the ward with lowest and the highest estimate of adult obesity (10.6% to 28.4%).

Regular physical activity can reduce the risk of many chronic conditions, both physical and mental, even relatively small increases in physical activity are associated with some protection and improved quality of life. In Merton we want to turn around the low levels of physical activity among adults and build on the success of the 2012 Olympics to embed physical activity into our everyday lives.

What do we need to do?

To achieve this we need to ensure we have a strategic approach to healthy weight and physical activity, building on latest evidence about what works. We need to ensure that we work in partnership to deliver activities and consistent messages to promote healthy weight. This will be a major priority for 2013.

Strategic intentions for 2013/14

- Review the latest evidence about promoting healthy weight, agree a multi-agency framework and prioritise resources towards further effective interventions, including family centred approaches.
- Commission effective adult weight management services and a clear pathway of care.
- Promote a healthier environment which supports physical activity and healthy food choices and extend opportunities for physical activity and active travel, including cycling.
- Support workplaces to promote healthy food choices and active travel
- Support staff to give confident and consistent messages about healthy weight

Outcome 2.3: Reduce the prevalence of people smoking

What are we aiming for:

More than 100 people still die every year from smoking related causes in Merton and adults who smoke lose an average of 13-14 years of their lives. It is estimated that 26,600 people smoke in Merton and spend approximately £47m per year on

tobacco products. The estimated cost to wider society in Merton is £41.5m per year. We want to support more people to successfully quit smoking and in particular support those residents who are more likely to be smokers.

What do we need to do?

Building on the success of smoke free legislation, we need to normalise smoke free environments, we need to ensure that we are enforcing tobacco control measures, that front line staff are confident about encouraging people to stop smoking and that we are offering flexible and accessible support to people who want to stop smoking.

Strategic Intentions 2013/14

- Increase the number of people using the NHS Stop Smoking Service to make a quit attempt.
- Support smokers from target groups to quit (routine and manual workers, BAME groups, young people, people with serious mental health problems)
- Continue to tackle illicit tobacco sales and ensure compliance with advertising and promotion regulations.
- Explore opportunities to normalise smoke free environments beyond the current legal requirements.
- Provide further education around smoking cessation to key frontline staff e.g. midwives

Outcome 2.4: Promote sensible drinking, reduce alcohol related harm and harm from drug misuse.

What are we aiming for:

Evidence on the harm alcohol can cause to health is clear, it is related to types of cancer, liver disease and circulatory disease and we aim to reduce this harm. Tackling the root causes and finding solutions to prevent harm from substance misuse requires a partnership approach that is well established in Merton, we aim to build on this to focus on prevention and improve treatment recovery outcomes.

What do we need to do?

We need to promote a culture of sensible drinking drawing on local and national evidence, we need to ensure that alcohol related prevention and treatment services are cost effective, targeted and deliver the best outcomes.

We need to focus on prevention to limit the predicted increase in drug misuse, as well as deliver robust Drug Treatment Plans for those at risk of harm.

The Safer Merton Partnership is currently re-commissioning the local adult substance misuse treatment service so that it is integrated (drug and alcohol), recovery focussed and outcomes based, and the proposed service will commence in April 2013.

Strategic Intentions 2013/14

- Improve the long-term mental and physical health and wellbeing and quality of life for people affected by substance misuse, including families, children and young people.
- Reduce substance dependency, improve health and reduce health inequalities as a result of substance misuse.
- Use available levers to minimise alcohol related harm including reducing illegal sales and proxy sales by adults and using the local authority's new public health responsibilities with regard to the Licensing Act.
- Ensure alcohol is integrated with the LiveWell health improvement service.
- Pilot a social marketing campaign to reduce harmful drinking among priority groups (18-24 year olds and over 65s), with a view to rolling out wider preventative campaigns.

Outcome 2.5: Improve Sexual Health and access to services

What are we aiming for:

We aim to ensure that people have good sexual health and access to high quality, timely services. We want to address priority needs including reducing the transmission and rate of undiagnosed HIV and sexually transmitted infections (STIs), improving access to sexual and reproductive health services and increasing the capacity of primary care. We want to address the inequalities in sexual health that impact on women, men who have sex with men (MSM), young people (aged 25 and under) and people from BME (black and minority ethnic) communities.

What do we need to do?

The growing incidence of HIV and Sexually Transmitted Infections (STIs) can only be arrested through the systematic introduction of health promotion, screening, STI testing, and prompt follow-up for both patients and their partners throughout the borough.

We need to reduce late HIV diagnoses because this tends to mean a poorer prognosis and premature mortality. We need to ensure that levers to promote HIV testing in General Practice, all general medical admissions and other settings are implemented.

We need to increase access to contraception and reduce the number of abortions, and repeat abortions. We need to reduce unplanned pregnancy locally and increase access to a range contraception including long-acting reversible contraception (LARC) and Emergency hormonal contraception (EHC). Over the last year much has been done to increase access, but more could be done including raising awareness and increasing access and uptake of services.

Chlamydia is the most common sexually transmitted infection in the UK, and can if left untreated result in pelvic inflammatory disease, ectopic pregnancy and infertility.

The National Chlamydia Screening Programme (NCSP) was established to control Chlamydia in under 25 year olds through early testing and treatment. To deliver this effectively we need to build capacity in general practice, contraceptive and sexual health clinics and a range non-clinical venues.

Strategic Intentions 2013/4

- Implement measures to reduce late HIV diagnosis, including a rapid HIV testing pilot in General Practices in high prevalence areas, and HIV testing in Contraception and Sexual Health Clinics.
- Partnership work to optimise comprehensive access to the full range of methods of contraception.
- Embed Chlamydia screening into core services to increase access to testing and achieve National Screening Programme targets.

Priority 3

Enabling people to manage their own health and wellbeing as independently as possible

Why is this important?

More people than ever before live with one or more chronic health conditions. Through helping people to manage their own health and wellbeing as independently as possible, we aim to improve the quality of life for people living with health conditions and to help them to live in their own homes as long as possible.

People with long term conditions and those with learning disabilities are intensive users of health and social care services. This has major implications for resources in a time of significant financial pressure. It also means there is a greater need than ever for effective community based services and preventative services. Achieving the highest possible standards of care within increasingly scarce resources is a key priority for Merton.

Life expectancy is increasing and the number of older people in Merton is projected to increase, so the number of people with long term conditions is rising and particularly people having two or more conditions. At any age long term conditions can have a significant impact on a person's ability to work and live a full life and stay connected to the community and those who matter to them.

Building on the evidence that preventative services can produce significant gains in the quality of life of older people it has been calculated that provision of such services can reduce the need for more intensive and expensive services. (Wanless Social Care Review, Department of Health 2010).

Our aim is to help people manage health and social care issues better, by providing accessible support in the community, timely assessment and good diagnosis. This will help reduce inappropriate hospital admissions and length of stay. Effective reablement and support on discharge is also important to help reduce unnecessary readmissions.

Dementia is by far the biggest mental health issue for people over the age of 65. It is vital to support people with dementia, and their carers to enable them to live well with their dementia. The National Dementia Strategy sets out the broader context in which local initiatives are focussed.

It is also important that those people with wider mental health issues have access to timely assessment, treatment and long term support for both their mental and physical wellbeing.

At the same time there is evidence that people with a learning disability are 2.5 times more likely to have health problems than other people (Disability Rights Commission

report, ‘Equal Treatment – Closing the Gap’ *). Guidance has noted the need to give particular consideration to commissioning services for people with learning disabilities because they experience poorer health than the general population and thus represent health inequalities. Some health inequalities relate to the barriers people with learning disabilities face in accessing health care and health screening.

The role of carers and those who can act as advocates for people who need them is valuable and we want to support people in this position. It has also been shown (Poor Health, Carers UK) that people who provide high levels of care for sick or disabled relatives or friends, unpaid, are more than twice as likely to suffer from poor health compared to people without caring responsibilities.

People say that they wish to be treated as a whole person and for those that deliver services to act as one team The patient’s experience of care needs to transcend the organisational boundaries of social, primary, community and secondary care. (Modernising the NHS, Department of Health 2011).

Where are we now?

The highest percentage of spend in adult social care is on long-term support. With substantial financial pressure there is an increasing focus on investing in preventative measures and supporting people in the community in order to reduce the pressure for long-term support.

Merton performs strongly on the ‘percentage of people supported in the community' consistently achieving over 80%. On 'the percentage of customers receiving individual budgets through self directed support' Merton is slightly below the London average though we started personalisation programme later than some boroughs and hope to achieve a significant increase over the next few years. The Delayed Transfer of Care position statement for 2012 reported Merton as the best performing borough in London in terms of having the lowest hospital patient delays in transfer.

Investment in ensuring quality support in the community, prevention and recovery is delivered through efficient processes and partnership working with the voluntary sector. This includes the new Ageing Well Programme encourage people to take responsibility for their own lives as much as possible, using their own strengths, resources and local community assets to help find solutions to their issues.

The Joint Mental Health Commissioning Strategy aims to create an effective mental health system that is more joined up to improve people’s outcomes and experience. We are working to reduce the number of people who experience a mental health crisis by delivering interventions that support people at an earlier point in the care pathway.

We know more work to support people who use services to manage their long term mental health condition is required. Changes made to in-patient mental health

services have already had a positive impact for some people who now receive greater levels of support in the community.

There has also been positive work from the multi agency team to support people with learning disabilities. The team aims to deliver self-directed support to people as quickly and efficiently as possible, with an effective safeguarding management process. Their success has been reflected by people with learning disabilities increasingly using direct payments.

The Sutton and Merton End of Life Network has been working together to deliver the Sutton and Merton End of Life Care Strategy 'A good end to life'. Through a partnership and collaborative approach between the NHS, voluntary sector, local authority, primary care, patients and carers services we have focused on delivering more resources in a community setting to enable more people to be cared for and die in their preferred place of care. We wish to ensure this work is continued and we enable more people and their families/carers to achieve their preferred place of care.

Merton Adult Social Care produces a Local Account which gives a self–assessment of services and includes details of outcomes achieved for service users. It also compares performance with other local authorities and provides customer case studies:

http://www.merton.gov.uk/health-social-care/adult-social-care/asc-plans-performance/asc-performance-2.htm

Priority 3. Enabling people to manage their own health and wellbeing as independently as possible.

Outcomes

3.1 Improve the health related quality of life and level of control for people with long term conditions.

3.2 Enable people with dementia and their carers have access to good quality early diagnosis and the support to live well with dementia.

3.3 Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support for their mental and physical wellbeing.

3.4 Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location.

3.5 Enable people to stay in their own home as long as possible.

3.6 Increase the preferred place of care and death for those who need end of life care services.

Outcome 3.1: Improve the health related quality of life and level of control for people with long term conditions.

What we are aiming for:

We want services to support people with long term conditions to have control to live as normal a life as possible and reduce the number of unnecessary emergency admissions and undue length of stay in hospital.

What we need to do:

To achieve this we need to ensure that people with one or more long term conditions have good access to the services they need to live independently and that those newly diagnosed have good information, advice and support. This includes people with long term physical and neurological conditions:

- Increase the proportion of people effectively supported to manage their own condition.
- Increase the support taken up by carers of people with long term conditions

- Improve people's experience of services that support their long term conditions

We need to continue to monitor and reduce unnecessary emergency admissions:

- Increase the number of GP practices that monitor risk scores for patients to improve clinical outcomes.
- Monitor emergency admissions for key long term conditions, measure and compare accident and emergency admissions and monitor unplanned hospital admissions to outpatients.

Strategic Intentions for 2013/14

- Implement new pathway for direct access to reablement services for people with long term conditions.
- Develop and implement programmes and individual support for carers.
- Roll out risk stratification tool to GP practices.
- Implement the urgent care at home scheme.

Outcome 3.2: Enable people with dementia and their carers to have access to good quality early diagnosis and the support to live well with dementia.

What we are aiming for

We want to support people with dementia and their carers to live as well as possible. Our aim is to improve early diagnosis and early identification of carers together and to deliver better care and support plan for individuals and their carers.

What we need to do

We need to increase the early detection of dementia and improve the dementia care:

- Increase the percentage of people over 65 with a recorded diagnosis of dementia.
- Improve quality dementia care in a residential setting.

We need to improve the way we identify carers and the level of support that is provided to them:

- Improve early identification of carers and development of an early support plan

Strategic Intentions for 2013/14:

- Improve access to memory clinic and increased screening in primary care.
- Consultation on local Dementia Care and Support Compact.
- Improve early identification of carers on diagnosis.
- Early support plan via Dementia Hub

Outcome 3.3: Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support for their mental and physical wellbeing.

What we are aiming for

We are aiming to create an effective mental health system that is more joined up and seamless; to deliver support that will improve both outcomes and experience of services and life choices including employment opportunities. We are also working to improve early interventions that support people at an earlier point in the care pathway making use of psychological therapies to build resilience to support prevention of crisis.

What we need to do

We need to ensure that mental health services are person centred and need to work to improve the integration of primary and secondary care:

- Ensure mental health services commissioned are person centred increasing self-defined recovery outcomes.
- Improve integrated working between primary and secondary care to ensure physical health care needs are met with regular physical health assessments by GPs of mental health service users.
- Improve communication between primary and secondary care to ensure mental and physical health outcomes with discharge summaries and care planning reviews are sent promptly to GPs

We need to improve the care provided to people with mental health needs delivering timely assessment and treatment, and supporting their physical health:

- Improve access to mental health services to enable early diagnosis.

- Improve physical health of those with secondary health needs.

We need to improve support for carers including young carers.

- Raise the visibility of the role and contribution of mental health carers.

Strategic Intentions for 2013/14

- Conduct an audit of care plans for people on CPA (Care Programme Approach).
- Discharge summaries to be sent to GPs within seven days of discharge.
- Improving information available through the new Merton-i web site.
- Ensure appropriate care setting of those with secondary physical health problems.
- Consultation on compact for local mental health carers.

Outcome 3.4: Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location.

What we are aiming for:

We aim to provide good quality diagnosis, treatment and care to people that is as appropriate as possible. In future Local Care Centres will allow for more timely access and aim to improve clinical outcomes and reduce waiting times for assessment.

What we need to do:

We need to increase timely assessments and treatment through the development of new local care centres that can provide convenient services for local people including for those working and others.

- Improve timely access to good quality diagnosis treatment and care through the development and delivery Local Care Centres

Strategic intentions for 2013/14:

- Development of Local Care Centres:
  - Nelson building works on time with project plan.
  - Mitcham development in accordance with project timeline.

Outcome 3.5: Enable people to stay in their own home as long as possible

What we are aiming for:

We want to reduce inappropriate emergency admissions to hospital and the length of stay. We aim to support people to live well in their own home for as long as possible and be active and connected within their local community with good access to local facilities.

What we need to do:

We need to deliver effective social care community support services to enable people to stay in their own home as long as possible to reduce the rates of unnecessary admission to care homes.

We also need to promote community connectedness to address issues of loneliness and isolation and ensure that good access to services is available:

- Deliver good quality effective reablement and rehabilitation support following discharge from hospital which is flexible and where required specialist.
- Improve access to telecare and telehealth care.
- Deliver three year preventative plan in partnership with the voluntary sector – Ageing Well.

Strategic intentions for 2013/14:

- Develop a clear reablement pathway understood by multiple providers/ agencies/patients and carers
- Pilot project on telehealth and telecare.
- Deliver the Ageing Well programme working in partnership with the voluntary and community sector to improve community connectedness and resilience.

Outcome 3.6: Increase the preferred place of care and death for those who need end of life care services.

What we are aiming for:
We aim to enable people who need end of life care to achieve their preferred place of care and death.

What we need to do:
We need to increase the number of people in the last stage of their lives who achieve their preferred place of care and death.

- Raise awareness of options for care and place of death and dying across our population.
- Raise awareness of Co-ordinate My Care Register and increase the number of people on the register.

Strategic intentions for 2013/14

- Increase in professionals' and patients' awareness of non-acute care.
- More people made aware of the Co-ordinate My Care Register and the benefits thereof.

Priority 4

Improving wellbeing, resilience and connectedness.

Why is this important?

Most people's individual wellbeing is influenced by the wellbeing of the community in which they live and the extent to which local services and infrastructure has the capacity to support wellbeing. It is well documented that people who live in disadvantaged areas experience poorer health, more illness and shorter lives. The economic downturn has placed pressure on local communities and reductions in public sector budgets creates a need to bolster the wellbeing and resilience of our population to reduce ever increasing demand for services.

This priority theme focuses on wider community wellbeing and resilience, building on community assets and prioritising enabling infrastructures. This will link with existing strategies in Merton .Improving opportunities for employment and skills, creating a safe and healthy environment with access to housing and infrastructure will support delivery of the strategy improving people's connectedness in terms of community engagement.

The relationship between social inequality and health inequality is recognised in the wider determinants of health analysed in Marmot's Causal Pathway. This argues that it is necessary to consider a 'total' response to health needs, over and above individual treatments. Social infrastructure can impact on deprivation, which is a cause of poor health; supporting community activity can improve people's confidence and resilience; positive behaviours keep people healthy. Obviously addressing material deprivation improves health in the long term, while treatment of individuals has an immediate effect.

A key trend within Merton is the significant divide between the west and east of the borough. As already noted, the area around Wimbledon and, to a lesser extent, Morden, is home to the vast majority of jobs in the borough, whilst Mitcham and the rest of the south east of the borough have far fewer jobs over a comparable area.

As far as data is available, it appears that other socio-economic indicators mirror the geography of employment. The positive association between education and health is well established. There are significant differences in skill levels between residents in the Wimbledon constituency and residents in the Mitcham and Morden constituency, which manifest themselves in terms of large differences in average annual pay, There are also significant differences in house prices between Wimbledon and Mitcham.

Deprivation is far more concentrated in the south east of the borough compared to the northwest. The proportion of benefit claimants is also significantly higher in the

South East of the borough compared to the North West, in terms of both job seekers and those on Employment Support Allowance (ESA).

Relative to the rest of London, Merton has relatively low numbers of jobs. Moreover, the number of jobs in the borough has remained almost static between 2003 and 2010, such that by 2013 Merton will have experienced a 'lost decade' without employment growth.

Sustainable neighbourhoods across the borough improve the quality of life for residents, workers and visitors. Merton's planning policies and development management and enforcement support new development that improves inclusive access and feelings of safety, develops new and affordable homes, within the constraints of conserving and enhancing the existing quality and character of the borough's suburban areas, the historic environment and the wealth of green spaces while providing the necessary services and infrastructure.

Merton has a young and diverse population that can help improve the borough's economic activity and convey its inherent cultural strengths through the delivery of high quality places of character and identity. Merton's older population is also increasing, which helps create stable communities. Merton's Core Planning Strategy helps to deliver specific needs associated with this, such as accommodating larger households and specialist homes, providing a changing range of community and cultural facilities and the need for more school places. Community engagement is an essential element, and the process itself can have a positive impact on health and wellbeing.

Ensuring that people are resilient reduces their chances of being victims of crime and/or repeat victims of crime. By improving peoples life chances so that they are less likely to become perpetrators of crime and disorder. Crime and anti-social behaviour has a large impact on the mental and physical health of those who are affected by it. By working with communities in order to make them 'safe aware' we can reduce the likelihood of becoming a victim. Managing problematic drug and alcohol usage ensures that our communities are safer and individuals who misuse these substances are less likely to harm themselves. The work of the Safer Merton Partnership is to reduce crime and anti-social behaviour, reduce re-offending rates and victim numbers, at the same time as reducing fear of crime, which contributes significantly to wellbeing.

Where are we now

Merton's Core Planning Strategy brings together a joined up approach with regeneration through planning, development and other measures to help reduce the inequalities identified in Merton. This includes access to jobs and services, including housing choices, healthy lifestyles and learning opportunities.

Merton Council's regeneration proposals for Mitcham and Morden will increase opportunities, improve people's quality of life, including housing choice, economic vitality, health facilities and the quality of the environment in the east and centre of the borough. Town centres across the borough provide accessible shops, services and opportunities to socialise in a safe environment, supported by Merton's Sustainable Communities Division and the Safer Merton Partnership.

Preventing further large out-of-centre retail developments through robust planning improves people's access to healthy food, especially for people without access to a car, and encourages walking, cycling and the use of public transport as well as helping to reduce congestion and pollution. Merton's planning policies and environmental health service also support healthy eating by minimising the concentration and impact of hot food takeaways.

Merton's Climate Change Strategy supports the changes in lifestyle and the nature of development that are necessary in order to combat the impacts of climate change. We are already feeling the effects of increased incidences of extreme weather conditions with flooding or drought affecting property and people and the consequent increase in energy and insurance bills, and effects on health. Merton's Climate Change strategy and planning policies ensure that the carbon footprint of existing and new development is reduced and new developments are built in a way that adapts to the inevitable changes to the climate. These planning policies require developers to take a holistic approach to building new homes which targets issues of flooding, waste, infrastructure, open space, design and transport.

Merton's Economic Development Strategy helps to tackle the skills shortage and improves job opportunities, which is especially important for deprived areas including those in the east. Addressing unemployment and educational attainment through Merton Council's education, economic development and planning powers all have an impact on physical and mental health.

The Localism Bill 2010 passes significant new rights direct to communities and individuals. The Bill introduced a new right for communities to draw up a Neighbourhood Development Plan. This enables people to come together through a local parish council or neighbourhood forum to have their say on development. Since the Bill was introduced no Neighbourhood Plans have been initiated in Merton.

Merton's Volunteering and Community Action Strategy's vision is for all individuals, groups and organisations to actively contribute within the time and resources they have available. Where volunteering and community action is recognised, encouraged and undertaken by diverse groups, individuals, and organisations. Volunteering and community action encourages community spirit, community contribution and a sense of ownership of Merton and supports partnership working

Safer Merton has a legislative responsibility to tackle crime and disorder. There is a strong partnership that works and delivers together in order to reduce crime and

associated issues. Each year the partnership undertakes a Strategic Assessment to assist the partnership in identifying the major issues within the local area, allocate resources and prioritise activities. The agreed strategic objectives are then taken forward through the Partnership Plan.

Priority 4: Improving wellbeing, resilience and connectedness.

Outcomes

4.1. Reduce poverty and increase income through economic development

4.2: Improve wellbeing through safer communities and community cohesion

4.3: Increase volunteering and make best use of local assets including parks, schools and leisure centres to promote wellbeing

4.4: More people make a positive contribution to their own wellbeing through access to learning and development of skills

4.5: Build a healthy environment including access to housing, local amenities and activities.

4.6: Improve community connectedness, improve independence and resilience of local communities

Outcome 4.1: Reduce poverty and increase income through economic development

What we are aiming for:

An economic development strategy that will provide equal opportunities to employment and reduce poverty

What we need to do:

- To do this we need to work closely with partners who deliver employment skills and training.
- We need to be able to understand the barriers that exist in Merton to employment and training opportunities, including financial, social and in

particular the changes to welfare benefits that affect employment and economic wellbeing.

Strategic intentions 2013/14

- To prepare a refreshed Economic Development Strategy as part of the councils Growth Strategy that considers ways of reducing unemployment.

- To create a Work Readiness Programme including apprenticeships and volunteering opportunities that leads onto employment.

Outcome 4.2: Improve wellbeing through safer communities and community cohesion

What we are aiming for:

To make Merton a place where all citizens share a greater sense of belonging and where there are strong and positive relations between people of different backgrounds, with a voluntary and community sector that is playing a full part in tackling social problems.

To reduce crime and disorder, the fear of crime, reduce re-victimisation and reduce re-offending in the borough.

To reduce the number of problematic drug users within the community and reduce substance misuse related crime, anti-social behaviour and re-offending (this agenda currently sits within the community safety partnership).

What we need to do:

Develop the capacity of the community and voluntary sector, including increasing the scope and impact of volunteering. (this may repeat some of what will go under 4.3)

Empower local people to have a greater choice and influence over local decision-making and a greater role in public service delivery

Increase community cohesion and integration through the actions set out in the Merton Partnership Community Cohesion Strategy
http://www.merton.gov.uk/community-living/equality-diversity/120612_community_cohesion_strategy_v13.pdf

The community safety partnership delivers a number of multi-agency multi-faceted approaches to current and emerging issues as well as implementing the new initiatives from central and regional government.

Currently the drug and alcohol services are being re-commissioned in order to ensure the highest level of service for the least financial input (as per best value principals). These contracts will need to be embedded and monitored.

Strategic intentions 2013/14

- Deliver the Merton Partnership Community Cohesion Strategy
- Deliver the annual Strategic Assessment by the Community Safety Partnership, which will identify major issues in the local area and inform allocation of resources and prioritisation of activities.
- Deliver the Partnership Plan to ensure delivery of services that meet local needs and reduce the volume of higher crime types.
- Strategic action plan and local needs assessment, for drug and alcohol work, undertaken and implemented, including reduce substance misuse related crime, anti-social behaviour and re-offending.

Outcome 4.3: Increase volunteering and make best use of local assets including parks, schools and leisure centres to promote wellbeing

What we are aiming for:

The mission of Merton Volunteering and Community Action Strategy is to enthuse and enable individuals, groups and organisations to take part in their community by having accessible and effective opportunities for the benefit of all

http://www.mertonconnected.com/sites/mertonconnected.com/files/Merton%20Partnership's%20Volunteering%20and%20Community%20Action%20Strategy%20and%20Action%20Plan%202012-2014.doc)

What we need to do:

We need to ensure that:

- Volunteering and community action is recognised, encouraged and undertaken by a high and diverse proportion of individuals, groups and organisations
- Volunteering and community action encourages community spirit, community contribution and a sense of ownership of Merton

- Volunteering and community action supports partnership working

Strategic intentions 2013/14

Deliver the Merton Volunteering and community Action Strategy 2012 –2014

- Protection and enhancement of open space creating no net loss of open space or sporting facilities unless justified in accordance with the Development Plan and National Playing Field criteria.
- To finalise the Wandle Valley Regional Park boundary and to deliver projects that improve the green infrastructure within the park, enhance its biodiversity and improve opportunities for formal and informal recreation within the park.
- Promoting culture, sport, recreation and play by safeguarding the existing (and working with partners to deliver more) cultural, leisure, recreational and sporting facilities.

Outcome 4.4: More people make a positive contribution to their own wellbeing through access to learning and development of skills

What we are aiming for:

Reducing the number of Merton residents that are claiming Job Seekers Allowance (JSA) and addressing the imbalance of skills in the borough including lifelong learning and encouraging adult education.

What we need to do:

To provide a coordinated offer of skills and training opportunities across the borough that is in line with employer requirements. This means having a clear understanding of employers needs and working with suppliers to provide the training that meets demand locally.

Strategic intentions 2013/14

- Preparation of a Skills and Training Strategy and Action Plan
- Creation of a Sustainable Communities and Transport Partnership sub-group that will be responsible for Economic Wellbeing

Outcome 4.5: Build a healthy environment including access to housing, local amenities and activities.

What we are aiming for:

- To make Merton a healthier and better place for people to live and work in by:
- Ensuring Merton is a well connected place where walking, cycling and public transport are the modes of choice when planning all journeys.
- Providing new homes and infrastructure within the town centres and residential areas, through physical regeneration and effective use of space.
- Promoting a well-designed high quality urban and suburban environment.
- Ensuring Merton is a municipal leader in improving the environment, taking the lead in tackling climate change, reducing pollution, developing a low carbon economy, consuming fewer resources and using them more effectively.

What we need to do:

We need to continue to work to the Local Development Scheme timetable of activities for implementation of the Local Development Framework. Merton has an Adopted Core Strategy (July 2011) and a Waste Plan (March 2012). It is hoped that by 2013/14 the Sites and Policies Development Plan Document, Proposals Maps and Community Infrastructure Levy will also be in place.

We also need to continue to monitor and report on the carbon emissions from our buildings and operations on an annual basis through our carbon reduction commitment.

Strategic intentions 2013/14

- To deliver the housing sites identified within the Core Strategy and Sites and Policies DPD and meeting the housing targets in the Core Strategy and London Plan (320 new homes across all tenures per year for the next ten years).
- Ensure all new housing developments deliver affordable housing units or financial contributions in accordance with the Development Plan policies.
- All new housing built to ‘Lifetime Homes’ Standards and 10% of all new housing designed to be wheelchair accessible, or easily adaptable for wheelchair users.
- To continue to maintain below the national average retail and vacancy rate in all our town centres.
- To have no net loss of employment land for which there is proven demand.

- To establish and provide the appropriate amount of pitches for gypsies and travellers by means of the Sites and Policies Development Plan Document.
- Delivering healthcare projects identified in the Core Strategy
- Waste Plan Annual Monitoring Report targets
- Adopting the Council's Climate Change Strategy by 2013 and implementing its targets and actions

Outcome 4.6: Improve community connectedness, improve independence and resilience of local communities

What we are aiming for:

To work closely in partnership with existing community groups to improve community connectedness.

To support the development of neighbourhood planning where communities feel that they would benefit from such locally led planning.

What we need to do:

We need to ensure that appropriate and effective public consultation is carried out when liaising with the public on community issues.

We need to inform and assist communities with the establishment of Neighbourhood Plans where the community is interested in forming Neighbourhood Forums and Neighbourhood Plans.

Strategic intentions 2013/14

- Deliver the Merton Partnership Community Cohesion Strategy
- Conduct consultation exercises in accordance with Merton's Statement of Community Involvement.
- Carry out a presentation at all of the Merton Community Forums on neighbourhood planning and the Localism Bill 2010.
- To maintain voluntary and community sector (VCS) engagement in the work of the Merton Partnership via the Community Engagement Network. VCS engagement in the work of the Merton Partnership has been an integral part of Merton's successful partnership working, and this is recognised through the reputation Merton has across London and beyond.

9. Consultation and Engagement

A full consultation and engagement programme took place from October to December 2012 across a range of activities, events and meetings involving a total of over 2,000 contacts with nearly 250 face to face contacts and over 100 documented responses received. Details of the programme and a summary of the comments and input received are included in Appendix 3.

A range of stakeholders, community and voluntary groups, local people and clinicians participated in the programme. A summary of the programme is given below.

LINkS Community Event

A LINkS community event took place on 21 November with over 50 delegates attending to hear presentations on the Strategy and take part in discussion groups on each of the four Priority Themes.

The event was positive with a good range of delegates from health, the council and the local voluntary sector. All had the opportunity to give their views through the discussion groups which were fully noted. A summary of the day and the contributions made is included in Appendix 3.

Stakeholder meetings and presentations

A special meeting of Healthier Communities and Older People Overview and Scrutiny was convened specifically to consider the Health and Wellbeing Strategy. The Strategy was also discussed by other stakeholder groups including: Merton Partnership Executive Board, the Children's Trust, the Safer and Stronger Strategy Group, Sustainable Communities Group, the Joint Consultative Committee and Merton GP Locality Meetings.

An email with an electronic link to the strategy was sent from Cllr Linda Kirby to a range of health, Council and voluntary sector colleagues.

On-line Survey and newsletters

An on-line survey on the Health and Wellbeing Strategy was hosted on the Merton Consultation website asking for views on the Strategy but also encouraging those responding to think about how they and their organisation could get involved in delivering the strategy. 55 responses were completed with many suggestions for involvement of a range of voluntary organisations.

A short piece on the strategy and link was also included in the Merton Connected newsletter and CCG newsletter. The corporate consultation team also stimulated some on-line debate through social network sites.

Health and Wellbeing in Annual Resident's Survey

For the first time a set of questions on wellbeing were included in Merton Annual Resident's Survey which includes 1,000 face to face interviews with adults and a further 500 interviews with young people. A summary of the findings is included in Appendix 3 with further details available on request.

Community Forum consultation jointly with Community Plan

In addition to the direct consultation on the Health and Wellbeing Strategy the opportunity was taken to link with engagement on the review of Merton Community Plan through the Community Forum meetings in Mitcham, Morden, Colliers Wood (with signposting to the Strategy at the later meetings in Raynes Park and Wimbledon). Participants were asked to list their priorities in terms of health and wellbeing and a range of responses were received.

The consultation programme closed in December and all comments and input has be analysed and considered and several changes have been made to the draft strategy to produce the final Merton Health and Wellbeing Strategy 2013/14.

A summary of the issues raised, comments made and input to the final Strategy are included in Appendix 3.

10. From Strategy to Delivery

An integrated approach is central to the delivery of the Health and Wellbeing Strategy but it is important that there is a clear, designated lead for specific areas of action.

The Health and Wellbeing Strategy Delivery Plan has been produced to set out how the Health and Wellbeing Strategy will be implemented over the next year. This is a working document and each of the four priority themes has given a set of high level outcomes including RAG Status with a further detailed plan for each outcome which will be managed by the lead delivery group. This includes milestones and indicators/success measures, frequency of reporting/by when and a specified a lead for each action.

The delivery plans have been prepared and will be delivered by the lead delivery group for the priority theme:

Priority 1 Giving every child a healthy start
Children's Trust Board

Priority 2 Supporting people to improve their health and wellbeing
Healthy Living Delivery Group

Priority 3 Enabling people to manage their own health as independently as possible
One Merton Group

Priority 4 Improving wellbeing, resilience and connectedness
Sustainable Communities Partnership

Each delivery group will have responsibility for performance monitoring the implementation of the delivery plan for their priority reporting to the HWB on the high level outcomes.

Each Priority Delivery Plan of the Health and Wellbeing Strategy will be reported to the Health and Wellbeing Board on an annual basis for performance management of high level strategic indicators and evaluation of overall progress. The Strategy will be refreshed on an annual basis in line with the new JSNA and it is envisaged that the Health and Wellbeing Strategy will be reviewed in 2014/15.

Further copies of the Health and Wellbeing Strategy are available at Insert www link

Further information on the Health and Wellbeing Strategy is available by emailing:**HealthandWellbeingBoard@merton.gov.uk**

Appendix 1
High Level Commissioning Implications from the Joint Strategic Needs Assessment - to Refresh in light of 2012/13 JSNA

Generally people living in Merton are very healthy; there is good life expectancy (exceeding the national and regional average) for both men and women. Merton has fewer people dying from conditions that could be avoided compared to the national and regional rates. In addition there are fewer people needing unplanned hospital admissions for diseases caused by smoking or alcohol or through suicide or unintentional injury, although the increase over time for some of these indicators is above regional or national rates.

Merton has significantly fewer children living in poverty than London as a whole and lower infant mortality, which is often used as a comparative measure of a nation's health and as a predictor of health inequalities. Currently there is less long term unemployment in Merton compared to national and regional rates and overall higher levels of employment, but the impact of the recession needs to be monitored on an ongoing basis.

However, these apparently favourable measures mask significant variation within the borough from east to west. Life expectancy is a very good measure of overall health and inequality, and across Merton there is a significant difference in life expectancy between different communities within the borough. Tackling health inequalities between east and west Merton remains a priority for commissioners, both in terms of targeting prevention, supporting vulnerable families and management of long term conditions to ensure greater quality of life and reduce unnecessary hospital admissions. Effective measures to raise life expectancy in east Merton should focus on:

- Reducing smoking in manual groups
- Tackling obesity - including families and children – getting more people eating healthily and more active
- Improving environmental factors such as housing conditions and reducing the risk of accidents
- Targeting the over 50s - among whom the greatest short term impact on life expectancy will be made

The main causes of the illness and early death result from our lifestyle choices; smoking, obesity and risky drinking behaviour. This means that many of these conditions are potentially preventable. With increasing pressure on resources, the focus for both social and health services needs to be on:

- prevention and early intervention by developing interventions and services (including information and advice services) to support and enable people to remain healthy
- Improving lifestyles across Merton focusing on reducing smoking, helping people maintain a healthy weight, and reducing alcohol related harm
- targeting the services to support people who are at risk of developing disease or needing social care
- supporting people to remain independent.

Although Merton has a relatively young population, similar to London rather than the England average, the population is ageing. With increasing age comes more complex health and social care needs; in our ageing population, if nothing else changes (for example the proportional prevalence of current long term conditions is unchanged) then there will be a significant increase in the absolute numbers of people who have a long term limiting illness such as Cardiovascular Disease, Diabetes, Osteoporosis, Dementia and Stroke and those who have Physical or Sensory Disabilities.

Commissioners need to focus on prevention and early intervention to help people remain as healthy and living as independently as possible, to help control increasing demand in future years. Supporting people to manage long term conditions and maintain independence through whole systems approaches by local partners includes primary prevention, access to health and social care, and support for rehabilitation to reduce overall prevalence of and disability caused by circulatory disease, stroke, respiratory disease and diabetes.

We also need to better understand the impact of the wider determinants of health in Merton and how we can work in partnership to positively influence these determinants; in particular how our living conditions (the environment and housing) impacts not just on our physical health but on our mental wellbeing and how we can work with local communities to improve mental wellbeing in our children and older people.

In addition to our increasing and ageing population our local communities are becoming more diverse and multicultural. We have to understand the different needs of all of our communities so that when care is needed, we can ensure people can access the right service at the right time and improve the outcomes of the care received. In order to understand how our communities are changing, not just culturally but for our vulnerable groups, such as some older people, carers, children, and people with disabilities, we need to have better information on our population. Next year when results of the 2011 census start to be published we will have more up to date information but we also need to get more detailed information through our

services and through other sources that are more responsive to changes in our communities.

While our aim is to help people stay healthy, we also want the best outcomes for those who need and use our services. People need to be able to access high quality services at the right time to meet their needs. We need to be better at evolving, adapting and targeting our services to meet the changing needs. To do this we need be better at collecting information on how our services are used and who uses them, and to have better insight into our diverse population to make services more equitable and more accessible to the people who need them.

Key to improving accessibility is the requirement for all partners to work together focusing on whole system pathways, including early intervention and prevention services and models of care delivery across health and social care for people with more complex needs so that people don't get lost between services and help and support is consistent.

Appendix 2

Health and Wellbeing Strategy Task Group Membership

A task and finish group was set up by the Merton Health and Wellbeing Board to develop the draft Health and Wellbeing Strategy. The draft was reported to, and discussed at, the full Health and Wellbeing Board and was the subject of a programme of consultation and engagement from October to December 2012. (see Section 9 Consultation and Appendix 3 for further details)

Members of Task Group:

- Dr Val Day, Interim Director of Public Health Merton, NHS South West London (Chair)
- Councillor Linda Kirby, Chair of Merton Health and Wellbeing Board and Cabinet Member for Adult Social Care and Health, Merton Council
- Simon Williams, Director of Community and Housing, Merton Council
- Eleanor Brown, Chief Operating Officer, Merton Clinical Commissioning Group
- Dr Geoff Hollier, Board Member, Merton Clinical Commissioning Group
- Rahat Ahmed Man, Head of Commissioning, Community and Housing, Merton Council
- Dave Hobday, Head of Community Engagement and Partnerships, Merton Voluntary Service Council
- Kathy Wocial/Sue Roostan, Assistant Director Borough Commissioning Merton, NHS South West London
- Paul Ballatt, Head of Commissioning Strategy and Performance, Children Schools and Families, Merton Council
- Leanne Wallder, Commissioning Manager, Children Schools and Families, Merton Council
- James McGinlay, Head of Sustainable Communities, Merton Council
- Julia Groom, Joint Consultant in Public Health, Merton Council/NHS South West London
- Clarissa Larsen, Health and Wellbeing Board Partnership Manager, Merton Council

Appendix 3

Health and Wellbeing Strategy Consultation and Engagement Programme - Summary of Findings

A full consultation and engagement programme took place from October to December 2012 across a range of activities, events and meetings .A range of stakeholders, community and voluntary groups, local people and clinicians participated in the programme.

A summary of the overall findings is given below together with the final strategy response and a further breakdown of findings by each consultation activity.

Overall comments on Health and Wellbeing Strategy

- Need for Delivery Plan with detailed actions, timescales and leads and monitoring arrangements. Indicators to be established by lead delivery groups.
  Strategy response: draft Delivery Plan being produced for each Priority

- Needs to be a 'whole population' strategy.
  Strategy response: updated and extended Health and Wellbeing in Merton section 6.reflecting whole population.

- Mental health as a cross cutting theme
  Strategy response: new Core Principle section 2. included *'recognising mental health as a cross cutting issue integral to wellbeing'*

- More on signposting and health information– link to Merton i
  Strategy response: link under Assets and Enablers section 3. to Merton i and under Priority 3 link to Merton Local Account.

Summary of Comments on Priority 1

- Particular focus on younger children where interventions have most impact.
- Emotional health including speech and language problems.
- Increasing immunisation rates.
- Targeting multi-agency interventions at most vulnerable families.
- Supporting parenting as a key priority.
- Free school meal uptake to be improved.
- Restriction of fast food outlets especially near schools.
- Active lifestyles for children including cycling and walking and the importance of road safety.
- Consider responses to domestic violence

Strategy response: issues being considered in development of Delivery Plan and it final draft of Priority 1.

Summary of Comments on Priority 2

- Public health initiatives to be targeted to meet the needs of individuals.
- Automatic sign-posting on hospital discharges into weight management, smoking cessation services
- Training around 'making every contact count'. Health and non-health professionals to have confidence to raise issues, eg. weight/ alcohol/ smoking
- Safer roads and promotion of cycling and walking
- Accident prevention, home safety working with the voluntary sector
- Consider motivations for unhealthy choices
- Link to allotments and other leisure services.

Strategy response: issues being considered in development of Delivery Plan and it final draft of Priority 2.

Summary of Comments on Priority 3

- Include reference to adults with learning disabilities
- More on advocacy and support for carers
- Include issues of loneliness and isolation
- Patient Participation groups present opportunities to get involved
- Opportunity to better integrate psychological therapies and pursue more work on resilience for those with a long-term condition (prevention of crisis episodes)
- Complexity of local provision requires advocacy roles to help guide people through process.
- Better monitoring and more support for those with mental health issues including support into employment.
- Explicit reference to the needs of people with long term neurological conditions.

Strategy response: reference now made to needs of people with learning disabilities in Priority 3 and services provided. More on the needs of carers in Priority 3.Reference to Patient Participation Groups. Other issues being considered in development of Delivery Plan and it final draft of Priority 3.

Summary of Comments on Priority 4

- Link to Merton Economic Wellbeing Board.
- More on public transport and access to services.
- Increased focus on the needs of disabled people.
- Improved facilities for cyclists, mobility scooter parking and bike lock-ups.
- Importance of residents enabled to feel they are making positive contributions through volunteering.
- Promote walking and reduce traffic congestion extending 20 mph speed limit.
- Extending payment of the living wage where possible across local employers.
- Educational opportunities for adults including improving employability skills.
- Promote and improve the function of libraries.
- Preserve green spaces and create new ones.

Strategy response: Inclusion of parks, open spaces and cycle ways as Assets in section 3. Inclusion of the Volunteering Strategy in Priority 4.Other issues being considered in development of Delivery Plan and it final draft of Priority 4.

Comments on Health and Wellbeing Strategy through Consultation and Engagement Activity

1. Stakeholder Groups

Healthier Communities and Older People Overview and Scrutiny, Safer and Stronger Strategy Group, Children's Trust, Sustainable Communities and Transport, Merton Joint Consultative Committee, Merton Partnership Executive Board, CMT, SMT Communities and Housing, Citizenship and Inclusion Group, GP Locality Meetings

Key comments:

Need for Delivery Plan with detailed actions, timescales and leads and monitoring arrangements. Indicators to be established by lead delivery groups.

Specific suggestions:

- Needs to be a 'whole population' strategy
- Mental health as a cross cutting theme
- More on signposting and health information– link to Merton i
- Public health initiatives to be targeted to meet the needs of individuals.
- Include reference to adults with learning disabilities
- Include loneliness and isolation
- Link to Economic Wellbeing Board
- More on transport and access
- More on advocacy and support for carers

GP Locality Meeting

Health & Wellbeing Strategy Consultation

- HWB Strategy should include longer term vision with 2 year Delivery Plan.
- Particular focus on children under 10 where interventions have most impact.

2. LINkS Consultation Event 21 November 2012

Over 50 delegates including representatives from the voluntary and community sector, Council and health.

Summary of views raised in priority discussion groups in table below supplied by Merton LINk.

Summary of issues raised in Discussion Groups on HWB Strategy

PRIORITY 1 Giving every child a healthy start	PRIORITY 2 Supporting people to improve their health and wellbeing	PRIORITY 3 Enabling people to manage their own health and wellbeing as independently as possible	PRIORITY 4 Improving wellbeing, resilience and connectedness
Emotional Health: speech and language problems prevention	Automatic sign-posting on hospital discharges into weight management, smoking cessation services	Importance of good local diagnostic care to prevent unnecessary A&E visits	Increased focus on the needs of disabled people required for both employment and housing
Immunisation: rates still too low	Consider wider determinants of health, eg. employment, housing	Services are not currently sufficiently joined up; good practice needs to be cascaded across health and social care services	Connectedness – scope for improvement by public transport providers, incl. Improved services
Transforming Families – targeting multi-agency interventions at most vulnerable families	Develop greater understanding of what motivates people; be creative in ways of engaging with the population	New 'Merton'I' information portal: to be made available in GP surgeries, libraries, local care centres, etc. Volunteers and voluntary organisations' presence in GP surgeries to work with patients.	Environment: improved signage for cyclists, encourage training for cyclists; more mobility scooter parking needed with bike lock-ups
Supporting parenting is seen as a key priority	Take a 'whole family' approach	Patient Participation groups present opportunities to get involved	Some impact of diversity on community cohesion
Obesity prevention – and links to poverty/needs/dis	Training around 'making every contact count'. Health and non-health	Opportunity to better integrate psychological therapies and pursue more work on resilience for those with a long-term condition	Lack of public toilets; signposting to community toilet scheme considered poor, particularly in

advantage	professionals to have confidence to raise issues, eg. weight/ alcohol/ smoking	(prevention of crisis episodes)	Raynes Park and Morden
Free school meals uptake to be improved	Ensure lessons are learned from past initiatives and programmes – do not repeat work which has already been done and failed	Focus on prevention needed – especially around mental well-being. Cross-cutting issue which needs to be reflect in HWB strategy	Flexibility and range of offer to be considered within action plan, particularly for people with disabilities, people with language barriers, older generation, those without access to IT
		Adults with Learning Disabilities: should benefit from activities/approach across all four priorities	
		Merton Carers Strategy review is needed to take a more integrated position on access to information and support	More publicity on information available – eg. printed materials
		Complexity of local provision requires advocacy roles to help guide people through process	Neighbourhood HealthWatch – develop schemes through interaction with VCS
			Importance of residents enabled to feel they are making positive contributions through volunteering

3. Health and Wellbeing Strategy On-line Survey

All contacts were directed to the HWBS on-line survey (total of 55 completions).

PRIORITY 1 Giving every child a healthy start

Over 80% agreed that the outcomes given were very important or important. Specific suggestions included:

- A focus on sexual health very important
- Active lifestyles for children including cycling and walking and the importance of road safety.
- Support for parents to achieve this priority
- Consider responses to domestic violence
- Accident prevention especially for children under 5 from disadvantaged families
- Restriction of fast food outlets especially near schools.

PRIORITY 2 Supporting people to improve their health and wellbeing

Over 90% agreed the outcomes given were very important or important. Specific suggestions included:

- Advertising restrictions on alcohol and tobacco
- Safer roads and promotion of cycling and walking
- Accident prevention, home safety working with the voluntary sector
- Addressing isolation and loneliness
- Consider motivations for unhealthy choices
- Link to allotments and other leisure services.

PRIORITY 3 Enabling people to manage their own health and wellbeing as independently as possible

Over 90% agreed the outcomes given were very important or important. Specific suggestions included:

- Better monitoring and more support for those with mental health issues including support into employment.
- Important to be aware of issues of isolation when people stay in their own homes.
- Good transport from home to town centres/ shops
- Explicit reference to the needs of people with long term neurological conditions.
- Joint working with clarity about lead agency

PRIORITY 4 Improving wellbeing, resilience and connectedness

Over 90% agreed the outcomes given were very important or important. Specific suggestions included:

- Promote cycling and walking and reduce traffic congestion by extending 20 mph speed limit
- Extending payment of the living wage
- Educational opportunities for adults including improving employability skills.
- Promote and improve the function of libraries.
- Good public transport serving all areas is vital.
- Preserve green spaces and create new ones.

4. Merton Residents' Survey

A sample of 1000 people were asked questions on satisfaction with health services and their own health and wellbeing.

- Respondents overall health and wellbeing is generally positive, with few reporting they feel dissatisfied, unhappy, anxious or worthless. Anxiety is the main concern, with 9% reporting that they felt very anxious yesterday.

- Satisfaction with family relationships and social life is seen as most important to respondents, and 31%feel this could be improved. Satisfaction with health and mental health and feeling safe in your local area are also seen as important to residents.

- Feeling safe in your local area, satisfaction with health and mental health, and satisfaction with household income and getting by financially are seen by respondents as the main areas that could be improved.

A further sample of 500 young people were asked the same questions:

- Young respondents overall health and wellbeing is generally positive, with few reporting they feel dissatisfied, unhappy, anxious or worthless. 5% reported that hey felt anxious or very anxious yesterday.

- Feeling safe in your local area is seen as most important to young respondents, and 56% feel this could be improved. Satisfaction with family relationships and your social life and satisfaction with your school/job and leisure time is also seen as important to respondents.

- Feeling safe in your local area, satisfaction with your school/job and leisure time, and satisfaction with household income and getting by financially are seen by young respondents as the main areas that could be improved.

A set of slides on all responses are available.

5. Joint Consultation with Community Plan

As part of the consultation programme on the refresh of the Community Plan a series of questions were asked at the Community Forum in Mitcham, Morden and Colliers Wood including specific questions relating to the draft Health and Wellbeing Strategy. Participants were asked to raise issues on post-it notes which included:

- Keep the hospitals in our area
- Provide healthy foods at organised events
- Encourage sport and exercise
- Better access to healthcare for working people
- Better awareness of the benefits of healthy eating
- Promote cycling and walking to reduce traffic congestion.

Community Forum meetings in Raynes Park and Wimbledon which took place after the Health and Wellbeing Strategy Consultation had closed were given the opportunity to make comments direct.

6. Mailing of Health and Wellbeing Strategy to wider stakeholders

A mailing of contacts in the public, health, voluntary and business sector took place with a letter from Cllr Linda Kirby giving a link to the draft strategy and an email address of healthandwellbeingboard@merton.gov.uk to which a number of comments were addressed including the following:

Carers Partnership Group (part of the Learning Disability Partnership Board)

- no mention or discussion of health inequalities experienced by people with a learning disability
- limited impact any area based policy will have on this type of health inequality
- lack of recognition of the health problems suffered by carers in general and means by which to address these

Jeremiah Project (drug awareness)

- epidemic of loneliness and the fact that lifestyle diseases are becoming the biggest killers.
- asking the questions 'Who is my neighbour?' and 'how is my neighbour?'

Campaign to End Loneliness

- hope new ASCOF and PHOF measures will help youto identify loneliness, and provide a new data set against which improved health of older populations can be benchmarked.
- look at our Loneliness Toolkit for Health and Wellbeing Boards.[1]This online resource is designed to support boards in understanding, identifying and commissioning interventions to tackle loneliness in older age.

Client Earth (Healthy Air Campaign)

- most deprived 10% of areas in England are subject to 41% higher concentrations of nitrogen dioxide from transport and industry than the average.
- air pollution is a public health issue relevant to the objectives and priorities of Health and Wellbeing Boards, the new public health structure brings functions such as transport and planning within the influence of the Health and Wellbeing Board, and so never have the public health profession been better equipped to tackle the problem.

St George's Mental Health Trust

- Strategy currently separates physical and mental health into two separate categories – needs to address the inter-relationships between physical and mental illness (IAPT report attached)

Public Health Merton

- The Mayor of London's Office is recommending local authorities use planning and regulatory measure to encourage good practice within the takeaway sector and have produced a "Fast Food Fix" toolkit promoted in Merton

Merton Cycling Campaign

- Track change comments emphasising importance of transport, cycling and active travel.

Other comments from individuals:

- Two respondents sent detailed track change comments including emphasis on preventative strategies.

- Concerns related to cyclists, pedestrians and speed limits.

- NICE guidance published this month on walking and cycling calls for local authorities, schools and workplaces to introduce ways to enable their communities to be more physically active and change their behaviours.

- Merton has done a lot to improve things, including the improvements in Wimbledon town centre and 20 mph areas. Would like an objective to make a safe (joined up) route for cyclists through the centre of Wimbledon. Also important that people feel ownership of their streets - so they can walk without feeling threatened

Appendix 4 - Glossary of Terms

Clinical Commissioning Groups (CCG):

The group of GP practices and other representatives from health and the local community who will take on responsibility for commissioning healthcare services for patients and the general population in their area from April 2013 after Primary Care Trusts are abolished. Here, Merton CCG has been established to commission health services in the local area.

Commissioning: Is the cycle of assessing the needs of local people, establishing priorities and strategic outcomes, specifying services, securing and delivering appropriate services and reviewing outcomes.

Health inequalities: The differences in health, life chances and life expectancy between different geographical areas and different groups of people.

Health and Wellbeing Board (HWB): The Merton Health and Wellbeing Board is a partnership of the Council, Merton Clinical Commissioning Group, the voluntary sector and the local Healthwatch. It will take on its statutory role from April 2013. Its main roles are to assess the needs of the local population

through the Joint Strategic Needs Assessment; develop a Health and Wellbeing Strategy to inform the commissioning of health, social care and public health services in Merton and to promote greater integration across health and social care.

Health and Wellbeing Strategy: The high level, overarching strategy against which commissioning plans for the CCG, social care, public health and other relevant and agreed services are developed.

Key worker: A professional practitioner e.g. social worker, whose time is entirely dedicated to an individual or family that needs coordinated support to tackle a range of health, care or other needs.

Local Healthwatch: This will assume the functions of Local Involvement Networks (LINkS). It will act as the local consumer voice for people who use and need health and social care services, to provide information about health and care services, and support people to make choices.

Joint Strategic Needs Assessment (JSNA): The JSNA provides an objective analysis of local, current and future health needs for adults and children. By assembling a wide range of quantitative and qualitative data, it supports strategic planning and the commissioning of services. The Merton JSNA is available at http://www.mertonjsna.org.uk

Looked After Children: Children and young people looked after by the state in accordance with relevant rules and regulations. This includes those who are subject to a Care Order or temporarily classed as looked after on a planned basis for short breaks or respite care.

Outcomes: The benefits a service user gains through a service, as distinct from activities and outputs which relate to more direct or immediate objectives. Thus, the outcome of training staff in end of life care will be that those approaching end of life and their carers feel more in control, involved and satisfied with the services they receive, whilst one of the outputs would be the number of staff trained.

Palliative care: Is an approach that improves the quality of life of patients, their families and carers facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Person centred (also referred to as 'personalised'): Sees patients, service users and their carers as equal partners in planning, developing and assessing their health and care to make sure services are most appropriate for their needs. It involves putting patients, their families and carers at the heart of all decisions.

Personal Budgets: The funding given to someone to meet their needs once they have been assessed as being eligible for social care support. They can have the money as a direct payment or can choose to manage it in different ways. Personal budgets are also being developed for health services.

Primary care: Services provided by GP practices, dental practices, community pharmacies and high street optometrists.

Primary Care Trusts (PCTs): The NHS body currently responsible for commissioning healthcare services for a local area. PCTs are being abolished under the Health and Social Care Bill and will cease to operate in April 2013 when Clinical Commissioning Groups will take over the commissioning of healthcare services.

Public Health: The protection and promotion of health and wellbeing outcomes and the reduction of health inequalities through the prevention of ill health and the prolonging of life. From April 2013, the responsibility for many Public Health functions will move from Primary Care Trusts to upper tier Local Government.

Re-ablement: Re-ablement is about helping people to do things for themselves rather than doing things to or doing things for people. It builds on what people currently can do, and supports them to regain skills to increase their confidence and independence.

Secondary care: Health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists. Secondary care includes hospitals.

Special Educational Needs (SEN): Is a legal definition referring to children who have learning difficulties or disabilities that make it harder for them to learn or access education than most children of the same age.

Merton Health and Wellbeing Strategy

Delivery Plan 2013/14

January 2013

Contents

Delivery Plan Priority Theme 1: Giving Every Child a Healthy Start

Lead Delivery Partner: One Merton Group

Outcomes:

1.1 Ensure every baby has the best start in life

1.2 Promote and improve the personal, social and mental wellbeing of our children and young people and their parents.

1.3 Promote and increase the proportion of healthy weight children and young people

1.4 Enable and increase the number of young people making healthy life choices

High Level Outcomes

Outcome	Outcome Measure and description	Polarity	Annual target	Result	Status (RAG)	Comments
1.1	Breastfeeding prevalence at 6-8 weeks (PHOF) Population vaccination coverage (PHOF)					
1.2	% of CYP from target groups accessing services (local)					
1.3	Excess weight in 10-11 year olds PHOF)					
1.4	Under 18 conceptions (PHOF)					

Outcome 1.1: Ensure every baby has the best start in life				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1. Work in partnership to promote public health initiatives that have a positive effect on infant development.	Roll out of the Start4Life 'healthy habits for baby and you' Leaflet to help facilitate conversations with mums-to-be on the need for a healthy lifestyle in pregnancy Action the findings of the recent breast feeding review to ensure a high standard of care in relation to infant feeding, in-line with current Government Guidelines. Active programme of promoting childhood immunisations in all Children's Centres, GP Surgeries and Health Clinics delivered. Deliver Social Marketing pilots on immunisation and breastfeeding.	Reduction in Number of women smoking in pregnancy Increased Breast Feeding Rate at 6-8 weeks Increase in Immunisation Rates	Quarterly Quarterly Quarterly	CCG CCG/National Commissioning Board (NCB) CCG/National Commissioning Board Public Health
2. Enable the early identification of need through take up of Children's Centre activities and the Healthy Child Programme	Children's Centre Registration promoted and enabled at New Birth Visit	Children's Centre 'reach' Take up of 2 year screen	Quarterly Quarterly	LBM Early Years in conjunction with Sutton and Merton

				Community Services
3. Development of a continuum of parenting support with improved pathways that target specific groups such as lone parents, teenage parents, victims of domestic violence	Publication of the new Parenting Strategy Development of a referral pathway across age range and different parenting programmes.	Completion rate of those parents attending accredited parenting programmes	March 2013 Termly	LBM Children Schools and Families

Outcome 1.2 : Promote and improve the personal, social and mental wellbeing of our children and young people and their parents				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1. Through Universal settings and provision, deliver targeted interventions that focus on building resilience in infants through bonding and attachment.	Alignment of the delivery of health visiting services with Children's Centres, ensuring universal delivery of Healthy Child programme	Number of mothers identified as having postnatal depression Take up of Children's Centre Services	Quarterly Quarterly	LBM Early Years in conjunction with SMCS
2. Continue to promote emotional well being and identify early those children with emerging mental health issues through preventative initiatives in schools	Further develop knowledge, capacity and understanding within the wider workforce through a marketed training programme delivered by the CAMH provider. Continued promotion and roll-out of the Targeted Mental Health in Schools initiative.	A reduced number of children that report bullying as evidenced by the number of schools rated 'good' or 'outstanding' for the Behaviour and Safety measure by Ofsted. Number of referrals that meet the threshold for specialist CAMH services.	Annual Quarterly	CCG in conjunction with CAMH Provider (South West London and St Georges MHT) CAMH Provider
3. Ensure that specialist mental health support is accessible to those children and young people that have a need.	Single point of entry to CAMH services established and promoted. Development and publication of clear Pathways into care for issues such as Eating Disorder, Serious Self-harm, Depressive Disorders, etc.	Reduction in Number of DNA (Did not attend) appointments Number of children and young people from targeted groups accessing services (for example Young carers, Looked After Children, Black and Minority Ethnic Groups) proportionate to prevalence rate	Quarterly Quarterly	CCG CCG

Outcome 1.3: Promote and increase the proportion of healthy weight children and young people				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1. Develop a multi-agency comprehensive Healthy Weight framework for Merton (children and adults),	Agree and launch Framework based on best evidence of effectiveness	Proportion of children age 10-11 classified as overweight and obese	Annually	Public Health
2.Improve our partnership approach to promotional activities to promote healthy weight in babies, toddlers and children.	Monthly events calendar produced for each Children's Centre to market the activities available Consistent approach to offering health promotion advice and healthy snacks/nutritious food across in-house and commissioned services.	Uptake of Children's Centre Services Take up of Free School Meals	Quarterly ?Termly	LBM Early Years
3.To continue to monitor levels of overweight and obesity	All Schools participating in the National Child Measurement Programme.	Number of children and young people taking part in the National Child Measurement Programme	Annual	SMCS
4.Promote and enhance access to leisure and sport activities, 'Inspiring a Generation', both in and out-of school for children, young people and their families	To add	Establish a baseline and develop an indicator in 2013-14	Ongoing	
5. Continue to support children and young people already overweight or obese to reduce their BMI	Quarterly Monitoring of Weight Management Programme contract Re-commission weight management services for 2014/15	Completion rate for intervention programme	Termly	CSF Commissioning/ Public Health

Outcome 1.4: Enable and increase the number of young people making healthy life choices				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1.Delivery of promotional services to support young people making healthy life choices	Improved access to services by vulnerable groups such as Youth Offenders, Looked After Children and Care Leavers, and Young Carers.	Take up of 'Check It Out' sexual health advice Take up of Chlamydia screening Teenage pregnancy rate	Quarterly Quarterly Quarterly	CSF Commissioning/ Public Health
2.Support young people already affected by alcohol and substance misuse (up to the age of 25yrs)	Delivery of Action Plan following Service Evaluation. Re-commissioning of Substance Misuse services for young people	Numbers of young people referred that successfully complete a 12-week intervention programme.	Quarterly	CSF Commissioning
3.Deliver accessible young people Stop Smoking services at venues that they are confident to attend	Delivery of programmes that target vulnerable young people such as those attending the SMART Centre, Melrose and Youth Justice Service.	Take up of smoking cessation services by Young People –Quit rate	Quarterly	Public Health

Delivery Plan Priority Theme 2: Supporting People to Improve their Health and Wellbeing

Lead Delivery Partner: Healthy Living Delivery Group

Draft Outcomes:

2.1 *Promote and deliver an integrated approach to healthy living*

2.2 Increase the proportion of people achieving a healthy weight and participating in the recommended levels of physical activity

2.3 Reduce the prevalence of people smoking

2.4 Promote sensible drinking and reduce alcohol related harm and harm from drug misuse

2.5 Improve sexual health and access to services

High Level Outcomes

Outcome	Outcome Measure and description	Polarity	Annual target	Result	Status (RAG)	Comments
2.1	Take up of NHS Health check by those eligible – health check take up (PHOF 2.22ii)	High				
	Number of self reported health improvement outcomes from residents supported by LiveWell (Local)	High				
2.2	Proportion of adults classified as overweight and obese (PHOF 2.12)	Low				
	Increase proportion of adults meeting the recommended guidelines on physical activity by 0.5% year on year (150 minutes per week) (PHOF 2.13)	High				

2.3	Reduction in smoking prevalence in adults (over 18 years) by x% year on year (PHOF 2.14) (current modelled prevalence 16.4%) Or quit rate	Low				
2.4	Reduction in number of alcohol related hospital admissions to ensure it remains at or below current rate (1,911 DSR per 100,000)(PHOF 2.18)	Low				
	Successful completion of drug treatment (PHOF 2.15)	High				
2.5	Reduce the number of people diagnosed late for HIV (PHOF 3.4).	Low				

Outcome 2.1: Promote and deliver an integrated approach to health and wellbeing				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting**	**Lead**
1. Achieve the target number of people receiving an NHS Health Check	• Secure transition of programme from NHS to local authority and agree contractual process and targets for primary care providers • Implement national policy change i.e. alcohol and dementia components, within agreed timelines • Commission three more community pharmacies	Percentage of eligible people who are offered an NHS Health Check (PHOF 2.22) Percentage of eligible people who take up an NHS Health Check (PHOF 2.22)	**Quarterly**	**Public Health**
2.Increase the number of health improvement outcomes via LiveWell	• Re-commission LiveWell as an integrated service alongside the stop smoking service. • Agree annual targets for new integrated service. • Develop innovative communication and engagement plan	Number of self reported health improvement outcomes from residents supported by LiveWell	**Quarterly**	**Public Health**
3. Target resources towards the east of Merton where we know there are the biggest health inequalities.	• Two rounds of Grant funding for Community and Voluntary organisations through the East Merton Health and Wellbeing Community Fund • Strategy for match funding to develop a sustainable Community Fund developed.	Number of outcomes achieved as specified in successful PRG Funding Bid.	**Annually**	**MVSC**
4. Ensure that health and other professionals deliver consistent health improvement messages and support as part of their day to day work.	• Partnership work with MCCG to develop 'Every Contact Counts' programme.	Number of referrals from health and other professionals into integrated LiveWell/Stop Smoking service.	**Annually**	**MCCG -tbc**
5. Engage businesses and employers to promote health	• Extend local Public Health Responsibility Deal to the end of March 2014.	Number of LiveWell clinics targeting employees (hosted at a variety of venues).	**Quarterly**	**Public Health/St**

through their services and support employees.		Number of businesses in Merton signed up to the Local Responsibility Deal		**Mary's University CWCH**
6. Develop Social Marketing insight to inform future commissioning of effective health improvement interventions.	• Completion of five social marketing research and development projects. Each project will produce recommendations and an evaluation framework for the future commissioning of tested interventions: • Childhood Immunisations • Breastfeeding • Healthy eating • Physical Activity • Access to health improvement by people with mental health issues	Completed projects by March 2013 Recommendations utilised in future commissioning intentions	**Annually**	**Public Health**
7.Ensure mental wellbeing is addressed through the development of all Health Improvement services	• Promote use of the National Mental Health Development Unit 'Mental Wellbeing Checklist' when commissioning and developing services.	Number of services used checklist	**Annually**	**LBM/MCCG/Vol Sector**
Outcome 2.2 : Increase the proportion of people achieving a healthy weight and participating in the recommended levels of physical activity				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting**	**Lead**
1. Develop a multi-agency comprehensive Healthy Weight framework for Merton, (adults and children)	• Agree and launch Framework based on best evidence of effectiveness	Proportion of adults classified as overweight and obese (PHOF 2.12)	**Annually**	**Public Health**

2. Increase options for personalised weight management support for overweight and obese adults	• Develop Obesity Care Pathway and agree • Integrate weight management services with Livewell • Commission a tier 2 community weight management programme for adults • Redesign Tier 3 Specialised weight management programme to be delivered by the Community Dietetic team as part of the contract with SMCS • Commission Weight Management training to support residents with learning disabilities.	Subject to agreement Three programmes delivered with up to a total of 50 participants.	**Quarterly**	**Public Health**
3. Promote Healthier Food Choices	• Extend local Public Health Responsibility Deal to the end of March 2014.	Number of caterers signed up to the local responsibility deal	**Annually**	**Consumer & Business Protection/St Mary University CWCH**
4.Increase in physical activity levels in adults	• Seek opportunities for inward investment to increase physical activity • Extend Active Celebration programme to the end of September 2013.	Increase proportion of adults meeting the recommended guidelines on physical activity by 0.5% year on year (150 minutes per week) (PHOF 2.13) 500 participants, 25 coaches and 250 additional volunteer hours.	**Annually**	**Leisure and Culture** **Public Health**
5.Promote a healthier environment which supports physical activity and healthy food choices	• Increase in promotion/support for residents to use active travel, particularly for short journeys.	Link to priority 4	**Annually**	**Environment & Regen**

Outcome 2.3: Reduce the prevalence of people smoking				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting**	**Lead**
1. Develop a multi-agency comprehensive Tobacco Control framework for Merton	Agree and launch framework based on best evidence of effectiveness	Reduction in smoking prevalence in adults (over 18 years) by x% year on year (PHOF 2.14) (current modelled prevalence 16.4%)	**Annually**	**Public Health/Environment& Regen**
2.Reduce smoking among adults, and reduce smoking among target groups including routine and manual workers and unemployed	Commission Stop Smoking services as part of an integrated service alongside the LiveWell programme. Agree targets for new provider, including routine and manual workers and unemployed.	Increase in number of 4 week quits and increase in success rate to over 50% Increase in number of Routine and Manual workers accessing the NHS Stop smoking service and quitting smoking (Local)	**Quarterly**	**Public Health/Provider**
3.Reduction in number of illegal tobacco sales to underage people from retail premises	Programme of test purchases across Merton.	Minimum of 80 test purchases at identified premises	**Annually**	**Consumer & Business Protection**
4.Enforce regulations on the display of tobacco products	Monitoring compliance in large retail stores with the Tobacco Advertising and Promotion Regulations	100% inspection of premises	**Annually**	**Consumer & Business Protection**
5.Explore opportunities to normalise smoke free environments beyond current legal requirements	Research into evidence on normalising smoke free environments and agree approach for Merton.	Programme for normalising smoke free environments agreed by partners.	**Annually**	**Public Health/ Consumer & Business Protection**
Outcome 2.4: Promote sensible drinking, reduce alcohol related harm and harm from drug misuse (Link to Safer Merton Partnership)				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting**	**Lead**
1. Reduce substance dependency, improve health and reduce health inequalities as a result of substance	• Re-commission evidence based substance misuse prevention and treatment services	Reduction in number of alcohol related hospital admissions to ensure it remains at or below	**Quarterly**	**Safer Merton**

misuse (Link to Outcome 4.2)	• Contract outcomes and targets achieved. • Merton's high performance maintained	current rate (1,911 DSR per 100,000)(PHOF 2.18) Increase number of Problematic Drug User's in effective treatment (target tbc). Increase percentage of people successfully completing treatment by x% (PHOF 2.15).		
2. Use available levers to minimise alcohol related harm	• Reduce the number of illegal alcohol sales to underage people • Reduce the number of proxy sales by adults. • Use Local Authority's new public health responsibilities with regard to the Licensing Act	Minimum of 80 test purchases Number of proxy sales pledges by businesses	**Quarterly**	**Consumer & Business Protection** **Public Health**
3. Ensure alcohol is integrated with wide health improvement programmes	• Alcohol integrated with Live Well and Health Check programmes	Number of alcohol related health improvement outcomes via LiveWell	**Quarterly**	**Safer Merton/ Provider**
4. Promote a culture of sensible drinking and increase awareness of impact of alcohol consumption on health and wellbeing	• Completion of social marketing research and pilot project with 18-24 females and over 65s. • Produce recommendations and an evaluation framework for the future commissioning of tested interventions:	Number of referrals to LiveWell via pilot projects Recommendations utilised in future commissioning intentions	**Annually**	**Public Health**
Outcome 2.5: Improve sexual health and access to services				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting**	**Lead**
1. Reduce late HIV diagnosis	• GP rapid HIV testing pilot in local General practices in high prevalence areas. • Introduce HIV testing into local	Reduce the number of people diagnosed late for HIV (PHOF 3.4).	**Annually**	**Public Health**

	Contraception and Sexual Health Clinics			
2. Increase access to contraception.	• Partnership work with MCCG to optimise comprehensive access to full range of methods of contraception. • Review activity and work with underperforming and performing community pharmacies to increase activity .	Increase the access of full range of methods of contraception. (local) Increase access to Emergency Hormonal contraception in women aged 13-25 years. (local)	**Quarterly**	**Public Health**
3. Achieve National Chlamydia Screening Programme under 25 year Chlamydia prevalence target.	• Embed Chlamydia screening in core services to increase access to testing. • Develop a transition plan for 2014/15 for the CSO function of the South West London Chlamydia screening programme	Achieve 2400 Chlamydia positive per 1000 persons (PHOF 3.2)	**Quarterly**	**Public Health**

Delivery Plan - Priority Theme 3: Enabling People to Manage their Own Health as Independently as Possible

Lead Delivery Partner: One Merton Group

High Level Outcomes

Outcome	Outcome Measure and description	Polarity	Annual target	Result	Status (RAG)	Comments
3.1	Improve health related quality of life for people with long term conditions.					
3.2	Enable people with dementia and their carers to have access to good quality, early diagnosis and support.					
3.3	Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support.					
3.4	Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location.					
3.5	Increase the preferred place of care and death for those that need end of life care services.					
3.6	Enable people to stay in their own home as long as possible.					

Outcome 3.1:Improve health related quality of life for people with long term conditions (CCG Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting**	**Lead**
1. Increase the proportion of people effectively supported to manage their own condition	• Implement new pathway for direct access to reablement services for people with LTCs • Implement a multi-disciplinary model of case management and risk stratification for people with LTCs	• Number of GP referrals to reablement Baseline: 0 (no current direct referral pathway) • Number of people with LTC managed through multi-disciplinary case management system. Baseline: 0 No trajectory set for first year as a pilot.	Quarterly	LBM
2. Increase the support taken up by carers of people with long term conditions	• Develop and implement programmes and individual support for carers	• Increase in number of carers enabled to provide support		LBM
3. Improve people's experience of services that support their long term conditions	• Introduction of systematic arrangements for analysis of Practice feedback collected Practice Participation Groups • Option to implement Patient Reported Outcome Measure as a CQUIN within SMCS services contract for 2013-14.	• Quarter by quarter increase in number of people with a positive experience of care for LTCs in primary and community services from Q1 2013/14 baseline	Quarterly	CCG
4. Increase the number of GP practices that monitor risk scores for patients to improve clinical outcomes	• Roll out risk stratification tool.	• Quarter by quarter increase in the number of GP practices using the tool, based on Q1 2013/14 baseline	Quarterly	CCG

5. Monitor emergency admissions for key long term conditions, measure and compare accident and emergency admissions and monitor unplanned hospital admissions to outpatients.	• Implement urgent care at home scheme	• CCG Outcomes indicator: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) Baseline: TBC	Quarterly	CCG
Outcome 3.2 :Enable people with dementia and their carers to have access to good quality, early diagnosis and support (LA Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1. Increase the percentage of people over 65 with a recorded diagnosis of dementia	• Improved access to memory clinic and increased screening in primary care	• Numbers of people newly diagnosed with dementia Baseline: TBC	• Every 6 months	• CCG Dementia Lead
2. Improve quality dementia care in a residential setting	• Consultation on local Dementia Care & Support Compact (March 2013)	• Extent of signatures to Compact	• Quarterly	• LBM Commissioner
3. Improve early identification of carers and development of an early support plan	• Early identification on diagnosis • Early support plan via Dementia Hub (April 2013)	• Numbers of carers identified • Numbers of carers using Hub	• Every 6 months	• CCG/ LBM Commissioning

Outcome 3.3:Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support (LA Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1. Ensure mental health services commissioned are person centred increasing self-defined recovery outcomes	1. An audit of care plans for people on CPA to show evidence of recovery focussed plan. 2.People on CPA have 2 self-defined recovery outcomes recorded on care plans.	1. An audit of care plans is conducted. 2. More than 50% of people have 2 self-defined recovery outcomes.	12 mthly Quarterly	CCG
2. Improve integrated working between primary and secondary care to ensure physical health care needs are met with regular physical health assessments by GPs of mental health service users	1. CPA register shared with primary care. 2. People on CPA to have had a physical health assessment by GP within the last 12 months.	1. Register shared twice a year. 2. More than 75% of all people on CPA to have had assessment.	1. 6 mthly 2. quarterly	CCG
3. Improve communication between primary and secondary care to ensure mental and physical health outcomes with discharge summaries and care planning reviews are sent promptly to GPs	1. Discharge summaries to be sent to GPs within 7 days of discharge. 2. CPA outcome review letter to be sent to GP within 2 weeks of CPA review.	1. 95% compliance 2. 95% compliance	1. quarterly 2. quarterly	CCG
4. Improve access to MH services to enable early diagnosis	1. Improving information on Merton-i. 2. LINk/Healthwatch to hold an event	1. More information stored on Merton Eye and more hits on website.	1. quarterly	1. LBM

	on looking at gaps in MH services. Referral awareness in regard to signposting to most appropriate service.	2. Clear feedback on gaps and next steps action plan. Increase to 50% recovery rate following referral to IAPT. Baseline: TBC	1. quarterly Quarterly	2.LINk/Health watch CCG
5. Improve physical health of those with secondary health needs	Ensure appropriate care setting for those with secondary physical health problems.	Increase in appropriate setting to treat those with secondary physical health problems.	Quarterly	CCG
6. Raise the visibility of the role and contribution of mental health carers	Consultation on compact for local mental health carers.	Numbers of signatures on compact Carers assessments.	6 mthly	LINK/ Healthwatch
Outcome 3.4:Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location (CCG Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1. 1.Improve timely access to good quality diagnosis treatment and care through the development and delivery of Local Care Centres	Development of Local Care Centres at the Nelson and Mitcham	Nelson LCC building works on time with project plan Mitcham LCC development in accordance with project timeline	6 mthly	CCG
Outcome 3.5:Enable people to stay in their own home as long as possible (LA Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1. Deliver good quality effective Reablement and rehabilitation support following discharge	A clear reablement pathway understood by multiple providers/agencies/patients and	• Number of people helped to stay at home 91 days after	• Every 6 months	LBM Reablement

from hospital which is flexible and where required specialist	carers.	discharge		Manager
2. Improve access telecare and telehealthcare	• CCG to confirm pilot project Outcomes for telehealth and telecare	• Numbers of people using Mascot telecare and telehealthcare	• Every 6 months	CCG Commissioner
3. Deliver three year preventative plan in partnership with the voluntary sector – Aging Well	• Announcement of Grant funded projects (January 2013)	• Preventative metrics	• Every 6 months	Head of Commissioning LBM//MVSC
Outcome 3.6:Increase the preferred place of care and death for those who need end of life care services (CCG Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
1. Raise awareness of options for care and place of death and dying across our population	1. Increase in professionals' and patients' awareness of non-acute EOLC facilities	Increased numbers of people achieving their preferred place of care. Baseline: TBC	Quarterly	CCG EOLC Lead
2. Raise awareness of Co-ordinate My Care register and increase the number of people on the register	More people made aware of the register and benefits thereof.	Increasing number of people registered.	6 mthly	CCG EOLC Lead

Delivery Plan - Priority Theme 4: Improving Wellbeing, Resilience and Connectedness

Lead Delivery Partner: Sustainable Communities Partnership

High Level Outcomes

Outcome	Outcome Measure and description	Polarity	Annual target	Result	Status (RAG)	Comments
4.1	Reduce poverty and increase income through economic development					
4.2	Improve wellbeing through safer communities and community cohesion					
4.3	Increase volunteering and make best use of local assets including parks, schools and leisure centres to promote wellbeing					
4.4	More people make a positive contribution to their own wellbeing through access to learning and development of skills					
4.5	Build a healthy environment including access to housing, local amenities and activities.					
4.6	Improve community connectedness, improve independence and resilience of local communities					

Outcome 4.1: Reduce poverty and increase income through economic development				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
Prepare a refreshed Economic Development Strategy as part of the council's Growth Strategy that considers ways of reducing unemployment.	A refreshed Economic Development Strategy for 2012 to 2015 approved by Cabinet	Cabinet approved on 22nd October 2012	December 2012	Future Merton
Create a Employment/Skills Programme including apprenticeships and volunteering opportunities that leads onto employment.	Production of a two year Employment and Skills Action Plan to commence in January 2013. This should deliver the 6 priorities identified by the EWG including: 1. Increasing employer demand and take-up of apprenticeships 2. Employer engagement 3. Simplifying the employer offer 4. Supporting those furthest from the labour market 5. Co-ordination and joint funding 6.Developing and marketing a Merton offer to employers and young people	Employment and skills delivery and monitoring needs to be in partnership. The programme is to be agreed by the newly formed Economic Well Being Sub Group of the SCTP in January 2013.	Quarterly from April 2013	Economic Well Being Sub Group

Outcome 4.2: Improve wellbeing through safer communities and community cohesion.				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
Deliver the annual Strategic Assessment by the Community Safety Partnership, which will identify major issues in the local area and inform allocation of resources and prioritisation of activities.	To be confirmed			
Deliver the Partnership Plan to ensure delivery of services that meet local needs and reduce the volume of higher crime types.	To be confirmed			
Strategic action plan and local needs assessment, for drug and alcohol work, undertaken and implemented, including reduce substance misuse related crime, anti-social behaviour and re-offending.	To be confirmed			
Outcome 4.3: Increase volunteering and make best use of local assets including parks, schools and leisure centres to promote wellbeing				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
Deliver the Merton Volunteering and community Action Strategy 2012 –	Delivery of key milestones in the strategy action plan.	Indicators and success measures contained in the strategy action	VCA Strategy Reference Group,	MVSC

2014		plan	quarterly Safer and Stronger Strategy Group, twice yearly. Merton Partnership Executive Board, as required	
Protect and enhance open space creating no net loss of open space or sporting facilities unless justified in accordance with the Development Plan and National Playing Field criteria.	Merton Open Space Study (MOSS) completed 2010 No real milestones but policy applied through planning applications and material consideration given to MOSS	No net loss of open space	Annually (December)	Sustainable Communities
Finalise the Wandle Valley Regional Park boundary and to deliver projects that improve the green infrastructure within the park, enhance its biodiversity and improve opportunities for formal and informal recreation within the park.	Adopt Policies Map by June 2014 to establish boundary of the Wandle Valley Regional Park. Heritage Lottery Fund bid for £1.9m for Living Wandle Project - January 2013	Adoption of Policies Map Bid outcome known by June 2013 New projects delivered by partners, for example: accessibility improvements, signage, water vole habitats etc.	On-going Annually (December)	Partnership led by the WVRP Trust.
Promote culture, sport, recreation and play by safeguarding the existing (and working with partners to deliver more) cultural, leisure, recreational and sporting facilities	Annual capital investment programme Merton Sports Pitch Strategy2011 Increase participation in sport, recreation, arts and cultural wellbeing activities	No net loss of playgrounds, tennis courts, MUGA's Manage leisure centre contract No net loss of open space New programmes delivered for	Annually (December)	Green Spaces L & C development

	Cultural Framework launch	example: BMX track, new sports pitches and playgrounds Implementation of online leisure and cultural bookings Deliver Ride London inaugural event		
Outcome 4.4: More people make a positive contribution to their own wellbeing through access to learning and development of skills				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
Preparation of a Skills and Training Strategy and Action Plan	Skills and Training Action Plan ready by January 2013	Action Plan adopted by February 2013	Quarterly from April 2013	Economic Well Being Group
Creation of a Sustainable Communities and Transport Partnership sub-group that will be responsible for Economic Wellbeing	Group operating by November 2012	Creation of sub group of the Sustainable Communities and Transport Partnership	January 2013	Future Merton
Outcome 4.5: Build a healthy environment including access to housing, local amenities and activities				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
To deliver the housing sites identified within the Core Strategy and Sites and Policies DPD and meeting the housing targets in the Core Strategy and London Plan (320 new homes across all tenures per year for the next ten years).	Publish housing trajectory annually to demonstrate delivery	320 new homes built per year (April-March)	Annually (December)	Future Merton

Ensure all new housing developments deliver affordable housing units or financial contributions in accordance with the Development Plan policies.	Publish monitoring report annually to demonstrate delivery	Number of planning appeals presented on this issue that are allowed by a planning inspector	Annually (December)	Future Merton
All new housing built to 'Lifetime Homes' Standards and 10% of all new housing designed to be wheelchair accessible, or easily adaptable for wheelchair users.	Publish monitoring report annually to demonstrate delivery	Number of planning appeals presented on this issue that are allowed by a planning inspector	Annually (December)	Future Merton
To continue to maintain below the national average retail and vacancy rate in all our town centres.	Survey town centres and publish results annually	% retail vacancy rate compared nationally	Annually (December)	Future Merton
To have no net loss of employment land for which there is proven demand.	Publish monitoring report annually to demonstrate delivery	Number of planning appeals presented on this issue that are allowed by a planning inspector	Annually (December)	Future Merton
To establish and provide the appropriate amount of pitches for gypsies and travellers by means of the Sites and Policies Development Plan Document.	Adopt Sites and Policies Plan by June 2014 to establish need for additional pitches	Examination report by independent planning inspector demonstrates satisfaction with the council's findings on this issue	June 2014	Future Merton
Waste Plan Annual Monitoring Report targets	Identify and publish the gap between how many tonnes of waste should be managed within south London and how many tonnes are being managed	Capacity gap = >500,000 tonnes	Annually (December)	Future Merton

	in south London ("capacity gap")			
Adopting the Council's Climate Change Strategy by 2013 and implementing its targets and actions	Adopt Strategy by end 2013	Actions set out in the proposed Strategy	December 2013	Future Merton
Outcome 4.6: Improve community connectedness, improve independence and resilience of local communities				
Key actions	**Milestones**	**Indicator/success measure**	**Frequency of reporting/by when**	**Lead**
Conduct development plan consultation exercises in accordance with Merton's Statement of Community Involvement.	January-February 2013	Examination report by independent planning inspector demonstrates satisfaction with the council's performance on this issue	Annually (December)	Future Merton
Carry out a presentation at all of the Merton Area Forums that express an interest on neighbourhood planning and the Localism Bill 2010.	Presentation delivered to Wimbledon June 2012. Presentations delivered to other forums that have requested this - annually	100% of requested presentations delivered	Annually (December)	Future Merton