Merton
Joint Strategic Needs Assessment
2013-14

London Borough of Merton
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Disclaimer

This report is a refresh of the Merton 2012-13 JSNA, using available local and national data, and taking into account comments, discussions and recommendations. We would like to thank all contributors for their enthusiastic and constructive responses to all aspects of this report. While we recognise the vital contribution of Merton Voice in shaping the services that address the health and wellbeing of people in Merton, enriching and contextualising quantitative (numbers) data used in this report, this report documents all the commentary from various consultations and reflects the views and opinions of individuals, not organisations.
List of Abbreviations and Acronyms

A&E – accident and emergency
AD – Alzheimer’s disease
ADASS – Association of Directors of Adult Social Services
ADHD – attention deficit hyperactivity disorder
AF – atrial fibrillation
AIE – Analysis of the Impact on Equality
AMR – antimicrobial resistance
APS – Active People Survey
ASB – Adult Skills Budget
ASB – anti-social behaviour
ASC – Adult Social Care (within the Community and Housing Department of Merton Council)
ASCOT – adult social care outcomes toolkit
ASD – autistic spectrum disorder
ASDR – age-standardised death rate
ASCOF – Adult Social Care Outcomes Framework
ASPD – anti-social personality disorder
AQMA – Air Quality Management Area
BAME – black, Asian and minority ethnic
BCS – British Crime Survey
BESD – behavioural, emotional and social difficulties
BHIVA – British HIV Association
BME – black and minority ethnic
BP – blood pressure
BPD – borderline personality disorder
BRE – Building Research Establishment
CAMH – child and adolescent mental health
CAMHS – Child and Adolescent Mental Health Service
CASH – Contraception and Sexual Health Clinics
CBT – cognitive behavioural therapy
CCG/CCGs – Clinical Commissioning Group(s)
CFPP – Choice Framework for local Policy and Procedures
CHD – coronary heart disease
ChiMat – Child and Mental Health Observatory
CMHT – Community Mental Health Team
CIN – children in need
CIPFA – Chartered Institute of Public Finance and Accountancy
CMC – Coordinate My Care
CMD – common mental disorder
COAD – chronic obstructive airways disease
COPD – chronic obstructive pulmonary disease
CPA – care plan approach
CPP – child protection plan
CQC – Care Quality Commission
CQUIN – Commissioning for Quality and Innovation
CrISP – Carers’ Information and Support Programme
CSEW – Crime Survey for England and Wales
CSGBC – Cancer Service Guidance for Breast Cancer
CSP – Community Safety Partnership
CYP – children and young people
DALYs – disability-adjusted life years
DAS – Dementia Adviser Service
DCLG – Department for Communities and Local Government
DCSF - Department for Children, Schools and Families (now replaced)
DH – Department of Health (referred to throughout)
DNAs – do not attends
DOMES – Diagnostic Outcomes Monitoring Executive Summary
DOT – directly observed therapy
DfE – Department for Education
DPPO – designated public places order
DSR – directly standardised mortality rate
DSWs – dementia support workers
DWP – Department for Work and Pensions
EAC – Elderly Accommodation Counsel
ECG – electrocardiogram
Echo – echocardiogram
EGPP – Ethnic Group Population Projection
EHC – emergency hormonal contraception
EoLC – end of life care
EPaCCS – electronic palliative care coordination system
ESA – employment support allowance
ESOL – English for speakers of other languages
ETE – education, training and employment
EWDs – excess winter deaths
EWDI – excess winter deaths index
EYFSP – Early Years Foundation Stage Profile
FGM – female genital mutilation
FNP – Family Nurse Partnership
FTEs – first-time entrants
GLA – Great London Authority
GPs – general practitioners
GUM – genito-urinary medicine

HCAI – healthcare associated infection
HCP – Healthy Child Programme
HF – heart failure
HIA – health impact assessment
HIS – Healthcare Infection Society
HIV – human immunodeficiency virus
HPA – Health Protection Agency (now part of PHE)
HRA – Housing Revenue Account
HPV – human papilloma virus
HRG – Healthcare Resource Group
HSV – herpes simplex virus
HUDU – Healthy Urban Development Unit
HWM – Healthwatch Merton
HIS – Integrated House Survey
HSCIS – Health and Social Care Information Centre
HUS – Haemolytic uraemic syndrome

IAPT – improving access to psychological therapies
ICSWP – Intercollegiate Stroke Working Party
IMD – English Indices of Multiple Deprivation

JCVI – Joint Committee on Vaccination and Immunisation
JSA – Job Seeker’s Allowance
JSNA – Joint Strategic Needs Assessment
KSI – Killed or Seriously Injured

LAC – looked-after children

LARC – long-acting reversible contraception

LAAs – local area agreements

LAPE – Local Alcohol Profiles for England

LAQN – London Air Quality Network

LAS – London Ambulance Service

LBM – London Borough of Merton

LBW – low birth weight

LCP – Liverpool Care Pathway

LGBT – lesbian, gay, bisexual and transgender

LHO – London Health Observatory

LINks – Local Involvement Networks

LSCB – Local Safeguarding Children Board

LST – life skills training

MAAT – Merton Adult Access Team

MAES – Merton Adult Education Service

MASH – Multi-Agency Safeguarding Hub

MCDS – Maternity and Children’s Data Set

MDRTB – multidrug-resistant TB

Merton CCG – Merton Clinical Commissioning Group

MILES – Merton Independent Living and Engagement Service

MMR – measles, mumps and rubella

MND – motor neurone disease

MNDA – Motor Neurone Disease Association

MoU – memorandum of understanding

MS – multiple sclerosis
MSM – men who have sex with men
MSOA – middle super output area
MST – multisystemic therapy
MST-PSB – multisystemic therapy for problem sexual behaviour
MTS – Mayor’s Transport Strategy
MVSC – Merton Voluntary Service Council

NAO – National Audit Office
NCIN – National Cancer Intelligence Network
NCMP – National Child Measurement Programme
NCSP – National Chlamydia Screening Programme
NDEC – National Drug Evidence Centre
NDTMS – National Drug Treatment Monitoring System
NEET – Not in Education, Employment or Training
NEoLCIN – National End of Life Care Intelligence Network
NEPHO – North East Public Health Observatory
NHV – New Homes Bonus
NICE – National Institute for Health and Care Excellence (formerly National Institute for Health and Clinical Excellence)
NHB – New Homes Bonus

NDSE – National Dementia Strategy for England
NHS DEP – NHS Dental Epidemiology Programme
NHS IQ – NHS Improving Quality
NHSLA – National Health Service Litigation Authority
NRT – nicotine replacement therapy
NSCLC – non-small-cell lung cancer
NTA – National Treatment Agency

OCD – obsessive-compulsive disorder
OCUs – opiate or crack cocaine users
OOH – out of hours
ONS – the Office for National Statistics
OPCS – Office of Population Censuses and Surveys
PALS – Patient Advice and Liaison Service
PANSI – Projecting Adult Needs and Service Information system
PbR – payment by results
PCTs – primary care trusts
PHE – Public Health England
PHAST – Public Health Action Support Team
PHOF – Public Health Outcomes Framework
POPPI – Projection Older People Population Information system
PPC – preferred priorities of care
PPD – preferred place of death
PSHE – personal, social, health and economic education
PTSD – post-traumatic stress disorder
QIPP - Quality, Innovation, Productivity and Prevention
QOF – Quality and Outcomes Framework
RCA – root cause analysis
RCP – the Royal College of Physicians
RSV – respiratory syncytial virus
SA – Strategic Assessment
SAR – standardised admission ratio
SCLC – small cell lung cancer
SEN – special educational needs
SEND – special education needs and disabilities
SFA – Skills Funding Agency
SGH – St George’s Hospital
SHLAA – Strategic Housing and Land Availability Assessment
SHMA – Strategic Housing Market Assessment
SII – Slope Index of Inequality
SLA – service level agreement
SLHP – South London HIV Partnership
SMI – severe mental illness
SMPCT – Sutton and Merton Primary Care Trust (now replaced)
SMR – Standardised mortality ratio
SPOT – spend and outcome tool
STIs – sexually transmitted infections
SWEP – Severe Weather Emergency Protocol
SWL Las – South West London local authorities
SWLSTG – South West London and St George’s
TaMHS – Targeted Mental Health in Schools
TB – tuberculosis
THT – Terrence Higgins Trust
TIA - transient ischaemic attack
UKPDS – UK Prospective Diabetes Study
VCFOs – voluntary, community and faith organisations
VHF – viral haemorrhagic fever
WHO – World Health
WMPHO – West Midlands Public Health Observatory
Foreword

The year 2013-14 brought significant changes nationally and locally for the NHS and for Public Health: Sutton and Merton Primary Care Trust was split into separate Clinical Commissioning Groups, and Public Health moved into each of the local governments.

We are pleased to publish our first JSNA for the London Borough of Merton within our new home in Merton Council. It is the result of strong partnership work within the Council as well as between the Council, Merton Clinical Commissioning Group and the voluntary sector. In addition to being a refresh of the information provided in last year’s JSNA, this year we have reorganised the report to bring together information using a life-course approach, including chapters on: Merton: the place and the people; Health inequalities in Merton; Social determinants; Lifestyle risk factors; Children and maternal health; Adults; Access to adult social care; Older adults: and Sexual health and infectious diseases. This should make it easier for partners to use the JSNA to inform commissioning decisions.

The JSNA is a work in progress with each new edition making improvements on the previous one. This year we have increased our focus on health inequalities and the underlying factors that drive differences in life expectancy. The information points to clear priorities for partners when commissioning services to address these inequalities.

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Executive Summary

Introduction

Merton JSNA 2013-14 is a refresh of last year's JSNA 2012-13. The 2012-13 assessment established the process that has been used to build this 2013-14 update to identify the current and future health and wellbeing needs of Merton through consultation and partnership between the organisations that contribute to health.

This edition of the JSNA is structured to follow a life-course approach. It is divided into 10 themes: Merton Voice: What are communities are saying; Merton: the place and the people; Health inequalities in Merton; Social determinants in Merton; Lifestyle risk factors in Merton; Children and young people, and maternal health in Merton; Adult health in Merton; Access to adult social care in Merton; Older adults in Merton; and Sexual health and infectious diseases in Merton.

Summary of JSNA 2013-14 themes

Theme 1: Merton Voice: What our communities are saying

Annual Residents Survey for Merton

In Merton the 2012 Annual Residents Survey is the last published survey. Although the 2013 survey has been recently completed the results will not be published until early 2014, at which point the JSNA will be updated with these results.

In the 2012 Merton Annual Residents Survey 65% of adults said they thought local health services were good (8% thought they were poor); 76% of young people thought health services were good (3% thought they were poor). Regarding social services the proportion of residents who thought adult social services were good was 20% (5% thought they were poor); 23% thought social services for children and families were good (4% thought they were poor); 40% of young people thought that social services were good (5% thought they were poor). The proportion who rated services as good or excellent was higher amongst service users than among all respondents to the survey.

The 2012 Merton Annual Residents Survey also contained extra questions on health and wellbeing:

- Respondents' views of their overall health and wellbeing were generally positive, with few reporting they felt dissatisfied, unhappy, anxious or worthless. Anxiety was the main concern with 9% reporting that they felt very anxious yesterday.
- Satisfaction with family relationships and social life was seen as most important to respondents, and 31% felt this could be improved. Satisfaction with health and mental health and feeling safe in your local area were also seen as important to respondents.
- Feeling safe in your local area, satisfaction with health and mental health, and satisfaction with household income and getting by financially were seen by respondents as the main areas that could be improved.

Young Residents Survey

Merton Council commissions a Residents Survey that includes a separate Young Residents Survey. The key findings from 2012-13 are as follows:

- Young people’s concerns were similar to those of adults, with crime the biggest concern. Bad behaviour and bullying were also concerns for young people, with both seeing an
increase in the level of concern since 2011, significantly so for bullying with a 10% increase in concern.

- Concern about lack of recreational facilities has fallen significantly this year.
- Merton Council was viewed fairly positively by respondents, with performance ahead of London on all attributes and with 72% feeling they get the services they need.
- Merton is significantly ahead of London for listening to the concerns of young people and doing enough to protect young people; 90% agreed Merton is a good place to live.
- Following a fall in 2011, there has been a significant increase in ratings for local health services and repair of roads. This year has also seen an increase in scores for leisure and sports facilities. All three areas are significantly ahead of London, as well as activities for young people, public transport, recycling facilities, libraries and street cleaning.
- Political involvement remains stable for young people, with almost all saying they would vote in an election.
- Young people were generally satisfied and happy, with 90% reporting they were either very or fairly satisfied and happy. The top four factors identified as most important to young people’s sense of wellbeing were:
  - feeling safe in the local area (65%)
  - satisfaction with family and social relationships (58%)
  - satisfaction with school (42%)
  - satisfaction with health and mental health (34%).

Merton JSNA Community Consultation Event, September 2013
A community consultation was organised jointly by Healthwatch Merton and the Merton Public Health Team in September 2013 at Vestry Hall for residents of Merton. This was a culminating community consultation event where all the insight collected over the past year as well as the present JSNA findings on health areas, services, gaps and recommendations were summarised and final feedback was sought. 38 residents in Merton attended the event.

Key commissioning implications based on what people are telling us
Commissioners have a legal duty to seek views of service users and patients when commissioning services. This includes looking at users’ experience of existing services, and seeking views about planned changes to services before they are made.

A better understanding of patient or service user experience can help drive improvement by showing where efforts need to be targeted. Commissioners can draw on a wide range of data sources, including national and local, and qualitative and quantitative, to support this process.

Commissioners also need to consider what the appropriate involvement approach for different projects is. For a major service change, a formal public consultation will be required. When seeking to improve health outcomes and access to services for specific groups, engagement may include social marketing insight work to help understand the beliefs and attitudes that influence health behaviours and use of services.

It is important that commissioners are proactive in seeking views from marginalised groups who often experience poorer health outcomes, often referred to as ‘seldom-heard voices’.
**Theme 2: Merton the place and the people**

Merton has a population projected in 2013 to be 202,750 persons living in nearly 79,000 occupied households. Population density tends to be higher in the west wards of the borough compared to the east.

Just over half the borough is female (50.7%) and the borough has a similar age profile to London as a whole. The largest number of households in the borough are single households (28% of all households) although 49% of the borough’s population live in family households with dependent children (31% of all households).

Based on current trends Merton’s population would increase by 16,000 people between 2011 and 2017. A significant feature of Merton’s population in 2017 is the changing age profile of the borough’s residents, with the most notable growth in those under the age of 9 years and those over 65 years of age. Looking at the ratio between the working age and non-working age populations (the age dependency ratio) we see a decrease in the proportion of the working age population from 69% to 67%. The ethnic composition of the borough is also forecast to change significantly, with the proportion of people from a black, Asian and minority ethnic (BAME) background increasing from 35% in 2011 to 39% in 2017. The Greater London Authority (GLA) population projection data for 2013 shows Merton’s BAME population to be 74,650 (36.8%) (Source: GLA 2012 Round Ethnic Group Population Projection (EGPP) using the Strategic Housing and Land Availability Assessment (SHLAA). At Census 2011 the percentage for BAME groups in Merton was 35.1%. This is lower than the percentage for London (40.2%).

If we overlay deprivation data from the Indices of Multiple Deprivation (IMD) we can see that population growth and highest density are in wards toward the east of the borough, which currently have higher levels of deprivation, compared with the west of the borough.

**Theme 3: Health inequalities in Merton**

Health outcomes for people in Merton are generally better than those in London and largely in line with or above the rest of England. The graph in Figure 3.1 below shows healthy life expectancy at age 65 or older in Merton compared with other boroughs in South West London, London and England.

In Merton, overall life expectancy at birth is longer than the England average, but there is a difference between the most and least deprived areas within the borough of about nine years for men and about 13 years for women. Between 2005-09 and 2006-10 this gap has remained the same for men, but has increased by about two years for women. The increase in the gap for women is because for women life expectancy has increased at a faster rate in the most affluent areas compared with the most deprived areas of the borough.

Premature mortality (deaths under 75 years) is very strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts. Looking at rates of death in a population (rather than life expectancy), if East Merton had the same rate of deaths as West Merton, there would be around 113 fewer deaths each year in East Merton – an 18% reduction on the 640 deaths each year among East Merton residents. Of the 113 deaths, 81 are under 75 years of age.

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1 GLA Population Projections 2012 Round SHLAA ward projection creator.
2 It should be noted that the IMD has not been updated since 2010.
In general East Merton is younger, poorer, ethnically more diverse and with relatively lower levels of education outcome and training qualifications than West Merton.

**High-level recommendations to tackle health inequalities**

- With limited resources, a much more targeted approach will be required to address the differences in health and social outcomes and to develop services that respond to our increasing ethnic diversity.
- Placing a priority on the early years offers opportunities for the largest gains in life expectancy.
- Priority on prevention will reduce future need for health and social care services. Risk factors such as smoking, obesity and risky drinking behaviour underlie increasing levels of long-term conditions, such as heart disease and cancer, especially in the more deprived groups. Efforts need to be spread proportionally by need across all social groups.
- Partnerships with the voluntary, community and business sectors will accomplish a broader outreach by embedding health as part of all frontline work.
- An improved understanding of the social determinants of health and of the role local government plays in creating health will lead to more effective use of local government levers, including early childhood development, education and training, and licensing and planning.
- Improvements in early detection and management of long-term conditions provide opportunities for the quickest gains in life expectancy. Along with improved access to services, this will improve residents’ quality of life and reduce the need for more expensive acute services.
- Improvements to ensure more robust data is captured on the population accessing services and better use of this data, through health equity audits, for example, would support understanding service need and design.

**Theme 4: Social determinants in Merton**

The influences on health – social determinants of health – are the conditions in which people are born, grow, live, work and age. These conditions combine to create health and ill health and are dependent on the quality of education, employment and economic wellbeing, and the built environment, and on a nurturing environment in childhood, for example.

**Education in Children and young people**

Education offers opportunities for significant improvements in life expectancy and inequalities. Education is linked to the ability to earn higher incomes, which in turn enables people to adopt healthier lifestyles such as never or quitting smoking. Education has a direct effect on health outcomes; it also has an indirect impact on other social outcomes:

- **Crime:** People with no qualifications are more likely to be persistent offenders. Men are especially less likely to commit a crime the more educated they are.
- **Poverty and income:** According to a study undertaken to examine the relationship between education and income in England and Wales, each additional year of education leads to approximately a 10% increase in income.

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Unemployment: The less education a person has, the more likely he or she is to be unemployed. Someone excluded from school is many times more likely to be unemployed than a graduate is.

There is high overall adult educational attainment in the borough. However, there are two areas that fall within the 20% most deprived for education. These areas also fall in the overall most deprived areas, reflecting an inequality in educational attainment.

In Merton schools in 2012:
- There were 23,735 full-time equivalent pupils in maintained schools in Merton.
- 89.5% of children aged 4 and 53.7% of children aged 11 attended Merton schools.
- 16.5% (3,500 pupils) of children were eligible for free school meals.
- 18.4% (4,599 pupils) had special educational needs (SEN), which includes 2.9% with a statement of SEN.
- 40.3% (10,026 pupils) spoke a first language other than English.
- 121 different languages were spoken in Merton schools.
- 62.2% (15,473 pupils) were from black and minority ethnic groups.
- 16.6% (4,126 pupils) lived outside Merton.
- 19.9% (4,951 pupils) were living in the bottom 30% IMD area.

Of Merton’s primary schools 84% were rated good or outstanding and of Merton’s secondary schools 71% were rated good or outstanding by Ofsted. The gap between those eligible for free school meals and their peers was the same as London and significantly narrower than England at secondary school level, but at primary level the gap in attainment was wider than both London and England. Overall both pupils with a statement of SEN and those with SEN but without a statement performed better than the England average. Overall pupils from mixed and Asian ethnic backgrounds performed better than white and black ethnic groups in Merton. Pupils from Chinese ethnic background performed the best, although the population is small in Merton. In Merton schools absence rates improved across primary schools and were below both London and England rates. Targeting pupils at risk of becoming persistent absentees improved persistent absentee rates, which were lower than London and England rates. At secondary school level overall absence and persistent absence remained higher than London and England rates.

Non-participation of young people in education, employment or training between the ages of 16 and 19 is a major predictor of later unemployment, low income, depression, involvement in crime, and poor mental health. In 2012 Merton’s NEET (Not in Education, Employment or Training) (16-18 year olds) figure was 4.64% compared with 4.50% for London and 13% for England. Merton’s NEET figure shows a downward trend with a reduction from 5.6% in 2009. Merton ranked 14th in London boroughs where 1 is the highest percentage and 32 the lowest. Of the NEET cohort 55% were young men; 22% were aged 18; and 67% were white. Significant totals for ‘vulnerable groups’ included those with learning difficulties and disabilities, and those who were teenage mothers, who represented 5.7% and 11% of the total NEET group respectively. The highest concentrations of the NEET cohort were in the east of the borough.

Key commissioning implications for access to education
- Overall educational outcomes in Merton are improving rapidly, however there is a need to continue to reduce the gap in attainment, including a focus on reducing the gap between pupils eligible for free school meals and their peers in primary schools; and reducing rates of school absence at secondary school level.

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There is a need to fully understand the implications for all services on the implementation of the Children and Families Bill, including school nursing, therapy services, school staff, Special Educational Needs and Disabilities Inclusion Services and Children’s Social Care.

The increase in school numbers has implications for School Nursing Services. More preventative work and school nursing ‘casework’ with children and young people ‘out of school’ for health reasons are needed.

Pupils’ health and well-being have an impact on their educational performance. Effective preventative work in schools and wider communities needs to be done to mitigate poor health and lifestyle choices becoming a barrier to learning and attainment. The Healthy Schools London programme is an opportunity for schools to address this.

**Adult Education**

Adult education services in Merton are provided mainly by South Thames College and Merton Adult Education Service (MAES), a division within Merton Council’s Community and Housing Department.

MAES operates out of three main centres and a number of venues such as libraries, children’s centres and other community locations across the borough. MAES delivers courses annually to over 5,000 learners. Programmes are delivered under three distinct contracts: Adult Skills Budget (ASB); Community Learning; and 16-18 Funding. Programmes are assessed against the Ofsted inspection framework, with self-assessments performed on a regular basis. The 2011 Ofsted inspection report graded MAES as good.

MAES has identified the following gaps:

- **Unfulfilled need for services**
  - English for speakers of other languages (ESOL) courses; MAES is unable to meet the current demand for these courses.

- **Areas for improvement**
  - Progression and destination capture.
  - A need for a community learning strategy document.
  - Areas of provision that fell below minimum performance levels.

The Ofsted report highlighted the following needs:

- Further develop recent strategies to improve retention, and so success rates, particularly for accredited provision.
- Improve the quality and use of individual learning plans by ensuring that targets give students meaningful goals that teachers use to plan effective lessons.
- Ensure that the service has more effective and comprehensive measures in place to gather and respond to users’ views across the provision.

**Key commissioning recommendations (MAES)**

- Respond to Ofsted recommendations.
- Develop closer links/commissioning related to health and prevention, identifying opportunities to embed health issues in existing courses.
- Expand ESOL classes to meet unmet demand.

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Employment and Economic Wellbeing

Deprivation and income are important influences on health. Levels of disposable income affect our ability to meet basic needs – the way we live, the quality of the home and work environment, and the ability of mothers to provide the kind of care they want for their children. The relationship between health and low income exists across almost all health indicators.7 If full employment were achieved in Britain, 2% of lives would be saved per year and 17% of deaths in areas with higher than national average mortality would be avoided.

In Great Britain, 70.9% of the population aged 16-64 years were in employment (April 2012-March 2013), and 7.81% of those who were defined as economically active were unemployed. In London, the level of employment was lower, at 69.5%, with 8.9% of the economically active unemployed. Employment levels were slightly higher in Merton than the London and national levels. In Merton, 72.6% of the population aged 16-64 years was in employment, with 7.1% of the economically active unemployed. There has been an increase in unemployment since 2008. In Merton, 3,455 people were claiming Jobseeker's Allowance (as of August 2013), representing 3.3% of the resident population aged 16-64 years. As of September 2013, the percentage of claimants is lower than the London (3.4%) and lower than England (3.1%) levels, and levels have been falling since March 2013. The proportion of working age population claiming the key out-of-work benefits peaked at 8.2% in August 2009, fell back to 7.5% in November 2010 and was 9.5% in February 2013; an increase of +1.7% when compared with February 2012. These levels are much lower than the level for London (13.2%) and Great Britain (14.3%)

In London, excluding the City of London, the median gross weekly pay for all full-time workers varied from £789.80 in Kensington and Chelsea to £544.00 in Brent. The median gross weekly pay in Merton was 14th highest of the London boroughs (based on 32 boroughs, with the City of London excluded due to the small number of residents) at £535.50. In general men work in higher paid jobs than women, even when considering full-time work.

Gaps and commissioning recommendations
Those in employment enjoy better levels of health than the unemployed. Unemployed people are significantly more likely than employed people to have poorer mental and physical health, including depression, anxiety and physical health problems. Helping local people to be productive in either paid or unpaid work to support their transfer towards future employment will have a beneficial effect on demand for health services in the future.

Policies and programmes that increase levels of employment will be of significant health benefit to individuals and the local community. For young families, access to affordable day care and family friendly employment can also make a critical difference to being able to work. Meaningful employment for young people, such as apprenticeships, is particularly important to reduce the risk of depression and other mental health problems.

With the introduction of increased university fees and the possible increase in young people looking for work and training rather than further education, the development of employment schemes for young people is a particular priority.

The health impact of the recession is unknown. Possible early indicators include prescribing rates for antidepressants, accident and emergency (A&E) attendances (linked to late presentation), increase in obesity in adults and children (linked to poor diet) and claimant count. The London Health Observatory (now part of Public Health England (PHE)) is working

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on developing measures to reduce the impact of the recession on health. Work needs to be done in partnership to try to mitigate the impact of the recession on health and wellbeing.

**Built Environment**

The Indices of Multiple Deprivation (IMD) measure levels of deprivation using a range of indicators under different areas or ‘domains’. The domain for ‘Deprivation and the Physical Environment’ is split into two subdomains: the ‘indoors’ physical environment, which measures the quality of housing, and the ‘outdoors’ physical environment, which contains two measures relating to air quality and road traffic accidents.

There are 44 areas that fall within the 20% most deprived for the physical environment in Merton. In terms of reduction in Killed or Seriously Injured (KSI) casualties, Merton has made significant progress in reducing the number of KSIs and further progress is expected. A reduction of 58% was achieved between the 1994-98 five-year average and 2009 (compared with an average reduction across all boroughs of 52%). Fatalities fell by 16% (159 to 134), KSI casualties increased by 8% in 2012 compared with 2011. Within this, the number of serious injuries increased by 9% (2,646 to 2,884). Slight injuries fell by 3% (26,452 to 25,762) and overall casualties in 2012 fell by 2%, compared with 2011.

Air quality is an important Public Health issue in London, as poor air quality contributes to shortening the life expectancy of all Londoners, disproportionately impacting on the most vulnerable. Air quality in London is the worst in the country. Poor air quality exacerbates heart and lung conditions such as asthma, and chronic obstructive pulmonary disease. Local authorities have a statutory duty to manage local air quality and are required to carry out regular reviews and assessments of air quality. The main issue with our local air quality has been found to be emissions (relating to NO\textsubscript{2} and PM\textsubscript{10}) emanating from road vehicles. Based on the non-automatic monitoring and assessments undertaken, it was found that some of the air quality objectives would be exceeded in areas where there was relevant exposure. As a consequence the Council designated the whole of the borough as an Air Quality Management Area (AQMA) for annual mean objective and 24-hour mean PM\textsubscript{10} objective.

The Council currently maintains one NO\textsubscript{2} automatic monitoring station located on the first floor of Morden Civic Centre, which therefore falls into the category of a roadside location. Sampling is taken 4m from ground level, at a distance of 3m from the kerbside. There is no automatic particulate monitoring.

**Local recommendations**

- Embed the health impact assessment (HIA) into existing assessment processes in the local authority.
- Expand access to green space.
- Prioritise policies and interventions that both reduce health inequalities and mitigate climate change, by improving:
  - active travel across the social gradient
  - the quality of open and green spaces across the social gradient
  - the quality of food in local areas across the social gradient
  - the energy efficiency of housing across the social gradient
- Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
- Support locally developed and evidence-based community regeneration programmes that use spatial planning to remove barriers to community participation and action and reduce social isolation.
• Use the Healthy Places resource, an online tool put together by a team from the National Heart Forum. This tool highlights how local authorities can use existing laws ‘that have the potential to change local environments and encourage more active lifestyles and better diets’.

**Housing**

The number of households in Merton is projected to increase to 89,000 by 2016 (8%) and 99,000 (15%) by 2021, an average annual household growth of 2.2%. This is ranked the fourth highest household growth in England with much of the increase expected to be of single person households. Single person households at the time of Census 2011 made up 28% of all households, but will increase by 7,800 by 2016, making up 42% of all households. Lone parent households are also set to increase by 9%. The projected percentage increases in households between 2013 and 2021 are: Merton: 19.2%; London: 12.4%; England: 7.8%.

Of the 78,757 households in Merton at the time of Census 2011, 60.1% (47,360) were owner-occupied (either owned outright or with a mortgage or loan, or in shared ownership), 14.1% (11,102) were social housing tenants and 24.8% (19,503) were renting privately.

Merton’s social housing stock is amongst the lowest in London at 14% of total stock. The London average is around 22% with social housing stock as high as over 59% in large boroughs such as Southwark. The profile of stock differs between owner-occupied and social housing in Merton, with 58% of social housing and 63% of private rented homes being flats compared with only 24% in the owner-occupied sector. Social housing and private rented homes also typically contain fewer rooms than those that are owner-occupied.

There is a high level of housing need amongst Merton residents. Merton’s Housing Needs Survey [date?] identified a need to develop an additional 1,848 affordable homes per annum between 2005 and 2010 if all housing needs in the borough were to be met. The 2010 Merton Strategic Housing Market Assessment (SHMA) 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 eastern part of the borough.

With projected increases in people aged over 65 years (estimated 11% increase between 2011 and 2017), one of the key concerns is the increase in older people living alone. This has implications for health and social care since 57% of the ‘fuel poor’ are aged 60 and over; poorly insulated homes and the continual rise in heating bills contribute to fuel poverty.

Although the number of homeless households in Merton is amongst the lowest in London, homelessness is on the increase, with homelessness applications rising from 188 in 2010-11 to 279 in 2011-12 and the number of households accepted as statutory homeless increasing from 89 in 2010-11 to 101 in 2011-12.

There are around 30 residents living on one permanent caravan site in Merton and there are also many gypsies and travelers living in ‘bricks and mortar’ housing in Merton; 139 people from the gypsies and travelers community took part in a research event organised by Merton.

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10 SHLAA.
Council in October 2011, and the latest Census 2011 shows that 217 people in Merton have identified themselves as gypsies and travellers. However, organisations working with this community believe that the figure is actually higher.

**Key commissioning recommendations**
The challenge for the borough is to be able to forecast future housing needs, to inform potential providers of what is required, and to feed into and underpin the borough’s housing strategies. In particular, people with learning disabilities surviving into older age will potentially have a significant increased need for accommodation to support them to remain as independent as possible.

With increasing age will come:
- increasingly complex social and health needs requiring more sophisticated solutions for supported living, including a greater need for sheltered and extra care accommodation for people with learning disabilities as well as older people who have dementia or other disabilities, as population projections show these client groups to be on the increase
- more people with learning disabilities outliving their parents and family carers, which will lead to an increase in the need for supported living as well as a potential increase in the need for tenure-based housing.

It is essential that local authorities and health services work together to provide accessible and appropriate services for these groups and to tackle health inequalities amongst homeless households and ethnic minority groups.

As councils become increasingly responsible for leading on health improvement within their local populations, planning experts will need to work closer with public health regarding regeneration and spatial planning to help deliver shared goals.

Health impact assessments are a useful tool for assessing the impact of local regeneration programmes and should be considered locally. A prospective health impact assessment can provide a useful opportunity to identify positive health impacts and opportunities and mitigate potential negative impacts for local regeneration programmes.

Local regeneration programmes should support the ‘people, places and markets’ regeneration framework published by the Department for Communities and Local Government (DCLG). This approach to regeneration encompassing physical regeneration, social or community regeneration, and economic development may influence health through broader determinants.

**Crime**

*Due to the timescales involved for the JSNA and the Community Safety Partnership Strategic Assessment that is currently under development by the London Borough of Merton’s Safer Merton partnership, the two documents at present cannot reflect one another completely. As the JSNA is a living document, the information from the Strategic Assessment will be utilised to update this section in due course, once it becomes available.*

**Key facts on crime in Merton**
The English Indices of Deprivation provide a relative measure of deprivation at small area level across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation, including crime, and an overall composite measure of multiple deprivation. The purpose of the crime domain is to measure the rate of recorded crime for four major crime types – violence, burglary, theft and criminal damage – representing the risk of personal and material victimisation at a small area level. Data
suggests that the areas to the south and east of the borough contain higher proportions of people who are experiencing these major crime types.

The Office for National Statistics (ONS) data for 2012-13 shows that there was a decrease in robbery, burglary and sexual offences but an increase in violent crime. In Merton, the rate for recorded crime attributable to alcohol was better than Croydon and Wandsworth, higher than Sutton, Kingston and Richmond, about the same as England and well below the London rate, with a declining trend since 2009-10. Merton had the fifth lowest rate in London for alcohol-related recorded crime and below the regional average, but was ranked 230 out of 326 local authorities in England (where 1 is best and 326 is the worst).

In Merton, domestic violence victimisation rates as reported to the police for 2011\(^{11}\) for women were 8.6 per 1,000 adult women (18+) and for men, 1.9 per 1,000 adult men (18+):

- 749 offences flagged as domestic were recorded in the borough in 2011, representing just over 5% of total crime. More incidents took place where the police were called but which did not result in criminal offences.
- 80% of domestic offence victims were female. 60% were white European; 20% African Caribbean; 13% Asian; and 3% dark European. 35% were aged in their twenties; 26% in their thirties; and 20% in their forties.
- 87% of victims were Merton residents.
- 81% of offenders suspected of a domestic offence last year were male. 51% were white European; 25% African Caribbean; 12% Asian; and 3% dark European. 31% of suspected offenders were in their twenties; 30% in their thirties; and 21% in their forties.

**Gaps and commissioning recommendations**

To tackle some of the root causes and to find solutions require close partnership working. There is also an opportunity, given the links between teenage pregnancy, offending behaviour, truancy, and the focus on alcohol and drug misuse, to look more holistically and take a whole system approach to tackling crime.

However, commissioners must also focus on primary preventative measures for both children and adults to ensure that the focus isn't only on where things have gone wrong but also on the things that can be prevented from going wrong. Partnership working structures need to reflect this approach.

In the context of understanding the impact of alcohol on individuals, families and local communities, particularly in regard to domestic violence, more in-depth work at a local level is needed. Working collaboratively, local Drugs and Alcohol and Community Safety Partnerships are well placed to undertake this work. In addition, the differential between reported crime and perceptions of crime needs to be reviewed.

**Theme 5: Lifestyle risk factors in Merton**

**Smoking**

Smoking is the UK’s single greatest cause of preventable illness and early death. Adults who smoke lose on average 13 to 14 years of their lives and more than 86,000 people in the UK die from smoking each year. There is evidence that smoking causes various cancers (particularly lung cancer), heart and blood vessel disease (including high blood pressure,
stroke and heart attacks), respiratory disease (e.g. chronic obstructive pulmonary disease) and many other conditions.

Since there is no definitive measure of how many people smoke, national modelled estimates of smoking were developed from national survey data. In Merton, it is estimated that 16.48% of the population smoke compared with 20% in London; this is the fifth lowest prevalence of all London boroughs. However, this masks variation across the borough where smoking rates vary from 9% to 24%. The higher rates are in line with the areas that have greater deprivation. These estimates are also supported by a survey of healthy living carried out in 2010 within Sutton and Merton, where people living in more deprived areas reported a smoking rate of about 24%. It has also been estimated that smoking prevalence among routine and manual workers is 23.5% in Merton.

**Key commissioning recommendations**

Merton has low overall smoking prevalence. However, there are clear inequalities in the levels of smoking across the borough and lower prevalence of quit rates compared with London and England. These factors, combined with plateauing mortality in circulatory disease, mean that tobacco control and tackling smoking should remain a high priority.

Recent figures on people stopping smoking have fallen short of local targets, however the integration with the LiveWell health improvement service will provide additional exposure to the programme. The stop smoking service also links into the NHS Health Check programme (a national initiative of regular vascular risk assessments) to provide support to help people reduce their risk of vascular disease caused by making changes to their lifestyle e.g. stopping smoking.

Since April 2013, Merton Council has been responsible for commissioning the Stop Smoking Service, rather than it being directly delivered by an in-house team in the NHS. The new provider, Hounslow and Richmond Community Healthcare NHS Trust, is focused on increasing the rate of residents accessing the programme and the number of smoking quitters, and will:

- continue to focus on access for ethnic groups, particularly minority ethnic males
- support younger people, particularly those most vulnerable
- focus on routine and manual workers, unemployed people and those on a low income
- support pregnant women to give up smoking early in pregnancy
- increase the outreach of the programme, branded under the LiveWell banner, to include workplaces e.g. staff working in council buildings
- link closely to Stoptober, the national campaign that encourages people not to smoke for the entire month. People who stop smoking for this length of time are less likely to start again.

Merton Council has worked to deliver effective comprehensive tobacco control in the borough, and at times nationally, with action leading to the banning of tobacco supplies from vending machines. With its partner agencies and organisations, Merton Council should continue to make tobacco control a priority to reduce the level of tobacco usage, as well as work towards normalising smoke-free environments beyond current legislation.

**Adult healthy weight**

Since there is no definitive measure of the proportion of overweight or obese adults, national modelled estimates of adult obesity rates were developed from population survey data. In Merton, these estimates suggest that overall 19.1% of adults (aged over 16 years) are obese, lower than London and England. Further estimates within the borough (at middle
super output area level, about 7,000 of the population) suggest the highest levels are in the more deprived areas, with prevalence ranging from 10.6% (1 in 10) to 28.4% (1 in 3) across the borough.

In Merton, it is estimated that only 7.7% (1 in 13) of residents take part in enough physical activity to benefit their health – and that 92% of residents do not. This compares with 11% of Londoners and 11.8% nationally. Over half (51.2%) of Merton residents reported that they had taken part in no physical activity at all in the past four weeks. Data from across the country, reflected in the London-wide data, shows that disabled groups, non-white groups and older groups are less likely to be active. Activity levels are also lower among residents in routine occupations and those that have never worked or are long-term unemployed, compared with those residents in higher and managerial professions. Groups that have been identified as having the lowest levels of physical activity are girls and women (particularly young adults), people with physical and mental health disabilities, older adults, ethnic minority groups and socially deprived communities.

Key commissioning recommendations
Tackling obesity and helping people achieve a healthy weight are key to preventing future illness. With an increasing population and rising numbers of people projected to live longer, helping to prevent future ill health such as diabetes, cancer and heart disease, is vitally important if health and social care services are going to be able to cope in the future. There is no simple solution to the challenge of obesity. It is important that an integrated and wide-ranging programme of solutions involving national and local action should be adopted to help tackle the growing problem.

Tackling obesity requires a multi-agency response across all ages, including whole family approaches, promoting of healthy food choices, building physical activity into our day-to-day lives, providing safe open spaces, promoting walking and cycling, promoting the role of employers, and providing personalised advice and support to individuals. As the lead organisation for public health and health improvement, Merton Council is well placed to address these areas across all its policies, including planning, housing, leisure services and social care.

Commissioners should prioritise the development of a clear weight management and obesity pathway, to ensure that services are available to support Merton residents with the level of expertise that they need in a setting that is appropriate and of interest to them.

Commissioners should also ensure that a prevention agenda is embedded across all contracts delivered in Merton by the Council, Merton Clinical Commissioning Group (Merton CCG) and its partners e.g. healthy vending in leisure centres and community dieticians delivering training to local people on how to eat healthily with minimal time and money.

Health services have a vital role to play in providing support and care; with consistent messages on achieving and maintaining a healthy weight and increasing levels of physical activity from health and other professionals being essential. How these messages are presented and delivered seems to be key to supporting behaviour change and to providing an opportunity to explore how to develop training for and ensure consistent messages are conveyed by all frontline workers in Merton.

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12 Sport England: Active People Survey 2012.
Lifestyles and health improvement for children and young people

Children’s wellbeing is strongly associated with parents’ physical and mental health, resources and parenting knowledge. The support needs of parents are dependent on many factors such as age, self-confidence, experience, personal circumstances etc. Support therefore needs to be sufficiently varied and flexible, ranging from someone to listen to a concern, to universally available and timely advice, through to specialist support, targeted where there is greatest need. Support to parents is through a range of universally available services to which all parents are entitled, targeted services for parents who need specific support at particular times, and mandatory interventions for those parents who are unable to seek out or engage with existing support services.

Evidence-based parenting programmes are a means 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. In Merton, the targeted parenting offer includes a range of accredited programmes.

Key commissioning implications
Commissioners need to:
- recognise the integrated nature of lifestyle behaviour and wellbeing, to continue to prioritise giving every child a healthy start in life and to adopt place-based public health systems
- ensure professionals are equipped to offer effective support to parents to support child wellbeing and resilience, and to provide targeted parenting programmes
- work in partnership with schools to promote physical and emotional health and wellbeing, targeting schools in areas with high health needs.

Healthy weight in children

The National Child Measurement Programme (NCMP) results for 2012-13 show that in Merton 9.0% of 5 year olds were classified as obese compared with 10.8% in London and 9.3% in England. This has reduced by 0.5% from 2011-12, and the overall trend is downwards from just over 12% in 2006-07. In Merton, 21.3% of 11 year olds were obese compared with 22.4% in London and 18.9% in England. This has increased by just under 1% from 2011-12, and the overall trend is upwards from just over 18% in 2006-07. There was a 12.3% difference in the level of obesity between 5 year olds and 11 year olds. This difference has increased by over 6% since 2006-07, when there was a gap of just over 6% in 2006-07. Looking at excess weight overall, over 21.2% (over 1 in 5) of 5 year olds were categorised as overweight or obese, rising to 35% (over one third) of 10-11 year olds. There was an increase of nearly 14% in excess weight between 5 year olds and 11 year olds. This has reduced by 2.8% for 5 year olds and increased by 0.9% for 11 year olds since 2006-07.

The significant increase in levels of obesity between 5 year olds and 11 year olds needs to be understood and action taken in schools, particularly in Years 3 and 4, and with communities and families, to start to reverse this trend. Information from the NCMP shows nationally that children from black and minority ethnic groups are more likely to be obese. In Merton, wards in the east of the borough have higher levels of obesity at ages 5 and 11 than those in the west.
Key commissioning recommendations

- Develop a sustainable, community-wide, multi-agency approach to increasing levels of healthy weight for children and young people and their families, which address inequalities by gender, ethnicity and area. Ensure that evidence from the National Institute for Health and Care Excellence (NICE) on working with local communities to achieve healthy weight is implemented and that all local levers are being maximised e.g. planning, parks and leisure, transport etc.
- Ensure on-going monitoring of the National Child Management Programme (NCMP) to inform targeting of resources in areas with children with higher levels of excess weight. Evidence on the increasing gap in obesity between 5 year olds and 11 year olds indicates the need to target children in school Years 3 and 4.
- Review and maximise capacity of School Nurses and delivery of preventative aspects of the Healthy Child Programme (5-19 years).
- Recommission Weight Management Services for children and young people, including an increased focus on prevention. Develop local obesity pathways for children and young people.
- Health and wellbeing of pupils have an impact on their educational performance. Effective preventative work in schools and wider communities needs to be done to mitigate [poor] health and lifestyle choices becoming a barrier to learning and attainment.
- Ensure opportunities for promoting healthy lifestyles in schools and wider communities are maximised, particularly among schools in the east of the borough. Increase number of schools registered with the Healthy Schools London programme.

Dental health in children

The latest NHS Dental Survey of 5 year olds in 2011-12 showed that 29.2%, or 3 in 10, of 5 year olds in Merton had decayed or missing teeth, which is better than London (32.9%) and similar to England (27.9%). For Merton, this is a 6.4% increase compared with 2008-09, when 22.8% of 5 year olds had decayed or missing teeth, which was lower than both England (30.9%) and London (32.7%).

In 2012, 13.1% of 5 year olds in Merton had tooth decay that had been filled by a dentist (the ‘Care Index’, a measure of the amount of diseased teeth that have been dentally treated), which is similar to London (13%) and higher than England (11.2%). The Dental Survey indicates that there has been a reduction of 11.3% in the Care Index in Merton, from 24.4% in 2008. This requires further investigation, particularly as children from lower socioeconomic backgrounds are disproportionately affected.

Key commissioning recommendations

- There is a need to improve access to NHS dental services for children, and particularly in the early years.
- There is a need to review progress on implementing the recommendations from the oral health promotion evaluation. These recommendations included:
  - beginning health promotion interventions antenatally and targeting a wider range of at-risk populations
  - linking with other health promotion programmes, such as smoking cessation, alcohol-related and diet programmes
  - including evaluation as a key component of the service
  - delivering an oral health promotion programme at a wider geographical level e.g. across South West London.
Substance misuse

In 2012-13, the London Borough of Merton (LBM) Safer Merton Team together with Public Health re-tendered for and recommissioned a new and fully integrated Recovery-Based Adult Substance Misuse Treatment Service, to meet the needs of those people within the borough’s population who are alcohol and drug dependent and/or at risk of suffering serious substance-related harm. Services for younger substance misusers locally are currently being reappraised and will be re-tendered in 2014-15. Together, we are also developing new substance misuse harm prevention frameworks for the borough that focus on whole population issues, public education and earlier identification and intervention methods aimed at stopping or reducing substance misuse before it has escalated into a more serious problem.

Alcohol – adults
The most recent data available indicates that higher-risk drinking is more widespread, and occurs more in deprived areas, suggesting that high levels of risky drinking is also occurring both at home and out of the home. In Merton, as highlighted in the Local Alcohol Profiles for England published in August 2012, the estimated prevalence of binge drinking was 13.8% compared with 14.3% in London and 20.1% nationally. However, for small geographic areas within the borough, at middle super output area level, the range as 7% to 20%. The estimated levels of the adult population drinking at ‘increasing risk’ (21%) and ‘higher risk’ (7.2%) were above London or England levels.

In terms of alcohol harm overall and in 2012, Merton ranked 55 out of 326 local authorities but was in higher percentiles for:
- Male mortality chronic liver disease (104/326)
- Female alcohol-specific hospital admissions (106/326)
- Male alcohol-specific hospital admissions (109/326)
- Male alcohol-attributable hospital admissions (151/326)
- Alcohol-related violent crimes (192/326)
- Alcohol-related sexual offences (208/326).

In terms of all alcohol-related crime and according to Local Area Profile Data for 2011-12, Merton with a rate of 7.3 recorded crimes per 1,000 populations was higher than the neighbouring boroughs Sutton (6.7) and Kingston (6.7) and the England average of 7 but lower than the London average of 11.1. The trend though in the five years since 2006-07 has generally been a downward one. Of people surveyed (‘My Place’ survey) in 2009, 49% thought that drunkenness and rowdy behaviour were a problem for the borough.

Drugs – adults
In 2012-13, Merton Substance Misuse Services were reported to be the highest performing nationally for successfully completed episodes, and were subsequently inspected and commended by the National Treatment Agency for Substance Misuse as an exemplar of good practice in this activity.

In terms of local treatment population statistics for drug misuse, in Merton in 2011-12 it was estimated that 5,024 people aged 18-64 were dependent on drugs and of these approximately two thirds were male. By 2020 it is predicted that the number of people dependent on drugs will increase by 11%. This includes all drug users and is based on a national prevalence rate of 3.4%. Most dependence is estimated to be on cannabis only (2.5%), rather than other drugs (0.9%).

PANSI (2011).
decreased by 25% from 2010-11 (675 clients in treatment); this may reflect a national trend with a modest decline in demand for services across the country.

In Merton in 2011-12 there were an estimated 1,029 opiate or crack cocaine users (OCUs), a rate of 7.1 per 1,000 population, lower than both London (9.4 per 1,000) and England (8.9 per 1,000). Of OCUs in Merton, just over 20% (n=209) were injecting drug users. Taking those already in treatment and/or those known to the treatment system, it is estimated that there were some 678 people in the community not presenting or having not ever presented to services – 65% of the total estimated users. This has grown from 2010-11 when the figure was estimated at 45%.

In 2011-12, of those starting treatment the proportion in effective treatment was 83% for OCUs and 86% for all drug users, and there was a high-planned exit rate from treatment, which shows they were successful completions. The planned exit rate in 2011-12 was 58% of all treatment exits, compared with 42% in London and 43% in England. The percentage of opiate-based successful completions was 44%, higher than both London (37%) and England (33%).

Key commissioning recommendations

For the treatment system as a whole:
- Continue to monitor local treatment services against an agreed Performance Assessment Framework and local indicators and outcomes for substance misuse as indicated in the Public Health Performance Dashboard.
- Safer Merton, Public Health and Merton CCG to review current usage of commissioned substance misuse inpatient (tier 4) bed nights and further develop community treatment capacity to manage down future demand for inpatient services.
- Safer Merton and Public Health to develop new substance misuse prevention frameworks and reinvestment proposals to complement these.
- Continue to develop assertive outreach capacity to support hard-to-engage populations.
- Further develop local capacity to respond to parents who misuse alcohol and other drugs, and to safeguard children.
- Maintain integrity, commitment and future resourcing for integrated substance misuse treatment services.

For alcohol:
- Develop an agreed local strategic framework for alcohol partnership work with an alcohol action work plan for 2013-14.
- Stream relevant elements of the alcohol work programme through a new Merton Harm Prevention Forum.
- Target street drinking and anti-social behaviour and effect appropriate responses through the Local Multi Agency Planning and Problem Solving Groups.
- Work with Trading Standards and the Metropolitan Police Licensing Team to target licensed premises and other alcohol outlets that continue to sell alcohol to children and/or are ‘hubs’ for anti-social behaviour in local communities.
- Have a Merton Alcohol Licensing and Planning Task Group.
- Through training, develop workforce capacity in identifying and responding appropriately to problem alcohol use.
- Have a specific alcohol arrest referral pathway to divert and support problem drinkers at an early point in the criminal justice system.

For drugs:
- Use the Targeted Drug Testing on Arrest programme effectively to identify and treat drug misusing (particularly class A) offenders.
• Ensure that local treatment services are linked and contribute to effective Integrated Offender Management work locally.

*Young people’s substance misuse*

In Merton, in terms of drinking behaviour, the only source of information on attitudes and beliefs towards drinking alcohol we have is from the TellUs 4 survey (2009) in which the majority of children (8 to 16 years) reported not having ever had an alcoholic drink. For those that did report drinking, the number getting drunk once, twice or three or more times in the past month was consistently lower than national figures. Drinking estimates for Merton young people extracted from the 2013 Merton Young People’s Sexual Health and Substance Misuse Needs Assessment, based on the National Centre for Social Research’s Smoking, Drinking and Drug Use survey (2011) suggest that 1,977 (19%) of young people between 11 and 15 years were drinking once a month or more, with an additional 2,090 (20%) drinking a few times per year. For young people aged 16-17 years consuming alcohol in the past week, the estimated number based on the Institute of Alcohol Studies was 2,476 (62%).

Latest reported figures from the Local Alcohol Profiles for England for alcohol-specific hospital admissions in the under 18 age group (2012) suggest a slight decrease in hospital admissions in the past six-year period. Merton, however, ranked ninth highest in London. As absolute numbers were small, one or two admissions would affect the ranking and did not include attendance at an A&E department, so therefore need to be treated with caution.

Merton saw an increase in the numbers of young people under 18 years presenting for specialist treatment interventions in 2011-12. An analysis of needs assessment data for 2011-12 reveals that 138 young people aged under 18 were in treatment, which represents a 23% increase on the previous year. Figures for 2012-13, however, return to levels seen in previous years of just under 100. In 2011-12, 46% came through the youth justice route and 27% were using alcohol and cannabis.

*Key commissioning recommendations*

A joint young people’s sexual health and substance misuse needs assessment was carried out in Merton in 2013, which highlighted local needs and gaps. The needs assessment indicated improvements could be made in relation to:

• strengthening preventive and early identification strands of support, including outreach provision
• providing referral pathways for substance misuse and further integration with sexual health services
• increasing training to improve early identification and increase referrals to specialist services
• provision for young people aged 18 to 24 in contact with criminal justice services but using Class A drugs was highlighted as a local gap
• providing effective transitions into adult substance misuse services for 18-24 year olds who require extended support and treatment
• providing an A&E intervention pathway for young people who present there with substance misuse issues
• upon completion of the review of the existing young peoples’ Substance Misuse Service, agreeing recommendations and re-tendering in 2014.
**Teenage pregnancy**

Teenage conception includes all conceptions before the mother’s 20th birthday, but the national focus is on conception under 18 as most potential mothers in this age group are in full-time education or training. The conception rate is the number of pregnancies that start before the mother’s 18th birthday (per 1,000 young women aged 15 to 17) and includes pregnancies that end either in birth or in termination.

In Merton, in 2011 the under 18-conception rate was 27.6 per 1,000, below that of London, and England and Wales. The rate had reduced 45.9% from the 1998 rate of 51 per 1,000. The latest rolling quarterly average for June 2012 was 24.7. However, this masks variation across the borough with the rates of some wards in line with Inner London. Evidence suggests it is the most disadvantaged, vulnerable young women with the greatest number of risk factors who are most likely to have a conception aged under 18 and are more likely to see the pregnancy through. This is supported by a strong association locally (74%) between women aged under 19 giving birth and living in more deprived areas. This in turn perpetuates the cycle of poor outcomes, including health outcomes, not just for young parents but for their babies as well.

The recent data (2011) on rates of abortion in Merton shows that the rate was higher (16.4 per 1,000 population) than England (15.1 per 1,000 population) but lower than London (17.5 per 1,000 population). In addition, teenage abortion rates are declining, as illustrated in Figure 5.26, in line with the conception rates, which is indicative that services in place are having a real impact on teenage conception rates. However, more than half of conceptions to young people under 18 in Merton in 2011 resulted in terminations, which was lower than London (61%) but higher than England (49.3%) proportions. The three-year rolling averages from the 1998 baseline show that the proportions of teenage conceptions leading to terminations are increasing in Merton. The proportion of all teenage conceptions leading to abortions has increased by 9% since the 1998 baseline although lower than London and England at 13% and 16% respectively.

**Key commissioning recommendations**

A joint young people’s sexual health and substance misuse needs assessment was carried out in Merton in 2013, which highlighted local needs and gaps. The needs assessment indicated improvements could be made in relation to:

- improving access to contraceptive services, condoms, emergency contraception and STI testing for young people
- continuing to raise the profile of services in schools, but interventions to be provided in youth settings that ensure privacy
- Improving training for frontline professionals on talking to children, young people and parents about sensitive issues
- increasing access and referral to sexual health services from mainstream and targeted youth support services
- further integrating sexual health activities with substance misuse prevention.

**Theme 6: Children and young people, and maternal health in Merton**

The Marmot Review, *Fair Society, Healthy Lives*, identified giving every child the best start as the highest priority in reducing the inequalities gap that exists between different groups of people. Action to reduce health inequalities needs to start before birth and be followed through the life of the child to improve adult health outcomes.
**Demographic trends**

Theme 2 (*Merton: The place and the people*) sets out demographic changes in Merton. Key findings for children and young people include:

- There has been a 40% net increase in births from 2,535 in 2002 to 3,537 births in 2011.
- By 2021 there will be an expected 20% increase in children born each year with future special needs (from 230 to 276).
- There are 47,500 children and young people aged under 20 years old, which is nearly 24% of the population in Merton.
- The number of children and young people aged 0-19 years is forecast to increase by around 3,200 (3%) by 2017. In particular, there is forecast to be an increase of 2,300 (20.3%) in the number of children aged 5 to 9 years.
- There are 15,000 (7.5%) 0-4 year olds, which is expected to rise by 780 by 2017.
- There are 32,500 (16.2%) children and young people aged 5-19 years, which is expected to rise by 2,400 by 2017.
- It is forecast that the proportion of BAME people in the 0-19 age group will increase from 44% in 2011 to 47% in 2017.

**Where Merton is doing well**

*Maternal health*

- The infant mortality rate is similar compared with London and England, at a rate of 4 infant deaths per 1,000, compared with 4.4 regionally and nationally.
- Fewer babies are born with a low birth weight compared with London.
- Breastfeeding initiation and breastfeeding rates at 6-8 weeks are higher compared with England.
- Smoking in pregnancy is lower than in England.

*Early years*

- The proportion of children achieving a good level of development at aged 5 is above the national average, at 66% for Merton compared with 64% for England

*Children*

- There are fewer children living in poverty (18.3% or about 7,000 children) compared with England (21%).
- Hospital admission rates for injury are lower compared with London and England.
- Hospital admissions as a result of self-harm are lower than for London and England.
- Educational attainment is in line with England and in 2013 provisional data shows an increase above the national average in pupils achieving five GCSEs at A*-C grades, including English and maths (provisional data for 2013).
- The rate of progress in performance in Merton schools is greater than the majority of other local authorities.
- The gap in educational attainment between pupils eligible for free school meals and their peers is narrower compared with England at secondary school level.

*Young people*

- Teenage pregnancy rates have reduced significantly over the past 13 years, down from 51 per 1,000 in 1989 to 27.6 per 1,000 in 2011.
- There has been a year-on-year reduction in first time entrants to the youth justice system over the past four years, and a reduction in the number of violence against the person crimes.
Where Merton has some challenges

*Maternal health*
- There is variation in low birth weight by area and ethnicity, with higher rates in more deprived wards and among BAME groups.
- There is variation in breastfeeding by area and ethnicity, with lower rates in more deprived areas and among white British ethnic groups.
- There are higher rates of delivery by caesarean section – 27% compared with 24% for England.

*Early years*
- There is nearly a 30% gap in child development at age 5 between the highest and lowest achievers.
- Childhood immunisation coverage is below London and England levels and the World Health Organization’s target of 95%, and there is variation in the level of immunisation coverage by GP practice.
- Emergency attendances for children aged 0-4 years are higher compared with England and there is variation by GP practice.

*Children*
- There is an increase of nearly 14% in levels of excess weight (overweight and obesity) in children between the ages of 5 and 11 years, from just over a fifth of Reception level children to just over a third of Year 6 level children.
- There is variation in obesity rates by gender, ethnicity and area, with higher levels of obesity associated with deprivation.
- Nearly 30% of 5 year olds are estimated to have decayed, missing or filled teeth, an increase of 6.4% between 2008 and 2012, and there has been a reduction in the proportion of decayed teeth filled by dentists. Nearly 38% of children in Sutton and Merton do not access an NHS dentist.
- There is a gap between the number of children and young people accessing Tier 3 Child and Adolescent Health Services and the estimated numbers with a mental health problem indicating a need for Tier 3 services.
- There has been an increase in the number of children with statements of SEN with autistic spectrum disorder (ASD) over the past three years.
- Nationally and in Merton there has been an increase in children in care and on a child protection plan.
- There has been an increase in the number of looked-after children (LAC).

*Young people*
- There is variation in teenage pregnancy rates by area, with higher rates concentrated in more deprived wards.
- Hospital admissions for alcohol specific conditions in children and young people aged under 18 are the ninth highest in London (although still lower compared with England).

**Key commissioning recommendations**

*Impact of demographic change*
The current picture of rising births and potentially less outward migration has implications for projecting future need and demand for services. Commissioners need to consider the implications for:
- Increasing need for maternity services – planning for additional capacity is needed linked to a regional strategy for maternity services.
• Impact on primary care and community services – planning for additional capacity to deliver the Healthy Child Programme, including health visiting and school nursing services.
• Increased incidence of long-term conditions in children and young people, such as asthma and diabetes.
• Impact on children social care, child protection and education services – planning for additional capacity.
• If the proportion of low and very low birth weight babies stays the same (approximately 7% of all births) there will be a rise in children born with future special needs – which will impact on planning for additional capacity for paediatric and neonatal services; SEN, and continuing care/short breaks.

**Impact of deprivation**
Deprivation is linked to poor health. Higher numbers of children are being born in the more deprived areas of the borough. Commissioners need to consider:

• The impact of the recession and welfare reform on longer-term child health, including long-term care and mental health.
• The significant link between deprivation, poverty and mental wellbeing in young people. More robust information is needed on the mental health and wellbeing of children and young people.
• The geographical inequalities that exist in health and lifestyles in maternal health, and children and young people, including breastfeeding rates, teenage pregnancy rates, levels of overweight and obesity, and oral health, which need to be addressed.
• The clear link between teenage pregnancy, offending behaviour, truancy and alcohol and drug misuse. Commissioners need to review the opportunities to look more holistically in tackling these issues.

**Service development**
The JSNA has identified a number of priorities and areas for development, many of which build on current commissioning and service development activity:

**Maternal health**

• Maintain a focus on action to ensure that infant mortality and low birth weight remain low in Merton, including:
  o reducing child and family poverty and housing needs
  o reducing maternal obesity and improving nutrition, particularly in more disadvantaged areas
  o improving the accessibility of antenatal care and support during the first year of life, targeting areas of higher needs.
• Review the rate of caesarean deliveries, both elective and emergency, and identify how this can be reduced.
• Develop and deliver a breastfeeding action plan that targets lower levels of breastfeeding in the more deprived areas of the borough, based on best evidence of effective practice.
• Ensure providers achieve Level 3 UNICEF Baby Friendly initiative.
• Ensure the effective delivery of the Family Nurse Partnership, targeting mothers aged under 20 years.
• Ensure that the South West London maternity dashboard is monitored to provide standardised data from providers. Ensure that there is robust analysis of data for the Merton population to inform commissioning.
• Going forward, ensure that the new national Maternity and Children's Data Set (MCDS), which over time will result in comprehensive data (HSCIS-MCDS), informs local commissioning.
Early years
- Monitor progress on childhood immunisation coverage towards local and WHO targets; ensure that improvements to childhood immunisation data systems are monitored and sustained.
- Deliver childhood immunisation action plans, including improving call-recall systems and increasing access to and awareness of immunisation for parents.
- Develop an outcomes model of commissioning for early years, based on evidence of best practice and underpinned by strong data systems.
- Develop early years prevention and early intervention pathways, with clear referral routes for all partners.
- Parental mental health has been identified as a significant factor in parenting; there is a need to increase parent support, ensure there is staff training and awareness, and develop clear pathways into mental health services.
- Implement a data sharing agreement across Early Years in order to strengthen the ability to provide earlier intervention for families identified as having additional needs.
- Establish a vision, model and transition plan for health visiting as commissioning responsibility for the service moves to the local authority in 2015.

Vulnerable children and young people
- Understand and address the impact of increasing numbers of low birth weight babies on the demand for health and social care services.
- Ensure children with long-term conditions are supported to access the full curriculum in schools and have a smooth transition to adult services.
- In light of the increasing numbers of children diagnosed and increasing waiting times for assessment, develop an autism pathway for children and young people, linked to the Autism Strategy.
- In order to gain a better understanding of the need for services and inform future commissioning strategy, undertake a needs assessment of the mental health and wellbeing of children and young people.
- Review the impact of implications of the Children and Families Bill 2013 on all services, including schools, health and therapy services, special educational needs and disabilities, and social care.
- Ensure pathways and links across services are in place to ensure effective access and intervention for children and young people on the threshold of care and looked-after children.
- Consider the impact on services of increasing numbers of LAC requiring timely health assessments.
- Substance misuse is a major factor in youth offending and there is a need to better market existing pathways into substance misuse services.

Access to health services
In light of existing and future financial constraints and at a time when the birth rate is increasing there is a need to:
- ensure that in the majority of cases children with both acute and long-term conditions are supported in the community as much as possible
- ensure the local pathway of unplanned care is underpinned by a consistent model of care for all organisations
- review data on hospital attendances for children aged 0-17 years, including a focus on the 0-4 age group, and further develop progress on local initiatives to reduce A&E attendances.
Theme 7: Adult health in Merton

Key facts on the major killers and causes of poor health

Overall for premature deaths – i.e. deaths in people aged under 75 years – many of which are considered preventable, in the period 2009-11 Merton had 1,204 premature deaths, which equates to 236 premature deaths per 100,000 population adjusted for various factors, including the age of the population. Out of 150 local authorities this ranked Merton at 29th (1= best, Wokingham; worst was Manchester), putting Merton overall in the ‘best outcomes’ category.14

In terms of under 75 mortality rates from all causes, in 2010 Merton had a directly standardised rate of 220.77 per 100,000 population, compared with 272.77 for England and 271.87 for London. This equates to 1,157 deaths in Merton from all causes. Compared with other boroughs in South West London, Merton had a mortality rate lower than Croydon and Kingston upon Thames, but higher than Richmond upon Thames, Sutton and Wandsworth. In terms of trend since 2006, compared with London and England, Merton’s mortality rates have been consistently lower than both and decreased in 2010 more than the rate in London or England. Breaking down the mortality by causes of death, the top three causes of death in those under 75 years of age were (in order of frequency, from most to least common) cancers, circulatory disease, and accidents and injuries – which accounted for 70% of all deaths in Merton.

Cancers

In terms of under 75 mortality rates from cancers, in 2010 Merton had a directly standardised rate of 78.58 per 100,000 population, compared with 108.05 for England and 102.85 for London. Compared with other boroughs in South West London, Merton had a mortality rate lower than Croydon, Kingston upon Thames, Richmond upon Thames, Sutton and Wandsworth. In terms of trend since 2006, compared with London and England, Merton’s mortality rates have been consistently lower than, and is decreased in 2010 more than, the rates in London or England.

Circulatory disease

In terms of under 75 mortality rates from circulatory disease, in 2010 Merton had a directly standardised rate of 72.13 per 100,000 population, compared with 64.67 for England and 68.16 for London – higher than both London and England. Compared with other boroughs in South West London, Merton had a mortality rate higher than all the boroughs barring Wandsworth (121.00). In terms of trend since 2006, compared with London and England, Merton’s mortality rates have been variable starting in 2006 lower than both England and London, then sharply increasing in 2007 until it equalled the England rate in 2008 and then steadily rose until in 2010 it was higher than both London and England.

Inequalities

There are clear inequalities across Merton in terms of mortality and ill health, especially when comparing East Merton with West Merton. These inequalities can be seen in the differences in prevalence of circulatory disease, including coronary heart disease (CHD) and stroke, and diabetes and for chronic obstructive pulmonary disease (COPD) across the different communities in Merton. Higher levels of these conditions are associated with areas of deprivation and are linked to higher levels of the major risk factors: smoking, hypertension and obesity. Looking at rates of death in a population (rather than life expectancy), if East Merton has the same rate of deaths as West Merton, there would be around 113 fewer deaths each year in East Merton – an 18% reduction on the 640 deaths each year among East Merton residents.

Overall Merton is a healthy place to live; however, there are a number of causes for concern:

- **Circulatory disease**: Under 75s death rate from circulatory disease (including stroke) is higher than for England and although the overall trend is downward there was a slight upturn in the last period and it is still the second biggest cause of premature death. The rate of stroke for the under 75s increased for both men and women in the last period, although the overall trend is also downwards (2008-10).

- **Diabetes**: Diabetes recorded in primary care is 5.3% for Merton CCG overall, but ranges from 2% to nearly 10% by GP practice. Comparing modelled with recorded prevalence of diabetes suggests a proportion remains undiagnosed, something that requires a more in-depth look.

- **Cancer**: Death rates from cancer in people aged under 75 have reduced, particularly for females; however, it is still the main cause of premature death and inequalities remain with a higher rate of deaths in the eastern wards.

- **Respiratory diseases**: Deaths from respiratory diseases have declined, but there are wide variations in hospital admissions by area. This needs to be studied in more depth.

- **Mental health**: levels of depression are higher than for England, and although proxy measures for mental health outcomes are good, recovery rates following the use of psychological therapies are lower than for England and London. Levels of depression need to be monitored in light of the potential impact of the recession on mental health and wellbeing.

**Key commissioning recommendations**

There are clear inequalities in terms of CHD, stroke, diabetes, respiratory disease (COPD) and cancer across the borough and between genders. The linking factors are smoking and obesity. Identifying people at risk of these conditions through screening or surveillance would enable prevention and early intervention to reduce future reliance on health and social care services.

- Current screening coverage for cervical and breast cancers is above regional but below national levels. Bowel screening uptake and coverage are very low. Improvement in the uptake and coverage of all screening services is needed for early identification, to prevent cancers becoming untreatable and improve outcomes. This improvement needs to be targeted at more deprived areas and disadvantaged groups in the community where uptake of screening programmes is generally lower.

- Commissioners need to use social marketing approaches to understand why the uptake of screening services is below national rates and how future uptake could be improved and to improve the systems to identify patients and non-attenders for screening services. Groups that need particular focus are: people with learning disabilities, ethnic minorities, younger women and socially deprived groups.

- Early identification of those at high risk of circulatory diseases (including stroke) and diabetes could improve outcomes for patients and create less reliance on services. The introduction of the NHS Health Check should support this and needs to be targeted at populations who are likely to be at increased risk, such as those in areas of deprivation.

- Interventions available to support individuals to reduce risk factors need to be in place. A coordinated programme of personalised advice and support services has been introduced to support people to make healthy lifestyle choices to achieve a healthy weight, become more physically active, and reduce risky drinking behaviour, to reduce risks of future ill health. This programme also includes the Stop Smoking Service.
However, the success of this programme will depend on Primary Care and other services (pharmacies, social care, voluntary sector) taking an active role in identifying those at risk and referring them into the service. Commissioners need to monitor and evaluate the success of this programme.

- There are variations in the prevalence of diseases identified through primary care practices across Merton and these need to be understood better. Where such variations exist, Merton CCG should work with practices to reduce these variations to ensure that patients are identified early and receive timely and appropriate treatment and support for their condition.

- As part of their new responsibility for health improvement, wider local authority input through existing contracts with services such as leisure and housing, and through planning responsibilities, will help to support people to achieve healthy lifestyles and will be of significance in reducing the risk of disease in a wider range of population groups, targeting people who are potentially at risk of poor health but who may not necessarily access existing health services on a regular basis.

- A whole systems approach focusing the model of care is needed to deliver ‘integrated’ services. This approach should include access to support for primary prevention (to focus on improving lifestyles and improving uptake of early intervention and prevention services), and for secondary prevention in primary care (community and secondary health care services); these services should work in close partnership with social services.

- There is a real opportunity afforded by the development of Clinical Commissioning Groups (CCGs) and the partnership in the Health and Wellbeing Boards to take this work forward.

Mental health

Currently a detailed review of adult mental health services is under way in Merton, which includes a mental health needs assessment. The review will result in the development of an adult mental health strategy for Merton and will be used to update the mental health section of the JSNA.

Key facts on mental health

One in four people in the UK will experience a mental health problem in the course of a year. The cost of mental health problems to the economy in England has recently been estimated at £105 billion each year and treatment costs are expected to double in the next 20 years (NEPHO). In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (including self-inflicted injury), compared with 16.2% for cardiovascular disease and 15.9% for cancer, as measured by disability-adjusted life years (DALYs). Depression alone accounts for 7% of the disease burden, more than any other health condition. It is predicted that, by 2030, neuropsychiatric conditions will account for the greatest overall increase in DALYs.

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Key commissioning implications for services to support improved mental health and wellbeing

As mentioned earlier, the Merton adult mental health services review is currently under way and will help to inform future commissioning intentions. The recommendations will be included in a refresh of the mental health section of the current JSNA when it is ready and available.

With changes proposed for commissioning in the NHS, as well as changes to Public Health, and the drive to provide care in community settings, it is imperative that consideration is given to the overlap between commissioning inpatient mental healthcare for people with dual diagnosis and support in the community. Further investigation is recommended to identify the specific needs of this group of individuals to assess whether the balance of admission and community support is appropriate and to understand which services care is accessed through.

In terms of treatment services, commissioners should focus on developing a whole system approach to mental health with more joined-up services to improve experience and outcomes. They should also focus on developing better data and local information on outcomes, and on addressing health inequalities in relation to mental health. There should be further investigation into why Merton has higher rates of depression than London, in light of its wider good health, and a focus on improving recovery rates following psychological therapies. Further work is also needed to understand access by and for ethnic minorities. A health equity audit for mental health services would be useful to support this.

Commissioners need to give consideration to local data that has suggested a number of areas where mental health can reduce health costs and lead to physical and mental health gains:

- High costs associated with unnecessary and unplanned admissions amongst people with a range of long-term conditions could be reduced with motivational work to support lifestyle change and psychological support to distinguish symptoms requiring medical attention from symptoms of anxiety or depression.
- High numbers of young people and their families presenting frequently and unnecessarily at A&E with asthma or minor injuries could be reduced with assistance to manage anxiety and improve self-care.
- High-cost areas (mostly associated with sheltered housing where the top 25% accounted for nearly half of cost) could be reduced with the provision of support to staff and people living in sheltered accommodation and residential care to manage difficult situations and distinguish symptoms requiring medical attention from symptoms of anxiety or depression.

Recommendations from the insight work by Resonant Media:
Resonant Media has developed recommendations across three areas to address these barriers and improve the existing service provision. These will inform, encourage and support service users to access physical health services.

Involving the service users themselves in shaping and delivering services is key to all the recommendation areas. This will build trust in the services and ensure that they are genuinely shaped for their needs.

GPs
Since GP practices are so busy it can be difficult to engage with them and change their practice. The research suggested initially developing a couple of best practice pilots. One or two selected GP surgeries would act as pilot projects to implement improved services for
those with SMI. Positive results from these pilots, on outcomes such as do not attends (DNAs), could then be used to encourage other GP practices to implement the improved services.

Further training on working with those with mental health problems is also suggested for all who work in GP practices. This should utilise existing training courses and times when the staff are already gathered together.

System level
To drive forward proper links locally between physical health and mental health services, a senior level champion needs to be identified. This champion could help with creating specific targets around physical health for those with SMI. They would also lead on the future development of co-located services and multidisciplinary teams.

The recommendations [of Resonant Media] address all four of the social marketing intervention modes – support; design; inform and educate; and control – to try to increase levels of those with SMI accessing physical health and health promotion services and thus reducing their health inequalities.

Key commissioning implications for services to reduce suicide
Commissioners need to give consideration to the recommendations in the Department of Health’s National Suicide Prevention Strategy for England:

- prevention targeted at high-risk groups e.g. those in recent contact with mental health services, those who have self-harmed, young men and those in high-risk occupations
- reducing access to lethal methods of self-harm, such as hanging and strangulation, in wards and prisons
- promoting positive mental health and social inclusion, particularly among the vulnerable
- multi-faceted strategies to prevent, identify and address behaviours linked to a high risk of suicide in school.

Neurological conditions

Key facts on neurological conditions
This section covers four long-term neurological conditions: epilepsy, Parkinson’s disease, multiple sclerosis (MS) and motor neurone disease (MND).

- In 2012-13, among those aged 18 or over and registered with a Merton GP, there were 863 people with diagnosed epilepsy (Quality and Outcomes Framework 2012-13, Health & Social Care Information Centre, October 2013). This gives a crude rate of 0.5%, and compares with the London rate of 0.6% and the England rate of 0.8%.
- The directly standardised mortality rate per 100,000 for epilepsy in under 75 year olds in 2011-12 was 1.1 for Merton CCG, compared with 1.5 for the ONS Cluster (London Suburbs). The rates are however based on small numbers.\(^{17}\)
- Applying the UK prevalence rates\(^ {18}\) to the 2013 projected population for Merton\(^ {19}\) we find that:
  - For Parkinson’s – with a prevalence rate of 195 per 100,000, there are an estimated 395 individuals with Parkinson’s disease in Merton.
  - For MS – with a prevalence rate of 161 per 100,000, there are an estimated 326 individuals with MS in Merton.
  - For MND – with a prevalence rate of 7 per 100,000, there are an estimated 14 individuals with MND in Merton.

\(^{17}\) Source: Spend and Outcome Factsheet 2011-12 for Merton CCG, Public Health England.
\(^{18}\) NeuroNavigator website, November 2013.
\(^{19}\) GLA Population Projections 2012 Round, Demographic projections – SHLAA.
Key commissioning recommendations

Commissioning safe, sustainable, high-quality services for the local population
Improving the quality and ensuring the safety of acute hospital, primary care, community, and mental health and specialist services are the highest priorities for the borough.

Integrating care and developing community services
Commissioners need to make improvements in care provided to individuals, which will result in a better experience, and improved outcomes and productivity, particularly for the vulnerable.

Theme 8: Access to adult social care in Merton

Key facts on adult social care
In Merton Council, the Community and Housing Department is responsible for housing needs, adult social care, libraries and heritage, and adult education in Merton. Adult Social Care (ASC), a division within the Community and Housing Department, provided services to approximately 3,640 people during the period 2012-13.

Major transformational changes have now taken place through Putting People First and as a result of building on the experience gained from person-centred planning for people with learning disabilities. Merton Council has delivered its major structural transformation programme and divided ASC’s infrastructure accordingly. There are three distinct elements: (1) Direct Provision; (2) Access and Assessment; and (3) Commissioning. The process of personalisation has, therefore, moved on to a different level. Efficiencies have been driven through the contracts and passed on to those planning support, and to the customers purchasing support. These efficiencies are also reflected in in-house provision and upheld by those supporting people to access and have assessments.

Merton has adopted a Social Care ‘Efficiency Framework’, which helps the Council to use resources in the most effective way as possible and is particularly relevant in the current economic climate.

In Merton, all ASC customers are provided with a personalised budget via a range of mechanisms as well as a personalised support plan. Budgets are based on a needs assessment as well as social capital, family support, and market efficiencies. National comparative information indicates that uptake of direct payments is increasing in the borough and the proportion of adults in receipt of direct payments or personal budgets, as a proportion of all those receiving community-based services, has increased from 8.6% in 2009-10 to 47.5% in 2012-13.

Recovery
The recovery model in Merton involves two primary aims. The first aim is to prevent admission to hospital, nursing or residential care by offering short-term, focused support when people face a potential crisis. This may relate to an individual’s ‘long-term condition’ or be as a result of a significant change of social circumstance. The second aim of the model is to provide an effective, multidisciplinary reablement service at the point of hospital discharge.

Merton works in partnership with other agencies to ensure that people are discharged from hospital in a timely way with appropriate support. Merton has one of the lowest levels of delays where people are not left in hospital if they are ready to leave. This means

preparation for release is carried out, and, where appropriate, services are provided, in a timely manner so people do not have to stay in hospital longer than they need to.

Merton is currently working with Health partners and has set up an Integration Transformation Programme to ensure close working between social care and health professionals. In addition to preventing admission, this programme is also to prevent attendance at hospital emergency units along with developing a key worker project for people with long-term conditions.

**What are the gaps?**

With integration becoming an increasingly critical issue in shaping future social care and health services, especially in a time of shrinking budgets, it is important for commissioners to gain a clearer understanding of integrated care and support in terms of being a whole partnership of all key stakeholders across Merton. There also needs to be a clearer understanding of the customer journey through the services – in relation to health (including mental health), social care and the voluntary sector.

Another gap is in relation to self-funders, i.e. individuals who fund their own social care and support and do not take recourse to any public funds. Commissioners need to understand who these individuals are (in terms of their demographics, and their health and social care issues and needs) and what the role of ASC is in relation to them.

The true cost of social care, including the financial impact of the Care Bill's implementation, needs to be determined. As the financial challenges continue for LBM, ASC will have contributed in the region of £12 million savings, as part of the Council’s overall savings programme between the periods 2013-14 and 2016-17. The impact of this budgetary reduction is not yet clear. As care and support funding is being reformed (through the forthcoming Care Bill) the landscape of social care is changing. The ASC customer base could potentially double, which will certainly increase the pressure on the decreasing ASC budget. The ASC savings have however to an extent been offset by some growth. Nonetheless, Merton Council, as much as other councils, is having to look at innovative, alternative ways to deliver its statutory responsibilities.

**Key commissioning implications**

There needs to be even greater emphasis on prevention in both health and social care. This implies greater investment in prevention in those adult and social care programmes and services that will reduce the cost of social care and enable the effective implementation of the key area of the Social Care ‘Efficiency Framework’ on prevention.

There is considerable work under way on health and social care integration in Merton. Integration activities need to focus on aspects that enable joint commissioning, including:

- understanding integrated care and support pathways
- multidisciplinary teams that cover the commissioning and service provision
- developing integrated performance metrics and data
- improving knowledge management of integrated services.

Furthermore, it is important to ensure that integration work does not duplicate health and social care resources.

While customer and user engagement is already happening, a framework should be developed to ensure the quality and consistency of such engagement.

With a potential reduction in the ASC budget of around £12 million by 2016-17 under the Council’s savings programme, there needs to be a clear understanding and appraisal of the
implications and impact on the organisation and delivery of adult social care in Merton in terms of the costs, benefits and outcomes. The ASC savings have to an extent been offset by some growth. Nonetheless, Merton Council, as much as other councils, is having to look at innovative, alternative ways to deliver its statutory responsibilities.

**Theme 9: Older adults in Merton**

**Dementia**

*Key facts on dementia*

Old age is the largest risk factor for dementia and prevalence doubles every five years after the age of 65. Some 68% of all people with dementia are aged over 80 and most will also have co-morbid conditions and illnesses that result in physical impairment.

Alzheimer’s disease (AD) accounts for 62% of all dementias, with vascular dementia and mixed dementia accounting for 27%. Dementia is a leading cause of disability and death in people aged over 65. A progressive disease, it is usually terminal some five to eight years after diagnosis. Women with dementia outnumber men by two to one.

In Merton, it is estimated that 7.2% of women and 5.3% of men aged over 65 have dementia (2007); by 2021 this is predicted to reduce to 6.7% for women and increase to 5.6% for men. It is estimated that the rate of diagnosis in Merton is only 39% (Alzheimer’s Society, 2013), and this is consistent with the low levels of recorded dementia in GP practices across Merton. The NHS Dementia Prevalence Calculator gives the current diagnosis rate in Merton as 42.7% and a dementia gap of 1,100 cases for 2013-14. This is lower than all other geographical neighbours barring Kingston upon Thames, and all statistical neighbours, barring Hounslow.

*Key commissioning implications for services to support dementia*

A review of Merton’s adult mental health services is currently under way, including dementia services, and will help to inform future commissioning intentions. The recommendations will be included in a refresh of the dementia section of the current JSNA when it is ready and available.

With the potential increase in the numbers of people aged over 65, if nothing else changes (i.e. proportionally the prevalence of current long-term conditions doesn’t change), then there will be a significant increase in the absolute numbers of people with dementia. Given the potential impact on social and health services, consideration needs to be given to the type of support services that will be required to support people with dementia to remain independent for as long as possible. With the impact of reducing resources for both health and social care, there is a need to target resources effectively.

In addition, the NICE quality standards – QS1 and QS30 – should also be considered when commissioning and providing a high-quality dementia service, as well as other relevant quality standards listed in related NICE quality standards.

As mentioned above, the NHS Dementia Prevalence Calculator showed that in Merton only 42.7% of dementia cases are diagnosed, which implies that each year approximately 57% of cases of dementia in the borough go undiagnosed. The Merton Dementia Hub will support individuals to obtain a diagnosis and will work with GPs to improve diagnosis rates. Merton Council will work with Merton CCG and other partners to develop an integrated approach to improving, upgrading and personalising the quality of care for people with dementia and will monitor outputs closely to track improvements.
Falls

Key facts on falls
As older people become frailer they are also more likely to become physically unsteady and fall more. The consequences of falling can be minor, but with increased frailty and osteoporosis they can be significant, resulting in a fractured neck of femur. This is often a turning point and older people recovering from a fall can require more continuing care from both health and social services. Fractures resulting from falls are a major cause of mortality and disability among older people. Falls are generally multifactorial, with osteoporosis as a major risk factor. The level of fractured hip (neck of femur) is often used as a proxy for the level of falls and can indicate the need for preventative measures.

The rate of hip fractures in people aged 65 and over is significantly lower in Merton (357 per 100,000) compared with England (451 per 100,000), and is the fourth lowest rate of all London boroughs. For over 80 year olds the rate is much higher (1,109 per 100,000), but again this is significantly lower than the England average.

Direct medical costs from fragility fractures to the UK healthcare economy were estimated at £1.8 billion in 2000, with the potential to increase to £2.2 billion by 2025, and with most of these costs relating to hip fracture care.21

What are the gaps?
The rapid review of the Sutton and Merton Community Services Falls Prevention Service indicated a few gaps in the service:

- There is no overall falls strategy or strategy group in Sutton and Merton. Neither is there an osteoporosis pathway.
- There is limited assurance of the interface between the service and the voluntary sector and social services, and this needs to be explored further.
- The service has not undertaken an equality impact assessment.
- The home response was not actually set up as an ‘Urgent Response’ service, but for those people requiring falls prevention advice at home. It is however now also being used for patients who do not require rehabilitation because there is no existing urgent falls/urgent rehabilitation provision excepting prevention of admission and supported discharge.

Key commissioning implications for services to prevent falls
The most common types of fracture related to osteoporosis occur within the hip, vertebral column and wrist. Disability and death rates tend to be higher for hip fractures than for other low trauma fractures. In a population the size of Merton, about 225 hip fractures necessitating treatment would be expected each year. With other low trauma fractures requiring attention it is estimated that there are about 750 episodes costing over £5 million per year. Any inpatient admissions relating to osteoporosis may involve a long length of hospital stay and the fragility of the bones may limit the surgical options available and subsequent mobilisation can sometimes prove to be difficult. In terms of overall costs it is estimated that the financial impact of osteoporosis is second only to circulatory disease.

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Given the potential increase in the numbers of people over 65 over the next 10 years (predicted to increase by 21% by 2021), if nothing else changes then there will be an increase in the absolute numbers of people who are likely to fall and require significant health and social care input. Prevention of falls has been shown to significantly reduce the level of fractures. Local authorities have taken over the responsibility for this area of prevention since April 2013.

As mentioned above, a review of the Sutton and Merton Community Services Falls Prevention Service has been recently completed, and included the following additional recommendations:

- Further investigate an exercise continuum so that participants can move from the NHS led programme into a ‘step down’ community class. As recommended by the Royal College of Physicians (RCP) 2012 National Audit.
  
  ‘Commissioners need to commission a local, integrated exercise continuum across health and local authorities/voluntary sector to ensure long term provision of evidence-based exercise programmes for reducing falls run by appropriately qualified staff.’

- Undertake stakeholder engagement with a wider audience, e.g. Age UK and social services, to explore the interfaces more.
- Reinstate a falls focus/strategy group with potential to design an osteoporosis pathway, in conjunction with clinical commissioners.
- Analyse the demographic data and benchmark to known risk groups in the local population. Map service provision to the identified risk groups.
- Analyse data to determine if any ‘spare’ capacity in the service exists and also to determine seasonal variations in uptake and activity.
- Support the service to undertake an equality impact assessment
- The home response was not actually set up as an ‘Urgent Response’ service, but for those people requiring falls prevention advice at home. It is however now also being used for patients who do not require rehabilitation because there is no existing urgent falls/urgent rehabilitation provision excepting prevention of admission and supported discharge. Commissioners should consider how the gap in urgent response service needs can be addressed.
- Use falls screening for case finding, using predictive modelling tools. Commissioners should include this in any future service specification.

Excess winter deaths

*Key facts on excess winter deaths*

The official winter period is from 1 November to 31 March each season. Excess winter deaths (EWDs) continue to be an important public health issue in the UK, potentially amenable to effective intervention. This excess death is greatest in both relative and absolute terms in elderly people and for certain disease groups. It also varies from area to area. EWDs are also associated with cold weather, but it has been observed that other countries in Europe, especially the colder Scandinavian countries, have relatively fewer excess deaths in winter compared with the UK.
In the past decade EWDs in Merton have not been statistically significantly different from the England average (measured by the 3 year rolling average Excess Winter Deaths Index – EWDI), except in the period 2006-09 where they were significantly higher at 26.4% compared with the England average of 17.5%. In the latest three-year rolling average for 2008-11 the Merton EWDI was 22.7% compared with the England EWDI of 19.1% and was not statistically different. For the last reported winter of 2011-12, Merton had 60 EWDs and was ranked 24th in all London boroughs (1 being the worst in terms of EWDI).

West Midlands Public Health Observatory (WMPHO) publishes data on EWDs on behalf of Public Health Observatories in England that gives yearly and three-year rolling averages for EWDs, overall, and also by age groups and conditions (e.g. circulatory disease, respiratory disease, and stroke). When the data from 2004-11 for EWDs is considered for all respiratory diseases and specifically for chronic lower respiratory diseases, while the Merton EWDI for all respiratory diseases is not statistically significantly different from England and London (see Table 9.4 below), Merton is ranked second worst out of all London boroughs. For specifically chronic lower respiratory diseases, the EWDI for Merton is significantly different from London and England and is ranked the worst in London.

Key commissioning recommendations to fill the gaps
The Environmental Health (Housing) Team has legal powers through the Housing Act 2004 to require private landlords to improve cold housing and reduce ‘excess cold’ hazards by serving improvement notices.

Current levels of resources limit the team to responding to complaints from the tenants of rented properties. However, a proactive approach could be adopted using additional resources to target rented homes in the more deprived parts of the borough and use formal and informal approaches to secure insulation and heating improvements to homes, reducing the risk of EWDs and fuel poverty.

The successful ‘Warm Homes Healthy People’ activities should be continued and further developed over forthcoming winters.

End of life care

Key facts on end of life care
End of life care (EoLC) affects all people regardless of cause. Good EoLC ensures all residents have a dignified, controlled and peaceful end to their life regardless of age and cause of death, ensuring that their choices and wishes are met. In order to achieve a good outcome, the needs of the patient, carer and family should be identified and services provided to meet these needs throughout the last phases of life and into bereavement. EoLC should include management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

The VOICES Survey showed that 71% of patients wished to die at home, so the proportion of deaths at home is used as a proxy indicator for the provision of EoLC. A higher proportion of deaths at home is considered to be desirable. While this is a proxy measure, the home death rate in Merton increased from 12.3% to 16.6% between 2004 and 2009. The measurement was changed to include usual place of residence in 2010 (to include care homes) and the current rate is approximately 36% with over 67.5% of patients with a Coordinate My Care (CMC) record achieving their preferred place of care and death.
Coordinate My Care (CMC)

Sutton and Merton Primary Care Trust (SMPCT) was a pilot site for CMC. CMC is an electronic palliative care coordination system (EPaCCs) that gives people with life-limiting illnesses the means to consent to sharing their EoLC records with community nurses, out of hours (OOH) services, London Ambulance Service (LAS) and secondary care. It has been developed so that users’ wishes and preferences for how and where they are treated and cared for as they near the end of their life can be shared. Most importantly it ensures that the appropriate health professional, such as the GP, community nurse, out-of-hours GP, and secondary care professional, legitimately involved in their care has access to advance care plans and clinical management plans, out of hours.

As of September 2013:
- 1,062 Merton residents have a CMC record.
- Of those Merton patients with a CMC record:
  - 47% have cancer and 53% have non-malignant conditions
  - 79% achieved their preferred priorities of care (PPC) and 67.5% their preferred place of death (PPD)
  - 26% died in hospital compared with 54% nationally.

In Merton, there was a greater percentage of males (20.5%) than females (16.1%) that died at home in the period 2008-10. In both cases this was lower than the London and England averages. There are therefore differences by sex for this metric.

What are the gaps in Merton?

An important gap is in relation to the capacity of EoLC services to spend adequate time with patients and use advanced communication skills to identify the right groups of patients for the services. In addition to capacity, this is also a training issue for community generalists in the EoLC team and carers.

If a patient has a CMC record and opts to have care at home, this has implications on capacity and will increase the number of visits required by community professionals in order for this to happen. There needs to be a corresponding shift in resources to community care to address this increased demand on capacity.

A telephone service was previously commissioned from a large bereavement charity to provide bereavement support at home, but this service was not able to meet the needs of the population and was therefore decommissioned. While the reprovision of a service to meet the needs of people in Merton is being reviewed, until a suitable provider is found or alternative ways of providing this service are developed, bereavement support at home remains a gap.

Accessibility to and adaptability of EoLC services to different faiths have been raised through a Community meeting. Faith groups’ leaders are now helping to inform the training of EoLC service staff.

Merton-specific commissioning recommendations

Commissioners should ensure that services continue to raise the population’s awareness of options for care and place of death and dying, and also to raise awareness of the CMC register so as to increase the number of people with CMC records.

There are plans to review the 2011 EoLC strategy in 2014-15, and it is important that this is done.
Currently there is a gap in the provision of a bereavement support service in Merton. Commissioners should consider the reprovision of the service through a suitable provider or developing alternative models for providing this service.

Commissioners are recommended to examine the size and nature of the gap in relation to the capacity of EoLC services to spend adequate time with patients and use advanced communication skills to identify right groups of patients for the services. In addition to capacity, there is also a training issue for community generalists in the EoLC Team and for carers. It is also recommended that commissioners consider how Merton performs in this area compared with other similar boroughs and perhaps learn from best practice in such boroughs that perform better.

Furthermore, commissioners should consider the implications on capacity when patients on CMC increasingly opt for care at home, as this will result in an increase in the number of visits required by community professionals to support this. Consideration should be given as to how to resource the additional work for community services and primary care services in addressing this potential surge in demand.

**Theme 10: Sexual health and infectious diseases in Merton**

**HIV**

*Key facts on HIV*

The human immunodeficiency virus is commonly known as HIV. It is a disease of the immune system primarily transmitted through unprotected sexual intercourse with an infected person. This includes vaginal, anal and oral sex. It can also be caught by sharing infected needles, or less commonly through contaminated blood transfusions and mother-to-child transmission in pregnancy.

Prevalence refers to the proportion of individuals within a defined population who are infected at a given time. In 2011, there were 561 people known to have HIV in Merton. This equates to a prevalence rate in Merton of 3.8 per 1,000 population aged 15-59 years (ONS, 2011). This was lower than the London rate (5.4 per 1,000) but higher than the England rate (2.0 per 1,000). In 2011, 29 adult residents (aged between 15 and 59 years) of Merton were newly diagnosed with HIV.

Prevalence varies across Merton, with the five wards with the highest rates accounting for 42% of all people diagnosed with HIV in Merton. These wards are Pollards Hill, Figgies Marsh, Lavender Fields, Colliers Wood and Abbey. The prevalence rate ranges from 5.7 per 1,000 in the former to 4.1 per 1,000 in the latter.

The majority of those diagnosed in 2011 were men (60%, 334). In terms of age, those aged 35-44 years followed by those aged 44-54 years, made up the biggest contribution to HIV diagnoses in Merton in 2011 (177, 32% and 173, 31% respectively).

Data analysis by ethnicity shows that two ethnic groups accounted for the majority of known HIV infections diagnosed in Merton: black African (276) and white (201). Given the ethnic diversity of the Merton population, black and minority ethnic (BME) groups appear to be disproportionately affected by HIV, which reflects the London trend.

In Merton, in 2011 heterosexual contact accounted for the largest proportion of residents diagnosed with HIV (324, 58%). This was higher than London and South West London at 46% and 53% respectively. Whilst men who have sex with men (MSM) accounted for a
significant proportion of HIV diagnoses in Merton (194, 35%), this was lower than London and South West London.

Late diagnosis is defined as people who have a CD4 count of less than 350 per cubic millimetre of blood at diagnosis. In 2011, 32% of people with HIV in Merton were diagnosed with a CD4 count of less than 350, compared with 44% in London overall; 10% of MSM were diagnosed late (compared with 31% in London) and 50% of heterosexuals were diagnosed late (compared with 61% in London).

What are the gaps?
- There is a need for more widespread HIV testing in primary care settings, in general medical admissions at Epsom and St Helier Hospitals and through the Contraception and Sexual Health (CASH) clinics.
- There is a gap in knowledge on HIV testing in pregnancy and work around mother-to-child transmission. There is a need to work with St George’s and St Helier Hospitals to investigate surrounding issues since most of Merton mothers attend there.
- Further understanding, including robust local data and a strategy for engaging effectively with MSM and black African Late diagnosis of HIV.
- There is a need for greater involvement of service users and those at risk of HIV in local commissioning and the development of effective interventions.

Key commissioning recommendations
- Reducing late HIV diagnosis in Merton should be a continuing public health priority. Twelve out of 20 wards in Merton have a prevalence of above 2.0 per 1,000 of the population.
- HIV testing should be offered more widely through primary care and through the CASH service.
- A pilot offering ‘opt out’ HIV testing in general medical admissions at Epsom and St Helier Hospitals should be considered.
- More targeted interventions aimed at MSM and black African communities need to be explored and commissioned.
- A South West London HIV forum and other ways to engage regularly with black African communities need to be considered with key partners.
- Decisions need to be made in partnership with South London colleagues about the future commissioning of HIV prevention and support work provided through the South London and South West London partnerships.

Sexually transmitted infections (STIs) excluding chlamydia

Genital human papillomavirus (genital warts)
Genital warts are the second most commonly diagnosed STI after chlamydia. Infections are extremely common among the sexually active population especially in the first few years after starting sexual intercourse.

They are the result of a viral skin infection caused by the human papillomavirus (HPV). There are more than 100 types of HPV, 40% of which can infect the genital tract and are sexually acquired. These infections don’t usually cause a serious threat to health but they can be difficult to treat with frequent recurrent symptoms.

Data from genito-urinary medicine (GUM) clinics shows the number of genital wart infections diagnosed in Merton residents has reduced by 10%, with the rate similarly reducing. This contrasts with London and England, where the rate is more stable.
Gonorrhoea
Gonorrhoea is caused by bacteria called Neisseria gonorrhoea or gonococci. These bacteria are found in the vaginal fluid or discharge of the penis of infected women and men, therefore gonorrhoea is mainly contracted through unprotected sex.

The rate of diagnosis of gonorrhoea in Merton in 2011 was 76.6 per 100,000, significantly higher than the England rate of 39.1 per 100,000 but lower than the London rate of 109.2 per 100,000. The rate and number of gonorrhoea infections are increasing in Merton (see Figure 10.6 below). This increase is in line with that seen in London and England. These changes may simply be due to increased incidence, but it is likely that other factors such as more complete reporting, increased testing and better coding have impacted on the recorded rates.

Gonorrhoea diagnoses in Merton are concentrated in specific population subgroups, including males, MSM and those aged 25 and above. The local picture largely mirrors that for England.

Genital herpes
Genital herpes is an incurable but generally manageable infection caused by the herpes simplex virus (HSV). There are two types of the virus, with one being genital herpes. The virus is highly contagious and can be easily passed from person to person. Many infections are asymptomatic or present only mild symptoms, and as a consequence 80% of people are unaware of being infected.

The rate of HSV diagnosis in Merton in 2011 was 78.5 per 100,000, which was higher than the England rate (58 per 100,000) but lower than London (92 per 100,000). Between 2009 and 2011 the number and rate of HSV infections in Merton showed no consistent pattern in contrast to the increase in London and England during the same period.

Syphilis
Syphilis is caused by a bacterium called Treponema Pallidum, which can be passed on through close contact with an infected sore, normally during vaginal, anal or oral sex. Pregnant women can pass syphilis on to their unborn child causing stillbirth or death shortly after birth. Injecting drug users can also contract it by sharing needles with someone who is infected.

In Merton, in 2011 the rate of syphilis was low at 8 per 100,000, lower than London (17.5 per 100,000) but higher than England (5.4 per 100,000). Males accounted for 90% of cases and the majority of cases in Merton (71%) were in MSM.

What are the gaps?
- STI testing is particularly low in men even though the prevalence of chlamydia, gonorrhoea and HIV is high in this group. There is a need to work with men to understand effective ways to engage with them to increase the acceptability of using sexual health services and increase the uptake of STI testing.
- The CASH service in Merton and Sutton is not providing an integrated service at present so only offers contraceptive provision. It will begin offering HIV testing this year but steps need to be made towards further integration.
- There is a lack of robust data relating to the activity, outcomes and service user experience of the GUM and CASH services. This is needed to inform future commissioning.
- General practice is an underutilised resource for sexual health service provision. Although general practices in Merton have seen an increase in STI testing, the numbers are still low and rates of testing vary considerably across the borough. Successful pilots
in London and other areas support both the feasibility and acceptability of HIV testing in primary care (HPA, 2011). There is potential in Merton to engage with GPs to discuss implementation of sexual health service provision.

**Key commissioning recommendations**

- There is a need to work towards the development of an integrated [level 2] sexual health service.
- The barriers to accessing the condom distribution scheme need to be identified and solutions developed to enhance distribution.
- There is a need to ensure that people, especially young people, are aware of local sexual health services and how to access them. In particular, investment in further advertising of [www.gettingiton.org.uk](http://www.gettingiton.org.uk).
- An independent review of the CASH service should be commissioned in order to fully understand accessibility, service user experience, what works, and any gaps or barriers.
- Data reporting for GUM and CASH services need to be strengthened and commissioner/provider relationships further developed so effective monitoring and management can take place.
- Good practice models of working with men need to be explored and local insight gained, so effective interventions can be commissioned that increase safe sexual health practice and STI testing and treatment.
- Opportunities to increase STI testing in GP practices need to be explored.

**Chlamydia**

**Key facts on disease**

Genital Chlamydia trachomatis is the most commonly reported bacterial STI in England. Over 186,000 new cases were diagnosed in England in 2011 (HPA) representing a substantial public health problem. Infection is asymptomatic in at least 70% of women and 50% of men and as a result the majority of infections remain undiagnosed.

Untreated, chlamydia infection has significant health consequences. It is associated with considerable reproductive morbidity in women, including pelvic inflammatory disease, ectopic pregnancy and blocked fallopian tubes causing infertility. In men complications include urethritis, epididymitis and Reiter’s syndrome.

In Merton, the rate of chlamydia diagnosis in 2011 was 335.7 per 100,000 of the population, which was lower than England (351.2 per 100,000).22 The National Chlamydia Screening Programme (NCSP), which started locally in Merton in 2008, specifically targets 15-24 year olds. In 2011, 5,419 chlamydia tests were undertaken by Merton residents aged 15-24. The number of tests was equivalent to coverage of 24% of the Merton 15-24 year old population, with a rate of positivity of 8%. This compares with coverage of 30% nationally, with a 7% positivity rate. The rate of positive chlamydia diagnoses in Merton in 2011 amongst 15-24 year olds was 1,987.8 per 100,000 population.

**What are the gaps?**

- The NCSP for 15-24 year olds is still a long way from being embedded effectively into core services, many of which are being paid additional money to offer this service.
- Primary care providers would prefer a more integrated model of sexual health where training is offered on the whole range of services together e.g. emergency hormonal contraception (EHC), c-card condom scheme.

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22 PHE, 2012.
Chlamydia screening needs to be made more accessible to over 25s as well as under-25s. At present, the only place someone over the age of 25 can be tested is at a GUM clinic.

**Key commissioning recommendations to fill the gaps**

- There needs to be a further focus on embedding chlamydia screening into core services especially the CASH service and in GP practices, as recommended by the NCSP.
- Commissioning models which address a whole range of health concerns and risk-taking behaviour need to be explored rather than chlamydia being considered separately.
- Increasing access to chlamydia screening to the over 25s needs to be considered so that GUM is not the only provider.
- Work needs to be undertaken to ensure that key preventative messages are given to those receiving a negative result.
- Sex and relationships education and information sources for young people need to be reviewed and considered to ensure that ‘myths’ are dealt with, and they have the knowledge and skills they need to make informed decisions about their sexual health.

**Contraception**

GPs are instrumental in contraception provision. It is estimated nationally that three quarters of all access to contraception is through general practice. There are 26 GP practices in Merton.

Oral contraception is the most common form of contraception prescribed by GPs. In 2011-12, the rate of prescribing in general practice was 42.8 prescriptions per 100 women (aged 15-49 years). Oral contraceptives accounted for 89% of all GP prescriptions. However, this does vary from practice to practice, ranging from 21.4 to 62.4 prescriptions per 100 women aged 15-49.

The average long-acting reversible contraception (LARC) prescription rate in GP practices in Merton was 46.2 prescriptions per 1,000 women aged 15-49. Due to the recent NHS transition, data reflecting the new organisations is not yet available. The prescription rate [for LARC] is low generally but only lower than 10 primary care trusts (PCTs) in London. The LARC prescription rate varies from practice to practice across Merton. In 2011-12 this varied from 0.4 to 15 per 100 women aged 15-49 years. Injections were the most common type of LARC prescribed.

There were 460 women recorded as having been prescribed EHC in Merton GP practices in 2011-12, an 11% reduction from the previous year. Eight out of nine of those women had been given information on LARC in the previous 15 months.

**What are the gaps?**

- There is a need to understand the reasons underlying the low prescribing rates for LARC in GP practices. The reasons could be due to training issues where nurses and GPs lack the necessary training to fit LARC confidently and competently or a lack of knowledge and acceptance of LARC amongst women. Although most practices are offering information on LARC, the timeliness and depth of the information as well as service pathways impact on uptake and need to be standardised.
- Data available on the uptake of sexual health services in general practice is poor and often unreliable. There are gaps in critical information, for instance the demographics of those attending, creating difficulty in identifying unmet needs and inequalities in access.
- The CASH service in Merton and Sutton is not providing an integrated service at present. It only offers contraceptive provision, and dual testing for chlamydia/gonorrhoea to under
25s. It will begin offering HIV testing this year but steps need to be made towards further integration.

- There is a lack of robust data relating to the activity, outcomes and service user experience of the CASH service. This is needed to inform future commissioning.

Key commissioning recommendations

- Opportunities for promoting the use of LARC and increasing uptake in GP surgeries need to be explored.
- An independent review of the CASH service should be commissioned in order to fully understand accessibility, service user experience, what works, and any gaps or barriers.
- Data reporting for the CASH service needs to be strengthened and commissioner/provider relationships further developed so effective monitoring and management can take place.
- There is a need to ensure that people, especially young people, are aware of local sexual health services and how to access them. In particular, investment in further advertising of www.gettingiton.org.uk.

Infectious diseases

‘Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another.’

(World Health Organization)

Although the effect on mortality of infectious diseases is greater in the developing world, infectious diseases in England generate a significant cost financially, socially, and on health and wellbeing. In the UK, infectious diseases have been estimated to account for half of GP consultations for children, and over a third of GP consultations for adults. Direct costs to the NHS were estimated in 2005 to be £6 billion, one tenth of the NHS budget. The majority of this cost is in primary care.

Vaccine-preventable diseases

Measles/Mumps/Meningococcal disease

Measles in Merton

- In the previous three years (2010-12), there were 10 reported cases of measles in Merton.
- The measles rate for 2012 (per 100,000 population) was 1.0 per 100,000 population.
- In 2012, Merton’s measles rate was ranked fourth out of the six South West London local authorities (SWL LAs).

Mumps in Merton

- Over the same period (2010-12), there were 27 reported cases of mumps in Merton.
- The mumps rate for 2012 per 100,000 population was 3.5 per 100,000 population.
- In 2012, Merton’s mumps rate ranked second out of the six SWL LAs.

Meningococcal disease in Merton


Meningococcal disease is a bacterial infection, potentially leading to serious sequelae such as: meningitis or inflammation of the lining of the brain; and septicaemia, or bloodstream infection. Vaccination is available for particular strains of meningococcal disease.

- From 2010-12, there were 17 cases of meningococcal disease in Merton.
- The rate of meningococcal disease for 2012 was 3.5 per 100,000 population.
- This ranked highest of the six SWL LAs.

Hepatitis

- Over the period from 2010-12, there were six cases of hepatitis A in Merton, and six cases of acute hepatitis B.
- The rates of hepatitis A and acute hepatitis B in Merton ranked Merton fifth out of the six SWL LAs in 2012.

Key commissioning recommendations

The NICE pathway ‘Immunisation for children and young people' includes a specific pathway and recommendations for immunisation strategy, policy and commissioning (see Figure 10.14 in Theme 10). Specific advice in ‘Strategy, policy and commissioning for immunisation services', is outlined in the document and can be found in Box 10.1 in Theme 10.

Tuberculosis

Key facts on tuberculosis

In 2011, London had the largest proportion of tuberculosis (TB) cases in the UK, close to 40% of all cases. London also has the highest incidence of TB of any western European capital. Mortality from TB has continued on a decreasing trend, however deaths from TB – a treatable disease – continue. In London, from 2001-10, 1,348 people died as the result of TB. TB disproportionately affects certain groups and individuals, and rates vary according to ethnicity, migrant status, gender, and social risk factors (such as homelessness, drug and alcohol misuse, imprisonment and mental health issues).

Drug resistance in TB and co-infection of TB and HIV are also of particular concern.

In Merton, both the number and rate of TB cases have been increasing over the past several years.

- The TB rate in Merton increased to 37/100,000 in 2012, the highest seen in recent years, and just below the London average.
- Patients were predominantly male, and aged 20-49 years old.
- While most were born outside the UK, 27% had been in the UK over ten years.
- The most common ethnic group was mixed/other; the most common countries of birth outside the UK were India, Sri Lanka and Pakistan.
- More than half had pulmonary TB, a rate of 21/100,000; a lower than average proportion of these were confirmed by culture.
- Merton residents had similar levels ofisoniazid resistance and higher multi-drug resistance, compared to the London average.
- Treatment completion was similar to the London average at 87%.

Source: Local Authority TB Profiles (2012 data)


26 Health Protection Agency (PHE) (2013). Tuberculosis Update.
Cases
- From 2010-12, there were 194 notified cases of TB in Merton.
- In 2012, there were 74 cases of TB, higher than in the previous three years.
- The rate of TB per 100,000 population in 2012 (36.6), was the highest of all SW London LAs.
- One third of cases in 2012 were diagnosed in 20 to 29 year olds.
- 13.5% of cases were born in the UK.

What are the gaps?
- TB rates are increasing for Merton, and remain high for London overall. Commissioning is fragmented at present between CCGs (non-specialist care) and NHS England (specialist care).
- TB teams in South West London require skilled staff resources for awareness raising and management of hard-to-reach groups.
- A needs assessment in 2008 identified the gaps outlined below. An updated needs assessment and input from continued cohort reviews are required.

From Review of TB Services in South West London, September 200884

Clinical gaps
- At some centres TB nurses have responsibility for both respiratory and TB patients; given the volume and complexity of TB patients, these services should be separated and funded appropriately.
- Agreement is need on minimum standards of clinical care to ensure equitable service provision; this could be achieved through the design of an effective integrated care pathway.
- Introducing an opt-out HIV testing programme would increase the provision of HIV testing for TB patients.
- Directly observed therapy (DOT) for the treatment of TB is used variably across South West London. Agreed criteria for commencing a patient on DOT should be introduced. This should be allied to an effective risk assessment process to identify the case mix more effectively.
- Variability in levels of chemoprophylaxis may be due to capacity or practice and agreed criteria for chemoprophylaxis should be agreed.

Commissioning and funding gaps
- Active commissioning will cost more in the short term but will improve outcomes of care and achieve a saving in the medium to long term.
- The service provided to a PCT resident varies significantly dependent on the provider; allied to this is significant cross-border movement of TB patients.
- Almost all funding currently enters the trusts through payment by results (PbR); it is difficult to identify if non-PbR funding has been added at any point. The existing PbR expenditure is variable dependent on the acute trust providing care. PbR needs to be managed more effectively to ensure value for money.
- There are no discrete contracts in place for TB; existing TB services are commissioned as part of the global sum service level agreement (SLA). This means that it is virtually impossible to track funding and investments. PCTs, as recommended in the national TB commissioning toolkit, should introduce a discrete section to the acute contracts for the TB service.
- TB services provide variable community and outreach services, and there is little or no identified funding in place to deliver additional community and outreach work. PCTs should invest in community/outreach services in 2009-10.
- PCTs should not demand manage TB and it should not be subject to choice as per national guidance.
Management and coordination gaps

Coordination: this is a challenging and ambitious agenda and the work should be taken forward by the network manager, when appointed. This person will need to support PCTs to commission TB services but also will have a significant role in stimulating the market and developing providers.

Key recommendations for commissioners

- **Coordination:**
  
  There is a need for increased coordination within South West London, but also more broadly within London, and nationally.\(^{27}\) This has been repeatedly highlighted, particularly the need for a national strategy and quality national data.\(^{80}\) This is even more important now that the commissioning of services is divided between CCGs (non-specialist care) and NHS England (specialist care).

- **Funding:**
  
  Designated funding for TB services should be maintained within acute trust contracts. Funding should also be designated for community and outreach services, particularly important for accessing hard-to-reach groups.

- **Information:**
  
  Regular needs assessments, including regular cohort reviews, should continue to inform local commissioning of services.

**Local recommendations: findings and recommendations from South West London TB services review (2008)\(^{84}\)**

The following **areas** were consistently highlighted in discussions with the TB teams:

- Increasing current capacity to work in the community rather than just in secondary care
- Increasing education and awareness for primary care staff and community groups
- A shortage of medical sessions to compete TB work
- The level of DOT coverage and the capacity of teams to deliver this
- A need to be more assertive in identifying new cases in high-risk groups
- A need to be more assertive in terracing defaulters from TB care.

The following **actions** could support some of these issues:

- A formal development programme should be devised for TB nurses, in terms of career and educational development. This is a process that should be led by nurses.
- All senior staff within TB services should be supported in developing management and leadership skills.
- Gaps in provision identified through the needs assessment should be filled using appropriately skilled staff.
- Nursing services should consider the introduction of timetabled sessions to ensure that time is given to essential activities such as outreach and health promotion.
- A case review board could be established to provide expert advice on complex cases management. The membership of this board could be flexible dependent upon the case. Similar groups could exist for multidrug-resistant tuberculosis (MDRTB), case management, screening and incident management if required.
- Greater standardisation of assessment and data collection should occur, based upon the data requirements of the London standards and the suggested Health Protection Agency (HPA) enhanced surveillance requirements.
- There should be better reporting of data and performance against London and national standards.

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- All TB services should have a dedicated budget.
- PCTs should identify a TB lead, lead clinician and commissioning lead.
- Budgets should reflect the need for funding items other than staffing.
- Investment in additional non-clinical staff to support enhanced case management and outreach.

*Source: Review of TB services in South West London, September 2008-09-19*
Introduction

In 2012-13 the NHS Sutton and Merton PCT’s Public Health Team worked with partners at LBM, the shadow Merton CCG and other stakeholders, to produce a Joint Strategic Needs Assessment (JSNA). The 2012-13 assessment established the process that has been used to build this 2013-14 update to identify current and future health and wellbeing needs of Merton through consultation and partnership between organisations that contribute to health.

This assessment examines the needs of all residents of Merton as opposed to individual residents to identify those groups that experience poor outcomes and access to services. This will provide evidence for these groups to be able to participate as equal partners, along with LBM, Merton CCG, Healthwatch Merton (HWM) and other stakeholders, in negotiations to establish priorities and to inform service planning and commissioning.

Our objective is to close the gap in health experience between the most and least disadvantaged residents of Merton.

Within this objective, we aim to:

- develop a profile of health and social needs in Merton
- identify gaps in services either arising from differences in existing services and need or national standards/frameworks
- establish priorities that are aligned with best practice as set out in the evidence provided in this assessment.
- develop services along a pathway that starts with the influences on health and prevention and continues through secondary prevention, early diagnosis, treatment and improved quality of life for those living with chronic conditions.

A needs assessment provides opportunities to:

- increase effectiveness of interventions by ensuring they respond to identified needs
- address health inequalities, targeting resources to those most in need
- involve partners in shared decision making, including communities, patients, service users, carers and both public and private providers
- reflect community views.

This report reflects our commitment to improve the lives of Merton residents by strengthening our commissioning competencies to target scarce government resources to meet health and social care needs better. The results of the JSNA will contribute towards improving the outcomes for all Merton residents across the life course, with particular emphasis on early years. This includes improved health and wellbeing, improved quality of life, making a positive contribution, increased choice and control, freedom from discrimination, economic wellbeing, and maintaining personal dignity and respect.

For the 2013-14 JSNA:

- We met with our partners in the statutory and voluntary sectors to understand their views of health and disadvantage in Merton.
- We are sharing the data with our commissioning partners across Merton to agree opportunities to refocus interventions to match community needs, where appropriate.
- We built on the Annual Residents Survey questionnaire conducted in 2012-13 and included additional questions on health and wellbeing in the 2013 Merton Annual Residents Survey.

We are working to identify inequalities between ethnic groups, gender, age, and deprived communities so that we can better target services to meet their needs. Success will however be limited by the availability of data. All public bodies have had a legal obligation to
ensure there is no racial discrimination since the Race Relations Amendment Act was passed in 2000. Collection of ethnicity data is one way of ensuring this. According to a report\textsuperscript{28} by the Parliamentary Office of Science and Technology: ‘the patchy ethnicity data in primary care undermines the planning and evaluation of policy and precludes the monitoring of changes over time.’ The JSNA offers an opportunity to show which groups of residents have the greatest needs for services, and the barriers they face to improve their health, so that our commissioning can take into account those barriers. Without this feedback, we are in danger of commissioning and planning services that don’t benefit the most disadvantaged people.

We are aligning the JSNA with the way the local authority organises its services around adults and children. The JSNA delivery group agreed that the JSNA is an ongoing effort and a work in progress.

An evolving approach

We are adopting a new approach this year, one that continues to rely on quantitative analysis of health and disease outcomes but that expands discussion of the influences on health. Until recently, health research tended to concentrate on NHS interventions, such as surgery, medicines, and smoking cessation. This is beginning to change as more research becomes available in areas that enable us to predict what could happen to life expectancy in a borough, for example, if we make changes to the number of years that young people stay in school, or if we reduce unemployment by a certain amount.

The effects of social and economic policy on life expectancy are now beginning to become measureable and predictable. Research from organisations such as the Government’s Social Exclusion Unit, the WHO Expert Group on Social Determinants, and the Joseph Rowntree Foundation brought to national awareness the impact on health in terms of likely numbers of deaths due to poverty and poverty-reducing measures. A Danish study revealed that it is not too difficult to show how lifestyle risk factors and number of years in education affect life expectancy.\textsuperscript{29} Because Denmark has a similar life expectancy to the UK, the effects of risk factors on health will be used in the Theme 5 (Lifestyle risk factors in Merton) of this report.

From this year forward, we will combine current research showing the specific impact of selected risk factors that affect health with this emerging research on the influences on health to estimate the possible impacts of specific interventions on life expectancy in the borough. We will begin to highlight joint initiatives that in combination have the largest impact on reducing life expectancy inequalities in the borough.

We will combine this with efforts to improve identification of specific groups in Merton that suffer inequalities in health outcomes and access to health care.

The rationale for a Joint Strategic Needs Assessment

WHO defines health as:

‘A state of complete physical, mental, and social well-being and not merely the absence of disease, or infirmity.’

Health is a cumulative state that involves the capacity, perceived or actual, of individuals to thrive in their social and physical environment and to function and cope with specific illnesses and life in general.\textsuperscript{30}

Health is therefore influenced by a wide range of factors. An adaptation of the Dahlgren and Whitehead’s model\textsuperscript{31} (Figure 1 below) proposes that genetic predisposition interacts with environmental influences and individual lifestyle behaviours to produce health or ill health, which is then mediated by health care services to restore health where required.

**Figure 1: Influences on health.**

![Figure 1: Influences on health.](image)

Source: Barton and Grant 2005 based on Dahlgren and Whitehead 1991

Worldwide evidence has shown that living standards and levels of education have the greatest influence on health. While current work in the NHS focuses on curative healthcare – fixing people once they become unwell – the local authority delivers services that influence health promotion and prevent people from getting ill in the first place. Working in partnership thus increases our chances of reducing inequalities in health. In addition, both LBM and Merton CCG provide services to the same populations that would be more effective if coordinated. More can and should be done to enable effective local leadership and partnerships to flourish in meeting the Government’s vision for an integrated approach to improving people’s health and wellbeing. These strategies set out a requirement to align systems supporting frontline local delivery, governance arrangements, commissioning,


access to information, workforce development and action to drive improvements in quality and outcomes.

**Process to develop the 2013-14 JSNA**

In Merton the JSNA has been developed to inform commissioners and gives an overview of the population's health and social care needs across the borough. The way in which the JSNA process fits into the commissioning cycle is described in Figure 2 below.

**Figure 2: JSNA process and commissioning cycle.**

The 2013-14 refresh of the JSNA core dataset builds on the previous JSNA and latest guidance. The last JSNA was used to inform priorities set out in the current Merton Health and Wellbeing Strategy.

The JSNA delivery group met in late August 2013 and agreed that the work would be led by the Director of Public Health and the Merton Public Health Team, supported by LBM’s council departments, the Merton CCG, HWM and Merton Voluntary Service Council (MVSC).

To complement the quantitative analysis, qualitative feedback was sought in various ways e.g. through the insight work commissioned by Public Health Merton, the specific quantitative work under way on different health areas by Public Health Merton and a culminating community consultation event held in September 2013 – please see Theme 1 (*Merton Voice: What our communities are saying*) for details. Results of these will be
interspersed throughout the themes where relevant in the Merton Voice section in each topic area.

**Organisation of this report**

This edition of the JSNA is structured to follow a life-course approach. It is divided into **10 themes**: Merton Voice: What our communities are saying; Merton: The place and the people; Health inequalities in Merton; Social determinants in Merton; Lifestyle risk factors in Merton; Children and young people, and maternal health in Merton, Adult Health in Merton – long-term conditions; Access to adult social care in Merton; Older adults in Merton; and Sexual health and infectious diseases in Merton.

This report uses data to describe the health and social care needs of residents of Merton, using the JSNA core dataset as a start. Further exploration and more in-depth work were commissioned on health inequalities by Public Health Merton, and the findings are described in the health inequalities theme and in other themes where relevant. Additional detailed work is reflected in different themes.

Some work is ongoing and will have a bearing on the findings in this edition e.g. the ongoing Merton Mental Health Review. Once the review findings are finalised these will be used to update the relevant sections of the JSNA and the same applies for other work being undertaken by Public Health Merton. The JSNA is thus a living document in many ways.

The online version of the previous 2012-13 JSNA will be updated to reflect the new format adopted in this edition of the JSNA and the content will be updated accordingly in 2014.
MERTON
JOINT STRATEGIC
NEEDS ASSESSMENT
(JSNA)
2013-14

THEME 1:
MERTON VOICE
Summary

Annual Residents Survey for Merton

In Merton the 2012 Annual Residents Survey is the last published survey. Although the 2013 survey has been recently completed the results will not be published until early 2014, at which point the JSNA will be updated with these results.

In the 2012 Merton Annual Residents Survey, 65% of adults said they thought local health services were good (8% thought they were poor); 76% of young people thought health services were good (3% thought they were poor). Regarding social services the proportion of residents who thought adult social services are good was 20% (5% thought they were poor); 23% thought social services for children and families were good (4% thought they were poor); 40% of young people thought that social services were good (5% thought they were poor). The proportion who rated services as good or excellent was higher amongst service users than among all respondents to the survey.

The 2012 Merton Annual Residents Survey also contained some extra questions on health and wellbeing.

- Respondents’ views of their overall health and wellbeing was generally positive, with few reporting they felt dissatisfied, unhappy, anxious or worthless. Anxiety was the main concern with 9% reporting that they felt very anxious yesterday.
- Satisfaction with family relationships and social life was seen as most important to respondents, and 31% felt this could be improved. Satisfaction with health and mental health and feeling safe in your local area were also seen as important to respondents.
- Feeling safe in your local area, satisfaction with health and mental health, and satisfaction with household income and getting by financially were seen by respondents as the main areas that could be improved.

Young Residents Survey

Merton Council commissions a Residents Survey that includes a separate Young Residents Survey. The key findings from 2012-13 are as follows:

- Young people’s concerns were similar to those of adults, with crime the biggest concern. Bad behaviour and bullying were also concerns for young people, with both seeing an increase in the level of concern since 2011, significantly so for bullying with a 10% increase in concern.
- Concern about lack of recreational facilities has fallen significantly this year.
- Merton Council was viewed fairly positively by respondents, with performance ahead of London on all attributes and 72% feeling they get the services they need.
- Merton is significantly ahead of London for listening to the concerns of young people and doing enough to protect young people; 90% agreed Merton is a good place to live.
- Following a fall in 2011, there has been a significant increase in ratings for local health services and repair of roads. This year has also seen an increase in scores for leisure and sports facilities. All three areas are significantly ahead of London, as well as activities for young people, public transport, recycling facilities, libraries and street cleaning.
- Political involvement remains stable for young people, with almost all saying they would vote in an election.
- Young people were generally satisfied and happy, with 90% reporting they were either very or fairly satisfied and happy. The top four factors identified as most important to young people’s sense of wellbeing were:
  - feeling safe in the local area (65%)
- satisfaction with family and social relationships (58%)
- satisfaction with school (42%)
- satisfaction with health and mental health (34%).

**Merton JSNA community consultation event, September 2013**

A community consultation was organised jointly by Healthwatch Merton and the Merton Public Health Team in September 2013 at Vestry Hall for residents of Merton. This was a culminating community consultation event where all the insight collected over the past year as well as the present JSNA findings on health areas, services, gaps and recommendations were summarised and final feedback was sought. 38 residents in Merton attended the event.

**Key commissioning implications based on what people are telling us**

Commissioners have a legal duty to seek the views of service users and patients when commissioning services. This includes looking at users’ experience of existing services, and seeking views about planned changes to services before they are made.

A better understanding of patient or service user experience can help drive improvement by showing where efforts need to be targeted. Commissioners can draw on a wide range of data sources, including national and local, and qualitative and quantitative, to support this process.

Commissioners also need to consider what the appropriate involvement approach for different projects is. For a major service change, a formal public consultation will be required. When seeking to improve health outcomes and access to services for specific groups, engagement may include social marketing insight work to help understand the beliefs and attitudes that influence health behaviours and use of services.

It is important that commissioners are proactive in seeking views from marginalised groups who often experience poorer health outcomes, often referred to as ‘seldom-heard voices’.
Introduction

Understanding the needs of the population and the performance of the services they use is useful but it is only part of the picture; a vital part of any needs assessment and commissioning process is hearing the voice of the people who live in the area. What people say about their needs and the services they use gives important information on how to improve the services being commissioned in a way that responds to the needs of the population. This is a two-way process – not only do commissioners need to listen to what people are saying but they also need to let people know about local needs and the services they are commissioning on their behalf.

This section looks at the main ways in which local health services and councils hear the voice of local people. It describes the key engagement activities that have taken place in the recent past and where possible we have included what is happening in response. It includes activity carried out by the London Boroughs of Sutton and Merton in relation to social care services for children, young people and adults. It also covers the ways in which local health services have involved patients and the public, the recent insight work by the Merton Public Health Team, and the JSNA community consultation event held in September 2013.

Why do we need to involve service users and communities?
National evidence suggests that good engagement can:
• lead to improved clinical and economic outcomes in health care
• improve experience of and satisfaction with health and social care services
• make services more responsive to individual needs
• help develop services that support people’s dignity and independence
• challenge established methods and ideas and encourage innovation and creativity
• encourage a better understanding of decision making, prioritisation and use of resources in health and social care services
• enable individuals to manage their health and social care more effectively, particularly in relation to long-term conditions.

Engagement and involvement strategies
Community engagement is the action taken to consult, involve, listen and respond to communities through on-going relationships and dialogue. Communities participate to develop solutions, and to shape and design policies and services. Engagement enables citizens and organisations to influence decisions as well as make decisions themselves. Engagement activities include the provision of information, consultations, surveys, interviews and focus groups. These activities can be conducted face to face, via telephone, by the provision of hardcopy written information or online.

Duty to Involve in Consultation Report
Health commissioners have a legal duty to consult patients and the public before making commissioning decisions that affect how health services are planned and provided. In 2010, a new legal duty came into force requiring PCTs to produce an annual report on consultation. NHS Sutton and Merton’s first Annual Report on the Duty to Involve in Consultation 2009-2010 includes full details on consultations carried out during the year, including commissioning decisions made, what consultation took place prior to the decision...
being made, what views were expressed, and how they were taken into account. A similar report is planned by Merton CCG.

How do we hear the views of patients and communities?

Healthwatch Merton
The Health and Social Care Act 2012 replaced the previous public and patient engagement mechanism, Local Involvement Networks (LINks), with a new body called Healthwatch. The Act required local authorities with adult social care responsibilities to commission a local Healthwatch from 1 April 2013. The new Healthwatch Merton is run by MVSC. Healthwatch Merton joins a network of Healthwatch organisations across England.

The role of Healthwatch Merton
Healthwatch Merton will ensure the views of patients and carers are heard, giving them the opportunity to share their concerns and opinions about their local health and social care services. Healthwatch Merton will be responsible for:

- providing information and advice to the public about accessing health and social care services and choice in relation to aspects of those services
- making the views and experiences of people known to Healthwatch England helping it to carry out its role as national champion
- making recommendations to Healthwatch England to advise the Care Quality Commission to carry out special reviews or investigations into areas of concern
- promoting and supporting the involvement of people in the monitoring, commissioning and provision of local care services
- obtaining the views of people about their needs for and experience of local care services and making those views known to those involved in the commissioning, provision and scrutiny of care services
- producing reports and making recommendations about how those services could or should be improved
- representing the voice of local communities at the Health and Wellbeing Board.

Community Engagement Networks
INOLVE is Merton's Community Engagement Network. It is a network of the community and voluntary sector and aims to make sure that the needs and preferences of service users, carers and the wider community are identified and kept central to the planning and delivery of future services in Merton.

Community Forums and Area Committees
Community Forums help people make sure that the borough and other agencies know about their concerns and aspirations for their community. Each Forum meeting is attended by a borough representative whose role is to follow up on issues raised and ensure that they are resolved.

As well as the area-based groups described above there are a wide range of other forums, networks, groups and partnerships that enable different sections of the population to express their views on local services and issues. Some examples include youth parliaments, BAME networks, learning and physical disability partnerships, faith-based forums, patient groups, and carer’s forums and partnerships.
Patient Advice and Liaison Service (PALS) and complaints
PALS provide a point of contact in the Merton CCG to resolve concerns or any difficulties experienced with health services. PALS will discuss the options available to any member of the public if that person has concerns about the services commissioned by Merton CCG. PALS will support that person to resolve those concerns and respect their right to confidentiality at all times.

National surveys
There are several surveys carried out on a national basis. The key results of these surveys and actions arising from them can be found in the national surveys.

Ad hoc consultation events
These are organised by the Council or Merton CCG for various focused areas of work. Public Health Merton has done a number of insight projects, and recently did some qualitative work for an on-going adult mental health review and a school nursing review. A JSNA community consultation event was jointly organised by Healthwatch Merton and Public Health Merton and is reported below.

Voice of children and young people
Listening and responding to the views of users is central to Merton Children’s Trust’s design and delivery of services. A core value of the Trust, as expressed in its Children and Young People Plan, is that children and young people have rights to participate in decisions affecting their lives, that they should be listened to and enabled to shape the services they receive, and that we should canvas and respond to the views of their parents and carers.

In addition to this core value, the Children’s Trust works to the National Youth Agency standard framework ‘Hear by Right’ and has implemented a ‘participation promise’ to young people. This is a promise that services will ensure that children’s views are key to service design and delivery, and that we will facilitate young people’s forums and activities which will link with, and have an impact on, the adult democratic process.

This core value and the ‘participation promise’ are implemented in the Children, Schools and Families Department by four key strands of work:

- An approach to practice across Merton’s children’s workforce, which puts children’s wishes and feelings at the centre of decision making and planning about their support needs.
- Youth participation through a range of children and young people’s participation forums including:
  - Youth Parliament, which meets every two weeks
  - Young Advisors, including a new group of youth health advisors
  - the Children’s School Council, which canvasses views on a range of issues, and aims to influence the adult democratic process
  - Youth Inspectors, who will accompany officers on local inspections
  - Your Shout, a group that meets once a month and is for young people with disabilities.
- Targeted user feedback which canvasses views from children, young people and families who have used our services, through a range of surveys and forums.
• Use of key messages from complaints and compliments to feed into service developments.

Feedback from users across these strands of work have been used to inform strategies including the Children and Young People’s Plan, Looked After Children Sufficiency Strategy and the Strategy for Looked-after Children, Children, Schools and Families service plans, and discrete improvement plans.

What our communities are saying

Individual theme areas in the JSNA have a Merton Voice section where relevant, and these sections describe in more depth the engagement work done around those key areas.

Engagement to reduce health inequalities

Vulnerable and marginalised groups are most likely to experience health inequalities, so there is a particular need to identify gaps in patient experience evidence relating to those not using services or whose voices are seldom heard. These groups include:
• vulnerable older people
• BAME groups
• recently arrived groups (refugees and asylum-seekers or migrants)
• homeless people
• drug and alcohol users
• people with disabilities
• carers
• people in routine and manual employment
• unemployed people.

Annual Residents Survey for Merton

Each year many local authorities across the country carry out a residents’ survey. The methods used to carry out the survey and the individual questions asked may differ between areas but in general the results of the surveys are used for measuring the organisation’s performance across a broad range of service areas and to help decide what can be done to improve services.

In Merton the 2012 Annual Residents Survey is the last published survey. Although the 2013 survey has been recently completed the results will not be published until early 2014, at which point the JSNA will be updated with these results. The survey is conducted by an independent organisation and involved 1,092 face-to-face questionnaire-based interviews with adults, children and young people. It was part of a London consortium which enables comparisons with other participating London boroughs.

In the 2012 Merton Annual Residents Survey 65% of adults said they thought local health services were good (8% thought they were poor); 76% of young people thought health services were good (3% thought they were poor). Regarding social services the proportion of residents who thought adult social services were good was 20% (5% thought they were poor); 23% thought social services for children and families were good (4% thought they were poor); 40% of young people thought that social services were good (5% thought they were poor).
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- Concern about lack of recreational facilities has fallen significantly this year.
- Merton Council was viewed fairly positively by respondents, with performance ahead of London on all attributes and 72% feeling they get the services they need.
- Merton is significantly ahead of London for listening to the concerns of young people and doing enough to protect young people; 90% agreed Merton is a good place to live.
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  - feeling safe in the local area (65%)
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  - satisfaction with health and mental health (34%).
Figure 1.1: Young people’s personal concerns.

Young people’s personal concerns
Concern about bullying has increased significantly this year

<table>
<thead>
<tr>
<th>Concern</th>
<th>% Mentioning (2011/12)</th>
<th>Change from 2011/12 (% pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crime</td>
<td>45%</td>
<td>+4</td>
</tr>
<tr>
<td>Bad behaviour</td>
<td>31%</td>
<td>+7</td>
</tr>
<tr>
<td>Bullying</td>
<td>21%</td>
<td>+10*</td>
</tr>
<tr>
<td>Litter/dirt in the streets</td>
<td>26%</td>
<td>+2</td>
</tr>
<tr>
<td>Standard of education</td>
<td>21%</td>
<td>+3</td>
</tr>
<tr>
<td>Not enough being done for young people</td>
<td>30%</td>
<td>-1</td>
</tr>
<tr>
<td>Lack of jobs</td>
<td>18%</td>
<td>-1</td>
</tr>
<tr>
<td>Drug use and pushers</td>
<td>18%</td>
<td>+4</td>
</tr>
<tr>
<td>Pollution of the environment</td>
<td>18%</td>
<td>-2</td>
</tr>
<tr>
<td>Traffic congestion</td>
<td>12%</td>
<td>+2</td>
</tr>
<tr>
<td>Poor public transport</td>
<td>18%</td>
<td>-2</td>
</tr>
<tr>
<td>Health</td>
<td>18%</td>
<td>-7*</td>
</tr>
<tr>
<td>Poverty</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Lack of recreational facilities</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

*Sig

Source: CY1 Which of these are you personally most concerned about?

Figure 1.2: Overall health and wellbeing and features needing improving.

Overall health and wellbeing...

NET satisfied/ happy/ relaxed/ worthwhile

<table>
<thead>
<tr>
<th>NET satisfaction</th>
<th>92%</th>
<th>90%</th>
<th>85%</th>
<th>88%</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>49</td>
<td>44</td>
<td>48</td>
<td>51</td>
</tr>
</tbody>
</table>

Source: CY11 A) Overall how satisfied are you with your life nowadays? B) Overall how happy did you feel yesterday? C) Overall how anxious did you feel yesterday? D) Overall, to what extent do you feel the things you do in your life are worthwhile?
Base: All young persons aged 11–17yrs (243)
2013 Merton Residents Survey

While the results of the 2013 Merton Residents Survey cannot be reported at the moment, three new questions were added for health and wellbeing:

1. From April 2013, Merton Council has a new responsibility for improving the health of local residents. Were you aware of this new responsibility?
   Answer options: Yes/No/Don’t know

2. a) Which three of the following factors do you think are the most important to your own sense of health and wellbeing?

2. b) and, which three of the following factors do you think could be most improved to increase your own sense of health and wellbeing?

- Satisfaction with family relationships and your social life
- Satisfaction with your health and mental health
- Satisfaction with your school/job
- Satisfaction with your housing
- Satisfaction with access to green spaces in your local area
- Feeling safe in your local area
- A sense of belonging in your local community
- Satisfaction with your household income and getting by financially
- Satisfaction with your qualifications and/or level of training
3. How concerned are you about the number of the following in your local area:
   - Fast-food outlets
   - Betting outlets
   - Payday loans outlets
   - Alcohol outlets

   Answer options: Very concerned/Fairly concerned/Neither concerned nor unconcerned/Not very concerned/Not at all concerned

**National GP Patient Survey 2012-13**
[http://www.gp-patient.co.uk/results/](http://www.gp-patient.co.uk/results/)
Primary care is the main gateway to other NHS and social care services. Improving the patient experience by enabling access to services, and providing services more conveniently to patients, together with high-quality care, is important in achieving more effective care, greater patient satisfaction, and value for money.

The purpose of this survey is to determine, from the patient’s perspective, the ease of access to primary care services. People can respond to the questionnaire by email, telephone or post. Due to recent changes in the structure of the NHS, the survey is now being produced at CCG level. The latest survey results are from July 2012 to March 2013.

**National Patient Choice Survey 2010**
Around half of respondents in Merton said that they were aware that they had a choice of hospitals to attend for their first appointment and were offered a choice. 62% said that they were able to go to the hospital they wanted. These results were in line with national results.

**National Inpatient Survey 2012 (Care Quality Commission)**
The quality of patient experience is increasingly recognised as a key element of the overall quality of acute healthcare. Each year, people who have been admitted to hospital and had at least one overnight stay are asked what they thought about different aspects of the care and treatment they received. The results from each trust take into account the age and sex of respondents, and whether their admission to hospital was planned or an emergency. The survey gives the scores for the key areas of experience, indicating how the main acute trusts serving the population of Merton compare with other trusts nationwide.

**National Outpatient Survey 2011 (Care Quality Commission)**
Each year, patients are asked about their most recent visit to an outpatient department. The survey includes questions on waiting for the appointment, hospital facilities, seeing a doctor, and any tests and treatment undertaken during the appointment, as well as any medications prescribed.
**Insight work by Public Health Merton**

Insight work was commissioned by the erstwhile Sutton and Merton Primary Care Trust which was completed and reported in 2013 on the following:

- Sutton and Merton Drink Debate, Over 65s Campaign Evaluation, April 2013
- Healthy eating in the London Boroughs of Merton and Sutton: Understanding the values and barriers to healthy eating amongst families with children aged one to five years, May 2013
- Social Marketing Projects Summary Report: Public health insight and recommendations for Sutton and Merton, July 2013
- Inform, encourage, support – accessing physical health services for those with severe mental illness (SMI) in Sutton and Merton, November 2013.

Additionally there were other recent reports:

- NHS South West London Childhood Immunisations and Vaccinations, June 2013
- NHS South West London Physical Activity Project, May 2013

All of these are reported in the related themes in the JSNA.

**Merton JSNA Community Consultation Event, September 2013**

A community consultation was organised jointly by Healthwatch Merton and the Merton Public Health Team in September 2013 at Vestry Hall for residents of Merton. This was a culminating community consultation event where all the insight collected over the past year as well as the present JSNA findings on health areas, services, gaps and recommendations were summarised and final feedback was sought. There were 38 Merton residents who attended the event.

Five themed workshops were held on the lines of the themes in this edition of the JSNA:

1. **Children, young people and maternal health**
   - Health related issues (e.g. causes of morbidity and mortality, immunisation)
   - Social care

2. **Adults**
   - Conditions affecting the 18-65 year old age group (e.g. long-term conditions, mental health, dementia, end of life care) including cancer, heart disease, respiratory diseases (e.g. COPD)
   - Social care

3. **Older adults (65+)**
   - Conditions affecting the 65 and over age group (e.g. long-term conditions, mental health, dementia, fractures and EOLC)
   - Social care

4. **Sexual health and infectious diseases**
   - Lifestyle risk factors
   - Teenage pregnancy

5. **Prevention – lifestyle and policy influences (built environment, licensing, planning)**
   - Lifestyle risk factors (e.g. smoking, physical activity, diet, alcohol, drugs)
   - Overview of social determinants of health and how they affect the Merton population
- Overview of correlation between specific health conditions and wider determinants (e.g. deprivation)
- Education
- Work/employment
- Built environment and regeneration
- Transport
- Crime

In each workshop the following three questions were explored and three key messages recorded:
- What did the presentation (on the key findings of the JSNA) bring up for you?
- What is missing?
- Where do you think we should focus?

Feedback from workshops

*Children and young people and maternal health theme*

> ‘The arts and creativity amongst younger people should be encouraged, giving them an interest…something to carry on into adulthood.’ – Merton resident

Key issues:
Workshop participants identified the following issues:
- Health issues are complex – mental health impacts across a range of issues, but is not always seen as a priority to tackle.
- No health without mental health – there is a lack of priority for improving children and young people’s mental health from an early age.
- Fears expressed over the future of the Child and Adolescent Mental Health Services (CAMHS).
- Concerns that there is a slow bureaucratic process for dealing with issues.
- Accessibility of services need to be improved.
- There is inequality across the borough in terms of reach of services; some schools, for example, have good access to healthy school related initiatives, others do not.
- Services need to be encouraged to make better use of the grants available through the East Merton Community Health and Wellbeing Fund from MVSC, for resourcing activities and programmes.
- Professionals are too quick to label young people with problems.

Gaps:
Concerns expressed at the workshop included:
- Eastern European communities are not accessing local services due to language barriers, and the need for support for young mothers was identified.
- Poor communication with different BME communities across the borough.
- There is an over-reliance on volunteers for offering help to services.
- Sustainability of projects, which are hampered by lack of funding.
- Need for more outreach with communities.
• Lack of appropriate support for families especially around domestic violence and alcohol.
• Parenting classes – gap in primary school years.

Priorities:
• Focus on children’s mental health to prevent difficulties in later life – for children aged 0-3 to build parent/infant relationship and increase prevention and early intervention services.
• Provide prenatal support for families/family support for first 12 weeks of pregnancy.
• Focus on the early years and improve access to children’s centres.
• Sustain targeted services.
• Ensure the right support for BME communities so that they can make the best use of services (language skills and support).
• The MMR vaccine has low uptake – it is no longer seen as important, so raise the profile of vaccinations.
• Raise awareness of the vast array of services through community days and increase involvement in local leisure services.
• Support schools to deliver better services and promote health.
• Develop a pastoral care unit in schools.
• Cyber bullying goes undetected and has an emotional impact – this needs to be challenged.
• Offer workshops to tackle bullying and raise low self-esteem.
• Train teachers to offer more support in schools, including group support, and to recognise the signs of mental health problems.
• Offer meditation in schools (follow the Japan model).
• Foster the school/college transition as this is a main critical period to get information/education/job and activities training to young people.

Adults theme

Key issues:
• Sharing of quality, reliable information (better network of referrals back and forth, and communication between clinicians and patient).
• Education of patients with long-term conditions (lack of education and support, and of information in GP surgeries).
• Increasing and improving our sense of personal responsibility (help to support self-management)
• Investment in the east of the borough where the need is greater.

Long-term medical conditions – there is a serious lack of education and support groups for people living with a long-term condition. Having more support groups could help with the self-management of care and have better outcomes. GP surgeries do not hold enough information leaflets on long-term conditions. Education and advice on long-term conditions could help with self-management of these conditions.
Lack of patient involvement groups are becoming an issue – there are no established groups. Patient participation groups are crucial in order to address the lack of communication between GPs and patients.

Referrals – referrals back and forth between services are very stressful and time consuming. Referral rates for long-term conditions take too long (overlapping into other services, as mentioned above).

Inequalities and unemployment in the borough and mental health issues – why have we got more services for some issues than others that could affect long-term conditions? More services are needed in the deprived areas. Investment in services is needed.

Take the service to the community – could NHS Health Checks be carried out in a community setting as well as GP settings? This is particularly important for patients with dementia who find it difficult accessing GP surgeries. A recent example of taking a service to a community setting was LiveWell attending the Mitcham Festival, which proved very popular. Have services in the community as well as in clinic settings.

Older adults theme

Key issues:
- Community development (one-to-one scheme, getting people together, choir, barrier to access transport, education for carers).
- Importance of addressing social isolation – lack of human contact (cuts increased due to increased use of technology – technology can increase social isolation).
- Signposting/information support (feel like prisoners in their own home, importance of GP engagement about social matters).

Things that could help:
- Age Concern (now Age UK) had a visiting scheme which worked well to enable people to visit others who are more isolated and less able to get out.
- Get people to do something together like sharing experiences of putting lunch together to share a meal. There are a lack of development workers and funding to do these things.
- Intergenerational scheme – like mentors in schools to help with reading schemes etc.

"…it is important that each of the 26 practices in Merton has a patient participation group. It would be good if good practice could be shared…we should have all 26 practices having an active group with GP involvement. Democratising the NHS is a necessity." – Merton resident

"Investment in the East of the borough!" – Merton resident

"Social exclusion has an impact on accessing services for people with a whole range of mental, physical and learning disabilities." – Merton resident
Other concerns:

- Worries about crime, social isolation, rising food prices, cuts to services, accessibility to activities due to cost.
- Lack of keep fit services, access to health information, volunteers, volunteering services and befriending services, continuity of care, advice and information specific to older people.
- GPs – difficulty in getting an appointment at a suitable time, language not understandable when GP uses jargon, GPs need to take more responsibility for social care related matters and get involved beyond treatment.

More focus on:

- Volunteer services
- Communication about core services
- Identification of socially isolated population
- Signposting/information
- Dedicated space in My Merton magazine about health
- Targeted page/information for older people in My Merton magazine
- Targeted information through GPs
- More clubs plus activities.

**Sexual health and infectious diseases**

Key issues:

- Need more adult education around sexual health – information, services and how to access.
- Need to focus on deprived areas and vulnerable groups, but not all resources should be focused on the east of the borough.
- Female genital mutilation (FGM) and under-age sex – need for prosecutions.
- Need to increase MMR and TB immunisations.

‘No JSNA is complete unless it has tackled access issues.’ – Merton resident

Sexual health related feedback:

- Age of consent – vulnerable people.
- HIV prevalence in women is a worrying statistic.
- Targeting communities and social stigma of HIV.
- Mother-to-child HIV transmission is a particular issue for Merton.
- Need to focus on why people are presenting late to antenatal services.
- Lots of advice for children and young people but not for adults.
- HIV testing should be offered during registration checks at GP practices.
- Pubs and social clubs should do more – posters etc. Good slogans in the right places – fast food outlets/pub toilets/libraries/buses/trams. Tell it how it is but with balance.
Many young people think HIV/AIDS is curable.
Grassroots organisations need to be used more frequently.
Use social media. Peer to peer for young people.
Young health champions – give them a remit around sexual health.
Many scared of taking an HIV test. Scared of the result and the consequences. Still many myths surrounding what happens and the implications of being positive e.g. insurance, GP confidentiality, ruins your life.
Cultural issue – getting the message across especially to BME males.
Schools – provision patchy as not statutory. State schools/academies/independent schools have different rules and obligations.
Religious and cultural issues in schools and homes.
Focus on relationships not just sexual health. Wrong image of sex from media and then parents don’t talk about it so there are lots of myths.
Need more detailed statistics to get to where problems are but data protection prevents us getting data in some areas which would give us a better idea of the gaps/issues.
East more deprived but need to ensure we don’t forget the west. Two-tier approach needed.
FGM should be on the agenda. Cultural issue particularly in the Somali population.
Forced marriages – more of an issue now the population is becoming more diverse – like FGM.
Engage faith groups to try to get messages across.
Impact of mass media on young people’s perception of sex and what is expected of them.
Early sexualisation. Being able to recognise inappropriate behaviour.
Facilitation for disabled individuals to have sex – more focus and information.
Increasing appropriate sex and relationship education (SRE) for people with SEN.
Focus on those who speak different languages and with cultural differences.

‘Sexual health in adults – how to get the message out about HIV etc.’ – Merton resident

Prevention – lifestyle and policy influences

Key issues:
Cheaper food at supermarkets.
Junk food too easily available on the high street.
Health education to get the message across about prevention.
Lack of information dissemination.
Build up community spirit.
Encourage people to walk.
Improve public transport and exercise facilities.

What strikes you about these issues?
Obesity – not just seen in those who are poor but in those with better disposable incomes and who have access to knowledge/information.
Shift in emotional issues – reasons why not altering behaviour.
• Psychological wellbeing – key in all areas.
• Closure of services e.g. Fanon Resource Centre, Merton MIND – people face issues of having nowhere to go and not being signposted where to go.
• Preventing isolation is key.
• Prevention of illness is important.
• Mental health – still has a stigma attached – need to try and remove the stigma to aid prevention.

Access to services – know where to go?
• More outreach work needed.
• Concessionary rates at local authority leisure centres – not that different from 'normal' membership prices (plus need to be promoted more).
• Provision of health options in food places is limited.
• A great deal is down to education, but parental input is just as important.

Promotion
• Promoting neighbourhood watch scheme.
• 'Walking buses' – encourage people to walk together.

Recommendations
• Take into consideration the ‘softer’ outcomes – not just numbers but also social inclusions.
• Opportunities for socialising.
• Use of technology more innovatively.
• Provision of groups for peer support.
• Subsidised rates at gyms, sessions etc.
• Using council policies, planning etc. to look at where lever change in takeaway, alcohol, food outlets etc.
• Increase the Council's objections to licensing applications.
• Payday loan shops – too many. Look at reducing number.
• Increase access to advice around debt and money issues.
• Education – is enough being done?
• Get more signposting and information out there e.g. information on walking routes, calories burnt, time to next bus stop.
• Utilise some of the money for prevention of illnesses, diseases, in improving housing provision e.g. insulation.
• Link in advice and information with housing – illness and housing often go together. Improving housing conditions will have knock-on effect on health.

Transport
• With so many clinics and services closing, people are having to travel further.
• Access to healthcare appointments – involve the help of GPs.
• Alternative means to car transport – different alternatives not promoted enough
Crime and employment
- Expand age criteria for apprenticeships.
- Working good for health – keep in work.
- Increase volunteering.
- Encourage mentoring.
- Work with employers – incentives.
- Social cohesion – increase this.

Key commissioning implications for improving services based on what people are telling us

Commissioners have a legal duty to seek the views of service users and patients when commissioning services. This includes looking at users' experience of existing services, and seeking views about planned changes to services before they are made.

A better understanding of patient or service user experience can help drive improvement by showing where efforts need to be targeted. Commissioners can draw on a wide range of data sources, including national and local, and qualitative and quantitative, to support this process.

Commissioners also need to consider what the appropriate involvement approach for different projects is. For a major service change, a formal public consultation will be required. When seeking to improve health outcomes and access to services for specific groups, engagement may include social marketing insight work to help understand the beliefs and attitudes that influence health behaviours and use of services.

It is important that commissioners are proactive in seeking views from marginalised groups who often experience poorer health outcomes, often referred to as 'seldom-heard voices'.
MERTON
JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)
2013-14

THEME 2:
MERTON – THE PLACE AND THE PEOPLE
Summary

Merton has a population projected in 2013 to be 202,750\(^{32}\) persons living in nearly 79,000 occupied households. Population density tends to be higher in the west wards of the borough than in the east wards.

Just over half the borough is female (50.7\%) and the borough has a similar age profile to London as a whole. The largest number of households in the borough are single households (28\% of all households) although 49\% of the borough’s population live in family households with dependent children (31\% of all households).

Based on current trends, Merton’s population would increase by 16,000 people between 2011 and 2017. A significant feature of Merton’s population in 2017 is the changing age profile of the borough’s residents, with the most notable growth in those under the age of 9 years and those over 65 years old. Looking at the ratio between the working age and non-working age populations (the age dependency ratio) we see a decrease in the proportion of the working age population from 69\% to 67\%. The ethnic composition of the borough is also forecast to change significantly, with the proportion of people from a BAME background increasing from 35\% in 2011 to 39\% in 2017. The GLA population projection data for 2013 shows Merton’s BAME population to be 74,650 (36.8\%) (Source: GLA 2012 Round SHLAA EGPP population). At the time of Census 2011 the percentage for BAME groups in Merton was 35.1\%. This was lower than the percentage for London (40.2\%).

If we overlay deprivation data from the IMD\(^{33}\) we can see that population growth and highest densities were in wards toward the east of the borough, which currently have higher levels of deprivation, compared with the west of the borough.

The People

Merton has a population projected in 2013 to be 202,750\(^{34}\) persons living in nearly 79,000 occupied households. Population density tends to be higher in the west wards of the borough than in the east wards.

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Population count and projections

Different sources use different methodologies to construct a population estimate of the borough – e.g. the ONS and GLA. All of these have different uses.

The most recent ONS census has given the borough a population of 199,693 as at March 2011.

\(^{32}\) GLA Population Projections 2012 Round, SHLAA ward projection creator.
\(^{33}\) It should be noted that the IMD has not been updated since 2010
\(^{34}\) GLA Population Projections 2012 Round, SHLAA ward projection creator.
Based on current trends Merton’s population would increase by 16,000 people between 2011 and 2017. If we look at the GLA’s SHLAA forecast that factors in housing availability, it suggests an increase of 6,000 additional people living in Merton. Therefore Merton’s population is likely to grow by between 3% and 8% over this period. Looking at the SHLAA forecast, the projected growth is less than Outer London (6%) and Greater London (7%).

Figure 2.1: Population in Merton 2011-17. This graph shows two population projections for Merton based on the methodology used.

Population by age, gender and ethnicity

Age
- A significant feature of Merton’s population in 2017 is the changing age profile of the borough’s residents.
- The number of children and young people aged 0-19 is forecast to increase by around 3,500 (3%) over this period. In particular, there is forecast to be an increase of 2,300 (20.3%) in the number of children aged 5-9.
- It is notable that the 20-35 age group is forecast to fall by 2017, perhaps reflecting the lack of affordable housing in the borough.
- There is also forecast to be an increase of 2,900 people (11%) in the over 65 age group with an increase of around 1,500 in the over 90 age group. These changes are likely to result in demand pressures in three key areas of service provision – education, children’s social care and adult social care.
- The high birth rate and increase in children under 5 will place additional demands on health services, in particular newborn and child screening, immunisations and six-week checks.
- The increase in the 0-4 age group will increase demand for affordable childcare and nursery provision.
- The rapid increase in the primary school age group will increase demand for primary places and subsequently for secondary places. The demand for SEN provision will also increase.
This is also likely to increase demand for children’s social care services and will require the Children’s Trust to maintain a focus on early intervention services designed to prevent problems escalating requiring costlier forms of intervention.

Data from the 2011 census reveals that the gender split in the borough is almost 50:50 with 50.7% of the population being female. The borough has a similar age structure to London as a whole with a larger percentage of children aged 0-4 years.

**Figure 2.2: 2011 Census age profile, Merton v England.**

The number of children and young people aged 0-19 is forecast to increase by 3,180 (7%) between 2011 and 2017. The number of people aged over 65 is also forecast to increase significantly over this period, rising by 2,900 people (11%). The number of people aged between 20 and 35 is forecast to decrease. These trends are significant in terms of service implications, in particular for education and social care, which are explored further in the next chapters. These demographic shifts are similar to what is happening in London as a whole, except for the decrease in the 20-35 age group.

*Source: 2011 Census, graphic by ONS Data Visualisation Centre*
Looking at the ratio between the working age and non-working age populations (the age dependency ratio) we see a decrease in the proportion of the working age population from 69% to 67%. This reflects the fall in the number of people aged between 20 and 35, and the increase in the younger and older cohorts. The reason for the fall in the 20-35 age group is not clear. It could reflect people moving away from Merton to seek work or because of the cost of housing in the borough.

Figure 2.3: Age profile for Merton 2011 and 2017.
Figure 2.4: Merton children and young people (aged 0-24 years) population 2001-17.  
Source: GLA 2012 SHLAA

Figure 2.5: Merton population by ward as at 2011.  
The ward maps below show Merton’s population by ward in 2011 for comparative purposes. The darker shades indicate a larger population.

1 Abbey  
2 Cannon Hill  
3 Colliers Wood  
4 Cricket Green  
5 Dundonald  
6 Figgies Marsh  
7 Graveney  
8 Hillside  
9 Lavender Fields  
10 Longthornton  
11 Lower Morden  
12 Merton Park  
13 Pollards Hill  
14 Ravensbury  
15 Raynes Park  
16 St Helier  
17 Trinity  
18 Village  
19 West Barnes  
20 Wimbledon Park
The forecast increase in the overall population is the product of the number of births forecast to be significantly highly than deaths: around 3,500 births a year over this period.

**Figure 2.6: Births, deaths and net migration 2011-17.**

![Births, Deaths and Net Migration 2011-2017](image)

**Ethnicity**
- The ethnic composition of the borough is also forecast to change significantly, with the proportion of people from a BAME background increasing from 35% in 2011 to 39% in 2017.
- The largest increases are in the Asian, black African and Pakistani ethnic groups.
- The ethnic composition of the borough’s residents also differs across age groups with a forecast increase in the proportion of BAME people in the 0-19 age group from 44% in 2011 to 47% in 2017.
- The increase in the BAME population has implications for public health where risks for specific diseases, lifestyle risks and lower awareness of prevention services result in higher prevalence of disease amongst the BAME.
- Census 2011 supports our understanding of the main languages spoken in Merton as Tamil, Polish, and Urdu.
- The School Census of Primary and Secondary schools however supports the identified languages in schools in order of greatest prevalence has changed to Tamil, Urdu and then Polish.

The GLA population projection data for 2013 shows the Merton's BAME (Black Asian and Minority Ethnic) population to be 74,650 (36.8%) (Source: GLA 2012 Round SHLAA EGPP population). At Census 2011, the percentage for BAME groups was 35.1%. This was lower than the percentage for London (40.2%). The distribution of ethnic groups at ONS Census 2011 is given in Table 2.1 below, together with comparisons with London and England.
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<th>Ethnic group</th>
<th>Merton</th>
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<th>England</th>
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<td>%</td>
<td>%</td>
<td>%</td>
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<tr>
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Merton’s ethnic profile is forecast to change significantly by 2017. The proportion of Merton’s BAME population is expected to increase from 35% in 2011 to 39% in 2017. However, this is still lower than the forecast BAME population in 2017 for London as a whole (45%) and Outer London (44%).

Looking at the breakdown of the BAME population, the largest increases are in Asian Other (notably Sri Lankan), Black African and Pakistani groups. In Outer London, the largest growth groups are forecasted to be Asian Other, Black African and Black Other. In Greater London, the BAME population is forecast to increase by 19%, with Asian Other (30%), Black Other (28%) and Other Ethnic (28%) groups the biggest increases.
Figure 2.7: Merton children and young people (0-19) ethnic population 2001-17.

Figure 2.8: Total proportion of BAME residents 2011 and 2017.

The increase in the proportion of people from BAME groups is across all age groups. However, the proportion of younger BAME people is considerably higher than that of older people.

Figure 2.9: Ethnic profile 0-19 age group 2011 and 2017.
Migration
As detailed in Figure 2.10 above, the overall levels of net migration in Merton are low. However, this masks a significant population churn. The GLA forecast suggests that in the region of 20,000 people a year will move in and out of Merton each year. Data from Census 2011 shows that 43% of residents were born outside the UK with the largest proportion born in Poland. This profile may change in future as EU working restrictions for residents of Romania and Bulgaria were lifted at the end of 2013.

Figure 2.11: Migration 2012 to 2017.
Figure 2.12: Merton residents born overseas.

Figure 2.13: Life expectancy in Merton.

Life expectancy
Life expectancy for both males and females in Merton has been increasing since 2000, in line with national trends. Figure 2.13 below shows the most recent data on life expectancy in Merton for 2009-11 demonstrating a continuous upward trend.

Family types
The total number of households in Merton at Census 2011 was [78], and the average household size in Merton was 2.5 persons per household which was exactly on par with London. The most common types of household were single adults: 22,300 persons (11.2%); households with children (dependent and non-dependent): 101,700 persons (51%); and cohabiting adults without children: 9,600 persons (5%).
As a proportion of the borough's population, most people were living in either family or other households with dependent or non-dependent children: 28,800 households (37% of the total households) or cohabiting households without children: 4,800 households (6%). A significant number were living in single parent households: 8,100 households (10%), or older cohabiting households with children: 8,700 (11%). There were 7,700 households (10%) with an older person 65 years and over living alone. (Census numbers have been rounded.)

**Lesbian, gay, bisexual and trans (LGBT) population**

Statistics for the size and composition of the LGBT population in Britain remain imperfect due to the lack of robust national data. Estimates range from 0.3% to 10% depending on the measures and sources employed.

The ONS has developed a sexual identity question that was included in the Integrated Household Survey (IHS) in 2009. The first results from this survey suggest that 0.9% of the population surveyed classified themselves as gay/lesbian with a further 0.5% bisexual. Extrapolating the national figures to a projected 2013 borough population of 202,750 would suggest that Merton has an LGBT population of around 2,840.

**Ward level forecasts**

**Population**

Wards to the east, in particular Longthornton, Pollards Hill and Colliers Wood, are forecast to see the largest increases in population between 2011 and 2017. The populations in these wards are expected to increase by over 4% (460+ people).

*Figure 2.14: Population growth (darkest is highest growth and lightest is lowest).*
In terms of population density overall, Cricket Green, Figges Marsh, Wimbledon Park and Colliers Wood are forecast to remain the most populous wards in Merton in 2017. However, the forecast 4.6% population growth in Pollards Hill, the second largest growth, will see it become the fifth most populous ward (from seventh).

**Figure 2.15: Population density (darker equates to highest population and lightest, lowest).**

1. Abbey
2. Cannon Hill
3. Colliers Wood
4. Cricket Green
5. Dundonald
6. Figges Marsh
7. Graveney
8. Hillside
9. Lavender Fields
10. Longthornton
11. Lower Morden
12. Merton Park
13. Pollards Hill
14. Ravensbury
15. Raynes Park
16. St Helier
17. Trinity
18. Village
19. West Barnes
20. Wimbledon Park

If we overlay deprivation data from the IMD\(^{35}\) we can see that population growth and highest density are in wards toward the east of the borough which currently have higher levels of deprivation compared with the west of the borough.

\(^{35}\) It should be noted that the IMD has not been updated since 2010
Age structure
Population growth in Pollards Hill ward is forecast to be driven by the population aged over-20, in particular those aged 65 and over, with a growth of around 205 people in this age group.

Similarly, in Longthornton ward, population growth will be driven by the over-20 age group. The 45-64 age range in particular is forecast to grow by 209 people. Both wards will see decreases in the children and young people population, driven mainly by a decrease in the 10-19 age range.

Colliers Wood ward is forecast to have large increases in the 0-19 age group and the 45-64 age group, by 327 and 256 people respectively. The 20-44 population is projected to see a fall of 257 people. This suggests that population growth in Colliers Wood will be driven by an increase in families with children.
We have also looked at the forecast age dependency ratio for 2017 (the proportion of the working age population compared with the non-working age population). The lighter shading in Figure 2.18 below indicates a higher proportion of working age residents. There is an overall increase in the non-working (dependent) population between 2011 and 2017 in a number of wards.

**Figure 2.17**: Age structure changes in Merton’s three fastest growing wards.

**Figure 2.18**: The age dependency ratio in 2017.

1. Abbey
2. Cannon Hill
3. Colliers Wood
4. Cricket Green
5. Dundonald
6. Figgies Marsh
7. Graveney
8. Hillside
9. Lavender Fields
10. Longthornton
11. Lower Morden
12. Merton Park
13. Pollards Hill
14. Ravensbury
15. Raynes Park
16. St Helier
17. Trinity
18. Village
19. West Barnes
20. Wimbledon Park
Ethnicity
The proportion of people from BAME groups also varies significantly by ward with those wards to the east of Merton having a higher proportion of people from BAME groups. Data is not available to forecast ethnicity in 2017.

Figure 2.19: White to BAME ratio 2011 (darkest is highest proportion of BAME residents).

The Place

Physical environment
Open spaces and the physical environment have particular roles to play with respect to encouraging healthy lifestyles. In an urban area with little access to countryside they represent one of the few places for outdoor exercise and relaxation for better mental health. Of particular significance are:
- regional parks for longer walks, horse riding and cycling
- local parks and open spaces for general exercise and wellbeing, informal sport and children’s play
- playing fields for organised sports
- allotments for exercise and healthy food.

Green spaces and air quality have been covered in Theme 4 (Social Determinants in Merton)

Future housing development
- The increase in the number of households, coupled with rising house prices and growth in the private rented sector, is likely to result in lower income households living in poor-quality accommodation and rising homelessness.
The increase in the number of children living in areas of deprivation to the east of Merton will increase the number of pupils experiencing factors that could affect educational attainment e.g. low income, poor housing etc.

Figure 2.20: Future housing development in Merton.

Economic activity

Qualifications
There is a distinct difference in the borough when qualifications are mapped against ward areas:
- There is a significant increase in the number of people with no qualifications since 2007 and the number of people with no qualifications is significantly greater towards the east of Merton (see map in Figure 2.21 below).
- Conversely the number of people with NVQ Level 4 or above qualifications is concentrated in the West in almost a mirror image of the distribution of people with no qualifications (see map in Figure 2.22 below).
- An increasing number of school leavers and an increase in the number of job seekers in Merton require a coordinated approach to improving pathways into work.
Figure 2.21: No qualifications: Significant increase in people with no qualifications since 2007.

Source: ONS Census 2011

Figure 2.22: NVQ Level 4 or above: Level four or above qualifications concentrated in the west of the borough.

Source: ONS Census 2011
**Employment**

- Those in active full-time employment are distributed all over Merton, with no discernible pattern except a slightly greater concentration towards the central and southern parts of Merton.
- Those who are unemployed are distinctly concentrated towards the eastern parts of Merton.
- Those who are self-employed are distinctly concentrated toward the western parts of the borough.

**Figure 2.23:** Merton distribution of the population in full-time employment, part-time employment, self-employed and unemployed.

Source: ONS Census 2011
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THEME 3:
HEALTH INEQUALITIES IN MERTON
Summary

Health outcomes for people in Merton are generally better than those in London and largely in line with or above the rest of England. The graph in Figure 3.1 below shows healthy life expectancy at age 65 or older in Merton compared with [other] boroughs in South West London, London and England.

In Merton, overall life expectancy at birth is longer than the England average, but there is a difference between the most and least deprived areas within the borough of about nine years for men and about 13 years for women. Between 2005-09 and 2006-10 this gap has remained the same for men, but has increased by about two years for women. The increase in the gap for women is because for women life expectancy has increased at a faster rate in the most affluent areas compared with the most deprived areas of the borough.

Premature mortality (deaths under 75 years) is very strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts. Looking at rates of death in a population (rather than life expectancy), if East Merton had the same rate of deaths as West Merton, there would be around 113 fewer deaths each year in East Merton – an 18% reduction on the 640 deaths each year among East Merton residents. Of the 113 deaths, 81 are under 75 years of age.

In general, East Merton is younger, poorer, ethnically more diverse and with relatively lower levels of education outcome and training qualifications than West Merton.

High-level recommendations to tackle health inequalities

- With limited resources, a much more targeted approach will be required to address the differences in health and social outcomes and to develop services that respond to our increasing ethnic diversity.
- Placing a priority on the early years offers opportunities for the largest gains in life expectancy.
- Priority on prevention will reduce future need for health and social care services. Risk factors such as smoking, obesity and risky drinking behaviour underlie increasing levels of long-term conditions, such as heart disease and cancer, especially in the more deprived groups. Efforts need to be spread proportionally by need across all social groups.
- Partnerships with the voluntary, community and business sectors will accomplish a broader outreach by embedding health as part of all frontline work.
- An improved understanding of the social determinants of health and of the role local government plays in creating health will lead to more effective use of local government levers, including early childhood development, education and training, and licensing and planning.
- Improvements in early detection and management of long-term conditions provide opportunities for the quickest gains in life expectancy. Along with improved access to services, this will improve residents’ quality of life and reduce the need for more expensive acute services.
- Improvements to ensure more robust data is captured on the population accessing services and better use of this data, through health equity audits, for example, would support understanding service need and design.
Introduction

It has been estimated that if all inequalities in access to health care were eliminated, inequalities in health would remain given the more important influences on health (discussed in Theme 4 (Social determinants in Merton)) that would still remain if nothing were done to mitigate their negative impacts. As shown in that section, inequities in health are related to social and economic policies that lead generally to better health for those with higher incomes and better education.

The Marmot Review, a major report entitled ‘Fair Society, Healthy Lives’ (2010), sets out the health inequalities challenges for England, priorities for action and evidence about how these could be translated into practice at national and local levels. Marmot’s key messages are that reducing health inequalities is not just about health services but is a matter of fairness. There is a social gradient in health – the lower a person’s social position, the worse his or her health. Action needs to focus on reducing this gradient in health.

Health inequalities result from social inequalities, and action on health inequalities requires action across all the social determinants for health – education, housing, environment and employment, as well as health and social care services. However, focusing solely on the most disadvantaged will not reduce health inequalities sufficiently – support and help to live a healthier life must be open to everyone, but the scale and intensity of that help need to be in proportion to the level of disadvantage.

Action to reduce health inequalities will benefit society in many ways, including increasing economic productivity and reducing health care costs.

Health inequalities are measured by differences in life expectancy. Life expectancy is a well-recognised measure of comparative health between countries, boroughs and sub-groups within the population. It is an estimate of how long a child born today might expect to live if current age and gender specific death rates applied throughout their life. The links between deprivation and health inequalities are strong, with the most deprived areas broadly correlating to the areas with lowest life expectancy.

Merton picture

Life expectancy
Health outcomes for people in Merton are generally better than those in London and largely in line with or above the rest of England. The graph In Figure 3.1 below shows healthy life expectancy at age 65 or older in Merton compared with [other] boroughs in South West London, London and England.
However, there are stark differences between different areas within the borough. In all wards but one (West Barnes) men experience a shorter than average life expectancy than women. This is still true but there is a stark difference between some of the most deprived communities in the east of the borough compared with the communities in the west.

In Merton, overall life expectancy at birth is longer than the England average, but there is a difference between the most and least deprived areas within the borough of about nine years for men and about 13 years for women. Between 2005-09 and 2006-10 this gap has remained the same for men, but has increased by about two years for women. The increase in the gap for women is because for women life expectancy has increased at a faster rate in the most affluent areas compared with the most deprived areas of the borough.

For the period 2006-10 life expectancy for Merton men overall was 80.7 years and ranged from 76.1 in Ravensbury to 84.8 in Wimbledon Park. In women, life expectancy overall was 84.6 years and ranged from 79.5 years in Figges Marsh to 92 years in Hillside.
As a whole West Merton has an average life expectancy for men around 2.8 years longer than for men in East Merton. For women, the difference is three years as demonstrated in Figure 3.3 below.

Figure 3.3: Difference between East and West Merton for average life expectancy, by gender, 2006-10.
Over time life expectancy has increased for both men and women in Merton, but the gap between West and East Merton has remained relatively constant, and may even have widened slightly for women in recent years.

Figure 3.4: Persistence in the difference between East and West Merton for average life expectancy, by gender, from 2002-06 to 2006-10.

Slope Index of Inequality

The Slope Index of Inequality (SII) is a measure of inequalities in life expectancy used nationally. This measure gives a description of the extent of inequality within a local authority and measures the gap in years in life expectancy between the least and most deprived tenths of the population (not based on wards). Areas with wide variations in deprivation tend to have a steeper slope, and areas with a relatively uniform population (either affluent or deprived) tend to have a flatter slope, meaning the more equal the life expectancy.

Figure 3.5 below shows that those in more deprived groups live the shortest lives for both males and females.
Figures 3.6 and 3.7 below compare the SII in life expectancy within each London borough for males and for females. The measure is broadly comparable between boroughs and, in terms of inequalities for males, Merton has the sixth lowest difference (i.e. the sixth most equal in terms of life expectancy difference) in London, but for females Merton has the 15th most unequal difference in life expectancy in London (out of 32 boroughs).
Life expectancy and mortality by disease
In Merton for men circulatory disease is the biggest cause of the gap in life expectancy followed by respiratory disease, and for women cancer is the biggest cause, also followed by respiratory disease. This is shown in the chart ‘Life Expectancy Gap by Disease’ in Figure 3.8 below, which gives a breakdown of the causes of the gap. The ‘stripes’ on the chart show the proportion of the gap attributable to different diseases and although this is based on fairly old data it is still relevant.
Over the past 15 years there has been a consistent difference of three to five years between life expectancy for women and men (women living longer than men); male and female life expectancy in Merton is significantly higher than in London. Life expectancy has increased by five years for men and four years for women (from 1994-96 to 2008-10), which is the same as the average across London of five years for men and four years for women. Estimates suggest life expectancy will continue to increase.

Using ‘All-Age All-Cause’ mortality, a measure of the rate at which people are dying, allows us to estimate ‘excess’ deaths between East and West Merton. On its own however the information is limited and needs to be looked at together with other mortality rates, such as the rate at which people die from specific conditions such as heart disease and the ages people die (both of which help us understand the causes of death that could be avoided i.e. avoidable mortality) and the rates at which people die in different areas (which can help us understand inequalities in health).
In Merton, All-Age All-Cause mortality rates have been progressively improving, consistent with the growth in life expectancy experienced across England as a whole. Current rates place Merton among the healthier areas in England, with mortality rates below national and regional levels.

Premature mortality (deaths under 75 years) is very strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts. When the standardised mortalities for each ward are plotted against their IMD scores, a very strong correlation is evidenced – the $R^2=0.89$ means that 89% of the variation in ward mortality rates is ‘explained’ by variations in deprivation. This is a very strong correlation between premature mortality and deprivation.

**Figure 3.9: Ward standardised mortality ratio (SMR) for all causes of death under 75 years 2006-10 and ward deprivation score, in Merton.**

Excess mortality in East Merton
Within Merton there is a marked difference in mortality rates, with the more deprived electoral wards having a much higher mortality ratio compared with the less deprived wards. After controlling for age (SMR*) the wards of Merton were found to have all-cause mortality rates that range from 37% lower in Hillside to around 18% higher in Figges Marsh compared with England. Only Figges Marsh had a significantly higher mortality rate and 12 wards were significantly lower (based on ward data for 2006-10).
Looking at rates of death in a population (rather than life expectancy), if East Merton had the same rate of deaths as West Merton, there would be around 113 fewer deaths each year in East Merton – an 18% reduction on the 640 deaths each year among East Merton residents.

**Index of Multiple Deprivation (IMD)**

The Index of Multiple Deprivation (IMD) sets out the relative position of local areas in terms of deprivation. It does not measure absolute deprivation but deprivation in relation to other areas, capturing a particular point in time. The following discussion focuses on the seven domains that make up the IMD, while specific inequalities in health outcomes will be discussed in the sections that follow dedicated to stages across the life course. The seven underlying domains are:

- income deprivation
- health deprivation and disability
- employment deprivation
- education, skills and training deprivation
- barriers to housing and services deprivation
- living environment deprivation
- crime deprivation.

Evidence has shown that deprivation/income, education, and employment are the largest influences on health. The discussion that follows therefore focuses on these domains, while recognising that the housing, living environment and crime domains also show a similar pattern of difference between East and West Merton.
The map in Figure 3.11 below of the deprivation domain across Merton illustrates the relatively higher level of deprivation in the east of Merton with pockets in the west in Raynes Park and Wimbledon Park. The Merton divide affects all ages – the two maps that follow show that deprivation affecting older people and children mirror the overall differences between East and West Merton.

Figure 3.11: Difference between East and West Merton for deprivation.
According to the model of social determinants of health, early childhood development, education and training are the precursors for individuals being able to find employment or work that enables people to provide for themselves and their families. The indicators that make up this measure are split into subdomains: one relates to education deprivation for children and young people in the area and the other to lack of skills and qualifications among the working age adult population.

Figure 3.12 below clearly shows that residents in the west of the borough have higher levels of education outcomes and training qualifications.

Figure 3.12: Difference between East and West Merton for education, skills and training, IMD 2010.

IMD 2010: Education, Skills and Training Deprivation

The knock-on effect between good education results and training that prepares individuals for life can be seen in Figure 3.13 below, which again shows employment deprivation highest in the east of the borough.
Key commissioning implications for services to help reduce health inequalities

There are clear inequalities in terms of life expectancy for both gender and levels of deprivation between East and West Merton.

The Marmot review of health inequalities in England (2010) sets out six policy objectives to tackle inequalities in health:

- Give every child a healthy start.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.

Delivering these objectives requires national, regional and local action across government, the NHS, the voluntary and community sectors and the private sector, and effective local delivery focused on health equity across all policies. It also, most importantly, requires participation and empowerment of individuals and local communities.

Specific recommendations will be set out in the sections that follow. High-level recommendations include:

- With limited resources a much more targeted approach will be required to address the differences in health and social outcomes and to develop services that respond to our increasing ethnic diversity.
• Placing a priority on the early years offers opportunities for the largest gains in life expectancy.
• Priority on prevention will reduce future need for health and social care services. Risk factors such as smoking, obesity and risky drinking behaviour underlie increasing levels of long-term conditions, such as heart disease and cancer, especially in the more deprived groups. Efforts need to be spread proportionally by need across all social groups.
• Partnerships with the voluntary, community and business sectors will enable a broader outreach by embedding health as part of all frontline work.
• An improved understanding of the social determinants of health and of the role local government plays in creating health will lead to more effective use of local government levers, including early childhood development, education and training, and licensing and planning.
• Improvements in early detection and management of long-term conditions provide opportunities for the quickest gains in life expectancy. Along with improved access to services, this will improve residents’ quality of life and reduce the need for more expensive acute services.
• Improvements to ensure more robust data is captured on the population accessing services and better use of this data, through health equity audits, for example, would support understanding service need and design.
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THEME 4:
SOCIAL DETERMINANTS IN MERTON
Summary

The influences on health – social determinants of health – are the conditions in which people are born, grow, live, work and age. These conditions combine to create health and ill health and are dependent on the quality of education, employment and economic wellbeing, the built environment and a nurturing environment in childhood, for example.

Education in Children and young people

Education offers opportunities for significant improvements in life expectancy and inequalities. Education is linked to the ability to earn higher incomes, which in turn enables people to adopt healthier lifestyles such as never or quitting smoking. Education has a direct effect on health outcomes; it also has an indirect impact on other social outcomes.: 36

- **Crime**: People with no qualifications are more likely to be persistent offenders. Men are especially less likely to commit a crime the more educated they are. 48

- **Poverty and income**: According to a study undertaken to examine the relationship between education and income in England and Wales, each additional year of education leads to approximately a 10% increase in income. 37 (See Figure 4.2 below.)

- **Unemployment**: The less education a person has, the more likely he or she is to be unemployed. Someone excluded from school is many times more likely to be unemployed than a graduate is. The less education a person has, the more likely he or she is to be unemployed.

There is high overall adult educational attainment in the borough. However, there are two areas that fall within the 20% most deprived for education. These areas also fall in the overall most deprived areas, reflecting an inequality in educational attainment.

In Merton schools in 2012: 38

- There were 23,735 full-time equivalent pupils in maintained schools in Merton.
- 89.5% of children aged 4 and 53.7% of children aged 11 attended Merton schools.
- 16.5% (3,500 pupils) of children were eligible for free school meals.
- 18.4% (4,599 pupils) had SEN, which includes 2.9% with a statement of SEN.
- 40.3% (10,026 pupils) spoke a first language other than English.
- 121 different languages were spoken in Merton schools.
- 62.2% (15,473 pupils) were from BME groups.
- 16.6% (4,126 pupils) lived outside Merton.
- 19.9% (4,951 pupils) were living in the bottom 30% IMD area.

Of Merton’s primary schools 84% were rated good or outstanding and of Merton’s secondary schools 71% were rated good or outstanding by Ofsted. The gap between those eligible for free school meals and their peers was the same as London and significantly narrower than England at secondary school level, but at primary level the gap in attainment was wider than both London and England. Overall both pupils with a statement of SEN and those with SEN but without a statement performed better than the England average. Overall pupils from mixed and Asian ethnic backgrounds performed better than white and black ethnic groups in

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Merton. Pupils from Chinese ethnic background performed the best, although the population is small in Merton. In Merton schools absence rates improved across primary schools and were below both London and England rates. Targeting pupils at risk of becoming persistent absentees improved persistent absentee rates, which were lower than London and England rates. At secondary school level overall absence and persistent absence remained higher than London and England rates.

Non-participation of young people in education, employment or training between the ages of 16 and 19 is a major predictor of later unemployment, low income, depression, involvement in crime, and poor mental health. In 2012, Merton’s NEET (16-18 year olds) figure was 4.64% compared with 4.50% for London and 13% for England. Merton’s NEET figure shows a downward trend with a reduction from 5.6% in 2009. Merton ranked 14th in London boroughs where 1 is the highest percentage and 32 the lowest. Of the NEET cohort 55% were young men; 22% were aged 18; and 67% were white. Significant totals for ‘vulnerable groups’ include those with learning difficulties and disabilities, and those who were teenage mothers, who represent 5.7% and 11% of the total NEET group respectively. The highest concentrations of the NEET cohort were in the east of the borough.

**Key commissioning implications for access to education**

- Overall educational outcomes in Merton are improving rapidly, however there is a need to continue to reduce the gap in attainment, including a focus on reducing the gap between pupils eligible for free school meals and their peers in primary schools; and reducing rates of school absence at secondary school level.
- There is a need to fully understand the implications for all services on the implementation of the Children and Families Bill, including school nursing, therapy services, school staff, Special Educational Needs and Disabilities Inclusion services and Children’s Social Care.
- The increase in school numbers has implications for School Nursing Services. More preventative work and school nursing ‘casework’ with children and young people ‘out of school’ for health reasons is needed.
- Pupils’ health and wellbeing have an impact on their educational performance. Effective preventative work in schools and wider communities needs to be done to mitigate [poor] health and lifestyle choices becoming a barrier to learning and attainment. The Healthy Schools London programme is an opportunity for schools to address this.

**Adult education**

Adult education services in Merton are provided mainly by South Thames College and Merton Adult Education Service (MAES), a division within Merton Council’s Community and Housing Department.

MAES operates out of three main centres and a number of venues such as libraries, children’s centres and other community locations across the borough. MAES delivers courses annually to over 5,000 learners. Programmes are delivered under three distinct contracts: Adult Skills Budget (ASB); Community Learning; and 16-18 Funding. Programmes are assessed against the Ofsted inspection framework, with self-assessments performed on a regular basis. The 2011 Ofsted inspection report graded MAES as good.

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MAES has identified the following gaps:

- **Unfulfilled need for services**
  - English for speakers of other languages (ESOL) courses; MAES is unable to meet the current demand for these courses.

- **Areas for improvement**
  - Progression and destination capture.
  - A need for a community learning strategy document.
  - Areas of provision that fell below minimum performance levels.

The Ofsted report\(^{55}\) highlighted the following needs:

- Further develop recent strategies to improve retention, and so success rates, particularly for accredited provision.
- Improve the quality and use of individual learning plans by ensuring that targets give students meaningful goals that teachers use to plan effective lessons.
- Ensure that the service has more effective and comprehensive measures in place to gather and respond to users' views across the provision.

**Key commissioning recommendations (MAES)**

- Respond to Ofsted recommendations.
- Develop closer links/commissioning related to health and prevention, identifying opportunities to embed health issues in existing courses.
- Expand ESOL classes to meet unmet demand.

**Employment and economic wellbeing**

Deprivation and income are important influences on health. Levels of disposable income affect our ability to meet basic needs – the way we live, the quality of the home and work environment, and the ability of mothers to provide the kind of care they want for their children. The relationship between health and low income exists across almost all health indicators.\(^{40}\) If full employment were achieved in Britain, 2% of lives would be saved per year and 17% of deaths in areas with higher than national average mortality would be avoided.

In Great Britain, 70.9% of the population aged 16-64 years were in employment (April 2012-March 2013), and 7.81% of those who were defined as economically active were unemployed. In London the level of employment was lower, at 69.5%, with 8.9% of the economically active unemployed. Employment levels were slightly higher in Merton than the London and national levels. In Merton, 72.6% of the population aged 16-64 years were in employment, with 7.1% of the economically active unemployed. There has been an increase in unemployment since 2008. In Merton, 3,455 people were claiming Jobseeker’s Allowance (as of August 2013), representing 3.3% of the resident population aged 16-64 years. As of September 2013, the percentage of claimants has been lower than the London (3.4%) and lower[higher?] than England (3.1%) levels, and levels have been falling since March 2013. The proportion of working age population claiming the key out-of-work benefits peaked at 8.2% in August 2009, fell back to 7.5% in November 2010 and was 9.5% in February 2013; an increase of +1.7% when compared with February 2012. These levels are much lower than the levels for London (13.2%) and Great Britain (14.3%).

In London, excluding the City of London, the median gross weekly pay for all full-time workers varied from £789.80 in Kensington and Chelsea to £544.00 in Brent. The median

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gross weekly pay in Merton was 14th highest of the London boroughs (based on 32 boroughs, with the City of London excluded due to the small number of residents) at £535.50. In general men work in higher paid jobs than women, even when considering full-time work.

**Gaps and commissioning recommendations**

Those in employment enjoy better levels of health than the unemployed. Unemployed people are significantly more likely than employed people to have poorer mental and physical health including depression, anxiety and physical health problems. Helping local people to be productive in either paid or unpaid work to support their transfer towards future employment will have a beneficial effect on demand for health services in the future.

Policies and programmes that increase levels of employment will be of significant health benefit to individuals and the local community. For young families, access to affordable day care and family friendly employment can also make a critical difference to being able to work. Meaningful employment for young people, such as apprenticeships, is particularly important to reduce the risk of depression and other mental health problems.

With the introduction of increased university fees and the possible increase in young people looking for work and training rather than further education, the development of employment schemes for young people is a particular priority.

The health impact of the recession is unknown. Possible early indicators include prescribing rates for antidepressants, A&E attendances (linked to late presentation), increase in obesity in adults and children (linked to poor diet) and claimant count. The London Health Observatory (now part of PHE) is working on developing measures to reduce the impact of the recession on health. Work needs to be done in partnership to try to mitigate the impact of the recession on health and wellbeing.

**Built Environment**

The IMD measures levels of deprivation using a range of indicators under different areas or ‘domains’. The domain for ‘Deprivation and the Physical Environment’ is split into two subdomains: the ‘indoors’ physical environment, which measures the quality of housing, and the ‘outdoors’ physical environment, which contains two measures relating to air quality and road traffic accidents.

There are 44 areas that fall within the 20% most deprived for the physical environment in Merton. In terms of reduction in Killed or Seriously Injured (KSI) casualties, Merton has made significant progress in reducing the number of KSI casualties, which is below 5% of all boroughs. A reduction of 58% was achieved between the 1994-1998 five-year average and 2009 (compared with an average reduction across all boroughs of 52%). Fatalities fell by 16% (159 to 134), KSI casualties increased by 8% in 2012 to 3,018 compared with 2011. Within this, the number of serious injuries increased by 9% (2,646 to 2,884). Slight injuries fell by 3% (26,452 to 25,762) and overall casualties in 2012 fell by 2%, compared with 2011.

Air quality is an important public health issue in London. Poor air quality contributes to shortening the life expectancy of all Londoners, disproportionately impacting on the most vulnerable. Air quality in London is the worst in the country. Poor air quality exacerbates heart and lung conditions such as asthma, and chronic obstructive pulmonary disease. Local authorities have a statutory duty to manage local air quality and are required to carry out regular reviews and assessments of air quality. The main issue with our local air quality has
been found to be emissions (relating to NO\textsubscript{2} and PM\textsubscript{10}) emanating from road vehicles. Based on the non-automatic monitoring and assessments undertaken, it was found that some of the air quality objectives would be exceeded in areas where there was relevant exposure. As a consequence the Council designated the whole of the borough as an Air Quality Management Area (AQMA) for annual mean objective and 24-hour mean PM\textsubscript{10} objective.

The Council currently maintains one NO\textsubscript{2} automatic monitoring station located on the first floor of Morden Civic Centre, which therefore falls into the category of a roadside location. Sampling is taken 4m from ground level, at a distance of 3m from the kerbside. There is no automatic particulate monitoring.

Local recommendations
- Embed HIA into existing assessment processes in the local authority.
- Expand access to green space.
- Prioritise policies and interventions that both reduce health inequalities and mitigate climate change, by improving:
  - active travel across the social gradient
  - the quality of open and green spaces across the social gradient
  - the quality of food in local areas across the social gradient
  - the energy efficiency of housing across the social gradient.
- Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
- Support locally developed and evidence-based community regeneration programmes that use spatial planning to remove barriers to community participation and action and reduce social isolation.
- Use the Healthy Places resource, an online tool put together by a team from the National Heart Forum. This tool highlights how local authorities can use existing laws 'that have the potential to change local environments and encourage more active lifestyles and better diets'.

Housing

The number of households in Merton is projected to increase to 89,000 by 2016 (8%) and 99,000 (15%) by 2021, an average annual household growth of 2.2%. This is ranked the fourth highest household growth in England\textsuperscript{41} with much of the increase expected to be of single person households. Single person households at the time of Census 2011 made up 28% of all households, but will increase by 7,800 by 2016, making up 42% of all households. Lone parent households are also set to increase by 9%. The projected percentage increases in households between 2013 and 2021\textsuperscript{42} are: Merton: 19.2 %; London: 12.4%; England: 7.8%.

Of the 78,757 households in Merton at the time of Census 2011, 60.1% (47,360) were owner-occupied (either owned outright or with a mortgage or loan, or in shared ownership) 14.1% (11,102) were social housing tenants and 24.8% (19,503) were renting privately.

Merton’s social housing stock is amongst the lowest in London at 14% of total stock. The London average is around 22% with social housing stock as high as over 59% in large boroughs such as Southwark. The profile of stock differs between owner-occupied and social housing in Merton, with 58% of social housing and 63% of private rented homes being flats compared with only 24% in the owner-occupied sector. Social housing and private rented homes also typically contain fewer rooms than those that are owner-occupied.

There is a high level of housing need amongst Merton residents. Merton’s Housing Needs Survey, 2005 identified a need to develop an additional 1,848 affordable homes per annum between 2005 and 2010 if all housing needs in the borough were to be met. The 2010 Merton Strategic Housing Market Assessment (SHMA) 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 eastern part of the borough.

With projected increases in people aged over 65 years (estimated 11% increase between 2011 and 2017), one of the key concerns is the increase in older people living alone. This has implications for health and social care since 57% of the ‘fuel poor’ are aged 60 and over; poorly insulated homes and the continual rise in heating bills contribute to fuel poverty.

Although the number of homeless households in Merton is amongst the lowest in London, homelessness is on the increase, with homelessness applications rising from 188 in 2010-11 to 279 in 2011-12 and the number of households accepted as statutory homeless increasing from 89 in 2010-11 to 101 in 2011-12.

There are around 30 residents living on one permanent caravan site in Merton and there are also many gypsies and travellers living in ‘bricks and mortar’ housing in Merton; 139 people from the gypsies and travellers community took part in a research event organised by Merton Council in October 2011, and the latest Census 2011 shows that 217 people in Merton have identified themselves as gypsies and travellers. However, organisations working with this community believe that the figure is actually higher.

**Key commissioning recommendations**

The challenge for the borough is to be able to forecast future housing needs, to inform potential providers of what is required, and to feed into and underpin the borough’s housing strategies. In particular, people with learning disabilities surviving into older age will potentially have a significant increased need for accommodation to support them to remain as independent as possible.

With increasing age will come:

- Increasingly complex social and health needs requiring more sophisticated solutions for supported living, including a greater need for sheltered and extra care accommodation for people with learning disabilities as well as older people who have dementia or other disabilities, as population projections show these client groups to be on the increase.

- More people with learning disabilities are outliving their parents and family carers which will lead to an increase in the need for supported living as well as a potential increase in the need for tenure-based housing.

It is essential that local authorities and health services work together to provide accessible and appropriate services for these groups and to tackle health inequalities amongst homeless households and ethnic minority groups.

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43 SHLAA [(2013)].
As councils become increasingly responsible for leading on health improvement within their local populations, planning experts will need to work closer with public health regarding regeneration and spatial planning to help deliver shared goals.

Health impact assessments are a useful tool for assessing the impact of local regeneration programmes and should be considered locally. A prospective health impact assessment can provide a useful opportunity to identify positive health impacts and opportunities and mitigate potential negative impacts for local regeneration programmes.

Local regeneration programmes should support a ‘people, places and markets’ regeneration framework (published by the DCLG). This approach to regeneration encompassing physical regeneration, social or community regeneration, and economic development may influence health through broader determinants.

**Crime**

*Due to the timescales involved for the JSNA and the Community Safety Partnership Strategic Assessment that is currently under development by LBM's Safer Merton Partnership, the two documents at present cannot reflect one another completely. As the JSNA is a living document, the information from the Strategic Assessment will be utilised to update this section in due course, once it becomes available.*

**Key facts on crime in Merton**

The English Indices of Deprivation provide a relative measure of deprivation at small area level across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation, including crime, and an overall composite measure of multiple deprivation. The purpose of the crime domain is to measure the rate of recorded crime for four major crime types – violence, burglary, theft and criminal damage – representing the risk of personal and material victimisation at a small area level. Data suggests that the areas to the south and east of the borough contain higher proportions of people who are experiencing these major crime types.

ONS data for 2012-13 shows that there was a decrease in robbery, burglary and sexual offences but an increase in violent crime. In Merton, the rate for recorded crime attributable to alcohol was better than Croydon and Wandsworth, higher than Sutton, Kingston and Richmond, about the same as England and well below the London rate, with a declining trend since 2009-10. Merton had the fifth lowest rate in London for alcohol-related recorded crime and below the regional average, but was ranked 230th out of 326 local authorities in England (where 1 is best and 326 is the worst).

In Merton, domestic violence victimisation rates as reported to the police for 2011 for women were 8.6 per 1,000 adult women (18+) and for men, 1.9 per 1,000 adult men (18+):

- 749 offences flagged as domestic were recorded in Merton borough in 2011, representing just over 5% of total crime. More incidents took place where the police were called but which did not result in criminal offences.
- 80% of domestic offence victims were female. 60% were white European; 20% African Caribbean; 13% Asian; and 3% dark European. 35% were aged in their twenties; 26% in their thirties; and 20% in their forties.
- 87% of victims were Merton residents.

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44 This data has been taken from the 2012-13 JSNA and therefore is a little out of date. An updated analysis on domestic violence will be undertaken through the Community Safety Partnership Strategic Assessment, which is not yet complete, but is anticipated will be available in March 2014.
• 81% of offenders suspected of a domestic offence last year were male. 51% were white European; 25% African Caribbean; 12% Asian; and 3% dark European. 31% of suspected offenders were in their twenties; 30% in their thirties; and 21% in their forties.

Gaps and commissioning recommendations
To tackle some of the root causes and to find solutions require close partnership working. There is also an opportunity given the links between teenage pregnancy, offending behaviour, truancy, and the focus on alcohol and drug misuse, to look more holistically and take a whole system approach to tackling crime.

However, commissioners must also focus on primary preventative measures for both children and adults to ensure that the focus isn't only on where things have gone wrong but also on the things that can be prevented from going wrong. Partnership working structures need to reflect this approach.

In the context of understanding the impact of alcohol on individuals, families and local communities, particularly in regard to domestic violence, more in-depth work at a local level is needed. Working collaboratively, local Drugs and Alcohol and Community Safety Partnerships are well placed to undertake this work. In addition, the differential between reported crime and perceptions of crime needs to be reviewed.
Introduction

The World Health Organization (WHO) defines health as:

‘A state of complete physical, mental, and social well-being and not merely the absence of disease, or infirmity.’\(^{45}\)

Health is a cumulative state that involves the capacity, perceived or actual, of individuals to thrive in their social and physical environment and to function and cope with specific illnesses and life in general.\(^{46}\)

Health is therefore influenced by a wide range of factors. Dahlgren and Whitehead’s model (see Figure 4.1)\(^{47}\) proposes that genetic predisposition interacts with environmental influences and individual lifestyle behaviours to produce health or ill health, which is then mediated by health care services to restore health where required.

Figure 4.1: Influences on health.

![Figure 4.1: Influences on health.](image)

Source: Dahlgren and Whitehead 1991

Worldwide evidence has shown that living standards and levels of education have the greatest influence on health. While current work in the NHS focuses on curative healthcare – fixing people once they become unwell – the local authority delivers services that influence health promotion and prevent people from getting ill in the first place. Working in partnership thus increases our chances of reducing inequalities in health. In addition, both Merton CCG


and LBM provide services to the same populations that would be more effective if coordinated.

The influences on health – social determinants of health – are the conditions in which people are born, grow, live, work and age. These conditions combine to create health and ill health and are dependent on the quality of education, employment and economic wellbeing, the built environment, housing and a nurturing environment in childhood, for example. They are shaped by policy decisions, which are mostly responsible for inequities in health – the unfair and avoidable differences in health status seen within and between groups of people. The negative influences associated with poverty are two-fold:

- People living in poverty are more likely to be exposed to conditions that are adverse to their health (crowded or slum living conditions, unsafe neighbourhoods).
- People living in poor circumstances are more likely to be negatively affected by these adverse conditions.

The rest of this section focuses on the following determinants of health and wellbeing:

Education
- Employment and economic wellbeing
- Built environment
- Housing
- Crime
Early Child Development and Education

Education offers opportunities for significant improvements in life expectancy and inequalities. Education is linked to the ability to earn higher incomes, which in turn enables people to adopt healthier lifestyles such as never or quitting smoking. A 2008 study by the Institute of Education sets out examples of the link between education and other health and social outcomes:

- ‘For every 100,000 women enrolled in adult learning in the UK an estimated 116-134 cancers could be prevented because of greater take-up of cervical smear tests.’
- ‘Success or failure at school is strongly related to propensity to commit crime or engage in anti-social behaviour’ and ‘a 16 percentage point rise in those educated to degree level could save this country more than £1 billion annually in reduced crime costs.’
- ‘…when poor achievement is coupled with poor engagement (measured by truancy from school) the risk of ill health in adulthood multiplies by 4.5.’

Education has a direct effect on health outcomes; it also has an indirect impact on other social outcomes:

- **Crime**: People with no qualifications are more likely to be persistent offenders. Men are especially less likely to commit a crime the more educated they are.
- **Poverty and income**: According to a study undertaken to examine the relationship between education and income in England and Wales, each additional year of education leads to approximately a 10% increase in income. (See Figure 4.2 below.)
- **Unemployment**: The less education a person has, the more likely he or she is to be unemployed. Someone excluded from school is many times more likely to be unemployed than a graduate is.

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Figure 4.2: Relationship between education and income in England and Wales, 1993-2001.

Education results in Merton

This section covers:

- Early child development
- Completed education
- Current education achievement
- Adult education

The indicators that make up the education domain in the IMD include adult education. It is split into subdomains: one relates to education deprivation for children and young people in the area and the other to lack of skills and qualifications among the working age adult population.
Figure 4.3: Addressing inequalities in Merton – Indices of Multiple Deprivation: Education. The English Indices of Deprivation provide a relative measure of deprivation at small area level across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation, including education, and an overall composite measure of multiple deprivation. The map suggests that the areas to the south and east of the borough contain higher proportions of people who are experiencing deprivation in terms of education.

Lower Super Output Areas (SOAs) by National Rank Quintiles

Source: http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10
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There is high overall adult educational attainment in the borough. However, there are two areas that fall within the 20% most deprived for education. These areas also fall in the overall most deprived areas, reflecting an inequality in educational attainment.

**Completed Education in Merton**

In Great Britain 34.4% of people aged 16-64 were qualified at NVQ4 (degree level equivalent or above) and 9.7% had no formal qualification. This compared with 47.6% of people in London educated at NVQ4 and 8.4% with no qualifications. In Merton, 76.9% of people aged 16-64 years were qualified at NVQ2 (five GCSE equivalent at grades A-C). (London NVQ2 level 75.1%).

As of Census 2011, of the total population of the borough aged 16 and over, 15.2% have no educational or skills qualification, while 31% have Levels 1-3 qualifications, and a further 41% have a qualification of Level 4 and above. Figure 4.4 below shows that, between 2007 and 2011, the level of qualifications of Merton residents decreased.
Figure 4.4: Change in level of qualifications of Merton residents, 2007 to 2011.

Figure 4.5 below shows the differences in final qualifications between the east and west of the borough, demonstrating a clear divide between the better educated west and the less educated east.

Figure 4.5: Distribution of qualifications gained in the borough of Merton.
Key facts on access to education

For information on Early Years Education see Theme 6, under *Child Health and Early Years*.

Educational attainment is such an important factor in employment opportunity, material prosperity and health. It is a key national performance target. However, some pupils start with a disadvantage due to their family circumstances. Attainment in the Key Stages of education (Key Stage 2 – 11 year olds and Key Stage 4 – GCSEs) is strongly associated with eligibility for free school meals. Schools with high free school meals eligibility have generally lower scores. Initial work looking at attainment for pre-school children has identified that where there are lower levels of attainment by children in the early years there seems to be a lower level of attainment at Key Stage 2.

Educational attainment at secondary school level is measured as the percentage of pupils with five or more GCSE (Key Stage 4) passes at grades A*-C (including English and maths). The evidence shows that school level educational attainment is strongly associated with deprivation (i.e. fewer pupils eligible for free school meals achieve A*-C grades).

In Merton schools in 2012:
- There were 23,735 full-time equivalent pupils in maintained schools in Merton.
- 89.5% of children aged 4 and 53.7% of children aged 11 attended Merton schools.
- 16.5% (3,500 pupils) of children were eligible for free school meals.
- 18.4% (4,599 pupils) had a SEN, which includes 2.9% with a statement of SEN.
- 40.3% (10,026 pupils) spoke a first language other than English.
- 121 different languages were spoken in Merton schools.
- 62.2% (15,473 pupils) were from black and minority ethnic groups.
- 16.6% (4,126 pupils) lived outside Merton.
- 19.9% (4,951 pupils) were living in the bottom 30% IMD area.

Key Stage 2

Key Stage 2 is completed for most pupils between Years 3 and 6 of the primary phase. National curriculum standards have been designed so that most pupils will progress by approximately one level every two years. Pupils are expected to achieve level 4 by the end of Key Stage 2 and to make two levels of progress between Key Stage 1 and Key Stage 2.

Merton’s performance is in line with national performance for the level 4 and above attainment indicators. The percentile rankings for value added ranks Merton 10, therefore Merton primary pupils have made more progress than pupils in 90% of other local authorities nationally. For English value added ranks Merton 9 and for maths gives a rank of 14.

Ofsted rates 84% of Merton’s primary schools as good or outstanding.

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51 Merton School Census (2012).
Figure 4.6: Percentage of pupils achieving level 4 or above in English and maths in Key Stage 2, 2006-12.

Key Stage 4
Key Stage 4, known as GCSE (General Certificate of Secondary Education), is the main qualification studied for by pupils in Years 10 and 11. GCSEs are studied in a wide range of academic and 'applied' (work related) subjects. For attaining five or more GCSEs A*-C, Merton has made a 36% improvement over seven years.

For five or more GCSEs A*-C, including English and maths, Merton has achieved a 19.6% improvement, from 39.5% in 2005-06 to 59.1% in 2011-12, which is in line with the England average (59%). Local data indicates this trend of improvement will continue in 2012-13 and that Merton is above the national average.

Percentile rankings for value added ranks Merton 14; therefore Merton secondary pupils have made more progress than pupils in 86% of other local authorities nationally. For English value added ranks Merton 18 and for maths gives a rank of 5. Expected progress in English and maths from Key Stage 2 to Key Stage 4 is significantly above the national averages. Expected progress in maths is 10% above national progress.

Ofsted rates 71% of Merton's secondary schools as good or outstanding.
Key facts on variation in educational attainment

**Free school meals**: For pupils in Merton eligible for free school meals, the key attainment measures, five or more A*-C grade, including English and maths, GCSEs, and the capped average point score, are significantly above that of the national groups. Expected progress for this cohort in English and maths is also significantly above national performance.
The gap between those eligible for free school meals and their peers is the same as London and significantly narrower than England at secondary school level, but at primary level the gap in attainment is wider than both London and England.

Figure 4.9: Attainment gap between Y6 pupils eligible for free school meals and their peers at Key Stage 2 (10/11 years of age).

Figure 4.10: Attainment gap between Y11 pupils eligible for free school meals and their peers at Key Stage 4 (15/16 years of age), 2010-12.
**Figure 4.11**: Key Stage 2 achievement gap between pupils eligible for free school meals and their peers, 2010-12.

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Source: DfE Statistical First Release SFR33/2012 - National Curriculum Assessments at Key Stage 2 in England 2011/2012 13 December 2012

**Figure 4.12**: Key Stage 4 achievement gap between pupils eligible for free school meals and their peers, 2010-12.

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Source: DfE Statistical First Release SFR03/2012 - GCSE and Equivalent Attainment by Pupil characteristics in England, 2010-2011 09 February 2012

Notes: 2011-2012 KS4 final data released 24 January 2013
Comparisons with previous years should be made with care because of the significant changes in definition.

**Special educational needs**: Overall in Merton both pupils with a statement of SEN and those with SEN but without a statement perform better than the England average.
Figure 4.13: Attainment of pupils with SEN at Key Stage 4, 2010-11.

Figure 4.14: Attainment gap between pupils with SEN and their peers, Key Stage 2, 2012.

Figure 4.15: Attainment gap between pupils with SEN and their peers, Key Stage 4, 2012.
Table 4.1: Achievement gap between pupils with SEN and their peers, Key Stage 2, 2010-12.

| National Indicator 104: Achievement gap between pupils with special educational needs (SEN) and their peers |
|---|---|---|---|
| | 2010 | 2011 | 2012 |
| Percentage of pupils achieving Level 4+ at KS2 including English and mathematics | Attainment gap | Percentage of pupils achieving Level 4+ at KS2 including English and mathematics | Attainment gap | Percentage of pupils achieving Level 4+ at KS2 including English and mathematics | Attainment gap |
| All pupils with SEN | Pupils with no identified SEN | All Pupils | All pupils with SEN | Pupils with no identified SEN | All Pupils | All pupils with SEN | Pupils with no identified SEN | All Pupils |
| Merton | 38 | 89 | 77 | 51 | 36 | 89 | 77 | 53 | 40 | 91 | 79 | 51 |
| London | 42 | 90 | 76 | 48 | 43 | 89 | 77 | 46 | 51 | 93 | 82 | 42 |
| England | 33 | 88 | 74 | 55 | 36 | 88 | 75 | 52 | 43 | 92 | 80 | 49 |

Source: DfE Statistical First Release SFR33/2012 - National Curriculum Assessments at Key Stage 2 in England 2011/2012 13 December 2012

Table 4.2: Achievement gap between pupils with SEN and their peers, Key Stage 4, 2010-12.

| National Indicator 105: Achievement gap between pupils with special educational needs (SEN) and their peers |
|---|---|---|---|
| | 2010 | 2011 | 2012 |
| Percentage of pupils achieving 5 or more A*-C GCSE's including English and mathematics | Attainment gap | Percentage of pupils achieving 5 or more A*-C GCSE's including English and mathematics | Attainment gap | Percentage of pupils achieving 5 or more A*-C GCSE's including English and mathematics | Attainment gap |
| All pupils with SEN | Pupils with no identified SEN | All Pupils | All pupils with SEN | Pupils with no identified SEN | All Pupils | All pupils with SEN | Pupils with no identified SEN | All Pupils |
| Merton | 17 | 63 | 52 | 46 | 27 | 70 | 60 | 43 | 27 | 70 | 59 | 43 |
| London | 27 | 71 | 58 | 44 | 29 | 74 | 62 | 45 | 31 | 74 | 62 | 42 |
| England | 21 | 67 | 55 | 46 | 22 | 70 | 58 | 48 | 23 | 70 | 59 | 47 |

Source: DfE Statistical First Release SFR03/2012 - GCSE and Equivalent Attainment by Pupil characteristics in England, 2010-2011 09 February 2012

Notes: 2011-2012 KS4 final data released 24 January 2013

Comparisons with previous years should be made with care because of the significant changes in definition.

Ethnicity: Overall in Merton pupils from mixed and Asian ethnic backgrounds perform better than white and black ethnic groups. Pupils from Chinese ethnic background perform the best, although the population is small in Merton.
School absences:
In Merton, school absence rates have improved across primary schools and are now below both London and England rates. Targeting pupils at risk of becoming persistent absentees has improved persistent absentee rates, making them lower than London and England rates. At secondary school level overall absence and persistent absence remains higher than London and England rates.

Figure 4.17a. School absence in Merton primary schools 2011-12.
School exclusions:
The data for the academic year September 2012-13 is as follows (provisional):
- An increase in the number of fixed term exclusions in primary schools from 86 (2011-12) to 122.
- The use of fixed-term exclusions in secondary schools continues to reduce.
- Merton maintained zero permanent exclusions from primary schools.
- At secondary school there was a small increase of permanent exclusions in 2012-13 from 12 to 13 pupils.
- Permanent exclusions were predominantly male pupils.
- There was an increase in the number of permanent exclusions for physical assaults on adults (+4), but a decline in the number of permanent exclusions for incidents involving a knife or bladed weapon.
- 77% of permanently excluded pupils in 2012-13 were from BME backgrounds.

16-18 year olds not in education, employment or training (NEET):
Non-participation of young people in education, employment or training between the ages of 16 and 19 is a major predictor of later unemployment, low income, depression, involvement in crime, and poor mental health. This was recognised in the Marmot Review ‘Fair Society, Healthy Lives’, which proposed an indicator to measure young people not in education, employment or training in order to capture skill development during the school years and the control that school leavers have over their lives. This indicator is therefore a wider measure than just youth unemployment as it also includes young people who are not being prepared for work.

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In 2012, Merton’s NEET (16-18 year olds) figure was 4.64% compared with 4.50% for London and 13% for England. Merton’s NEET figure (see Figure 4.18 below) shows a downward trend with a reduction from 5.6% in 2009. Merton ranked 14th in London boroughs where 1 is the highest percentage and 32 the lowest.

Figure 4.18: 16-18 year olds Not in Education, Employment or Training (NEET), 2012.

Latest local data shows Merton’s NEET figure at July 2013 was 5%.

55% of the NEET cohort were young men; 22% were aged 18; and 67% were white. Significant totals for ‘vulnerable groups’ include those with learning difficulties and disabilities, and those who were teenage mothers, representing 5.7% and 11% of the total NEET group respectively.

The highest concentrations of the NEET cohort were in the east of the borough with the highest being in the wards of Cricket Green (8.8%) and St Helier (6.1%) and the lowest being in Village (0.6%) and Wimbledon Park (1.4%).

Key commissioning implications for access to education

- Overall educational outcomes in Merton are improving rapidly, however there is a need to continue to reduce the gap in attainment, including a focus on reducing the gap between pupils eligible for free school meals and their peers in primary schools; and reducing rates of school absence at secondary school level.
• There is a need to fully understand the implications for all services on the implementation of the Children and Families Bill, including school nursing, therapy services, school staff, Special Educational Needs and Disabilities Inclusion services and Children’s Social Care.

• The increase in school numbers has implications for School Nursing Services. More preventative work and school nursing ‘casework’ with children and young people ‘out of school’ for health reasons is needed.

• Pupils’ health and wellbeing have an impact on their educational performance. Effective preventative work in schools and wider communities needs to be done to mitigate health and lifestyle choices becoming a barrier to learning and attainment. The Healthy Schools London Programme is an opportunity for schools to address this.
Adult Education

Adult education can improve health and wellbeing, skills and employability, and increase community cohesion and civic partnership.\textsuperscript{53}

Key facts on adult education services in Merton

Adult education services in Merton are provided mainly by South Thames College and Merton Adult Education Service (MAES), a division within Merton Council’s Community and Housing Department.

South Thames College

South Thames College provides Adult and Higher Education Services in Merton. Adult education courses are available in.\textsuperscript{54}

Vocational and professional training, including:
- MBAs
- Accountancy qualifications
- Plumbing
- Access to nursing courses.

Leisure courses, including classes in:
- Business
- Languages
- Fitness
- Cookery.

English and maths courses, including:
- English for Speakers of Other Languages (ESOL)
- GCSE English and maths
- English for International Students
- Basic English and maths.

Higher education courses; including:
- Art, Craft and Graphic Design
- Business and Administration
- Childcare, Health, Care and Science
- Computing and IT
- Engineering
- Games Design and Development
- Hair, Beauty and Complementary Therapy

\textsuperscript{54} http://www.south-thames.ac.uk/
• Hospitality and Catering
• Music and Performing Arts
• Sport
• Teaching and Training
• Travel and Tourism.

**Merton Adult Education Service (MAES)**
MAES operates out of three main centres and a number of venues such as libraries, children’s centres and other community locations across the borough. MAES delivers courses annually to over 5,000 learners. Programmes are delivered under three distinct contracts:

- **Adult Skills Budget (ASB):** Qualification programmes based on a formula related to the number of learning hours generated. First Steps courses are short non-qualification courses designed to support progression into further education.

- **Community Learning:** Non-qualification courses, including Personal Community Development Learning, Family Learning, Family English and Maths, and Neighbourhood Learning for Deprived Communities.

- **16-18 Funding:** Qualification programmes for 16-18 year olds. The service offers a broad range of programmes across 10 subject areas, available six days a week and over four evenings. Around four fifths of provision is non-accredited adult safeguarded learning. MAES receives around three quarters of its funding from the Skills Funding Agency (SFA), the remainder deriving from course fees and project funding.

The objective of MAES is to increase the skills, knowledge and educational attainment of adults through the provision of a range of accredited and non-accredited courses. The course offering is developed in response to both government priorities and emerging local needs.

Programmes are assessed against the Ofsted inspection framework, with self-assessments performed on a regular basis. The 2011 Ofsted inspection report graded MAES as good.

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Key statistics for MAES (SAR 2011-2012):57

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total enrolments</td>
<td>6,915</td>
<td></td>
</tr>
<tr>
<td>Total learners</td>
<td>3,533</td>
<td></td>
</tr>
<tr>
<td>16-18 learners</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Accredited learners (ASB)</td>
<td>1,185</td>
<td></td>
</tr>
<tr>
<td>Non accredited learners (CL)</td>
<td>2,766</td>
<td></td>
</tr>
<tr>
<td>Income generated learners</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Total new learners</td>
<td>1,121</td>
<td></td>
</tr>
<tr>
<td>New accredited learners</td>
<td>374</td>
<td></td>
</tr>
<tr>
<td>New non-accredited learners</td>
<td>912</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>753</td>
<td>21%</td>
</tr>
<tr>
<td>Female</td>
<td>2,780</td>
<td>79%</td>
</tr>
<tr>
<td>Non-white</td>
<td>1,166</td>
<td>33%</td>
</tr>
<tr>
<td>White</td>
<td>2,326</td>
<td>66%</td>
</tr>
<tr>
<td>Under 25</td>
<td>244</td>
<td>7%</td>
</tr>
<tr>
<td>25-59</td>
<td>2,734</td>
<td>77%</td>
</tr>
<tr>
<td>60+</td>
<td>555</td>
<td>16%</td>
</tr>
<tr>
<td>Total staff</td>
<td>154</td>
<td>(121 tutors)</td>
</tr>
</tbody>
</table>

Student profile by programme

ASB qualification student profile
- 36% of learners live in a disadvantaged ward
- 70% of learners are non-white
- 21% of learners are Eastern European
- 63% of learners are looking for work.

Community Learning (Non-qualification) student profile
- 27% of learners live in a disadvantaged ward
- 45% of learners are non-white
- 14% of learners are Eastern European.

What are the gaps?

MAES has identified the following gaps:

- Unfulfilled need for services
  - ESOL courses; MAES is unable to meet the current demand for these courses.

57 MAE Self-Assessment Report (SAR), 2011-12.
• **Areas for Improvement**
  o Progression and destination capture
  o A need for a community learning strategy document
  o Areas of provision that fell below minimum performance levels:
    ▪ RHS – what is this?
    ▪ Mind and Body
    ▪ Skills for Life.

The Ofsted report highlighted the following needs:
• Further develop recent strategies to improve retention, and so success rates, particularly for accredited provision.
• Improve the quality and use of individual learning plans by ensuring that targets give students meaningful goals that teachers use to plan effective lessons.
• Ensure that the service has more effective and comprehensive measures in place to gather and respond to users’ views across the provision.

**Key commissioning recommendations (MAES)**

• Respond to Ofsted recommendations.
• Develop closer links/commissioning related to health and prevention, identifying opportunities to embed health issues in existing courses.
• Expand ESOL classes to meet unmet demand.

**Other sources**

Employment and Economic Wellbeing

Deprivation and income are important influences on health. Levels of disposable income affect our ability to meet basic needs – the way we live, the quality of the home and work environment, and the ability of mothers to provide the kind of care they want for their children. The relationship between health and low income exists across almost all health indicators. The outcomes associated with low family socioeconomic status include poor maternal nutrition, infant mortality, low birth weight, childhood injuries, child mortality, dental caries in children, malnutrition in children, infectious disease in children and adults, health care services use, chronic diseases in adulthood and excess mortality. The risk associated with poverty is two-fold:

- People living in poverty are more likely to be exposed to conditions that are adverse for development (e.g. crowded or slum living conditions, unsafe neighbourhoods, etc.).
- People living in poverty are also more likely to be negatively affected by these adverse conditions.

From the late 1960s, Professor Sir Michael Marmot studied the effect of income on health in the Whitehall Studies I and II. He found a strong inverse relationship between position in the civil service hierarchy and death rates. Those in the lowest grade had a death rate three times that of those in the highest grade. The explanation could not be poverty or unemployment as all people in the study were employed. This led to further research that established that it is not absolute poverty but relative poverty that has a strong influence on health (see Figure 4.19 below).59,60

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If full employment were achieved in Britain, 2% of lives would be saved per year and 17% of deaths in areas with higher than national average mortality would be avoided (see Table 4.3 below).  

Table 4.3: Lives saved with full employment – Population aged 16-64.

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>%</th>
<th>Women</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives saved</td>
<td>2,090</td>
<td>3</td>
<td>414</td>
<td>1</td>
<td>2,504</td>
<td>2</td>
</tr>
<tr>
<td>Lives saved in areas of excess mortality</td>
<td>1,432</td>
<td>21</td>
<td>270</td>
<td>8</td>
<td>1,702</td>
<td>17</td>
</tr>
</tbody>
</table>

Research shows that labour force participation is important for reasons that go well beyond earning money; employment matters for social inclusion, physical health, and psychological wellbeing. Losing a job undermines mental health, as it represents not just a loss of income, but also a loss of identity, status, structure and social support.

**Key facts on employment and economic wellbeing in Merton**

In Great Britain, 70.9% of the population aged 16-64 years were in employment (April 2012-March 2013), and 7.81% of those who were defined as economically active were

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61 Mitchell, R. et al. (2000). *Inequalities in life and death. What if Britain were more equal?* Joseph Rowntree Foundation.
unemployed. In London, the level of employment was lower, at 69.5%, with 8.9% of the economically active unemployed. Employment levels were slightly higher in Merton than the London and national levels.

In Merton, 72.6% of the population aged 16-64 years were in employment, with 7.1% of the economically active unemployed. There has been an increase in unemployment since 2008. This trend is visible in Figure 4.20 below.

**Figure 4.20: Overall employment rate April 2008 to June 2013: Merton, London, England.**

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**Occupations and qualifications**

The occupations of those who are employed are broken down into four major categories: managers and professionals; administrative, secretarial and skilled trades; personal service, sales and customer service; and machine workers and elementary occupations.

The distribution of occupations in Merton was close to the London distribution (professional and managerial: 54.4% Merton, 55.4% London; administrative and trades: 17.8% Merton, 18% London; service and sales: 14.1% Merton, 14% London; machine workers and elementary: 12.7% Merton, 13.4% London).
Income and pay

Gross weekly pay is a measure of the kind of work that people who live in Merton undertake, and is related to the deprivation of the borough overall. In general, wealthier areas attract residents who have higher paid jobs. In London, excluding the City of London, the median gross weekly pay for all full-time workers varied from £789.80 in Kensington and Chelsea to £544.00 in Brent. The median gross weekly pay in Merton was 14th highest of the London boroughs (based on 32 boroughs, with the City of London excluded due to the small number of residents) at £535.50.

In general men were working in higher paid jobs than women, even when considering full-time work. The range in median gross weekly pay for men varied from £854.90 (Kensington and Chelsea) to £550.70 (Newham). Median gross weekly pay for men in Merton was
£547.20 (11th highest in London). For men, 79.9% in Merton were in employment, higher than in London overall at 76.5% and Great Britain (76.1%).

Median gross weekly pay for women varied from £678.70 (Richmond) to £501.60 (Barking and Dagenham). For women particularly, the median gross weekly pay will be affected by the extent to which those women in less deprived circumstances, who might be expected to work in better paid jobs, are economically active, rather than at home. Median gross weekly pay for women in Merton was £518.30 (15th highest in London). In Merton, 68.4% of women aged 16-64 years were in employment, higher than in London overall (62.3%) but lower than in Great Britain (65.8%).

**Unemployment**

Jobseeker’s Allowance (JSA) is paid to those who are out of work, capable of, available for and actively seeking work during the week in which the claim is made. The maximum weekly allowance for single people is £56.80 for those under 25 years of age and £71.70 for those aged 25 and over, up to pensionable age. The amount paid may be less depending on any income and savings.

In Merton, 3,455 people claimed Jobseeker’s Allowance (as of August 2013), 3.3% of the resident population aged 16-64 years.

As of September 2013, the percentage of claimants has been lower than the London (3.4%) and lower than England (3.1%) levels, and levels have been falling since March 2013. (see Figure 4.24 below).
Figure 4.23: Unemployment in Merton: Benefit claimants and jobseeker's allowance claimants, 2013.

Figure 4.24: Jobseeker's Allowance (JSA) claimant's percentage of population by quarter; March 2008 to September 2013: Merton, London, England.
In Merton, the highest percentage of JSA claimants as a proportion of the resident population of the same age, were those aged 18-24 years. For this age group, 4.4% claimed JSA compared with 5.1% for London and 5.8% in England.

The percentage of claimants as a proportion of the older age groups was slightly lower; 2.3% (aged 25-49 years) and 2.1% of those aged 50-64 years were claiming JSA. In London, 3.3% aged 25-49 years and 3% aged 50-64 years were JSA claimants. For England, the levels were 3.3% aged 25-49 years and 2.0% aged 50-64 years.

The distribution of unemployment across the borough may be seen from analysis of JSA claimants at ward level. There are higher percentages of claimants in Cricket Green (4.8%), Pollards Hill (4.7%), and Figges Marsh (4.1%), with low percentages in Village (0.5%), Dundonald (0.9%) and Hillside (0.9%).

Table 4.4: Employment and unemployment, Merton (July 2012 to June 2013).

<table>
<thead>
<tr>
<th>Employment and unemployment Merton (July 2012 to June 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All People</td>
</tr>
<tr>
<td>Economically active</td>
</tr>
<tr>
<td>In employment</td>
</tr>
<tr>
<td>Employees</td>
</tr>
<tr>
<td>Self Employed</td>
</tr>
<tr>
<td>Unemployed (model based)</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Economically active</td>
</tr>
<tr>
<td>In employment</td>
</tr>
<tr>
<td>Employees</td>
</tr>
<tr>
<td>Self Employed</td>
</tr>
<tr>
<td>Unemployed (model based)</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Economically active</td>
</tr>
<tr>
<td>In employment</td>
</tr>
<tr>
<td>Employees</td>
</tr>
<tr>
<td>Self Employed</td>
</tr>
<tr>
<td>Unemployed (model based)</td>
</tr>
</tbody>
</table>

Benefits

Other benefits are available to working-age people from the Department for Work and Pensions, although the Government has signalled its intention to rationalise the range of different types of benefit available to any one person or household. The key current benefits available in January 2013 were: bereavement benefit, carer’s allowance, disability living allowance, employment and support allowance (ESA) and incapacity benefit, severe disablement allowance, income support, and jobseeker’s allowance. The proportion of the
population aged 16-64 years who claimed the wider range of benefits was much higher than those who claimed JSA alone.

In Merton, the proportion of working age population claiming the key out-of-work benefits peaked at 8.2% in August 2009, fell back to 7.5% in November 2010 and was 9.5% in February 2013; an increase of +1.7% when compared with February 2012. These levels are much lower than the levels for London (13.2%) and Great Britain (14.3%).

Figure 4.25: Proportion of working age people on out-of-work benefits, April 2009 to February 2013: Merton, London, England.

The big increases in unemployment nationally in 2008 and 2009 associated with the recession stabilised in 2010-11 and there are signs that unemployment is going down with the exception of those aged 24 or below.

In addition, people who are without work and on low incomes will experience a greater impact from the level of inflation (consumer price index) which was 2.7% in August 2013 compared with 2.2% in September 2012.

Both food and heating costs have increased, with the cost of home energy doubling since 2004, with the average annual household bill standing at £1,132 in July 2011. The increased cost of living increases stress and poorer mental and physical health of people who are without work.
16-18 year olds not in education, employment or training (NEET)

Non-participation of young people in education, employment or training between the ages of 16 and 19 is a major predictor of later unemployment, low income, depression, involvement in crime, and poor mental health. This was recognised in the Marmot Review ‘Fair Society, Healthy Lives’, which proposed an indicator to measure young people not in education, employment or training in order to capture skill development during the school years and the control that school leavers have over their lives. This indicator is therefore a wider measure than just youth unemployment as it also includes young people who are not being prepared for work.

Figure 4.26 16-18 year olds not in education, employment or training by London borough, 2012.

In 2012, Merton’s NEET (16-18 year olds) figure was 4.64% compared with 4.50% for London and 6.13% for England. Merton’s NEET figure shows a downward trend with a reduction from 5.6% in 2009. Merton ranked 14th in London boroughs where 1 is the highest percentage and 32 the lowest.

Latest local data shows Merton’s NEET figure at July 2013 was 5%.

Of the NEET cohort 55% were young men; 22% were aged 18; and 67% were white. Significant totals for ‘vulnerable groups’ include those with learning difficulties and disabilities, and those who were teenage mothers, who represented 5.7% and 11% of the total NEET group respectively.

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62 Department for Education/Child and Maternal Health Observatory (PHE).
63 London Health Programmes and Department for Education, 2013.
The highest concentrations of the NEET cohort were in the east of the borough with the highest being in the wards of Cricket Green (8.8%) and St Helier (6.1%) and the lowest being in Village (0.6%) and Wimbledon Park (1.4%).

Key policy issues

Impact of welfare reform
The Welfare Reform Act 2012 is one of the largest policy changes to be introduced by the Government. The Act has been designed to deliver a £18 billion saving from the welfare budget as announced in the budget and spending review of 2010. There are likely to be significant economic implications of the Act for:

- Individuals and families, which include:
  - Looked-after young people and care leavers
  - Foster carers
  - Adults with physical or learning disabilities or mental health difficulties
  - Larger families and those with dependent children
  - Older people.
- The local economy:
  - If households have less income, there will be an impact on the local economy.

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. A reduction in benefits may result in higher incidences of homelessness, higher levels of fuel poverty, as well as limiting the ability to make healthy lifestyle choices.

The mitigation of the adverse impact of welfare reform depends on the creation of employment opportunities and their take-up by the population of Merton.

Gaps and commissioning recommendations

Improving employment chances
Those in employment enjoy better levels of health than the unemployed. Unemployed people are significantly more likely than employed people to have poorer mental and physical health including depression, anxiety and physical health problems. Helping local people to be productive in either paid or unpaid work to support their transfer towards future employment will have a beneficial effect on demand for health services in the future.

Policies and programmes that increase levels of employment will be of significant health benefit to individuals and the local community. For young families, access to affordable day care and family friendly employment can also make a critical difference to being able to work. Meaningful employment for young people, such as apprenticeships, is particularly important to reduce the risk of depression and other mental health problems.
With the introduction of increased university fees and the possible increase in young people looking for work and training rather than further education, the development of employment schemes for young people is a particular priority.

The health impact of the recession is unknown. Possible early indicators include prescribing rates for antidepressants, A&E attendances (linked to late presentation), increase in obesity in adults and children (linked to poor diet) and claimant count. The London Health Observatory is working on developing measures of the impact of the recession on health. Work needs to be developed in partnership to try to mitigate the impact of the recession on health and wellbeing.

**Further sources**
*Labour market, employment and qualifications are for 2012 and 2013. Source: www.nomisweb.co.uk
**All figures for Job Seeker’s Allowance claimants are for February 2013. Source: www.nomisweb.co.uk
***Figures are based on the above and London Health Programmes Health Needs Assessment (HNA) Toolkit.
Built Environment

Key facts on deprivation and the physical environment

The IMD measures levels of deprivation using a range of indicators under different areas or ‘domains’. The domain for ‘Deprivation and the Physical Environment’ is split into two subdomains: the ‘indoors’ physical environment, which measures the quality of housing, and the ‘outdoors’ physical environment, which contains two measures relating to air quality and road traffic accidents.

There are 44 areas that fall within the 20% most deprived for the physical environment in Merton.

Figure 4.27: Addressing inequalities in Merton – IMD: Physical Environment.
Key facts on transport

Risk of death and serious injury on the roads
The Mayor's Transport Strategy (MTS) sets out his transport vision for London and details how Transport for London and partners will deliver the plan over the next 20 years (2010-2030) – road traffic casualty reduction is of the highest priority.

From Police STATS19 forms information (recorded when the police attend a collision) the main causal factors in road traffic accidents are attributed to human error. These are issues of failing to look properly, reckless or in a hurry, and poor manoeuvring of vehicle. In certain incidents street lighting and weather conditions were also contributory factors. Mention is made in the Mayor's Plan of Haddon's Matrix, which is a system advising how, when and where to act in reducing casualties.

Factors listed of pre-crash, crash and post-crash interventions show that Merton already provides the human and environment recommendations of education, training, campaigns and enforcement as detailed below.

Of significant concern is the average cost per reported road accident casualty and per reported road accident: GB 2011 (see Table 4.5 below).

Table 4.5: Cost per casualty and per road accident (GB 2011).

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost per casualty</th>
<th>Cost per accident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatal</td>
<td>£1,686,532</td>
<td>£1,877,583</td>
</tr>
<tr>
<td>Serious</td>
<td>£189,519</td>
<td>£216,203</td>
</tr>
<tr>
<td>Slight</td>
<td>£14,611</td>
<td>£23,136</td>
</tr>
</tbody>
</table>

Source: Department for Transport. A valuation of road accidents and casualties in Great Britain in 2011

The Mayor’s new target is a 40% reduction in Killed or Seriously Injured (KSI) casualties, from a baseline figure of 65 (2005-09 year average).

The reduction in road traffic KSIs from the new Mayoral baseline of 65 casualties to 45 should be achievable, based on Merton’s previous actions on delivering casualty reduction targets, including:

- Reduction of road traffic casualties is a priority for the Council (e.g. Merton’s Community Plan).
- Merton’s LIP2 includes a proposed MP1 specifically to address reducing road traffic casualties.
- The Mayor’s Safe Streets for London Action Plan provides an improved methodology for tackling casualty reduction.
Merton has made significant progress in reducing the number of KSIs and further progress is expected.

A reduction of 58% was achieved between the 1994-98 five-year average and 2009 (compared with an average reduction across all boroughs of 52%).

Fatalities fell by 16% (159 to 134), KSI casualties increased by 8% in 2012 to 3,018) compared with 2011. Within this, the number of serious injuries increased by 9% (2,646 to 2,884). Slight injuries fell by 3% (26,452 to 25,762) and overall casualties in 2012 fell by 2%, compared with 2011.

In 2012, overall casualty figures rose in nearly all sectors but most significantly for pedal cyclists, car drivers (and passengers) and bus/coach drivers (and passengers). Cyclist statistics rose by 31% over the previous year with no fatalities but 50% more KSIs recorded. Most collisions occurred at “T” or staggered junctions, which make the proposed work to these junctions appropriate.

Other areas of concern were at give way or uncontrolled junctions and also incidences of skidding. This could be addressed with a mixture of education and maintenance measures. The majority of car driver (and passenger) casualties occurred at T- and staggered and give-way/uncontrolled junctions and most collisions involved drivers aged 25-59 years old.

**Table 4.6: Merton performance indicators and targets: road traffic accidents.**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Data source</th>
<th>Base year</th>
<th>Base year value</th>
<th>Trajectory data</th>
<th>Long term target year</th>
<th>Long term target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PI 4:</strong> Reduction in total number of people killed or seriously injured in road traffic accidents in Merton</td>
<td>Number</td>
<td>LRSU</td>
<td>Av of 2007-2009</td>
<td>65</td>
<td>(65)</td>
<td>45</td>
<td>2020</td>
</tr>
<tr>
<td><strong>PI 5:</strong> Reduction in total road traffic casualties (KSIs &amp; slights)</td>
<td>Number</td>
<td>LRSU</td>
<td>Av of 2007-2009</td>
<td>512</td>
<td>(536)</td>
<td>458</td>
<td>2020</td>
</tr>
</tbody>
</table>

**What works and current services in the public realm and active travel**

Promoting and enabling sustainable ‘active’ travel modes, such as walking, cycling and using public transport, enable people to integrate increased physical activity levels into their
everyday lives. Against a backdrop of gradually falling car trips in outer London, the impact of the economic recession and population growth provides the optimum opportunity to encourage reduction in private car trips and increase in more sustainable modes particularly walking and cycling. The long-term target has therefore been retained until a clearer picture becomes available.

Over the past three years, much of Merton’s delivery programme has been directed towards tackling access issues across a range of modes. The majority of schemes contained significant pedestrian improvements to support this target. Schemes were typically located in areas with higher footfalls and defined walking problems where the greatest benefit could be achieved, busy movement corridors and those locations where notable barriers to movement were apparent.

Table 4.7: Merton transport performance indicators and targets.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Data source</th>
<th>Base year</th>
<th>Base year value</th>
<th>Trajectory data 2012-13 (or 2012) (actual)</th>
<th>Long-term target year 2016-17 (or 2016)</th>
<th>Long-term target</th>
</tr>
</thead>
<tbody>
<tr>
<td>PI 1: Increase in the mode share for walking in LBM</td>
<td>%</td>
<td>LTDS</td>
<td>Av of 2006/7-2008/9</td>
<td>33.3</td>
<td>33.5</td>
<td>33.9</td>
<td>2025-26</td>
</tr>
<tr>
<td>PI 2: Increase in the mode share for cycling in LBM</td>
<td>%</td>
<td>LTDS</td>
<td>Av of 2006/7-2008/9</td>
<td>1.3</td>
<td>2.2</td>
<td>3.1</td>
<td>2025-26</td>
</tr>
<tr>
<td>PI 3: Maintain mean Bus Excess Waiting Time</td>
<td>Minutes</td>
<td>iBUS</td>
<td>2009-10</td>
<td>1.1</td>
<td>1.0</td>
<td>0.94</td>
<td>2019-20</td>
</tr>
<tr>
<td>PI 6: Reduction in CO2 emissions in LBM</td>
<td>('000) kilo-tonnes</td>
<td>GLA</td>
<td>2008</td>
<td>164</td>
<td>138</td>
<td>123</td>
<td>2025</td>
</tr>
</tbody>
</table>

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Examples include Destination Wimbledon, Merton High Street, South Wimbledon Business Park and Lower Downs Road Railway Tunnel. Other interventions, such as new crossing points or dropped kerbs, were targeted towards more localisation, but nevertheless were important areas where movement problems had been identified.

The Smiles programme also developed walks for health. Supporting these scheme-based interventions, the Council has delivered 20km of improved footways through its maintenance programme and delivered an extensive programme of educational and road safety courses focused towards ensuring that people have the right skills needed to walk safely.

**Key facts on air quality**

Air quality is an important public health issue in London. Poor air quality contributes to shortening the life expectancy of all Londoners, disproportionately impacting on the most vulnerable.

Air quality in London is the worst in the country. Poor air quality exacerbates heart and lung conditions such as asthma, and chronic obstructive pulmonary disease. It is thought that the effects of air pollution contribute to many thousands of premature deaths of people who have serious illnesses. PM$_{10}$ (particulate matter) and PM$_{2.5}$ can penetrate deep into the lungs and even pass in the bloodstream and cause oxidative stress. Therefore minimising emissions of key pollutants and reducing concentration are essential for good health. The UK average mortality attributable to long-term exposure to PM$_{2.5}$ is 5.6%.$^{65}$

The GLA estimated that in 2008 there were 4,267 deaths attributable to long-term exposure to small particles. The new Public Health Outcomes Framework includes an indicator for air quality which local authorities will be expected to show progress on.$^{27}$

**National air quality standards**

The Government’s Air Quality Strategy sets air quality standards for a range of pollutants and for PM$_{10}$ and NO$_2$:

<table>
<thead>
<tr>
<th>Pollutant</th>
<th>Annual mean not exceeding (µg/m$^3$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrogen Dioxide</td>
<td>Annual mean not exceeding 40 µg/m$^3$</td>
</tr>
<tr>
<td>Nitrogen Dioxide</td>
<td>200 µg/m$^3$ not to be exceeded more than 18 times a year when measured as an hourly mean value</td>
</tr>
<tr>
<td>PM$_{10}$ Particulate</td>
<td>Annual mean less than 40 µg/m$^3$</td>
</tr>
<tr>
<td>PM$_{10}$ Particulate</td>
<td>50 µg/m$^3$ not to be exceeded more than 35 times a year when measured as a daily mean value</td>
</tr>
</tbody>
</table>

---

$^{65}$ GLA (2013).
Standards for air pollution are concentrations over a given time period that are considered to be acceptable in the light of what is known about the effects of each pollutant on health and on the environment. They can also be used as a benchmark to see if air pollution is getting better or worse.

**Air quality focus areas**

In 2011, the GLA identified four Air Quality Focus Areas within LBM, outlined in the image in Figure 4.28 below (represented by yellow area with description in yellow box). These areas are not necessarily situated at the same locations as the monitoring equipment (represented by an orange arrow), the location of which was chosen for a number of reasons including ease of access.

Air quality focus areas have been selected by the GLA as areas where there is the most potential for improvements in air quality within the Capital. These areas have been selected through an analysis of the following factors:

- Baseline air quality for NO\textsubscript{2} and PM\textsubscript{10} by 20m grid resolution
- Locations where air pollution limit values have been exceeded
- Level of human exposure
- Local geography and topography
- Local sources of air pollution
- Traffic patterns
- Future predicted air quality trends.

**Figure 4.28: LBM focus areas and air quality monitors, London Atmospheric Emissions Inventory.**
Table 4.9: NOx emissions from transport sources in LBM ID area.

<table>
<thead>
<tr>
<th>ID</th>
<th>Area Description</th>
<th>% of road transport NOx emissions from each mode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Taxi</td>
</tr>
<tr>
<td>165</td>
<td>Raynes Park junctions Kingston Road/Bushey Road</td>
<td>1</td>
</tr>
<tr>
<td>166</td>
<td>Wimbledon The Broadway/Merton</td>
<td>1</td>
</tr>
<tr>
<td>167</td>
<td>Road/Morden Road/Kingston Road</td>
<td>1</td>
</tr>
<tr>
<td>168</td>
<td>Morden Morden Road/London Road/Morden Hall Road/Martin Way</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mitcham London Road A216 from Cricket Grn to Streatham Road Jnct</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: http://data.london.gov.uk/laei-2008

Figure 4.29: Annual mean concentrations of PM$_{10}$ in LBM 2011.
Figure 4.30: Annual mean concentrations of NO\textsubscript{2} in LBM 2011.
Table 4.6: Fraction of mortality attributable to long-term exposure to PM$_{2.5}$ by London borough.

The statistics for each of the London boroughs are included in Table 3 below. LB Merton is 16% higher than the UK average and is ranked 12$^{th}$ best in London.

**Table 3 – Fraction (%) of mortality attributable to long term exposure to PM2.5**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Fraction (%) of mortality attributable to long term exposure to PM2.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bromley</td>
<td>6.3</td>
</tr>
<tr>
<td>Havering</td>
<td>6.3</td>
</tr>
<tr>
<td>Harrow</td>
<td>6.4</td>
</tr>
<tr>
<td>Sutton</td>
<td>6.4</td>
</tr>
<tr>
<td>Croydon</td>
<td>6.5</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>6.5</td>
</tr>
<tr>
<td>Bexley</td>
<td>6.6</td>
</tr>
<tr>
<td>Enfield</td>
<td>6.6</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>6.7</td>
</tr>
<tr>
<td>Barnet</td>
<td>6.8</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td>6.8</td>
</tr>
<tr>
<td>Merton</td>
<td>6.9</td>
</tr>
<tr>
<td>Redbridge</td>
<td>7</td>
</tr>
<tr>
<td>Barking &amp; Dagenham</td>
<td>7.1</td>
</tr>
<tr>
<td>Haringey</td>
<td>7.1</td>
</tr>
<tr>
<td>Hounslow</td>
<td>7.1</td>
</tr>
<tr>
<td>Brent</td>
<td>7.2</td>
</tr>
<tr>
<td>Ealing</td>
<td>7.2</td>
</tr>
<tr>
<td>Greenwich</td>
<td>7.2</td>
</tr>
<tr>
<td>Lewisham</td>
<td>7.2</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>7.3</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>7.3</td>
</tr>
<tr>
<td>Newham</td>
<td>7.6</td>
</tr>
<tr>
<td>Camden</td>
<td>7.7</td>
</tr>
<tr>
<td>Lambeth</td>
<td>7.7</td>
</tr>
<tr>
<td>Hackney</td>
<td>7.8</td>
</tr>
<tr>
<td>Hammersmith and Fulham</td>
<td>7.9</td>
</tr>
<tr>
<td>Islington</td>
<td>7.9</td>
</tr>
<tr>
<td>Southwark</td>
<td>7.9</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>8.1</td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>8.3</td>
</tr>
<tr>
<td>Westminster</td>
<td>8.3</td>
</tr>
<tr>
<td>City of London</td>
<td>9</td>
</tr>
</tbody>
</table>
Figure 4.31: Benefits of air quality improvement.

There are a wide range of potential benefits of measures to improve air quality, not only for the improvement of health and the reduction of health inequalities, but also for the economy, environment, climate change adaptation and mitigation. A selection are listed below.

**Biodiversity**

Long term exposure to pollutants can restrict the growth of plants and trees so improving air quality reduces costs to local authorities in replacing urban greenery as well as benefitting the environment.

**Economic benefits**

Improving air quality reduces the costs to local authorities of building maintenance and cleaning. As outlined in section 6.3 the cost to the economy of the health impacts of poor air quality are significant.

**Climate Change**

Ozone, which is caused by pollutants such as NOx and volatile organic compounds (VOCs) reacting in sunlight are powerful greenhouse gases which contribute to global warming directly. Also black carbon (which is part of the particulate emissions from diesel engines) contributes to climate change.

Source: GLA 2013, Air Quality in Merton A Guide for Public Health Professionals
Local air quality management
The Council declared the borough an Air Quality Management Area (AQMA) in 2003 as the review and assessment process showed that air quality in the borough was not likely to meet the National Air Quality Strategy objectives by the target dates.

Local measures
Local authorities have a statutory duty to manage local air quality and are required to carry out regular reviews and assessments of air quality.

The main issue with our local air quality has been found to be emissions (relating to NO$_2$ and PM$_{10}$) emanating from road vehicles. Based on the non-automatic monitoring and assessments undertaken it was found that some of the air quality objectives would be exceeded in areas where there was relevant exposure. As a consequence, the Council designated the whole of the borough as an AQMA for annual mean objective and 24-hour mean PM$_{10}$ objective.

The Council currently maintains one NO$_2$ automatic monitoring station located on the first floor of Morden Civic Centre, which therefore falls into the category of a roadside location. Sampling is taken 4m from ground level, at a distance of 3m from the kerbside. There is no automatic particulate monitoring.

Air quality is also monitored at two automatic monitoring sites in the borough but there was insufficient data to report for 2011.

Pollution data is recorded on the London Air Quality Network (LAQN) website (http://www.londonair.org.uk). Results for the Civic Centre site to date (October 2011) show that recorded levels remain within the Government’s Air Quality Strategy objectives.

Predominately, passive diffusion tubes monitor air quality in Merton. The diffusion tube network demonstrates that there are exceedances of the annual objective at the majority of sites. In two separate locations (Colliers Wood High Street (HA) and Plough Lane (PA), the diffusion tube data has read as being over 60μg/m3, indicating that there could be exceedances of the hourly objective.

Spatial planning and health

What is spatial planning?

Spatial planning is a process of place shaping and delivery. It aims to:

- produce a vision for the future of places that respond to the local challenges and opportunities, and is based on evidence, a sense of local distinctiveness and community-derived objectives, within the overall framework of national policy and regional strategies
• translate this vision into a set of priorities, programmes, policies, and land allocations together with the public sector resources to deliver them

• create a framework for private investment and regeneration that promotes economic, environmental and social wellbeing for the area

• coordinate and deliver the public sector components of this vision with other agencies and processes [e.g. Local Area Agreements (LAAs)]

• create a positive framework for action on climate change

• contribute to the achievement of sustainable development.

Good use of spatial planning offers opportunities to change the environment in which people make choices about their health, making it easier to choose the healthy option. The Marmot review of health inequalities in 2010 identified a convergence in policies aimed at improving health and wellbeing with those designed to advance sustainability and address climate change. For example, a well-designed public realm with high-quality green open space will encourage physical exercise, improve mental health, and increase biodiversity. The case for delivering improvements to health and wellbeing through spatial planning policy should therefore be seen as part of the wider case for delivering sustainable communities.

One study showed that in areas in England with more green spaces the gradient in deaths from circulatory disease by income deprivation is reduced. This suggests that the amount and the distribution of green space have great potential to reduce health inequalities.

Links between spatial planning and health date from rapid urbanisation in the 19th century, which created health and social problems that led to the passage of legislation promoting sanitary and healthy living conditions. As the burden of ill health moved from communicable diseases to chronic diseases associated with unhealthy lifestyles in the 20th century, attention moved away from the built environment to individual behaviours. However there is now strong evidence that the built environment continues to shape health outcomes. This explains in part why the Coalition Government moved public health professionals back to local authorities. High-quality healthy environment is unlikely to emerge spontaneously and integrated decision making across a range of service areas is more likely to deliver real outcomes. With local public health, now in local government, opportunities are available to join up actions to address some of the behavioural, social and environmental factors linked with health.

As part of the remit of spatial planning, policy measures, as different as they may be on housing, transport, economy, industry and commerce, built and natural environment, waste, pollution, water and energy, must now take health into account.
What works for spatial planning?

Planning decisions made adopting a spatial planning approach have a greater capacity not only to overtly change environments, but also to create new environments which encourage people to lead healthier lives.

Evidence of effective interventions
- Evidence is good for integrated appraisal in one statutory process including health, social and environmental considerations, with involvement through the whole plan, policy or project process, so that health objectives are integrated into the thinking from the outset.
- There is strong evidence that spatial planning for open space that is safe and easy to get to increases the amount that people exercise and that it improves mental health.
- The NHS’s London Healthy Urban Development Unit (HUDU) planning development tool provides one effective approach. Integrating health into spatial planning is cost-effective. It needs to happen through consultation with communities. There are potentially very large gains to be obtained from effective integration of health and planning for whole-town infrastructure for walking and cycling and the retrofit of home zones that will often far outweigh the cost of incorporating health considerations early in the planning process.
- Spatial planning linked into the Joint Strategic Needs Assessment process will secure the long-term wellbeing of communities. JSNAs to produce more location-specific profiles should enable a more targeted approach to planning interventions. This will help to improve local health and wellbeing in relation to issues such as access to quality primary care services, and also issues such as access to fresh food, reducing obesity, and health links to deprivation, air and noise pollution.
- The largest opportunity to make a difference in improving the health and well-being of people and communities lies at local and neighbourhood (and ward) levels. The development management process offers opportunities for both the JSNA as health evidence and local NHS organisations to be influential in the outcome of decisions. Examples of opportunities include in the master planning process, pre-application discussions, consultation on planning applications, and playing a role in delivery and implementation.

Local recommendations
- Embed HIA into existing assessment processes in the local authority.
- Expand access to green space.
- Prioritise policies and interventions that both reduce health inequalities and mitigate climate change, by improving:
  - active travel across the social gradient
  - the quality of open and green spaces across the social gradient
  - the quality of food in local areas across the social gradient
  - the energy efficiency of housing across the social gradient.
- Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
- Support locally developed and evidence-based community regeneration programmes that use spatial planning to remove barriers to community participation and action and reduce social isolation.
- Use the Healthy Places resource, an online tool put together by a team from the National Heart Forum. This tool highlights how local authorities can use existing laws ‘that have the potential to change local environments and encourage more active lifestyles and better diets’.
- Review health outcomes through local planning documents (as set out in Figure 4.32 below) to identify existing local examples and gaps for improving health outcomes through local planning.

Figure 4.32: Supporting health outcomes through local planning documents.

<table>
<thead>
<tr>
<th>Potential Applications</th>
<th>JSNA core dataset contribution</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Core Strategy DPD**  | - Overall vision, strategic objectives for the area, a delivery strategy for achieving these objectives with locations for strategic development indicated on a key diagram, and arrangements for managing and monitoring delivery. | Demography, Socio-environmental services | Brent (2010) 
Waikfield (2009) |
| **Development Control DPD** | - Topic based policies and criteria against which planning applications for the development and use of land and buildings will be considered. | Socio-environmental context, burdens of ill-health, access to health services, behaviour | South Cambridgeshire (2007) 
Brent (Preferred Option) 
Richmond (Pro-submission) |
| **Area Action Plan DPD** | - Planning framework for areas/ neighbourhoods where significant change with a focus on implementation. | Demography, local area, socio-environmental context, employment, burdens of ill-health, access to health services, behaviour, user perspectives | Central Wakefield (2009) |
| **Supplementary Planning Documents** | - Local planning authorities and other bodies to provide greater detail on the policies in development plan documents. | Demography, living arrangements, economic, transport, burdens of ill-health, behaviour | Salford (2008) 
GoTony (2009) 
Milton Keynes (2005) 
Sedlocks (2009) 
Wealltham forest (2009) 
Salford (2007) |
| **Statements of Community Involvement** | - Identify and explain the process and methods for community and delivery stakeholder involvement through the different stages of plan preparation, including in pre-application and planning obligations. | Demography, user perspectives | North Somerset (2007) |

Housing

Influence on health

Housing quality is an important determinant of health and a marker for poverty. The condition of housing stock is a major influence on the borough’s capacity to reduce inequality.

Figure 4.33: Wider determinants of health: Housing.

Wider Determinants of Health – Housing

<table>
<thead>
<tr>
<th></th>
<th>Heart disease</th>
<th>Respiratory disease</th>
<th>Obesity</th>
<th>Mental Health</th>
<th>Increased mortality, morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess winter deaths</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Physical activity</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Excess heat</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Air pollution</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Safe community</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Traffic accidents</td>
<td></td>
<td></td>
<td>++</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noise Pollution</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Flooding</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Access to food</td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>

Evidence of planning and health relationship

++ Strong evidence  + Anecdotal evidence

Source: Kings Fund, The health impacts of spatial planning decisions
Where people live and the quality of their home have a substantial impact on health; a warm, dry and secure home is associated with better health. In addition to basic housing requirements, other factors that help to improve wellbeing and the ability to live independently include the neighbourhood, security of tenure and modifications for those with disabilities.

Factors that create risks to health include the presence of lead, asbestos, radon, house dust mites, cockroaches and other infestations, extreme low or high temperatures and inadequate ventilation, inferior air quality, dampness/mould, cramped conditions and multiple family occupancy, among others. Health outcomes that may result from these conditions include asthma and TB. Overcrowding and homelessness not only impact on physical health but also on mental health. It is estimated by the Building Research Establishment (BRE) that poor housing costs the NHS in England at least £600 million per year. Figure 4.33 above sets out the relationship between housing and health.

**Key facts on housing in Merton**

The map in Figure 4.34 below identifies the proportion of the population experiencing barriers to housing and key local services in an area. The indicators fall into two subdomains: ‘geographical barriers’ and ‘wider barriers’, which include issues relating to access to housing such as affordability. There are two areas that fall within the 20% most deprived for barriers to housing and services. IMD measures are relative, in relation to other areas in England. The domain is also not specifically housing alone.

**Figure 4.34 : IMD: Barriers to housing and services.**

Lower Super Output Areas (SOAs) by National Rank Quintiles


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Merton’s population in 2013 is projected to be 202,750, and projected to increase by 2021 to 205,730, an increase of 1.5% on the 2013 SHLAA figure.

The number of households in Merton is projected to increase to 89,000 by 2016 (8%) and 99,000 (15%) by 2021 an average annual household growth of 2.2%. This is ranked the fourth highest household growth in England with much of the increase expected to be of single person households. Single person households at the time of Census 2011 made up 28% of all households, but will increase by 7,800 by 2016, making up 42% of all households. Lone parent households are also set to increase by 9%.

Figure 4.35: Number of households, annual average percentage change, England 2011-2021.

Source: National Statistics, Dept. for Communities and Local Government Household Interim Projections 2011 to 2021

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GLA (2012). SHLAA ward projection creator.
HSSA (2011).
Projected percentage increase in households between 2013 and 2021\textsuperscript{69}

- Merton: 19.2%
- London: 12.4%
- England: 7.8%.

Of the 78,757 households in Merton at the time of Census 2011, 60.1% (47,360) were owner-occupied (either owned outright or with a mortgage or loan, or in shared ownership), 14.1% (11,102) were social housing tenants and 24.8% (19,503) were renting privately.

Merton’s social housing stock is amongst the lowest in London at 14% of total stock. The London average is around 22% with social housing stock as high as over 59% in large boroughs such as Southwark. The profile of stock differs between owner-occupied and social

housing in Merton, with 58% of social housing and 63% of private rented homes being flats compared with only 24% in the owner-occupied sector. Social housing and private rented homes also typically contain fewer rooms than those that are owner-occupied. England has 64.1% households owner-occupied, 17.7% social housing and 16.8% privately rented. London overall has 49.5% households owner-occupied, 24.1% social housing and 25.1% privately rented.\(^{70}\)

There is a high level of housing need amongst Merton residents. Merton’s Housing Needs Survey 2005, identified a need to develop an additional 1,848 affordable homes per annum between 2005 and 2010 if all housing needs in the borough were to be met. The 2010 Merton Strategic Housing Market Assessment (SHMA) 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 eastern part of the borough. The SHMA has taken into account migrations into and out of Merton and estimates show an average net loss of about 2,000 persons between 2002 and 2006. There are now over 7,500 households on Merton’s Housing Register, up from 6,350 in April 2011. Around 42% of households on the Register fall within the statutory ‘reasonable preference’ categories which councils have to give priority to when allocating social housing.

**Housing for vulnerable groups**

**Older people**

With projected increases in people aged over 65 years (estimated 11% increase between 2011 and 2017) (from GLA 2012 Round Demographic projections),\(^ {71}\) one of the key concerns is the increase in older people living alone. This has implications for health and social care since 57% of the ‘fuel poor’ are aged 60 and over; poorly insulated homes and the continual rise in heating bills contribute to fuel poverty.

It is also necessary to increase housing choice for older people who are owner-occupiers, as 67% of all older people households in Merton are owner-occupiers, but, at present, 79% of designated older people homes are for social rent, with only 21% catering for older owner-occupiers. We also know that, in Merton, there are fewer extra care homes and leasehold sheltered homes per 1,000 pensioner households compared with the London average.\(^{72}\) The ‘Pantiles’ extra care scheme completed in 2009 included 10 shared ownership homes (33%) that cater for owner-occupiers.

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\(^{71}\) SHLAA [(2013)].

\(^{72}\) Elderly Accommodation Counsel (EAC) Database (2010).
People with learning disabilities

The focus for Merton over recent years has been on the resettlement of people living in NHS long-stay accommodation and introducing the transformation change, including personalisation in social care to support a better quality of life for people with learning disabilities. Support is needed to help people with learning disabilities remain independent and living in their own homes. Availability of housing and supported housing that can support an ageing population of people with learning disabilities is required and effective support is needed, both services and legal, to assist people to maintain tenancies.

There are a small number of people with learning disabilities who do not live with their families and for whom housing or supported living will not meet their needs. In this instance a protected environment offered by a registered care home is ideal. Over the past 10 years there has been a significant shift in commissioning patterns where more people with learning disabilities are living in the community so that registered care may only be needed for a very small number of people in the future.
Homeless people
Homeless people are more likely to be affected by poor health. Living in temporary accommodation can affect the health of children, and homeless families can find it hard to access health services with a temporary address. A national audit undertaken by Homeless Link found that 8 in 10 single homeless people have one or more physical health needs, and 7 in 10 have at least one mental health problem. Poor health can also cause a person to become homeless in the first place, and many often leave health problems untreated until they reach a crisis point, making health problems more expensive to treat and hospital waiting lists longer, leading to people being less able to support themselves in their homes.

Although the number of homeless households in Merton is amongst the lowest in London, homelessness is on the increase, with homelessness applications rising from 188 in 2010-11 to 279 in 2011-12 and the number of households accepted as statutory homeless increasing from 89 in 2010-11 to 101 in 2011-12. There has been a drop in the number of single homeless young people being referred to Merton Council’s Young Persons Nominations Panel, reduced from 68 referrals in 2010-11 to 53 in 2011-12. There were also 51 referrals of rough sleepers to the Council’s Rough Sleepers Case Conference Panel in 2010-11 or winter provisions through the Severe Weather Emergency Protocol (SWEP), and 50 referrals in 2011-12.

Gypsies and travellers
Determinants of health also vary according to ethnic group. By nearly all measures of health, the health of ethnic minority populations in the UK is poorer than that of the white population (Public Health Observatories). In particular, there is evidence to show that the health of gypsies and travellers is much poorer compared with the general population, even when allowing for factors such as variable socioeconomic status and/or ethnicity, with one research
study finding that gypsy and traveller communities are the most at-risk health group in the UK with the lowest life expectancy and the highest child mortality rate.\textsuperscript{73}

There are around 30 residents living on one permanent caravan site in Merton and there are also many gypsies and travellers living in ‘bricks and mortar’ housing in Merton. 139 people from the gypsies and travellers community took part in a research event organised by Merton Council in October 2011, and the latest Census 2011 shows that 217 people in Merton have identified themselves as gypsies and travellers. However, organisations working with this community believe that the figure is actually higher.

It is essential that local authorities and health services work together to provide accessible and appropriate services if we are to tackle health inequalities amongst homelessness households and ethnic minority groups.

What works and best practice

Planning and housing design
The planning process, through design and layout, ensures that new developments and redevelopments implement sustainable design. Measures to improve housing conditions and reduce the occurrence of ‘sick building syndrome’ include:

- The use of sustainable design and construction standards (such as the Code for Sustainable Homes) helps to focus attention on issues relating to health and wellbeing, with credits available for ensuring attention is paid to daylighting, sound insulation, private space, volatile organic compound use, drying space and ventilation.
- High-quality refurbishment and energy efficiency retrofit works can reduce fuel poverty and improve thermal comfort.
- Appropriate re-housing and refurbishment initiatives are also likely to have beneficial health outcomes, including improvement in mental health.

As well as improving the sustainability of new homes through the planning process, there are also many initiatives being undertaken to improve the condition of existing housing stock in the social housing sector as well as the private sector. These include Merton Priory Home’s Decent Homes programme, which will improve around 6,500 homes to ‘Merton Standard’, which is over and above the ‘Decent Homes’ standard set by the Government, by 2015. The Council also runs a number of energy efficiency and home improvement initiatives by providing grants and loans to vulnerable households.

Regeneration programmes have been defined as reversing economic, social and physical decline in areas where market forces will not do this alone. A recent review of literature on Regeneration and Health\textsuperscript{74} suggested that regeneration interventions have had a mild or small impact on improving health. The indicators of health most measured have been self-reported general health measures or those that specifically reflect mental health and

\textsuperscript{73} University of Sheffield (2004). The Health Status of Gypsies & Travelers in England. A report to the Department of Health.

\textsuperscript{74} NHSSM, 2010.
wellbeing. Important caveats to note are that most of the findings from the literature relate primarily to physical regeneration, in particular housing improvement, and that health outcomes assessed have been in the short or medium term.

Key policy issues

Impact of housing policy reforms
Following its election, the Coalition Government introduced a number of new housing and related policies and initiatives, which will have a profound impact on the housing landscape.

The majority of the proposals are set out in the policy paper ‘Local decisions: a fairer future for social housing’, and subsequently included in the Localism Act 2011. In addition to the budgetary measures, housing policies enacted through the Localism Act include changes to tenure, housing waiting list, the homelessness duty, the introduction of a new ‘affordable rent’ tenancy, and changes to the Housing Revenue Account (HRA) and decent homes funding. All these policy changes will have an impact on Merton households, with the exception of the implementation of ‘self-financing’ within the Housing Revenue Account, as Merton Council no longer owns any housing stock having transferred all council housing to Merton Priory Homes in March 2010.

Affordable housing provision
The Spending Review [2013] has significantly reduced funding for the development of new affordable housing. At the same time the Government has introduced a new product – Affordable Rent – with rents charged at up to 80% of market rents for all new housing in receipt of government funding and the use of increased revenue generated from the conversion of a proportion of existing social rented units to Affordable Rent upon re-letting, to assist the delivery of targets for new supply.

All new build affordable homes and a proportion of existing social housing are now being let at Affordable Rent of up to 80% of market rent. This can still meet a significant proportion of need but there are risks around charging much higher rents to low-income households. Although at present social rents at 80% of market would be fully covered by housing benefit, the switch to Affordable Rent could see increased benefit dependency, and should the proposed total benefit cap be introduced (see below) such units could be completely unaffordable to larger out-of-work households.

Tenure reform
The Government introduced radical reform to tenancy policy through the Localism Act 2011, by giving local authority and housing association landlords the option to offer a new type of ‘flexible’ fixed-term tenancies to new tenants. The driver for change is to ensure that social housing, an increasingly scarce public resource, can be ‘focused on those who need it the most, for as long as they need it’.

Following the transfer of council housing stock to Merton Priory Homes in March 2010, all social housing in Merton is now owned by housing associations. Housing associations in
Merton now have the options to offer new tenants fixed-term tenancies with a range of periods of no less than five years, with no maximum limit to be set. Housing associations will also be able to offer flexible tenancies as an alternative to assured tenancies at either an ‘affordable rent’ or a social housing (‘target’) rent. Merton Council is working with housing associations to promote tenure mobility for those who aspire to home ownership or whose housing needs have changed over time, in order to release much needed affordable housing, particularly family-sized homes, while providing a stable base and a safety net for the most vulnerable people in society.

Tenancy strategy
Local authorities have a duty to publish a ‘tenancy strategy’ that is drawn up in consultation with tenants and social landlords, and to set out the objectives to be taken into consideration by social landlords when developing their own tenancy policies relating to the granting of fixed-term tenancies. Local authorities will need to set out and publish the circumstances under which either lifetime tenancies or fixed-term tenancies will be granted and the circumstances under which the latter will be reissued. The overarching aim of Merton’s Tenancy Strategy (January 2013) states that housing associations should adopt a people-centred approach when granting initial tenancies and further fixed-term tenancies. Housing associations are expected to ensure that the most vulnerable households in society – such as older people; people with disabilities; injured ex-armed forces personnel; low-income households – are given the security they require for as long as they need it, and provided with homes suited to their changing needs.

Homelessness and social housing allocations
The Localism Act 2011 includes powers for local housing authorities to place homeless households in private rented sector lettings without having to seek the applicants’ consent. The Act also allows an authority to limit who can apply for and who can be given social housing within their areas but councils are required to continue to give priority to households who fall within the ‘reasonable preference’ categories as defined in the Housing Act 1996. Again, these are new powers extending an authority’s local discretion for dealing with homeless and other housing applicants and determining how to make best use of social housing to meet housing need. Merton Council has since refreshed its allocations policy, to include giving priorities to ex-armed forces personnel and to working households under certain allocations bands.

New Homes Bonus
The Government has introduced the New Homes Bonus (NHB) to incentivise local authorities to encourage new housing development, with an added premium for new affordable housing. The NHB, paid in the form of sums related to council tax income, will also be paid for empty homes brought back into use.

Impact of welfare benefit reforms
Wider government legislation, including the Welfare Reform Act 2012, will impact on factors which can determine health and wellbeing. The Department for 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. DWP acknowledges this 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.

Overall the proposed measures, whilst designed to better incentivise work, could result in greater levels of poverty particularly for larger households. There is widespread concern that the welfare benefit reforms will result in both private rented and social rented sector tenants struggling to maintain their tenancies. A reduction in benefits resulting from the welfare benefit reforms may result in higher incidences of homelessness and higher levels of fuel poverty as well as limiting the ability to make healthy lifestyle choices.

Key commissioning recommendations

The challenge for the borough is to be able to forecast future housing needs, to inform potential providers of what is required, and to feed into and underpin the borough’s housing strategies. In particular, people with learning disabilities surviving into older age will potentially have significant increased need for accommodation to support them to remain as independent as possible.

With increasing age will come:

- Increasingly complex social and health needs requiring more sophisticated solutions for supported living, including a greater need for sheltered and extra care accommodation for people with learning disabilities as well as older people who have dementia or other disabilities, as population projections show these client groups to be on the increase.

- More people with learning disabilities outliving their parents and family carers, which will increase the need for supported living as well as a potential increase in the need for tenure-based housing.

It is essential that local authorities and health services work together to provide accessible and appropriate services for these groups and to tackle health inequalities amongst homeless households and ethnic minority groups.

As councils become increasingly responsible for leading on health improvement within their local populations, planning experts will need to work closer with public health regarding regeneration and spatial planning to help deliver shared goals.

Health impact assessments are a useful tool for assessing the impact of local regeneration programmes and should be considered locally. A prospective health impact assessment can provide a useful opportunity to identify positive health impacts and opportunities and mitigate potential negative impacts for local regeneration programmes.

Local regeneration programmes should support the ‘people, places and markets’ regeneration framework ([published by] DCLG). This approach to regeneration
encompassing physical regeneration, social or community regeneration, and economic
development may influence health through broader determinants.

Crime

Due to the timescales involved for the JSNA and the Community Safety Partnership Strategic
Assessment that is currently under development by LBM's Safer Merton partnership, the two
documents at present cannot reflect one another completely. As the JSNA is a living
document, the information from the Strategic Assessment will be utilised to update this
section in due course, once it becomes available.

Safety and crime

Crime rates affect people’s sense of security and increases their experience of stress. Stress,
in turn, causes hormonal levels to rise with potentially damaging health consequences. Crime affects health in a number of ways – directly, indirectly and by influences on the healthcare system:

- **Directly**, through violence, injury, rape and other offences against the person.
- **Indirectly**, through the psychological and physical consequences of injury, victimisation
  and isolation because of fear.
- **As a determinant** of illness, along with poverty and other inequalities, which increases
  the burden of ill health on those communities least able to cope.
- **By causing preventable health burdens**, such as alcohol-related crime, motor vehicle
  incidents and drug dependency.\(^\text{75}\)

Poverty and social inequality are two key factors in triggering violence, while social integration
presents particular challenges for immigrants. Combined with feelings of being powerless to
change their situation, these factors can all contribute to poor health outcomes by turning on
stress response elevating hormones that raise heart rates and divert blood to muscles. Over
the long term this can lead to increased infections, diabetes, high blood pressure, heart
attack, stroke, depression and aggression.\(^\text{76}\)

Safer Merton, the Community Safety Partnership (CSP) for the LBM, which includes the
Council, Metropolitan Police, Fire Brigade, Probation Service and Merton CCG (in addition to
a number of cooperative bodies), has a statutory duty to produce a Strategic Assessment
(SA) on at least an annual basis. The SA seeks to identify the key community safety priorities
for the borough, through analysing data and research and consulting with those who both live
and work in the borough.

The proposal was that the final SA document would be completed by mid February 2014,
with the aim of having action plans for each of the priorities in place for April 2014 as part of
the Partnership Plan.


Key facts on crime in Merton

Anti-social behaviour, public disorder, race crime, violent crime, vandalism, fly-tipping and the misuse of drugs and alcohol are identified as key behaviours and activities that have an adverse impact on the health of the population. Fear of crime and concern for personal safety also affects wellbeing and can lead to vulnerability and isolation.

**Figure 4.40: Addressing inequalities in Merton – IMD: Crime.** The English Indices of Deprivation provide a relative measure of deprivation at small area level across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation, including crime, and an overall composite measure of multiple deprivation. The purpose of the crime domain is to measure the rate of recorded crime for four major crime types – violence, burglary, theft and criminal damage – representing the risk of personal and material victimisation at a small area level. The map suggests that the areas to the south and east of the borough contain higher proportions of people who are experiencing these major crime types.

![Map of Merton showing IMD Crime](http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10)

In terms of a measure of overall crime, the Crime Survey for England and Wales (CSEW), which replaced the British Crime Survey (BCS), measures the extent of crime in England and Wales by asking people whether they have experienced any crime in the past year. This is useful, although it does have some limitations, as clearly results only reflect reported crime and therefore the level of unreported crime could significantly affect the findings. The recorded crime CSEW comparator is a subset of recorded crimes, which can be aligned to categories in the survey and this subset covers about 60% of all recorded crimes. In Merton,
between 2010-11 and 2011-12 the overall CSEW comparators saw a decrease of 4%. Furthermore, ONS data for 2012-13 shows that there was a decrease in robbery, burglary and sexual offences but an increase in violent crime. (See Table 4.12 below.)


<table>
<thead>
<tr>
<th>Borough</th>
<th>Violence % change within 12 months</th>
<th>Robbery % change within 12 months</th>
<th>Sexual Offences % change</th>
<th>Domestic Burglary % change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>-4.2</td>
<td>10.8</td>
<td>-3.3</td>
<td>2.6</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>-6.5</td>
<td>-12.9</td>
<td>-2.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td>2.7</td>
<td>-8.4</td>
<td>-12.5</td>
<td>21.1</td>
</tr>
<tr>
<td>Sutton</td>
<td>3.8</td>
<td>-6.9</td>
<td>0.0</td>
<td>18.6</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>-1.3</td>
<td>3.9</td>
<td>-4.5</td>
<td>-1.9</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

(This data is taken from the database used for the national statistical bulletin on Crime in England and Wales, year ending June 2013 published by the Office for National Statistics (ONS), 17 October 2013.

(http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales) Recorded crime figures remain subject to revision in future publications, as forces resubmit data to reflect the latest information.)

Table 4.9: Merton recorded crime and ASB 2012 ranked by ward. 1 = highest level, 20 = lowest level; Source: http://maps.met.police.uk/tables.htm

<table>
<thead>
<tr>
<th>Crime level rank</th>
<th>ASB level rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey</td>
<td>6</td>
</tr>
<tr>
<td>Cannon Hill</td>
<td>20</td>
</tr>
<tr>
<td>Colliers Wood</td>
<td>7</td>
</tr>
<tr>
<td>Cricket Green</td>
<td>1</td>
</tr>
<tr>
<td>Dundonald</td>
<td>17</td>
</tr>
<tr>
<td>Figgles Marsh</td>
<td>2</td>
</tr>
<tr>
<td>Graveney</td>
<td>10</td>
</tr>
<tr>
<td>Hillside</td>
<td>18</td>
</tr>
<tr>
<td>Lavender Fields</td>
<td>11</td>
</tr>
<tr>
<td>Longthornton</td>
<td>12</td>
</tr>
<tr>
<td>Lower Morden</td>
<td>14</td>
</tr>
<tr>
<td>Merton Park</td>
<td>5</td>
</tr>
<tr>
<td>Pollards Hill</td>
<td>4</td>
</tr>
<tr>
<td>Ravensbury</td>
<td>8</td>
</tr>
<tr>
<td>Raynes Park</td>
<td>13</td>
</tr>
<tr>
<td>St Helier</td>
<td>9</td>
</tr>
<tr>
<td>Trinity</td>
<td>3</td>
</tr>
<tr>
<td>Village</td>
<td>19</td>
</tr>
<tr>
<td>West Barnes</td>
<td>16</td>
</tr>
<tr>
<td>Wimbledon Park</td>
<td>15</td>
</tr>
</tbody>
</table>
Table 4.9 above sets out the ranking for each ward in Merton for crime level and anti-social behaviour (ASB).

Alcohol-related disorder is very much a visible problem and as such can have quite a noticeable impact upon resident's concerns about crime and the associated anti-social behaviour. Figure 4.41 below shows that the Merton rate for recorded crime attributable to alcohol was better than Croydon and Wandsworth, higher than Sutton, Kingston and Richmond, about the same as England, and well below the London rate. Figure 4.42 below then shows the trend from 2006-07 to 2011-12, where the rate in Merton has declined since 2009-10.

Figure 4.41: Recorded crime attributable to alcohol, Merton compared with South West London, London overall, England, 2011-12.
Figures for 2011-12 from the Local Alcohol Profiles for England (LAPE), produced by the North West Public Health Observatory, are the most current data available, and show that Merton had the fifth lowest rate in London for alcohol-related recorded crime and below the regional average, but was ranked 230th out of 326 local authorities in England (where 1 is best and 326 is the worst).

**Domestic violence and abuse**

Domestic violence is a serious crime and has a significant impact on the overall health and wellbeing of individuals, families and their communities. Domestic violence and abuse is defined [by the Home Office] as:

‘Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Family members are defined as mother, father, son, daughter, brother, sister, and grandparents, whether directly related, in-laws or stepfamily. It also includes issues of concern to BME communities such as so-called 'honour-based violence', FGM and forced marriage.

Domestic violence is a widespread and often hidden crime which crosses all social, racial and religious boundaries. One in four women will suffer domestic violence at some stage during their life. It affects the whole family and frequently includes children as well as adults; victims suffer emotional and psychological trauma as well as actual physical harm.

In Merton, domestic violence victimisation rates as reported to the police for 2011\textsuperscript{77} for women were 8.6 per 1,000 adult women (18+) and for men, 1.9 per 1,000 adult men (18+):
- 749 offences flagged as domestic were recorded in Merton borough in 2011, representing just over 5% of total crime. More incidents took place where the police were called but which did not result in criminal offences.
- 80% of domestic offence victims were female. 60% were white European; 20% African Caribbean; 13% Asian; and 3% dark European. 35% were aged in their twenties; 26% in their thirties; and 20% in their forties.
- 87% of victims were Merton residents.
- 81% of offenders suspected of a domestic offence last year were male. 51% were white European; 25% African Caribbean; 12% Asian; and 3% dark European. 31% of suspected offenders were in their twenties; 30% in their thirties; and 21% in their forties.

The impact of domestic violence on children is likely to be both physical and emotional and there is a clear correlation between domestic violence and child abuse. Many children are harmed physically and the impact of the abuse depends on its severity, the age of the child and their emotional resilience.

Vulnerable adults can also be victims of domestic violence. Their reliance on others for their care and protection can place them at greater risk from abusive partners or family members.

**Perceptions of crime**

The impact of crime on health is not just about the actual level of crime; perception of the level of crime can be just as important in affecting how safe people feel. There are differences in perception as to what constitutes a problem and how well local police services are dealing with perceived issues, which can also have a big impact on mental wellbeing and social isolation.

From the 2012 Merton Annual Residents Survey\textsuperscript{78}, crime is the issue respondents have the biggest personal concern about (mentioned by 34%) but concerns over crime continue to fall.

\textsuperscript{77} This data has been taken from the 2012-13 JSNA and therefore is a little out of date. An updated domestic violence will be undertaken through the Community Safety Partnership Strategic Assessment, and is anticipated will be available in March 2014.
The new Annual Residents Survey figures for 2013 will be publicly available very shortly (believed January 2014) and will provide a more current picture of residents’ concerns.
Worry about people being drunk and rowdy

% saying Very worried/Fairly worried

1. Village/ Hillside/ Raynes Park/ Wimbledon Park
2. Dundonald/ Trinity/ Abbey
3. Cannon Hill/ Merton Park/ West Barnes/
Lower Morden
4. Lavender Fields/ Pollards Hill/ Figges Marsh
5. Ravensbury/ St Helier/ Cricket Green
6. Colliers Wood/ Graveney/ Longthornton

2012 Average 43%

Source: Q6 How worried are you about each of the following in Merton? ...People being drunk and rowdy
Base: All adults (c1000)

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Worry about anti-social behaviour

% saying Very worried/Fairly worried

1. Village/ Hillside/ Raynes Park/ Wimbledon Park
2. Dundonald/ Trinity/ Abbey
3. Cannon Hill/ Merton Park/ West Barnes/
Lower Morden
4. Lavender Fields/ Pollards Hill/ Figges Marsh
5. Ravensbury/ St Helier/ Cricket Green
6. Colliers Wood/ Graveney/ Longthornton

2012 Average 45%

Source: Q6 How worried are you about each of the following in Merton? ...Anti-social behaviour
Base: All adults (c1000)
The data below is taken from the 2012 Strategic Assessment Consultation, and was based on a sample of 429 responses and was determined according to how people responded to the following issues in terms of them being a very big or fairly big problem. The main concern for residents was burglary, followed by motor vehicle crime and theft from shops.

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burglary</td>
<td>63</td>
</tr>
<tr>
<td>Motor Vehicle Crime</td>
<td>59</td>
</tr>
<tr>
<td>Theft from Shops</td>
<td>48</td>
</tr>
<tr>
<td>Robbery</td>
<td>46</td>
</tr>
<tr>
<td>Theft from Person</td>
<td>44</td>
</tr>
<tr>
<td>Criminal Damage</td>
<td>40</td>
</tr>
<tr>
<td>Litter and Fly-tipping</td>
<td>37</td>
</tr>
<tr>
<td>Alcohol Disorder/Behaviour</td>
<td>33</td>
</tr>
<tr>
<td>Street Drinking</td>
<td>32</td>
</tr>
<tr>
<td>Violence</td>
<td>31</td>
</tr>
<tr>
<td>Groups of People/Letting</td>
<td>28</td>
</tr>
<tr>
<td>Knive Crime</td>
<td>28</td>
</tr>
<tr>
<td>Identity Theft</td>
<td>27</td>
</tr>
<tr>
<td>Underage Drinking</td>
<td>25</td>
</tr>
<tr>
<td>Graffiti</td>
<td>22</td>
</tr>
<tr>
<td>Hate Crime</td>
<td>19</td>
</tr>
<tr>
<td>Noise Nuisance</td>
<td>19</td>
</tr>
<tr>
<td>Drug Use</td>
<td>19</td>
</tr>
<tr>
<td>Underage Alcohol Sales</td>
<td>19</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>18</td>
</tr>
<tr>
<td>Intimidation and Harassment</td>
<td>18</td>
</tr>
<tr>
<td>Behaviour Related to Drug Use</td>
<td>17</td>
</tr>
<tr>
<td>Drug Possession</td>
<td>17</td>
</tr>
<tr>
<td>Fly posting</td>
<td>16</td>
</tr>
<tr>
<td>Supply/ Saling of Drugs</td>
<td>14</td>
</tr>
<tr>
<td>Sexual Related Crime</td>
<td>14</td>
</tr>
<tr>
<td>Fire-work Misuse</td>
<td>14</td>
</tr>
<tr>
<td>Animal Nuisance</td>
<td>12</td>
</tr>
<tr>
<td>Neighbour Nuisance</td>
<td>11</td>
</tr>
<tr>
<td>Gun Crime</td>
<td>8</td>
</tr>
<tr>
<td>Begging</td>
<td>7</td>
</tr>
<tr>
<td>Drug Paraphernalia (syringes etc.)</td>
<td>7</td>
</tr>
<tr>
<td>Arson</td>
<td>5</td>
</tr>
<tr>
<td>Bell Games</td>
<td>5</td>
</tr>
<tr>
<td>Prostitution and Krob Crawling</td>
<td>2</td>
</tr>
</tbody>
</table>

Yellow = Crime  
Blue = ASB  
Green = Drugs/Alcohol

Source: Safer Merton Partnership Strategic Assessment 2013-14

The Public Attitude Survey (see Figure 4.45 below) conducted by the Metropolitan Police asks respondents to what extent they agree that the local police are dealing with the things that matter to people in their community. 73% agreed (5% Strongly agree, 68% Agree) that this was the case, compared with 5% who disagreed (1% Strongly disagree, 4% Disagree). The findings from the 2012 Merton Annual Residents Survey revealed that 56% of respondents thought that policing was excellent, very good or good. Merton performance is better than the London average but has fallen compared with previous years (see Figure 4.44 below).
Figure 4.44: Policing performance in Merton.

Policing

Merton performance is ahead of London average and continuing to improve

Figure 4.45: MPS Public Attitude Survey, Confidence Result 2011-12.

Confidence Results - Merton

The MPS Public Attitude Survey asks residents of the following questions to measure confidence in local policing.

The below results represent Merton residents' views.

Taking everything into account, how good a job do you think the police in this area are doing?

- Excellent - 8%
- Good - 67%
- Fair - 22%
- Poor - 2%
- Very poor - 1%

To what extent do you agree that the local police are dealing with the things that matter to people in this community?

- Strongly agree - 5%
- Agree - 68%
- Neither agree nor disagree - 22%
- Disagree - 4%
- Strongly disagree - 1%
Despite the fact that concern over crime is falling, the 2012 Merton Annual Residents Survey found that concern over anti-social behaviour fell in 2012 to 45% after a rise in 2011, which it was felt was linked to the riots across London in August 2011 making respondents more concerned about how anti-social behaviour may affect them. However, 29% of respondents felt informed about measures to tackle anti-social behaviour, which was a fall on the previous year.

Figure 4.46: Concern about anti-social behaviour in Merton, 2012.

The survey also found that concern about drunk and rowdy behaviour is perceived to be a bigger problem than drugs, with 43% of respondents very or fairly worried about people being drunk or rowdy compared with 34% being worried about drug users. The level of the contribution that alcohol makes to behaviours/activities such as domestic violence and the impact that it is having on local communities needs further local investigation.

Concerns about drunk and rowdy behaviour appear to be higher in areas with more active night-time economy areas, such as Wimbledon town centre. This correlates to estimates of binge drinking but not the use of health services. It is not clear how alcohol impacts on families and local communities, particularly in terms of domestic violence, and needs to be better understood.
In terms of health, fear of crime as well as the results of crime can have a major impact on long-term mental and physical wellbeing. In Merton, issues around the misuse/abuse of alcohol are perceived to be a bigger problem than drugs.

**What works and best practice**

- Crime prevention through addressing and challenging offending behaviour and tackling hate crime.
- Early identification and diversion of young people at risk of becoming involved in criminal activity.
- Targeted work with young offenders to undermine the supporting criminal and anti-social sub-culture.
- Projects to create community resistance to racially motivated crime.
- Neighbourhood and street warden schemes in the most disadvantaged communities.
- Effective education to reduce alcohol and drug misuse.
- Targeting of prolific offenders.

**Gaps and commissioning recommendations**

To tackle some of the root causes and to find solutions requires close partnership working. There is also an opportunity, given the links between teenage pregnancy, offending behaviour, truancy, and the focus on alcohol and drug misuse, to look more holistically and take a whole system approach to tackling crime.

However, commissioners must also focus on primary preventative measures for both children and adults to ensure that the focus isn't only on where things have gone wrong but also on the things that can be prevented from going wrong. Partnership working structures need to reflect this approach.

In the context of understanding the impact of alcohol on individuals, families and local communities, particularly in regard to domestic violence, more in-depth work at a local level is needed. Working collaboratively, local Drugs and Alcohol and Community Safety Partnerships are well placed to undertake this work. In addition, the differential between reported crime and perceptions of crime needs to be reviewed.
MERTON
JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2013-14

THEME 5:
LIFESTYLE RISK FACTORS IN MERTON
Summary

Smoking

Smoking is the UK’s single greatest cause of preventable illness and early death. Adults who smoke lose on average 13 to 14 years of their lives and more than 86,000 people in the UK die from smoking each year. There is evidence that smoking causes various cancers (particularly lung cancer), heart and blood vessel disease (including high blood pressure, stroke and heart attacks), respiratory disease (e.g. chronic obstructive pulmonary disease) and many other conditions.

Since there is no definitive measure of how many people smoke, national modelled estimates of smoking were developed from national survey data. In Merton, it is estimated that 16.48% of the population smoke compared with 20% in London, this is the fifth lowest prevalence of all London boroughs. However, this masks a variation across the borough where smoking rates vary from 9% to 24%. The higher rates are in line with the areas that have greater deprivation. These estimates are also supported by a survey of healthy living carried out in 2010 within Sutton and Merton, where people living in more deprived areas reported a smoking rate of about 24%. It has also been estimated that smoking prevalence among routine and manual workers is 23.5% in Merton.

Key commissioning recommendations

Merton has low overall smoking prevalence. However, there are clear inequalities in the levels of smoking across the borough and lower prevalence of quit rates compared with London and England. These factors, combined with plateauing mortality in circulatory disease, mean that tobacco control and tackling smoking should remain a high priority.

Recent figures on people stopping smoking have fallen short of local targets, however the integration with the LiveWell health improvement service will provide additional exposure to the programme. The stop smoking service also links into the NHS Health Check programme (a national initiative of regular vascular risk assessments) to provide support to help people reduce their risk of vascular disease caused by making changes to their lifestyle e.g. stopping smoking.

Since April 2013, Merton Council has been responsible for commissioning the Stop Smoking Service, rather than it being directly delivered by an in-house team in the NHS. The new provider, Hounslow and Richmond Community Healthcare NHS Trust, is focused on increasing the rate of residents accessing the programme and the number of smoking quitters, and will:

- continue to focus on access for ethnic groups, particularly minority ethnic males
- support younger people, particularly those most vulnerable
- focus on routine and manual workers, unemployed people and those on a low income
- support pregnant women to give up smoking early in pregnancy
- increase the outreach of the programme, branded under the LiveWell banner, to include workplaces e.g. staff working in council buildings
- link closely to Stoptober, the national campaign that encourages people not to smoke for the entire month. People who stop smoking for this length of time are less likely to start again.

Merton Council has worked to deliver effective comprehensive tobacco control in the borough, and at times nationally, with action leading to the banning of tobacco supplies from vending machines. With its partner agencies and organisations Merton Council should
continue to make tobacco control a priority in order to reduce the level of tobacco usage, as well as work towards normalising smoke-free environments beyond current legislation.

**Adult healthy weight**

Since there is no definitive measure of the proportion of overweight or obese adults, national modelled estimates of adult obesity rates were developed from population survey data. In Merton, these estimates suggest that overall 19.1% of adults (aged over 16 years) are obese, lower than London and England. Further estimates within the borough (at middle super output area level, about 7,000 of the population) suggest the highest levels are in the more deprived areas, with prevalence ranging from 10.6% (1 in 10) to 28.4% (1 in 3) across the borough.

In Merton, it is estimated that only 7.7% (1 in 13) of residents take part in enough physical activity to benefit their health – and that 92% of residents do not. This compares with 11% of Londoners and 11.8% nationally. Over half (51.2%) of Merton residents reported that they had taken part in no physical activity at all in the past four weeks.\(^79\) Data from across the country, reflected in the London-wide data, shows that disabled groups, non-white groups and older groups are less likely to be active. Activity levels are also lower among residents in routine occupations and those that have never worked or are long-term unemployed, compared with those residents in higher and managerial professions. Groups that have been identified as having the lowest levels of physical activity are girls and women (particularly young adults), people with physical and mental health disabilities, older adults, ethnic minority groups and socially deprived communities.

*Key commissioning recommendations*

Tackling obesity and helping people achieve a healthy weight are key to preventing future illness. With an increasing population and rising numbers of people projected to live longer, helping to prevent future ill health, such as diabetes, cancer and heart disease, is vitally important if health and social care services are going to be able to cope in the future. There is no simple solution to the challenge of obesity. It is important that an integrated and wide-ranging programme of solutions involving national and local action should be adopted to help tackle the growing problem.

Tackling obesity requires a multi-agency response across all ages, including whole family approaches, promoting healthy food choices, building physical activity into our day-to-day lives, providing safe open spaces, promoting walking and cycling, promoting the role of employers and providing personalised advice and support to individuals. As the lead organisation for public health and health improvement, Merton Council is well placed to address these areas across all council policies, including planning, housing, leisure services and social care.

Commissioners should prioritise the development of a clear weight management and obesity pathway, to ensure that services are available to support Merton residents with the level of expertise that they need in a setting that is appropriate and of interest to them.

Commissioners should also ensure that a prevention agenda is embedded across all contracts delivered in Merton by the Council, Merton CCG and its partners e.g. healthy vending in leisure centres and community dieticians delivering training to local people on how to eat healthily with minimal time and money.

\(^79\) Sport England: Active People Survey 2012.
Health services have a vital role to play in providing support and care; with consistent messages on achieving and maintaining a healthy weight and increasing levels of physical activity from health and other professionals being essential. How these messages are presented and delivered seems to be key to support behaviour change and to provide an opportunity to explore how to develop training for and ensure consistent messages are conveyed by all frontline workers in Merton.

Lifestyles and health improvement for children and young people

Children’s wellbeing is strongly associated with parents’ physical and mental health, resources and parenting knowledge. The support needs of parents are dependent on many factors such as age, self-confidence, experience, personal circumstances etc. Support therefore needs to be sufficiently varied and flexible ranging from someone to listen to a concern, to universally available and timely advice, through to specialist support, targeted where there is greatest need. Support to parents includes a range of universally available services to which all parents are entitled, targeted services for parents who need specific support at particular times, and mandatory interventions for those parents who are unable to seek out or engage with existing support services.

Evidence-based parenting programmes are a means 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. In Merton, the targeted parenting offer includes a range of accredited programmes:

- Incredible Years Baby/Toddler (6 weeks-2 years)
- Incredible Years Pre-school (3-5years)
- Incredible Years School Age (6-12 years)
- Triple P ‘Stepping Stones’ Children with Disability (2-12years)
- Strengthening Families Strengthening Communities (8-17years)
- Domestic Abuse Programme
- Caring Dads
- Escape (8-17years).

Key commissioning implications

Commissioners need to:

- recognise the integrated nature of lifestyle behaviour and wellbeing, continue to prioritise giving every child a healthy start in life and adopt place-based public health systems
- ensure professionals are equipped to offer effective support to parents to support child wellbeing and resilience, and to provide targeted parenting programmes
- work in partnership with schools to promote physical and emotional health and wellbeing, targeting schools in areas with high health needs.

Healthy weight in children

[The National Child Measure Programme (NCMP) results for 2012-13 show that] in Merton 9.0% of 5 year olds were classified as obese compared with 10.8% in London and 9.3% in England. This has reduced by 0.5% from 2011-12, and the overall trend is downwards from just over 12% in 2006-07. In Merton, 21.3% of 11 year olds were obese compared with 22.4% in London and 18.9% in England. This has increased by just under 1% from 2011-12, and the overall trend is upwards from just over 18% in 2006-07. There was a 12.3% difference in the level of obesity between 5 year olds and 11 year olds. This difference has
increased by over 6% since 2006-07, when there was a gap of just over 6% in 2006-7. Looking at excess weight overall, over 21.2% (over 1 in 5) of 5 year olds are categorised as overweight or obese, rising to 35% (over one third) of 10-11 year olds. There was an increase of nearly 14% in excess weight between 5 year olds and 11 year olds. This has reduced by 2.8% for 5 year olds and increased by 0.9% for 11 year olds since 2006-07.

The significant increase in levels of obesity between 5 year olds and 11 year olds needs to be understood and action taken in schools, particularly in Years 3 and 4, and with communities and families, to start to reverse this trend. Information from the NCMP shows nationally that children from BME groups are more likely to be obese. In Merton, wards in the east of the borough have higher levels of obesity at ages 5 and 11 than those in the west.

**Commissioning recommendations**

- Develop a sustainable, community-wide, multi-agency approach to increasing levels of healthy weight for children and young people and their families, which addresses inequalities by gender, ethnicity and area. Ensure that evidence from NICE on working with local communities to achieve healthy weight is implemented and that all local levers are being maximised, e.g. planning, parks and leisure, transport etc.
- Ensure ongoing monitoring of the NCMP to inform targeting of resources in areas with children with higher levels of excess weight. Evidence on the increasing gap in obesity between 5 year olds and 11 year olds indicates the need to target children in school Years 3 and 4.
- Review and maximise the capacity of School Nurses and delivery of preventative aspects of the Healthy Child Programme (5-19 years).
- Recommission Weight Management services for children and young people, including an increased focus on prevention. Develop local obesity pathways for children and young people.
- Pupils’ health and wellbeing have an impact on their educational performance. Effective preventative work in schools and wider communities needs to be done to mitigate health and lifestyle choices becoming a barrier to learning and attainment.
- Ensure opportunities for promoting healthy lifestyles in schools and wider communities is maximised, particularly among schools in the east of the borough. Increase number of schools registered with the Healthy Schools London programme.

**Dental health in children**

The latest NHS Dental Survey of 5 year olds in 2011-12 showed that 29.2%, or 3 in 10, 5 year olds in Merton had decayed or missing teeth, compared with 27.9% for England and 32.9% for London. This is a 6.4% increase compared with 2008-09, when 22.8% of 5 year olds in Merton had decayed or missing teeth, which was lower than both England (30.9%) and London (32.7%).

In 2012, 13.1% of 5 year olds in Merton had tooth decay that had been filled, compared with 11.2% for England. This compares with 31% for Merton in 2008-09, which was the highest in the Care Index in London, and indicates a 17.9% reduction. This requires further investigation. Children from lower socioeconomic backgrounds are disproportionately affected.

**Key commissioning recommendations**

- There is a need to improve access to NHS dental services for children and particularly in the early years.
There is a need to review progress on implementing the recommendations from the oral health promotion evaluation. These recommendations included:
- beginning health promotion interventions antenatally and targeting a wider range of at-risk populations
- linking with other health promotion programmes, such as smoking cessation, alcohol-related and diet programmes
- including evaluation as a key component of the service
- delivering an oral health promotion programme at a wider geographical level e.g. across South West London.

Substance misuse

In 2012-13, LBM’s Safer Merton Team together with Public Health re-tendered and recommissioned a new and fully integrated Recovery-Based Adult Substance Misuse Treatment Service, to meet the needs of those people within the borough’s population, who are alcohol and drug dependent and/or at risk of suffering serious substance-related harm. Services for younger substance misusers locally are currently being re-appraised and will be re-tendered in 2014-15. Together, we are also developing new substance misuse harm prevention frameworks for the borough that focus on whole population issues, public education and earlier identification and intervention methods aimed at stopping or reducing substance misuse before it has escalated into a more serious problem.

Alcohol – adults

The most recent data available indicates that higher-risk drinking is more widespread, and occurs more in deprived areas, suggesting that high levels of risky drinking are also occurring both at home and out of the home. In Merton, as highlighted in the LAPE published in August 2012, the estimated prevalence of binge drinking was 13.8% compared with 14.3% in London and 20.1% nationally. However, for small geographic areas within the borough, at middle super output area level, the range was 7% to 20%. The estimated levels of the adult population drinking at ‘increasing risk’ (21%) and ‘higher risk’ (7.2%) were above London or England levels.

In terms of alcohol harm overall and in 2012, Merton ranked 55 out of 326 local authorities but was in the higher percentiles for:
- Male mortality chronic liver disease (104/326)
- Female alcohol-specific hospital admissions (106/326)
- Male alcohol-specific hospital admissions (109/326)
- Male alcohol-attributable hospital admissions (151/326)
- Alcohol-related violent crimes (192/326)
- Alcohol-related sexual offences (208/326).

In terms of all alcohol-related crime and according to Local Area Profile Data for 2011-12, Merton with a rate of 7.3 recorded crimes per 1,000 populations was higher than the neighbouring boroughs Sutton (6.7) and Kingston (6.7) and the England average of 7 but lower than the London average of 11.1. The trend though in the five years since 2006-7 has generally been a downward one. Of people surveyed (‘My Place’ survey) in 2009, 49% thought that drunkenness and rowdy behaviour were a problem for the borough.

Drugs – adults

In 2012-13, Merton Substance Misuse Services were reported to be the highest performing nationally for successfully completed episodes, and were subsequently inspected and
commended by the National Treatment Agency for Substance Misuse as an exemplar of good practice in this activity.

In terms of local treatment population statistics for drug misuse, in Merton in 2011-12 it was estimated that 5,024 people aged 18-64 were dependent on drugs and of these approximately two thirds were male. By 2020 it is predicted that the number of people dependent on drugs will increase by 11%. This includes all drug users and is based on a national prevalence rate of 3.4%. Most dependence is estimated to be on cannabis only (2.5%), rather than other drugs (0.9%). In [2011-12] 505 clients were actually in treatment, of which 370 were men and 133 were women 39% (n=196) of clients in treatment presented with crack and/or opiates as their main drug used. The total number of clients presenting has decreased by 25% from 2010-11 (675 clients in treatment); this may reflect a national trend with a modest decline in demand for services across the country.

In Merton, [in 2011-12] there were an estimated 1,029 opiate or crack cocaine users (OCUs), a rate of 7.1 per 1,000 population, lower than both London (9.4 per 1,000) and England (8.9 per 1,000). Of OCUs in Merton, just over 20% (n=209) were injecting drug users. Taking those already in treatment and/or those known to the treatment system, it is estimated that there were some 678 people in the community not presenting or having not ever presented to services – 65% of the total estimated users. This has grown from 2010-11 when the figure was estimated at 45%.

In 2011-12 of those starting treatment the proportion in effective treatment was 83% for OCUs and 86% for all drug users and there was a high-planned exit rate from treatment, which shows they were successful completions. The planned exit rate in 2011-12 was 58% of all treatment exits, compared with 42% in London and 43% in England. The percentage of opiate-based successful completions was 44%, higher than both London (37%) and England (33%).

Key commissioning recommendations

For the treatment system as a whole:

- Continue to monitor local treatment services against an agreed Performance Assessment Framework and local indicators and outcomes for substance misuse as indicated in the Public Health Performance Dashboard.
- Safer Merton, Public Health and Merton MCG to review current usage of commissioned substance misuse inpatient (tier4) bed nights and further develop community treatment capacity to manage down future demand for inpatient services.
- Safer Merton and Public Health to develop new substance misuse prevention frameworks and reinvestment proposals to complement these.
- Continue to develop assertive outreach capacity to support hard-to-engage populations.
- Further develop local capacity to respond to parents who misuse alcohol and other drugs and to safeguard children.
- Maintain integrity, commitment and future resourcing for integrated substance misuse treatment services.

For alcohol:

- Develop an agreed local strategic framework for alcohol partnership work with an alcohol action work plan for 2013-14.
- Stream relevant elements of the alcohol work programme through a new Merton Harm Prevention Forum.

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80 PANSI (2011).
• Target street drinking and anti-social behaviour and effect appropriate responses through the Local Multi-Agency Planning and Problem Solving Groups.
• Work with Trading Standards and the Metropolitan Police Licensing Team to target licensed premises and other alcohol outlets that continue to sell alcohol to children and/or are ‘hubs’ for anti-social behaviour in local communities.
• Have a Merton Alcohol Licensing and Planning Task Group.
• Through training, develop workforce capacity in identifying and responding appropriately to problem alcohol use.
• Have a specific alcohol arrest referral pathway to divert and support problem drinkers at an early point in the criminal justice system.

For drugs:
• Use the Targeted Drug Testing on Arrest programme effectively to identify and treat drug misusing (particularly Class A) offenders.
• Ensure that local treatment services are linked and contribute to effective Integrated Offender Management work locally.

Young people’s substance misuse

In Merton, in terms of drinking behaviour the only source of information on attitudes and beliefs towards drinking alcohol we have is from the TellUs 4 survey (2009) in which the majority of children (8 to 16 years) report not having ever had an alcoholic drink. For those that do report drinking, the number getting drunk once, twice or three or more times in the past month was consistently lower than national figures. Drinking estimates for Merton young people extracted from the 2013 Merton Young People’s Sexual Health and Substance Misuse Needs Assessment, based on the National Centre for Social Research’s Smoking, Drinking and Drug Use survey (2011), suggest that 1,977 (19%) of young people between 11 and 15 years are drinking once a month or more, with an additional 2090 (20%) drinking a few times year. For young people 16-17 years consuming alcohol in the last week, the estimation based on the Institute of Alcohol Studies was 2,476 (62%).

Latest reported figures from the LAPE for alcohol-specific hospital admissions in the under 18 age group (2012) suggest a slight decrease in hospital admissions in the past six-year period. Merton, however, ranked ninth highest in London. As absolute numbers were small, one or two admissions would affect the ranking and didn’t include attendance at an A&E department, so therefore need to be treated with caution.

Merton has seen an increase in the numbers of young people under 18 years presenting for specialist treatment interventions in 2011-12. An analysis of needs assessment data for 2011-12 reveals that 138 young people aged under 18 were in treatment, which represents a 23% increase on the previous year. Figures for 2012-13, however, return to levels seen in previous years of just under 100. In [2011-12], 46% came through the youth justice route and 27% were using alcohol and cannabis.

Key commissioning recommendations
A joint young people’s sexual health and substance misuse needs assessment was carried out in Merton in 2013, which highlighted local needs and gaps. The needs assessment indicated improvements could be made in relation to:
• strengthening preventive and early identification strands of support, including outreach provision
• providing referral pathways for substance misuse and further integration with sexual health services
• increasing training to improve early identification and increase referrals to specialist services
• provision for young people aged 18 to 24 in contact with criminal justice services but using Class A drugs were also highlighted as a local gap
• providing effective transitions into adult substance misuse services for 18-24 year olds who require extended support and treatment
• providing an A&E intervention pathway for young people who present there with substance misuse issues
• upon completion of the review of the existing young peoples’ Substance Misuse Service, agreeing recommendations and retendering in 2014.

Teenage pregnancy

Teenage conception includes all conceptions before the mother’s 20th birthday, but the national focus is on conception under 18 as most potential mothers in this age group are in full-time education or training. The conception rate is the number of pregnancies that start before the mother’s 18th birthday (per 1,000 young women aged 15 to 17) and includes pregnancies that end either in birth or in termination.

In Merton, the under 18 conception rate was 27.6 per 1,000 (2011), below that of London and England and Wales. The rate had reduced 45.9% from the 1998 rate of 51 per 1,000. The latest rolling quarterly average for June 2012 was 24.7. However, this masks a variation across the borough with the rates of some wards in line with Inner London. Evidence suggests it is the most disadvantaged, vulnerable young women with the greatest number of risk factors who are most likely to have a conception aged under 18 and are more likely to see the pregnancy through. This is supported by a strong association locally (74%) between women aged under 19 giving birth and living in more deprived areas. This in turn perpetuates the cycle of poor outcomes, including health outcomes, not just for young parents but for their babies as well.

The recent data (2011) on rates of abortion in Merton shows that the rate was higher (16.4 per 1,000 population) than England (15.1 per 1,000 population) but lower than London (17.5 per 1,000 population). In addition, teenage abortion rates are declining, as illustrated in Figure 5.26 below, in line with the conception rates, which is indicative that services in place are having a real impact on teenage conception rates. However, more than half of conceptions to young people under 18 in Merton in 2011 resulted in terminations, which was lower than London (61%) but higher than England (49.3%) proportions. The three-year rolling averages from the 1998 baseline show that the proportions of teenage conceptions leading to terminations are increasing in Merton. The proportion of all teenage conceptions leading to abortions has increased by 9% since the 1998 baseline, although lower than London and England at 13% and 16% respectively.

Key commissioning recommendations

A joint young people’s sexual health and substance misuse needs assessment was carried out in Merton in 2013 which highlighted local needs and gaps. The needs assessment indicated improvements could be made in relation to:

• improving access to contraceptive services, condoms, emergency contraception and STI testing for young people
• continuing to raise the profile of services in schools, but for interventions to be provided in youth settings that ensure privacy
• Improving training for frontline professionals on talking to children, young people and parents about sensitive issues – highlighted as a local need.
- increasing access and referral to sexual health services from mainstream and targeted youth support services.
- further integrating sexual health services with substance misuse prevention services.
Smoking

Key facts on smoking

Smoking is the UK's single greatest cause of preventable illness and early death. Adults who smoke lose on average 13 to 14 years of their lives and more than 86,000 people in the UK die from smoking each year. There is evidence that smoking causes various cancers (particularly lung cancer), heart and blood vessel disease (including high blood pressure, stroke and heart attacks), respiratory disease (e.g. chronic obstructive pulmonary disease) and many other conditions. Smoking also affects child health increasing the likelihood of low birth weight and child mortality. Nationally the number of people who smoke is quoted as about 21%. However, this is not uniform and people are more likely to smoke if they are in manual or routine jobs, live in deprived areas or belong to specific groups such as lesbian, gay and bisexual groups who have higher reported rates of smoking than the general population.81

Since there is no definitive measure of how many people smoke, national modelled estimates of smoking were developed from national survey data. In Merton, it is estimated that 16.48% of the population smoke compared with 20% in London; this is the fifth lowest prevalence of all London boroughs.

Additional indicators, such as smoking-related deaths and illness (as measured by hospital admissions), suggest that overall in Merton there is on average less smoking-related harm compared with London or England.


Figure 5.1: Smoking prevalence, Merton compared with statistical neighbours and London boroughs, April 2011- March 2012.

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81 Department of Health (2007).
However, this masks variation across the borough where smoking rates vary from 9% to 24%. The higher rates are in line with the areas that have greater deprivation. These estimates are also supported by a survey of healthy living carried out in 2010 within Sutton and Merton, where people living in more deprived areas reported a smoking rate of about 24%. It has also been estimated that smoking prevalence among routine and manual workers is 23.5% in Merton. See Figure 5.2 below.

Figure 5.2: Map of smoking prevalence by area – estimates of the proportion of adults who are current smokers by MSOA (2006-08).

<table>
<thead>
<tr>
<th>Key</th>
<th>Percentage</th>
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<tr>
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<td>0 to 14.8%</td>
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<td></td>
<td>14.9 to 15.9%</td>
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<td>16 to 19.9%</td>
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<td>20% and over</td>
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Source: Association of Public Health Observatories
Estimates of Adults’ Health and Lifestyles, Percentage of the adult population who are current smokers, 2006-08, by MSOA (modelled estimate)
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Services – what works and best practice

Helping people to stop smoking
A major factor in reducing smoking prevalence is to ensure ready access to the Stop Smoking Service and support. Due to changes due to the implementation of the Health and Social Care Act 2012, the Stop Smoking Service was externalised as part of a competitive procurement exercise and is now delivered by Hounslow and Richmond Community Healthcare NHS Trust. This procurement exercise also gave commissioners the opportunity to integrate the service with the LiveWell health improvement programme, resulting in a service that can support smokers to stop and also provide support around other health behaviours e.g. increasing physical activity levels to reduce potential weight gain that is sometimes experienced by those who stop smoking.

In the most recent Health Equity Audit (2009) of the service, the effect of age on service access was more prominent for males than females. Females were shown to have
significantly higher rates of service access than males. A significantly higher proportion of white males were accessing services than [males] from ethnic minorities. However, the gap in the rate has narrowed indicating the effects of targeted action by the service since the first audit. Geographic variation in access rates had been shown with certain wards displaying markedly lower rates. There was also evidence of some of the most deprived wards having proportionally higher access rates due to targeted action. More recently, those in routine and manual employment have been entering services at a greater rate, particularly males, due to the efforts to target this demographic group by the Stop Smoking Service.

Smoking in pregnancy may not only affect the health of the mother but also the long-term health of the baby. Babies born to mothers who smoke are often of a much lower weight and prone to more ill health. In Merton, the levels of smoking recorded at time of delivery are around the average for London.

Overall there has been a reduction in the rate of people accessing the Stop Smoking Service, with 987 Merton residents accessing the service in 2012-13 compared with 1,600 in 2009-10. This could be in part explained by the reduction in the level of stop smoking marketing activity conducted nationally, and the previous success of the local Stop Smoking Service, leaving the hardened smokers who are not ready to consider stopping smoking.

The success rate of the service has dipped slightly to 45% (from 50%) of service users quitting at four weeks, which is lower than England and London levels. Targeted action is taking place to promote the integrated LiveWell stop smoking and health improvement service to increase both service users entering the service and the success rate.

**Tobacco control**
The effective enforcement of tobacco control legislation is a key element of any comprehensive approach to tobacco control. Laws are already in place regulating the way that tobacco products are presented for sale, to ensure that tobacco is not sold to people under the age of 18, and to reduce the exposure and effects of second-hand smoke. Local Trading Standards and Environmental Health Services have a recognised and essential role to play in wider efforts to reduce smoking rates and the Tobacco Control Plan for England (2011) places both services at the heart of its plan to reduce smoking as both have a growing contribution to public health.

In Merton, Trading Standards and Environmental Health Services take a proportionate, risk-based approach to enforcement and continue to build compliance with tobacco legislation, including through provision of advice and information to businesses, with enforcement action taken only where the law is deliberately flouted. The enforcement of tobacco legislation, which will contribute to the efforts to drive down the rates of tobacco use in the community, remains a priority with both services making a significant contribution through core activities such as:

- age-restricted sales test purchasing, including a related programme for ‘proxy’ sales
- tackling the supply of illicit products i.e. counterfeit and unsafe tobacco products
- tobacco advertising and promotion
• product labelling
• point-of-sale display requirements
• ensuring compliance with smoke-free legislation.

The majority of these activities have remained at the heart of tobacco control for the past 10 years following the publication of the ‘Smoking Kills’ White Paper, but they have been supplemented with the additional enforcement responsibilities around tobacco advertising, labelling, illicit products and smoke-free requirements in recent years.

Reducing smoking among children and pregnant women
National Institute for Health and Care Excellence (NICE) has produced evidence-based guidance on smoking in children and pregnant mothers. The guidance on children recommends school-based interventions to prevent the uptake of smoking, including:
• whole-school approaches, such as smoke-free policy
• adult-led and peer-led interventions
• training and development
• coordinated approach as part of a local tobacco control strategy and embedded in the curriculum.

Follow the link below for further information on the NICE guidance

The guidance on helping pregnant women quit smoking during pregnancy and following childbirth recommends:
• identifying pregnant women who smoke, referring to NHS Stop Smoking Services, and providing ongoing support
• Using nicotine replacement therapy (NRT) and other pharmacological support
• engaging with partners and others in the household who smoke
• ensuring NHS Stop Smoking Services meet the needs of disadvantaged pregnant women who smoke
• Providing training for all professionals involved in the delivery of interventions.

Follow the link below for further information on the NICE guidance

Use of smokeless tobacco in South Asian communities
National guidance on smokeless tobacco cessation in South Asian communities has also been produced. This has not been identified as a major issue locally in Merton. However, awareness and using local community information to assess changes in tobacco use is important.

Follow the link below for further information on the NICE guidance
**Tobacco: harm-reduction approaches to smoking**

National guidance has been developed on how to support people, particularly those that are highly dependent on nicotine, to reduce the harm that they face from smoking. Stopping smoking in one step (sometimes called 'abrupt quitting') offers the best chance of lasting success and is currently the approach that is supported in Merton.


**Key commissioning recommendations**

Merton has low overall smoking prevalence. However, there are clear inequalities in levels of smoking across the borough and lower prevalence of quit rates compared with London and England. These factors, combined with plateauing mortality in circulatory disease, mean that tobacco control and tackling smoking should remain a high priority.

Recent figures on people stopping smoking have fallen short of local targets, however the integration with the LiveWell health improvement service will provide additional exposure to the programme. The stop smoking service also links into the NHS Health Check programme (a national initiative of regular vascular risk assessments) to provide support to help people reduce their risk of vascular disease caused by making changes to their lifestyle e.g. stopping smoking.

Since April 2013, Merton Council has been responsible for commissioning the Stop Smoking Service, rather than it being directly delivered by an in-house team in the NHS. The new provider, Hounslow and Richmond Community Healthcare NHS Trust, is focused on increasing the rate of residents accessing the programme and the number of smoking quitters, and will:

- continue to focus on access for ethnic groups, particularly minority ethnic males
- support younger people, particularly those most vulnerable
- focus on routine and manual workers, unemployed people and those on a low income
- support pregnant women to give up smoking early in pregnancy
- increase the outreach of the programme, branded under the LiveWell banner, to include workplaces e.g. staff working in council buildings
- link closely to Stoptober, the national campaign that encourages people not to smoke for the entire month. People who stop smoking for this length of time are less likely to start again.

Merton Council has worked to deliver effective comprehensive tobacco control in the borough, and at times nationally, with action leading to the banning of tobacco supplies from vending machines. With its partner agencies and organisations, Merton Council should continue to make tobacco control a priority in order to reduce the level of tobacco usage, as well as work towards normalising smoke-free environments beyond current legislation.
Healthy Weight

Key facts on healthy weight

Obesity has become one of the major public health challenges for the 21st century. The cause of obesity is complex having behavioural, genetic, environmental and social components. This makes it a key health inequality issue. The health risks associated with being overweight or obese are many, including increasing risk of diabetes, cancer, heart and liver disease, and these risks increase the more weight people put on.

The national ‘Call to Action on Obesity’ (2011) spells out the key challenges for local government and the NHS in tackling obesity: to build effective partnerships, to invest to ensure future health, to take effective action to reduce inequalities at a local level and to establish health as a way of life for individuals and communities. This builds on a number of earlier policies, including the Public Health White Paper Choosing Health (2004), the Children’s National Service Framework and the earlier National Strategy on Obesity, Healthy Weight, Healthy Lives (2008).

Since there is no definitive measure of the proportion of overweight or obese adults, national modelled estimates of adult obesity rates were developed from population survey data.

In Merton, these estimates suggest that overall 19.1% of adults (aged over 16 years) are obese, lower than in London and England.

Figure 5.3: Estimated prevalence of obesity in adults, compared with statistical neighbours and London boroughs, 2006-08.
Further estimates within the borough (at middle super output area level, about 7,000 population) suggest the highest levels are in the more deprived areas, with prevalence ranging from 10.6% (1 in 10) to 28.4% (1 in 3) across the borough.

Figure 5.4: Achieving a healthy weight by area – estimated levels of healthy eating (adults) by MSOA, 2006-08.

<table>
<thead>
<tr>
<th>Key</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 32.4%</td>
<td></td>
</tr>
<tr>
<td>32.5 to 34.9%</td>
<td></td>
</tr>
<tr>
<td>35 to 40.9%</td>
<td></td>
</tr>
<tr>
<td>41% and over</td>
<td></td>
</tr>
</tbody>
</table>

Source: Association of Public Health Observatories - Estimates of Adults' Health and Lifestyles, Percentage of the adult population that eat healthily, 2006-08, by MSOA ©Crown copyright 2012. All rights reserved. ©1994-2012 ACTIVE Solutions Europe Ltd.

Key facts on healthy eating and physical activity

Simplistically, achieving a healthy weight has two components: energy in and energy out; in essence, eating healthily and being physically active to burn off the calories consumed.

As a proxy for healthy eating, an estimated proportion of people eating healthily has been modelled based on national survey data for people eating at least five portions of fruit and vegetables a day. In general people in Merton eat more healthily compared with London and the rest of England and it is estimated that just under 40% of adults eat five a day. However, this masks a variation across the borough with more deprived areas eating less healthily.
In 2011, the Chief Medical Officer issued new guidelines for physical activity ‘Start Active, Stay Active’. The guidance has a renewed focus on being active everyday and spells out the recommended minimum levels of activity for adults in order to achieve health benefits:

- **Adults (19-64 years old) and older people (65+)**: 150 minutes – two and half hours – each week of moderate to vigorous intensity physical activity (and adults should aim to do some physical activity every day). Muscle strengthening activity should also be included twice a week.

In Merton, it is estimated that only 7.7% (1 in 13) of residents take part in enough physical activity to benefit their health – and that 92% of residents do not. This compares with 11% of Londoners and 11.8% nationally. Over half (51.2%) of Merton residents reported that they had taken part in no physical activity at all in the past four weeks.\(^8\)

Data from across the country, reflected in the London-wide data, shows that disabled groups, non-white groups and older groups are less likely to be active. Activity levels are also lower among residents in routine occupations and those that have never worked or are long-term unemployed, compared with those residents in higher and managerial professions.

\(^8\) Sport England: Active People Survey (APS) (2012).
Most recent data (APS Q3 to APS7 Q2) estimated that 23.1% of adults participate in 3x30 minutes of activity a week, which is an increase of 1.2% since 2005-06 (APS5/6).

Figure 5.6: Adult participation in sport and physical activity (3x30), 2011-13.

This also estimated that 35.25% of adults participate in 1x30 of activity a week.

Groups that have been identified as having the lowest levels of physical activity are girls and women (particularly young adults), people with physical and mental health disabilities, older adults, ethnic minority groups and socially deprived communities.

Figure 5.7: Adult participation in sport and physical activity (1x30), 2012-13.
What works and best practice

Helping people to achieve a healthy weight
NICE has published guidance on evidence-based approaches to enabling communities and specific at-risk groups achieve a healthy weight.

Guidance on working with local communities to achieve a healthy weight (NICE 2012) recommends to:

- develop a coherent sustainable, community-wide, multi-agency approach
- align action to tackle obesity with other disease-specific prevention and health improvement strategies, such as for CHD and diabetes
- ensure strategic leadership and support at all levels
- coordinate local action and communication in public health teams, local business and social enterprises, voluntary and community organisations
- train and develop all partners, professionals and those in local services
- communicate strategy through appropriate branding, language and advocacy
- monitor and evaluate of cost-effectiveness
- embed scrutiny and accountability.


Guidance on weight management before, during and after pregnancy (NICE 2010) recommends:

- weight management for women with a BMI 30 or more preparing for pregnancy
- help for pregnant women to adopt healthy lifestyles during pregnancy especially those with BMI 30 or more
- supporting women after childbirth at postnatal check-ups
- community-based services
- adequate skills for involved professionals.


Guidance on walking and cycling (NICE 2010) recommends:

- developing a local strategy and policy support for walking and cycling networks and infrastructure
- developing road safety partnerships and strategies
- addressing motor traffic speeds and introducing engineering measures
- ensuring all relevant planning considers walking and cycling
- developing cross-sector walking and cycling programmes
- commissioning personalised travel planning
- community-wide walking programmes, including for older people and providing individual support
- developing cycling programmes.

Merton Voice

Overview
To support the development of services and programmes to support healthy lifestyles, a programme of engagement was led by Public Health in late 2012/early 2013. This insight focused on childhood immunisations and vaccinations, healthy eating, breastfeeding, physical activity in young adults and the use of physical health services by people with severe mental illness.

[Public Health] engaged with local residents, frontline workers and health professionals to explore provision, barriers and motivations, and produced a number of common themes. Although the numbers of people engaged in the process were relatively small, the insights gained could help form the golden thread of what local residents would like to see.

Continuity of care and consistent messages
Local residents sometimes feel they do not know who to address or trust, as each time they come into contact with the health service they see new people, and different health professionals can also give differing/conflicting advice.

Using available local resources effectively
There are lots of trusted local community groups and resources (e.g. gyms and local clubs and mental health community groups), which could be engaged to support the health agenda more effectively and sustainably.

People like to hear from people ‘like them’
Local residents sometimes feel that their peers have a greater empathy for their situation than health professionals and so that increased levels of peer support and advice will help local audiences to improve their health. This could be as simple as giving local people visibility in literature and ensuring their voices are heard.

Information needs to be local and specific
In some of the health issues like healthy eating and physical activity there is a lot of information available but to make it as easy as possible to adopt behaviours people need information about what is around the corner and feasible for them rather than generic, national or even borough-level information.

Use appropriate marketing channels effectively
Local residents, particularly parents, often prefer to receive information face to face that can be tailored specifically for them. Engagement events could help to deliver this and to address several health issues (e.g. breastfeeding, immunisations and healthy eating). However, online channels (particularly Facebook and via smartphones) are increasingly where young adults first turn to for information.

Healthy eating specific insight
The research around healthy eating identified 13 barriers to healthy eating amongst target families, which can be grouped into three broad categories:
Knowledge and understanding

- Cooking inspiration – parents lack confidence in cooking, especially from scratch.
- Lack of understanding – confusion over healthy eating guidelines and what constitutes a healthy diet.
- Lack of knowledge – food labelling and conflicting or unclear messaging from food manufacturers.
- Healthy is punitive – association of healthy eating messaging being negative rather than supporting.
- Confusion over portion sizes.
- Rise in snacking culture – snacking as a norm and symbols of parental love and nurturing.

Cost and time

- The perceived cost of healthy food – fresh fruit, vegetables and meat are perceived as being expensive, especially amongst low socioeconomic groups.
- Difficulty finding the ‘time’ for healthy eating – especially in relation to easing stress levels by feeding children tried-and-tested meals.
- Catering for fussy eaters – the challenges of children that won’t eat and the stress it can cause parents.

Influence of others

- The influence of others – absent parents, grandparents and other influencers who believe in ‘treats’.
- Resistance to labelling their children (or themselves) – difficulty accepting their child may be overweight or obese.
- Following the ‘Joneses’ – social norms and feeling guilty removing unhealthy foods if they think other families are not adopting healthy behaviours.
- Own role modelling overlooked – parents often have one rule for themselves and another for their children.

The research also identified six values around healthy eating that need to be understood to ensure that healthy eating interventions are relevant:

- Keep it local – families consistently place a great deal of importance on access to local facilities, information and support.
- Appetite for healthy eating (and physical activity) is growing – families are showing greater awareness of their health risk behaviours in relation to their diet and activity choices.
- Child happiness is a key motivator – often being ‘happy’ is equated with being ‘healthy’.
- Short-term often trumps long-term – more value placed on short-term benefits than on those that will only occur in the distant future.
- Obesity and weight is a sensitive issue – the delivery of messaging in this context was criticised as unsupportive.
- But parents do want to ‘monitor progress’ – parents are keen to know about their
children’s weight, however current worries are more that they might be underweight or lacking vital nutrients.

**Key commissioning recommendations**

Tackling obesity and helping people achieve a healthy weight are key to preventing future illness. With an increasing population and rising numbers of people projected to live longer, helping to prevent future ill health, such as diabetes, cancer and heart disease, is vitally important if health and social care services are going to be able to cope in the future. There is no simple solution to the challenge of obesity. It is important that an integrated and wide-ranging programme of solutions involving national and local action should be adopted to help tackle the growing problem.

Tackling obesity requires a multi-agency response across all ages, including whole family approaches, promoting healthy food choices, building physical activity into our day-to-day lives, providing safe open spaces, promoting walking and cycling, promoting the role of employers and providing personalised advice and support for individuals. As the lead organisation for public health and health improvement, Merton Council is well placed to address these areas across all council policies, including planning, housing, leisure services and social care.

Commissioners should prioritise the development of a clear weight management and obesity pathway, to ensure that services are available to support Merton residents with the level of expertise that they need in a setting that is appropriate and of interest to them.

Commissioners should also ensure that a prevention agenda is embedded across all contracts delivered in Merton by the Council, Merton CCG and its partners e.g. healthy vending in leisure centres and community dieticians delivering training to local people on how to eat healthily with minimal time and money.

Health services have a vital role to play in providing support and care; with consistent messages on achieving and maintaining a healthy weight and increasing levels of physical activity from health and other professionals being essential. How these messages are presented and delivered seems to be key to support behaviour change and to provide an opportunity to explore how to develop training for and ensure consistent messages are conveyed by all frontline workers in Merton.
Lifestyles and Health Improvement for Children and Young People

Key facts about child wellbeing and resilience

Wellbeing is more than the absence of illness and is linked to physical health, health behaviours and resilience (ability to cope with adverse circumstances). Children’s wellbeing is strongly associated with neighbourhoods in which they live and by their parents’ resources, health, environment, housing conditions, social networks and parenting knowledge. Health behaviours also relate to individual wellbeing and recent research\(^3\) has confirmed the following associations:

- Screen time (including computer use for non-homework, watching television, DVDs and videos and time spent playing computer games) is negatively associated with young people’s wellbeing.
- Physical activity is associated with lower levels of anxiety and depression, with children being happier with their appearance and reporting higher levels of self-esteem, happiness and satisfaction with their lives.
- Healthy eating and diet: eating breakfast has a positive impact on short-term cognition and memory; family meal times appear to be important to wellbeing; in England of 11-15 year olds nearly 40% drink soft drinks at least once a day, just over 60% report eating breakfast and between a third and just under a half report eating fruit or vegetables every day.
- A young people’s health is positively associated with their mother’s wellbeing; getting on well with siblings is associated with high levels of happiness and less worry; and having lots of friends at school is associated with happiness and wellbeing.

Parents’ role in child wellbeing and resilience

Children’s wellbeing is strongly associated with parents’ physical and mental health, resources and parenting knowledge. The support needs of parents are dependent on many factors such as age, self-confidence, experience, personal circumstances etc. Support therefore needs to be sufficiently varied and flexible, ranging from someone to listen to a concern, to universally available and timely advice, through to specialist support, targeted where there is greatest need. Support to parents includes a range of universally available services to which all parents are entitled, targeted services for parents who need specific support at particular times, and mandatory interventions for those parents who are unable to seek out or engage with existing support services.

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).

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Evidence-based parenting programmes are a means 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. In Merton the targeted parenting offer includes a range of accredited programmes e.g:

- Incredible Years Baby/Toddler (6 weeks-2 years)
- Incredible Years Pre-school (3-5yrs)
- Incredible Years School Age (6-12 years)
- Triple P ‘Stepping Stones’ Children with Disability (2-12yrs)
- Strengthening Families Strengthening Communities (8-17yrs)
- Domestic Abuse Programme
- Caring Dads
- Escape (8-17yrs).

**Schools’ role in child wellbeing and resilience**

Schools can be an important driver of resilience in children. They can provide children with learning opportunities and the competencies to develop a positive identity and healthy behaviours, as well as the skills to negotiate life’s challenges. However, school can also function as a risk to children’s health and wellbeing. Factors such as bullying and poor educational attainment can impact negatively on children’s mental health status.

For further details on access to education – see Theme 4, under *Early Child Development and Education*.

There are many evidence-based opportunities to promote health and wellbeing through schools, including personal, social, health and economic education (PSHE), and emotional learning in school; extra-curricular activities; positive classroom management; and links with family and wider community. School Nurses play an important role to support schools and pupils; and in Merton there are a number of services that provide support for young people in schools and colleges, including good sexual health promotion, advice on substance misuse, stop smoking support and weight management programmes. Healthy Schools London is an awards programme that recognises schools’ achievements in improving pupil health and wellbeing across four areas: healthy eating; physical activity; PSHE; and emotional health and wellbeing.

**Key commissioning implications**

**Commissioners need to:**

- recognise the integrated nature of lifestyle behaviour and wellbeing and to continue to prioritise giving every child a healthy start and to adopt place-based public health systems
- ensure professionals are equipped to offer effective support to parents to support child wellbeing and resilience, and to provide targeted parenting programmes
- work in partnership with schools to promote physical and emotional health and wellbeing, targeting schools in areas with high health needs.
Key facts about children achieving a healthy weight

Childhood obesity has been increasing over the past two to three decades worldwide but there was very little robust data to identify what the increase was on a local basis. In 2006 the NCMP was introduced to measure the height and weight of all children by the time they reached 5 and 11 years old (Reception and Year 6), year on year.

The NCMP results for 2012-13 show that coverage was at 93.5% for Reception and 96.4% for Year 6 pupils:

- 9.0% of 5 year olds in Merton were classified as obese compared with 10.8% in London and 9.3% in England. This has reduced by 0.5% from 2011-12, and the overall trend is downwards from just over 12% in 2006-07.

- 21.3% of 11 year olds in Merton were obese compared with 22.4% in London and 18.9% in England. This has increased by just under 1% from 2011-12, and the overall trend is upwards from just over 18% in 2006-07.

- There was a 12.3% difference in the level of obesity between 5 year olds and 11 year olds. This difference has increased by over 6% since 2006-07, when there was a gap of just over 6% in 2006-07.

- Looking at excess weight overall, over 21.2% (over 1 in 5) of 5 year olds were categorised as overweight or obese, rising to 35% (over 1 third) of 10-11 year olds. There was an increase of nearly 14% in excess weight between 5 year olds and 11 year olds. This has reduced by 2.8% for 5 year olds and increased by 0.9% for 11 year olds since 2006-07.

The significant increase in levels of obesity between 5 year olds and 11 year olds needs to be understood and action taken in schools, particularly in Years 3 and 4, and with communities and families, to start to reverse this trend.
Figure 5.8: Excess weight (overweight and obesity) in children in Reception Year, 2011-12.

Figure 5.9: Excess weight (overweight and obesity) in children in Year 6, 2011-12.
Variation by gender: Information from the NCMP shows that, in Merton, boys are more likely to be obese than girls, particularly at age 11, where the prevalence of obesity is 6% higher among boys than girls.
Variation by ethnicity: Information from the NCMP shows nationally that children from BME groups are more likely to be obese. Nationally 2012-13 data shows that at age 5 years prevalence of obesity was 8.6% for white groups; 10.3% for Asian or Asian-British groups; and 15.5% for black or black-British groups. At age 11 years prevalence of obesity was 17.6% for white groups; 20.3% for Asian or Asian-British groups; and 27.1% for black or black-British groups.

Variation by area: It is clear that the levels of children who are overweight or obese are significant and that the levels of overweight and obesity increase as children get older. Information locally confirms there is a link to deprivation, so that children of poorer households have a greater risk of being overweight or obese and are therefore at greater risk of certain diseases. In Merton, wards in the east of the borough have higher levels of obesity at ages 5 and 11 than those in the west.
Physical activity: The Chief Medical Officer’s guidelines for physical activity ‘Start Active, Stay Active’ (2011) have a focus on being active every day and set out the recommended minimum levels of activity for children and young people in order to achieve health benefits:
• Under 5 years old: 180 minutes – three hours daily, spread throughout the day, once a child is able to walk.
• Children and young people (5-18 year olds): 60 minutes and up to several hours every day of moderate to vigorous intensity physical activity. Three days a week should include vigorous intensity activities that strengthen muscle and bone.

The most recent data available shows that 58% of children in Merton took part in three hours of physical activity or sport per week, higher than the regional or national averages (2009-10). No data is available for pre-school age children.

Key facts about services to promote healthy weight

There is no simple solution to the challenge of reducing obesity. It is important that integrated and wide-ranging approaches involving national and local action should be adopted to help tackle the growing problem. Tackling obesity requires a multi-agency response across the life course, including whole family approaches, promoting healthy food choices, building physical activity into our day-to-day lives, providing safe open spaces, promoting walking and cycling, promoting the role of employers and business, and providing personalised advice and support to individuals.

The role of the local workforce in addressing healthy weight is crucial and includes promotion of healthy weight in pregnancy, promotion of breastfeeding, physical activity and healthy eating activity in children’s centres, schools, health services and community settings, weight management support, and work with fast food businesses through a local ‘Responsibility Deal’.

The national Healthy Child Programmes (Pregnancy and the first five years of life and From 5-19 years\textsuperscript{84}) set out the recommended framework of universal and progressive services for infants, children and young people to promote optimal health and wellbeing, bringing together a wide range of programmes and interventions. They recommend how health, education and other partners working together across a range of settings can significantly enhance a child or young person’s life chances. Promoting healthy weight is one of a range of priorities within the programmes. The School Nursing Service delivers the NCMP and has an important role in promoting and supporting healthy weight among children and parents.

Merton has a targeted service for child weight management which aims to support and empower parents and children from 4-19 years old to adopt healthy eating practices, increase physical activity levels, reduce sedentary behaviour and build self-esteem. A secondary aim is to contribute towards children improving their long-term health through achieving and maintaining a healthy body weight. The 12-week programme is aimed at children in Merton aged between 4 and 19 years who are overweight, plus their families. There is an education and behavioural change component to each session with the children taking part in at least 40 minutes of physical activity per session. Between July 2012 and July

\textsuperscript{84} DH (2009), Healthy Child Programme: Pregnancy and the First Five Years; DH (2009) Healthy Child Programme: From 5-19 years...
2013, 91 families from Merton completed the programme. An extended training programme for professionals also provides advice on how to raise the issue of weight and provide general advice on appropriate lifestyle changes.

What works to help people to achieve a healthy weight?

NICE has published guidance on evidence-based approaches to enabling communities and specific at-risk groups achieve a healthy weight.

Guidance on working with local communities to achieve a healthy weight (NICE 2012) recommends to:
- develop a coherent sustainable, community-wide, multi-agency approach
- align action to tackle obesity with other disease specific prevention and health improvement strategies, such as for CHD and diabetes
- ensure strategic leadership and support at all levels
- ensure coordinated local action and communication in public health teams, local business and social enterprises, voluntary and community organisations
- train and develop all partners, professionals and those in local services
- develop a communication strategy through appropriate branding, language and advocacy
- monitor and evaluate cost-effectiveness
- embed scrutiny and accountability.

Follow the link for further information on the guidance

Guidance on walking and cycling (NICE 2010) recommends:
- developing a local strategy and policy support for walking and cycling networks and infrastructure
- developing road safety partnerships and strategies
- addressing motor traffic speeds and introducing engineering measures
- ensuring all relevant planning consider walking and cycling
- developing cross sector walking and cycling programmes
- commissioning personalised travel planning
- developing community-wide walking programmes, including for older people and providing individual support
- developing cycling programmes.

Follow the link for further information on the guidance
http://pathways.nice.org.uk/pathways/walking-and-cycling#

Guidance on managing overweight and obesity among children and young people (NICE 2013) recommends:
- Action on planning, commissioning and delivery to ensure that family-based, multi-component lifestyle weight management services for children and young people are available as part of a community-wide multi-agency approach to healthy weight and prevention and management of obesity.
- The core elements of services to be provided as part of a locally agreed obesity care or weight management pathway.
Commissioning implications for supporting children and young people to achieve a healthy weight

Tackling obesity and helping people achieve a healthy weight are key to preventing future illness. With an increasing population and rising numbers of people projected to live longer, helping to prevent future ill health, such as diabetes, cancer and heart disease, is vitally important if health and social care services are going to be able to cope in the future. It is important that an integrated and wide-ranging programme of solutions involving national and local action is implemented.

Tackling obesity requires a multi-agency response across all ages, including whole family approaches, promoting healthy food choices, building physical activity into our day-to-day lives, providing safe open spaces, promoting walking and cycling, promoting the role of employers, and providing personalised advice and support to individuals. As the lead organisation for public health and health improvement since April 2013, Merton Council is well placed to address these areas across all council policies, including planning, housing, leisure services and social care.

Health services have a vital role to play in providing support and care. Consistent messages from health and other professionals about healthy weight and physical activity are essential and training and support are needed. How messages on achieving and maintaining a healthy weight are presented are key to support behaviour change. Commissioners need to ensure that positive messages are presented, and that any interventions are fun (not overtly health oriented) and locally available, with local champions to support healthy choices. Commissioning implications:

Commissioning recommendations:

- Develop a sustainable, community-wide, multi-agency approach to increasing levels of healthy weight for children and young people and their families, which addresses inequalities by gender, ethnicity and area. Ensure that evidence from NICE on working with local communities to achieve healthy weight is implemented and that all local levers are being maximised, e.g. planning, parks and leisure, transport etc.

- Ensure ongoing monitoring of the NCMP to inform targeting of resources in areas with children with higher levels of excess weight. Evidence on the increasing gap in obesity between 5 year olds and 11 year olds indicates the need to target children in school Years 3 and 4.

- Review and maximise capacity of School Nurses and delivery of preventative aspects of the Healthy Child Programme (5-19 years).
- Recommission Weight Management services for children and young people, including an increased focus on prevention. Develop local obesity pathways for children and young people.

- Pupils’ health and wellbeing have an impact on their educational performance. Effective preventative work in schools and wider communities needs to be done to mitigate health and lifestyle choices becoming a barrier to learning and attainment.

- Ensure opportunities for promoting healthy lifestyles in schools and wider communities is maximised, particularly among schools in the east of the borough. Increase the number of schools registered with the Healthy Schools London programme.
Key facts on dental health of children

Oral health is a key measure of inequality. Children, particularly those in deprived areas, tend to have poorer oral health, which can lead to or be predictive of other conditions. Tooth decay is predominantly preventable, however, significant levels remain (nationally, 28% of 5 year old children have observable decay) resulting in pain, sleep loss, time off school and, in some cases, treatment under general anaesthetic.

The Public Health Outcomes Framework includes ‘tooth decay at 5 years’ as an indicator to encourage local authorities to focus on oral health improvement initiatives to reduce levels of decay. This indicator measures the average severity of tooth decay per child based on the NHS Dental Survey. In Merton in 2012 it was estimated that the average number of teeth per child aged 5 years which had decay was 0.92, which was better than London (1.23), and similar to England (0.94).

NHS Dental Survey

The NHS Dental Epidemiology Programme for England (NHS DEP)\(^5\) 2011-12, an oral health survey of 5 year old children, gives estimates for disease prevalence and severity reported at national, regional and local authority levels. Overall, 27.9% of 5 year old children in England whose parents gave consent for participation in this survey had experienced dental decay. On average these children had 3.38 teeth that were decayed, missing or filled (at age 5, children normally have 20 primary teeth). The average number of decayed, missing or filled teeth in the whole sample (including the 72.1% who were decay free) was 0.94.

At regional and local authority levels, the results revealed wide variation in the prevalence and severity of dental decay; the areas with poorer oral health tend to be in the north and in the more deprived local authorities. Findings from the NHS DEP estimate that in Merton 29.2% of 5 year olds had tooth decay, which was better than London (32.9%) and similar to England (27.9%).

The survey also estimates the proportion of decayed teeth filled by dentists (Care Index), which reflects the extent of restorative care to teeth in need of this. In 2012, 13.1% of 5 year olds in Merton had tooth decay that had been filled, similar to London (13%), and higher than England (11.2%).

Trends in oral health

The methodology used in the 2012 survey enables comparisons with a previous survey in 2008. Nationally the results show a reduction in the proportion of children with dental decay from 30.9% in 2008 to 27.9% in 2012. Reductions in severity were also evident, with the average number of decayed, missing or filled teeth falling from 1.11 in 2008 to 0.94 in 2012.

However, in Merton the results show an increase in the proportion of dental decay in 5 year olds from 22.8% in 2008 to 29.2% in 2012. This is an increase of 6.4% and there was an increase in the average number of decayed, missing or filled teeth per child from 0.76 in 2008 to 0.92 in 2012.

\(^5\) 2011-12 Survey Results of 5 Year Old Children (2012). NHS Dental Epidemiology Programme (www.nwph.info/dentalhealth).
2008 to 0.92 in 2012. However, these findings should be treated with some caution as the sample sizes at local level are small. At a regional level the proportion of children with dental decay in London increased slightly from 32.7% in 2008 to 32.9% in 2012.

Trends in the Care Index estimate that the proportion of decayed teeth filled by dentists in Merton reduced from 24.4% in 2008 to 13.1% in 2012. This is a reduction of 11.3%; however, again, this must be treated with caution as the sample size at local level is small. At a regional level, the proportion of decayed teeth filled by dentist increased from 12.1% in 2008 to 13% in 2012.

The Care Index shows considerable variation within regions and in London the range in 2012 was from 6.2% in Havering to 29.5% in Kingston. The Care Index should be interpreted alongside other intelligence, such as deprivation, disease prevalence and the provision of dental services. This requires further investigation in Merton, particularly as children from lower socioeconomic backgrounds are disproportionately affected.

**Key facts on services for dental health**

**Access to NHS Dentistry**
Everyone should be able to access good quality NHS dental services. Dental care is provided by dental practitioners across Merton.

In terms of the number of people accessing NHS Dentistry, currently data is only available for Sutton and Merton combined. However, based on this 62.3% of children in Merton accessed NHS dentistry in 2013, indicating that nearly 38% of children do not access NHS Dentistry. This is similar to London but lower than national averages. Compared with 2006, the uptake of NHS Dentistry in Sutton and Merton has remained the same for adults but has reduced by 5.4% for children.

**Table 5.1: NHS dental patients as a percentage of the population, 2005-06 and 2012-13.**

<table>
<thead>
<tr>
<th>NHS dental patients seen in the previous 24 months as a percentage of the population, by patient type, 2006 and 2013</th>
<th>Adults</th>
<th>Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sutton &amp; Merton</td>
<td>46.6</td>
<td>46.7</td>
<td>67.7</td>
</tr>
<tr>
<td>London</td>
<td>48.2</td>
<td>47.1</td>
<td>65.7</td>
</tr>
<tr>
<td>England</td>
<td>51.6</td>
<td>52.5</td>
<td>70.7</td>
</tr>
</tbody>
</table>

Source: HSCiS
Services to promote dental health
The Oral Health Promotion Service is provided by the Sutton and Merton Community Dental Services. Health promotion professionals provide training, advice and direct promotion to:

- Children’s Centres (targeting parents of children aged under 5 years)
- Health visitors (targeting parents of children aged under 5 years)
- Primary schools (targeting children aged 3-12 years)
- Supported living institutions (targeting adults with learning disabilities)

In 2011, an evaluation of dental health promotion\(^{86}\) was carried out to describe the current Oral Health Promotion Service in Sutton and Merton and make recommendations for the service. This identified that the service was meeting a range of quality standards and identified opportunities for further development.

Key commissioning recommendations

- There is a need to improve access to NHS dental services for children and particularly in the early years.

- There is a need to review progress on implementing the recommendations from the oral health promotion evaluation, ensuring that they are implemented effectively. These recommendations included:
  - beginning health promotion interventions antenatally and targeting a wider range of at-risk populations
  - linking with other health promotion programmes, such as smoking cessation, alcohol-related and diet programmes
  - including evaluation as a key component of the service
  - delivery of oral health promotion at a wider geographical level e.g. across South West London.

Substance Misuse

(Writer’s note: a degree of caution should be exercised in the reading of this document as there may be some variance and ‘volatility’ with data presented here. JSNA Support packs for alcohol and drug treatment with refreshed data are due to be released by Public Health England in October 2013 with updated Local Alcohol Profiles England available from January 2014)

‘Drug and alcohol misuse is a complex issue. Whilst the number of people with a serious issue is relatively small, someone’s substance misuse and dependency affects everybody around them...studies including the National Audit Office report show that drug treatment provides value for money and independently verified national statistics show that drug treatment is effective and continually improving. Drug treatment benefits everyone, reducing crime and keeping communities safe.’

The National Drug Strategy 2010 set a new tone and direction for drug treatment, toward a more recovery oriented model that focuses on enabling people to receive treatment, and successfully complete and stay out with appropriate support. For the first time also in this new strategy, the importance of tackling alcohol misuse was duly acknowledged and positioned within an integrated services context.

In March 2012, the Coalition Government launched its Alcohol Strategy with a pledge to ‘tackle binge drinking and support local areas to tackle local problems, reduce alcohol-fuelled crime on our streets and tackle health inequalities.’ In July [2013] and following a period of consultation it was announced that although the proposal for a minimum unit price for alcohol remains under consideration, it will not be introduced at this time.

In April 2013, Public Health England having formally taken ownership of substance misuse, devolved responsibilities for commissioning and monitoring alcohol and drug treatment services down to Public Health Teams in local authorities. In Merton specifically, responsibility is shared between Safer Merton and Public Health and with the Children, Schools and Families Department in relation to young people.

Public Health England has published its priorities for 2013-14, with alcohol included in the first priority ‘Helping people to live longer and more healthy lives’.

Allied with the substantial health impact from substance dependence, alcohol and drug misuse are major causes of crime and disorder, particularly violent (including domestic violence) and acquisitive crimes that seriously harm the lives of individuals and blight the communities in which they live.

In 2012-13, LBM’s Safer Merton Team together with Public Health re-tendered and recommissioned a new and fully integrated Recovery-Based Adult Substance Misuse Treatment Service to meet the needs of those people within the borough’s population who

87 National Treatment Agency for Substance Misuse, as part of Public Health England 2013.
are alcohol and drug dependent and/or at risk of suffering serious substance related harm. Services for younger substance misusers locally are currently being reappraised and will be re-tendered in 2014-15. Together, we are also developing new substance misuse harm prevention frameworks for the borough that focus on whole population issues, public education and earlier identification and intervention methods aimed at stopping or reducing substance misuse before it has escalated into a more serious problem.

Alcohol – Adults

Key facts on reducing harm from alcohol

About 90% of adults in the UK consume alcohol to a greater or lesser extent and an increasing number of young people are binge drinking. The Public Health White Paper, ‘Healthy Lives, Healthy People’ (2010) identified reducing harm from alcohol misuse and encouraging sensible drinking as priorities, highlighting that regular heavy drinking is leading to a rapid rise in liver disease, which is now the fifth biggest cause of death in England.

Evidence on the harm that alcohol can cause is clear; it can cause cancers of the oral cavity and pharynx, larynx, oesophagus and liver, and misuse (i.e. drinking at levels that can cause harm) can be directly linked to ill health and death from liver cirrhosis and circulatory disease. The level at which alcohol can cause harm (i.e. the number of units per day or week) is less clear. Current guidance recommends not regularly drinking more than 3-4 units of alcohol a day for men (equivalent to a pint and a half of 4% beer) and not more than 2-3 units of alcohol a day for women (equivalent to a 175 ml glass of wine, depending on the strength). Evidence is still being established on these levels as there are a range of other factors that influence harm; such as age, weight and gender, how much you have eaten and how much sleep you have had. However, what is known is that the risk of harm is significantly increased if more than 30 units are consumed per week (less than half a bottle of wine of average strength per night).

The impact of alcohol misuse is not just on health; it is also associated with a wide range of criminal offences, including drink driving, being drunk and disorderly, criminal damage, assault and domestic violence, all of which can also indirectly impact on health. In younger people, risky drinking behaviour is associated with anti-social behaviour and teenage conceptions.

The picture of risky drinking behaviour is complex. Information from modelled estimates on binge drinking does not suggest a link with deprivation in Merton. However, this may reflect more on how the estimates have been modelled and does not reflect the pattern of health services use. The most recent data available indicates that higher risk drinking is more widespread, and occurs more in deprived areas, suggesting that high levels of risky drinking is also occurring both at home and out of the home. In Merton, as highlighted in the Local Alcohol Profiles for England published in August 2012, the estimated prevalence of binge drinking was 13.8% compared with 14.3% in London and 20.1% nationally. However, for small geographic areas within the borough, at middle super output area level, the range was
7% to 20%. The estimated levels of the adult population drinking at ‘increasing risk’ (21%) and ‘higher risk’ (7.2%) were above London or England levels.

Figure 5.15: Prevalence of risky drinking behaviour by area – percentage of the adult population that binge drink by MSOA, Merton, 2007-08, (modelled estimate).

Alcohol-related mortality and morbidity were generally low suggesting levels of risky drinking behaviour have been lower than that in London or nationally. However, as the consequences of high levels of alcohol intake can take a number of years to become apparent, this may reflect a historical pattern of drinking. Alcohol-related hospital admission rates were lower compared with rates in London or across England, but are increasing, suggesting a change in drinking behaviour in Merton:

- There are clear age and gender differences in the consequences of drinking behaviour.
- For older population – chronic conditions such as hypertension or alcohol-associated cardiac conditions.
- For the younger population – acute conditions (including the impact of alcohol related violence) and mental health conditions.
Figures 5.16a and 5.16b show that hospital admissions for alcohol-related harm in Merton in 2008-09 were higher for hypertensive, cardiac arrhythmia and mental health conditions. While lower than London and England, these admissions have increased consistently over time.

**Figure 5.16a:** Alcohol-related harm hospital admissions by cause and gender in Merton, 2008-9; **Figure 5.16b:** Admission episodes for alcohol-attributable conditions 2012.

![Alcohol Related Harm Hospital Admissions by cause and gender in Merton 2008/09](chart1.png)

![Admission episodes for alcohol-attributable conditions](chart2.png)

Merton is ranked highest in South West London boroughs for the 2011-12 [directly standardised rate] (DSR), and ninth in all London boroughs.
A Health Status Assessment on alcohol misuse was commissioned by Public Health in 2010 as part of the priorities for more in-depth understanding of key issues affecting the health of the population and to gain a better understanding of the current scope and extent of alcohol-related harm in Merton and particularly around drinking behaviour. Following its report and recommendations, an independent Alcohol Needs Assessment for the borough was commissioned by Safer Merton in 2012.

In 2012, in terms of alcohol harm overall, Merton ranked 55 out of 326 local authorities, but was in the higher percentiles for:

- Male mortality chronic liver disease (104/326)
- Female alcohol-specific hospital admissions (106/326)
- Male alcohol-specific hospital admissions (109/326)
- Male alcohol-attributable hospital admissions (151/326)
- Alcohol-related violent crimes (192/326)
- Alcohol-related sexual offences (208/326).
Figure 5.18: Alcohol-related crimes in Merton, 2007-08 to 2011-12.

Source: North West Public Health Observatory Merton Local Alcohol profile

Strategic Assessment Consultation 2012
Alcohol-related disorder was a concern expressed by participants in Safer Merton’s Strategic Assessment Consultation, which took place between October and November 2012. Table 5.2 below outlines the top concerns for alcohol (respondents indicating an issue was a ‘very big’ or ‘fairly big’ problem).

Table 5.2: Top concerns for alcohol, Safer Merton Strategic Assessment Consultation.

<table>
<thead>
<tr>
<th>Drugs and Alcohol</th>
<th>Number of responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol disorder/behaviour</td>
<td>140</td>
<td>33</td>
</tr>
<tr>
<td>Street drinking</td>
<td>136</td>
<td>32</td>
</tr>
<tr>
<td>Under-age drinking</td>
<td>108</td>
<td>25</td>
</tr>
<tr>
<td>Under-age alcohol sales</td>
<td>80</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: Results of Merton’s Public consultation for a proposed borough-wide designated public places order (DPPO) also known as a controlled drinking zone.
The Department of Health Ready Reckoner estimates for Merton [at that time] [what time?], suggested populations of:

- Hazardous/Increasing Risk Drinkers at 29,285
- Harmful/High Risk Drinkers at 7,030
- Dependent Drinkers at 3,788.
Messages on alcohol and support need to be consistent and well managed in a coordinated way by providers across a range of agencies. [Data] also highlight[s] a potential need to target support to both men and older people.

In terms of available statistics on alcohol treatment, nationally in 2011-12 there were some 108,906 people over the age of 18 in contact with structured treatment services and a further 33,689 clients citing problem alcohol use as secondary to a primary drug problem. For Merton, in March 2013, there were 344 adults receiving treatment for alcohol-related problems from commissioned substance misuse services, a very slight decline on the number reported as being in treatment in the previous April. Very high alcohol consumption is a feature of this population with on average about 20% of this group reporting having consumed in excess of a thousand units of alcohol in the 28 days before starting treatment.

In terms of morbidity and mortality, current trends suggest that there will be a considerable impact on local health and criminal justice systems as well as implications for the number of working days lost due to alcohol. The demand for healthcare resources due to alcohol-related admissions is likely to increase. Commissioners need to consider investment in prevention through early identification and advice for hazardous and harmful drinkers to
reduce alcohol-related morbidity and mortality, and subsequently contribute to reducing the burden on healthcare resources. Evidence shows that alcohol harm reduction interventions can deliver short, medium and longer term cost benefits whilst also improving clinical outcomes and promoting health gain:

- For every pound invested in identification and advice for increasing and higher-risk drinkers, £4.30 is saved as a return on investment within 12 months.
- For every pound invested in treatment of dependent drinkers, £3.10 would be saved as a return on investment within 12 months.

In terms of all alcohol-related crime and according to Local Area Profile Data for 2011-12, Merton with a rate of 7.3 recorded crimes per 1,000 populations was higher than the neighbouring boroughs Sutton (6.7) and Kingston (6.7) and the England average of 7 but lower than the London average of 11.1. The trend though in the five years since 2006-07 has generally been a downward one. From the people surveyed (‘My Place’ survey) in 2009, 41% thought that drunkenness and rowdy behaviour were a problem for the borough.

Alcohol-related harm costs the local health economy over £17 million. The total cost of alcohol-related harm represents 7% of healthcare costs. The high cost of tackling both alcohol-related crime and the health consequences indicate the need to work in a collaborative way to ensure that there is a coordinated approach across health services, local authority, the police and voluntary sector. The well-established Safer Merton partnerships include work to tackle alcohol-related crime and anti-social behaviour.

A costings report by NICE on harmful drinking in 2010 cited the estimated annual costs of crime and anti-social behaviour linked to alcohol misuse in England, uplifting the 2004 estimated costs to 2009, totalled some £8,016,000,000.

Work on alcohol-related harm amongst older people, particularly, concluded that, whilst there are gaps in local data on the prevalence of alcohol problems in this age group, any development of alcohol services needs to consider and address the needs of older people. This should include the targeting of public education messages, brief intervention services and development of referral pathways between alcohol and older people’s services.

There is also some locally emerging and anecdotal evidence to suggest that levels of alcohol-related harm might also be rising in our eastern European population, though this is yet to be fully quantified.

**Services, what works and best practice**

Evidence about what works to prevent harmful drinking has been produced by NICE in 2010. The evidence recommends that a combination of population and individual approaches are needed, including:
• At a national level, policy control on price, availability and marketing, including introducing a minimum price per unit, revising licensing legislation and reducing exposure of children and young people to alcohol advertising, particularly web-based channels.

• At a local level, adopting a ‘cumulative impact policy’ if an area is considered saturated with licensed premises, preventing under age and proxy sales, and ensuring full legal sanctions are applied to businesses that break the law.

• Investing in resources for commissioning screening and brief interventions for individuals, and extended brief interventions and referral to specialist services.

• Supporting children and young people aged 10-15 years and commissioning screening and extended brief interventions for young people aged 16-17 years.

In July 2013 and following analysis of the consultation’s responses, the Government announced that it would not be proceeding with minimum unit pricing. The policy would ‘remain under consideration’, but at present there was not enough ‘concrete evidence’ that it would be effective in reducing the harms associated with problem drinking ‘without penalising people who drink responsibly’. The Government would instead ban the sale of alcohol below the level of alcohol duty plus VAT. This would mean that it would no longer be legal to sell a can of ordinary-strength lager for less than 40p.

In Merton, we now have a borough-wide controlled drinking zone and two cumulative impact zones in place around the Wimbledon area.

In 2013-14 and as part of the Alcohol Merton work programme, we are further investing in alcohol screening, brief and extended brief interventions with targeted groups and in targeted locations such as A&E Departments, pharmacies and GP practices. We are also developing an enhanced support pathway for young people who present at A&E with substance-related conditions.

Drugs – Adults

Key facts on reducing harm from drugs

When engaged in treatment, fewer people use illegal drugs, and will commit less crime, improve their health and manage their lives better.

Accordingly, drug treatment planning and service provision for Merton has been specifically set up to ensure the achievement of the following core objectives, namely an increase in:

• those reducing their drug and alcohol misuse and those achieving abstinence
• those reducing their offending including repeat offenders
• those improving health and wellbeing
• those reintegrating with education, training and employment, housing and other services.
‘In effective treatment’ has been the standard performance measure and outcome in drug misuse for a number of years now and includes all individuals in contact with Tier 3 or 4 services for 12 weeks or more, or who had a planned exit from treatment within 12 weeks. Since 2012 and in line with the recovery agenda, a new national measure for substance misuse has been introduced to work alongside this. ‘Successfully Completed Treatment Episodes’ highlight the importance of people being able to leave treatment in a planned and positive way.

The National Drug Treatment Monitoring System (NDTMS) records drug users presenting to specialist drug agencies and GPs offering structured care. The database includes people treated in London agencies and excludes local residents treated elsewhere, though this number is probably small.

From the NDTMS records, annual statistics on substance misuse are calculated and published and in 2012-13 in England 185,429 adults were reported as in effective treatment and a further 29,855 people were successfully leaving treatment and free from dependency; 20,688 young people under the age of 18 years were reported as being in treatment also. Data from the National Drug Evidence Centre (NDEC) in 2013 suggests that the number of heroin and crack cocaine users in England has fallen below 300,000 for the first time. The latest estimates support the continuing shift away from the most harmful drugs, particularly among young people. However behind this positive picture, an older and vulnerable population of users poses major challenges for local treatment systems.

In 2012-13 Merton Substance Misuse Services were reported to be the highest performing nationally for successfully completed episodes, and were subsequently inspected and commended by the National Treatment Agency for Substance Misuse as an exemplar of good practice in this activity.

In terms of local treatment population statistics for drug misuse, in Merton in 2011-12 it was estimated that 5,024 people aged 18-64 were dependent on drugs and of these approximately two thirds were male. By 2020 it is predicted that the number of people dependent on drugs will increase by 11%. This includes all drug users and is based on a national prevalence rate of 3.4%. Most dependence is estimated to be on cannabis only (2.5%), rather than other drugs (0.9%). In [2011-12] 505 clients were actually in treatment, of which 370 were men and 133 were women; 39% (n=196) of clients in treatment presented with crack and/or opiates as their main drug used. The total number of clients presenting has decreased by 25% from 2010-11 (675 clients in treatment); this may reflect a national trend with a modest decline in demand for services across the country.

In Merton, there are an estimated 1,029 opiate or crack cocaine users (OCUs), a rate of 7.1 per 1,000 populations, lower than both London (9.4 per 1,000) and England (8.9 per 1,000). Of OCUs in Merton, just over 20% (n=209) are injecting drug users. Taking those already in treatment and/or those known to the treatment system, it is estimated that there are some 678 people in the community not presenting or having not ever presented to services – 65%

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88 PANSI (2011).
of the total estimated users. This has grown from 2010-11 when the figure was estimated at 45%.

Figure 5.21: Trends in problematic drug users in treatment.

In 2011-12, of those starting treatment the proportion in effective treatment was 83% for OCUs and 86% for all drug users and there was a high-planned exit rate from treatment which shows successful completions. The planned exit rate in 2011-12 was 58% of all treatment exits, compared with 42% in London and 43% in England. The percentage of opiate-based successful completions was 44%, higher than both London (37%) and England (33%).

Vulnerable groups at greater risk of developing problematic drug use include homeless people, sex workers, offenders, young people excluded or truanting from school, looked-after children, and children whose parents misuse drugs. Alcohol, tobacco and cannabis use is strongly related with youth offending.

Heroin use is linked with less affluent groups in the population, while unemployed 16 to 29 year olds have higher rates of drug use for any drug, for heroin and for Class A drugs. Socio-economic status and geographical area of residence, as well as age and sex, are among the factors linked to levels and patterns of drugs misuse.

The Diagnostic Outcomes Monitoring Executive Summary (DOMES) for the last quarter of 2013-14 shows that there were 239 adult opiate users and 212 non-opiate users in effective treatment in Merton (slightly below the national average). The average length of time spent in treatment for all clients was 2.4 years. 10% of clients were long-term (predominantly opiate) users, having been in treatment for more than six years. Successful completion rates for opiate users are in the top quartile of national performance, which is in line with a national decline in new opiate users presenting for treatment. 53% of non-opiate clients successfully exited treatment (a 6% increase on the previous year), with 35% of this group not
representing within six months of having left. No client had to wait more that three weeks to start drug treatment.

**Key commissioning recommendations**

For the treatment system as a whole:

1. Continue to monitor local treatment services against an agreed Performance Assessment Framework and local indicators and outcomes for substance misuse as indicated in the Public Health Performance Dashboard.
2. Safer Merton, Public Health and the Merton CCG to review current usage of commissioned substance misuse inpatient (Tier 4) bed nights and further develop community treatment capacity to manage down future demand for inpatient services.
3. Safer Merton and Public Health to develop new substance misuse prevention frameworks and reinvestment proposals to complement these.
4. Continue to develop assertive outreach capacity to support hard-to-engage populations.
5. Further develop local capacity to respond to parents who misuse alcohol and other drugs, and to safeguard children.
6. Maintain integrity, commitment and future resourcing for integrated substance misuse treatment services.

For alcohol:

7. Develop an agreed local strategic framework for alcohol partnership work with an alcohol action work plan for 2013-14
8. Stream relevant elements of the alcohol work programme through a new Merton Harm Prevention Forum.
9. Target street drinking and anti-social behaviour and effect appropriate responses through the Local Multi-Agency Planning and Problem Solving Groups.
10. Work with Trading Standards and the Metropolitan Police Licensing Team to target licensed premises and other alcohol outlets that continue to sell alcohol to children and/or are ‘hubs’ for anti-social behaviour in local communities.
11. Have a Merton Alcohol Licensing and Planning Task Group.
12. Through training, develop workforce capacity in identifying and responding appropriately to problem alcohol use.
13. Have a specific alcohol arrest referral pathway to divert and support problem drinkers at an early point in the criminal justice system.

For drugs:

11. Use the Targeted Drug Testing on Arrest programme effectively to identify and treat drug misusing (particularly Class A) offenders.
12. Ensure that local treatment services are linked and contribute to effective Integrated Offender Management work locally.
Further Figures:

Figure 5.22a: Proportion of age-specific admissions for accidents and injury, alcohol, and violence, Sutton and Merton, 2008-9; Figure 5.22b: Percentage of alcohol-specific admissions related to mental and behavioural disorders for Merton, by age group.

![Age Specific N139 Admission profiles for Acute Conditions 2008/09 for Sutton and Merton](image1)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Accidents and Injury</th>
<th>Alcohol Specific</th>
<th>Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>50+ yrs</td>
<td>53.2</td>
<td>12.1</td>
<td>10.9</td>
</tr>
<tr>
<td>30-49 yrs</td>
<td>26.7</td>
<td>39.4</td>
<td>35.9</td>
</tr>
<tr>
<td>18-29 yrs</td>
<td>17.3</td>
<td>40.4</td>
<td>40.9</td>
</tr>
<tr>
<td>0-17 yrs</td>
<td>2.7</td>
<td>8.1</td>
<td>12.3</td>
</tr>
</tbody>
</table>

![Percentage of alcohol specific admissions (N139) related to mental and behavioural disorders for Merton by age group](image2)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage of admissions by age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>3.3</td>
</tr>
<tr>
<td>19-29</td>
<td>11.7</td>
</tr>
<tr>
<td>30-49</td>
<td>30.3</td>
</tr>
<tr>
<td>50-64</td>
<td>30.1</td>
</tr>
<tr>
<td>65+</td>
<td>15.6</td>
</tr>
</tbody>
</table>
Figure 5.23: Percentage of alcohol-specific conditions for chronic conditions by disease and age group, Merton, 2012.
Young people’s substance misuse

Key facts on young people’s substance misuse

The Government’s drug strategy (2010) recognises that young people’s drug use is a distinct problem. Most young people do not use drugs and the majority of those that do are not dependent. However, drug or alcohol use can have a major impact on young people’s education, health, family and longer-term chances in life. While drug and alcohol education should be offered to all, specialist interventions should prevent young people’s drug and alcohol use from escalating, reduce the harm young people can cause to themselves or others, and prevent them from becoming drug or alcohol-dependent adults. Furthermore, the cross-governmental policy Positive for Youth (2011) makes clear the links between substance use and risky behaviour, and stresses the importance of prevention, early intervention and support to those who need it.

Vulnerable groups including sex workers, offenders, young people excluded or truanting from school, homeless people, looked-after children (children under the care of social services) and children whose parents misuse drugs are at greater risk of developing problematic drug use. Alcohol, tobacco and cannabis use is strongly related with youth offending. Heroin use is linked with less affluent groups in the population, while unemployed 16 to 29 year olds have higher rates of drug use for any drug, for heroin and for Class A drugs especially. In younger people, risky drinking behaviour is associated with anti-social behaviour and teenage conceptions.

Drinking and young people

In Merton, in terms of drinking behaviour, the only source of information on attitudes and beliefs towards drinking alcohol we have is from the TellUs 4 survey (2009) in which the majority of children (8 to 16 years) reported not having ever had an alcoholic drink. For those that did report drinking, the number getting drunk once, twice or three or more times in the past month was consistently lower than national figures. Drinking estimates for Merton young people extracted from the 2013 Merton Young People’s Sexual Health and Substance Misuse Needs Assessment, based on the National Centre for Social Research’s Smoking, Drinking and Drug Use survey (2011), suggest that 1,977 (19%) of young people between 11 and 15 years are drinking once a month or more, with an additional 2,090 (20%) drinking a few times year. For young people 16-17 years consuming alcohol in the last week, the estimation based on the Institute of Alcohol Studies was 2,476 (62%).

Latest reported figures from the Local Alcohol Profiles for England for alcohol-specific hospital admissions in the under 18 age group (2012) suggest a slight decrease in hospital admissions in the past six-year period. Merton, however, ranked ninth highest in London. As absolute numbers were small, one or two admissions would affect the ranking and didn’t include attendance at an A&E department, so therefore need to be treated with caution.
Drugs and young people
The Government's drug strategy states that specialist interventions should prevent young people’s drug and alcohol use from escalating, reduce the harm young people can cause to themselves or others, and prevent them from becoming drug or alcohol-dependent adults.

Specialist interventions should be delivered according to a young person's age, degree of vulnerability, and the severity of the problem. Good practice is to meet their substance misuse needs as part of a broader package of care that includes support with housing, education and family relationships and contributes to improving health and wellbeing, educational attendance and achievement, and reduced risk-taking behaviour, such as offending, smoking and unprotected sex.

In the Merton Young Residents Survey 2012, young people expressed concerns about drug use and pushers, which had increased by 4% in 2012 from 2011, rising to 18%, although below the London average.

Merton saw an increase in the numbers of young people under 18 years presenting for specialist treatment interventions in 2011-12. An analysis of needs assessment data for 2011-12 reveals that 138 young people aged under 18 were in treatment, which represents a 23% increase on the previous year. Figures for 2012-13, however, return to levels seen in previous years of just under 100. In this year 46% came through the youth justice route and 27% were using alcohol and cannabis.

The risk-harm profile identifies 10 key items to gauge the vulnerability of young people entering specialist substance misuse services, including contracting an STI, having a child, being in contact with the Youth Justice Service, receiving benefits before the age of 18 and being NEET. The higher the score, the more complex the need. In 2012-13, 78% of young people coming for treatment in Merton presented with two to four vulnerability factors, an increase on the previous year; 52% were using two or more substances and 75% began using substances under the age of 15 (NTA 2013). A more in-depth analysis of the 2011-12 figures reveal that Merton young people in treatment had a high-risk profile for polydrug use, offending and early onset.

Effective treatment for young people can be achieved in a relatively short time, as their use is not as entrenched, but others will need support for longer periods of time. The proportion of those leaving in a planned way as a percentage of all exits was 82% in 2012-13 in Merton compared with the national figure of 79% (NTA 2013). Of the planned exits, 97% did not represent to services within six months. This is an increase on previous years.

Key facts on services
A Department for Education cost-benefit analysis found that every £1 invested in specialist treatment interventions delivered up to £8 in long-term savings and almost £2 within two years.
LBM currently commissions a specialist Substance Misuse Service to provide three key work strands: increasing substance awareness; identification of needs and referrals; and providing treatment. This is achieved through:

- providing support to universal or targeted services via advice and consultancy
- developing capacity to identify substance-related needs of young people through joint working with, advice to and training of service staff working with vulnerable young people
- providing a service for young people aged 18 to 24
- delivering education workshops in schools, colleges and via education, training and employment services
- providing a range of specialist, care-planned substance misuse treatment interventions
- supporting services for parents through interventions that enable them to support the young person in the family, or as a young parent. Interventions are also offered to kin carers, and foster carers.

A specialist Substance Misuse Service also operates through the CAMHS service and is commissioned to work with young people with a dual diagnosis of substance misuse and mental health. Early identification and prevention elements for substance misuse are also integrated into mainstream youth service delivery.

**What works and best practice**

To tackle some of the root causes and to find solutions to prevent harm from drug and alcohol misuse require tight partnership working. The provision of specialist substance misuse services for young people is also outlined within the memorandum of understanding (MoU) between the Department for Education and Public Health England (formally the National Treatment Agency). The MoU highlights that local delivery of young people’s substance misuse interventions should be integrated into broader children’s services provision, with planning and commissioning becoming an integral part of strategic children’s and young people’s planning. This presents an opportunity to ensure specialist interventions are integrated with wider children’s services to effectively address the root causes of their problems and build the resilience they need to resist substance misuse in the future.

Evidence about what works to prevent harmful drinking has been produced by NICE in 2010. For young people the evidence recommends supporting children and young people aged 10-15 years and commissioning screening and extended brief interventions for young people aged 16-17 years.

NICE further recommends school-based interventions on alcohol, including:

- screening for young people aged 16-17 years
- brief intervention for hazardous or harmful drinking
- age-sensitive school-based education and advice on potential damage through alcohol use
- introducing a 'whole school' approach to alcohol
- ensuring locally defined care pathways for alcohol treatment.
For vulnerable young people who are problematic substance misusers, offering motivational interviewing has been shown to be effective in reducing or stopping substance misuse. Vulnerable young people assessed to be at high risk, specialist interventions should offer:

- family-based programmes of structured support, and more intensive support for those who need it
- group-based behavioural therapy
- parents or carers group-based training in parenting skills
- counselling-based techniques to encourage behavioural and emotional change
- pharmacological interventions, including prescribing for detoxification.

In terms of primary prevention, interactive education programmes should be part of a comprehensive prevention programme that includes:

- in schools, interventions with children, parents and teachers
- multi-component programmes (e.g. school-based drug education; parent or carer involvement; media campaigns; community partnerships; local health initiatives)
- life skills training (LST).

Commissioners must also focus on primary preventive measures for all children to ensure that the focus isn't solely on secondary prevention (i.e. those already at risk). Merton's joint Teenage Pregnancy and Substance Misuse Partnership Board oversees the delivery of annual locally agreed action plans that focus on both primary preventive measures and secondary prevention. This includes:

- The delivery of a young people’s specialist Substance Misuse Service (up to age 24) providing a range of specialist interventions and targeted prevention programmes.
- Support for the delivery of effective drug and alcohol education.
- Commissioning of an interactive Theatre in Education project addressing sexual health and consequences of alcohol consumption in Merton secondary schools and youth settings.
- Further development of the successful South West London Gettington sexual health website to include information on drugs and alcohol.
- Workforce training and development on early identification of young people at risk.

**Key commissioning recommendations**

A joint young people’s sexual health and substance misuse needs assessment was carried out in Merton in 2013 which highlighted local needs and gaps. This needs assessment indicated improvements could be made in relation to:

- strengthening preventive and early identification strands of support, including outreach provision
- providing referral pathways for substance misuse and further integration with sexual health provision
- increasing training to improve early identification and increase referrals to specialist services
• provision for young people aged 18 to 24 in contact with criminal justice services but using Class A drugs were also highlighted as a local gap
• providing effective transitions into adult Substance Misuse Services for 18-24 year olds who require extended support and treatment
• providing an A&E intervention pathway for young people who present there with substance misuse issues
• upon completion of the review of the existing young people’s Substance Misuse Service, agreeing recommendations and re-tender in 2014.

Further sources

DCSF and NTA (2008). Memorandum of Understanding between the Department for Children, Schools and the Families (DCSF) and National Treatment Agency for Substance Misuse Treatment (NTA) on Young People’s Specialist Substance Misuse Treatment. FINAL.


Teenage Pregnancy

Key facts on teenage pregnancy

Teenage conception includes all conceptions before the mother’s 20th birthday, but the national focus is on conception under 18 as most potential mothers in this age group are in full-time education or training. The conception rate is the number of pregnancies that start before the mother’s 18th birthday (per 1,000 young women aged 15 to 17) and includes pregnancies that end either in birth or in termination.

Evidence indicates that high rates of teenage pregnancy are most often associated with low educational attainment and disengagement from school, economic deprivation, and poor mental health. Young people at increased risk of early parenthood and teenage pregnancy include children of teenage mothers, looked-after young people, young people misusing alcohol, young people involved in crime, those with low self-esteem and some BME groups. Early onset of sexual activity, poor contraceptive use and repeat abortions are other significant risk factors. Teenage conception rates for England and Wales have also seen a dramatic fall since the launch of the national teenage pregnancy strategy. The UK now has the lowest levels of teenage pregnancy since records began. In 2011, the rate fell to 30.7 per 1,000 women.

In Merton, the under 18 conception rate was 27.6 per 1,000 (2011), below that of London, and England and Wales. The rate had reduced 45.9% from the 1998 rate of 51 per 1,000. The latest rolling quarterly average for June 2012 was 24.7.

Figure 5.24: Under 18 conception rate in Merton, 1998-2011.
However, this masks variation across the borough with the rates of some wards in line with inner London. The electoral wards with the highest under 18 conception rates (aggregated data for 2009-11) were Pollards Hill (78.7) and Cricket Green (54.1). As ward conception numbers are relatively small (even when aggregated for three years) rates may vary markedly from year to year and should be interpreted with some caution. Merton has set a new local teenage pregnancy target of 27 per 1,000 for 15 to 17 year olds by the year 2015.

Evidence suggests it is the most disadvantaged, vulnerable young women with the greatest number of risk factors who are most likely to have a conception aged under 18 and are more likely to see the pregnancy through. This is supported by a strong association locally (74%) between women aged under 19 giving birth and living in more deprived areas. This in turn perpetuates the cycle of poor outcomes, including health outcomes, not just for young parents but for their babies as well.

Deliveries to Merton women aged under 19 years have been gradually decreasing though the variation is due to small numbers as shown in Figure 5.25 below. However, delivery data does not provide a full picture of under-18 conceptions. Consistently, data suggests that about 60% of under-18 conceptions locally lead to termination (59.5% in Merton in 2011 – there is some year-on-year variation). Therefore knowledge of the number of terminations is important.

**Figure 5.25: Teenage deliveries April 2009-December 2012 quarters (aged 15-17).**

![Teenage deliveries by borough, with trendlines, quarterly rolling averages (April 2009 to December 2012)
Source: SUS 2012](image)

The recent data (2011) on rates of abortion in Merton shows that the rate was higher (16.4 per 1,000 population) than England (15.1 per 1000 population) but lower than London (17.5 per 1,000 population). In addition, teenage abortion rates are declining as illustrated in Figure 5.26, in line with the conception rates, which is indicative that services in place are having a real impact on teenage conception rates.
However more than half of conceptions to young people under 18 in Merton in 2011 resulted in terminations, which was lower than London (61%) but higher than England (49.3%) proportions. Three-year rolling averages from the 1998 baseline show that the proportions of teenage conceptions leading to terminations are increasing in Merton as shown in Figure 5.27 below. The proportion of all teenage conceptions leading to abortions has increased by 9% since the 1998 baseline, although lower than London and England at 13% and 16% respectively.

Figure 5.26: Teenage abortion rates in Merton.

![Graph showing Under 18 abortion rate in Merton.](image)

Source: ONS

Figure 5.27: Percentage of teenage conceptions leading to abortions.

![Graph showing Percentage of Under 18 conceptions leading to abortion in Merton.](image)

Source: Teenage Pregnancy Unit
What works and best practice

In July 2006 the Government produced guidance on the effective delivery of local teenage pregnancy strategies. This set out 10 key factors local areas needed to take into account to deliver an effective local strategy. The factors were based on both international evidence and learning from areas achieving significant reductions in their under-18 conception rates.

Of the key factors the strongest empirical evidence for the reduction of teenage conceptions is high-quality education about relationships and sex, and access to and correct use of effective contraception. One fifth of births conceived to under-18 conceptions are second or subsequent births. Early intervention programmes such as the Family Nurse Partnership can help to prevent second conceptions and increase young parents’ take-up of work, education or training. The provision of supported housing may also increase participation rates, boost self-esteem and delay further motherhood. As teenage pregnancy contributes to poor outcomes, and can further exacerbate vulnerability, the continued reduction of teenage conceptions is now recognised as a Public Health Outcome. This is reflected in the new Framework for Sexual Health Improvement in England (2013).

LBM will continue to support the delivery of this framework through the well-established Teenage Pregnancy and Substance Misuse Partnership Board and is guided by locally agreed annual action plans that focus on both primary preventive measures and secondary prevention. This includes:

- The delivery of a young people’s sexual health service in education and youth settings alongside the mainstream CASH service.
- Supporting the delivery of effective sex and relationships education.
- Increasing access to emergency contraception and condoms.
- Further development of the successful South West London Gettington sexual health website.
- Workforce training and development on early identification of young people at risk.
- Supporting teenage parents through the forthcoming Family Nurse Partnership and increasing access to children’s centres.

Key commissioning recommendations

A joint young people’s sexual health and substance misuse needs assessment was carried out in Merton in 2013 which highlighted local needs and gaps. The needs assessment indicated improvements could be made in relation to:

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• improving access to contraceptive services, condoms, emergency contraception and STI testing for young people.
• continuing to raise the profile of services in schools, but for interventions to be provided in youth settings that ensure privacy
• improving training for frontline professionals on talking to children, young people and parents about sensitive issues – highlighted as a local need
• increasing access and referral to sexual health services from mainstream and targeted youth support services
• further integrating sexual health services with substance misuse prevention services.

Further sources


The Royal College of Paediatrics and Child Health (2010). Not just a Phase: A guide to the participation of children and young people in health services.
MERTON
JOINT STRATEGIC NEEDS ASSESSMENT
(JSNA)
2013-14

THEME 6:
CHILDREN AND YOUNG PEOPLE,
AND MATERNAL HEALTH IN MERTON
Summary and Overview of Recommendations

The Marmot Review, *Fair Society, Healthy Lives*, identified giving every child the best start as the highest priority in reducing the inequalities gap that exists between different groups of people. Action to reduce health inequalities needs to start before birth and be followed through the life of the child to improve adult health outcomes.

**Key findings**

**Demographic trends**
Theme 2 (*Merton: The Place and the People*) sets out demographic changes in Merton. Key findings for children and young people include:
- There has been a 40% net increase in births from 2,535 in 2002 to 3,537 births in 2011.
- By 2021 there will be an expected 20% increase in children born each year with future special needs (from 230 to 276).
- There are 47,500 children and young people aged under 20 years old, which is nearly 24% of the population in Merton.
- The number of children and young people aged 0-19 years is forecast to increase by around 3,200 (3%) by 2017. In particular, there is forecast to be an increase of 2,300 (20.3%) in the number of children aged 5 to 9 years.
- There are 15,000 (7.5%) 0-4 year olds, which is expected to rise by 780 by 2017.
- There are 32,500 (16.2%) children and young people aged 5-19 years, which is expected to rise by 2,400 by 2017.
- It is forecast that the proportion of BAME people in the 0-19 age group will increase from 44% in 2011 to 47% in 2017.

**Where Merton is doing well**

*Mature health*
- The infant mortality is similar to London and England, at a rate of 4 infant deaths per 1,000, compared with 4.4 regionally and nationally.
- Fewer babies are born with a low birth weight compared with London.
- Breastfeeding initiation and breastfeeding rates at 6-8 weeks are higher compared with England.
- Smoking in pregnancy is lower compared with England.

*Early years*
- The proportion of children achieving a good level of development at age 5 is above the national average, at 66% for Merton compared with 64% for England.

*Children*
- There are fewer children living in poverty (18.3% or about 7,000 children) compared with England (21%).
- Hospital admission rates for injury are lower compared with London and England.
- Hospital admissions as a result of self-harm are lower than for London and England.
Educational attainment is in line with England and in 2013 provisional data shows an increase above the national average in pupils achieving five GCSEs at A*-C grades, including English and maths (provisional data for 2013).

The rate of progress in performance in Merton schools is greater than the majority of other local authorities.

The gap in educational attainment between pupils eligible for free school meals and their peers is narrower compared with England at secondary school level.

**Young people**

- Teenage pregnancy rates have reduced significantly over the past 13 years, down from 51 per 1,000 in 1989 to 27.6 per 1,000 in 2011.
- There has been a year-on-year reduction in first-time entrants to the youth justice system over the past four years, and a reduction in the number of violence against the person crimes.

**Where Merton has some challenges**

**Maternal health**

- There is variation in low birth weight by area and ethnicity, with higher rates in more deprived wards and among BAME ethnic groups.
- There is variation in breastfeeding by area and ethnicity, with lower rates in more deprived areas and among white British ethnic groups.
- There are higher rates of delivery by caesarean section – 27 % compared with 24% for England.

**Early years**

- There is nearly a 30% gap in child development at age 5 between the highest and lowest achievers.
- Childhood immunisation coverage is below London and England levels and the World Health Organization’s target of 95%, and there is variation in the level of immunisation coverage by GP practice.
- Emergency attendances for children aged 0-4 years are higher compared with England and there is variation by GP practice.

**Children**

- There is an increase of nearly 14% in levels of excess weight (overweight and obesity) in children between the ages of 5 and 11 years, from just over a fifth of Reception level children to just over a third of Year 6 level children.
- There is variation in obesity rates by gender, ethnicity and area, with higher levels of obesity associated with deprivation.
- Nearly 30% of 5 year olds are estimated to have decayed, missing or filled teeth, an increase of 6.4% between 2008 and 2012, and there has been a reduction in the proportion of decayed teeth filled by dentists. Nearly 38% of children in Sutton and Merton do not access an NHS dentist.
- There is a gap between the number of children and young people accessing Tier 3 Child and Adolescent Health Services and the estimated numbers with a mental health problem indicating a need for Tier 3 services.
• There has been an increase in the number of children with statements of SEN with ASD over the past three years.
• Nationally and in Merton there has been an increase in children in care and on a child protection plan.
• There has been an increase in the number of looked-after children (LAC).

Young people
• There is variation in teenage pregnancy rates by area, with higher rates concentrated in more deprived wards.
• Hospital admissions for alcohol-specific conditions in children and young people aged under 18 are the ninth highest in London (although still lower compared with England).

Summary of recommendations for commissioners

Impact of demographic change
The current picture of rising births and of potentially less outward migration has implications for projecting future need and demand for services. Commissioners need to consider the implications for:
• Increasing need for maternity services – planning for additional capacity is needed linked to a regional strategy for maternity services.
• Impact on primary care and community services – planning for additional capacity to deliver the Healthy Child Programme, including health visiting and school nursing services.
• Increased incidence of long-term conditions in children and young people, such as asthma and diabetes.
• Impact on children social care, child protection and education services – planning for additional capacity.
• If the proportion of low and very low birth weight babies stays the same (approximately 7% of all births) there will be a rise in children born with future special needs – which will impact on planning for additional capacity for paediatric and neonatal services; SEN; and continuing care/short breaks.

Impact of deprivation
Deprivation is linked to poor health. Higher numbers of children are being born in the more deprived areas of the borough. Commissioners need to consider:
• The impact of the recession and welfare reform on longer-term child health, including long-term care and mental health.
• The significant link between deprivation, poverty and mental wellbeing in young people. More robust information is needed on the mental health and wellbeing of children and young people.
• The geographical inequalities that exist in health and lifestyles in maternal health, and children and young people, including breastfeeding rates, teenage pregnancy rates, levels of overweight and obesity, and oral health, which need to be addressed.
• The clear link between teenage pregnancy, offending behaviour, truancy and alcohol and drug misuse. Commissioners need to review the opportunities to look more holistically in tackling these issues.

Service development
The JSNA has identified a number of priorities and areas for development, many of which build on current commissioning and service development activity:

Maternal health
• Maintain a focus on action to ensure that infant mortality and low birth weight remain low in Merton, including:
  o reducing child and family poverty and housing needs
  o reducing maternal obesity and improving nutrition, particularly in more disadvantaged areas
  o improving the accessibility of antenatal care and support during the first year of life, targeting areas of higher needs.
• Review the rate of caesarean deliveries, both elective and emergency, and identify how this can be reduced.
• Develop and deliver a breastfeeding action plan that targets lower levels of breastfeeding in the more deprived areas of the borough, based on best evidence of effective practice.
• Ensure providers achieve Level 3 UNICEF Baby Friendly initiative.
• Ensure the effective delivery of the Family Nurse Partnership, targeting mothers aged under 20 years.
• Ensure that the South West London maternity dashboard is monitored to provide standardised data from providers. Ensure that there is robust analysis of data for the Merton population to inform commissioning.
• Going forward, ensure that the new national Maternity and Children’s Data Set (MCDS), which over time will result in comprehensive data (HSCIS-MCDS), informs local commissioning.

Early years
• Monitor progress on childhood immunisation coverage towards local and WHO targets; ensure that improvements to childhood immunisation data systems are monitored and sustained.
• Deliver childhood immunisation action plans, including improving call-recall systems and increasing access to and awareness of immunisation for parents.
• Develop an outcomes model of commissioning for early years, based on evidence of best practice and underpinned by strong data systems.
• Develop early years prevention and early intervention pathways, with clear referral routes for all partners.
• Parental mental health has been identified as a significant factor in parenting; there is a need to increase parent support, ensure there is staff training and awareness and develop clear pathways into mental health services.
• Implement a data sharing agreement across early years in order to strengthen the ability to provide earlier intervention for families identified as having additional needs.
• Establish a vision, model and transition plan for health visiting as commissioning responsibility for the service moves to the local authority in 2015.

**Vulnerable children and young people**

• Understand and address the impact of increasing numbers of low birth weight babies on the demand for health and social care services.
• Ensure children with long-term conditions are supported to access the full curriculum in schools and have a smooth transition to adult services.
• In light of the increasing numbers of children diagnosed and increasing waiting times for assessment, develop an autism pathway for children and young people, linked to the Autism Strategy.
• In order to gain a better understanding of the need for services and inform future commissioning strategy, undertake a needs assessment of the mental health and wellbeing of children and young people.
• Review the impact of implications of the Children and Families Bill 2013 on all services, including schools, health and therapy services, special educational needs and disabilities, and social care.
• Ensure pathways and links across services are in place to ensure effective access and intervention for children and young people on the threshold of care and looked after children.
• Consider the impact on services of increasing numbers of LAC requiring timely health assessments.
• Substance misuse is a major factor in youth offending and there is a need to better market existing pathways into substance misuse services.

**Access to health services**

In light of existing and future financial constraints, and at a time when the birth rate is increasing, there is a need to:

• ensure that in the majority of cases children with both acute and long-term conditions are supported in the community as much as possible
• ensure the local pathway of unplanned care is underpinned by a consistent model of care for all organisations.
• review data on hospital attendances for children aged 0-17 years, including a focus on the 0-4 age group, and further develop local initiatives to reduce A&E attendances.
Introduction

The Marmot Review, *Fair Society, Healthy Lives*, identified giving every child the best start as the highest priority in reducing the health inequalities gap that exists between different groups of people. Action to reduce health inequalities needs to start before birth and be followed through the life of the child to improve adult health outcomes.

This is the first year that Merton JSNA has included a separate section on the needs of children and young people and maternal health. The aim is that this will provide a clear focus on children and young people and make it easier to access information on their needs.

This section sets out the high level needs of children, young people and maternal health. It outlines services to meet those needs, highlights evidence of good practice and sets out implications and recommendations. The aim is to improve outcomes for children and young people in Merton by informing and influencing commissioning and service delivery.

This section covers:
- Maternal health
- Child health and early years 0-5
- Vulnerable children and young people
- Access to health services

In addition, information on lifestyles and health improvement is set out in Theme 5 (*Lifestyle Risk Factors in Merton*); information on wider determinants of health, including access to education, is set out in Theme 4 (*Social Determinants in Merton*); and information on the voice of young people in Merton is set out in Theme 1 (*Merton Voice*).

It is recognised that this is a developing section of the JSNA and in future years we aim to strengthen aspects of this section. In a number of areas data is still only available at PCT level (Sutton and Merton). Over time this will change as health data is recorded at CCG level (Merton).

**Strategic priorities for children and young people**

Strategic priorities for children and young people are set out in the Health and Wellbeing Strategy and the Children and Young People Plan:

*Merton Health and Wellbeing Strategy* has identified ‘Giving every child a healthy start’ as a key priority. The strategy includes a commitment to further strengthen partnership approaches to prevention strategies for children and young people, across universal services and settings. This will ensure the earliest identification of health and wellbeing issues to better target services to those families that are in the greatest need of support, particularly for residents living in the east of the borough.
The Merton Children and Young People Plan 2013-16 sets out the Children’s Trust Board’s commitments to improving outcomes, life chances and choices for children and young people. The Children’s Trust Board provides a focus for integrated planning and delivery of children’s services, particularly focusing on key groups of children vulnerable to poor health outcomes. Further details are available at: www.merton.gov.uk.

Further resources
The Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better – Prevention Pays, sets out evidence about challenges and priorities to improve the health and wellbeing of children and young people:

Further sources, including a child health profile for Merton is available at the Public Health England Child and Maternal Health Observatory (ChiMat): http://www.chimat.org.uk/
Maternal Health

Key facts on maternal health

Maternal health refers to the health of the woman during pregnancy, childbirth and the postpartum period. It includes issues such as birth outcomes; recovery from childbirth; newborn care; nutrition and breastfeeding; and family planning. Risk factors include obesity, alcohol, drug misuse, homelessness, mental ill health, teenage pregnancy, domestic violence and sexually transmitted infection. Women on low income, women with a low level of education and previously ill women are more at risk of developing complications during childbirth and after delivery.

In Merton, in 2010-11:

- There has been a 40% net increase in births from 2,535 in 2002 to 3,537 births in 2011; this is forecast to peak at 3,618 births in 2014.
- Half of these babies are delivered at St George’s Healthcare NHS Trust.
- Birth rates are significantly higher than in England as a whole.
- The proportion of babies born to older mothers is also significantly higher, with more than one quarter of babies born to mothers over 35 years.
- Nearly 60% of babies are born to mothers born outside the UK.
- Over three quarters of pregnant women had an antenatal assessment within the first 12 weeks of pregnancy, which is similar to the London average.
- The proportion of deliveries by caesarean section was significantly higher than the national average; this includes both elective and emergency caesarean deliveries.
- Infant mortality rates are statistically similar to the national average.
- The proportion of babies born with low birth weight is significantly lower than for England as a whole.

These findings from the London Maternity Pathway profile 2011-12\(^{92}\) and ChiMat\(^{93}\) provide an overview of key issues and are based on nationally available data. It is important to note that some data is only available at PCT level (Sutton and Merton) and that it may not reflect more recent local data.

Mother’s age

Analysis of women giving birth in Sutton and Merton during 2010-11 shows that the highest proportion of deliveries were to women aged 30-34 years old, accounting for 34.8% of all deliveries. 25% of deliveries were to women aged 35 and over. 2.6% of deliveries were to mothers under 20 years, compared with 3.1% for London and 5.5% for England.

Mothers aged 19 and under and mothers over 35 years old, and their babies, are at greater risk. Teenage mothers are at increased risk due to late presentation and the mother’s

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lifestyle and diet. Older mothers present a series of different challenges. They have a greater chance of developing medical disorders such as diabetes, high blood pressure or other chronic diseases. The likelihood of still births and multiple births also increases with the mother’s age. For more information on teenage pregnancy, see Theme 5 (Lifestyle Risk Factors in Merton).

Mother's ethnicity
There are a number of reasons why the ethnicity of mothers in a local area may influence the needs which the services provided must meet. For example:

- Certain conditions are known to be more common in particular ethnic groups, such as diabetes.
- Mothers or their families who have recently moved to the UK may have difficulty reading or speaking English.
- Different cultural norms may exist.

In Merton, just under 60% of babies were born to mothers who were born outside of the UK, which was similar to London, but significantly higher than England.

Figure 6.1: Babies born by country of mother’s birth 2012.

In 2013, 35.2% of all women aged 15-44 in Merton were from BME groups. This is projected to rise to just under 40% by 2021.

Figure 6.2: Percentage of females aged 15-44 years by ethnic group – 2013.

Figure 6.3: Percentage of females aged 15-44 years by ethnic group – 2021
Maternity care

Antenatal care
The early stages of pregnancy are a key time in a baby's development and a mother's health. It is important for a woman to meet her midwife early and plan the care that she and her baby will need. All women are encouraged to contact Maternity Services as soon as they are pregnant and especially before 13 weeks of pregnancy.

In Sutton and Merton in 2010-11, 77.9% of women recorded had an antenatal assessment before the first 13 weeks of pregnancy, compared with 75.5% for London and 84% for England. This means that about 1,000 women in Sutton and Merton did not receive antenatal care within 13 weeks of pregnancy. However, this data should be treated with caution as the level or recording has historically been low. Analysis by ethnic group shows that recording was lower for black and mixed race groups.

Smoking in pregnancy
Smoking is the UK's single greatest cause of preventable illness and early death. Smoking during pregnancy can cause complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy. Children may also suffer from on-going health risks such as symptoms of asthma and problems of ear, nose and throat if growing up in a home where there are smokers.

In Sutton and Merton in 2011-12, the levels of smoking recorded at the time of delivery was 6.6%, similar to London at 6% and significantly lower than England at 13.2%. This equates to just over 200 mothers recorded as smoking during pregnancy in Sutton and Merton.

Labour and postnatal care
In 2009-10, 55.4% of mothers had normal deliveries in Sutton and Merton, which is lower than both London (58.5%) and England (61.4%). The proportion of deliveries by caesarean section was significantly higher than the national average, at 27% for Sutton and Merton, compared with 24% for England. Of these, in Sutton and Merton 10.8% were elective caesareans and 16.2% emergency.

Key facts on Maternity Services

Maternity Services
Of the births in Merton mothers can choose to go to St George’s Hospital NHS Trust; Epsom and St Helier University Hospitals NHS Trust; or Kingston Hospital NHS Foundation Trust. About half of mothers deliver at St George’s Hospital. From April 2013, Merton CCG is responsible for commissioning Maternity Services.

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95 DH reported on ChiMat ([2011]). Integrated Performance Measures Monitoring: 22.1% of 4,531 women in 2010-11.
Most of the care and support provided to women and their babies before, during and after pregnancy are provided by GPs, the three hospital Midwifery Services, obstetricians and paediatricians at the three hospital trusts and Sutton and Merton Community Services (The Royal Marsden NHS Foundation Trust).

The Care Quality Commission (CQC) undertook a review of women’s experiences of maternity care (CQC 2010), which showed that Epsom and St Helier Hospitals, Kingston Hospital and St George’s Hospital were performing ‘about the same’ in terms of patient experience as other similar hospitals that were surveyed. Experience of feeding baby in the first few days at St George’s Hospital was identified as worse than similar hospitals. For more information on breastfeeding, see section below.

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<th>NHS Trust</th>
<th>Care during pregnancy</th>
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<th>Staff during labour and birth</th>
<th>Care in hospital after the birth</th>
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In 2009-10, in Sutton and Merton spend on maternity care was an average of £5,435 per birth, which was slightly lower than the London average, but the same as for England. When broken down by secondary and primary care settings, Sutton and Merton had significantly lower average spend in primary care, at £112 per birth, compared with £256 in London and £392 for England as a whole.

Programme budgeting data based on PCT level spend (Sutton and Merton 2010-11) indicates that Merton has higher spend and better outcomes on its Maternity Services relative to other CCGs.

A recent report on maternity and newborn services in South West London97 identified the challenges in the provision of maternity services, in particular: the impact of rising birth rates; increase in maternal age; high rates of maternal obesity and diabetes; and migration, affecting both the demand for services and types of services needed.

The South West London & Surrey Downs Maternity Network has been established and is attended by Merton CCG representatives alongside other local CCG and acute trust representatives from across South West London and Surrey Downs.

Evidence on what works and best practice

The NICE provides guidance based on best available evidence and gives a range of advice and recommendations e.g. on effective interventions. NICE has produced pathways and clinical guidance for antenatal care; caesarean section; and antenatal and postnatal mental health.

NICE has also produced a pathway for guidance for pregnant women with complex social factors (NICE 2010). These include: recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or understanding English; age under 20; domestic abuse; poverty; homelessness; substance misuse. This is particularly important in terms of addressing health inequalities. General recommendations include:

- tailor services to meet the needs of the local population – ensure there is good recording of women with complex needs to guide service provision
- involve women in their antenatal care – ensure women are asked about satisfaction and that their feedback is used to guide service provision
- provide training on multi-agency needs assessment and information sharing
- give information and offer referral at the first contact
- reinforce contact at the first booking appointment
- coordinate care and communicate sensitively
- keep handheld records up to date

www.pathways.nice.org.uk

Key commissioning recommendations for maternity care

- With increasing birth rates, commissioners need to assess the need for increased capacity in Maternity Services to meet the needs of Merton mothers, in the context of a regional strategy for maternity care.
- With increasing numbers of mothers born outside the UK and from BAME backgrounds, commissioners need to ensure that Maternity Services are culturally sensitive.
- In order to address health inequalities in outcomes, there is a need to ensure that Antenatal and Maternity Services address the needs of pregnant women with complex social factors in line with NICE guidelines.
- It is recommended that commissioners review progress on recording of early antenatal assessment to increase the number of women who receive early access to Maternity Services before 13 weeks of pregnancy, and to increase access to women from BME communities.
- It is recommended that commissioners review the rate of caesarean deliveries, both elective and emergency, and identify how this can be reduced.
- There is a need to ensure that the South West London maternity dashboard is monitored to provide standardised data from providers and ensure that there is robust analysis of data for the Merton population to inform commissioning.
• Going forward, commissioners need to ensure that the new national Maternity and Children’s Data Set, which started collecting data in May 2013 and over time will result in comprehensive data (HSCIS-MCDS), informs local commissioning.
Infant Mortality

Key facts on infant mortality

Infant mortality is defined as the death of a child in the first year of life. The infant mortality rate (IMR) is the number of babies born alive who die in the first year of life per 1,000 live births. There is a clear link between high levels of infant mortality, deprivation and poor health outcomes. It is therefore often used as a comparative measure of a nation’s health as well as a predictor of health inequalities.

In 2011, the IMR for England was 4.1 per 1,000 live births, compared with 4.9 in 2006 (ONS). IMRs show large socioeconomic and ethnic differences at national level. For example, IMRs for babies born to Pakistani and black Caribbean parents were 8.5 and 7.4 deaths per 1,000 live births respectively (2011, ONS). Explanations for variations in infant mortality between ethnic groups are complex, involving the interplay of deprivation, physiological, behavioural and cultural factors.98

Other groups at higher risk include babies born to: mothers with multiple births; mothers not born in the UK; single mothers and mothers who register their baby alone; mothers over 40 and less than 20; mothers who smoke; and mothers who are obese.

Birth weight is also a good indicator of long-term health for individuals and in communities. Low birth weight is often used as an important predictor of future health and mortality since a child with a low birth weight is more likely to die early or have poorer life outcomes.

Fortunately the numbers of infant deaths at a local level are too few to demonstrate this. However, reducing the variation in IMR is a key national target for tackling inequality and requires initiatives to improve maternal health, child health and the wider determinants of health, such as education and housing.

For the three years 2009 to 2011, Merton’s infant mortality rate was 4 per 1,000 live births and the borough was ranked 12th lowest out of the 32 boroughs of London. This means that for every 1,000 babies born alive, an average of 4 babies die in the first year of life. This was similar to London and England, which both had an IMR of 4.1 (2011, ONS).

While the IMR has shown quite large variation, the overall reduction in IMR over the past two decades has been in line with the regional trend. The variation seen is likely to be a reflection of very small numbers.

Nationally, immaturity and congenital defects are the two commonest causes of death in infants and together account for about 75% of infant deaths. In Merton, the main cause of infant death was neonatal/prematurity (69%); congenital/inherited factor was the cause of 10% of deaths and factors related to the perinatal period the cause of 10% of deaths (ONS 2009-11).
Evidence of what works and best practice

NICE provides guidance based on best available evidence and gives a range of advice and recommendations e.g. on effective interventions. NICE has produced guidance relevant to reducing infant mortality, including quitting smoking during pregnancy, weight management, sexually transmitted infections, and under-18 conceptions.

The guidance on helping pregnant women quit smoking during pregnancy and following childbirth (NICE PH26 2010) recommends:

- identifying pregnant women who smoke, referring to NHS Stop Smoking Services, and providing ongoing support
- using nicotine replacement therapy (NRT) and other pharmacological support
- engaging with partners and others in the household who smoke
- ensuring NHS Stop Smoking Services meet the needs of disadvantaged pregnant women who smoke
- providing training for all professionals involved in the delivery of interventions.

For further information on the NICE guidance see:

Guidance on weight management before, during and after pregnancy (NICE 2010) recommends:

- weight management for women with a BMI 30 or more who are preparing for pregnancy
- help for pregnant women to adopt healthy lifestyles during pregnancy especially those with BMI 30 or more

Table 6.2: Infant mortality 2009-11.

| Number and rate of deaths of children under 1 year, 2009-11, pooled data. | Source: Health & Social Care Information Centre |
|---|---|---|---|---|---|
| | Infant age under 1 year | Infant age under 28 days | Infant age under 7 days |
| | Number of deaths | Rate per 1,000 live births | Number of deaths | Rate per 1,000 live births | Number of deaths | Rate per 1,000 live births |
| Croydon | 72 | 4.4 | 49 | 3.0 | 40 | 2.4 |
| Kingston upon Thames | 27 | 3.9 | 19 | 2.7 | 15 | 2.2 |
| Merton | 42 | 4.0 | 29 | 2.8 | 22 | 2.1 |
| Richmond upon Thames | 29 | 3.3 | 19 | 2.2 | 14 | 1.6 |
| Wandsworth | 55 | 3.4 | 39 | 2.4 | 30 | 1.8 |
| London | 1,753 | 4.4 | 1,201 | 3.0 | 922 | 2.3 |
| England | 9,062 | 4.4 | 6,254 | 3.1 | 4,827 | 2.4 |
• supporting women after childbirth at postnatal check-ups
• community-based services
• adequate skills for involved professionals.
For further information on the NICE guidance see:

Guidance on maternal and child nutrition (NICE 2008) recommends:
• providing women with information and advice on the benefits of taking vitamin D supplements in pregnancy, and breastfeeding
• providing healthy start vitamins for eligible women (folic acid, vitamins C and D)
• implementing a structured programme to encourage women to breastfeed, including training for health professionals
• encouraging breastfeeding by providing information, practical advice, and ongoing support, including the help of breastfeeding peer supporters
• promoting healthy weaning at aged 6 months.
For further information on the NICE guidance see:

**Key commissioning recommendations for reducing infant mortality**

In order to improve maternal health and reduce infant mortality, commissioners should focus on the following:
• improving the quality and accessibility of antenatal care and support during the first year of life, particularly in disadvantaged areas and among BME groups.
• improving nutrition in pregnancy and infancy and access to affordable food
• increasing the number of mothers who breastfeed, targeting areas of greatest need.
• further reducing smoking in pregnancy
• preventing teenage pregnancy and supporting teenage parents
• improving housing conditions, especially for children in disadvantaged areas
• developing culturally sensitive care for women and families.

While levels of infant mortality are similar to the regional average, there needs to be a continuing focus on key interventions, especially those where partnership working can make a significant difference, such as in reducing teenage pregnancy, improving housing conditions and improving the quality of and access to antenatal care, and breastfeeding rates.

**Key facts on low birth weight**

Birth weight is a good measure of infant health. Low birth weight (LBW) is strongly associated with poorer health and poorer life chances and is an important predictor of future infant, child and adult health. LBW babies are at greater risk of dying in their first year than
heavier babies. LBW is defined as births under 2,500 gm; LBW is more common for babies born:
- to mothers under the age of 20 and over the age of 40
- in deprived areas
- to parents in social classes IV and V
- to lone mothers
- to mothers born outside the UK.

Compared with the national profile, Merton overall has a lower level of LBW babies: 7.1% of babies were born with LBW in 2011 (ONS), which equates to 251 babies. This was lower compared with London (8%) and England (7.4%).

Since 2005, although the proportion of LBW babies has remained similar, there has been an overall increase in absolute numbers of LBW babies in line with the 40% increase in number of births.

Figure 6.4: Low Birth Weight 2005-2011.

At ward level, data is available for 2008-10 and indicates that within the borough there is variation: LBW births in Merton ranged from 3.9% in Wimbledon Park to 8.8% in Longthornton. However, none of the variation seen is statistically significant.

In 2008-10, no wards in Merton had LBW rates that were significantly higher than the national average and two wards were significantly lower. Over the course of six years, eight wards have shown an increase in the proportion of LBW babies comparing 2008-10 to 2002-04 although none of the increases was significant. The increases seen were spread across both deprived and more affluent wards and may just be due to small numbers.
Ethnicity is also a key factor for infant mortality and LBW. Nationally, Pakistani and Caribbean groups have particularly high IMRs, 8.9 and 8.1 deaths per 1,000 live births respectively. This is more than double the rate of babies born in the white British group which was 3.7 deaths per 1,000 live births (ONS, 2010). This is of particular significance in Merton, where 35.2% of all women aged 15-44 are from BME groups, and this is projected to rise to just under 40% by 2021.

**Evidence about what works and best practice**

See evidence for infant mortality above.

**Key commissioning recommendations for reducing LBW**

If nothing changes and we take no action to reduce the levels of low and very low birth weight babies so the proportion stays the same (approximately 7% of all live births in Merton), then, because of the increase in the number of babies being born, there will be an absolute increase in numbers of children who are at risk of poor health and social outcomes; based on current live births for 2011 it is expected there will be around 250 babies with future

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special needs born in Merton per annum. Commissioners need to assess the implications for services, including:

- Paediatric and neonatal services
- Children’s centres, community health services, social care services
- Mainstream and specialist education
- Increased pressure on continuing care/short breaks budget.

See section on children with disabilities and special educational needs below for further information.

Deprivation is linked to poor health and LBW. With higher numbers of children being born in deprived areas and with the country experiencing a significant recession there is a need to look at the impact of the recession on longer-term child health including long-term care and mental health needs.

Many of the measures to reduce LBW are the same as those to reduce infant mortality. It is recommended that commissioners consider relevant NICE guidance and ensure that action (services to prevent LBW) is focused on:

- addressing the wider determinants of health, including reducing child and family poverty and housing needs
- reducing maternal obesity; improving nutrition and access to affordable healthy food; and improving breastfeeding rates – targeted particularly within more disadvantaged areas
- further reducing smoking in pregnancy – targeted particularly within more disadvantaged areas.
- improving access to maternity care, ensuring pregnant women are assessed before 13 weeks of pregnancy, particularly in more deprived areas and BME groups
- promoting folate supplements for pregnant women to reduce the risk of children being born with spina bifida.
Breastfeeding

Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet.

In recent years, research has shown that infants who are not breastfed are more likely to have infections in the short term such as gastroenteritis, respiratory and ear infections, and particularly infections requiring hospitalisation. In the longer term, evidence suggests that infants who are not breastfed are more likely to become obese in later childhood, which means they are more likely to develop type 2 diabetes and tend to have slightly higher levels of blood pressure and blood cholesterol in adulthood. For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. A recent study also suggests a positive association between breastfeeding and parenting capability, particularly among single and low-income mothers.\(^{100}\)

Evidence also demonstrates that improving breastfeeding rates not only improves longer-term health for children and reduces risks of future disease, but can also have rapid financial return on investment to the health service, reducing hospital admissions and attendances in primary care.\(^{101}\)

National data on breastfeeding is currently only available at PCT level (Sutton and Merton combined). This data shows that in 2012-13 breastfeeding initiation was 86.2\% compared with 86.8\% for London and 73.9\% for England. Breastfeeding at 6-8 weeks was 60.6\% in Sutton and Merton compared with 46.6\% for England. London data is incomplete, therefore an average is not available. The drop-off rate between initiation and 6-8 week prevalence in Sutton and Merton was about 26\%. There has been no increase in levels of women initiating breastfeeding at birth since 2010-11, when the prevalence was 60.5\%.

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\(^{101}\) Renfrew, M.J. et al. (2012). *Preventing Disease and Saving Resources: the potential contribution of increasing breastfeeding rates in the UK.* UNICEF UK.
Figure 6.6: Prevalence of breastfeeding initiation at birth, 2012-13.

2012-2013 Breastfeeding Initiation. All London PCT
(excluding Kensington & Chelsea for which there is incomplete data)
Source: DH Integrated Performance measure returns
Q1 - Q4 data June 2013

Breastfeeding initiated  Breastfeeding status unknown
Local data indicates that rates of breastfeeding are higher in Merton than Sutton. In Merton local data for 2012-13 suggested the prevalence of breastfeeding at 6-8 weeks after birth was 64%. There is also variation in breastfeeding by ethnicity and area. Just over half of white British women were recorded as breastfeeding at 6-8 weeks, compared with over 80% of black mothers and over 76% of Asian mothers. This is based on recording the ethnicity of 70% of mothers; 30% was not recorded (548/1,822 mothers).
Analysis of local data by area indicates that women are less likely to breastfeed at 6-8 weeks in the eastern wards of the borough including Cricket Green, Figges Marsh, Pollards Hill, St Helier and Lower Morden.

Figure 6.9: Prevalence of breastfeeding at 6-8 weeks by wards in Merton 2012-13 (Source: Sutton and Merton Community Services RIO, 2013).
Key facts on services

Increasing rates of breastfeeding requires a multi-faceted approach. Services to support mothers to breastfeed in Merton are provided by Midwifery Services, health visiting and children’s centres, in line with the national Healthy Child Programme: Pregnancy and the first five years of life. Supported by commissioners, Sutton and Merton Community Services has signed up to UNICEF Baby Friendly accreditation, which aims to improve breastfeeding rates.

A recent review of Breastfeeding Services in Sutton and Merton identified the need to increase inter-organisational working and information sharing; establish a core data set; and focus on developing interventions to support breastfeeding across a pathway, including more antenatal education.

A Sutton and Merton Breastfeeding Steering Group has been established to develop a local action plan and increase breastfeeding, targeting mothers in greatest need of support.

What works and best practice

NICE has developed a maternal and child nutrition pathway (2012), which brings together current guidance on nutrition and breastfeeding. This includes support for the UNICEF baby friendly standards. Recommendations for commissioners and managers are to:

- adopt a multi-faceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:
  - activities to raise awareness of the benefits of, and how to overcome the barriers to, breastfeeding
  - training for health professionals
  - breastfeeding peer-support programmes
  - joint working between health professionals and peer supporters
  - education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period
- work with local partners to ensure mothers can feed their babies in public areas.

Key commissioning recommendations

- Investing in services to support breastfeeding is particularly important for mothers from low income groups, as it is known that they are less likely to breastfeed. Breastfeeding protects the health of babies and mothers, and reduces the risk of illness.
- A multi-agency Merton Breastfeeding Action Plan should be developed and monitored to increase rates of breastfeeding at 6-8 weeks, targeting mothers in greatest need of support.
- Current data indicates that support should be targeted at mothers living in more deprived wards with lower rates of breastfeeding, including Cricket Green, Figges Marsh, Pollards Hill, St Helier and Lower Morden.
- There is a need to establish a core data set and performance indicators to monitor performance effectively, including the ‘drop off’ period between initiation and 6-8 weeks.
- All providers should work towards achieving stage 3 UNICEF Baby Friendly Initiative.
- Increased training for professionals to promote and support breastfeeding.
- Increased support on breastfeeding for pregnant women in the antenatal period.
- A Breastfeeding Welcome campaign should be developed to support more mothers to breastfeed in public places.
Child Health and Early Years 0-5

The Marmot Review, *Fair Society, Healthy Lives*\(^{102}\) (2010), sets out the case for focusing investment on early years and advocates a life-course approach to tackling health inequalities, demonstrating that giving every child the best start in life is crucial to reducing health inequalities across the life course.

As the foundations of human development are laid in early childhood, the review proposed an indicator of readiness for schools to capture early years development. While there is currently no ideal indicator for this, the percentage of children achieving a good level of development at age 5 years provides a readily available measure of early development across England. This indicator is based on data collected from the Early Years Foundation Stage Profile (EYFSP). Children are normally assessed by a teacher in the year in which they turn five. The assessment is based on observation of the child’s behaviour and understanding.

In Merton, in 2012, 66% of local children achieved the expected level of development across all six areas of learning, which was above the England average of 64%. This has been an improving picture for Merton, rising from 61% in 2011.

Figure 6.10: Percentage of children achieving a good level of development at age 5 2010-12.

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The gap in good development at age 5 between the highest and the lowest achievers was nearly 30% and had increased slightly from 28.4% in 2010 to 29.6% in 2012. This was similar to London (30.8%) and England (28.6%) (DfE/ChiMat). There is variation in early development by area, linked to deprivation, with lower levels of good development in the east of the borough.

**Figure 6.11: Child development at age 5, by MSOA, 2011 (Source: ChiMat).**

![Map showing child development by MSOA in Merton](image)

**Child mortality**

Deaths in childhood are very rare but can be used as an indicator of child health. Pooled data for 2008-10 shows there were 53 deaths in children under 15 years old in Merton. 74% of childhood deaths (0-14 years) occurred before the age of 1 year in both Merton and England.

In Merton, the age standardised death rate (ASDR) for children under 15 years is below national rates. The commonest cause of death in the 0-19 year age group was from conditions arising in the perinatal period/prematurity, accounting for 43% of total deaths. In the 15-19 age group the two commonest causes of deaths were cancers accounting for 29%; and external causes, including accidental injuries, also accounting for 29%.
### Table 6.3: Child mortality in children under 15 years, 2008-10.

<table>
<thead>
<tr>
<th></th>
<th>&lt;1 year</th>
<th>&lt; 1 as a % of deaths in under 15 years</th>
<th>1-14 years</th>
<th>Total &lt;15 years</th>
<th>Age standardised death rates per 100,000 aged 0-15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merton</td>
<td>39</td>
<td>73.6</td>
<td>14</td>
<td>53</td>
<td>41.30</td>
</tr>
<tr>
<td>Croydon</td>
<td>78</td>
<td>78.0</td>
<td>22</td>
<td>100</td>
<td>46.79</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>53</td>
<td>73.6</td>
<td>19</td>
<td>72</td>
<td>39.90</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td>24</td>
<td>68.6</td>
<td>11</td>
<td>35</td>
<td>30.69</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>21</td>
<td>84.0</td>
<td>4</td>
<td>25</td>
<td>27.39</td>
</tr>
<tr>
<td>London</td>
<td>1,747</td>
<td>76.1</td>
<td>550</td>
<td>2,297</td>
<td>46.50</td>
</tr>
<tr>
<td>England</td>
<td>9,260</td>
<td>74.3</td>
<td>3,205</td>
<td>12,465</td>
<td>45.50</td>
</tr>
</tbody>
</table>

### Table 6.4: Causes of mortality, children and young people 0-19 years, 2009-11.

<table>
<thead>
<tr>
<th>Cause of death: children and young people aged 0-19 years, Merton, 2009-11</th>
<th>% &lt;1 years</th>
<th>% 1-14 years</th>
<th>% 15-19 years</th>
<th>% 0-19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>16</td>
<td>29</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Circulatory disease</td>
<td>2</td>
<td>5</td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>Congenital/inherited</td>
<td>10</td>
<td>21</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Diseases of nervous system</td>
<td>1</td>
<td>16</td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>Diseases of digestive system</td>
<td>5</td>
<td>5</td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>External cause</td>
<td>11</td>
<td>29</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Infectious and parasitic</td>
<td>14</td>
<td></td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>Neonatal/prematurity</td>
<td>69</td>
<td></td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>11</td>
<td>29</td>
<td>10</td>
</tr>
<tr>
<td>Related to perinatal period</td>
<td>10</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>2</td>
<td>11</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Undetermined event</td>
<td>5</td>
<td></td>
<td>&lt;5</td>
<td></td>
</tr>
</tbody>
</table>

Source: ONS Annual District Mortality File, Sutton and Merton PCT

External causes, including accidental injuries, accounted for 29% of child mortality in 15-19 year olds in Merton. This can be compared with hospital admission rates for unintentional injury, which are about the same as the London average for 0-4 year olds, but lower than the London average for 5-17 year olds. See Figure 6.14 below.
Figure 6.12: Rate of hospital admissions for deliberate and unintentional injury to children aged 0-4 years, 2010-11.

Figure 6.13: Rate of hospital admissions for deliberate and unintentional injury to children aged 5-17 years, 2010-11.

Figure 6.14: Rate of hospital admissions for deliberate and unintentional injury to children aged under 18 years, 2010-11.
Childhood immunisation

After clean water, vaccination (immunisation) is the most effective public health intervention in the world for saving lives and promoting good health and is responsible for the virtual elimination of the previous epidemics of measles, German measles (rubella), mumps, whooping cough and polio.

The primary aim of vaccination is to protect the individual who receives the vaccine. Vaccinated individuals are also less likely to be a source of infection to others. This reduces the risk of unvaccinated individuals being exposed to infection. This means that individuals who cannot be vaccinated will still benefit from the routine vaccination programme. This concept is called population (or ‘herd’) immunity. The World Health Organization (WHO) recommends at least 95% of pre-school children should receive the recommended vaccinations to achieve population immunity.

Table 6.5: Routine childhood immunisations, as of June 2013.

<table>
<thead>
<tr>
<th>When to immunise</th>
<th>Diseases protected against</th>
<th>Vaccine given</th>
<th>Immunisation site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two months old</td>
<td>Diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type b (Hib)</td>
<td>DTaP/IPV/Hib</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>PCV</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Rotavirus (from July 2013)</td>
<td>Rotavirus</td>
<td>By mouth</td>
</tr>
<tr>
<td>Three months old</td>
<td>Diphtheria, tetanus, pertussis, polio and Hib</td>
<td>DTaP/IPV/Hib</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Meningococcal group C disease (MenC)</td>
<td>Men C</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Rotavirus (from July)</td>
<td>Rotavirus</td>
<td>By mouth</td>
</tr>
<tr>
<td>Four months old</td>
<td>Diphtheria, tetanus, pertussis, polio and Hib</td>
<td>DTaP/IPV/Hib</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>PCV</td>
<td>Thigh</td>
</tr>
<tr>
<td>Between 12 and 13 months old – within a month of the first birthday</td>
<td>Hib/MenC</td>
<td>Hib/MenC</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>PCV</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella (German measles)</td>
<td>MMR1</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td>Three years four months old or soon after</td>
<td>Diphtheria, tetanus, pertussis and polio</td>
<td>dTaP/IPV or DTaP/IPV</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella</td>
<td>MMR2 (check first dose has been given)</td>
<td>Upper arm</td>
</tr>
<tr>
<td>Girls aged 12 to 13 years old</td>
<td>Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)</td>
<td>HPV</td>
<td>Upper arm</td>
</tr>
<tr>
<td>Around 14 years old</td>
<td>Tetanus, diphtheria and polio</td>
<td>Td/IPV, and check MMR status</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>MenC</td>
<td>MenC</td>
<td>Upper arm</td>
</tr>
</tbody>
</table>

The uptake of MMR (measles, mumps and rubella) vaccine has fallen nationally and locally since discredited publicity suggesting a link with autism. Consequently, across London there had been an increasing number of measles and mumps outbreaks in recent years.

In Sutton and Merton, the 2012-13 uptake of childhood immunisations has been low. For example, the uptake of one dose of MMR1 at age 2 was 80.7% compared with 87.1% for
London and 92.3% for England. Uptake of two doses of MMR at age 5 was 68.9% compared with, 80.8% for London and 87.7% for England, and there is wide variation by GP practice. Provisional data for Q1-2 (April-September) 2013-14 indicates improvements in uptake of some childhood vaccinations, including MMR1 and MMR,2 in Sutton and Merton.

Table 6.6: Percentage of coverage for childhood immunisations to age 5 years, 2012-13.

<table>
<thead>
<tr>
<th>% Coverage for Childhood Immunisations to age 5, 2012-13</th>
<th>Source: HSCIS NHS Immunisation Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>% immunised by 1st birthday</td>
<td></td>
</tr>
<tr>
<td>DTaP/IPV/Hib MenC PCV</td>
<td></td>
</tr>
<tr>
<td>primary primary primary</td>
<td></td>
</tr>
<tr>
<td>% % %</td>
<td></td>
</tr>
<tr>
<td>England 94.7 93.9 94.4</td>
<td></td>
</tr>
<tr>
<td>London 91.1 89.9 90.8</td>
<td></td>
</tr>
<tr>
<td>Sutton &amp; Merton 82.6 83.6 83.2</td>
<td></td>
</tr>
<tr>
<td>% immunised by 2nd birthday</td>
<td></td>
</tr>
<tr>
<td>DTaP/IPV/Hib MenC MMR Hib/MenC PCV</td>
<td></td>
</tr>
<tr>
<td>primary primary 1st dose booster booster</td>
<td></td>
</tr>
<tr>
<td>% % % % % % % % %</td>
<td></td>
</tr>
<tr>
<td>England 96.3 95.1 92.3 92.7 92.5</td>
<td></td>
</tr>
<tr>
<td>London 93.6 90.9 87.1 87.3 86.6</td>
<td></td>
</tr>
<tr>
<td>Sutton &amp; Merton 89.2 88.1 80.7 80.3 80.2</td>
<td></td>
</tr>
<tr>
<td>% immunised by 5th birthday</td>
<td></td>
</tr>
<tr>
<td>Diptheria Tetanus Polio Hib MMR Hib/MenC MMR PCV PCC</td>
<td></td>
</tr>
<tr>
<td>primary primary booster 1st dose 1st &amp; 2nd doses booster</td>
<td></td>
</tr>
<tr>
<td>% % % % % % % % %</td>
<td></td>
</tr>
<tr>
<td>England 95.8 95.4 88.9 93.9 87.7 91.5</td>
<td></td>
</tr>
<tr>
<td>London 92.8 92.5 79.9 90.6 80.8 86.9</td>
<td></td>
</tr>
<tr>
<td>Sutton &amp; Merton PCT 83.0 83.6 67.0 82.1 68.9 75.7</td>
<td></td>
</tr>
</tbody>
</table>

Charts showing variation in childhood immunisations among geographical neighbours show that in 2012-13 Sutton and Merton had the lowest level of coverage for most childhood immunisations. See Figures 6.17, 6.18 and 6.19 below.
Figure 6.15: Proportion immunised for Meningitis C by 1st and 2nd Birthdays, 2012-13.

Figure 6.16: Proportion immunised for Hib Men C booster by 2nd and 5th Birthdays, 2012-13.

Figure 6.17: Proportion immunised for diphtheria, tetanus, pertussis and Hib by 1st and 2nd Birthdays, 2012-13.
Figure 6.18: Proportion immunised for measles, mumps and rubella by 2\textsuperscript{nd} and 5\textsuperscript{th} Birthdays, 2012-13.

Figure 6.19: Proportion immunised for pneumococcal by 1\textsuperscript{st} and 2\textsuperscript{nd} Birthdays, 2012-13.

Figure 6.20: Proportion immunised for DTAP/IPV pre-school booster by 5\textsuperscript{th} Birthday, 2012-13.
The charts in Figures 6.23 and 6.24 below show the variation in childhood immunisations between GP practices and indicate that in Merton in 2012-13 very few practices reached the WHO aim of 95% coverage.

Figure 6.21: Proportion immunised for measles, mumps and rubella – 1 dose by 2\textsuperscript{nd} Birthday, by practices in Merton CCG, 2012-13.

Figure 6.22: Proportion immunised for measles, mumps and rubella – 2 doses by 5\textsuperscript{th} Birthday, by practices in Merton CCG, 2012-13.
Figure 6.23: Proportion immunised for DTAP/IPV by 5\textsuperscript{th} Birthday by practices in Merton CCG, 2012-13.

![Graph showing proportion immunised for DTAP/IPV](image)

Figure 6.24: Proportion immunised for HiB Men C by 5\textsuperscript{th} Birthday by practices in Merton CCG, 2012-13.

![Graph showing proportion immunised for HiB Men C](image)

Figure 6.25: Proportion immunised for PCV by 5\textsuperscript{th} Birthday by practices in Merton CCG, 2012-13.

![Graph showing proportion immunised for PCV](image)
Key facts on services

The national Healthy Child Programme: pregnancy and the first five years of life (DH 2009) sets out the importance of delivering early childhood immunisations. Childhood immunisations age 0-5 are delivered by general practices across Merton. Community Health Services are responsible for promoting immunisation to 0-4 year olds, and delivering immunisations to school age children, and managing central data recording systems.

From April 2013, NHS England is responsible for commissioning immunisation services. A Sutton and Merton Immunisation Task Group has been established and an action plan developed to increase coverage of childhood immunisation.

Data recording has been identified as a potential issue affecting the accuracy of published data, and plans have been implemented in Sutton and Merton to improve the data recording systems. From 2013-14 data is due to be available at a borough level.

Recent social marketing research103 aiming to understand the barriers and challenges to accessing immunisations in Sutton and Merton highlighted that there was variation in the level of knowledge about immunisation and low awareness of the consequences of not immunising children. Pregnancy was identified as a good time to promote awareness of immunisation. Barriers to immunisation included concerns about side effects; forgetting/ time; negative past experience of parent; access, e.g. knowing about out of hours; issues with childcare; and language barriers.

Key commissioning recommendations

- Commissioners should aim to increase uptake of childhood immunisations to reach the World Health Organization's aim of 95% coverage to ensure population immunity.

- Commissioners should focus on delivering childhood immunisation action plans, including:
  - monitoring the progress on childhood immunisation coverage towards achieving local and WHO targets
  - ensuring that improvements to childhood immunisation data systems are monitored and sustained
  - reducing variations in uptake by GP practice
  - increasing access to immunisation for parents
  - improving uptake and access, including delivery of immunisations at weekends
  - improving knowledge and awareness among parents, including via health visitors, children’s centres, schools and nurseries.

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Key facts on Early Years Services for children age 0-5

The Healthy Child Programme: pregnancy and the first five years of life (DCSF 2009) sets out an integrated approach to improving the health and wellbeing of children and supporting families and sets out recommended standards for service delivery. The Healthy Child Programme (HCP) has been defined as ‘the early intervention public health programme that lies at the heart of universal services for children and families. At a crucial stage of life the HCP’s universal reach provides an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes’ (HCP 2009).

[The HCP approach is well established in Merton, with an integrated approach to Children’s Centres and Health Visiting services across the Children’s Centres in Merton.] Children’s Centre Services include significant delivery of the HCP by health visitors and to a lesser extent by Midwifery Services (from St George’s Hospital NHS Foundation Trust and Epsom and St Helier University Hospitals Trust).

Merton’s network of 11 children’s centres, delivered through three localities, provides a range of universal and more targeted services for all families with young children living in the borough. Ofsted has awarded a grading of good or above to 100% of the centres that it has inspected.

Figure 6.26: Map showing Merton’s children’s centres locality model.

An integral part of Merton’s Children’s Centre Services’ delivery is its partnership working with statutory, as well as community and voluntary, agencies. This enables the Children’s Centre Services’ universal offer to include health, early education and information services
across a range of determinants of health. This co-delivery of a range of services across the children’s centres includes:

- Midwifery antenatal and post natal services
- Health visiting/Healthy Child Programme (health reviews of newborn/8 months and 2 years)
- Speech and language advice, guidance and early support
- Play and development
- Targeted home visiting
- Evidenced-based parenting – both core and targeted (enhanced)
- Support for employment, training and back to work
- Childcare brokerage
- Advice for income maximisation and financial inclusion
- Housing advice
- Co-ordinated support for children with lower level SEND (special educational needs and disabilities) in settings and the home
- Access to targeted and specialist services, such as mental health, 0-5s Supporting Families Team, CSC, CAMHS
- Pre-schools for [?] to 2 year old funded places
- Advice/access to funded early education.

**Family Nurse Partnership**

Merton and Sutton are developing a Family Nurse Partnership (FNP) programme. The FNP is an evidence-based prevention and early intervention programme for vulnerable first-time mothers that aims to:

- improve pregnancy outcomes
- improve child health and development through helping parents provide more competent care
- improve parents economic self-sufficiency.

The programme has been developed in the US over 30 years. It provides intensive and structured home visiting, using a psycho-educational approach focusing on adaptive behaviour change during pregnancy and until the child turns 2 years old. The programme is being adopted in England under licence to ensure replication of the original research. Merton was invited to develop a joint programme with Sutton, and, based on 2010 data, it is estimated that about 90 young mothers are eligible in each borough, but due to the rising birth rate and population changes this may be higher.

**Early education**

Merton has a mixed model of early years and child care provision and works in partnership with all Ofsted registered providers and schools to support this sector in delivering high-quality play and learning environments. Early intervention to support children’s readiness for school is important in improving the long-term health, emotional, educational and social outcomes of young people and reducing the risk of negative outcomes such as anti-social or violent behaviour or children not achieving their potential.
A summary of free early education for 2 year olds (national policy being to target disadvantaged children) is as follows:

- Of 2 year olds, 183 (6.4% of the 2 year old population in Merton) were supported to access a place prior to the new statutory duty commencing September 2013.
- 67% of the brokered 2 year old places went to children resident in the Mitcham planning area.
- 2 year old places were predominantly brokered in playgroup or pre-school provision.
- As the criteria for funded 2 year old places includes income deprivation factors, location of residents with funded places correlates with deprivation areas. The areas with the largest proportion of the 2 year old population in receipt of a funded place are Pollards Hill, Figges Marsh and Lavender Fields.
- 7% of the 2 year olds with a funded place have some level of additional/special educational needs.

Early education funded provision for 3-4 year olds:

- The majority of 3 and 4 year old funded provision is accessed through maintained schools nursery and Reception classes. Typically all 4 year old (Reception) funded education is in maintained or independent school classes. Independent education figures may be suppressed as not all take part in the free entitlement funding offer.
- Mitcham area has the largest number of 3 and 4 year olds claiming free entitlement in Merton provision (90%); 89% of Merton’s 3 and 4 year old population access their entitlement within Merton.
- 760 children resident outside of Merton access their free place through Merton provision. 60% of these children take up this provision in maintained schools, 22% in day nurseries and 9% in both playgroup and pre-school provision and independent schools.
- 6% of 3 and 4 year olds in Merton’s funded provision have a level of SEN recorded.
- Mitcham planning area residents and the residents of wards bordering it to the west of Morden and Wimbledon have the greater proportion of population accessing funded provision.

**Evidence about what works and best practice**

Recent evidence from a report, *Conception to age 2: the age of opportunity*, identified both improved outcomes and financial returns on well-designed early interventions. It identified the need to focus on three areas to improve outcomes for 0-2 year olds:

Assess and identify where help is needed:

- Mental health risk assessment as early as possible in pregnancy; Neonatal Behavioural Assessment three weeks after birth.
- In addition to age 6 weeks health visitor assessment, undertake an age 3-4 months assessment of parent-child attunement, and an attachment assessment at age 12-15 months.

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104 WAVETrust report – a Department for Education (DfE) invited response (2013). *Conception to age 2: the age of opportunity.* WAVE Trust/DfE.
Provide adequate support when needed:

- Full implementation of Healthy Child Programme; promote attunement, secure attachment; Family Nurse Partnership; parent-infant psychotherapy; 8% of pregnant women warrant a referral to specialist perinatal mental health services.
- High-quality health-led children’s centres; potential for health visitors to act as team leaders, supervisors and/or mentors; high-quality outreach to engage most vulnerable families; follow principles of highly successful multi-agency work.

Ensure Early Years Services workforce have requisite skills, training, and supervision as follows:

- health visitors are trained to evaluate mother-baby interaction, and carry out motivational interviewing
- all practitioners have awareness of risk factors that can jeopardise infant mental health
- domestic violence – prioritise identification and support by midwives, GPs, other professionals, especially in pregnancy
- ensure a good understanding of pre-birth to 3 years child development, attunement and attachment
- emotional intelligence, skills to form empathic relationships with parents; good quality reflective supervision.

**Commissioning recommendations for Early Years**

A recent review of the Children’s Centre Services and Early Years Services identified a number of priorities for commissioners and managers:

- Develop an outcomes model of commissioning for Early Years Services, based on evidence of best practice and underpinned by strong data systems.
- Develop early years prevention and early intervention pathways, with clear referral routes for all partners.
- Parental mental health has been identified as a significant factor in parenting; there is a need to increase parent support, including for lower level mental health problems and parental relationships, ensure staff training and awareness, and develop clear pathways into mental health services.
- Children’s centres should contribute further to public health outcomes, including reducing obesity strategy and increasing levels of healthy weight, and breastfeeding.
- Implement a data sharing agreement across early years in order to strengthen the ability to provide earlier intervention for families identified as having additional needs.

In addition:

- Increase access to immunisations for children through children’s centres in order to increase coverage in more vulnerable/disadvantaged groups.
- Additional early speech and language support accessed via children’s centres would improve school readiness of more vulnerable/disadvantaged children.
- The Family Nurse Partnership should support better coordination of pathways and access to support. A risk management approach will need embedding.
are in a good position to work with younger parents who will access the forthcoming Family Nurse Partnership.

- Establish a vision, model and transition plan for the Health Visiting Service as commissioning responsibility for the service moves to the local authority in 2015.
Vulnerable Children and Young People

This section focuses on the needs of vulnerable children and young people in Merton, including in relation to disabled children and children with SEN; children with mental health needs; safeguarding; looked after children; young carers; and youth offending.

The Merton Children and Young People Plan 2013-16 sets out the Children’s Trust Board’s commitments to improving outcomes, life chances and choices for children and young people, including narrowing the gap in outcomes between groups of children. The Children’s Trust Board provides a focus for integrated planning and delivery of children’s services, particularly focusing on key groups of children vulnerable to poor health outcomes. Further detail and a needs analysis is available at: www.merton.gov.uk/council/plansandpolicies/cypplan.htm

Children and young people with disabilities

An estimated 7% of children in the UK are disabled. Under the Children Act 1989, local authorities are required to keep a register of all children with disabilities. Registration is voluntary and is not a prerequisite for receiving services. Referrals to the register may be from statutory and voluntary agencies or by self-referral from the young person, their parent or carer. The completeness of registration for milder disabilities is difficult to estimate as registration depends on parental response and consistency between professionals in the application of registration criteria.

In Merton, there were a total of 618 children on the Children’s Disability Register in January 2013. Two thirds of the children registered were boys, reflecting the fact that boys are far more likely to be diagnosed with autism spectrum disorder (ASD) than girls. In Table 6.8 below, which looks at the types of disability recorded, the figures are greater than the total number of children on the Register. This is because many children are registered in more than one category.

Some children with profound multiple disabilities also have complex health needs. Over the past decade the prevalence of severe disability and complex needs has risen due to factors including the increased survival of preterm babies, the greater likelihood that children will survive following severe trauma or illness, and increased survival in life-limiting conditions. Changes in models of care have also resulted in fewer children in this group being in residential education and care and an increase in the numbers being cared for in the community and accessing local schools and services.

In recent years there has been a rise in children and young people registered with ASD but also a decrease in children diagnosed as having communication problems, which suggests that some of the increase in ASD is the result of a change in diagnostic practice. Studies have suggested that about 157 children out of 10,000 will have some form of ASD, including
previously undiagnosed cases. This suggests that there could be up to 745 children and young people under the age of 19 in Merton with some form of ASD.

Table 6.7: Children with disabilities in Merton, 2013.

<table>
<thead>
<tr>
<th>Information on children with disabilities</th>
<th>Merton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: Merton Children's Disability Database (0-19 years), 8 January 2013</td>
<td>618</td>
</tr>
<tr>
<td>Total registered (%)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>429 (69%)</td>
</tr>
<tr>
<td>Female</td>
<td>189 (31%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>0 to 4</td>
<td>22 (4%)</td>
</tr>
<tr>
<td>5 to 9</td>
<td>130 (21%)</td>
</tr>
<tr>
<td>10 to 14</td>
<td>224 (36%)</td>
</tr>
<tr>
<td>15 to 19</td>
<td>242 (39%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>357 (58%)</td>
</tr>
<tr>
<td>Asian</td>
<td>80 (13%)</td>
</tr>
<tr>
<td>Black</td>
<td>94 (15%)</td>
</tr>
<tr>
<td>Chinese</td>
<td>3 (0%)</td>
</tr>
<tr>
<td>Mixed</td>
<td>66 (11%)</td>
</tr>
<tr>
<td>Other</td>
<td>8 (1%)</td>
</tr>
<tr>
<td>Not given</td>
<td>10 (2%)</td>
</tr>
</tbody>
</table>

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Table 6.8: Type of disability recorded for children in Merton, 2013.

<table>
<thead>
<tr>
<th>Type of disability recorded</th>
<th>Merton</th>
</tr>
</thead>
<tbody>
<tr>
<td>NB: Children may have more than one type of disability recorded</td>
<td></td>
</tr>
<tr>
<td>Source: Merton Children’s Disability Database (0-19 years), 8 January 2013</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic severe illness</td>
<td>58</td>
</tr>
<tr>
<td>Communication difficulty</td>
<td>331</td>
</tr>
<tr>
<td>Development and learning difficulty</td>
<td>438</td>
</tr>
<tr>
<td>Emotional/Behavioural difficulties</td>
<td>249</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>41</td>
</tr>
<tr>
<td>Mental health</td>
<td>46</td>
</tr>
<tr>
<td>Physical difficulty</td>
<td>121</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>73</td>
</tr>
<tr>
<td>Other</td>
<td>143</td>
</tr>
</tbody>
</table>

Children and young people with statements of special educational needs (SEN)

In 2013, 3.3% of pupils in Merton had a statement of SEN (DfE 2013). This has remained fairly consistent over the past 10 years, and is slightly higher compared to London (2.7%) and England (2.8%).

In January 2013, 986 pupils had a statement of SEN maintained by LBM. Based on the number of statements maintained by the borough over the past five years and future changes in the population, it is projected that the number of pupils with statements aged 0 to 19 will increase to 1,134 by 2021 (an increase of 148 pupils from 2013). With current reforms to SEN the number of children and young people aged 0 to 25 with SEN is projected to increase to 1,478 by 2021.

Over the past three years, the percentage of pupils with statements of SEN with ASD as their primary special need has increased in both England (21.9%) and Merton, and now make up a quarter (24.4%) of all statements in the borough. This means that annually about 245 children have a statement for ASD, whilst overall, based on estimates of prevalence, it is estimated that there could be up to 745 children in Merton with some form of ASD.

Similarly, the percentage of pupils with statements of SEN with behavioural, emotional and social difficulties (BESD) has increased in Merton (11.5%) over the past three years. Percentages of BESD in England have decreased, although the percentage remains higher than in Merton at 13.9%.
Key commissioning recommendations for children with disabilities and SEN

- One of the major causes of disabilities in children is low and very low birth weight. If nothing changes and the proportion of low and very low birth weight babies stays the same (7.1% of all births), there will be an absolute increase in numbers of these children. It would be expected there could be 250 children with future special needs born in Merton per annum (based on ONS live annual births figures for 2011).

- LBW will have implications for: paediatric and neonatal services, children’s centres, community health services, social care services; mainstream and specialist education; there will also be increased pressure on the continuing care/short breaks budget. If the trend of increasing demand in continuing care and palliative care continues, community services for children with disabilities and complex health needs will need to be strengthened and increased.

- National policy changes in the Children and Families Bill 2013, effective from 2014, will have significant implications for SEN children and young people. The Bill includes creating a single system for children and young people identified with SEN from birth to age 25, duties for Children with Disabilities/SEN extended to age 25 and a requirement for integrated education, health and care plans.

- Detailed work based on current predictions of the range of provision likely to be needed in the future is under way. Keeping pupils close to home wherever possible is desirable in terms of both pupil outcomes and value for money.

- In light of the rising numbers of children diagnosed with ASD and increasing waiting times for assessment, there is a need for an autism pathway and consideration of the range of services available, linked to the autism strategy.

- Integrated approaches are needed to commissioning speech and language therapy, behaviour management and child and adolescent mental health (CAMH) services recognising the links between speech, language and communication disorder, conduct disorder, ASD, BESD and low achievement and exclusions.
Children with Mental Health Needs

Mental and emotional health is fundamental to good health and wellbeing. There are strong links between the emotional wellbeing of children and young people and their personal and social development and educational performance. As such it is an important factor in ensuring that they achieve their full potential.

Emotional wellbeing includes confidence and self-esteem, which contributes to an ability to form good relationships with family and friends. Poor emotional and psychological health or mental health problems may result in educational failure, family disruption, anti-social behaviour and offending. Unrecognised and untreated mental health problems create distress not only for children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

Social, emotional and behavioural difficulties are common and affect 30-40% of children and young people at some time. Normal development will include behaviour of concern to adults. Young children may show certain behaviours, such as poor concentration, aggression, lying, stealing, tantrums, toileting or bedtime problems, food fads, specific fears or anxiety; whereas teenagers may have relationship problems or poor anger control or conflict with adults over appearance, school progress or household rules. Mostly these are transient reactions to a particular life event, but for some they may be more prolonged.

Risk factors that increase the likelihood of a child experiencing a mental health problem include:
- environment, e.g. poverty, social housing, homelessness or refugee status
- family e.g. parental unemployment (20% of children where neither parent works have mental health problems, compared with 8% where both parents work. Poverty may also contribute); poor parenting; and circumstances which result in a child being looked after by the local authority
- child health e.g. physical disability, chronic health problems, learning difficulties
- school e.g. bullying and several of the above risk factors may result in relative social exclusion at school, which may further increase the risk of bullying.

School-age children

Currently there is very little comparative information to give a good picture of the mental health and wellbeing of children and young people locally. The national indicator set from the TellUs 4 Survey provided a useful summary of the views of children and young people and an indication of mental wellbeing. Data from the survey is included below, however the survey is no longer undertaken centrally, and latest data is from 2009-10.

More recent data from the Merton Annual Young Residents Survey 2012-13 indicates that young people are generally satisfied and happy, with 90% reporting they are either very or fairly satisfied and happy. The top four factors identified as most important to young people’s sense of wellbeing were:
- feeling safe in the local area (65%)
- satisfaction with family and social relationships (58%)
- satisfaction with school (42%)
- satisfaction with health and mental health (34%).

However, the survey also indicates that bullying is the third highest personal concern for 11-17 year olds in Merton, and this has increased significantly from 21% in 2011 to 31% in 2012, which is now the same as London overall.\textsuperscript{106} (See Theme 1 (Merton Voice: What our Communities are Saying) for further details.)

\textbf{Figure 6.27: Emotional health of children 2009-10.}

\begin{figure} [H]
\centering
\includegraphics[width=\textwidth]{ni50}
\caption{NI 50: Emotional Health of Children 2009-10 Merton compared to London ONS Statistical Neighbours}
\end{figure}

\textbf{Figure 6.28: Children who have experienced bullying, 2009-10.}

\begin{figure} [H]
\centering
\includegraphics[width=\textwidth]{ni69}
\caption{NI 69: Children who have experienced bullying 2009-10 Merton compared to London ONS Statistical Neighbours}
\end{figure}

\textsuperscript{106} Merton Residents Survey (2012/13), London Borough of Merton.
Estimates from national prevalence figures suggest that Merton would expect to have over 3,250 children or young people aged 5-16 years with specialist mental health needs, based on the 2012 population. At Tier 3 there is a gap of 34% between observed and estimated use of services (observed: 524 CYP on active caseload for Tier 3 CAMHS 2012-13; estimated: 825 CYP), indicating a level of unmet need.

Table 6.9: Estimated number of children and young people under 18 years with a mental health problem appropriate for a Child and Adolescent Mental Health Service (CAMHS) response, 2012.

<table>
<thead>
<tr>
<th>Tier</th>
<th>% of children and under (%)</th>
<th>Merton (ONS mid-year estimates 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 – CAMHS</td>
<td>15.00%</td>
<td>6,670</td>
</tr>
<tr>
<td>Tier 2 – CAMHS</td>
<td>7.50%</td>
<td>3,115</td>
</tr>
<tr>
<td>Tier 3 – CAMHS</td>
<td>2.50%</td>
<td>825</td>
</tr>
<tr>
<td>Tier 4 – CAMHS</td>
<td>0.50%</td>
<td>222</td>
</tr>
</tbody>
</table>

Table 6.10: Estimated prevalence of mental health disorders among children and young people, 2012.

<table>
<thead>
<tr>
<th>Expected prevalence of mental health disorders. Source: ChiMat</th>
<th>% of CYP* (5-16 years)</th>
<th>Merton 2012 (ONS mid-year estimates 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct disorders</td>
<td>5.3%</td>
<td>1,525</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>4.3%</td>
<td>950</td>
</tr>
<tr>
<td>Being hyperactive</td>
<td>1.4%</td>
<td>410</td>
</tr>
<tr>
<td>Less common disorders</td>
<td>1.3%</td>
<td>365</td>
</tr>
</tbody>
</table>
In 2011-12 the rate of mental health related hospital admissions for children and young people aged under 18 years were lower compared with London and England. But it is important to note that these are very small numbers (32 admissions in Merton 2011-12) and relate to the most severe mental health needs.

Figure 6.30: Mental health hospital admissions for children 0-17 years, 2011-12.

Key facts on services to support better mental wellbeing in children

Child and Adolescent Mental Health Services (CAMHS) include universal services (health visitors, school nurses, early years staff, school staff) who identify and support the parents of children and other relevant staff in contact with children showing early signs of emotional and behavioural problems to manage their problems. These services are designated:

**Tier 1 services:** promote mental health and wellbeing, manage the majority of children and young people with emotional and behavioural problems and refer to more specialist services if appropriate.

**Tier 2 services:** offer more specialist assessment and intervention from a single mental health professional, including primary mental health workers, psychologists and counsellors; and include services delivered in the community such as paediatric clinics, social care premises, schools and youth services.

**Tier 3 services:** usually multidisciplinary teams working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders. These teams can include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, and art, music and drama therapists.
**Tier 4 tertiary level services**: for children and young people with the most serious problems. They comprise highly specialised outreach teams and inpatient units, including secure forensic adolescent units, eating disorders units and other specialist teams (e.g. services for those with severe learning disabilities).

Most children and young people with mental health problems will be seen in Tiers 1 and 2 services. However, a child or young person may require services from a number of tiers at the same time, or referral between tiers and services at different times. Although most of the CAMHS service is delivered by Tiers 1 and 2, there is no systematic documentation of need for these services.

Following the NHS changes in April 2013, Tier 4 CAMHS is now commissioned by NHS England. Tier 3 CAMHS, commissioned by Merton CCG, and is provided by South West London and St George’s Mental Health NHS Trust. This team includes child and adolescent psychiatrist, clinical psychologist, child and adolescent psychotherapist and clinical nurse specialist roles. In Merton, in 2012-13, 954 referrals by other professionals were made to this service, with approximately 542 children and young people on the active caseload.

Targeted Mental Health in Schools (TaMHS) aims to transform the way that mental health support is delivered to children, to improve their mental wellbeing and to tackle problems in a timely way. The intervention brings together the effective work that schools are already doing to build social and emotional skills and wellbeing and the clinical and therapeutic expertise available through CAMHS, providing an integrated approach to promoting mental health for children and young people and timely identification and prompt intervention for emerging mental health problems and disorders. There are 21 primary schools and one secondary school in Merton which have directly commissioned TAMHS in 2012/13.

**Evidence about what works and best practice**

NICE has produced a pathway for social and emotional wellbeing for children and young people, which bring together evidence-based guidance (NICE PH12 2008). This pathway covers recommendations for commissioners, including the following:

- Commissioners need to ensure arrangements are in place for integrated commissioning of universal services and targeted services for children aged under 5. This includes services offered by general practice, maternity, health visiting, school nursing and all early years providers. The aim is to ensure:
  - vulnerable children at risk of developing (or who are already showing signs of) social, emotional and behavioural problems are identified as early as possible by universal children and family services
  - targeted, evidence-based and structured interventions are available to help vulnerable children and their families – these should be monitored against outcomes
  - all primary schools adopt a comprehensive, whole-school approach to children's social and emotional wellbeing.
- Commissioners of services for young people in secondary education should enable all secondary education establishments to adopt an organisation-wide approach to
promoting the social and emotional wellbeing of young people. This should encompass organisation and management issues as well as curriculum and extra-curriculum provision.

NICE has also produced a clinical guidance and quality standards for young people with mental health disorders including: Depression in children and young people (NICE CG28 2005 and NICE QS48 2013); and Psychosis and schizophrenia in children and young people (NICE CG155 2013).

**Key commissioning recommendations for services to support better mental wellbeing in children**

- Given the link between deprivation, poverty and mental wellbeing in young people, better and more robust information is needed to gain a better understanding of the need for local services, so as to inform future commissioning strategies for CAMHS Tiers 1-4.

- Estimates of the expected number of children with a mental health problem appropriate for a mental health service response indicate that there is unmet need at Tier 3 CAMHS.

- Access to specialist CAMHS: assessment and intervention for children and young people on the threshold of care and looked-after children. There is a need to ensure pathways and links across partner agencies and areas of support, such as substance misuse, transition to adult mental health services, Youth Justice, Multisystemic Therapy (MST) and MST-PSB (problem sexual behaviour) and domestic violence.

- Information from the TellUs 4 Survey has been invaluable in assessing mental wellbeing needs and the impact of key risk factors. However, given that it is now no longer undertaken centrally, local systems need to be used to gather information, including full use of the Residents Surveys. Consideration should be given to doing this on a wider scale, possibly regionally, to allow benchmarking.
Safeguarding

Key facts on safeguarding

Nationally and locally the numbers of children in care and on a child protection plan have risen. This has been attributed to an increased general awareness of child protection and safeguarding issues, as well as pressures on families due to the financial context of the country, which together are resulting in higher numbers of children coming to the attention of Children’s Social Care Services in Merton.

In Merton, a 40% increase in the birth rate since 2002 and the changing composition of our communities have provided additional local factors that have impacted on these increased numbers. The increase in demand for services as a result of these demographic and legislative changes is reflected in a number of key performance measures, including (data as at 31 March 2013):

- Number of Children in Need (CIN): 1,486
- Number of Child Protection Plans (CPP): 162
- Number of Looked-After Children (LAC): 140

In [2012], Merton had the second highest rate of CIN compared with geographical neighbours and was higher than the England average. The main reason for children being in need was abuse or neglect (48.4%), followed by family dysfunction (22.1%). Other reasons included: child disability or illness; acute family stress; absent parenting; parent disability or illness.

Figure 6.31: Children in Need, 2012.
Figure 6.32: Children in Need by reason, 2012.

Children in need
South West London 2012 percentage by reason categories
Source: Dept. for Education / ChiMat web site

- Abuse or neglect
- Child disability or illness
- Parent disability or illness

Croydon  | Merton  | Wandsworth | Sutton  | Kingston upon Thames | Richmond upon Thames | England
---|---|---|---|---|---|---

Figure 6.33: Children in Need by reason, 2012.

Children in Need
South West London 2012 percentage by reason categories
Source: Dept. for Education / ChiMat web site

- Acute family stress
- Family dysfunction
- Absent parenting
- Cause not known/not stated

Croydon  | Merton  | Wandsworth | Sutton  | Kingston upon Thames | Richmond upon Thames | England
---|---|---|---|---|---|---
A breakdown of CIN by ethnic group shows that there was a 4.5% greater proportion of children from ‘Minority Ethnic’ groups (48.5%) compared with the population of Merton (44%).

Table 6.12: Children in Need by ethnic group, 2012.

<table>
<thead>
<tr>
<th>2012 Children in need South West London boroughs</th>
<th>Children in need, rate per 10,000 children</th>
<th>Children in need, Polish or unknown gender</th>
<th>Children in need, White ethnicity</th>
<th>Children in need from minority ethnic group</th>
<th>Children in need with recorded disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>449.6</td>
<td>4,011</td>
<td>1.8</td>
<td>74</td>
<td>31.3</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>250.1</td>
<td>847</td>
<td>1.8</td>
<td>15</td>
<td>59.1</td>
</tr>
<tr>
<td>Merton</td>
<td>371.3</td>
<td>1,613</td>
<td>3.8</td>
<td>61</td>
<td>43.7</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td>195.0</td>
<td>794</td>
<td>1.5</td>
<td>12</td>
<td>64.6</td>
</tr>
<tr>
<td>Sutton</td>
<td>258.7</td>
<td>1,118</td>
<td>2.2</td>
<td>25</td>
<td>70.7</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>303.0</td>
<td>1,692</td>
<td>2.1</td>
<td>36</td>
<td>33.5</td>
</tr>
<tr>
<td>England</td>
<td>325.7</td>
<td>369,400</td>
<td>2.0</td>
<td>7,500</td>
<td>73.0</td>
</tr>
<tr>
<td>Source: ChildNet website downloaded data 29/10/2013</td>
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<td></td>
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</tbody>
</table>

Key facts on services to support safeguarding

Maintaining robust safeguarding arrangements and achieving positive outcomes for looked-after children are at the core of all activity of children’s services in Merton. The 2012 Ofsted inspection of safeguarding and looked-after children services examined a comprehensive set of criteria, including:

- ambition and prioritisation
- leadership and management
- quality of provision
- performance management and quality assurance
- partnership working
- overall effectiveness and capacity for improvement.

Merton Council and its partners were rated as ‘good’ in all judgement areas. No priority areas for action were specified although some areas for improvement were identified. A post-inspection action plan to address these areas was agreed by the Merton, Safeguarding Children Board, which is monitoring progress. The Board produces an Annual Report which sets out progress and priorities for safeguarding children: [http://www.merton.gov.uk/health-social-care/children-family-health-social-care/lscb/lscb-about/mscb_publications.htm](http://www.merton.gov.uk/health-social-care/children-family-health-social-care/lscb/lscb-about/mscb_publications.htm).

Merton’s Local Safeguarding Children Board (LSCB) and Children’s Trust partners have been planning for the implementation of a Multi-Agency Safeguarding Hub (the MASH) in Merton. The MASH is designed to improve information and intelligence sharing across key
agencies – and to improve, therefore, the response and intervention – in respect of concerns about the wellbeing or safety of individual children. The MASH began operation in April 2013 and is staffed by social care, education, police, health and probation practitioners.

The establishment of the MASH is part of a wider ‘whole system’ change programme, which will impact on Merton’s current Child and Young Person Wellbeing Model, Common Assessment Framework and referral pathways into and out of the MASH to specialist and early intervention and prevention services. This work needs to ensure that the ‘right’ children receive the ‘right’ level of intervention and support in a timely manner and that our safeguarding and family support resources are more sharply targeted to achieve best outcomes and best value.

Partners are also engaged in the delivery of the Transforming Families initiative in Merton, which involves targeted intensive interventions with some of the borough’s most challenging families alongside a community development approach in specific areas, including, initially, the Phipps Bridge estate. Specifically focusing on reducing anti-social behaviour, improving school attendance and tackling worklessness, the initiative is a three-year programme with an element of payment by results which, if successful, will reduce the burden on some of the partnership’s specialist services.

**What works and best practice**

Evidence and guidance on effective safeguarding systems are set out in the following documents:


**Key commissioning recommendations**

- Ensure robust safeguarding systems are maintained in the context of increasing numbers of children in need, children on a child protection plan and children in care.

- Ensure effective pathways across services to ensure access and interventions for children and young people on the threshold of care.
Looked-After Children

Key Facts on the needs of looked-after children

Looked-after children (LAC) are a vulnerable group who, compared with their peers, have significantly more educational and mental health problems, and on leaving care have worse outcomes as adults. Nationally, LAC and care leavers are between four and five times more likely to self-harm in adulthood. They are at five-fold increased risk of all childhood mental health, emotional and behavioural problems. Looked-after teenage girls are 2.5 times more likely to become pregnant than other teenagers.107

The numbers of LAC have increased from a low of 106 in March 2008 to current 140 as at 31 March 2013. There are a number of reasons for this increase, including the impact of serious case reviews across the country in terms of increased awareness, unaccompanied asylum seekers and an increasing birth rate.

Merton’s (2013) rate of LAC is 30 per 10,000, in line with its statistical neighbours in 2012. A greater number of 16 and 17 year old children have started to be looked after than in previous years (65% increase on 2012).

Gender distributions are similar to the national averages. Merton has a lower rate of LAC across age groups 0-9 years than the national rate. Generally Merton has lower rates of younger children in care but higher rates of older children in care compared with the national average.

Merton has a changing profile of ethnic groups for LAC. There are fewer ‘white’ LAC than in the population of Merton (6%) and a greater proportion of LAC in ‘other ethnic groups’ (10%). This is a change from 2012 where white LAC was 2% below the population and LAC in other ethnic groups was 1% above.

In the increased category of ‘other ethnic groups’, in 2013, as at 31 March 2013, 72% of these children and young people are unaccompanied asylum seeking children.

There is an educational achievement gap between LAC and their peers. In 2012, at Key Stage 4, 40% of LAC achieved five or more GCSEs at A-C grades, including English and maths, compared with 59% of children not looked after. However, LAC within Merton schools achieved above the national children in care averages.

The health of LAC in Merton (i.e. children looked after continuously for at least 12 months, ending 31 March 2013) has been assessed as:

- 90% had there immunisations up to date (national 83%, 2012)
- 99% had their teeth checked by a dentist (national 82%, 2012)

- 98% had their annual health assessment (national, 86% 2012).

**Table 6.14: Trends in looked-after children, 2009-2013.**

<table>
<thead>
<tr>
<th></th>
<th>2009 (31st March)</th>
<th>2010 (31st March)</th>
<th>2011 (31st March)</th>
<th>2012 (31st March)</th>
<th>2013 (31st March)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Rate per 10,000</td>
<td>No.</td>
<td>Rate per 10,000</td>
<td>No.</td>
</tr>
<tr>
<td>Merton</td>
<td>116</td>
<td>28</td>
<td>137</td>
<td>33</td>
<td>132</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>129</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>140</td>
</tr>
<tr>
<td>National</td>
<td>60,890</td>
<td>55</td>
<td>64,410</td>
<td>58</td>
<td>65,520</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>67,050</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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</tbody>
</table>

Source: OC2 and SSDA903

Merton has the lowest rate of LAC compared with statistical neighbours. See Figure 6.42 below.

**Figure 6.34: Looked-after children, rate per 10,000 population, 2012.**
Evidence about what works to improve the health and wellbeing of looked-after children

NICE has produced guidance on the health and wellbeing of looked-after children and young people (NICE PH29 2010) and more recent quality standards (NICE QS31 2013), which define best practice and describe high-priority areas for quality improvements. These focus on promoting resilience, including warm nurturing care, a sense of belonging and emotional support.

The Chief Medical Officer’s Annual Report 2012 outlines recent evidence on the risk factors associated with entering care and outcomes.

Key commissioning recommendations

- There are increasing numbers of LAC who require timely health assessments and other services.

- There is a local and national emphasis on increasing the numbers of foster carers and speeding up the permanency process for prospective foster carers and adopters in relation to LAC requiring timely health assessments.
Key facts on the needs of young carers

There are nearly 600 known young carers in Merton, with the actual number likely to be a good deal higher.

Young carers are an often overlooked and vulnerable group of young people with a great variety of needs and circumstances. Young carers take on responsibilities more usually associated with an adult which may be inappropriate – responsibilities in caring for parents, siblings and others, who could have disabilities, mental ill health, drug or alcohol dependency or a whole range of other issues. This can affect the young people’s ability to simply be children, enjoy their childhood and grow up with the same opportunities as their peers. They can be subject to stigmatisation or bullying and may significantly underachieve at school.

Young carers are concerned about their own health, especially their emotional wellbeing. Their physical health can suffer often because of tiredness or poor diet. They can have limited time for active pursuits and exercise and can be exposed to inappropriate levels of caring. The Merton Young Carers Strategy and action plan 2013-16 highlight the priorities for young carers and aim to address these in order that [commissioners] can make a significant difference to the quality of young carers’ lives.

Key Commissioning Implications

- Effective whole family approaches to assessment are recognised as essential to improving support for adults and young carers alike.

- There is a need to assess the implications of the Children and Families Bill and Care Bill for young carers, including proposals for a legislative framework for local authorities to consider the needs of the whole family, deliver coordinated packages of support, and protect children and young people from excessive and inappropriate caring roles.  

Key facts on youth offending, gangs and youth violence

Children and young people in contact with the youth justice system are more likely to have mental health problems than those who are not, and to have more than one mental health problem alongside a range of other challenges. Nationally, over the past decade there has been a reduction in the number of young people entering the youth justice system, but this reduction is not uniform and there is evidence of growing levels of multiple, complex and damaging health and social needs among those who have come into contact with the youth justice system.109

In Merton, there has been a year-on-year reduction of first-time entrants (FTEs) to the youth justice system over the past four years, with 77 FTEs in 2012-13, down from 188 FTEs in 2008-09, 144 in 2010-11 and 111 in 2011-12.

Improvements have been achieved by identifying children and young people at risk of offending or being involved in anti-social behaviour through a multi-agency Youth Inclusion and Support Panel and offering evidence-based targeted means of intervention, such as accredited parenting programmes designed to reduce risks and strengthen protective factors.

Although the trend is downwards, in 2011-12 Merton had a slightly higher rate of FTEs (881 per 100,000) when compared with London (864 per 100,000) and England (712 per 100,000).

Figure 6.36: First-time entrants to the Youth Justice System, rate per 100,000, 2008-12.

![Graph showing first-time entrants to the Youth Justice System](image-url)

England Average, 2011-12

Serious youth violence
Overall in the financial year 2011-12, Merton recorded 160 serious youth violence offences. The types of Serious Youth Violence Offence in 2012 were: 19% Violence Against the Person; 13% Robbery; 15% Theft and Handling; and 15% Drug Offences. In the two years 2011 to 2012, the number of ‘violence against the person’ crimes reduced from 95 to 60.

Gangs
The general consensus is that a gangs problem exists across London, and in October 2013 the Mayor of London appointed a Gangs Czar to assist in the fight against London’s gangs. The issue is more evident and widespread in specific local authorities, particularly in those which are classified as Inner London, but the issue is still prevalent in many, if not all, Outer London areas. Whilst evidence and data indicate that Merton does not have a serious gangs issue, it is apparent that there are well-founded concerns indicating that the borough has not escaped the issues that the rest of London faces in this regard.

During a Home Office ‘Ending Gang and Youth Violence’ Peer Review (October 2013), Merton was praised for the speed within which it tackles gang-oriented issues on a multi-agency level. One of the recommendations within the action plan was for the public health agenda to be expanded to take the needs of young people engaged in, and on the periphery of gangs, into consideration. It was also suggested that this agenda incorporate a strategy that benefited young women who are victims of, or at risk of, sexual exploitation (through gangs and serious youth violence).

A strategy is currently being formulated in relation to public health and the gangs agenda and should be beneficial to residents of Merton. Indeed, seeing crime, particularly youth violence, as a public health issue holds a number of benefits. For example, it opens up a number of opportunities to engage with and help those involved in gangs and violence, such as support with mental health issues and help with reducing alcohol and substance misuse.

Key commissioning implications

- Substance misuse is a major factor in youth offending – criminal behaviour while under the influence of/or to fund/or to deal in substances is high-incidence youth crime. Work is needed to better market existing pathways into substance misuse services.
- Universal Substance Misuse prevention strategy needs strengthening e.g. in schools/youth provision.
- Easier access to a wider range of therapeutic interventions for young people committing violent and sexual crime is needed.
- CAMHS’s engagement with young people involved in gang activity/victims of gang activity needs to be strengthened e.g. in relation to exiting gangs; and sexual exploitation.
- Recognising youth crime and gangs as a public health concern is critical in identifying innovative ways of tackling the issue.
Access to Health Services

Key facts on health services for children and young people

The health of children and young people has improved significantly over the last century. Remarkably few children and young people die. The major killers of children, infectious diseases and accidents, have been largely overcome by a combination of increasing standards of housing, diet and sanitation; and immunisation and universal education. However, nationally, although there are far fewer deaths, longer-term childhood illnesses such as asthma and diabetes have increased; obesity is currently increasing which is likely to lead to a higher level of Type 2 diabetes in a younger population in the future, and accidental injury remains a potentially avoidable cause of hospital admission and death. The current increasing birth rate in Merton includes areas of deprivation. In the current economic situation this could lead to more children in poverty and poorer short- and longer-term health needs. The differences in populations within the borough in terms of ethnicity and socioeconomic factors will also have an impact on the types of health conditions being seen and the services required.

While children in the UK now experience far fewer deaths than 50 years ago, chronic childhood illnesses such as asthma and diabetes have increased. This suggests that the treatment of these conditions has improved vastly and that children can continue to live normal lives even if they have long-term conditions. However, little information is currently available specifically on the treatment of childhood conditions, even through the Primary Care GP Quality and Outcomes Framework, since most of the clinical indicators only relate to adults.

Emergency attendances at hospital

In 2012-13, there were a total of 16,447 attendances at local A&E by 0-19 year olds registered with a Merton GP (source: Merton CCG), which means on average 45 children and young people attended a local A&E every day (note, there is fluctuation by day and season).

The rate of attendances at A&E in 2010-11 was higher in Merton among 0-4 year olds (698.2 per 100,000) compared with London (648.4 per 100,000) and England (483.9 per 100,000). Merton ranked 11th highest out of all London boroughs for the 0-4 age group.

The rate of A&E attendances in 2010-11 was higher in Merton among 5-9 year olds (354.9 per 100,000) compared with London (323.5 per 100,000) and England (255 per 100,000).

The rate of A&E attendances in 2010-11 was higher in Merton overall for 0-17 year olds (483.3 per 100,000) compared with London (438.2 per 100,000) and England (353.9 per 100,000).
Emergency admissions to hospital

A review of admissions for conditions common in childhood can provide an understanding of childhood hospital conditions locally and how services are used. Potentially avoidable emergency admissions for conditions in children and young people that could be managed in the community include lower respiratory tract infections and asthma, diabetes and epilepsy.

Emergency admissions in 2011-12 in Merton for asthma, diabetes and epilepsy among under 19 year olds was 223.3 per 100,000, the 11th lowest rate compared with other London boroughs.

Figure 6.38: Rate of unplanned hospital admissions for asthma, diabetes and epilepsy, under 19 years, 2010-11 to 2011-12.
Emergency admissions in 2011-12 for lower respiratory tract infections for under 19 year olds was 211 per 100,000. The chart in Figure 6.41 below compares Merton with our geographical and statistical neighbours.

Figure 6.39: Rate of emergency hospital admissions for lower respiratory tract infections, under 19 years, 2010-11 to 2011-12.

Emergency hospital admissions (2006-10) due to injury amongst under 18 year olds was lower in Merton (1,130.8 per 100,000) compared with London (1,229.7 per 100,000) and England (1,443.2 per 100,000).

Emergency hospital admissions (2011-12) due to self-harm amongst under 18 year olds was lower in Merton (43.9 per 100,000) than London (64.4 per 100,000) and England (115.5 per 100,000), although it must be noted that actual numbers are very small.

Urgent care services in South West London
A detailed analysis of children’s health services in South West London was undertaken in 2012.\textsuperscript{110} This identified that access to care for children with urgent care needs can be confusing for parents who must choose between a range of different services e.g. GP services, walk-in centres and A&E departments. The lack of readily accessible primary care services can encourage presentation to A&E departments, which may in turn lead to inappropriate admission to hospital.

The report noted that it was not clear why a rapid rise in emergency short-stay admissions has taken place when it could be argued that the number of severe illnesses in children is decreasing. It may relate to parental anxiety (which could be reduced through improved

education and support), new clinical protocols and professionals being risk averse (which may reduce with the advent of a more consultant-delivered service).

The number of A&E attendances nationally has risen steadily in recent years and this increase in attendances is especially pronounced in the treatment of children: according to NHS data, in a typical year in England up to half of infants under 12 months and one quarter of older children will attend A&E. Up to 25% of all A&E attendances at local hospitals are by children aged under 15 years.

Recent data for emergency medical care in South West London showed that:
- Over half of A&E attendances for 0-17 years old were discharged with no follow-up treatment required.
- Only 11% were admitted to the same hospital for further treatment.
- There is significant variation in the number of emergency admissions, length of stay and patient outcomes between hospitals across London.

**Length of stay in hospital**
The charts in Figures 6.42 and 6.43 below show comparatively how St George’s Healthcare NHS Trust and Epsom and St Helier University Hospitals NHS Trust perform in terms of the inpatient mean length of stay [as recorded] by Healthcare Resource Group (HRG).

Overall in paediatric medicine the average number of bed days for St George’s Hospital were higher than expected and for Epsom and St Helier Hospitals were also slightly higher than expected.

Looking further into this overall position a number of areas can be identified where the average number of bed days is higher than expected. For St George’s Hospital this includes respiratory tract infections, and asthma or wheeze. For Epsom and St Helier Hospitals this includes respiratory tract infections, asthma or wheeze, and febrile convulsions. The findings need to be linked into developing new pathways for children and young people, in particular the pathway for unplanned care particularly in respect of infections and respiratory conditions.
Figure 6.42. Length of hospital stays by clinical specialty (paediatrics), St George’s Hospital 2011-14.
Key commissioning implications for health services for children and young people

In light of existing and future financial constraints, and at a time when the birth rate is increasing, there is an opportunity to review children's health services to ensure that in the majority of cases children with both acute and long-term conditions are supported in the community as much as possible, reducing the need for hospital inpatient stays, in particular focusing on:

- ensuring the local pathway for unplanned care is underpinned by a consistent model of care for all organisations
- reviewing data on hospital attendances for children aged 0-17 years, including a focus on 0-4 age group, and reviewing progress on local initiatives to reduce A&E attendances
- how children with long-term conditions can be supported to access the full curriculum in schools and have a smooth transition into adult services.
THEME 7:
ADULT HEALTH IN MERTON – LONG TERM CONDITIONS
Summary: Major Killers and Causes of Poor Health

Key facts on the major killers and causes of poor health

Merton has a young age profile with the highest proportion of its residents around the late 20s to early 40s age range and with an ethnically diverse population, which is similar to the population structure of Inner London boroughs.

Overall for premature deaths – i.e. deaths in people aged under 75 years of age – many of which are considered preventable, in the period 2009-11 Merton had 1,204 premature deaths, which equates to 236 premature deaths per 100,000 population adjusted for various factors, including the age of the population. Out of 150 local authorities this ranked Merton at 29th (1 = best, Wokingham; worst was Manchester) putting Merton overall in the ‘best outcomes’ category.111

In terms of under 75 mortality rates from all causes, in 2010 Merton had a directly standardised rate of 220.77 per 100,000 population, compared with 272.77 for England and 271.87 for London. This equates to 1,157 deaths in Merton from all causes. Compared with other boroughs in South West London, Merton had a mortality rate lower than Croydon and Kingston upon Thames, but higher than Richmond upon Thames, Sutton and Wandsworth. In terms of trend since 2006, compared with London and England, Merton’s mortality rates have been consistently lower than both and decreased in 2010 more than the rates in London or England (see Figure 7.1 below).

Figure 7.1: Mortality rates in Merton from 2006-10 from all causes, compared with London and England.

Source: Health & Social Care Information Centre website 13.11.2013

Breaking down the mortality by causes of death, the top three causes of death in those under 75 years of age were (in order of frequency, from most to least common) cancers, circulatory disease and accidents and injuries – which accounted for 70% of all deaths in Merton.

**Cancers**
In terms of under 75 mortality rates from cancers, in 2010 Merton had a directly standardised rate of 78.58 per 100,000 population, compared with 108.05 for England and 102.85 for London. Compared with other boroughs in South West London, Merton had a mortality rate lower than Croydon, Kingston upon Thames, Richmond upon Thames, Sutton and Wandsworth. In terms of trend since 2006, compared with London and England, Merton’s mortality rates have been consistently lower than, and decreased in 2010 more than, the rates in London or England.

**Figure 7.2: Under 75 mortality rates in Merton from 2006-10 from cancers, compared with London and England.**

![Directly standardised mortality rate (DSR) per 100,000. Less than 75 years for All Cancers. Merton compared to London and England. Source: Health & Social Care Information Centre](image)

**Circulatory disease**
In terms of under 75 mortality rates from circulatory disease, in 2010 Merton had a directly standardised rate of 72.13 per 100,000 population, compared with 64.67 for England and 68.16 for London – higher than both London and England. Compared with other boroughs in South West London, Merton had a mortality rate higher than all the boroughs barring Wandsworth (121.00). In terms of trend since 2006, compared with London and England, Merton’s mortality rates have been variable starting in 2006 lower than both England and London, then sharply increasing in 2007 until it equalled the England rate in 2008 and then steadily rose until in 2010 it was higher than both London and England.

**Inequalities**
There are clear inequalities across Merton in terms of mortality and ill health, especially when comparing East Merton with West Merton. These inequalities can be seen in the differences in circulatory disease, including coronary heart disease (CHD) and stroke, and diabetes and...
for chronic obstructive pulmonary disease (COPD) across the different communities in Merton. Higher levels of these conditions are associated with areas of deprivation and are linked to higher levels of the major risk factors: smoking, hypertension and obesity.

Figure 7.3: Mortality rates in Merton from 2006-10 from circulatory disease, compared with London and England.

Looking at rates of death in a population (rather than life expectancy), if East Merton had the same rate of deaths as West Merton, there would be around 113 fewer deaths each year in East Merton – an 18% reduction on the 640 deaths each year among East Merton residents.

Figure 7.4: Mortality rates in West and East Merton. Graph compares the estimated standardised mortality ratio (SMR)* for East and West Merton, derived from ward level 2006-10 SMRs. Expected deaths are the sum of ward expected deaths. ‘Excess’ deaths in East Merton are derived from calculating expected deaths using West Merton SMR.

Mortality rates are higher in East Merton

* SMR = Standardised mortality ratio. This is a ratio of the observed number of deaths in an area to the number expected if the area had the same age-specific rate as England.
When the 113 excess deaths are analyzed further by cause of death and by whether these were under 75 years (described as premature deaths as many of these are considered as preventable) or 75 years of age and over, 41 excess deaths in East Merton occurred due to circulatory disease, 24 due to cancer and 48 due to other causes, in each year [between 2006 and 2010]. A significant element of the ‘other causes’ will be respiratory disease. As can be seen from the graph in Figure 7.5 below, a significant proportion of these excess deaths were premature deaths in the under 75’s (81 in total) and many of these would have been preventable.

Figure 7.5: Excess deaths [between 2006 and 2010] in Merton by cause.

The wards in Merton with a mortality rate higher than the England average are also those that are the most deprived and are some of the more ethnically diverse. There are potential issues in terms of the most in need accessing appropriate services at the right time to improve outcomes.

When East and West Merton are compared against the England average for the number of admissions in the population aged under 75 years (see Figure 7.6 below) for all causes, accidental falls, cancer, circulatory diseases and respiratory diseases, for each of these categories East Merton had more admissions than West Merton. All the metrics are however below the England average and the desired direction for improvement is to reduce the number of admissions.
Figure 7.6: Standardised hospital admissions ratios* in under 75 years [2006-10] in East and West Merton.

This graph shows that both East and West Merton are achieving lower rates of hospital admissions than the average in England but there are much higher rates in East Merton compared with West Merton.

* SAR = Standardised admission ratio. This is a ratio of the observed number of admissions in an area to the number expected if the area had the same age-specific rate as England.

There are also differences in incidence and mortality for all cancers, not only geographically but also between genders. This is reflected in differences in the prevalence of some of the main risk factors, such as smoking and obesity. Uptake of screening (the opportunity for early diagnosis) is above regional but below national uptake for breast and cervical cancer. For bowel screening, it is very low.

In terms of smoking there are clear differences in rates within the borough with much higher levels seen in more deprived communities. The levels of obesity and lack of physical activity are linked to deprivation in Merton and show an increasing trend that is of concern for future health.

Overall Merton is a healthy place to live, however there are a number of causes for concern:

- **Circulatory disease**: Under 75s death rate from circulatory disease (including stroke) is higher than for England and although the overall trend is downward there was a slight upturn in the last period and it is still the second biggest cause of premature death. The rate of stroke for under 75s increased for both men and women in the last period, although the overall trend is also downwards (2008-10).
- **Diabetes:** Diabetes recorded in primary care is 5.3% for Merton CCG overall, but ranges from 2% to nearly 10% by practice. Comparing modelled with recorded prevalence of diabetes suggests a proportion remains undiagnosed, which is something that requires a more in-depth look.

- **Cancer:** Death rates from cancer in people aged under 75 have reduced, particularly for females. However, it is still the main cause of premature death and inequalities remain with a higher rate of deaths in the eastern wards.

- **Respiratory diseases:** Deaths from respiratory diseases have declined, but there are wide variations in hospital admissions by area. This needs to be studied in more depth.

- **Mental health:** Levels of depression are higher than for England, and although proxy measures for mental health outcomes are good, recovery rates following the use of psychological therapies are lower than for England and London. Levels of depression need to be monitored in light of the potential impact of the recession on mental health and wellbeing.

**Key facts on services**

The Public Health England CCG Spend and Outcome Factsheets and Tool (SPOT) (see Figure 7.7 below) for NHS Merton CCG in 2011-12 shows:

- **Lower spend and better outcome** areas were: cancer, mental health and genito-urinary medicine.

- **Higher spend and better outcome** areas were: respiratory, neurological, dental, gastrointestinal system, trauma and injuries, maternal and neonatal.

- **Lower spend and worse outcome** areas were: endocrinal, nutritional and metabolic (of which diabetes is a part), healthy individuals and vision.

- **Higher spend and worse outcome** areas were: circulatory and musculoskeletal.

- **Lower spend and average outcome** areas were: social care needs, learning disabilities and hearing.

- **Higher spend and average outcomes** areas were: skin, adverse effects and poisoning, and blood disorders.
Figure 7.7: Spend and outcomes in NHS Merton CCG 2011-12, relative to other CCGs in England.

Interpreting the chart:
Spend: By population, Population: Unified Weighted
Each [diamond] dot represents a programme budget category. The three largest spending programmes nationally (mental health, circulatory diseases and cancer) are represented by larger dots [diamonds].
The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. This means that for some programmes no outcome data is available.
The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.

A programme lying outside the solid +/- 2 z scores box may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome.

Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.

Z score:
A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further.
Key commissioning recommendations

There are clear inequalities in terms of CHD, stroke, diabetes, respiratory disease (COPD) and cancer across the borough and between genders. The linking factors are smoking and obesity. Identifying people at risk of these conditions through screening or surveillance would enable prevention and early intervention to reduce future reliance on health and social care services.

- Current screening coverage for cervical and breast cancers is above regional but below national levels. Bowel screening uptake and coverage are very low. Improvement in the uptake and coverage of all screening services is needed for early identification, to prevent cancers becoming untreatable and improve outcomes. This improvement needs to be targeted at the more deprived areas in Merton and disadvantaged groups in the community where uptake of screening programmes is generally lower.

- Commissioners need to use social marketing approaches to understand why the uptake of screening services is below national rates and how future uptake could be improved and to improve the systems to identify patients and non-attenders for screening services. Groups that need particular focus are: people with learning disabilities, ethnic minorities, younger women and socially deprived groups.

- Early identification of those at high risk of circulatory diseases (including stroke) and diabetes could improve outcomes for patients and create less reliance on services. The introduction of the NHS Health Check programme should support this and needs to be targeted at populations who are likely to be at increased risk, such as those in areas of deprivation.

- Interventions available to support individuals to reduce risk factors need to be in place. A coordinated programme of personalised advice and support services has been introduced to support people to make healthy lifestyle choices to achieve a healthy weight, become more physically active, and reduce risky drinking behaviour, to reduce risks of future ill health. This programme also includes the Stop Smoking Service. However, the success of this programme will depend on primary care and other services (pharmacies, social care, voluntary sector) taking an active role in identifying those at risk and referring them into the service. Commissioners need to monitor and evaluate the success of this programme.

- There are variations in the prevalence of diseases identified through primary care practices across Merton and these need to be understood better. Where such variations exist, Merton CCG should work with practices to reduce these variations to ensure that patients are identified early and receive timely and appropriate treatment and support for their condition.

- As part of their new responsibility for health improvement, wider local authority input through existing contracts with services such as leisure and housing, and through planning responsibilities, will help to support people to achieve healthy lifestyles and will be of significance in reducing the risk of disease in a wider range of population groups, targeting people who are potentially at risk of poor health but who may not necessarily access existing health services on a regular basis.

- A whole systems approach focusing the model of care is needed to deliver ‘integrated’ services. This approach should include access to support for primary prevention (to focus on improving lifestyles and improving uptake of early intervention and prevention
services), and for secondary prevention in primary care (community and secondary health care services); these services should work in close partnership with social services.

- There is a real opportunity afforded by the development of CCGs and the partnership in the Health and Wellbeing Boards in taking this work forward.

**Mental health**

_Currently a detailed review of adult mental health services is under way in Merton, which includes a mental health needs assessment. The review will result in the development of an adult mental health strategy for Merton and will be used to update the mental health section of the JSNA._

**Key facts on mental health**

One in four people in the UK will experience a mental health problem in the course of a year. The cost of mental health problems to the economy in England has recently been estimated at £105 billion each year and treatment costs are expected to double in the next 20 years (NEPHO). In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (including self-inflicted injury), compared with 16.2% for cardiovascular disease and 15.9% for cancer, as measured by disability-adjusted life years (DALYs). Depression alone accounts for 7% of the disease burden, more than any other health condition. It is predicted that, by 2030, neuropsychiatric conditions will account for the greatest overall increase in DALYs.

**Key commissioning implications for services to support improved mental health and wellbeing**

As mentioned earlier, the Merton adult mental health services review is currently under way and will help to inform future commissioning intentions. The recommendations will be included in a refresh of the mental health section of the current JSNA when it is ready and available.

With changes proposed for commissioning in the NHS, as well as changes to Public Health, and the drive to provide care in community settings, it is imperative that consideration is given to the overlap between commissioning inpatient mental healthcare for people with dual diagnosis and support in the community. Further investigation is recommended to identify the specific needs of this group of individuals to assess whether the balance of admission and community support is appropriate and to understand which services care is accessed through.

In terms of treatment services, commissioners should focus on developing a whole system approach to mental health with more joined-up services to improve experience and outcomes. They should also focus on developing better data and local information on outcomes, and on addressing health inequalities in relation to mental health. There should be further investigation into why Merton has higher rates of depression than London, in light of its wider good health, and a focus on improving recovery rates following psychological therapies. Further work is also needed to understand access by and for ethnic minorities. A health equity audit for mental health services would be useful to support this.

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Commissioners need to give consideration to local data that has suggested a number of areas where mental health can reduce health costs and lead to physical and mental health gains:

- High costs associated with unnecessary and unplanned admissions amongst people with a range of long-term conditions could be reduced with motivational work to support lifestyle change and psychological support to distinguish symptoms requiring medical attention from symptoms of anxiety or depression.
- High numbers of young people and their families presenting frequently and unnecessarily at A&E with asthma or minor injuries could be reduced with assistance to manage anxiety and improve self-care.
- High-cost areas (mostly associated with sheltered housing where the top 25% accounted for nearly half of cost) could be reduced with the provision of support to staff and people living in sheltered accommodation and residential care to manage difficult situations and distinguish symptoms requiring medical attention from symptoms of anxiety or depression.

*Recommendations from the insight work by Resonant Media*

Resonant Media has developed recommendations across three areas to address these barriers and improve the existing service provision. These will inform, encourage and support service users to access physical health services.

Involving the service users themselves in shaping and delivering services is key to all the recommendation areas. This will build trust in the services and ensure that they are genuinely shaped for their needs.

*GPs*

Since GP practices are so busy it can be difficult to engage with them and change their practice. The research suggested initially developing a couple of best practice pilots. One or two selected GP surgeries would act as pilot projects to implement improved services for those with SMI. Positive results from these pilots, on outcomes such as do not attends (DNAs), could then be used to encourage other GP practices to implement the improved services.

Further training on working with those with mental health problems is also suggested for all who work in GP practices. This should utilise existing training courses and times when the staff are already gathered together.

*System level*

To drive forward proper links locally between the physical health and mental health services, a senior level champion needs to be identified to drive this forward. This champion could help with creating specific targets around physical health for those with SMI. They would also lead on the future development of co-located services and multidisciplinary teams.

The recommendations of Resonant Media address all four of the social marketing intervention modes – support; design; inform and educate; and control – to try to increase levels of those with SMI accessing physical health and health promotion services and thus reducing their health inequalities.

*Key commissioning implications for services to reduce suicide*

Commissioners need to give consideration to the recommendations in the Department of Health’s National Suicide Prevention Strategy for England:
• prevention targeted at high-risk groups e.g. those in recent contact with mental health services, those who have self-harmed, young men and those in high-risk occupations
• reducing access to lethal methods of self-harm, such as hanging and strangulation, in wards and prisons
• promoting positive mental health and social inclusion, particularly among the vulnerable
• multi-faceted strategies to prevent, identify and address behaviours linked to a high risk of suicide in school.

Neurological conditions

Key facts on neurological conditions
This section covers four long-term neurological conditions: epilepsy, Parkinson’s disease, multiple sclerosis (MS) and motor neurone disease (MND).
• In 2012-13, among those aged 18 or over and registered with a Merton GP, there were 863 people with diagnosed epilepsy (Quality and Outcomes Framework 2012-2013, Health & Social Care Information Centre, October 2013). This gives a crude rate of 0.5%, and compares with the London rate of 0.6% and the England rate of 0.8%.
• The directly standardised mortality rate per 100,000 for epilepsy in under 75 year olds in 2011-12 was 1.1 for Merton CCG, compared with 1.5 for the ONS Cluster (London Suburbs). The rates are however based on small numbers.\textsuperscript{114}
• Applying the UK prevalence rates\textsuperscript{115} to the 2013 projected population for Merton\textsuperscript{116} we find that:
  • For Parkinson’s – with a prevalence rate of 195 per 100,000, there are an estimated 395 individuals with Parkinson’s disease in Merton.
  • For MS – with a prevalence rate of 161 per 100,000, there are an estimated 326 individuals with MS in Merton.
  • For MND – with a prevalence rate of 7 per 100,000, there are an estimated 14 individuals with MND in Merton.

Key commissioning recommendations

Commissioning safe, sustainable, high-quality services for the local population
Improving the quality and ensuring the safety of acute hospital, primary care, community, and mental health and specialist services are the highest priorities for the borough.

Integrating care and developing community services
Enabling improvements in care provided to individuals resulting in a better experience, improved outcomes and productivity, particularly for the vulnerable.

\textsuperscript{114} Source: Spend and Outcome Factsheet 2011-2012 for Merton CCG, Public Health England.
\textsuperscript{115} NeuroNavigator website, November 2013.
\textsuperscript{116} GLA Population Projections 2012 Round Demographic projections – SHLAA.
Cancer

Key facts on cancer

Cancer is a term that is used to refer to a number of conditions where the body's cells begin to grow and reproduce in an uncontrollable way. There are many different types of cancer. The most common in the UK by number of new cases, are the cancers of breast, lung, prostate, and bowel.\(^{117}\)

Nationally cancer was the biggest killer in this country in 2011 and 2012, with circulatory disease being the second most common cause of death\(^{118}\). In the UK more than 1 in 3 will develop cancer at some stage in their lives,\(^ {119}\) and cancer deaths accounted for more than 1 in 4 of all deaths in the UK. In 2010, approximately 325,000 people were diagnosed with cancer and around 157,275 people died from the disease.\(^ {120}\) An individual's risk of being diagnosed with cancer depends on many factors, including age, lifestyle and genetic factors. It is estimated that more than 4 in 10 cancer cases could be prevented by lifestyle changes, such as not smoking, cutting back on alcohol, maintaining a healthy body weight, and avoiding excessive sun exposure.\(^ {121}\)

Treatments for cancer include surgery, chemotherapy and radiotherapy. Some cancers can be cured if detected early enough, therefore high achievement in screening programmes is vitally important to detect the early presence of cancer and treat appropriately. In 2012-13, cervical and breast cancer screening in Sutton and Merton (still reported as Sutton and Merton PCT) was lower than all other South West London boroughs barring Wandsworth, higher than London and lower than England.\(^ {122}\)

In Merton, based on GP registers (Quality and Outcomes Framework (QOF)) for 2011-12, the prevalence of cancer (the number of people who have cancer at this time) was 1.4%; i.e. about 1 in 72 people have had a cancer compared with 1.8% nationally, i.e. 1 in 56 people. Within the overall prevalence, different types of cancer may be more or less prevalent e.g. breast and prostate cancer are the most common forms and will have higher prevalence. In terms of the numbers of new cases of cancer, Merton was slightly lower than regional and national levels.

Deaths from cancer for those aged under 75 years is taken as a proxy measure for deaths from cancer that could be avoided. In terms of the rate of deaths from cancer for people in this age group, there is a downward trend and Merton was significantly lower than the


\(^{122}\) 2013, HSCIC data.
national average for 2011, and the lowest of other CCGs in South West London. A closer look at gender shows there was a higher rate of deaths among men than women, which reflects the national picture and there has been a more rapid reduction in deaths for women since 2005-07 (see Figures 7.8 to 7.11 below).

For premature deaths due to cancer – i.e. deaths in people aged under 75 years – many of which are considered preventable, in the period 2009-11 Merton had 89 premature deaths per 100,000 population adjusted for various factors, including the age of the population. Out of 150 local authorities this ranked Merton second (1st = best, Harrow; worst was Manchester) putting Merton in the ‘best outcomes category’ for cancer.123

Higher levels of cancer are found in the more deprived areas and in BME groups, reflecting an inequality in the burden of the disease, with the highest rates of under 75 mortality in St Helier, Ravensbury, Cricket Green and Pollards Hill wards.

Figure 7.8: Merton cancer mortality (under 75 years) by gender, 3-year rolling averages 1993-2010. This graph shows that premature mortality is higher in England, London and Merton in males compared with females. While the overall trend is downwards, the gap continues to exist. In Merton in the period from 2004-07 male mortality dropped significantly, to the extent that it was actually marginally lower than in females during the period 2005-07. Since then the gap has again widened and appears to be widening further.

Figure 7.9: Cancer mortality (under 75 years) comparing Merton with London, statistical and geographical neighbours, 2011. Merton has one of the lowest premature mortality rates out of all London boroughs.

Figure 7.10: Merton cancer mortality (under 75 years) compared with South West London by CCG, 2011. Merton CCG has the lowest premature mortality rate for cancer out of all geographically neighbouring CCGs.
Figure 7.11: Mortality for cancer by Merton wards, 2006-10. The darker the shaded areas are in the map, the higher the premature mortality from cancer. As can be seen, the areas with the highest mortality are concentrated towards the east of Merton.

While cancer can affect 1 in 3 people, there are some cancers where incidence rates in people from BME communities are higher than that of the white British population:

- African Caribbean men are three times more likely to be diagnosed with prostate cancer than white men
- South Asian women over the age of 65 have a higher risk of cervical cancer than white women of the same age.

Cancer can affect any age group, including younger people, but the majority of people (65-70%) diagnosed with cancer are over the age of 65. The incidence of some cancer types is growing exponentially in specific minority ethnic groups and the overall risk is predicted to rise as these populations age. The Irish population currently has a higher percentage of older people in comparison with other ethnic groups and many, including gypsies and travellers from diverse ethnic groups, are less likely to be aware of cancer, or cancer services. There is also evidence to suggest, that for a limited number of cancer types, people from specific ethnic groups are more likely to be diagnosed with cancer at younger ages than expected.
- Black men are more likely to be diagnosed with more aggressive prostate cancer approximately five years younger than white men.
- Premenopausal (under 50s) black and South Asian women are more likely to be diagnosed with triple negative breast cancer.

**Key facts on the services to help prevent cancer and support people who have cancer**

Some cancers can be cured if detected early enough, therefore high achievement in screening programmes is vitally important to detect the early presence of cancer and treat appropriately. After the restructuring of the NHS, the breast, cervical and bowel cancer screening programmes are managed by NHS England, with public health locally having the role of assuring that the services are effective.

In Merton, the coverage of screening services for breast and cervical cancer screening are lower than national levels but higher than London and above the minimum national target of 70% coverage (see Tables 7.1 and 7.2 below). The data is still being reported for Sutton and Merton together as Sutton and Merton PCT (SMPCT). The coverage of bowel screening in Merton is very low, however, with coverage in the age group of 60-69 being 47.4% and for the extended age group of 60-74 it is 42.2% (see Table 7.3 below).

**Table 7.1: NHS Breast Screening Programme: coverage of women aged 53-64 and 53-70 by Primary Care Organisation, 2011-12 compared with 2010-11.**

<table>
<thead>
<tr>
<th>Primary Care Organisation</th>
<th>NHS Breast Screening Programme: coverage of women aged 53-64 by Primary Care Organisation</th>
<th>NHS Breast Screening Programme: coverage of women aged 53-70 by Primary Care Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011-2012 coverage (less than 3yrs since last test) %</td>
<td>2010-2011 coverage (less than 3yrs since last test) %</td>
</tr>
<tr>
<td>England</td>
<td>77.0</td>
<td>77.4</td>
</tr>
<tr>
<td>London</td>
<td>69.6</td>
<td>69.3</td>
</tr>
<tr>
<td>Croydon</td>
<td>70.8</td>
<td>71.1</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>73.8</td>
<td>72.6</td>
</tr>
<tr>
<td>Richmond &amp; Twickenham</td>
<td>71.8</td>
<td>72.5</td>
</tr>
<tr>
<td>Sutton &amp; Merton</td>
<td>73.3</td>
<td>73.2</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>65.9</td>
<td>65.6</td>
</tr>
</tbody>
</table>

Source: KC63, Health & Social Care Information Centre, 2013
Next update 2012-13 due February 2014
Lower uptake of cancer screening services in BME communities is problematic, as cancer screening services can help save lives. Late presentation and late diagnosis, leading to poorer cancer survival rates in BME communities, may be increased as a result of poor uptake.

Although variation in terms of mortality from cervical cancer for Merton is greater than regional and national averages due to small numbers, the rate of decline is now greater and is lower than regional and national trends (see Figure 7.12 below).

Table 7.2: NHS Cervical Screening Programme: coverage of women aged 25-64 by Primary Care Organisation, 2012-13 compared with 2011-12.

<table>
<thead>
<tr>
<th>Primary Care Organisation</th>
<th>NHS Cervical Screening Programme: coverage of women aged 25-64 by Primary Care Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012-2013 coverage (less than 5 yrs since last test)</td>
</tr>
<tr>
<td>England</td>
<td>78.3</td>
</tr>
<tr>
<td>London</td>
<td>74.1</td>
</tr>
<tr>
<td>Croydon</td>
<td>76.8</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>75.2</td>
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<td>Richmond &amp; Twickenham</td>
<td>77.9</td>
</tr>
<tr>
<td>Sutton &amp; Merton</td>
<td>76.8</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>75.0</td>
</tr>
</tbody>
</table>

Source: KC53 parts A2 & A3, Health & Social Care Information Centre, 2013
Next update 2013-2014 due October 2014
Table 7.3: Merton bowel screening data for Q1-Q4 2011-12 for standard age range 60-69 yrs, and extended age range 60-74 yrs.

<table>
<thead>
<tr>
<th>Standard Age Range (60-69)</th>
<th>No. of eligible people on last day of review period</th>
<th>193,867</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of people invited for screening in previous 12 months</td>
<td>95,026</td>
</tr>
<tr>
<td></td>
<td>No. of people screened within 6 months of invitation</td>
<td>43,842</td>
</tr>
<tr>
<td></td>
<td>No. of people screened in previous 30 months</td>
<td>91,982</td>
</tr>
<tr>
<td></td>
<td>Uptake %</td>
<td>46.1</td>
</tr>
<tr>
<td></td>
<td>2.5-year coverage %</td>
<td>47.4</td>
</tr>
<tr>
<td></td>
<td>No. of eligible people on last day of review period</td>
<td>261,580</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extended Age Range (60-74)</th>
<th>No. of people invited for screening in previous 12 months</th>
<th>116,486</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No. of people screened within 6 months of invitation</td>
<td>53,396</td>
</tr>
<tr>
<td></td>
<td>No. of people screened in previous 30 months</td>
<td>110,273</td>
</tr>
<tr>
<td></td>
<td>Uptake %</td>
<td>45.8</td>
</tr>
<tr>
<td></td>
<td>2.5-year coverage %</td>
<td>42.2</td>
</tr>
</tbody>
</table>

Source: Merton CCG, Merton Q1-Q4 2011-12 OPCS
Figure 7.12: Merton mortality due to cancer of the cervix (females), 1993-2010. This graph compares time trends in female mortality from cancer of the cervix for Merton with London and England, with three-year rolling averages from 1993-95 to 2008-10. Merton’s rate has been variable with an overall downward trend. There were peaks in 1996-98 and 2005-07, after which it has been coming down and in 2008-10 was well below the London and England averages.

Key factors relating to inequalities in cancer
The National Cancer Intelligence Network (NCIN) published evidence on cancer inequalities in March 2010. The report identified the following evidence-based findings on inequalities in cancer in England:

Gender
- Adjusting for women’s longer life expectancy, men are diagnosed with more cancers and have a higher mortality from cancer. As a result, there are more women than men living with or beyond a diagnosis of cancer. Men’s one-year survival is generally similar to or slightly better than women’s for individual cancer types.

Socioeconomic deprivation
- The incidence and mortality of cancer are considerably higher in deprived groups compared with more affluent groups. A large part of this is likely to be attributable to lifestyle factors, and especially the higher smoking rates in deprived groups. The excess mortality may also be linked to later presentation/diagnosis in more deprived groups.
- Awareness of the signs and symptoms of cancer is lower amongst socially deprived groups than the population as a whole and, for the cancers where there is a national screening programme, uptake of screening is also lower.

- People from more deprived social groups are less likely to die at home than those from more affluent groups.
- There is a socioeconomic gradient in survival after diagnosis of breast, lung and colorectal cancers and this has widened over recent years. This may be due to a number of factors, but in particular later diagnosis of cancer and factors unrelated to healthcare such as social support.

**Age**
- For the vast majority of cancers, incidence increases with age. Just over half of all cases of cancer diagnosed in 2003-5 in England occurred in people over 70 years and over a fifth in people over 80 years. Despite this, older people may not be aware of their increased risk and may have lower awareness of cancer symptoms than younger age groups.
- Significant reductions in cancer mortality have been achieved among the under 75s over the past decade. However, the improvement has been much less marked for the over 75s. Cancer survival decreases with age and there is evidence that older people’s cancers are investigated and treated less intensively.

**Ethnicity**
- There are variations in cancer incidence between ethnic groups, which are likely to be the result of a mixture of lifestyle and genetic factors. White men and women have a higher incidence of many cancers than those from other ethnic groups.
- Women from BME groups are more likely to present with more advanced breast cancers and have poorer survival than white women.
- Awareness of cancer is generally lower in BME groups than amongst white men and women and screening uptake is generally lower in minority ethnic groups than in the population as a whole. Although there may be some cultural factors involved in this, it is also likely to be related to deprivation.
- There is a need for access to culturally relevant information about cancer and its signs and symptoms; existing cancer information rarely reflects multi-ethnicity in terms of images and language.

**Sexuality**
- There is evidence for differences in health and other behaviours among lesbian, gay and bisexual people compared with the general population and these may lead to differences in cancer incidence.
- Perceptions of risk and healthcare-seeking behaviour may also vary. For example, there is some evidence to suggest that lesbians may delay seeking help from a healthcare professional when compared with heterosexual women.

**Disability**
- Disability encompasses a wide range of issues from mental health to learning disability and sensory impairment as well as physical disability. There is no national information on variations in cancer incidence, treatment and outcomes for people with a disability.
There is some evidence for increased incidence of cancer associated with some mental illnesses (although those with schizophrenia may have a lower incidence of respiratory cancers). This is associated with increased cancer mortality.

People with learning disabilities appear to have a similar age standardised incidence to the general population although patterns of incidence may be different.

Screening uptake for those with learning disabilities and mental health needs seems to be lower than the general population. People with physical disabilities may also experience barriers to screening.

Those with learning difficulties may struggle to express changes to their health, potentially complicating and delaying diagnosis.

Religion

There is very little information on differences in cancer incidence, treatment or outcomes by religion and none at a national level. Many issues faced by religious groups are closely linked to ethnicity and culture.

Religious practices (e.g. fasting during Ramadan) can impact upon cancer treatment.

BME patients with cancer often report a poorer experience than white British cancer patients regardless of tumour type or regional variations. There has been no improvement in that experience over the past 10 years. Therefore there is a need to develop cultural sensitivity within the health services to support both BME patients and NHS staff, particularly for personal and end of life care of BME cancer patients.

From Programme Budgeting information, charts on spending indicate that spend for cancer is generally less than other CCGs within our peer group and lower than average within the region. Outcomes are generally better, but underlying this are significant inequalities in mortality geographically and between genders for certain cancers.

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Figure 7.13: Spend for cancer – Merton CCG compared with other CCGs, 2011-12. This chart depicts the spend and outcome of different CCGs for the cancers and tumours programme budget. Merton CCG is the large greenish-blue circle and is in the ‘lower spend better outcome’ quadrant. It is lower than average in spend and higher than average for outcomes.

What works and best practice


This guidance aims to help people of South Asian origin who are living in England to stop using traditional South Asian varieties of smokeless tobacco. The phrase ‘of South Asian origin’ refers here to people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.

The term ‘smokeless tobacco’, as it is used in this guidance, refers to three broad types of product:

- Tobacco with or without flavourants e.g.: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers e.g.: khaini, naswar (niswar, nass) and gul.
Tobacco with slaked lime as an alkaline modifier and areca nut e.g.: gutkha, zarda, mawa, manipuri and betel quid (with tobacco). Products, like ‘snus’ or similar oral snuff products, are not included.

The guidance is for commissioners and providers of tobacco cessation services (including stop smoking services), health education and training services, health and wellbeing boards and health and social care practitioners.

NICE Public Health Guidance PH32: Skin cancer prevention: information, resources and environmental changes, 2011 http://www.nice.org.uk/guidance/PH32
This guidance is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, preventing skin cancer. This includes, for example, GPs, local authority planners, pharmacists, practice nurses, public health practitioners, school nurses and skin cancer specialists. It also includes those involved in, or responsible for, employee health and wellbeing. In addition, it may be of interest to those working in the wider public, private, voluntary and community sectors and to members of the public. The six recommendations aim to raise and maintain awareness – and increase knowledge – of the risks of exposure to natural and artificial ultraviolet (UV). They also aim to influence attitudes and prompt people to change their behaviour to protect themselves against skin cancer.

In 1996, the Department of Health published a document called Improving Outcomes in Breast Cancer. It recommended which healthcare professionals should be involved in the treatment, management and care of women with breast cancer. It also recommended how these services should be organised so that women with breast cancer across England and Wales would receive high-quality healthcare.

The key recommendations are:
- Women should be treated by a multidisciplinary team
- Women should be treated promptly
- Services should be more consistent
- Intensive, hospital-based follow-up is not beneficial.

This clinical guideline offers evidence-based advice on the care and treatment of people with lung cancer. Recommendations are included on communication, diagnosis and staging, selection of patients with non-small-cell lung cancer (NSCLC) for treatment with curative intent, surgery with curative intent for NSCLC, smoking cessation, combination treatment for NSCLC, treatment for small-cell lung cancer (SCLC), managing endobronchial obstruction, managing brain metastases, and follow-up and patient perspectives.
NICE Cancer Service Guidance for Colorectal Cancer (CSGCC), 2004
http://guidance.nice.org.uk/CSGCC
In 1997, the Department of Health published a document called Improving Outcomes in Colorectal Cancer. NICE has now published an updated version for the NHS in England and Wales. Some of the original recommendations have been updated, and further recommendations have been added.

The key recommendations are:
- People who may have colorectal cancer should be offered rapid referral for endoscopy
- Endoscopy should be available for diagnosis
- People should be treated by a multidisciplinary team
- Colorectal teams treating people with rectal cancer should have special training
- People who need emergency treatment should be treated by a colorectal cancer team
- Information and support should be improved.

NICE Clinical Guidance CG131: Colorectal Cancer, 2011
http://www.nice.org.uk/guidance/CG131
This clinical guideline offers evidence-based advice on the diagnosis and management of colorectal cancer. In colorectal cancer, cells in the colon or in the rectum start to grow in an uncontrolled way, forming a lump called the primary cancer or primary tumour. Like other cancers, colorectal cancer starts in a small area but can spread to other parts of the body to form metastatic tumours. The term colorectal cancer covers cancers in both the colon (colon cancer) and the rectum (rectal cancer).

NICE Breast cancer quality standard, QS12, 2011
This quality standard covers the management of early (ductal carcinoma in situ and invasive), locally advanced and advanced breast cancer in adults. This includes the management of both screen-detected and symptomatic breast cancers from the point of referral to a specialist team.

NICE quality standard for lung cancer, QS17, 2012
http://publications.nice.org.uk/quality-standard-for-lung-cancer-qs17
This quality standard covers the diagnosis and management of lung cancer in adults (18 years and over), and the supportive care provided to people with lung cancer.

NICE quality standard for colorectal cancer, QS20, 2012
This quality standard covers the diagnosis and management of adults (18 years and older) with newly diagnosed and recurring adenocarcinoma of the colon and rectum. It includes diagnosis of suspected colorectal cancer, staging of the disease, management of both local and metastatic disease, and follow-up and regular surveillance for those free from disease after treatment.

There is also a NICE quality standard for ovarian cancer, QS18, 2012
http://publications.nice.org.uk/quality-standard-for-ovarian-cancer-qs18
What are the gaps?

While Merton is overall second best in the country in terms of cancer mortality, the evidence shows that there are health inequalities across the borough with a distinct east-west divide. These inequalities express themselves in the differential mortality rates across Merton, and it is likely, based on the findings of the National Cancer Intelligence Network (NCIN), that there are inequalities in the access to services, including screening programmes and treatment. There could be a gap in terms of access to culturally relevant information about cancer and its signs and symptoms; existing cancer information rarely reflects multi-ethnicity in terms of images and language.

Key commissioning implications on services to prevent cancer

- **Primary prevention**: Primary prevention needs to focus on reducing the risk factors for cancer including smoking, drinking too much alcohol, being obese, having a poor diet, lack of physical activity and prolonged exposure to sunlight.

- **Cancer screening**: Improvement in the uptake of all screening services, particularly bowel cancer screening, is needed for early identification, to prevent cancers becoming untreatable and improve outcomes. This improvement needs to be targeted at more deprived areas in Merton and disadvantaged groups in the community where uptake of screening programmes is generally lower. This improvement needs to be targeted to more deprived areas and disadvantaged groups in the community where uptake of screening programmes is generally lower. Commissioners need to use social marketing approaches to understand why the uptake of screening services is below national rates and how future uptake could be improved, and to improve the systems to identify patients and non-attenders for screening services. Groups that need particular focus are: people with learning disabilities, ethnic minorities, younger women and socially deprived groups.

- **Value for money**: Commissioners need to consider all cancer services in terms of the costs per outcome achieved and whether existing services are targeted most appropriately to get the best outcomes for those most in need. This work needs to pay particular attention to cultural differences and the reduced access and poorer experience of health services that are experienced by vulnerable groups.

- **Vulnerable groups**: Vulnerable groups that need particular focus are people with learning disabilities, ethnic minorities, younger women and socially deprived groups. A whole system approach (patient pathway) to developing services, including primary prevention, screening (early detection) and treatment, would be of benefit.
Circulatory Diseases

Key facts on circulatory diseases

The term coronary heart disease (CHD) is generally considered to be narrower than circulatory disease as it does not include people who have had a stroke or who have peripheral vascular disease; however CHD still accounts for the majority of circulatory diseases.

While CHD is the single most common cause of premature death in the UK, it is however the second most common cause of premature death in Merton. It is the commonest cause of mortality in those aged over 65 years in Merton, and the biggest cause of emergency admissions in the over 50s. The evidence relating to good management of CHD in terms of outcomes for an individual is well established and if implemented can reduce the risk of death from this disease and improve quality of life for patients.

The main risk factors for CHD and circulatory disease are smoking and obesity, and higher levels of disease are associated with areas of deprivation. In Merton those electoral wards with CHD mortality rates higher than the England average are the most deprived. The incidence of CHD is higher amongst men, the elderly and in the more deprived geographical areas. The association with deprivation is likely to be due to the higher levels of smoking. The impact of risky drinking behaviour (alcohol) on CHD is not yet clear but evidence is beginning to suggest that it may be greater than first thought, and in particular has a significant impact on rates of hypertension. This has implications not just for CHD but also for stroke.

Based on GP registers (Quality Outcomes Framework (QOF)), prevalence of CHD (the percentage of people in Merton who have CHD) is 2.2%, i.e. about 1 in 46 people have CHD compared with 3.4% nationally, which is 1 in every 30 people. However, looking at the modelled expected prevalence against registered prevalence recorded by GPs, it is suggested that a significant proportion of the population in Merton who are likely to have CHD/circulatory disease have yet to be identified within primary care. The introduction of the NHS Health Check (a national initiative of regular vascular risk assessment) is likely to help identify more people who are at risk.

In terms of death caused by circulatory disease in Merton, although overall the trend is downwards and the comparison of causes of death suggests that there has been a significant reduction proportionally in deaths due to circulatory disease, it remains the single biggest cause of death in the older age groups. Notably, the rate of premature death (deaths under 75 years) from CHD in Merton is the highest in South West London and is also higher than England, at 71.3 per 100,000 population for Merton, compared with 65.6 per 100,000 for England. The rate of premature deaths for both men and women has increased slightly from 2006-08 (see Figure 7.19 below). This requires further investigation.
For heart disease and stroke-related premature deaths – i.e. deaths in people aged under 75 years of age – many of which are considered preventable, in the period 2009-11 Merton had 68 premature deaths per 100,000 population adjusted for various factors, including the age of the population. Out of 150 local authorities this ranked Merton at 91st (1st = best, Wokingham; worst was Manchester), putting Merton in the ‘worst outcomes’ category for heart disease and stroke.\textsuperscript{126}

\textbf{Figure 7.14: Premature mortality for cardiovascular disease in Merton compared with other London boroughs, 2011.} This graph shows the mortality rates on account of cardiovascular disease in Merton compared with neighbouring and statistically similar London boroughs. Merton is above the England average and higher than two thirds of London boroughs.

\textsuperscript{126} Public Health England, Longer Lives. \url{http://longerlives.phe.org.uk/area-details#are/E09000024/par/E92000001}
Figure 7.15: Premature mortality for cardiovascular disease in Merton CCG compared with other CCGs in South West London boroughs, 2011. This graph shows the mortality rates on account of cardiovascular disease in Merton CCG compared with neighbouring South West London CCGs. Merton is above the England average and higher than the other South West London CCGs, but the differences are not statistically significant except with Richmond CCG.

The modelled prevalence for circulatory disease by ethnic group shows that the white and Asian ethnic groups have the highest prevalence in Merton, with the combined prevalence of black, Asian, mixed and other far outnumbering the white ethnicity group. For all the ethnic groups the prevalence is less than London and much lower than England in the white and black ethnicities, while being comparable in ‘Asian’, ‘Mixed’ and ‘Other’ categories (see Figure 7.16 below).

Figure 7.16: Circulatory disease modelled prevalence, by ethnic group for Merton compared with London and England, 2011.
Figure 7.17: Ratio of recorded to modelled coronary heart disease prevalence, comparing Merton with other London boroughs and England, 2011-12. This graph suggests that fewer cases of heart disease are being diagnosed than predicted in Merton. The green line depicts the England average (0.58) and while the data suggests under-diagnosis, the ratio in Merton is higher than England and is fourth best of London boroughs.

Figure 7.18: Ratio of recorded to modelled coronary heart disease prevalence, comparing Merton with other South West London boroughs and England, 2011-12.
Inequalities in circulatory disease in Merton
While the prevalence of circulatory disease is lower than it is nationally, Merton is in the worst outcomes category for heart disease and stroke. These outcomes, as can be seen in the map in Figure 7.19 below, are not evenly spread across the borough and there is a distinct east-west Merton divide. However, comparing the 2011 QOF recorded prevalence of coronary heart disease with the estimated prevalence separately for East and West Merton (see Figure 7.20 below) suggests that, while there are a number of undiagnosed cases in both areas, there is no discernible difference between recorded and estimated prevalence in the two geographical areas of Merton.

There is also a distinct gap by gender in circulatory disease mortality, with a higher mortality in males in Merton as well as in London and England (see Figure 7.21 below). While the trend is downwards, the gap persists. The rates have decreased over time, although towards the last years (2007-10) both male and female rates have increased. The difference in the rates for males and females has also narrowed.

Figure 7.19: Figure: Merton premature mortality from circulatory disease by middle super output area (MSOA) 2006-10. This map highlights the inequalities in cardiovascular disease premature mortality in Merton – the darker the shading the higher the mortality rate. This suggests there are more people in Merton dying prematurely towards the east of the borough compared with the west.

Figure 7.20: Primary care recorded and estimated* coronary heart disease (CHD) prevalence in East and West Merton, 2011. Graphs showing number of patients on QOF register and proportion possibly being missed based on modelled estimates.

*The estimated percentage of people with coronary heart disease is derived from a model developed at the Dept of Primary Care and Social Medicine, Imperial College, London. The model was developed using data from the 2003-04 Health Surveys for England. The model takes into account age, sex, ethnicity, smoking status and deprivation score, using input data from 2009-11.

Figure 7.21: Circulatory disease mortality rates, under 75 years by gender, Merton compared with London and England; 3 year rolling averages 1993-2010. This graph shows the death rates due to circulatory disease in Merton compared with London and England separated by gender. The rates have decreased over time, although towards the last years (2007-10) both male and female rates have increased. The difference in the rates for males and females has also narrowed.
Key facts on services that support people who have a circulatory disease

The achievement of the key Quality and Outcomes Framework (QOF) clinical targets for diseases of the heart is generally in line with other practices across London and England. However, more attention could be given to encouraging people to stop smoking. The development of CCGs presents an opportunity for whole system patient pathways to be reviewed and refined to ensure that those people most at risk appropriately access services.

Figure 7.22: Merton’s achievement of CHD Quality and Outcomes Framework Targets, compared with London and England, 2011-12.

![Merton CCG comparison of CHD QOF targets 2011/12](image)

In terms of overall spend and outcomes for circulatory disease, Merton CCG compared with other CCGs has slightly higher costs and worse outcomes (see Figure 7.23 below).
Figure 7.23: Spend on problems of circulation – Merton CCG compared with other CCGs, 2011-12. This chart depicts the spend and outcome of different CCGs for the problems of circulation programme budget. Merton CCG is the large greenish-blue circle and is in the ‘higher spend worse outcome’ quadrant.

What works to prevent cardiovascular disease

NICE has produced commissioning guidance on Services for the Prevention of Cardiovascular Disease (May 2012). This states that prevention of cardiovascular disease should be a priority for local authority and clinical commissioners, and recommends that commissioners should adopt an integrated approach to commissioning. The guidance sets out the invest-to-save potential of a range of interventions to prevent modifiable risk factors, including:

- population-wide and community approaches that modify the environment to encourage physical activity, to regulate access to items that increase cardiovascular disease risk such as tobacco, and to reduce the availability of foods that are high in fat, salt and sugar
- assessing individual risk, including NHS Health Check and ‘Making Every Contact Count’
- behaviour change and lifestyle interventions using brief advice, brief interventions and motivational interviewing
- medical interventions – commissioners should satisfy themselves that primary care professionals are prescribing NICE recommended medical interventions for the management of cardiovascular disease risk factors.

http://www.nice.org.uk/usingguidance/commissioningguides/integratedcommissioningforpreventionofcvd/CardiovascularDisease.jsp
NICE Public Health Guidance 25, Prevention of Cardiovascular Disease, PH25, 2010

CVD includes coronary heart disease (CHD), stroke and peripheral arterial disease. These conditions are frequently brought about by the development of atheroma and thrombosis (blockages in the arteries). They are also linked to conditions such as heart failure, chronic kidney disease and dementia. The guidance is for government, the NHS, local authorities, industry and all those whose actions influence the population's cardiovascular health. This includes commissioners, managers and practitioners working in local authorities and the wider public, private, voluntary and community sectors. It may also be of interest to members of the public.

What are the gaps?

The evidence relating to good management of CHD in terms of outcomes for individuals is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients.

Key findings relating to inequalities in heart disease and high blood pressure are:
- There is lower achievement of cholesterol lowering in deprived geographical areas and in areas with a large minority ethnic population.
- Older people with heart disease are less likely to receive treatment with cholesterol lowering drugs.
- Women with heart disease are less likely to receive effective primary care interventions than men.
- The control of high blood pressure is poorer among older people.
- The detection or control of high blood pressure does not have a socioeconomic gradient.
- People of South Asian origin are 50% more likely to die prematurely from CHD than the general population.

Key commissioning implications for services for circulatory disease

Levels of death from heart disease: The evidence that Merton has a higher rate of premature death from heart disease than England, and that Merton CCG has higher spend and worse outcomes than other CCGs, indicates that heart disease should continue to be a priority area. Commissioners need to ensure that services to support those with established CHD are delivering improved outcomes, including cardiac rehabilitation services and the promotion of self-care.

Early risk identification and interventions: The evidence in terms of deaths due to circulatory disease and the prevalence of CHD compared with what a population the size of Merton should have suggests that more work is required to ensure that those at risk are identified early and interventions are available to support people to reduce their risk.
The introduction of NHS Health Check should support this. Public Health commissioners and Merton CCG need to work together to ensure that the NHS Health Check identifies those at risk and crucially that there are interventions available to support individuals to reduce risk factors. A coordinated programme of personalised advice and support services/interventions has been introduced to support people to make healthy lifestyle choices to achieve a healthy weight, become more physically active, and reduce risky drinking behaviour to reduce risks of future ill health. However, the success of this programme will depend on primary care taking an active role in identifying those at risk and referring them into the service. Commissioners need to monitor and evaluate the success of this programme.
Respiratory Diseases

Key facts on respiratory diseases

There are more than 40 conditions that affect the lungs and/or airways and impact on a person’s ability to breathe. They include lung cancer, tuberculosis (TB), asthma, chronic obstructive pulmonary disease (COPD, which is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease (COAD)), and cystic fibrosis. It has been estimated that 1 person in every 7 in the UK is affected by lung disease.

Respiratory disease is the most commonly reported long-term illness in children and the third most commonly reported in adults. In England, 1 in 7 boys and 1 in 8 girls aged 2 to 15 years report having long-term respiratory illness. Smoking is the key risk factor for COPD but the causes of asthma are less clear. However, for both diseases exacerbation of the condition is often caused by smoky or polluted environments.

The three biggest conditions that impact on services and mortality are COPD, asthma and pneumonia, of which COPD and pneumonia are potentially avoidable, either through reduction of known risk factors (such as smoking for COPD) or preventative treatment (such as immunisation for those at risk of pneumococcal disease). In terms of mortality, when combined, respiratory disease is the second biggest killer in the UK.

The mortality rate from respiratory disease in people under 75 years in Merton is lower than the national average. The trend in COPD shows a decline in deaths for both men and women, with rates for both now below regional and national rates. However, mortality from pneumonia and COPD combined was the fourth major cause of death in under 75 year olds. Given that the biggest risk factor for COPD is smoking and that many types of pneumonia could be prevented by vaccination, it is likely some of this mortality is avoidable.

Overall in Merton, there is a prevalence of 1.1% for COPD compared with 1.1% in London and 1.7% nationally, and 4.8% prevalence for asthma compared with 4.7% in London and 5.9% nationally.

For lung disease related premature deaths – i.e. deaths in people aged under 75 years of age – many of which are considered preventable, in the period 2009-11 Merton had 18 premature deaths per 100,000 population adjusted for various factors, including the age of the population. Out of 150 local authorities this ranked Merton at 33rd (1st = best, Bromley; worst was Blackpool), putting Merton in the ‘best outcomes’ category for lung disease.\(^{128}\)

In terms of emergency hospital admissions, respiratory-related conditions (excluding cancer) for all age groups accounted for 7% of all emergency admissions in 2011-12. The biggest impact was in the over 60 year olds. There was a wide variation in the level of hospital

\(^{128}\) Public Health England, Longer Lives. \(\text{http://longerlives.phe.org.uk/area-details#area/E09000024/par/E92000001}\)
admissions by where people live, with higher admission rates in the eastern wards of the borough. Overall Merton is generally in line with or slightly below regional and national averages in terms of mortality for COPD for women but substantially lower in recent years for men.

Figure 7.24: Premature mortality from respiratory disease, Merton compared with other London boroughs, 2011. This graph shows the premature mortality from respiratory disease for Merton compared with other London boroughs. Merton is roughly in the middle and below the England average.

Figure 7.25: Premature mortality for respiratory disease in Merton CCG compared with other CCGs in South West London boroughs, 2011. This graph shows the mortality rates on account of respiratory disease in Merton CCG compared with neighbouring South West London CCGs. Merton is below the England average and third highest in the six South West London CCGs, but the differences are not statistically significant.
Figure 7.26: Premature mortality rates by gender for COPD in Merton compared with other South West London boroughs, London and England, 2008-10. The two graphs below show the comparative mortality rates for COPD in females and males. Mortality rates in males are higher than females in all boroughs, London and England. Merton rates are lower than London and England, and second lowest for females, and third lowest for males in the South West London area.
Figure 7.27: Trends in mortality for COPD disease (all ages) by gender in Merton, compared with London and England, by three-year rolling average 1993-2010. This graph shows the mortality rates for COPD over time in Merton compared with London and England. The number of males dying from COPD markedly dropped after 2001-03 and the gap narrowed significantly between Merton male and female mortality rates. All the rates show a downward trend.

Figure 7.28: Hospital admissions for respiratory diseases in Merton by ward, London and England, 2010-11. This graph indicates that Merton overall has lower levels of hospital admissions for respiratory diseases than London and England, and that there is considerable variation across ward areas. This implies that there could be under-diagnosis of respiratory diseases in the borough.
What works and best practice

NICE Clinical Guidance CG101: *Chronic obstructive pulmonary disease* (updated), 2010
http://www.nice.org.uk/guidance/CG101
This guidance is for the care and treatment of people with chronic obstructive pulmonary disease (which is usually shortened to COPD) in the NHS in England and Wales. It explains guidance (advice) from NICE. It is written for people with COPD but it may also be useful for their families or carers or for anyone with an interest in the condition. The advice in the NICE guideline covers: the diagnosis, treatment and care of adults with COPD.

NICE quality standard QS10: *Chronic obstructive pulmonary disease (COPD)*, 2011
http://guidance.nice.org.uk/QS10
This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people with COPD in the following ways:
- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill health, or following injury.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The quality standard is also expected to contribute to the following overarching indicators from the 2011-12 Adult Social Care Framework:
- Enhancing quality of life for people with care and support needs.
- Ensuring that people have a positive experience of care and support.
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

Other NICE Guidelines

http://www.nice.org.uk/CG69
The advice in this guideline covers respiratory tract infections – antibiotic prescribing: prescribing of antibiotics for self-limiting respiratory tract infections in adults and children in primary care.

NICE Clinical Guideline CG117: *Tuberculosis: Clinical diagnosis and management of tuberculosis, and measures for its prevention and control*, 2011
http://www.nice.org.uk/guidance/CG117
The guideline offers evidence-based advice on the diagnosis and treatment of active and latent tuberculosis in adults and children, and on preventing the spread of tuberculosis, for example by offering tests to people at high risk, and by vaccination. The guideline does not explain tuberculosis or its treatments in detail.
http://guidance.nice.org.uk/PH37
This guidance aims to improve the way tuberculosis (TB) among hard-to-reach groups is identified and managed. It is for commissioners and providers of TB services and other statutory and voluntary organisations that work with hard-to-reach groups.

NICE quality standard QS25: Quality standard for asthma, 2013
http://www.nice.org.uk/guidance/QS25
The quality standard for asthma requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole asthma care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to adults, young people and children with asthma.

NICE Clinical Guidance on Pneumonia under development.

Key commissioning implications for services to support people with respiratory disease

Respiratory disease, in particular COPD and pneumonia, has a big impact in terms of costs to the NHS and in terms of disability due to the condition.

In 2012 the Department of Health issued a guideline on best practice actions and interventions for improved outcomes in respiratory conditions. These are split into five areas:

- Preventing people from dying prematurely. Actions in this area include more accurate and earlier diagnosis, appropriate smoking cessation support and promoting regular physical activity.
- Enhancing the quality of life for people with these conditions. This includes support for people to self-manage their condition, integrated community and specialist care, and appropriate rehabilitation services.
- Helping people to recover from episodes of ill health. It is important to agree a local pathway of care for acute exacerbations and to develop a hospital discharge scheme with appropriate support and follow-up.
- Ensuring that people have a positive experience of care. This includes personalised information, and ensuring psychological support and social care needs are assessed as well as consideration of palliative care needs.
- Treating and caring for people in a safe environment.

A whole systems approach (patient pathway), including primary prevention (to focus on reducing smoking and improving immunisation rates) and access to healthcare in terms of both primary and secondary care, is needed. This development needs to include a better understanding of respiratory disease, particularly with respect to the avoidable use of services.
Stroke

Key facts on stroke

Stroke is the third most common cause of death in the developed world. One quarter of stroke deaths occur in those aged under 65. There is evidence that appropriate diagnosis and management can improve outcomes. Stroke is a medical emergency and prompt treatment is vital to reduce possible damage.

In England strokes are a major health problem and, with over 111,000 people having a stroke every year, they are the third largest cause of death. Brain damage caused by stroke is the largest cause of adult disability in the UK.

Based on GP registers (QOF 2011), the prevalence of stroke in Merton is 1.1%; i.e. about 1 in 95 people have had a stroke, compared with 1.7% nationally which is 1 in 58 people.

The main risk factor for stroke is hypertension, followed by smoking, obesity, poor diet (including high salt intake), diabetes and high alcohol intake.\(^\text{129}\) There is considerable scope for preventing stroke by addressing these key risk factors. Where levels of smoking, obesity and risky drinking behaviour in the community are high, there are likely to be higher levels of illness and death due to stroke. People aged over 65 years are those most at risk, but strokes can affect people of any age, including children.\(^\text{130}\) There is also a higher risk of stroke for people in the black African and black Caribbean ethnic groups due to a genetic predisposition towards some of the key risk factors, including hypertension – they are twice as likely as white people to have stroke.\(^\text{131}\)

Better management of stroke can also help to reduce its impact. There is strong evidence that people are more likely to survive and to recover more function if admitted promptly to a specialist stroke unit. Drug treatment (and tackling lifestyle factors) can help prevent second strokes. Approximately 20,000 strokes in England alone could be avoided by preventative work on high blood pressure, irregular heartbeats, smoking cessation and wider statin use.\(^\text{132}\)

For both stroke and heart disease, action to tackle the underlying socioeconomic determinants of health could help to reduce overall death rates and disease burden and also to narrow the inequalities gap. The costs of stroke are estimated to be between £3.7 billion


and £8 billion. These estimated costs include direct healthcare costs, productivity losses due to mortality and morbidity, and informal care costs.\textsuperscript{133} 134

Figure 7.29: Prevalence of the main risk factor for stroke – hypertension – in Merton compared with other London boroughs, London and England, 2011-12. This graph shows the prevalence of high blood pressure (hypertension), the main risk factor for stroke, in Merton and other London boroughs. Merton has the 14th highest prevalence in London boroughs and is marginally higher than the London average, but lower than the national average. Merton is second highest in South West London boroughs second only to Croydon.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{hypertension-prevalence.png}
\caption{Hypertension prevalence (unadjusted) comparing Merton to London statistical and geographical neighbours (2011-12)}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{hypertension-prevalence-south-west.png}
\caption{Hypertension prevalence (unadjusted) comparing Merton to South West London Boroughs}  
\end{figure}


Stroke death rates for females aged under 75 years show an overall decline in line with London and national figures. Death rates for males under 75 years are more variable reflecting small numbers and in recent years have shown a sharper decline than both regional and national figures but it is unclear if this is clinically significant. For both genders, the rate increased in the latest time period, 2008-10.

Figure 7.30: Trends in premature mortality from stroke (under 75 yrs.) by gender in Merton, compared with London and England, by three-year rolling average 1993-2010. This graph shows the trends in premature mortality rates for stroke over time in Merton compared with London and England. The number of males dying prematurely from stroke markedly dropped after 2001-03 and dropped below the female rates from 2005 to 2009. Then the rates for both males and females have increased with both rates similar to each other.

Key facts on services available for people who have a stroke

Approximately 25% of people who recover from their first stroke will have another one within five years. The risk of having another stroke is greatest within 30 days of the first one. One third of recurrent strokes take place within two years of the first stroke. Recurrent strokes are a major contributor to stroke disability and death. The risk of severe functional restrictions or death increases with each stroke recurrence. There is a risk related to ethnicity for people of African-Caribbean origin due to a genetic predisposition for the risk factors. The prevalence of stroke among African-Caribbean and South Asian men is 40-70% higher than the general population.

Better management of stroke can help to reduce its impact. There is strong evidence that people who have a stroke are more likely to survive and to recover more function if admitted

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promptly to a specialist stroke unit. Drug treatment (and tackling lifestyle factors) can help prevent second strokes. Clinical standards in primary care for treating stroke indicated that Merton CCG is achieving about the national average for all of the key QOF indicators on stroke.

The development of CCGs presents an opportunity for whole system patient pathways to be reviewed and refined to ensure that both the people most at risk and those that have previously had a stroke appropriately access services. In 2012, the National Clinical Guideline for Stroke was updated.\textsuperscript{136} It includes the high-level recommendation that commissioning organisations should ensure that their commissioning portfolio encompasses the whole stroke pathway from prevention through acute care, early rehabilitation and initiation of secondary prevention, on to palliation, later rehabilitation in the community and long-term support.

Figure 7.31: Merton’s achievement of stroke-related Quality and Outcomes Framework targets, compared with London and England, 2011-12.

For both stroke and heart disease, action to tackle the underlying socioeconomic determinants of health could help both to reduce overall death rates and disease burden and to narrow the inequalities gap.

What works and best practice

NICE Clinical Guideline CG68: Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA), 2008
http://publications.nice.org.uk/stroke-cg68
This guideline covers interventions in the acute stage of a stroke ('acute stroke') or transient ischaemic attack (TIA). Most of the evidence considered relates to interventions in the first 48 hours after onset of symptoms, although some interventions up to two weeks are covered.

The Intercollegiate Stroke Working Party (ICSWP) National Clinical Guideline for Stroke (published July 2008), includes all of the recommendations from this NICE guideline (see below).

This guideline offers evidence-based advice on the care of adults and young people aged 16 years and older who have had a stroke with continuing impairment, activity limitation or participation restriction.

NICE quality standard QS2: Stroke, 2010
http://guidance.nice.org.uk/QS2
This quality standard covers care provided to adult stroke patients by healthcare staff during diagnosis and initial management, acute-phase care, rehabilitation and long-term management.

NICE quality standard QS28: Hypertension, 2013
http://guidance.nice.org.uk/QS28
This quality standard covers the management of primary hypertension in adults, including diagnosis and investigations, treatment to reduce risk of cardiovascular disease, monitoring of treatment efficacy, and specialist referral. For more information, see the scope for this quality standard.

The stroke guideline provides a comprehensive coverage of stroke care, encompassing the stroke pathway from acute care through to longer-term rehabilitation, including secondary prevention. It informs healthcare professionals about what should be delivered to stroke patients and how this should be organised, with the aim of improving the quality of care for everyone who has a stroke, regardless of age, gender, type of stroke, or location. It also has a detailed section on commissioning of stroke care, which will be useful for fledgling clinical commission groups in the changing healthcare landscape.
The guidance includes the following recommendations to commissioners:

- Commissioning organisations should ensure that their commissioning portfolio encompasses the whole stroke pathway from prevention through acute care, early rehabilitation and initiation of secondary prevention on to palliation, later rehabilitation in the community and long-term support.

- Ambulance services, including call handlers, should be commissioned to respond to every patient presenting with a possible acute stroke as a medical emergency.

- Acute services should be commissioned to provide:
  - imaging of all patients in the next slot or within one hour if required to plan urgent treatment (e.g. thrombolysis), and always within 12 hours
  - thrombolysis in accordance with recommendations in this guideline
  - active management of physiological status and homeostasis
  - completion of all investigations and treatments to reduce risk of stroke for transient ischaemic attacks and minor strokes within one week or within 24 hours for high-risk cases
  - an acute vascular surgical service to investigate and manage people with neurovascular episodes in ways and in timescales recommended in this guideline
  - a neuroscience service to admit, investigate and manage all patients referred with potential subarachnoid haemorrhage, both surgically and with interventional radiology
  - a neuroscience service delivering neurosurgical interventions as recommended for major intracerebral haemorrhage, malignant cerebral oedema, and hydrocephalus.

- Commissioners should ensure that every provider specifically enacts all the secondary prevention measures recommended, and this should be the subject of regular audit or monitoring by commissioners.

- Commissioning organisations should commission:
  - an inpatient stroke unit capable of delivering stroke rehabilitation as recommended in this guideline for all people with stroke admitted to hospital
  - early supported discharge to deliver specialist rehabilitation at home or in a care home
  - rehabilitation services capable of meeting the specific health, social and vocational needs of people of all ages
  - services capable of delivering specialist rehabilitation in outpatient and community settings in liaison with inpatient services, as recommended in this guideline.


This DH document describes among other things a 10-point plan for action (see Table 7.4 below).
Table 7.4: Department of Health (2007) National stroke strategy, 10-point plan of action.

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Improve public and professional awareness of stroke symptoms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing stroke</td>
<td>Support healthier lifestyles and take action to tackle vascular risk, for example hypertension, atrial fibrillation and high cholesterol.</td>
</tr>
<tr>
<td>Involvement</td>
<td>Involve people with stroke in their care planning. Involve those who have had a stroke in planning and evaluating local services.</td>
</tr>
<tr>
<td>Acting on the warnings</td>
<td>TIAs are a clear warning sign that a further stroke may occur and the time window for action is very short – in about half of cases, a matter of days. Put in place a system that responds quickly (within 24 hours) to people who have had a TIA.</td>
</tr>
<tr>
<td>Stroke as a medical emergency</td>
<td>Get people quickly to the right hospital where there are specialists who can deliver acute treatments including thrombolysis. Ensure that everyone who could benefit from urgent care is transferred to an acute stroke centre that provides 24-hour access to scans and specialist stroke care.</td>
</tr>
<tr>
<td>Stroke unit quality</td>
<td>Stroke unit care is the single biggest factor that can improve a person’s outcomes following a stroke. Successful stroke units are built around a stroke skilled multidisciplinary team that is able to meet the needs of the individuals.</td>
</tr>
<tr>
<td>Rehabilitation and community support</td>
<td>Intensive rehabilitation immediately after stroke, operating across the seven-day week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or a care home, ensuring that health, social care and voluntary services together provide the long-term support people need as well as access to advocacy, care navigation, and practical and peer support.</td>
</tr>
<tr>
<td>Participation</td>
<td>Assistance to overcome physical, communication and psychological barriers to engage and participate in community activities helps people to lead more autonomous lives and move on after stroke. This will be across the range of community services – housing, education, leisure, transport, employment – that can help people to participate in community life again.</td>
</tr>
<tr>
<td>Workforce</td>
<td>People with stroke need to be treated by a skilled and competent workforce. Resources to assist services in planning their workforce requirements are signposted in this strategy.</td>
</tr>
<tr>
<td>Service improvement</td>
<td>Services working together in networks, looking across all aspects of the care pathway. Regular local and national audit and increased participation in clinical trials will also drive improvements in stroke care.</td>
</tr>
</tbody>
</table>

Key commissioning implications for services for stroke survivors

In light of clear inequalities in stroke mortality rates across the borough and high levels of the most significant risk factors, stroke remains a high priority to tackle in Merton.

A whole systems approach is required to reduce overall prevalence and disability caused by stroke focusing on: primary prevention; improving access to healthcare and the quality of services for those at risk and those who have had a stroke; and support for rehabilitation with social services working in a more integrated way with health services.

The National Clinical Guideline for Stroke: Fourth edition. London: Royal College of Physicians includes the following recommendations to commissioners:

- Commissioning organisations should ensure that their commissioning portfolio encompasses the whole stroke pathway from prevention through acute care, early rehabilitation and initiation of secondary prevention on to palliation, later rehabilitation in the community and long-term support.
- Ambulance services, including call handlers, should be commissioned to respond to every patient presenting with a possible acute stroke as a medical emergency.
• Acute services should be commissioned to provide:
  o imaging of all patients in the next slot or within one hour if required to plan urgent treatment (e.g. thrombolysis), and always within 12 hours
  o thrombolysis in accordance with recommendations in this guideline
  o active management of physiological status and homeostasis
  o completion of all investigations and treatments to reduce risk of stroke for transient ischaemic attacks and minor strokes within one week or within 24 hours for high-risk cases
  o an acute vascular surgical service to investigate and manage people with neurovascular episodes in ways and in timescales recommended in this guideline
  o a neuroscience service to admit, investigate and manage all patients referred with potential subarachnoid haemorrhage, both surgically and with interventional radiology
  o a neuroscience service delivering neurosurgical interventions as recommended for major intracerebral haemorrhage, malignant cerebral oedema, and hydrocephalus.

• Commissioners should ensure that every provider specifically enacts all the secondary prevention measures recommended, and this should be the subject of regular audit or monitoring by commissioners.

• Commissioning organisations should commission:
  o an inpatient stroke unit capable of delivering stroke rehabilitation as recommended in this guideline for all people with stroke admitted to hospital
  o early supported discharge to deliver specialist rehabilitation at home or in a care home
  o rehabilitation services capable of meeting the specific health, social and vocational needs of people of all ages
  o services capable of delivering specialist rehabilitation in outpatient and community settings in liaison with inpatient services, as recommended in the guideline.
Diabetes

Key facts on diabetes

There are two types of diabetes. Type 2 diabetes is increasingly the more common form. Type 1 diabetes occurs when the body produces no insulin and usually develops before the age of 40 and more commonly in the early teenage years. It is the least common of the two main types and accounts for around 10% of all people with diabetes. Type 2 diabetes occurs when there is too little insulin produced or when the cells in the body do not react properly to insulin (insulin resistance). In the majority of cases, Type 2 diabetes is associated with obesity and usually develops after the age of 40, though it can develop much younger. Type 2 diabetes is avoidable in many cases and is the more common of the two main types and accounts for around 90% of people with diabetes.

Type 2 diabetes symptoms may be controlled simply by following a healthy diet and monitoring blood glucose levels. However, the disease is progressive if uncontrolled and complications are the same as with Type 1. Type 2 diabetes reduces life expectancy by up to 10 years. It increases the risk of death from heart disease five-fold, and of death from stroke three-fold. It magnifies the effect of other heart disease risk factors, such as high cholesterol levels and blood pressure, smoking and obesity. Diabetes is associated with other significant health problems. It is a leading cause of renal failure, limb amputations and blindness, and can lead to serious complications in pregnancy.

Most health experts agree that the UK is facing a huge increase in the number of people with diabetes. Since 1996 the number of people diagnosed with diabetes has increased from 1.4 million to 2.9 million. By 2025 it is estimated that five million people will have diabetes. Most of these cases will be Type 2 diabetes, because of our ageing population and rapidly rising numbers of overweight and obese people. Around 4.45% of the UK adult population are known to have diabetes.

In Merton, based on GP registers (QOF, 2011-12) prevalence of diabetes (both types but only adults) is 5.3%; that is about 1 in 19 adults have diabetes compared with 5.8% in England, which is 1 in 17 adults. However, the level of recorded diabetes in GP practices across Merton ranges from under 2% to nearly 10%. There are clear inequalities in mortality within Merton. Although relatively speaking, mortality due to diabetes is low compared with other areas in London, the difference is significant. Further investigation suggests mortality may be more prominent in the ethnic population who may have higher risk factors and who may be less able to access appropriate services. Comparing modelled expected prevalence against registered prevalence it is suggested that a proportion of the Merton population is likely to have diabetes but remain undiagnosed, but this is less than the regional and national averages.

Figure 7.32: Ratio of recorded to modelled diabetes prevalence, comparing Merton with other London boroughs, 2011-12. This graph suggests that less cases of diabetes are being diagnosed than predicted in Merton.

Figure 7.33: Ratio of recorded to modelled diabetes prevalence, comparing Merton with other South West London boroughs, 2011-12. This graph suggests under-diagnosis across all of SW London, with Merton having the least proportion of under-diagnosis when compared with the rest of South West London and England.
Risk factors

Obesity is the key risk factor for diabetes (caused by poor diet and physical inactivity). However, diabetes is also more common in certain ethnic and social groups who are more likely to be overweight or have a genetic predisposition for the condition.

Once a person has diabetes, if the condition isn’t well controlled (i.e. if their blood sugar is not maintained at normal levels), they are more likely to develop heart attack, stroke, and other vascular problems involving small (microvascular) blood vessels which can lead to eye and kidney problems.

The aim of treatment is to control diabetic symptoms and to reduce the chances of developing blood-vessel-related complications. The evidence for this comes from the UK Prospective Diabetes Study (UKPDS), one of the world’s largest studies of the health of people with diabetes.¹³⁹

Inequalities

In terms of inequalities:

- The most deprived people in the UK are 2.5 times more likely to have diabetes.
- 80% of people with type 2 diabetes are overweight or obese at diagnosis.
- 1.3 million people with diabetes are aged over 65.
- People from BAME groups are up to six times more likely to develop diabetes.
- One in five people with a severe mental illness has diabetes.
- The prevalence of diabetes in nursing homes can be as high as 25%, compared with 3% in the general population.

• Complications of diabetes such as heart disease, stroke and kidney damage are 3.5 times higher in lower socioeconomic groups.

• People from deprived or ethnic communities are less likely to have their body mass index or smoking status recorded. They are also less likely to have records for blood sugar levels, retinal screening, blood pressure, and neuropathy or flu vaccination.

• Those who are least well educated are more likely to have retinopathy, heart disease and poor diabetes control.

**Key facts on services to support people with diabetes**

Diabetes is associated with other significant health problems: it is a leading cause of renal failure, limb amputations and blindness, and can lead to serious complications in pregnancy. While mortality due to diabetes is reported nationally it is likely to be underestimated since cause of death is more usually reported as a complication of diabetes such as CHD.

Key findings relating to inequalities in diabetes relate to the management of the condition, which includes:

• Patients in areas of high deprivation and with larger minority ethnic populations receive poorer diabetic care in terms of the control of their blood sugar or blood pressure and the identification of complications such as eye disease.

• Women with diabetes tend to receive poorer care than men (although this may reflect more the pattern of women not attending services for their own needs rather than specific targeting).

Comparing registered against modelled expected prevalence, it is suggested that a proportion of the Merton population are likely to have diabetes but remain undiagnosed. Compared with South West London CCGs the clinical standards in primary care for diabetes indicated that measurement of blood pressure and cholesterol is in line with that of the region, but blood glucose levels of people with diabetes could be improved, which would have a significant impact on outcomes, including hospital admissions. While there has been improvement over the past year these indicators are still below national average for HbA1c.
The introduction of NHS Health Check is likely to help identify more people at risk, not just of heart disease but also of diabetes. The development of CCGs presents an opportunity for whole system patient pathways to be reviewed and refined to ensure that services are appropriately accessed by those most at risk.

Figure 7.36: Quality and Outcomes achievement for diabetes, QOF 2011-12.
From programme budgeting information, the chart on spend (see Figure 7.37 below) indicates that spend for endocrine, nutrition and metabolic disease (which diabetes would be part of) is generally average for Merton CCG relative to other CCGs within its peer group and that it is in the better outcomes quadrant. Underlying this are inequalities in mortality and morbidity in diabetes within the borough and between genders that need to be reviewed.

Figure 7.37: Spend on diabetes – Merton CCG compared with other CCGs, 2011-12. This chart depicts the spend and outcome of different CCGs for the endocrine, nutrition and metabolic diseases programme budget (of which diabetes is a part). Merton CCG is the large greenish-blue circle and is in the ‘average spend better outcome’ quadrant. It is average in spend and higher than average for outcomes.

What works to prevent type 2 diabetes and identify people at high risk

NICE recommends community-level interventions in preventing type 2 diabetes
- Integrating national strategies on non-communicable diseases.
- National action to promote a healthy diet and physical activity.
- Locally developing an integrated approach to the prevention of long-term conditions, including diabetes, in those at high risk.
- Interventions for communities at high risk of type 2 diabetes.
- Delivery of consistent messages to the local population.
- Promotion of healthy lifestyles.
- Training of those involved to spread awareness and promote healthy lifestyles.

NICE also recommended action identifying people at high risk of type 2 diabetes (2012):

- Risk assessment and risk-reassessment by GPs and other health professionals and community health practitioners.
- Encouraging people to have a risk assessment.
- Risk identification using a validated computer-based risk assessment tool in all primary health care settings and venous blood tests.
- Matching interventions to risk.
- Commissioning risk identification and intensive lifestyle-change programmes.
- Quality assuring intensive lifestyle-change programmes.
- Training and development for professionals involved.


**NICE quality standard QS6: Diabetes in adults, 2011**

This quality standard covers clinical management of diabetes in adults excluding children, young people and pregnant women.

**Key Commissioning implications for services to support people with diabetes**

There are clear inequalities in mortality rates in diabetes across Merton. There are high and increasing levels of the most significant risk factor (obesity) and potential issues in terms of at-risk populations, such as specific ethnic groups accessing appropriate services.

More needs to be done locally on:

- helping people and families to achieve and maintain a healthy weight,
- early identification of those at risk and having disease
- ensuring access to appropriate services to support people with diabetes to control their blood sugar levels and reduce potential complications.

There are significant costs associated with repeated hospital admissions for complications. Improving control and access to services could make a significant impact on the costs of diabetes to individuals, the NHS and to social care. A whole systems approach (patient pathway), including primary prevention, and access to healthcare in terms of both primary and secondary care is needed.

A focus on ensuring continuing implementation of NHS Health Checks would support early identification of those at risk, but it is crucial that health improvement interventions are available to support individuals to reduce risk factors including obesity, such as through LiveWell.
Mental Health

Key facts on mental health and wellbeing

Mental illness is generally applied to conditions on a spectrum ranging from those almost entirely managed in primary care to conditions that are almost exclusively managed by specialists. The link between mental health problems and social exclusion is intricate and well documented. Mental ill health can be both the cause and the consequence of social exclusion leading to a vicious cycle of homelessness, unemployment, and worsening physical and mental health.

In the UK, 1 in 4 people will experience a mental health problem in the course of a year. The cost of mental health problems to the economy in England has recently been estimated at £105 billion each year and treatment costs are expected to double in the next 20 years (NEPHO). In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (including self-inflicted injury), compared with 16.2% for cardiovascular disease and 15.9% for cancer, as measured by DALYs. Depression alone accounts for 7% of the disease burden, more than any other health condition. It is predicted that by 2030, neuropsychiatric conditions will account for the greatest overall increase in DALYs.

In 2011, the Department of Health launched its strategy ‘No Health Without Mental Health’ (DH 2011), which takes a cross-government approach, including promoting mental wellbeing, reducing stigma and focusing on improving outcomes for people with mental illness.

The key inequalities experienced by people with mental health problems are:

- Low levels of employment: less than 25% of people with mental ill health work although many would like to do so. Of those with severe and enduring mental illness, 58% are capable of employment. During long-term unemployment, mental health can deteriorate thus further reducing the chance of gaining work.
- Social exclusion: this might arise through stigma, discrimination and difficulties in maintaining social and family networks.
- Barriers to accessing health services: the Social Exclusion Report (2004) indicated that 44% of people with mental ill health were dissatisfied with their GP because their physical health problems/symptoms were dismissed as a mental health issue.
- Poorer physical health and increased mortality from some diseases. This may result from misdiagnosis of physical ailments; reluctance or inability to access health services; and unhealthier lifestyles e.g. poor diet, less exercise and higher levels of smoking.

Key inequalities in physical health for people with serious mental health problems are:

- A person with schizophrenia is at risk of dying on average 20 years prematurely.\(^{142,143}\)
- Around 50% of people with mental ill health smoke (this varies with the type of mental illness and gender), compared with around 27% of the general population.
- Approximately 30% of people misusing drugs have mental health problems. In one study, half of alcohol-dependent adults said they had a mental health problem.
- People with serious mental illnesses have twice the risk of developing diabetes compared with the general population,\(^{144}\) 2-3 times the risk of hypertension and 3 times the risk of dying from coronary heart disease.\(^{145}\)

The inequalities described above are present and often more severe amongst people in BAME groups with mental health problems. Additional inequalities include:

- increased risk of hospital admission and coercive care under the provisions of the Mental Health Act 1983
- greater difficulty accessing mental health assessment and treatment
- higher levels of dissatisfaction with mental health services
- greater likelihood of considering their diagnosis inappropriate
- greater likelihood of having medical problems misattributed to mental health.

A recent report by Rethink, ‘Lethal Discrimination’, published in September 2013,\(^{146}\) found that:

- more than 40% of all tobacco is smoked by people with mental illness, but they are less likely to be given support to quit
- fewer than 30% of people with schizophrenia are being given a basic annual physical health check
- people gain an average of 13lbs in the first two months of taking antipsychotic medication and this continues over the first year. Despite this, in some areas 70% of people in this group are not having their weight monitored
- many health professionals are failing to take people with mental illness seriously when they raise concerns about their physical health.

Locally there is limited definitive data on prevalence and incidence of mental health conditions. The local Mental Health Strategy included a basic review of expected mental health needs in Merton, based on national evidence. This estimated that overall 15,800 adults have depression and/or anxiety, 2,600 adults have bipolar disorder and 900 adults have schizophrenia (2010).

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However currently a detailed review of adult mental health services is under way in Merton, which includes a mental health needs assessment. The review will result in the development of an adult mental health strategy for Merton and will be used to update the mental health section of the JSNA.

Table 7.5: Expected prevalence of mental health conditions in working age adults (18-64) in Merton, London and England in 2012 and 2018. The table shows the modelled prevalence for mental health conditions in Merton, London and England for two periods – 2012 and 2018. The figures show that the prevalence increases in time at all administrative levels and for all conditions.

<table>
<thead>
<tr>
<th>Working age adults (18-64)</th>
<th>2012</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Merton</td>
<td>London</td>
</tr>
<tr>
<td>Common mental disorder</td>
<td>22,182</td>
<td>894,822</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>620</td>
<td>25,019</td>
</tr>
<tr>
<td>Anti-social personality disorder</td>
<td>480</td>
<td>19,400</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>551</td>
<td>22,233</td>
</tr>
<tr>
<td>Two or more psychiatric disorders</td>
<td>9,910</td>
<td>399,958</td>
</tr>
</tbody>
</table>


Table 7.6: Expected prevalence of depression and severe depression in older people (65+) in Merton, London and England in 2012 and 2018. The table shows the modelled prevalence in Merton, London and England for two periods – 2012 and 2018. The figures show that the prevalence increases in time at all administrative levels and for all conditions.

<table>
<thead>
<tr>
<th>Older People (65+)</th>
<th>2012</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Merton</td>
<td>London</td>
</tr>
<tr>
<td>Depression</td>
<td>2,085</td>
<td>80,909</td>
</tr>
<tr>
<td>Severe Depression</td>
<td>656</td>
<td>25,679</td>
</tr>
</tbody>
</table>

Source: Projecting Older People Information System (POPPI) web site 08.10.2013

Table 7.7: Estimated prevalence of depression in men and women (65+) in England.

Rates for men and women diagnosed with depression:

<table>
<thead>
<tr>
<th>Age range</th>
<th>% Males</th>
<th>% Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>5.8</td>
<td>10.9</td>
</tr>
<tr>
<td>70-74</td>
<td>6.9</td>
<td>9.5</td>
</tr>
<tr>
<td>75-79</td>
<td>5.9</td>
<td>10.7</td>
</tr>
<tr>
<td>80-84</td>
<td>9.7</td>
<td>9.2</td>
</tr>
<tr>
<td>85+</td>
<td>5.1</td>
<td>11.1</td>
</tr>
</tbody>
</table>


Prevalence rates have been applied to ONS population projections of 65+ populations to give estimated numbers predicted to have depression.
Figure 7.38: Estimated prevalence of mental health conditions in Merton compared with other London boroughs, NEPHO 2006.

**Mental illness prevalence: All Phobias**
Rates per 1,000 population 16-74 comparing Merton with London Boroughs
Source: NEPHO 2006

**Mental illness prevalence: Mixed Anxiety/Depression**
Rates per 1,000 population 16-74 comparing Merton with London Boroughs
Source: NEPHO 2006

**Mental illness prevalence: Any Neurotic Disorder**
Rates per 1,000 population 16-74 comparing Merton with London Boroughs
Source: NEPHO 2006
Figure 39: Estimated numbers of people in Merton predicted* to have a common mental disorder or two or more psychiatric disorders projected from 2012 to 2020.

<table>
<thead>
<tr>
<th></th>
<th>% males</th>
<th>% females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common mental disorder</td>
<td>12.5</td>
<td>19.7</td>
</tr>
<tr>
<td>Two or more psychiatric disorders</td>
<td>6.9</td>
<td>7.5</td>
</tr>
</tbody>
</table>

*The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2020.

Common mental disorders (CMDs) cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They include depression, anxiety, and obsessive compulsive disorder. The report found that 19.7% of women and 12.5% of men surveyed met the diagnostic criteria for at least one CMD.

Psychiatric comorbidity – or meeting the diagnostic criteria for two or more psychiatric disorders – is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. Disorders include the most common mental disorders (namely anxiety and depressive disorders) as well as: psychotic disorder; anti-social and borderline personality disorders; eating disorder; post-traumatic stress disorder (PTSD); attention deficit hyperactivity disorder (ADHD); alcohol and drug dependency; and problem behaviours such as problem gambling and suicide attempts. Just under a quarter of adults (23.0%) met the criteria or screened positive for at least one of the psychiatric conditions under study. Of those with at least one condition: 68.7% met the criteria for only one condition, 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions. Numbers of identified conditions were not significantly different for men and women.
Figure 7.40: Estimated numbers of working age people in Merton predicted* to have a personality or psychotic disorder projected from 2012 to 2020.

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>% males</th>
<th>% females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline personality disorder</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Anti-social personality disorder</td>
<td>0.6</td>
<td>0.1</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>0.3</td>
<td>0.5</td>
</tr>
</tbody>
</table>

*The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2020.

**Personality disorders** are long-standing, ingrained distortions of personality interfering with the ability to make and sustain relationships. Anti-social personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.

ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed. ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women).

BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour are common. The overall prevalence of BPD was similar to that of ASPD, at 0.4% of adults aged 16 or over (0.3% of men, 0.6% of women).
**Psychoses** are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bipolar disorder. The overall prevalence of psychotic disorder was found to be 0.4% [of adults aged 18 or over] (0.3% of men, 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively). The age standardised prevalence of psychotic disorder was significantly higher among black men (3.1%) than men from other ethnic groups (0.2% of white men, no cases observed among men in the South Asian or ‘other’ ethnic group). There was no significant variation by ethnicity among women.

**Mental wellbeing**  
Having good mental health and wellbeing is of vital importance for long-term physical health. The Foresight Report published in 2008 highlights the link between long-term stress and poorer physical health. Until recent years there has been much less focus on mental wellbeing compared with mental health but the evidence emerging from the Foresight Report and the WHO has put an emphasis on both local authority and Health Services working together to tackle wellbeing, not only for the population they cover but also for the workforce.

The five factors identified as key in achieving mental wellbeing are:
- Connecting – creating strong social networks
- Physical activity
- Taking notice – noticing not only what is happening around you but also noticing your own feelings
- Lifelong learning
- Giving – supporting family and friends and volunteering in the community.

The Office for National Statistics (ONS) is leading a programme of work to develop new measures of national wellbeing. Based on estimates of subjective wellbeing (2012) in Merton:
- 27% of adults reported low satisfaction with their lives, higher than for England (24%).
- 22% of adults reported a low score for feeling the things they do in life are worthwhile, similar to England (20%).
- 30% of adults reported low levels of happiness, similar to England (29%)
- 43% of adults reported a high anxiety score, higher than England (40%).

**Mental ill health and physical ill health**  
There is a significant link between mental ill health and physical ill health, not only from the perspective that poor mental health and wellbeing can lead to poor physical health but also that people who have poor mental health can have physical health problems that often go undetected.

A briefing document by South-West London and St. George’s NHS Mental Health Trust summarised recent evidence to highlight these issues. It found people with mental health and physical health needs often find it difficult to access services for their physical health concerns for a variety of reasons. These include:
- few mental health inpatient units have GPs attached to them
• for many people with mental health needs, especially secondary care mental health needs, GP practices often seem unwelcoming or unsupportive environments
• when such a person approaches physical health services the clinician may well perceive their physical health needs as being a construction of their patient’s mental health – “diagnostic overshadowing.”

This situation can have a very severe impact on the health and wellbeing of those people as it decreases the opportunities for prevention and early intervention. As a consequence, those individuals may only access physical health services through A&E or when their physical health needs have reached a very developed state.

A range of research indicates that the reasons for health inequalities among people with severe mental illness are complex and likely to include poverty, lifestyle, access to health assessments and treatments, and the side effects of antipsychotic and mood stabiliser medication. These inequalities cannot be explained by the mental health problem alone.

The GP consultation rate for people who use mental health services is much higher than average: 13-14 times per year compared with 3-4 times for the general population.

The landmark 1980 study by Richard Hall et al found that 46% of the psychiatric patients thoroughly examined had physical ailments causing or exacerbating their mental symptoms.

A significant proportion of people with a range of physical health needs also have co-existing mental health needs or their mental state is made worse by their physical condition. Examples of this are:

• A serious physical illness can affect every area of life, such as relationships, work, spiritual beliefs and how people socialise. This can result in increased levels of anxiety and depression.
• Some drug treatments, such as steroids, affect the way the brain works and so cause anxiety and depression directly.
• Some physical illnesses, such as an underactive thyroid, affect the way the brain works. They cause anxiety and depression directly.
• Recent research has shown that a history of celiac disease makes the risk of developing schizophrenia 3.2 times higher.
• Cancer – 33% of patients suffer depression and these patients remain in hospital 40% longer, resulting in 35% more costs. Meta-analysis of PCTs revealed sustained beneficial gain from short-focused cognitive behavioural therapy (CBT) in terms of mental health, functional adjustment (return to work), and physical symptoms. There is also evidence of increased survival rates and increased coping and quality of life-years.

147 Rethink Briefing: Physical health and mental health accessed on 07/06/2011.
150 Royal College of Psychiatrists Physical Illness and Mental Health.
Many long-term conditions (LTCs) are associated with elevated rates of mental ill health e.g. anxiety and depression are 2-3 times more common in people with diabetes compared with general population, at 4 times the health cost of diabetes without an LTC.

**NEPHO profile of Mental Health in Merton**
Community Mental Health Profiles (NEPHO, January 2013) provide an overview of mental health risks, prevalence and services, and provide useful comparative information to supplement local data. However, it is important to note that they only provide a borough-wide overview and do not reflect geographical, gender or ethnic variations across Merton.

The Mental Health Profiles indicate that overall in Merton mental health risks, prevalence and access to services are generally either similar to or better than England. However, there are a number of indicators where Merton is significantly worse than England.

**Wider determinants of mental health**
Social and environmental conditions influence the mental and physical health of individuals and communities, such as deprivation, employment, crime, alcohol and drug misuse. In Merton, indicators are generally significantly better than England, however the rate of unemployment has been identified as a factor that is worse than England, but better than London.

**Mental health risk factors**
Individual factors that increase the likelihood of developing mental health problems include homelessness, long-term illness, youth crime and low levels of physical activity. In Merton, first-time entry into the youth justice system has been identified as a risk factor where rates are significantly worse than England and slightly worst than London. Levels of physical activity are also lower than England and London.

**Levels of mental health and illness**
Nationally at any one time about 1 in 6 people will be experiencing a mental health problem, and it is important to monitor levels of mental health. In Merton, the proportion of adults with dementia and depression is significantly lower than in England, but higher than in London.

**Mental health treatment services**
Treatment and early intervention can help to minimise the impact of mental illness. A high number of people in contact with mental health services may indicate high prevalence, but may also reflect good recognition and diagnosis of mental health conditions and availability of services.

The NEPHO profile for Merton states that overall the rate of total contacts with mental health services was significantly lower than England and London. However, for hospital admissions for mental health the rate was significantly higher than England, but lower than London, as was the rate of admissions for schizophrenia, schizotypal and delusional disorders. The rate of people on a ‘Care Programme Approach’ and rate of contact with Community Psychiatric Nursing were significantly lower than England and London. Average spend for mental health per health of population each year was similar to both England and London. This finding
suggests that patients are not being identified and treated early and requires a more detailed review to support service redesign if necessary.

*Mental health outcomes*

The overall aim of mental health services is to improve patient outcomes. Little data is available at a national level about patients following their use of mental health services. Proxy indicators include people with mental illness in settled accommodation, emergency hospital admissions for self-harm, and hospital admissions caused by unintentional and deliberate injuries. For these indicators Merton was significantly better than England and better than London. However, recovery rates following the use of Improving Access to Psychological Therapies (IAPT) were significantly lower than in both England and London, supporting a need to review accessibility of early intervention and prevention services for mental health.

Overall in Merton mental health risks, prevalence and access to services are generally either similar to or better than England. However there are a number of areas where Merton is significantly worse than England. In terms of risk factors, there should be continued focus on reducing unemployment, particularly in the east of the borough, and a focus on reducing youth crime and entry into the criminal justice system. Increasing levels of physical activity would have an impact on improving both mental and physical health.

In terms of treatment services, commissioners should focus on developing a whole system approach to mental health with more joined-up services to improve experience and outcomes. They should also focus on developing better data and local information on outcomes, and on addressing health inequalities in relation to mental health. There should be further investigation into why Merton has higher rates of depression than London, in light of its wider good health, and a focus on improving recovery rates following psychological therapies. For further details see: www.nepho.org.uk/cmhp/.

**Key facts on suicide**

Mental illness increases the likelihood of suicide. For example, suicide rates are nine times higher amongst those with schizophrenia than in the general population. About one quarter of people committing suicide have had contact with mental health services in the year before death. Suicide is a leading cause of premature death and has important social inequalities:

- Suicide is five times more common in men (aged 20-64) in social class V than social class I.
- Those at risk are often socially excluded and vulnerable to other health inequalities. Key associated factors are: unemployment, confinement in prison, living alone, and alcohol and drug misuse.
- Men are more likely than women to commit suicide at any age.

Between 1993 and 2010, on average 14 local residents died of suicide and injury undetermined each year and there was an overall reduction in the standardised rate over time. Generally over this time mortality rates for Merton were below those for London and England (based on a three-year rolling average of directly standardised rates).
Figure 7.41: Merton mortality due to suicide by gender compared with London and England, three-year rolling averages from 1993-2010. The graphs show that mortality from suicide or injury of undetermined intent in males and females is lower in Merton than in London or England. However the trend has been variable in time and it shows a current downward trend in females but in contrast an upward trend in males. Whether this trend continues from 2010 to 2013 needs to be studied.

Key facts on local Mental Health Services

How services are structured in Merton

*South West London and St George’s Mental Health NHS Trust*

The local mental health trust for Merton is the South West London and St George’s Mental Health NHS Trust. The Trust has its base at Springfield Psychiatric Hospital in Tooting, which houses inpatient wards. The community mental health services (run on a hub and spoke model) are based at the Wilson Hospital, with a community spoke provided in the west of the
borough. The Wilson Hospital site is temporary and due for redevelopment under the Better Healthcare Closer to Home project. It has various other services but these do not include a GP practice. The structures for Merton includes an assessment service for all new referrals, three locality-based Recovery and Support Teams, an Early Intervention Service, a Personality Disorder Service and a Crisis Resolution/Home Treatment Team. About 2,500 Merton residents will be treated in secondary care, and 3,000 in IAPT’s over any year.

When someone is referred to the Trust their first contact is with the Assessment Team, who assesses their needs and will either advise the GP about their treatment within physical care, or signpost them to the appropriate secondary care service. Referrals to the Mental Health Trust could come through GPs, the inpatient wards or other health services such as A&E.

Figure 7.42: Journey of a service user from referral to the Mental Health Trust to return to primary care.

People are admitted to the inpatient wards if they present a risk to themselves or the public that could not be managed in the community. As soon as patients are admitted, the Trust begins to consider their discharge and the services they can use after discharge from the ward. Information is given to patients and services are signposted where possible.

If someone experiences a psychosis for the first time, they will receive intensive treatment from the Early Intervention Service using a psycho-social model for a two-year period to help the service user to best manage their illness and to prevent their illness progressing further.
Service users will then either be referred on to the Recovery and Support Team or, if they have stabilised, back to their GP.

Recovery and Support Team
The three Recovery and Support Teams in Merton provide on-going care for people with serious mental illness (SMI). The team is mainly staffed by community psychiatric nurses, social workers, doctors, psychologists, employment workers and Recovery and Support Team workers.

The nurses, social workers and occupational therapists will undertake the role of the Care Coordinators and establish an overview of the service user’s care; ensuring appropriate linkages are made into other services such as supported housing or social services.

There is a shift in approach at the moment, with Care Coordinators having a greater focus on enabling recovery and agreed outcomes within agreed timescales and specific goals for their service users – the intention is to ensure people’s independence wherever possible and for them to be supported in the least restrictive manner consequent to their needs. Care Coordinators see their service users about once every two weeks on average although this will vary according to the service user’s condition. In between these visits, the service users will be seen by their Recovery and Support workers. Most service users are seen in their homes but they may also come to the team base, especially if they need blood tests for their medication.

The Mental Health Trust tries to maintain consistency in providing care workers for service users but due to the impact of people changing jobs and restructuring this is not always possible.

Recovery College
The South West London Recovery College, operated by the Mental Health Trust, runs self-management courses to help service users to develop the skills to manage their own recovery. Carers and Community Mental Health Team (CMHT) staff can also attend the courses. The Recovery College approach is to help people recognise and develop their personal resourcefulness and the message is ‘hope’ – that service users can recover a meaningful life.

There are short introductory courses (half a day) and longer-term ones (three to 10 weeks, half-day weekly sessions) on, for example, spirituality and the five ways to wellbeing. There are also more practical courses such as an introduction to the Internet.

The college runs on a hub and spoke model with courses delivered both at Springfield Hospital as the hub and at a variety of places within the community – libraries, adult education centres and community halls across South West London. The community venue in Merton is Vestry Hall in Mitcham.
How care is structured

Care Plan Approach (CPA)

Each service user normally has a Care Plan Approach (CPA) review every six months. In this meeting, usually held with a consultant psychiatrist, views can be expressed, problems identified, progress discussed, medication reviewed and necessary changes made to the care plan.

Each service user also has a personalised care plan that should include identifying and achieving their recovery goals. These goals are agreed with the service users – they are about moving their life forward and building the life they want to live.

Care clusters and care packages

New mental health care clusters and care packages were introduced in April 2013 but have not yet been agreed at a national level as the model for contracting. The care clusters are groupings of service users that define their needs within super clusters – psychosis, non-psychosis and organic. Care packages are written descriptions of the care that service users in each of the care clusters will receive.

The care packages include information about the amount of time spent by different Mental Health Trust staff with the service user, therapeutic services that should be offered (e.g. ‘physical health monitoring and intervention’) and enabling services (such as the Recovery College – mentioned above). However, given the individuality of patient need, many patients do not neatly fit the prescribed clusters and their care plans will also vary as a result.

A snapshot review starts to give us a picture and to indicate what further work we need to do to start to understand local needs better. The analysis draws on information provided by mental health services at the South West London and St George’s Mental Health NHS Trust for the period July 2010 to June 2011. More updated data for the past five years from 2009-2013 has been made available but is currently under analysis as part of the Merton Mental Health Review. This analysis will be used to update the following section when available.

Age affects the type of caseload for mental health services. In older adults there is higher demand for acute services by patients with organic mental health conditions. These include conditions such as dementia and Alzheimer’s. In working age adults there, is a high demand for acute services by patients with schizophrenia or mood disorders.

Locally, because we have very little definitive data on the prevalence and incidence of mental health conditions, a detailed review of adult mental health services is under way in Merton, which includes a mental health needs assessment. The review will result in the development of an adult mental health strategy for Merton, and will be used to update the mental health section of the JSNA.
Figure 7.43: Breakdown of diagnosis for Merton inpatient admissions for adults and older people, South West London and St George's Mental Health NHS Trust, Apr 2012- Mar 2013. The pie charts below show that for working age adults the commonest reasons for inpatient admissions were schizophrenia and mood disorders, while in older adults the commonest reasons were spread equally between schizophrenia, mood disorders and organic conditions including dementia.
Figure 7.44: Breakdown of diagnosis in the Merton Community Mental Health Team for adults based on average monthly caseload, South West London and St George’s Mental Health NHS Trust, Nov 2011- Oct 2012. The pie chart below shows that for adults the commonest condition for which they were seen was schizophrenia followed by mood disorders, neurotic disorders and personality disorders. The bar chart below shows the breakdown by age groups.
In Merton, schizophrenia and mood disorders are the most common cause of mental health admissions. However, it is unclear what proportion of these admissions are readmissions and so it is not possible to identify the prevalence of mental health conditions locally from this data. Schizophrenia and mood disorders also account for most mental health cases for the CMHT in Merton. There appears to be a gender difference in conditions, with a higher proportion of the schizophrenia caseload being male, and a higher proportion of the mood disorders caseload being female. Psychoactive substance use accounts for 6% of acute admissions, a little higher in comparison with the contribution to the community caseload, which is 4%. This may be due to a number of reasons, e.g. that a high proportion of these admissions are readmissions or that patients who use psychotropic substance have more complex conditions (dual diagnosis) and therefore have greater need for specialist services. Further investigation is recommended to identify the specific needs of this group of individuals to assess if the balance of admission and community support is appropriate and to understand which services care is accessed through.

Figure 7.45: Merton’s use of Community Mental Health Services for adults by gender, Nov 2011-Oct 2012.
Figure 7.46: Merton’s inpatient admissions for adults by gender, Mar 2012- Apr 2013.

Figure 7.47: Merton’s inpatient admissions for adults by age range, Mar 2012- Apr 2013.
A breakdown of acute admissions data by ethnic group suggests that compared with the expected proportion of the population black populations are well represented. This may reflect a more ethnically diverse population in Merton or a greater increase in prevalence for mental health issues in ethnic minority groups. This suggests ethnic communities are accessing mental health services in Merton but further investigation is needed to understand whether ethnic minority groups are equitably diagnosed with mental health conditions, or are equitably accessing or have access to appropriate mental health services. This pattern is also seen in the ethnic breakdown for the CMHT’s caseloads in Merton.

Figure 7.49: Merton’s use of Community Mental Health Services by ethnic group, Nov 2011 to Oct 2012.
Figure 7.50: Merton’s inpatient admissions for working age adults by ethnic group, Mar 2012- Apr 2013.

Proportion of Merton inpatient admissions (Working Age Adults) by ethnic group
Apr 12-Mar 13
Source: SWLStG Mental Health Trust

- Asian or Asian British: 14%
- Black or Black British: 23%
- White British: 43%
- White Other: 11%
- Other: 4%
- Mixed: 4%
- Unknown/Not stated: 1%

Figure 7.51: Merton’s inpatient admissions for older people by ethnic group, Mar 2012- Apr 2013.

Proportion of Merton inpatient admissions (Older people) by ethnic group
Apr 12-Mar 13
Source: SWLStG Mental Health Trust

- Asian or Asian British: 6%
- Black or Black British: 12%
- White Other: 21%
- White British: 55%
- Unknown/Not stated: 6%
Information on Mental Health Services for older people can be found in the section on dementia.

What works and best practice

There is a vast array of NICE publications on mental health and related conditions. It is not possible to list them all here but the reader is advised to look these up at the NICE website.

However there are some key points on what works to improve mental health and wellbeing of people with mental health problems:

- employment support for people with mental health problems
- information and support for people with mental health problems to improve access to work and social opportunities (e.g. through day care or primary care services)
- promotion of positive mental health in schools
- improved diagnosis and management of common mental disorders in primary care, e.g. anxiety and depression
- equitable access to mental health services e.g. for BAME communities
- supporting community involvement for people who are at risk of social isolation or where they are disaffected.


(The Strategy)

The Strategy focuses on six shared objectives:

(i) More people will have good mental health.
(ii) More people with mental health problems will recover.
(iii) More people with mental health problems will have good physical health.
(iv) More people will have a positive experience of care and support.
(v) Fewer people will suffer avoidable harm.
(vi) Fewer people will experience stigma and discrimination.

The objectives are based on three guiding principles.

1. Freedom
2. Fairness

The strategy aims to bring about significant change in people’s lives. Bringing the changes, for everyone, across the country and in the most effective way, will mean that:

1. Mental health has ‘parity of esteem’ with physical health within the health and care system.
2. People with mental health problems, their families and carers, are involved in all aspects of service design and delivery.
3. Public services improve equality and tackle inequality.
4. More people have access to evidence-based treatments.
5. The new public health system includes mental health from day one.
6. Public services intervene early.
7. Public services work together around people's needs and aspirations.
8. Health services tackle smoking, obesity and co-morbidity for people with mental health problems.
9. People with mental health problems have a better experience of employment.
10. We tackle the stigma and discrimination faced by people with mental health problems.

**Department of Health Analysis of the Impact on Equality (AIE)**

The AIE explains and analyses the impact of equality on the six shared objectives identified in the Strategy. The Equality Act 2010 covers nine protected characteristics, and there is a public sector duty to advance equality and reduce inequality for people with these protected characteristics.

There are three aspects to reduce mental health inequality:
- tackling the inequalities that lead to poor mental health
- tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health
- tackling the inequalities in service provision – in access, experience and outcomes.

**Department of Health No Health Without Mental Health: Implementation framework**

The national policy integrates mental health and physical health and suggests that there should be a collaborative programme of action to achieve the ambition that mental health is on a par with physical health:
1. Local planning and priority setting should reflect the mental health needs of the population. Mental health and wellbeing are integral to the work of CCGs, health and wellbeing boards, and other local organisations.
2. To translate the vision into reality, people with mental health, and their families and carers, should be fully involved in planning, priority setting and delivery of services.
3. Services should actively promote equality and be accessible, acceptable, and culturally appropriate to all the communities. Public bodies should meet their obligations under the Equality Act 2010. People including children, young people, older people, and people from ethnic minorities should have access to IAPT.
4. All people should receive evidence-based mental health promotion. Schools and colleges should promote good mental health for all children and young people, alongside targeted support for those at risk of mental health problems.
5. The Public Health Outcomes Framework (PHOF) includes mental health measures. Local public health services deliver clear plans for mental health.
6. All organisations should recognise the value of promoting good mental health.
7. Public services should recognise and identify people at risk of mental health problems and take appropriate, timely action, including using innovative service models. Early recognition and intervention will enable stopping serious consequences from occurring.
8. Public health campaigns should include people’s mental health as well physical health. Services tackle and support people with dual diagnosis and substance misuse to achieve better outcomes and reduce cost.

9. Services working together support people with mental health problems to maintain, or to return to employment.

10. Frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health.

No health without public mental health: The case for action, Royal College of Psychiatrists (RCP), 2010
http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

This report describes the key points and features that should be part of a public mental health strategy:

1. There is no public health without public mental health. Investment is needed to promote public mental health. This will enhance population wellbeing and resilience against illness, promote recovery, and reduce stigma and the prevalence of mental illness.

2. The Royal College of Psychiatrists strongly supports the findings of the Marmot Strategic Review of Health Inequalities in England post 2010. It recognises that inequality is a key determinant of illness, which then leads to even further inequality. Government policy and actions should effectively address inequalities to promote population mental health, prevent mental ill health and promote recovery.

3. Physical health is inextricably linked to mental health. Poor mental health is associated with other priority public health conditions, such as obesity, alcohol misuse and smoking, and with diseases such as cancer, cardiovascular disease and diabetes. Poor physical health also increases the risk of mental illness.

4. Interventions which apply across the life course need to be provided. Since the majority of mental illnesses have childhood antecedents, childhood interventions which protect health and wellbeing and promote resilience to adversity should be implemented. If mental health problems occur there should be early and appropriate intervention. Strategies to promote parental mental health and effectively treat parental mental illness are important since parental mental health has a direct influence on child mental health.

5. Older people also require targeted approaches to promote mental health and prevent mental disorder, including dementia. Action is needed to promote awareness of the importance of mental health and wellbeing in older age as well as ways to safeguard it. Ageist attitudes need to be challenged and values promoted that recognise the contributions older people make to communities, valuing unpaid, voluntary work as we do economic productivity.

6. An effective public health strategy requires both universal interventions, applied to the entire population, and interventions targeted at those people who are less likely to benefit from universal approaches and are at higher risk, including the most socially excluded groups. Such groups include children in care or subject to bullying and abuse, people of low socioeconomic status, those who are unemployed or homeless, those with addictions or intellectual disability, and other groups subject to discrimination, stigma or social exclusion. Health promotion interventions are particularly important for those recovering
from mental illness or addiction problems. Those with poor mental health as well as poor physical health require effective targeted health promotion interventions.

7. The prevention of alcohol-related problems and other addictions is an important component of promoting population health and wellbeing. The RCP supports the development of a minimum alcohol pricing policy and a cross-government, evidence-based addictions policy.

8. Smoking is the largest single cause of preventable death and health inequality. It occurs at much higher rates in those with mental illness, with almost half of total tobacco consumption and smoking-related deaths occurring in those with mental disorder. Therefore, mental health needs to be mainstreamed within smoking prevention and cessation programmes.

9. A suicide prevention strategy should remain a government priority and should include strategies to address and reduce the incidence of self-harm.

10. Collaborative working is required across all government departments in view of the cross-government benefits of public mental health interventions across a range of portfolios, such as education, housing, employment, crime, social cohesion, culture, sports, environment and local government. Actions to combat stigma related to mental illness should be included in these strategies.

11. Doctors can be important leaders in facilitating local and national implementation of public mental health strategies. Many psychiatrists already adopt a public mental health approach in their work and influence national and local strategy. Psychiatrists should be supported in assessing the needs of their local population for health promotion.

12. Psychiatrists should be engaged in the commissioning process and inform commissioners of the expected prevalence of specific disorders to anticipate levels of service provision and unmet need, and to help prioritise resource allocation. Support and training are required to facilitate this.

13. Commissioners should take into account the effects of mental health and mental illness across the life course as well as the economic benefits of protecting and promoting mental health and wellbeing.

14. Commissioners should consider the existing arrangements and adequacy of services for comorbid disorders and unexplained medical symptoms where cost-effective interventions could be provided.

**What works to improve mental wellbeing in older people (NICE 2008)**

- Occupational therapy involvement in the design and development of locally relevant training schemes for those working with older people.
- Advice and support to older people and carers.
- Regular sessions based on occupational therapy principles to aid daily routine activities.
- Advice and information on health, personal care, safety and other issues.
- Commissioning tailored exercise programmes.
- Developing, organising and promoting walking schemes.

NICE Clinical Guideline CG123: Common mental health disorders: Identification and pathways to care, 2011
http://www.nice.org.uk/guidance/CG123

Common mental health disorders are depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder. Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability. This guideline offers best practice advice on the care of adults with a common mental health disorder.

This guideline offers advice on the identification and the care of adults who have common mental health disorders with a particular focus on primary care.

The priorities for implementation are:
1. Improving access to services: Services need to be integrated for delivery, with clear explicit criteria for entry to the services, focused on entry and not on exclusion criteria. There should be multiple ways to entry to the services including self-referral, and multiple points of access with links to wider healthcare system. People with a common mental health problem should be provided with information about services and available treatments according to their knowledge and understanding of mental health disorders appropriate to the communities. Local care pathways should promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system, and ex-service personnel.
2. Stepped care: Use of the stepped-care model, to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals, is the most effective way of interventions.
3. Identification and assessment: It is important to identify early possible depression particularly in people with a past history, and assessment should be done by competent staff and provide appropriate treatment and referral accordingly.
5. Developing local care pathways: A collaborative local care pathway needs to be developed for people with common mental health problems. The local care pathway should promote implementation of the key principles of good care. It should be negotiable, workable, accessible and acceptable by wider communities who are in need of the services. It should be outcome focused.

NICE quality standard QS8: Depression in adults, 2011
http://www.nice.org.uk/guidance/QS8

This quality standard covers the assessment and clinical management of persistent subthreshold depressive symptoms, or mild, moderate or severe depression in adults (including people with a chronic physical health problem).
NICE quality standard QS14: Service user Experience in adult mental health, 2011
http://guidance.nice.org.uk/QS14

This quality standard outlines the level of service that people using the NHS mental health services should expect to receive. It covers improving the experience of people using adult NHS mental health services. It does not cover mental health service users using NHS services for physical health problems, or the experiences of families or carers of people using NHS services specifically.

Merton Voice

A detailed review of the adult mental health services is currently under way, which also includes qualitative work to explore user, carer and provider perspectives on mental health services in Merton.

In the recent past the following has been done to explore patient voice and perspectives:

Inform, encourage, and support – accessing physical health services for those with severe mental illness (SMI) in Sutton and Merton, Resonant Media, November 2013 for Sutton and Merton Public Health Teams

This research mapped the service provision in Merton, and explored the weaknesses and opportunities. In addition the research explored the barriers, which prevent people with SMI accessing physical health and health improvement services. These barriers include both services related issues, and emotional and mental illness issues:

Service-related issues
• Lack of understanding of mental health issues
• Surroundings and systems are unwelcoming
• Lack of coordination between physical and mental health services
• Lack of awareness of services among service users
• Health promotion is not targeted for service users.

Psychological/mental illness issues
• Fear and lack of motivation
• Need for support/lack of confidence
• Maybe not right time/not focused.

Mental health acute inpatient survey 2009: Key Facts
This was the first survey of mental health acute inpatient services in NHS trusts in England. People were eligible for the survey if they were aged 16-65, and had stayed on an acute ward or a psychiatric intensive care unit for at least 48 hours. The final report shows how each trust scored for each question in the survey in comparison with national benchmark results.
South West London and St George's (SWLSTG) Mental Health NHS Trust Survey

The averages of the scores for the key areas of experience were calculated, showing how the Trust’s score compares with the threshold of lowest and highest scoring in 20% of NHS Trusts. It shows that for three experience areas (hospital staff, your care and treatment and the overall rating), the Trust’s average score was definitely within the lowest, scoring fifth out of the Trusts.

In light of these results SWLSTG has developed a Patient Experience Improvement programme, incorporating three key strands of work:

- The patient experience: how service users and carers feel about the care they have received.
- Resources (including the workforce): looking at training, new ways of working, skill mix and communications.
- The environment: how to design new facilities, as well as look at the way existing ones are managed, to ensure that services are being run in safe, therapeutic and sustainable environments.

The Trust’s Quality Account for 2009-10 details two priorities to improve patient experience:

- reducing reliance on bank and agency staff (service user feedback suggests that frequent use of such staff is detrimental to the patient experience)
- reducing the number of transfers between wards during an admission (service users report that the process of transferring between wards during an admission is unsettling, unpleasant and detrimental to their experience).

Community mental health services survey 2010

The 2010 survey included all service users in contact with local NHS mental health services, including those who receive care under the Care Programme Approach (CPA). The final report shows how each trust scored for each question in the survey in comparison with national benchmark results.

Key commissioning implications for services to support improved mental health and wellbeing

As mentioned earlier, the Merton adult mental health services review is currently underway and will help to inform future commissioning intentions. The recommendations will be included in a refresh of the mental health section of the current JSNA when it is ready and available.

With changes proposed for commissioning in the NHS, as well as changes to Public Health, and the drive to provide care in community settings, it is imperative that consideration is given to the overlap between commissioning inpatient mental healthcare for people with dual diagnosis and support in the community. Further investigation is recommended to identify the specific needs of this group of individuals to assess whether the balance of admission and community support is appropriate and to understand which services care is accessed through.
In terms of treatment services, commissioners should focus on developing a whole system approach to mental health with more joined-up services to improve experience and outcomes. They should also focus on developing better data and local information on outcomes, and on addressing health inequalities in relation to mental health. There should be further investigation into why Merton has higher rates of depression than London, in light of its wider good health, and a focus on improving recovery rates following psychological therapies. Further work is also needed to understand access by and for ethnic minorities. A health equity audit for mental health services would be useful to support this.

Commissioners need to give consideration to local data that has suggested a number of areas where mental health can reduce health costs and lead to physical and mental health gains:

- High costs associated with unnecessary and unplanned admissions amongst people with a range of LTCs could be reduced with motivational work to support lifestyle change and psychological support to distinguish symptoms requiring medical attention from symptoms of anxiety or depression.
- High numbers of young people and their families presenting frequently and unnecessarily at A&E with asthma or minor injuries could be reduced with assistance to manage anxiety and improve self-care.
- High-cost areas (mostly associated with sheltered housing where the top 25% accounted for nearly half of cost) could be reduced with the provision of support to staff and people living in sheltered accommodation and residential care to manage difficult situations and distinguish symptoms requiring medical attention from symptoms of anxiety or depression.

**Recommendations from the insight work by Resonant Media:**
Resonant Media has developed recommendations across three to address these barriers and improve the existing service provision. These will inform, encourage and support service users to access physical health services.

Involving the service users themselves in shaping and delivering services is key to all the recommendation areas. This will build trust in the services and ensure that they are genuinely shaped for their needs.

**GPs**
Since GP practices are so busy it can be difficult to engage with them and change their practice. The research suggested initially developing a couple of best practice pilots. One or two selected GP surgeries would act as pilot projects to implement improved services for those with SMI. Positive results from these pilots, on outcomes such as do not attends (DNAs), could then be used to encourage other GP practices to implement the improved services.

Further training on working with those with mental health problems is also suggested for all who work in GP practices. This should utilise existing training courses and times when the staff are already gathered together.
System level
To drive forward proper links locally between the physical health and mental health services, a senior level champion needs to be identified. This champion could help with creating specific targets around physical health for those with SMI. They would also lead on the future development of co-located services and multidisciplinary teams.

The recommendations address all four of the social marketing intervention modes – support; design; inform and educate; and control – to try to increase levels of those with SMI accessing physical health and health promotion services and thus reducing their health inequalities.

Key commissioning implications for services to reduce suicide

Commissioners need to give consideration to the recommendations in the Department of Health’s National Suicide Prevention Strategy:

- prevention targeted at high-risk groups e.g. those in recent contact with mental health services, those who have self-harmed, young men and those in high-risk occupations
- reducing access to lethal methods of self-harm, such as hanging and strangulation, in wards and prisons
- promoting positive mental health and social inclusion, particularly among the vulnerable
- multi-faceted strategies to prevent, identify and address behaviours linked to a high risk of suicide in school.
Neurological Conditions

Key facts on neurological conditions

This section covers four long-term neurological conditions: epilepsy, Parkinson’s disease, multiple sclerosis (Ms) and motor neurone disease (MND).

- In 2012-13, among those aged 18 or over and registered with a Merton GP, there were 863 people with diagnosed epilepsy (Quality and Outcomes Framework 2012-2013, Health & Social Care Information Centre, October 2013). This gives a crude rate of 0.5%, and compares with the London rate of 0.6% and the England rate of 0.8%.

- The directly standardised mortality rate per 100,000 for epilepsy in under 75 year olds in 2011-12 was 1.1 for Merton CCG, compared with 1.5 for the ONS Cluster (London Suburbs). The rates are however based on small numbers. (Source: Spend and Outcome Factsheet 2011-2012 for Merton CCG, Public Health England.)

- Applying the UK prevalence rates (NeuroNavigator website, November 2013) to the 2013 projected population for Merton (GLA Population Projections 2012 Round Demographic Projections – SHLAA) we find that:
  - For Parkinson’s – with a prevalence rate of 195 per 100,000, there are an estimated 395 individuals with Parkinson’s disease in Merton.
  - For MS – with a prevalence rate of 161 per 100,000, there are an estimated 326 individuals with MS in Merton.
  - For MND – with a prevalence rate of 7 per 100,000, there are an estimated 14 individuals with MND in Merton.

What is a long-term neurological condition?

A long-term neurological condition results from damage to or disease of the body’s nervous system. These can be broadly categorised as follows:

- sudden onset conditions – e.g. stroke or TIA
- progressive conditions – e.g. motor neurone disease, Parkinson’s disease
- intermittent/unpredictable conditions – e.g. MS, epilepsy
- stable neurological conditions – e.g. cerebral palsy, post-polio syndrome

These can cause a range of problems for the individual, including impaired movement, muscle weakness, coordination problems, seizures and paralysis.

This section focuses on four key long-term neurological conditions:

*Epilepsy*

Epilepsy is the most common chronic disabling neurological condition in the UK. It is characterised by recurrent seizures, and classified as an intermittent condition. Epileptic
seizures are the clinical manifestation of abnormal, excessive or synchronous neuronal activity in the brain. Epilepsy can have many causes and should be seen as a symptom of different neurological disorders, rather than a single disease entity. Epilepsy affects the brain and causes repeated seizures, also known as fits. Epilepsy usually begins during childhood, although it can start at any age. Epilepsy can be caused by a head injury, an infection (e.g. meningitis) or a stroke, and it can also be inherited. Much of the time, however the reason a person develops epilepsy is unknown.

Epilepsy affects around about 1 in 130 people in the UK, totalling 456,000 across the country.

*Parkinson’s disease*

Parkinson’s disease is a progressive neurological condition in which part of the brain becomes damaged over many years. The cause of Parkinson’s disease remains unknown, but the disease is characterised by a lack of dopamine-containing cells in the movement centre of the brain, resulting in three main symptoms related to movement:

- involuntary shaking of particular parts of the body (tremor)
- muscle stiffness that can make everyday tasks such as getting out of a chair very difficult (rigidity)
- physical movements become very slow (bradykinesia/ hypokinesia).

It is not known why people get Parkinson’s disease. Most people are aged over 50 when symptoms first manifest, however one person in 20 is under the age of 40 (Source: Parkinson’s UK). There is currently no cure for Parkinson’s disease.

The prevalence of Parkinson’s disease in the UK is estimated at 195 per 100,000, which equates to around 122,000 people living with the condition in the UK (Source: NeuroNavigator).

*Multiple sclerosis*

Multiple sclerosis (MS) is a disease affecting nerves in the brain and spinal cord, causing problems with muscle movement, balance and vision. In those suffering from MS the protective myelin sheath surrounding the nerves in the brain breaks down, disrupting the transfer of nerve signals. This causes a wide range of potential symptoms, such as loss of vision, ataxia and fatigue. MS is more common among women than men, with the most likely time for diagnosis between 20 and 40 years of age.

The rate of MS in the UK is around 161 per 100,000, which equates to 101,000 people living with the condition in the UK.

*Motor neurone disease*

Motor neurone disease (MND) is a rare condition that progressively damages the nervous system, causing the muscles to waste away. As the condition progresses, people with motor neurone disease will find walking, speaking and even breathing and swallowing increasingly difficult, and eventually impossible. The cause of this condition is currently unclear, although there are a number of theories. Men are almost twice as likely to acquire MND as women,
with the majority of people being over 40 years of age at diagnosis, and the highest incidence between the ages of 50 and 70.

The rate of MND in the UK is 7 per 100,000, which equates to around 4,000 people in the UK with the condition.

**What is the Merton picture?**

**Parkinson’s disease**
In Merton there are an estimated 395 individuals suffering from Parkinson’s disease. Table 7.8 below gives the breakdown of those with the condition split into the following phases:

**Table 7.8: Parkinson’s disease in Merton by phase.**

<table>
<thead>
<tr>
<th></th>
<th>Diagnosis</th>
<th>Maintenance</th>
<th>Complex</th>
<th>Palliative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinson’s</td>
<td>43</td>
<td>160</td>
<td>133</td>
<td>59</td>
<td>395</td>
</tr>
</tbody>
</table>

Source: Calculations according to NeuroNavigator website 12.11.2013 using GLA projection for 2013 (SHLAA Round 2012)

**Multiple sclerosis**
The rate of MS in the UK is 161 per 100,000. Applied to the population of Merton, this results in an estimate of 326 individuals with MS locally. This can be split into the following phases:

**Table 7.9: Multiple Sclerosis in Merton by phase.**

<table>
<thead>
<tr>
<th></th>
<th>Diagnosis</th>
<th>Minimum-moderate impairment</th>
<th>Complex</th>
<th>Palliative/End of Life</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple</td>
<td>15</td>
<td>136</td>
<td>167</td>
<td>8</td>
<td>326</td>
</tr>
</tbody>
</table>

Source: Calculations according to NeuroNavigator website 12.11.2013 using GLA projection for 2013 (SHLAA Round 2012)

**Motor neurone disease**
The rate of MND in the UK is 7 per 100,000. Applied to the GLA projected population for 2013, this estimates that 14 individuals have MND in Merton.

**Key facts on services**

**Community Neurotherapy Team**
The Community Neurotherapy Team works in Sutton and Merton, providing specialist, multidisciplinary rehabilitation and care in the community for people with neurological conditions. The service offers access to early supported discharge for stroke patients and outpatient physiotherapy for a wide number of neurological conditions. The service aims to be an integrated dynamic team providing a patient-focused service.
Inclusion criteria
- Housebound patients mainly with outpatient clinics for physiotherapy
- 16 years and over
- Registered with a Sutton or Merton GP.

Exclusion criteria
Patients with a primary problem not related to or impacted on by their neurological diagnosis.

Neurorehabilitation services
St George's Healthcare neurorehabilitation services provide specialist care not available at other hospitals or in the community. The services treat patients from across South West London and the Home Counties at St George's Hospital, Tooting and Queen Mary's Hospital, Roehampton.

The trust provides specialist neurorehabilitation to patients who require intensive therapy following acquired neurological conditions resulting in physical or psychological disabilities. This includes patients who have had strokes, traumatic injuries to the brain or spine, anoxic brain damage, diseases or infections of the nervous system, and long-term conditions like MS. Services are provided on an inpatient or day patient basis. We also provide a range of assessment and diagnostic clinics, and advises on the care of patients at other treatment centres.

A comprehensive treatment service is provided by multidisciplinary teams to address patients' needs and maximise their recovery. The teams include nurses, occupational therapists, physiotherapists, social workers, speech and language therapists, medical staff and clinical neuropsychologists. The service also has consultants in neurology, stroke medicine, rehabilitation medicine, neuropsychiatry and clinical neuropsychology, as well as doctors in training. Visiting clinicians include chiropodists, dieticians and pharmacists.

The Merton spend per head for neurological conditions was £87 for 2011-2012. This is compared with £78 per head of population for our ONS Cluster (London Suburbs). [S can be seen] in the SPOT (spend and outcomes tool) chart in Figure 7.52 below. Merton is in the higher spend better outcome quadrant.
Figure 7.52: Merton CCG spend and outcome for neurological conditions, compared with other CCGs, 2011-12. The chart shows Merton CCG as the large blue dot in the right upper quadrant which denotes high spend and better outcomes relative to other similar CCGs. The outcome measured in this chart is premature (under 75) mortality from epilepsy.

**Spend and Outcome relative to other CCGs**

Interpreting the chart:
Each dot represents a CCG. CCGs in the same ONS Cluster and/or SHA are highlighted. If your CCG lies outside the solid blue +/- 2 z scores box, you may need to investigate further. If the CCG lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. CCGs outside the box at the corners may need a review of both spend and outcome.

**What works and best practice**

**Epilepsy**

*NICE Clinical Guideline CG137: The epilepsies: The diagnosis and management of the epilepsies in adults and children in primary and secondary care, 2012*

This includes the following key priorities:
Diagnosis – all those with a recent diagnosis should be seen within two weeks by a specialist.

Management – the person with epilepsy should be able to participate as a partner in all of their care decisions, there should be a care plan and the drug strategy should be individualised according to the needs of the patient.

Treatment – for those with prolonged or repeated seizures and convulsive status epilepticus, administer buccal midazolam or rectal diazepam only; if an intravenous access is already available and resuscitation facilities are available, administer intravenous lorazepam (new 2012 guidelines).

Ensure woman of childbearing age and their partners are given appropriate advice with regard to issues surrounding contraception, conception, pregnancy, caring for children, breastfeeding and menopause.

Review and referral – all those with epilepsy should have a review at least annually, for children and young people this must be with a specialist. If there have been issues with seizure control or there is diagnostic uncertainty, then the patient should be referred to tertiary services within four weeks.

**Parkinson’s disease**

There is no known cure and no definitive risk factor for Parkinson’s disease, so there is little that can be done in terms of prevention.

**NICE Clinical Guideline CG35: Parkinson’s disease: diagnosis and management in primary and secondary care, 2006**

This guideline outlines the following key priorities for implementation:

- Referral - people with suspected Parkinson’s disease should be referred to a specialist quickly.
- Diagnosis and review – the diagnosis of Parkinson's disease should be reviewed regularly and reconsidered if atypical clinical features develop.
- Regular access to specialist nursing care.
- Access to the following therapies should be available where appropriate:
  - physiotherapy
  - occupational therapy
  - speech and language therapy.
- Palliative care – the palliative requirements of people with Parkinson’s disease should be considered throughout all phases of the disease.

**Multiple sclerosis**


NICE issued guidelines for MS in 2003, and there are updated guidelines due out in 2014. The 2003 guidelines outline the following key priorities for implementation:

- Specialised services – neurological and neurological rehabilitation services should be available to every person with MS, when they need them.
- Rapid diagnosis – an individual suspected of having MS should be referred to a specialist and seen within six weeks.
• Seamless services – organisations agree and publish protocols for sharing and transferring responsibility for and information about people with MS, so as to make the service seamless from the individual's perspective.
• A responsive service – the unique needs of each person with MS should be taken into account during treatment, and they should be actively involved in all decisions related to their care.
• Thorough problem assessment – regular contact in order to detect ‘hidden’ problems contributing to their clinical situation.
• Self-referral after discharge – every person with MS should be informed about how to make contact with the service when he or she is no longer under regular treatment or review.

**Motor neurone disease**

**NICE Clinical Guideline CG105: Motor neurone disease: the use of non-invasive ventilation in the management of motor neurone disease, 2010**
The NICE guidance issued in 2010 addresses the use of non-invasive ventilation in patients with MND, and the Motor Neurone Disease Association has issued general advice:
• A multidisciplinary team should coordinate and provide ongoing management and treatment for a patient with MND, including regular respiratory assessment and provision of non-invasive ventilation.
• Ensure that non-invasive ventilation is offered if appropriate. Provide the patient and their carers with support and assistance to manage non-invasive ventilation.

**Motor Neurone Disease Association (MNDA): Standards of Care (2010)**
• Rapid and accurate diagnosis
• Earliest possible assessment by a neurologist
• Appropriate emotional/psychological support
• Appropriate information is made available, in a timely manner
• Immediate identification of a single point of contact (key worker/case manager)
• Access to appropriate expertise and services at the appropriate time
• Timely referral to specialist palliative care and respite care
• Regular monitoring and review.

**Key commissioning recommendations**

1. Commissioning safe, sustainable, high quality services for the local population
   Improving the quality and ensuring the safety of acute hospital, primary care, community, and mental health and specialist services are of the highest priority for the borough.

2. Integrating care and developing community services
   Enabling improvements in care provided to individuals resulting in a better experience, improved outcomes and productivity, particularly for vulnerable
MERTON
JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)
2013-14

THEME 8:
ACCESS TO ADULT SOCIAL CARE IN MERTON
Summary

Key facts on adult social care
In Merton Council, the Community and Housing Department is responsible for housing needs, adult social care, libraries and heritage, and adult education in Merton. Adult Social Care (ASC) provided services to approximately 3,640 people during the period 2012-13.

Major transformational changes have now taken place through Putting People First and as a result of building on the experience gained from person-centred planning for people with learning disabilities. Merton Council has delivered its major structural transformation programme and divided its ASC infrastructure accordingly. There are three distinct elements: (1) Direct Provision; (2) Access and Assessment; and (3) commissioning. The process of personalisation has, therefore, moved on to a different level. Efficiencies have been driven through the contracts and passed on to those planning support and to the customers purchasing support. These efficiencies are also reflected in in-house provision and upheld by those supporting people to access and have an assessment.

Merton has adopted a Social Care ‘Efficiency Framework’, which helps the Council to use resources in the most effective way as possible and is particularly relevant in the current economic climate.

In Merton, all ASC customers are provided with a personalised budget via a range of mechanisms as well as a personalised support plan. Budgets are based on a needs assessment as well as social capital, family support, and market efficiencies. National comparative information indicates that uptake of direct payments is increasing in the borough and the proportion of adults in receipt of direct payments or personal budgets, as a proportion of all those receiving community-based services has increased from 8.6% in 2009-10 to 47.5% in 2012-13.

Recovery
The recovery model in Merton involves two primary aims. The first aim is to prevent admission to hospital, nursing or residential care by offering short-term, focused support when people face a potential crisis. This may relate to an individual’s ‘long-term condition’ or be as a result of a significant change of social circumstance. The second aim of the model is to provide an effective, multidisciplinary reablement service at the point of hospital discharge.

Merton works in partnership with other agencies to ensure that people are discharged from hospital in a timely way with appropriate support. Merton has one of the lowest levels of delays where people are not left in hospital if they are ready to leave. This means preparation for release is carried out, and, where appropriate, services are provided, in a timely manner so people do not have to stay in hospital longer than they need to.

Merton is currently working with Health partners and has set up an Integration Transformation Programme (now called Better Care Fund) to ensure close working between social care and health professionals. In addition to preventing admission, this programme is also to prevent attendance at hospital emergency units along with developing a key worker project for people with long-term conditions.

What are the gaps?
With integration becoming an increasingly critical issue in the shape of future social care and health services, especially with shrinking budgets it is important that a clearer understanding is developed of integrated care and support as a whole partnership of all key stakeholders across Merton. There needs to be a clearer understanding of the customer journey through
the service (including mental health) - in relation to health, social care and the voluntary sector.

Another gap is in relation to self-funders, i.e. individuals who fund their own social care and support and do not take recourse to any public funds. A clear understanding is lacking of who these individuals (their demographics, health and social care issues and need) are and what the role of Adult social Care is in relation to them.

The true cost of social care, including the financial impact of the Care Bill implementation, needs to be determined. As the financial challenges continue for LBM, ASC will have contributed in the region of £12 million savings, as part of the Council's overall savings programme between the periods 2013-14 and 2016-17. The impact of this budgetary reduction is not yet clear. As care and support funding is being reformed (through the forthcoming Care Bill) the landscape of social care is changing. The ASC customer base could potentially double, which will certainly increase the pressure on the decreasing ASC budget. The ASC savings have however to an extent been offset by some growth. Nonetheless, Merton Council, as much as other councils, is having to look at innovative alternative ways to deliver statutory its responsibilities.

**Key commissioning implications**

There needs to be even greater emphasis on prevention in both health and social care. This implies greater investment in prevention in those adult and social care programmes and services that will reduce the cost of social care and enable the effective implementation of the key area of the Social Care “Efficiency Framework” on prevention.

There is considerable work under way on health and social care integration in Merton. Integration activities need to focus on aspects that enable joint commissioning, including:

- understanding integrated care and support pathways
- multidisciplinary teams that cover the commissioning and service provision
- developing integrated performance metrics and data
- improving knowledge management of integrated services.

Furthermore, it is important to ensure that integration work does not involve duplication of health and social care resources.

While customer and user engagement is already happening, a framework should be developed to ensure the quality and consistency of such engagement.

With a potential reduction in the ASC budget of around £12 million by 2016-17 under the Council’s savings programme, there needs to be a clear understanding and appraisal of the implications and impact on the organisation and delivery of adult social care in Merton, in terms of the costs, benefits and outcomes. The ASC savings have to an extent been offset by some growth. Nonetheless, Merton Council, as much as other councils, is having to look at innovative alternative ways to deliver its statutory responsibilities.
Introduction

In 2012 the Department of Health published the White Paper, *Caring for our Future*, which set out the policy direction for the adult care and support system. The aim was to develop a system that focused on people’s wellbeing and supported them to stay independent for longer; introduced greater national consistency in access to care and support; provided better information to help people make choices about their care; gave people more control over their care; improved support for carers; and ensured quality and integration of different services.

In Merton Council, the Community and Housing Department is responsible for housing needs, adult social care, libraries and heritage, and adult education in Merton. Adult Social Care (ASC) provided services to approximately 3,640 people during the period 2012-13.

Major transformational changes have now taken place through Putting People First and as a result of building on the experience gained from person-centred planning for people with learning disabilities. Merton Council has delivered its major structural transformation programme and divided its ASC infrastructure accordingly. There are three distinct elements: (1) Direct Provision; (2) Access and Assessment; and (3) Commissioning. The process of personalisation has therefore, moved on to a different level. Efficiencies have been driven through the contracts and passed on to those planning support and to the customers purchasing support. These efficiencies are also reflected in in-house provision and upheld by those supporting people to access and have an assessment.

Key facts on adult social care

Merton has adopted a Social Care ‘Efficiency Framework’ which helps the Council to use resources in the most effective way as possible and is particularly relevant in the current economic climate.

Efficiency Framework – a whole system approach

The Social Care ‘Efficiency Framework’ was developed by the Directors of Adult Social Care (ADASS) and brought together by Simon Williams, the Director of Merton’s Community and Housing Service. The framework provides guidance, identifies performance measures and offers approaches to efficient delivery of services. This approach helps councils to use their resources in the most effective way possible and is particularly relevant set against the current economic climate. The six key areas within the Efficiency Framework are set out below.
In Merton, all ASC customers are provided with a personalised budget via a range of mechanisms as well as a personalised support plan. Budgets are based on a needs assessment as well as social capital, family support, and market efficiencies. Some customers choose to access their budget via a direct payment. This method of deployment is popular amongst younger people with a range of physical and/or learning difficulties. It is less popular amongst Merton’s elderly population as whilst the method offers greatest choice and control it also requires greatest personal responsibility. In Merton, therefore, many choose to have a directly managed budget, whereby the Council purchases on the customer’s behalf. All deployment methods now utilise a prepaid support card for ease of purchasing for customers.

National comparative information indicates that uptake of direct payments is increasing in the borough and the proportion of adults in receipt of direct payments or personal budgets, as a proportion of all those receiving community-based services has increased from 8.6% in 2009-10 to 47.5% in 2012-13.

**Figure 8.1: People receiving direct payments or personal budgets, Merton and South West London 2012-13.**
Where are our inequalities in health and disability?
The map below identifies areas with relatively high rates of people who die prematurely or whose quality of life is impaired by poor health or who are disabled.

In Merton, there are no areas that fall within the 20% most deprived for health and disability, reflecting overall good health and less disability compared with the rest of the country. However, there is a significant variance across the borough demonstrating significant inequalities in health and differences in need.

Figure 8.2: Merton map of Indices of Deprivation, Health deprivation and Disability domain, 2010. The index of multiple deprivation has several domains, one of which is ‘health deprivation and disability’. This map shows the distribution of the health deprivation and disability domain in Merton, with the more deprived areas for this domain in darker shades.
People who need social and healthcare services have a combination of disabilities, health needs, and physical or mental frailties. The numbers of people likely to have a disability or poorer health are determined by:
- trends in population
- trends in health, which means not only the incidence and prevalence of health conditions, but also lifestyle (particularly exercise, diet and smoking), levels of deprivation, and access to appropriate health and social services
- ability of people to stay healthy and independent, or to recover from illness or injury and regain a degree of independence.

**Recovery**

The recovery model in Merton involves two primary aims. The first aim is to prevent admission to hospital, nursing or residential care by offering short-term, focused support when people face a potential crisis. This may relate to an individual's 'long-term condition' or be as a result of a significant change of social circumstance. The second aim of the model is to provide an effective, multidisciplinary reablement service at the point of hospital discharge.

The Council offers reablement wherever appropriate to all those approaching ASC for help, and to those being discharged from hospital, as part of an overall aim to promote independence. The Council does not commit to long-term support without first checking that maximum recovery has been achieved. This strategy is resulting in reductions in the numbers of people receiving long-term support at home (and/or reductions in the size of their packages), and is proving cost-effective once the costs of the reablement intervention are taken into account.

Figure 8.3 below highlights the Adult Social Care Outcomes Framework (ASCOF) indicator 2b(1) – the proportion of older people who were still at home 91 days following reablement. The graph shows that in 2012-13 84% of older people were still at home three months after receiving a reablement service from Merton – an increase since 2011-12.
Merton works in partnership with other agencies to ensure that people are discharged from hospital in a timely way with appropriate support. Merton has one of the lowest levels of delays where people are not left in hospital if they are ready to leave. This means preparation for release is carried out, and, where appropriate, services are provided, in a timely manner so people do not have to stay in hospital longer than they need to.

ASCOF indicator 2c measures delayed transfer rate of care from hospital per 100,000 population. The graph below shows that in 2012-13 this has reduced from the 2011-12 rate of 3.3 to 2.5 per 100,000 population. This is much lower than London, Outer London and CIPFA comparators.
The Reablement Service in Merton also prescribes simple adaptations and small pieces of equipment as part of its service offering to the customer. This enables customers to be supported in accessing an efficient service for daily living aids thus effectively promoting and maintaining their independence.

Merton is currently working with Health partners and has set up an Integration Transformation Programme to ensure close working between social care and health professionals. In addition to preventing admission, this programme is also to prevent attendance at hospital emergency units along with developing a key worker project for people with long-term conditions.

**Continued support**
Where people require continued long term support Merton provides value for money and offers all eligible customers personal budgets. This can be by having a direct payment or a service set up and organised by the Council. Personal budgets enable people to know how much money can be spent on their care and support needs and give people more choice and control over how their needs are met.

Merton aims to support as many people as possible in the community and in their own homes. This is achieved by using technology such as care alarms and sensors, a range of accommodation options such as Supported Living, Shared Lives and Extra Care Supported Housing, and equipment and adaptations within people’s homes. Where people’s needs are at a higher level, residential and nursing care is provided. Merton compares favourably with the rest of London in terms of numbers of people placed in residential and nursing home care. For all customer groups the Council is achieving a shift from residential and nursing home care to community-based support.
Use of residential care: Merton has been one of the lowest users of residential and nursing care compared with the rest of London.

Figure 8.5: ASCOF 2a (1) – New admissions to care homes per population, for Merton and CIPFA (Chartered Institute of Public Finance and Accounting) designated cluster for Merton, aged 18 to 64 years, 2012-13.

Figure 8.6: ASCOF 2a (2)- New admissions to care homes per population, for Merton and CIPFA (Chartered Institute of Public Finance and Accounting) designated cluster for Merton, aged 65 years and over, 2012-13.

The self-directed support process uses a costing-based model where each customer’s service package is negotiated individually by the new brokerage team. This has helped to both reduce costs and ensure greater choice and control for the customer.
Integration with health services has been a major focus this year. Social care staff are working more closely with the newly formed CCGs and have aligned the community social work teams according to the GP practice localities to strengthen working relationships to best support customers.

With the implementation of the Care Bill next year, ASC is working hard to ensure that the service complies with its key themes and amendments to further improve outcomes for social care customers in Merton.

There have also been some positive changes to better support young people with social care needs going through transition in preparation for the Children and Families Act 2014.

Contributions
Everyone should be able to, and is expected to, contribute to their care whether it is in kind or financial. Merton ASC has a clear fairer contributions policy, which expects users to pay for services if they can afford to do so, including from appropriate benefits. The self-directed support process is clear about the contribution in kind expected from the customer and any informal carers and family members.

Support to carers:
- Carers' Grant: This is to be paid as part of the new Area Based Grant since 2008, and is a non-ring-fenced general grant. As such, councils are able to determine locally how best to spend the grant in order to deliver local and national priorities in their areas. Merton provides benefits, including respite, day care, home care, direct payments, and discretionary payments, to carers following an assessment.
- Carers' Discretionary Payment Budget: This provides an easily accessible budget source of funds to allow for the provision of those services for carers that are not usually considered appropriate when sourced from the community care budget. A total of just over £30,000 was assigned for 2012-13 with a limit of £100 set per carer. The Council may contribute up to £100 toward an appropriate service in one application, or may consider two or more applications over the year, provided the ceiling of £100 is not breached. This grant is to benefit the informal carers who are assessed under the legislative framework of the Carers and Disabled Children Act 2000.
- Merton adult social care fund Carers’ Support Merton to provide both services and information and advice to carers directly.

Key facts on Adult Social Care

Adult Social Care provided services to approximately 3,640 people during the period 2012-13. The following graphs in Figures 8.7 to 8.10 below show the breakdown of services provided; residential and nursing care services are used as a last resort when no other alternative is viable.
Figure 8.7: Numbers of people aged 18 to 64 receiving services during 2012-13.

Figure 8.8: Numbers of people aged 65 and over receiving services during 2012-13.
Figure 8.9: Community-based services provided to people aged 18 to 64 during 2012-13. Some customers have more than one community-based service and therefore figures are provided by service type and not by customer.

Figure 8.10: Number of community-based services provided to people aged 65 years and over, during 2012-13. Some customers have more than one community-based service and therefore figures are provided by service type and not by customer.
The ASC Service has enabled all customers requesting and/or requiring assessment to be supported through the self-directed support process. The overall aim of the assessment is to meet the identified needs of eligible individuals by supporting them to make cost-effective choices to maintain their independence, support them to remain at home, and maintain and improve their safety and quality of life.

Merton’s Adult Access Team (MAAT) acts as the first point of contact for all new referrals and enquiries, which makes things simple for people to get speedy access to information and advice and/or initial screening for a full assessment of their needs.

Merton Independent Living and Engagement Service (MILES) provides intense home support and personalised professional intervention in order to prevent people being admitted to hospital and/or long-term dependent care.

MILES also provides a small, focused home care service for those customers with highly complex urgent needs.

MASCOT Telecare is a service that provides technical solutions to help people maintain their independence at home. This service is expanding and becoming a key part of adult social care work in enabling people to remain at home for longer and use the Council's resources more effectively.

The new brokerage service provides cost-effective alternative value care and support solutions for customers. The team will commission the most cost effective service whilst helping people to exercise choice and control. This new team has been creative in delivering the outcomes for people in a different way. The brokerage also assist in identifying gaps in the market and uses data intelligence to develop this market. These gaps are slowly being filled as new services are developed in the area. The new brokerage team has also helped to relieve pressure on social workers, releasing some aspects of care management and enabling them to concentrate on case work.

ASC informs the wider community of the care and support solutions available locally via the dedicated online portal called Merton-i.

For further information about the services provided, please click on the link below or copy the link to your internet browser: [http://merton-i.merton.gov.uk/kb5/merton/asch/home.page](http://merton-i.merton.gov.uk/kb5/merton/asch/home.page)

The Merton Home Treatment Team is a 24-hour crisis service responding 365 days a year. It provides access to acute mental health services. This also includes an early intervention team providing early detection of psychosis to help unnecessary hospital admission.

Voluntary sector
The Volunteer Centre Merton works with a wide range of organisations in the public, voluntary and community sectors to develop and match the skills and interests of new volunteers to volunteering opportunities. They deliver good practice support to organisations involving volunteers in their work, and provide information and advice about volunteering alongside training for organisations and volunteers. They work closely with voluntary and community organisations and the Merton Compact partners in Merton (the partnership between government and the voluntary sector), and lead on campaigns to raise awareness.
of volunteering, to gain recognition for the contribution of volunteers and to highlight issues that affect volunteers.

**Merton Voluntary Service Council (MVSC)** works to support the voluntary and community sectors in Merton. They do this in a number of ways:

- Practical support to voluntary, community and faith organisations (VCFOs): providing for the basic needs of VCFOs through information and advice, training, and access to practical resources such as IT/internet, desk space, equipment loan.
- Development: identifying new social and community needs; initiating new groups and/or providing support and facilities to strengthen existing groups by advising on a range of management and governance issues, including financial management and fund-raising.
- Enabling volunteering and community action.
- Ageing Well: programme of support to older people to develop activities and clubs (see below).

**Prevention**

Community involvement and voluntary action are essential to the quality of life in Merton, and the voluntary and community sectors make a valuable contribution to the borough’s economic, environmental and social development. The Merton ‘Compact’ is a partnership agreement between Merton Council, SMPCT and the voluntary and community sectors. The ‘Compact’ is a national framework for how councils should work with the voluntary sector.

**Ageing Well Programme**

The Adult Social Care Ageing Well Programme was launched on 30 April 2013. The key features of the programme are that it:

- enables people to live for longer in their own homes and delaying or reducing spend on Council funded social care
- is based on the evidence of triggers that cause people to go into care homes – such as incontinence, dementia, isolation, loss of mobility, and depression/anxiety
- is outcomes-focused and takes an asset based approach
- builds social connectedness - instead of relying on services which keep older people segregated from others, it actively encourages people to mix
- promotes stronger local neighbourhoods and putting older people in touch with local people and opportunities
- will be measured by a set of metrics – a combination of inputs by voluntary groups, individuals or objective assessment of ‘wellbeing’ among older people against certain key factors and whether the services are actually having a ‘preventive’ effect
- has cross-borough coverage for outcomes, whether by one organisation or through collaboration between organisations
- consults with older people on what they actually want.

The services funded by the Ageing Well Programme are:

- **Age UK Merton** – Life after Stroke; continence awareness and support service.
- **Carers Support Merton** – neighbourhood peer support groups/networks; self-financed activities for carers as respite; carry on caring workshops; emotional support and coaching.
- **Merton & Morden Guild of Social Service** – ‘Fit for Life’ exercise programme; falls prevention programme; opportunities for volunteering.
- **Merton Community Transport** – volunteer community car service.
- **Merton Mencap** – ‘Evolutions’ support service for non-FACs (Fair Access to Care Services) eligible people with autism; activities club and carers community advice service
- **Merton Vision** – buddying programme, emotional support and counselling, training to use equipment
Volunteer Centre Merton - Supported Volunteering Programme for mental health service users and people with learning, physical or sensory disabilities.
Wimbledon Guild of Social Welfare – community coaching sessions; menu of services; informal drop-in café.

ASC budget position
LBM spends around 35% of its budget on ASC, compared with a current national average of 34%. (The gross budget for ASC was £81.4 million and the net budget was £57.5 million in 2013-14.) Merton is a low-spending council overall and its actual expenditure on ASC is correspondingly low.

Merton has applied a range of measures to reduce its expenditure on ASC over time. Some of the most important of these are:

- The Council spends a relatively low percentage (36%) of its ASC budget on residential and nursing home placements, and has broadly contained this area of expenditure.
- The Council’s rigorous approach has involved managing the number of new placements by renegotiating the fees paid for some high-cost placements; and freezing the fees paid to residential care providers since 2010-11.
- The Council’s resources are increasingly targeted towards people with intense or complex needs (with consequent increases in the costs of individual packages, especially for younger adults). Even so, its average expenditure on community services per person per year is low for all customer groups, and this is also an unusual achievement.
- Merton has reduced the unit costs of its own services (of which there are relatively few), and of those purchased from the independent sector, to the extent that the average costs of residential and day care are now exceptionally low, and the costs of other services are around average.
- The Council has made some staffing reductions (especially from its directly provided services). Its assessment and care management processes are broadly cost-effective compared with other councils in the sense that quite high levels of activity are delivered at relatively low cost.

The following table shows the Adult Social Care 2012-13 final spend against its budget:

<table>
<thead>
<tr>
<th>Service</th>
<th>Total 2012-13</th>
<th>Budget 2012-13</th>
<th>Final Out-turn 2012-13</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>£9,522,180</td>
<td>£9,782,775</td>
<td></td>
<td>+£260,595</td>
</tr>
<tr>
<td>Mental Health</td>
<td>£3,316,740</td>
<td>£2,989,655</td>
<td></td>
<td>-£327,085</td>
</tr>
<tr>
<td>Older People/Homecare</td>
<td>£19,839,780</td>
<td>£18,868,236</td>
<td></td>
<td>-£971,544</td>
</tr>
<tr>
<td>Physical &amp; Sensory</td>
<td>£4,783,420</td>
<td>£4,440,951</td>
<td></td>
<td>-£342,469</td>
</tr>
<tr>
<td>Service Strategy</td>
<td>£356,270</td>
<td>£384,253</td>
<td></td>
<td>+£27,983</td>
</tr>
<tr>
<td>Support Services</td>
<td>£2,354,820</td>
<td>£2,317,265</td>
<td></td>
<td>-£37,555</td>
</tr>
<tr>
<td>Concessionary Fares &amp; Taxicard</td>
<td>£8,279,750</td>
<td>£8,245,964</td>
<td></td>
<td>-£33,786</td>
</tr>
<tr>
<td>No Recourse to Public Funds</td>
<td>£210,470</td>
<td>£263,565</td>
<td></td>
<td>+£53,095</td>
</tr>
<tr>
<td>Other</td>
<td>£434,330</td>
<td>£287,709</td>
<td>-£146,621</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Supporting People</td>
<td>£2,666,490</td>
<td>£2,575,397</td>
<td>-£91,093</td>
<td></td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>£51,764,250</strong></td>
<td><strong>£50,155,770</strong></td>
<td><strong>-£1,608,480</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Costs of Adult Social Care Services**
The following graphs in Figures 8.11 to 8.18 below show how the costs of ASC Services compare with other statistically similar boroughs in 2012-13. (The average cost of the service is worked out by dividing the number of customers by the amount of money spent per day, week, etc.)

Our comparator boroughs are: Bexley; Brent; Croydon; Ealing; Enfield; Greenwich; Harrow; Hounslow; Kingston; Lewisham; Redbridge; Richmond; Sutton, Waltham Forest and Wandsworth.

**Costs of Residential and Nursing Care per person per week**

**Figure 8.11:** Cost of residential and nursing care per person per week, older people aged 65 years and over, 2012-13.

**Key points:**
- Nursing care costs are slightly higher than the comparator average.
- Residential care costs are lower than the comparator average.
Figure 8.12: Cost of residential and nursing care per person per week, people with learning disabilities aged 18-64 years, 2012-13.

Learning Disabilities aged 18-64

<table>
<thead>
<tr>
<th>Service</th>
<th>Merton</th>
<th>Comparator Boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care</td>
<td>£1,250</td>
<td>£1,157</td>
</tr>
<tr>
<td>Residential care</td>
<td>£1,303</td>
<td>£1,408</td>
</tr>
<tr>
<td>Residential and nursing care</td>
<td>£1,302</td>
<td>£1,403</td>
</tr>
</tbody>
</table>

**Key points:**
- Nursing care costs are slightly higher than the comparator average.
- Residential care costs are lower than the comparator average.

Figure 8.13: Cost of residential and nursing care per person per week, people with mental health illnesses aged 18-64, 2012-13.

Mental Health aged 18-64

<table>
<thead>
<tr>
<th>Service</th>
<th>Merton</th>
<th>Comparator Boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care</td>
<td>£1,286</td>
<td>£964</td>
</tr>
<tr>
<td>Residential care</td>
<td>£592</td>
<td>£851</td>
</tr>
<tr>
<td>Residential and nursing care</td>
<td>£607</td>
<td>£857</td>
</tr>
</tbody>
</table>

**Key points:**
- Nursing care costs are higher than the comparator average.
- Residential care costs are lower than the comparator average.
**Key points:**
- Nursing care costs are slightly higher than the comparator average.
- Residential care costs are noticeably lower than the comparator average.

**Costs of Home Care per person per week**

Figure 8.15: Cost of home care per person per week, older people, people with learning disabilities, mental health illnesses and physical disabilities, 2012-13.

**Key points:**
- Home care costs are similar to the average for older people, and mental health and physical disabilities groups.
- Home care costs are noticeably higher than comparators for people with learning disabilities.
- Unit costs per hour are also higher at £21 with a comparator average of £17. This does include both internal and external home care services.
Costs of **Direct Payments** per person per week

Figure 8.16: Cost of direct payments per person per week, older people, people with learning disabilities, mental health illnesses and physical disabilities, and all direct payments, Merton and comparator boroughs, 2012-13.

**Key points:**
- Direct payments costs are below average for all customer groups except older people, which are higher than the average.
- However, the overall unit costs are slightly lower than the average.

Costs of **Day Care** per person per day

Figure 8.17: Cost of day care per person per day, older people, and people with learning disabilities, mental health illnesses and physical disabilities, Merton and comparator boroughs, 2012-13.

**Key points:**
- Day care costs are noticeably below average for all customer groups.
Costs of **Meals** per person per day

Figure 8.18: Cost of meals per person per day and per person per week, Merton and comparator boroughs, 2012-13.

**Key points:**
- Costs of meals are lower per meal and per week compared with the average.

**Access to Services**

In Merton, there has been a reduction in the number of residents in the age groups under 65 years accessing ASC Services. In working age adults from 18-64 years of age, there has been a 42.4% reduction in the numbers accessing services compared with CIPFA comparators where the reduction has been less pronounced at 12.12%. However in the 65 years and over group, while there has been a 4.1% reduction in the numbers accessing services in the CIPFA comparators, in Merton by contrast there has been a 8.8% increase (see Figure 8.19 below).

In 2012-13, there were 16,829 service users of ASC. 2,706 of these were 18+, 878 between 18-64 years of age and 13,245 65 years of age and over. In the 18-64 age group the numbers accessing ASC were lower than CIPFA comparators and in 65 and over the numbers were considerably more than CIPFA comparators (see Figure 8.20 below).
Figure 8.19: Percentage change in service users accessing ASC in 2012-13 compared with 2011-12, Merton compared with CIPFA comparators.

Figure 8.20: Number of service users accessing ASC in 2012-13, Merton compared with CIPFA comparators.
**Key points:**
- An overall reduction in service users since 2011-12 and compared with CIPFA comparators.
- Big decrease for 18-64 but increase in 65+.
- However, 18+ by population shows slightly higher proportion compared to CIPFA comparators; a lower proportion for 18-64 and higher for 65+.

**Types of services 18+ (% change and by population)**

Figure 8.21: Percentage change in the types of services for 18+ group, 2012-13 compared with 2011-12, Merton and CIPFA comparators.

![Types of Services % Change](chart1)

Figure 8.22: Types of services for the 18+ group, 2012-13, Merton compared with CIPFA comparators.

![Types of Services by Population](chart2)
**Key points:**
- Larger decreases in community-based services, residential and compared to CIPFA comparators.
- Overall however, by population community based services are slightly higher than CIPFA comparators.

**Types of services 18-64 (% change and by population)**

Figure 8.23: Percentage change in the types of services for 18-64 group, 2012-13 compared with 2011-12, Merton and CIPFA comparators.

Figure 8.24: Types of services for the 18-64 group, 2012-13, Merton compared with CIPFA comparators.
**Key points:**
- 18-64 - Large decrease in community based services and small increase in residential
- However, residential is less than the CIPFA by population

**Types of services 65+ (% change and by population)**

Figure 8.25: Percentage change in the types of services for 65+ group, 2012-13 compared with 2011-12, Merton and CIPFA comparators.

![Graph showing percentage change in types of services for 65+ group](image1)

Figure 8.26: Types of services for the 65+ group, 2012-13, Merton compared with CIPFA comparators.

![Graph showing types of services by population](image2)
Key points:
65+ – Increase in community-based services but decrease in both residential and nursing care. This picture is similar by population against CIPFA comparators.

Breakdown of community-based services (CBS) per 100,000 population

CBS 18-64: % change 2011-12 and 2012-13:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home care</td>
<td>9.3%</td>
</tr>
<tr>
<td>Day care</td>
<td>6.3%</td>
</tr>
<tr>
<td>Meals</td>
<td>10.8%</td>
</tr>
<tr>
<td>Short-term residential</td>
<td>-7.7%</td>
</tr>
<tr>
<td>Direct payments</td>
<td>32.0%</td>
</tr>
<tr>
<td>Equipment</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

CBS 65+: % change 2011-12 and 2012-13:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home care</td>
<td>16.0%</td>
</tr>
<tr>
<td>Day care</td>
<td>6.3%</td>
</tr>
<tr>
<td>Meals</td>
<td>0.7%</td>
</tr>
<tr>
<td>Short-term residential</td>
<td>12.9%</td>
</tr>
<tr>
<td>Direct payments</td>
<td>63.0%</td>
</tr>
<tr>
<td>Equipment</td>
<td>14.1%</td>
</tr>
</tbody>
</table>

Home care intensity:

<table>
<thead>
<tr>
<th>Home Care</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 hours per week</td>
<td>10.2%</td>
</tr>
<tr>
<td>More than 10 hours per week</td>
<td>5.1%</td>
</tr>
</tbody>
</table>
New admissions to residential and nursing care

Figure 8.27: ASCOF 2A (1) and ASCOF 2A (2): 18-64 & 65+ permanent admissions per 100,000 population to residential and nursing care compared with our CIPFA comparators.

**Key points:**
- Numbers supported in both residential and nursing care homes are less per population compared with CIPFA comparators for all age groups.
- New admissions to both residential and nursing care homes are less per population compared with CIPFA comparators for all age groups.
Reviews

Figure 8.28: Total number of existing clients for whom a review was completed during the period (% change since last year).

% change in the Number of Reviews Completed

![Bar chart showing % change in number of reviews completed for different age groups.]

Figure 8.29: Percentage of people in receipt of a service who received a review during the year.

Number of Reviews as % of Services

![Bar chart showing number of reviews as percentage of services for different age groups.]

Key points:

- Overall there has been a decrease in the number of reviews completed since 2011-12. The largest decrease being in 18-64 with a slight increase in 65+.
- Reviews as a percentage of all service users is lower overall compared with CIPFA comparator boroughs. However, reviews for 18-64 are higher than comparators although there has been quite a large decrease since 2011-12.
Carers

Figure 8.30: Percentage change in carers services information and advice.

Figure 8.31: Carers services and information and advice by population.
Key points:
- There has been a decrease in services, and information and advice, provided to carers since last year.
- However, carers provided with information and advice per 100,000 population is much higher than CIPFA average.

Self-Directed Support

Figure 8.32: ASCOF 1C (1): Proportion of people using social care who receive self-directed support; and ASCOF 1C (2): Proportion of people using social care who receive direct payments.

Key points:
- The proportion of people receiving self-directed support has increased since 2011-12 although lower than comparators. However, not all councils use the same definition for this measure. The information centre will be changing the definition for 2014-15 to ensure all councils are measuring in the same way.
The proportion of people receiving direct payments is higher than the comparator averages.

Figure 8.33: Proportion of people using social care who receive self-directed support (ADASS), 2012-13 compared with 2011-12.

**Key points:**
- This is a new ADASS definition showing self-directed support as a proportion of all community-based services as a snapshot at the end of the period rather than during the period. This means that one-off pieces of equipment and other one-off services are not included unless they were open on 31 March 2013.

Living independently

Figure 8.34: ASCOF 1E: Proportion of adults with learning disabilities in paid employment, 2012-13 compared with 2011-12.
**Key points:**
- The number of people with learning disabilities in employment has increased slightly since 2011-12 although slightly below CIPFA comparators.

Figure 8.35: ASCOF 1F: Proportion of adults in contact with secondary mental health services in paid employment, 2012-13 compared with 2011-12.

**Key points:**
- The proportion of people with mental health problems in employment is considerably higher than comparators and while most of the comparators have seen a drop in numbers since 2011-12 ASC has managed to maintain performance on this measure.

Figure 8.36: ASCOF 1G: Proportion of adults with learning disabilities who live in their own home or with their family, 2012-13 compared with 2011-12.
**Key points:**
- The proportion of adults with learning disabilities living in their own home or with family is higher than comparator averages.

Figure 8.37: ASCOF 1H: Proportion of adults in contact with secondary mental health services who live in their own home or with their family, 2012-13 compared with 2011-12.

**Key points:**
- The proportion of mental health users living in their own home or with family decreased slightly from 2011-12 and was just below comparator averages in 2013-14.

**Assisting discharge – reablement and delayed transfers of care**

Figure 8.38: ASCOF 2B (1): Proportion of older people who were still at home 91 days following discharge from hospital into reablement or rehabilitation services, 2012-13 compared with 2011-12.
**Key points:**
- The proportion of older people still at home 91 days following discharge is slightly lower than comparators.

Figure 8.39: ASCOF 2B (2): Proportion of older people aged 65 and over offered reablement services following discharge from hospital, 2012-13 compared with 2011-12.

![Graph showing the proportion of older people aged 65 and over offered reablement services following discharge from hospital, with data for Merton, London, Outer London, and CIPFA for the years 2011-12 and 2012-13.]

**Key points:**
- The proportion of older people that are offered reablement is noticeably lower than comparators.

Figure 8.40: ASCOF 2C: Delayed transfers of care from hospital per 100,000 population, 2012-13 compared with 2011-12.

![Graph showing the proportion of people who are delayed in hospital longer than they need to be per 100,000 population, with data for Merton, London, Outer London, and CIPFA for the years 2011-12 and 2012-13.]

**Key points:**
- The proportion of people being delayed in hospital once they are ready to leave has reduced since 2011-12 and is noticeably lower than comparators.
What are the gaps?

With integration becoming an increasingly critical issue in the shape of future social care and health services, especially with shrinking budgets it is important that a clearer understanding is developed of integrated care and support as a whole partnership of all key stakeholders across Merton. There needs to be a clearer understanding of the customer journey through the service (including mental health) - in relation to health, social care and the voluntary sector.

Another gap is in relation to self-funders, i.e. individuals who fund their own social care and support and do not take recourse to any public funds. A clear understanding is lacking of who these individuals (their demographics, health and social care issues and need) are and what the role of Adult social Care is in relation to them.

The true cost of social care, including the financial impact of the Care Bill implementation, needs to be determined. As the financial challenges continue for LBM, ASC will have contributed in the region of £12 million savings, as part of the Council’s overall savings programme between the periods 2013-14 and 2016-17. The impact of this budgetary reduction is not yet clear. As care and support funding is being reformed (through the forthcoming Care Bill) the landscape of social care is changing. The ASC customer base could potentially double, which will certainly increase the pressure on the decreasing ASC budget. The ASC savings have however to an extent been offset by some growth. Nonetheless, Merton Council, as much as other councils, is having to look at innovative alternative ways to deliver its statutory responsibilities.

Merton Voice

The ASCOF indicators also capture user views and quality of life outcomes.

User views and Quality of Life Outcomes

Figure 8.41: ASCOF 1A: Social care related quality of life indicator, 2011-12 and 2012-13, Merton and comparators. This indicator gives an overarching view of the quality of life of users of social care. It is based on the outcome domains of social care related quality of life identified in the adult social care outcomes toolkit (ASCOT). It is a composite measure using responses to survey questions covering the eight domains identified in the ASCOT (control, dignity, personal care, food and nutrition, safety, occupation, social participation, and accommodation).
Key points:
- There has been a slight decrease in this indicator since 2011-12 – a decrease in 18-64 and a slight increase in 65+.
- Merton’s indicator is slightly lower than comparator averages.

Figure 8.42: ASCOF 1B: Proportion of people who use services who have control over their daily life, 2011-12 and 2012-13, Merton and comparators.

Key points:
- There has been a slight decrease in this indicator since 2011-12 – a decrease in younger males and a small increase in older females.
- Merton’s indicator is slightly lower than the comparator averages.

Figure 8.43: ASCOF 4A: Proportion of people who use services who feel safe, 2011-12 and 2012-13, Merton and comparators.
**Key points:**
- There has been a decrease in this indicator since 2011-12; a noticeable decrease in 18-64 and a small increase in 65+.

Figure 8.44: ASCOF 4B: Proportion of people who use services who say that those services have made them feel safe and secure, 2011-12 and 2012-13, Merton and comparators.

![Proportion of people who use services who say that those services have made them feel safe and secure](chart)

**Key points:**
- There has been an increase in this indicator since 2011-12 although still low compared with comparators.

Figure 8.45: ASCOF 3A: Overall satisfaction of people who use services with their care and support, 2011-12 and 2012-13, Merton and comparators.

![Overall satisfaction of people who use services with their care and support](chart)
**Key points:**
- There has been an increase in this indicator since last year although still slightly lower than comparators.

**Figure 46: ASCOF 3D: Proportion of people who use services and carers who find it easy to find information about services, 2011-12 and 2012-13, Merton and comparators.**

**Key points:**
- An increase since 2011-12, and better than comparators.

**Summary of other user survey outcomes**

There has been a small decrease in the following outcomes since 2011-12:
- the proportion of people who are happy with their appearance
- the proportion of people who feel they get food and drink when they want
- the proportion of people who are happy with the cleanliness of their accommodation.

There has been a noticeable decrease in the following outcomes since last year:
- The proportion of people who feel they have as much social contact as they want decreased from 70% to 64% (CIPFA 76%).
- The proportion of people who spend time doing things they want to do has decreased from 67% to 59% (CIPFA 66%).
- The proportion of people who feel they are treated with dignity has decreased from 90% to 87% (CIPFA 91%).
Carers’ views and Quality of Life Outcomes

Figure 8.47: ASCOF 3B: Overall satisfaction of carers with social services, 2012-13, Merton and comparators.

Key points:
- This was a new measure for carers in 2012-13. The out-turn was better than comparators.

Figure 8.48: ASCOF 3C: Proportion of carers who report that they have been included or consulted in discussion about the person they care for, 2012-13, Merton and comparators.

Key points:
- This was a new measure for carers in 2012-13. The out-turn was better than comparators.
Other Carers’ views and outcomes:

Similar to the CIPFA average:

ASCOF 1D carer reported quality of life:
- Proportion of carers who spend time doing things they want to do
- Proportion of carers who feel they have control over their daily life
- Proportion of carers who are happy with their appearance
- Proportion of carers who feel safe.

Higher than the CIPFA average:

- Proportion of carers who feel they have as much social contact as they want: 40% (CIPFA 38%).
- Proportion of carers who feel they get enough support in their caring role: 40% (CIPFA 39%).
- Proportion of carers who found it easy to find information and advice about support, services or benefits: 68% (CIPFA 64%).

Customer Satisfaction Surveys:
- There were 325 Customer/Carer Satisfaction responses received from customers following a review of service (59%) or a service from the MILES Team (Merton Independent Living and Engagement Service – 29%). The surveys indicate that a high percentage of customers have found it easy to find information about the support provided by Merton with an increase in those accessing this via the Internet.
- Overall 95% of customers stated that the quality of their life had improved following the services received from LBM. This increased to 97% following review which indicates increased satisfaction once service is established.
- The surveys provide an opportunity for customer/carers to request further information about the services available in Merton and 26% of responses resulted in 200 leaflets being sent to 85 customers/carers.
- An Occupational Therapy Assessment Centre evaluation form was completed by 170 customers of the Occupational Therapy Service who had attended the Centre, which enables people to try out equipment. The responses recorded a 99% satisfaction in the convenience of the date and time given, the time given to customers during the assessment, and the helpfulness of the person who provided the assessment.
- Following this assessment, 95% of customers advised they were able to obtain equipment and/or rails when offered a prescription, which they then redeemed at an accredited retailer for equipment and/or rails.
- The Occupational Therapy Service has recently developed a Customer/Carer Satisfaction Survey, which it has been sending to customers following assessment and provision of equipment since April. To date, the responses received have shown very positive feedback with high levels of satisfaction with the service, with 46% including compliments, many of which were regarding specific workers who supported them during the assessment process and subsequent provision of service.
- Direct payment (DP) customers are sent a Direct Payments Customer Satisfaction Survey to fill in and return in order to establish the DP customer’s views on the services they are receiving. The surveys showed a high level of satisfaction with the service provided and the visits and support received by the DP officers, as well as the information received and the length of time taken to set up the DP. The survey recorded that 80% advised that they would recommend DPs to a friend.
Key commissioning implications

There needs to be even greater emphasis on prevention in both health and social care. This implies greater investment in prevention in those adult and social care programmes and services that will reduce the cost of social care and enable the effective implementation of the key area of the Social Care ‘Efficiency Framework’ on prevention.

There is considerable work under way on health and social care integration in Merton. Integration activities need to focus on aspects that enable joint commissioning, including:

- understanding integrated care and support pathways
- having multidisciplinary teams that cover the commissioning and service provision
- developing integrated performance metrics and data
- improving knowledge management of integrated services

Furthermore, it is important to ensure that integration work does not involve duplication of health and social care resources.

While customer and user engagement is already happening, a framework should be developed to ensure the quality and consistency of such engagement.

With a potential reduction in the ASC budget of around £12 million by 2016-17 under the Council’s savings programme, there needs to be a clear understanding and appraisal of the implications and impact on the organisation and delivery of ASC in Merton in terms of the costs, benefits and outcomes. The ASC savings have to an extent been offset by some growth. Nonetheless, Merton Council, as much as other councils, is having to look at innovative alternative ways to deliver its statutory responsibilities.
MERTON
JOINT STRATEGIC
NEEDS ASSESSMENT
(JSNA)
2013-14

THEME 9:
OLDER ADULTS IN MERTON
Summary

Dementia

Key facts on dementia
Old age is the largest risk factor for dementia and prevalence doubles every five years after the age of 65. Some 68% of all people with dementia are aged over 80 and most will also have co-morbid conditions and illnesses that result in physical impairment.

Alzheimer’s disease (AD) accounts for 62% of all dementias, with vascular dementia and mixed dementia accounting for 27%. Dementia is a leading cause of disability and death in people aged over 65. A progressive disease, it is usually terminal some five to eight years after diagnosis. Women with dementia outnumber men by two to one.

In Merton, it is estimated that 7.2% of women and 5.3% of men aged over 65 have dementia (2007); by 2021, this is predicted to reduce to 6.7% for women and increase to 5.6% for men. It is estimated that the rate of diagnosis in Merton is only 39% (Alzheimer’s Society, 2013), and this is consistent with the low levels of recorded dementia in GP practices across Merton. The NHS Dementia Prevalence Calculator gives the current diagnosis rate in Merton as 42.7% and a dementia gap of 1,100 cases for 2013-14. This is the lower than all other geographical neighbours barring Kingston upon Thames, and all statistical neighbours barring Hounslow.

Key commissioning implications for services to support dementia
A review of Merton’s adult mental health services is currently under way, including dementia services, and will help to inform future commissioning intentions. The recommendations will be included in a refresh of the dementia section of the current JSNA when it is ready.

With the potential increase in the numbers of people aged over 65, if nothing else changes (i.e. proportionally the prevalence of current long-term conditions doesn't change), then there will be a significant increase in the absolute numbers of people with dementia. Given the potential impact on social and health services, consideration needs to be given to the type of support services that will be required to support people with dementia to remain independent for as long as possible. With the impact of reducing resources for both health and social care, there is a need to target resources effectively.

In addition, the NICE quality standards – QS1 and QS30 – should also be considered when commissioning and providing a high-quality dementia service, as well as other relevant quality standards listed in related NICE quality standards.

As mentioned above, the NHS Dementia Prevalence Calculator showed that in Merton only 42.7% of dementia cases are diagnosed, which implies that each year approximately 57% of cases of dementia in the borough go undiagnosed. The Dementia Hub will support individuals to obtain a diagnosis and will work with GPs to improve diagnosis rates. Merton Council will work with Merton CCG and other partners to develop an integrated approach to improving, upgrading and personalising the quality of care for people with dementia and will monitor outputs closely to track improvements.

Falls

Key facts on falls
As older people become frailer they are also more likely to become physically unsteady and fall more. The consequences of falling can be minor, but with increased frailty and
osteooporosis they can be significant resulting in a fractured neck of femur. This is often a turning point and older people recovering from a fall can require more continuing care from both health and social services. Fractures resulting from falls are a major cause of mortality and disability among older people. Falls are generally multi-factorial, with osteoporosis as a major risk factor. The level of fractured hip (neck of femur) is often used as a proxy for the level of falls and can indicate the need for preventative measures.

The rate of hip fractures in people aged 65 and over is significantly lower in Merton (357 per 100,000) compared with England (451 per 100,000), and is the fourth lowest rate of all London boroughs. For over 80 year olds the rate is much higher (1,109 per 100,000), but again this is significantly lower than the England average.

Direct medical costs from fragility fractures to the UK healthcare economy were estimated at £1.8 billion in 2000, with the potential to increase to £2.2 billion by 2025, and with most of these costs relating to hip fracture care.\textsuperscript{152}

\textit{What are the gaps?}

The rapid review of the Sutton and Merton Community Services Falls Prevention Service indicated a few gaps in the service:

- There is no overall falls strategy or strategy group in Sutton and Merton. Neither is there an osteoporosis pathway.
- There is limited assurance of the interface between the service and the voluntary sector and social services, and this needs to be explored further.
- The service has not undertaken an equality impact assessment
- The home response was not actually set up as an ‘Urgent Response’ service, but for those people requiring falls prevention advice at home. It is however now also being used for patients who do not require rehabilitation because there is no existing urgent falls/urgent rehabilitation provision excepting prevention of admission and supported discharge.

\textit{Key commissioning implications for services to prevent falls}

The most common types of fracture related to osteoporosis occur within the hip, vertebral column and wrist. Disability and death rates tend to be higher for hip fractures than for other low trauma fractures. In a population the size of Merton, about 225 hip fractures necessitating treatment would be expected each year. With other low trauma fractures requiring attention it is estimated that there are about 750 episodes costing over £5 million per year. Any inpatient admissions relating to osteoporosis may involve a long length of hospital stay and the fragility of the bones may limit the surgical options available and subsequent mobilisation can sometimes prove to be difficult. In terms of overall costs it is estimated that the financial impact of osteoporosis is second only to circulatory disease.

Given the potential increase in the numbers of people over 65 over the next 10 years (predicted to increase by 21% by 2021), if nothing else changes then there will be an increase in the absolute numbers of people who are likely to fall and require significant health and social care input. Prevention of falls has been shown to significantly reduce the level of fractures. Local authorities have taken over the responsibility for this area of prevention since April 2013.

As mentioned above, a review of the Sutton and Merton Community Services Falls Prevention Service has been recently completed, and this included the following additional recommendations:

- Further investigate an exercise continuum so that participants can move from the NHS led programme into a ‘step down’ community class. As recommended by the Royal College of Physicians (RCP) 2012 National Audit. ‘Commissioners need to commission a local, integrated exercise continuum across health and local authorities/voluntary sector to ensure long term provision of evidence-based exercise programmes for reducing falls run by appropriately qualified staff.’
- Undertake stakeholder engagement with a wider audience, e.g. Age UK and social services, to explore the interfaces more.
- Reinstate a falls focus/strategy group with potential to design an osteoporosis pathway, in conjunction with clinical commissioners.
- Analyse the demographic data and benchmark to known risk groups in the local population. Map service provision to the identified risk groups.
- Analyse data to determine if any ‘spare’ capacity in the service exists and also to determine seasonal variations in uptake and activity.
- Support the service to undertake an equality impact assessment.
- The home response was not actually set up as an ‘Urgent Response’ service, but for those people requiring falls prevention advice at home. It is however now also being used for patients who do not require rehabilitation because there is no existing urgent falls/urgent rehabilitation provision excepting prevention of admission and supported discharge. Commissioners should consider how the gap in the urgent response service needs can be addressed.
- Use falls screening for case finding, using predictive modelling tools. Commissioners should include this in any future service specification.

**Excess winter deaths**

*Key facts on excess winter deaths*

The official winter period is from 1 November to 31 March each season. Excess winter deaths (EWDs) continue to be an important public health issue in the UK, potentially amenable to effective intervention. This excess death is greatest in both relative and absolute terms in elderly people and for certain disease groups. It also varies from area to area. EWDs are also associated with cold weather, but it has been observed that other countries in Europe, especially the colder Scandinavian countries, have relatively fewer excess deaths in winter compared with the UK.

In the past decade, EWDs in Merton have not been statistically significantly different from the England average (measured by the three-year rolling average Excess Winter Deaths Index – EWDI), except in the period 2006-09 where they were significantly higher at 26.4% compared with the England average of 17.5%. In the latest three-year rolling average for 2008-11 the Merton EWDI was 22.7% compared with the England EWDI of 19.1% and was not statistically different. For the last reported winter of 2011-12, Merton had 60 EWDs and was ranked 24th in all London boroughs (1 being the worst in terms of EWDI).

West Midlands Public Health Observatory (WMPHO) publishes data on EWDs on behalf of Public Health Observatories in England that give yearly and three-year rolling averages for
EWDs, overall and by age groups and conditions (e.g. circulatory disease, respiratory disease, stroke). When the data from 2004-11 on EWDs is considered for all respiratory diseases and specifically for chronic lower respiratory diseases, while the Merton EWDI for all respiratory diseases is not statistically significantly different from England and London (see Table 9.4 below), Merton is ranked second worst out of all London boroughs. For specifically chronic lower respiratory diseases, the EWDI for Merton is significantly different from London and England and is ranked the worst in London.

**Key commissioning recommendations to fill the gaps**
The Environmental Health (Housing) Team has legal powers through the Housing Act 2004 to require private landlords to improve cold housing and reduce ‘Excess Cold’ hazards by serving improvement notices.

Current levels of resources limit the team to responding to complaints from the tenants of rented properties. However, a proactive approach could be adopted using additional resources to target rented homes in the more deprived parts of the borough and use formal and informal approaches to secure insulation and heating improvements to homes, reducing the risk of EWDs and fuel poverty.

The successful ‘Warm Homes, Healthy People’ activities should be continued and further developed over forthcoming winters.

**End of life care**

*Key facts on end of life care*

End of life care (EoLC) affects all people regardless of cause. Good EoLC ensures all residents have a dignified, controlled and peaceful end to their life regardless of age and cause of death, ensuring that their choices and wishes are met. In order to achieve a good outcome, the needs of the patient, carer and family should be identified and services provided to meet these needs throughout the last phases of life and into bereavement. EoLC should include management of pain and other symptoms and the provision of psychological, social, spiritual and practical support.

The VOICES Survey showed that 71% of patients wished to die at home, so the proportion of deaths at home is used as a proxy indicator for provision of EoLC. A higher proportion of deaths at home is considered to be desirable. While this is a proxy measure, the home death rate in Merton increased from 12.3% to 16.6% between 2004 and 2009. The measurement was changed to include usual place of residence in 2010 (to include care homes) and the current rate is approximately 36% with over 67.5% of patients with a Coordinate My Care (CMC) record achieving their preferred place of care and death.

**Coordinate My Care (CMC)**

SMPCT was a pilot site for CMC. CMC is an electronic palliative care clinical coordination system (EPaCCS) that gives people with life-limiting illnesses the means to consent to sharing their EoLC records with community nurses, OOH services, LAS and secondary care. It has been developed to enable users’ wishes and preferences for how and where they are treated and cared for as they near the end of their life to be shared. Most importantly it ensures that the appropriate health professional, such as the GP, community nurse, out-of-hours GP, and secondary care professional, legitimately involved in their care, has access to advance care plans and clinical management plans, out of hours.

As of September 2013:

- 1,062 Merton residents have a CMC record.
• 47% of Merton patients with a CMC record have cancer and 53% have non-malignant conditions.
• 79% of patients with a CMC record achieved their preferred priorities of care (PPC) and 67.5% their preferred place of death (PPD).
• 26% of patients with a CMC record died in hospital compared with 54% nationally.

In Merton, there was a greater percentage of males (20.5%) than females (16.1%) that died at home in the period 2008-10. In both cases this was lower than the London and England averages. There are therefore differences by sex for this metric.

What are the gaps in Merton?
An important gap is in relation to the capacity of EoLC Services to spend adequate time with patients and use advanced communication skills to identify the right groups of patients for the services. In addition to capacity, this is also a training issue for community generalists in the EoLC Team and for carers.

If a patient has a CMC record and opts to have care at home, this has implications on capacity and will increase the number of visits required by community professionals in order for this to happen. There needs to be a corresponding shift in resources to community care to address this increased demand on capacity.

A telephone service was previously commissioned from a large bereavement charity to provide bereavement support at home, but this service was not able to meet the needs of the population and was therefore decommissioned. While the reprovision of a service to meet the needs of people in Merton is being reviewed, until a suitable provider is found or alternative ways of providing this service are developed, bereavement support at home remains a gap.

The accessibility to and adaptability of EoLC Services to different faiths have been raised through a Community meeting. Faith groups are now helping to inform the training of EoLC Services staff.

Merton-specific commissioning recommendations
Commissioners should ensure that services continue to raise the population’s awareness of options for care and place of death and dying and also raise awareness of the CMC register so as to increase the number of people with CMC records.

There are plans to review the 2011 EoLC strategy in 2014-15 and it is important that this is undertaken.

Currently there is a gap in providing a bereavement support service in Merton. Commissioners should consider the reprovision of the service through a suitable provider or developing alternative models for providing this service.

Commissioners are recommended to examine the size and nature of the gap in relation to the capacity of EoLC Services to spend adequate time with patients and use advanced communication skills to identify right groups of patients for the services. In addition to capacity, there is also a training issue for community generalists in the EoLC Team and for carers. It is also recommended that commissioners consider how Merton performs in this area compared with other similar boroughs and perhaps learn from best practice in such boroughs that perform better.

Furthermore, commissioners should consider the implications on capacity when patients on CMC increasingly opt for care at home, as this will increase the number of visits required by
community professionals to support this. Consideration should be given as to how to resource the additional work for both community services and primary care services in addressing this potential surge in demand.
Dementia

Key facts on dementia

By far the biggest issue for mental health services for people over the age of 65 is dementia. Dementia has a significant impact on individuals and their families, presents major challenges for health and social services and remains a misunderstood and stigmatised disease. It is a syndrome, a term for a group of diseases and conditions that are characterised by the decline and eventual loss of cognitive functions, such as memory, thinking and reasoning, and by changes in personality and mood.

Old age is the largest risk factor for dementia and prevalence doubles every five years after the age of 65. Some 68% of all people with dementia are aged over 80 and most will also have co-morbid conditions and illnesses that result in physical impairment.

Alzheimer’s disease (AD) accounts for 62% of all dementias, with vascular dementia and mixed dementia accounting for 27%. Dementia is a leading cause of disability and death in people aged over 65. A progressive disease, it is usually terminal some five to eight years after diagnosis. Women with dementia outnumber men by two to one.

In the UK, people from BAME groups make up just 1.7% of the total population affected by dementia. This group is expected to increase by 15% over the next decade. The younger age profile is reflected in the larger proportion of people from BAME groups with early onset dementia, 6.1% [in Merton] compared with 2.2% for the UK153.

In Merton, it is estimated that 63.5% of people with dementia live in the community, of whom two thirds are supported by carers and one third live alone. Approximately 36.5% live in care homes. The majority of residents in care homes for older people have a dementia.

In Merton, it is estimated that 7.2% of women and 5.3% of men aged over 65 have dementia (2007); by 2021, this is predicted to reduce to 6.7% for women and increase to 5.6% for men. It is estimated that the rate of diagnosis in Merton is only 39% (Alzheimer’s Society, 2013), and this is consistent with the low levels of recorded dementia in GP practices across Merton. The NHS Dementia Prevalence Calculator gives the current diagnosis rate in Merton as 42.7% and a dementia gap of 1,100 cases for 2013-14 (this is calculated by estimating the number of dementia cases by applying the adjusted national dementia prevalence by age groups, to the current Merton population and then applying the 42.7% diagnosis rate. The undiagnosed cases are the difference between the two).

Figure 9.1: Estimated prevalence of dementia by gender over time in Merton compared with South West London 2007 and 2021. The first graph shows that the estimated prevalence of dementia in females will reduce from 2007 to 2012 in all SW London boroughs with Merton continuing to have the lowest prevalence in SW London. By contrast the prevalence in males will increase in all SW London boroughs, and, while prevalence of dementia for males in Merton is estimated to increase from 2007 to 2021, Merton continues to have the lowest prevalence in SW London.

Table 9.1 below shows the estimated prevalence of dementia in 2011-12, broken down by estimates in community settings and in residential care. The table also shows the actual numbers diagnosed in the corresponding period according to the Quality and Outcomes Framework (QOF) records. These two numbers enable the calculation of a diagnosis rate which is a percentage derived by dividing the numbers diagnosed by the estimated prevalence in 2011-12. In Merton this is 42.7% which implies that each year approximately 57% of cases of dementia in the borough go undiagnosed. The diagnosis rate allows the estimation of the number of undiagnosed cases which is called the dementia gap. Table 9.1 shows that in Merton it is estimated that there will be 1,100 undiagnosed cases in 2013-14. This is the lower than all other geographical neighbours, barring Kingston upon Thames, and all statistical neighbours, barring Hounslow.

Dementia prevalence is difficult to model, estimate and capture. The national standard for prevalence figures in use is from the Dementia UK report of 2007. However, these figures
are not considered sensitive enough for small populations at general practice level resulting in practice level prevalence being skewed. In order to overcome this skewing the calculator applies the 2007 prevalence to general practice registered populations by age and gender to estimate local prevalence.

Table 9.1: Dementia numbers and forecasts using adjusted dementia prevalence, Merton compared with statistical and geographical neighbours

<table>
<thead>
<tr>
<th></th>
<th>Merton</th>
<th>Croydon</th>
<th>Kingston on Thames</th>
<th>Richmond upon Thames</th>
<th>Sutton</th>
<th>Wandsworth</th>
<th>Barnet</th>
<th>Ealing</th>
<th>Harrow</th>
<th>Hounslow</th>
<th>Redbridge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total estimated number of people with dementia in 2011-2012</td>
<td>1,799</td>
<td>3,690</td>
<td>1,686</td>
<td>1,988</td>
<td>2,118</td>
<td>1,945</td>
<td>4,303</td>
<td>2,684</td>
<td>2,077</td>
<td>1,708</td>
<td>2,495</td>
</tr>
<tr>
<td>This number is estimated as living in the community in 2011-2012</td>
<td>1,307</td>
<td>2,511</td>
<td>1,230</td>
<td>1,563</td>
<td>1,551</td>
<td>1,317</td>
<td>2,914</td>
<td>2,034</td>
<td>1,616</td>
<td>1,324</td>
<td>1,830</td>
</tr>
<tr>
<td>This number is estimated as living in residential care in 2011-2012</td>
<td>492</td>
<td>1,179</td>
<td>456</td>
<td>425</td>
<td>567</td>
<td>628</td>
<td>1,389</td>
<td>650</td>
<td>461</td>
<td>384</td>
<td>665</td>
</tr>
<tr>
<td>Dementia register 2011-2012, this is number of people diagnosed under Qualities &amp; Outcomes Framework (QoF)</td>
<td>769</td>
<td>1,539</td>
<td>666</td>
<td>993</td>
<td>833</td>
<td>730</td>
<td>2,287</td>
<td>1,327</td>
<td>747</td>
<td>745</td>
<td>1,106</td>
</tr>
<tr>
<td>Diagnosis rate 2011-2012, this is the % of the estimated prevalence number that has been diagnosed</td>
<td>42.7</td>
<td>41.7</td>
<td>39.5</td>
<td>50.2</td>
<td>39.3</td>
<td>37.5</td>
<td>53.1</td>
<td>49.4</td>
<td>36</td>
<td>43.6</td>
<td>44.3</td>
</tr>
<tr>
<td>Number of diagnosed cases forecasted in 2013-2014</td>
<td>820</td>
<td>3,948</td>
<td>1,803</td>
<td>2,114</td>
<td>2,262</td>
<td>2,085</td>
<td>4,605</td>
<td>2,870</td>
<td>1,419</td>
<td>1,822</td>
<td>2,666</td>
</tr>
<tr>
<td>Dementia gap - these will be undiagnosed cases in 2013-2014</td>
<td>1,100</td>
<td>2,302</td>
<td>1,091</td>
<td>1,503</td>
<td>1,373</td>
<td>1,303</td>
<td>2,158</td>
<td>1,452</td>
<td>2,216</td>
<td>1,028</td>
<td>1,485</td>
</tr>
<tr>
<td>Number of diagnosed cases forecasted in 2014-2015</td>
<td>837</td>
<td>4,028</td>
<td>1,840</td>
<td>2,157</td>
<td>2,308</td>
<td>2,127</td>
<td>4,699</td>
<td>2,928</td>
<td>2,261</td>
<td>1,859</td>
<td>2,720</td>
</tr>
</tbody>
</table>

Source: NHS Dementia Prevalence Calculator v2.0 08.10.2013
The Adjusted National Dementia Prevalence uses General Practice patient list numbers.

Figures 9.2, 9.3 and 9.4 are graphs depicting the data in Table 9.1 above in diagrammatic form, comparing the estimated numbers diagnosed in 2011-12, the dementia diagnosis rate and the dementia gap in Merton, compared with statistical and geographical neighbours.
Figure 9.2: Estimated number of dementia cases diagnosed in 2011-12 (QOF Dementia Register) in Merton, compared with statistical and geographical neighbours.

Figure 9.3: Estimated dementia diagnosis rate in Merton, compared with statistical and geographical neighbours.
Key facts on services for people with Dementia

The National Dementia Strategy *Living Well with Dementia* (2009) provides a five-year plan toward the development of dementia care services that are fit for the 21st century. The aim of the strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness; earlier diagnosis and intervention; and a higher quality of care. The strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia.

Age affects the type of mental health caseload for mental health services. In older adults high demand for acute services is seen by patients with organic mental health conditions, including conditions such as dementia and Alzheimer’s disease. As the absolute number of older people will increase in future, there is likely to be a greater need and demand for mental health services that support conditions such as dementia.

In terms of gender there is a higher demand for older people’s services by females, particularly for organic disease. This would be expected in terms of longer life expectancy and the major risk factor for dementia being age.

Figures 9.5, 9.6 and 9.7 below are based on locally collected data for 2011-12. The Merton Mental Health Review currently under way will look at the past five years' worth of local data and will be used to update these figures once the analysis is completed.
Breakdown of diagnosis in the Merton Community Mental Health Team for older adults based on average monthly caseload, South West London and St George’s Mental Health NHS Trust, Nov 2011-Oct 2012. The pie chart below shows that for older adults the overwhelmingly commonest condition for which they were seen was organic, which includes dementia, followed by mood disorders and schizophrenia.

Breakdown by Diagnosis of average monthly caseload for Merton Community Mental Health Team (Older People) Nov 2011 to Oct 2012

Breakdown by Diagnosis and Gender for Merton Community Mental Health Team (Older People) Nov 2011 to Oct 2012

Source: SWLSiG Mental Health Trust

<table>
<thead>
<tr>
<th>Condition</th>
<th>Organic (includes Dementia)</th>
<th>Schizophrenia</th>
<th>Mood disorders</th>
<th>Neurotic disorders</th>
<th>Other (Non MH)</th>
<th>Total Caseload</th>
<th>Pending Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>354</td>
<td>13</td>
<td>44</td>
<td>13</td>
<td>8</td>
<td>458</td>
<td>24</td>
</tr>
<tr>
<td>Male</td>
<td>188</td>
<td>8</td>
<td>16</td>
<td>8</td>
<td>234</td>
<td>234</td>
<td>14</td>
</tr>
</tbody>
</table>

* Caseload: for Psychotropic substance, Personality Disorders, and some figures by gender not shown as numbers too low. Numbers less than 5 not included.
In Merton, in terms of ethnicity, while we would expect to see the same proportion of the total caseload for BAME groups as in the general population of over 65 year olds, data from local services would suggest that ethnic groups are under-represented in terms of access to older people's services. The diagnosis of mental health conditions such as dementia in older ethnic groups and the accessibility of services for these conditions warrant further investigation to ensure equity of diagnosis and access across the older ethnic populations.

**Local services in Merton to support dementia care**

**NHS**
For medical diagnosis, treatment and management of dementia the NHS provides services through primary care (GPs) and secondary/tertiary/specialised services through the South West London and St George’s Mental Health NHS Trust. The Mental Health Trust also provides community support through a community mental health team. It is also running a Memory Clinic at Claire House, St George's Hospital, where patients with dementia are reviewed along with their medication. The Memory Clinic also diagnoses people with a diagnosis of dementia for the first time. Breaking bad news, like a diagnosis of dementia, for the person concerned and their family/carer can be very difficult and distressing.

**Merton Council – Social Care**
Merton Council provides a variety of services for people with mild to moderate dementia, who need opportunities for additional social support and contact, and respite for carers – these needs are predominantly met through non-specialist day centres.
The main dementia service commissioned in 2013 by Merton Council is the Merton Dementia Hub situated in Mitcham with additional outreach services held across the borough by the Alzheimer’s Society. The Alzheimer’s Society works in partnership with the Merton Older Peoples CMHT (Community Mental Health Trust) Memory Clinic. Representatives from the Alzheimer’s Society are available to meet and talk with patients and their carers providing advice and support about how best to live well with dementia. The Alzheimer’s Society provides a range of activities and by working in partnership with the Memory Clinic enables everyone to engage in the many activities they provide. The emphasis of the Dementia Hub is very much on early diagnosis, improving prognosis, promoting a dementia friendly borough, and providing a weekly ‘one stop shop’ facility through a dedicated team.

Merton Dementia Hub aims to:

- **Raise awareness and understanding**
  The information worker raises awareness and promotes the benefits of diagnosis amongst professionals and the local community. This includes presentations to community groups and information provision in community settings such as libraries, supermarkets, local shops and places of worship. Developing volunteer capacity across the borough will enhance this activity, particularly within specific communities.

- **Provide early diagnosis and support**
  The Dementia Adviser Service (DAS) supports individuals to obtain a diagnosis and works with newly diagnosed individuals to identify their specific needs and preferred sources and styles of support. An individual support plan then allows identification and signposting to the most appropriate services. Service users are encouraged to return for further planning support when they feel their needs have changed, with the service being accessible to them throughout their dementia journey.

  Facilitated peer support was identified through the consultation for the National Dementia Strategy for England (NDSE) as important to many people affected by dementia following a diagnosis and Merton Dementia Hub offers peer support appropriate for people at this stage as well as further on in the dementia journey. Training provided for carers through Carer Information and Support Programme (CrISP) sessions helps in understanding the condition, developing coping strategies and knowing sources of support.

- **Support the Living Well with Dementia strategy**
  Both the DAS and Dementia Support Workers (DSWs) develop support plans with people and the DSWs will continue with those who need more support to achieve their identified outcomes. They give an individualised service, often through home visits, and provide continuity of service by being available as a person’s condition progresses and their needs change.

Continuing information and support are provided also through peer support activities such as the Dementia Cafes. These, along with activities like Singing for the Brain, also address the social needs of people with dementia and their carers. They can be an opportunity for both
parties to enjoy a more social activity together.

The Merton Dementia Hub provides the following services:

**Dementia Support Service**
A service for people with dementia and their carers, providing:
- information, including a welcome pack with details of local support and services, information sheets, Alzheimer's Society leaflets and newsletter
- telephone and email support and home visits if required
- signposting to other local support services
- encouragement to become socially active
- information and support available weekly at St George's Hospital Memory Clinic.

**Peer Support Service**
- **Support groups for carers:** Friendly informal meetings where carers can support each other and share experiences, information and advice.
- **Younger persons' group:** A group designed specifically for people under 65 with a diagnosis of dementia.
- **The Friday Club:** A meeting place for people with dementia, carers and family members to meet in a relaxed atmosphere to get information and support, to talk freely about dementia and enjoy a range of activities.

**Information Service**
Raising awareness and understanding of dementia in the community through talks, presentations, information stands, forums, media articles and access to a library of factsheets, books and DVDs.

**Workshops**
- **Carers' Information and Support Programme (CrISP)**
  A series of workshops for people caring for a family member or friend with dementia.

  **Singing for the Brain**
  A stimulating group activity, for people in the early to moderate stages of dementia and their carers, which can help with general wellbeing and confidence.

  **Life After Diagnosis (LAD)**
  Support for people with a new diagnosis of dementia.

**Other Dementia Services** commissioned by the Council are:
- **Day Centres** (Woodlands and Eastway Day Centres), which provide:
  - social support to people with dementia and long-term mental health problems
  - short breaks for carers (respite) for carers
  - information and support to carers.

  **South Thames Crossroads:** provides practical support and respite care to carers.

  **Carers Support Merton:** provides support for carers.
Figure 9.8 below describes the Merton roadmap of Dementia Services.

**Figure 9.8: Roadmap of Merton’s Dementia Services.**

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**What works and best practice**

**National Dementia Strategy, *Living Well with Dementia*, 2009**


The National Dementia Strategy *Living Well with Dementia* (2009) provides a five-year plan toward the development of dementia care services that are fit for the 21st century. The aim of the strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness; earlier diagnosis and intervention; and a higher quality of care. The strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia.

**NICE quality standard for supporting people to live well with dementia (QS30), April 2013**

[Link](http://publications.nice.org.uk/quality-standard-for-supporting-people-to-live-well-with-dementia_qs30)

This quality standard covers supporting people to live well with dementia. It applies to all social care settings and services working with and caring for people with dementia. It should be read alongside the NICE dementia quality standard (QS1) (see below), which covers care...
provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings.

**NICE Dementia quality standard (QS1), June 2010**
http://publications.nice.org.uk/dementia-quality-standard-qs1
This quality standard covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings. It should be read alongside the NICE supporting people to live well with dementia quality standard (QS30) (see above), which applies to all social care settings and services working with and caring for people with dementia.

**Merton’s Joint Commissioning Strategy 2010-2015** is built around the outcome objectives of the National Dementia Strategy, ‘Living Well with Dementia’ (2009). In particular Merton is focusing on raising awareness and understanding of dementia, and ensuring early diagnosis and support. The newly commissioned ‘Dementia Hub’ delivered with the Alzheimer’s Society will implement these objectives. Service outcomes will include enhanced quality of life for people with care and support, ensuring people have a positive experience of this care and support, and delaying or reducing the need for council-funded social care.

**What are the gaps?**

Currently a detailed review of adult mental health services is under way in Merton, which includes a mental health needs assessment and covers dementia too. The review will result in the development of an adult mental health strategy for Merton and will be used to update the dementia and mental health sections of the JSNA.

**Merton Voice**

A workshop was held on 26 July 2012 with customers and carers about dementia services. This was organised by Merton Council and the key themes that emerged, and helped shape current services, were:

*Information and advice*

Participants frequently talked about different aspects of information and advice that they wanted. Key to this was a feeling that information from health professionals, especially GPs, was important – especially information about dementia itself and what to expect as the disease progresses. There was also strong feeling that information needs to be readily available stage by stage as dementia progresses to help to plan and to understand what to expect at each stage of the disease and how to cope with it. Several people mentioned that they would like to have received a ‘dementia roadmap’ that showed what to expect and where to get help at different parts of the journey. Some mentioned the need for advice about how to cope with reduced mental capacity to make informed decisions.
A number of participants expressed some concern about accessibility of information on the Internet as they felt they could not access this. Some wanted leaflets, books and other printed resources.

There were concerns about emergency planning and planning for the future as well as the need for advice about financial support and benefit entitlement. People appreciated general information but also wanted specifically local resources and information.

Several participants highlighted the importance of faster diagnosis to allow for considering information and planning.

**Support**
Participants mentioned a wide variety of services that they found helpful. It is worth noting that the services that people found most helpful often shifted as dementia progressed. Most importantly, people wanted a variety of services that gave them choice and flexibility. In particular people mentioned peer support (both for carers and customers), the opportunity for activities, trips and outings for carers, customers and both together, respite that was flexible enough to allow carers a real break of their choosing, telephone support, and specialist affordable day-care options.

Many people did note how valuable they find some of the services that they currently receive.

**Accessibility of services**
Many people felt that they had been inundated with confusing amounts of paperwork that seemed to be repeated by different agencies and felt that this could be simplified. They also felt that some services did not work closely enough together and could perhaps do more to collaborate.

Concerns were expressed that some services are too inflexible to allow for choice and dignity to be paramount – for example respite that was too short to allow for the carer to do more than get briefly to the local shop or a customer being put to bed at 5pm because that was when the support was available.

Several times people said that they felt that some services were more expensive than they could afford and that this was a concern.

**Quality of services**
Particular emphasis was given to the importance of the quality and continuity of services. Participants highlighted concerns that there was a need to offer more training in some non-specialist settings such as primary care, hospitals and other community settings so that people become more aware of how to better support people with dementia. Also emphasised was the importance of having excellent home care practice and services with well-trained care support workers who understand dementia.

Participants wanted communication from agencies to be clear and in plain English.
The importance of personalised services that take full account of an individual’s needs, including changes as the disease progresses, was raised regularly, along with the need for continuity of personnel, especially for the people with dementia.

Dementia hub
The suggested idea of a dementia hub in the borough was broadly welcomed by participants. Most people felt that the idea of a central place to go, as long as it was well publicised, especially by GPs, was good. Some concerns were raised about where this might be and whether it would be accessible. People raised a wide range of things that they would value from a hub, including:

- things to do together with the cared-for and other carers
- social activities/friendships for the cared-for – memory activities, group activities
- open access to services (clinicians, dementia consultants, psychiatric nurses, chiropodist/podiatry, challenging behaviour team, referral for home services, physio, hairdresser, optician, dentist, fall prevention specialist, and telecare were all suggested)
- training venue – place to educate carers about how to cope/manage with their relations – all stages from onset to late stages, including depression
- 24-hour phone line
- physical and virtual support
- somewhere to go to get a break
easy access – good transport links, support to get to the hub, parking available
- educating others about dementia awareness
- some kind of mobile hub was suggested
- information on what is available in Merton
- a one-stop shop
- information, books, benefits etc.
- an assessment clinic – quicker diagnosis
- reminiscence resources
- open house for carers – for peer support and help to understand stages of dementia
- a cup of tea
- ex-carers who have a wealth of knowledge who would be willing to share their own experience
- a hub would be a good place to meet (this would need facilitating).

Key commissioning implications for services to support dementia

As mentioned earlier, the Merton adult mental health services review is currently under way, including dementia services, and will help to inform future commissioning intentions. The recommendations will be included in a refresh of the dementia section of the current JSNA when it is ready and available. Additionally LBM is revising the local dementia strategy to address many of these challenges.

With the potential increase in the numbers of people aged over 65, if nothing else changes (i.e. proportionally the prevalence of current long-term conditions doesn't change), then there will be a significant increase in the absolute numbers of people with dementia. Given the potential impact on social and health services, consideration needs to be given to the type of support services that will be required to support people with dementia to remain independent
for as long as possible. With the impact of reducing resources for both health and social care, there is a need to target resources effectively.

In addition, the NICE quality standards – QS1 and QS30 (see above) – should also be considered when commissioning and providing a high-quality dementia service, as well as other relevant quality standards listed in related NICE quality standards.

The NHS Dementia Prevalence Calculator showed that in Merton only 42.7% of dementia cases are diagnosed, which implies that each year approximately 57% of cases of dementia in the borough go undiagnosed. Merton Dementia Hub will support individuals to obtain a diagnosis and will work with GPs to improve diagnosis rates. Merton Council will work with Merton CCG and other partners to develop an integrated approach to improving, upgrading and personalising the quality of care for people with dementia and will monitor outputs closely to track improvements.
Falls

Key facts on falls

Older people are not a homogeneous group, particularly when ethnic background is also considered, and they have a wide range of needs. However, older people may be broadly divided into three groups:

- **Entering old age** – These are people entering into the age at which people traditionally retire (a socially-constructed definition of old age). In general, this group of people are active and independent and many remain so into late old age. The goals of health and social care policy are to promote and extend healthy active life and to compress morbidity (the period of life before death spent in frailty and dependency).

- **Transitional phase** – This group of older people are in transition between healthy, active life and frailty. The goals of health and social care policy are to identify emerging problems ahead of crisis, and ensure effective responses to prevent crisis and reduce long-term dependency.

- **Frail older people** – This group of people are vulnerable as a result of health problems, social care needs, or a combination of both. The goals of health and social care policy are to anticipate and respond to problems, recognising the complex interaction of physical, mental and social care factors that can compromise independence and quality of life.

The conditions that older people are more at risk of getting are chronic diseases, such as circulatory disease, COPD or bronchitis, osteoporosis and dementia. However, as older people become frailer they are also more likely to become physically unsteady and fall more. The consequences of falling can be minor, but with increased frailty and osteoporosis they can be significant, resulting in a fractured neck of femur. This is often a turning point and older people recovering from a fall can require more continuing care from both health and social services.

Fractures resulting from falls are a major cause of mortality and disability among older people. Falls are generally multi-factorial, with osteoporosis as a major risk factor. The level of fractured hip (neck of femur) is often used as a proxy for the level of falls and can indicate the need for preventative measures.

The rate of hip fractures in people aged 65 and over is significantly lower in Merton (357 per 100,000) compared with England (451 per 100,000), and is the fourth lowest rate of all London boroughs. For over 80 year olds the rate is much higher (1,109 per 100,000), but again this is significantly lower than the England average.

Direct medical costs from fragility fractures to the UK healthcare economy were estimated at £1.8 billion in 2000, with the potential to increase to £2.2 billion by 2025, and with most of these costs relating to hip fracture care.154

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The map in Figure 9.10 below shows hospital admissions for falls in people over 65 years, which shows higher rates in areas where there are higher numbers of older people living. There are slightly higher rates in areas where the older deprived population live but this association is weak.

The rate of deaths from fractured neck of femur (see Figure 9.11 below) is disproportionately high compared with other areas in South West London and compared with London and national rates. However, caution should be applied when interpreting this data as absolute numbers are small and due to the way that deaths are classified.

Figure 9.9: Hip fractures in people aged 65 and over in Merton compared with other London boroughs and England, 2010/11. This graph shows that Merton has the fourth lowest rate of hip fractures in the 65 years and over age group in London.
Figure 9.10: Merton map of admissions for fracture in people aged 65 and over, 2011-12 by MSOA. This map depicts the number of hospital admissions due to falls for those aged 65 years and over, showing that a significant proportion of falls admissions takes place in the south of the borough and in parts of West Merton.

Number of hospital admissions due to falls for those aged 65 and over, 2011-12, by MSOA
Source: Sutton and Merton PCT

<table>
<thead>
<tr>
<th>Key</th>
<th>Number of falls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 to 20</td>
</tr>
<tr>
<td></td>
<td>22 to 26</td>
</tr>
<tr>
<td></td>
<td>27 to 36</td>
</tr>
<tr>
<td></td>
<td>37 to 59</td>
</tr>
</tbody>
</table>

Map: ©Crown copyright 2013. All rights reserved. ©1994-2013 ACTIVE Solutions Europe Ltd.
Figure 9.11: Comparison of mortality rates from fractured neck of femur – all ages, comparing Merton with South West London boroughs, 2008-10. The graph shows that Merton has the highest rate of mortality from fractured neck of femur compared with other South West London boroughs and this is higher than London and England as well.

**Mortality from Fractured Neck of Femur, all ages comparing Merton with South West London**

*Source: NHS Information Centre 2008-10*

<table>
<thead>
<tr>
<th>Borough</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merton</td>
<td>4.21</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>3.05</td>
</tr>
<tr>
<td>Sutton</td>
<td>2.21</td>
</tr>
<tr>
<td>Richmond</td>
<td>1.66</td>
</tr>
<tr>
<td>Croydon</td>
<td>1.11</td>
</tr>
<tr>
<td>Kingston</td>
<td>0.42</td>
</tr>
<tr>
<td>London</td>
<td>1.86</td>
</tr>
<tr>
<td>England</td>
<td>2.49</td>
</tr>
</tbody>
</table>

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**Key facts on Falls Prevention Service**

Merton Public Health commissions a community Falls Prevention Service jointly with Sutton Public Health under the Sutton and Merton Community Services. The service is provided by The Royal Marsden Hospital. The overall service aim is to reduce falls and fractures in older people and is designed to empower patients to improve functional mobility, gain confidence and increase their knowledge of falls prevention. This is delivered by a therapy-based intervention either in a client’s home or in a community setting. The Falls Prevention Services operates as follows:

- It receives referrals from health professionals including GPs.
- It has links with NHS secondary care, social services and the voluntary sector as part of the Sutton and Merton Falls Pathway.
- It is staffed by a falls coordinator, an administrator, senior physiotherapists and assistant practitioners.
- Its core offer is six to eight Staying Steady classes per week x 48 weeks per annum. Classes are of eight weeks’ duration with follow-up services.
- It provides an ‘OTAGO’ type home exercise plan for those unable to participate in group exercise.

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155 OTAGO, named after University of Otago, New Zealand, is a home-based exercise programme.
It also includes a Home Response Team for falls prevention which operates in conjunction with LAS, the Rapid Response Team and Mascot home alerts.

It supports the fracture liaison service by providing prevention to those at high risk of falls with fractures.

It uses falls screening for case finding using predictive modelling tools.

It promotes National Falls Awareness week.

It provides falls awareness talks and health promotion.

Table 9.2: Merton Community Falls Prevention Service: Number of referrals and participants monthly, April 2012-March 2013.

<table>
<thead>
<tr>
<th>MERTON BOROUGH</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of accepted referrals</td>
<td>25</td>
<td>28</td>
<td>20</td>
<td>31</td>
<td>32</td>
<td>28</td>
<td>23</td>
<td>22</td>
<td>16</td>
<td>18</td>
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<td>Home response referrals</td>
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<td>5</td>
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<td>15</td>
<td>8</td>
<td>12</td>
<td>7</td>
<td>13</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Falls classes</td>
<td>19</td>
<td>19</td>
<td>14</td>
<td>15</td>
<td>9</td>
<td>21</td>
<td>13</td>
<td>9</td>
<td>8</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>OTAGO home-exercise programme</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The ‘Staying Steady’ classes are run in two venues in Merton. The venues are selected for accessibility, particularly in terms of good public transport links. All the venues are community based with suitable facilities for the classes. They are:

- Morden Baptist Church – Morden
- Holy Trinity Church – Wimbledon.

What works and best practice

What works to reduce accidents in older people?

- Multi-faceted falls prevention, including home exercise programmes; medication review; assessment of balance, gait, and blood pressure; and addressing environmental risk factors.
- Handrails can produce a 60% reduction in falls.
- Among those with low impact fractures, treatment for osteoporosis reduces the chance of further fracture.
The Department of Health guidance document: *Falls and fractures: effective interventions in health and social care*, 2009

This document recommends a systematic approach to falls and fracture prevention. Objective three is ‘Early intervention to restore independence and reduce future injuries’. This consists of the following interventions in the community:

- A falls care pathway
- A falls service
- A falls coordinator
- Multi-factorial interventions
- Community-based therapeutic exercise.

NICE Clinical Guideline CG161: *Falls: assessment and prevention of falls in older people*, June 2013

This guideline provides recommendations for the assessment and prevention of falls in older people. It is an extension to the remit of NICE clinical guideline 21 (published November 2004) to include assessing and preventing falls in older people during a hospital stay (inpatients). The new recommendations for older people in hospital (2013) sit alongside the original recommendations from the 2004 guideline. It is important to emphasise that all of the 2004 recommendations are just as relevant and important now as they were when they were originally published.

The following recommendations have been identified as key priorities for implementation:

Preventing falls in older people

- Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.
- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multi-factorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multi-factorial intervention.

Preventing falls in older people during a hospital stay

- Regard the following groups of inpatients as being at risk of falling in hospital and manage their care according to recommendations:
  - all patients aged 65 years or older
  - patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition.
- For patients at risk of falling in hospital, consider a multi-factorial assessment and a multi-factorial intervention.
• Ensure that any multi-factorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay. These may include:
  o cognitive impairment
  o continence problems
  o falls history, including causes and consequences (such as injury and fear of falling)
  o footwear that is unsuitable or missing
  o health problems that may increase their risk of falling
  o medication
  o postural instability, mobility problems and/or balance problems
  o syncope syndrome
  o visual impairment.

NICE Clinical Guideline CG146: Osteoporosis: assessing the risk of fragility fracture, August 2012
Fragility fractures are fractures that result from mechanical forces that would not ordinarily result in fracture, known as low-level (or 'low energy') trauma. The World Health Organization (WHO) has quantified this as forces equivalent to a fall from a standing height or less. Reduced bone density is a major risk factor for fragility fracture. Other factors that may affect the risk of fragility fracture include the use of oral or systemic glucocorticoids, age, sex, previous fractures and family history of osteoporosis. Because of increased bone loss after the menopause in women, and age-related bone loss in both women and men, the prevalence of osteoporosis increases markedly with age, from 2% at 50 years to more than 25% at 80 years in women. As the longevity of the population increases, so will the incidence of osteoporosis and fragility fracture. This guideline offers best practice advice on the assessment of fragility fracture risk in adults.

Royal College of Physicians: Falling Standards, broken promises: report of the national audit of falls and bone health in older people, 2010
http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf
Data has been collected and analysed on the clinical care of 9,567 patients who had sustained a fragility fracture following a fall in 2010. Over 90% of healthcare organisations in England, Wales, Northern Ireland and the Islands participated in this audit – including 100% of acute trusts. The report describes the headline findings and recommendations from this national audit of the organisation and provision of falls and bone health services for older people. Results from 16 Key Indicators are being made available in the public domain for all participating commissioning and provider organisations. This report includes site-by-site results on the Key Indicators for these healthcare organisations.

What are the gaps?

The rapid review of the Sutton and Merton Falls Prevention Service indicated a few gaps in the service:
• There is no overall falls strategy or strategy group in Sutton and Merton. Neither is there an osteoporosis pathway.
• There is limited assurance of the interface between the service and the voluntary sector and social services, and this needs to be explored further.
• The service has not undertaken an equality impact assessment
• The home response was not actually set up as an ‘Urgent Response’ service, but for those people requiring falls prevention advice at home. It is however now also being used for patients who do not require rehabilitation because there is no existing urgent falls/urgent rehabilitation provision excepting prevention of admission and supported discharge.

**Merton Voice**

**Assessment of service user experience**
All participants of the ‘Staying Steady’ classes are requested to complete a patient questionnaire. The service presented a paper to commissioners on the patient questionnaire April 2012–February 2013. The questionnaire consists of three sections:
• Patient perception of the classes
• Patient perception of the effectiveness of the class
• Patient understanding of the benefits of the class and motivation.

The responses were all scored highly with positive participant comments. Although ‘transport is reliable’ is a criteria there are no questions on acceptability of class timings or locations.

**Royal College of Physicians 2012 National Patient Satisfaction Audit**
Additionally the ‘Staying Steady’ service was a participating site in the Royal College of Physicians 2012 National Patient Satisfaction Audit. In October 2011, each participating site was sent 40 questionnaires to be distributed to patients. The service was able to identify 40 patients that met the sample criteria. There were 21 patient questionnaires in the analysis equating to a response rate of 52.5%. From the responses, 100% found the exercise class ‘satisfactory’ with the majority stating that the waiting time was ‘about right’. The majority continued exercise on discharge underpinning the positive ‘exercise for life’ message.

**Key commissioning implications for services to prevent falls**

The most common types of fracture related to osteoporosis occur within the hip, vertebral column and wrist. Disability and death rates tend to be higher for hip fractures than for other low trauma fractures. In a population the size of Merton, about 225 hip fractures necessitating treatment would be expected each year. With other low trauma fractures requiring attention it is estimated that there are about 750 episodes costing over £5 million per year. Any inpatient admissions relating to osteoporosis may involve a long length of hospital stay and the fragility of the bones may limit the surgical options available and subsequent mobilisation can sometimes prove to be difficult. In terms of overall costs it is estimated that the financial impact of osteoporosis is second only to circulatory disease.

Given the potential increase in the numbers of people over 65 over the next 10 years (predicted to increase by 21% by 2021), if nothing else changes then there will be an
increase in the absolute numbers of people who are likely to fall and require significant health and social care input. Prevention of falls has been shown to significantly reduce the level of fractures. Local Authorities have taken over the responsibility for this area of prevention since April 2013.

A review of the Sutton and Merton Community Services Falls Prevention Service has been recently completed, and this included the following additional recommendations:

- Further investigate an exercise continuum so that participants can move from the NHS-led programme into a ‘step down’ community class. As recommended by the RCP 2012 National Audit.

  ‘Commissioners need to commission a local, integrated exercise continuum across health and local authorities/voluntary sector to ensure long term provision of evidence-based exercise programmes for reducing falls run by appropriately qualified staff.’

- Undertake stakeholder engagement with a wider audience, e.g. Age UK and social services, to explore the interfaces more.
- Reinstate a falls focus/strategy group with potential to design an osteoporosis pathway, in conjunction with clinical commissioners.
- Analyse the demographic data and benchmark to known risk groups in the local population. Map service provision to the identified risk groups.
- Analyse data to determine if any ‘spare’ capacity in the service exists and also to determine seasonal variations in uptake and activity.
- Support the service to undertake an equality impact assessment
- The home response was not actually set up as an ‘Urgent Response’ service, but for those people requiring falls prevention advice at home. It is however now also being used for patients who do not require rehabilitation because there is no existing urgent falls/urgent rehabilitation provision excepting prevention of admission and supported discharge. Commissioners should consider how the gap in urgent response service needs can be addressed.
- Use falls screening for case finding using predictive modelling tools. Commissioners should include this in any future service specification.
Excess Winter Deaths

Key facts on excess winter deaths (EWDs) in England and Wales

The official winter period is from 1 November to 31 March each season. Excess winter deaths (EWDs) continue to be an important public health issue in the UK, potentially amenable to effective intervention. This excess death is greatest in both relative and absolute terms in elderly people and for certain disease groups. It also varies from area to area. EWDs are also associated with cold weather, but it has been observed that other countries in Europe, especially the colder Scandinavian countries, have relatively fewer excess deaths in winter compared with the UK.

Information on EWDs is important in:
- tackling certain premature deaths
- supporting energy efficient interventions in housing
- encouraging fuel poverty referral.

Older people are more vulnerable than others during the winter; hence there are a range of policies aimed at tackling EWDs aimed at older people. Although EWDs are often associated with low temperatures, conditions relating directly to cold, such as hypothermia, are not the main cause of excess winter mortality. The majority of additional winter deaths are caused by respiratory diseases, circulatory diseases and dementia and Alzheimer’s disease.\(^{156}\)

Excess winter mortality is apparent across many European countries, but paradoxically it is more evident in countries such as the UK, and warmer countries such as Portugal and Spain, than in colder countries such as Scandinavian countries. The number of extra deaths occurring in winter varies depending not only on temperature, but also on other factors such as level of circulating flu.

Definitions

Excess winter deaths (EWDs) are a measure of the number of deaths in the four winter months (December to March) minus the average number of deaths during the preceding four months (August to December) and the subsequent four months (April to July).

Excess Winter Deaths Index (EWDI) is the excess winter deaths expressed as a percentage of the average number of deaths in the autumn and summer months (April to November).

Recently, the Public Health Outcomes Framework *Healthy lives, healthy people: Improving outcomes and supporting transparency*, published in January 2012, proposed reducing excess winter mortality as one of the outlined outcomes for the ‘Healthcare public health and preventing premature mortality’ domain.

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Key findings

- An estimated 31,100 EWDs occurred in England and Wales in 2012-13 – a 29% increase compared with the previous winter.
- As in previous years, there were more EWDs in females than in males in 2012-13.
- Between 2011-12 and 2012-13 male EWDs increased from 10,590 to 13,100, and female deaths from 13,610 to 18,000.
- The majority of deaths occurred among those aged 75 and over; there were 25,600 excess deaths in winter in this age group in 2012-13 compared with 5,500 in people aged under 75.
- The excess winter mortality index was highest in the North West in 2012-13 and lowest in London. London had the highest level of excess winter mortality in 2011-12.

However the Excess Winter Mortality Report 2012-13, which was published by Public Health England in August 2013, indicates that in the winter of 2012-13 the number of observed deaths registered was higher than expected.

Overall excess mortality (England and Wales)
The Office for National Statistics (ONS) collates and reports to PHE estimated total all-cause death registrations every week. PHE uses this data to statistically estimate the expected number of weekly death registrations for a given week in the year through a well-established regression model. PHE can then assess whether the numbers of observed death registrations are significantly higher than the calculated expected numbers, allowing for variation, thus indicating an excess in all-cause mortality.

- The number of observed death registrations during 2012-13 was higher than expected. Out of 32 weeks (week 40 in 2012 to week 20 in 2013) 25 (78%) were above baseline levels and 14 (44%) were above the upper significance limit.
- Further analysis of subdivisions of all-cause data showed the excess to be found predominantly in the elderly (85 years and over) and in deaths coded as resulting from respiratory causes (typically seen in winter when temperatures are low and influenza is circulating).

Age group

- The pattern of excess mortality by week of death corresponded to the pattern observed by week of death registration. During 2012-13, two periods of excess mortality were seen in England across all regions: firstly for four weeks from week 50 in 2012 to week 1 in 2013, and secondly from weeks 9 to 15 in 2013.

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When an age group was modelled, excess mortality was seen in the over 65s in the same weeks as above (week 50 in 2012 to week 1 in 2013 and weeks 9 to 15 in 2013). A small excess was also seen for one week in the 5-14 year age group (week 51 in 2012). No significant excess was seen in the under five year olds or among the 15-64 year olds.

The cumulative number of excess deaths among the over 65s (defined as the number of deaths relative to the baseline summed across the season) during 2012-13 is the highest since 2008-09. A similar observation was made in several countries across Europe.

Conclusions

- 2012-13 has seen the largest excess all-cause mortality in England since 2008-09.
- Further analysis showed the excess was found predominantly in the elderly and in deaths coded as resulting from respiratory causes.
- The magnitude of excess all-cause mortality varied considerably by region within England.
- Excess mortality in 2012-13 coincided with influenza, respiratory syncytial virus (RSV) and cold weather, with an unusually prolonged influenza season and late cold period reported.
- Statistical regression modelling of excess mortality over the past few seasons, including 2012-13, has shown influenza to be a major explanatory factor.

Excess winter deaths in Merton

In the past decade the EWDs in Merton have not been statistically significantly different from the England average (measured by the three-year rolling average Excess Winter Deaths Index – EWDI), except in the period 2006-09 where they were significantly higher at 26.4% compared with the England average of 17.5%. In the latest three-year rolling average for 2008-11 the Merton EWDI was 22.7% compared with the England EWDI of 19.1% and was not statistically different. For the last reported winter of 2011-12, Merton had 60 EWDs and was ranked 24th in all London boroughs (1 being the worst in terms of EWDI) (see Table 9.3 below).

West Midlands Public Health Observatory (WMPHO) publishes data on EWDs on behalf of Public Health Observatories in England that give yearly and three-year rolling averages for EWDs, overall, and also by age groups and conditions (e.g. circulatory disease, respiratory disease, stroke). When data from 2004-11 for EWDs is considered for all respiratory diseases and specifically for chronic lower respiratory diseases, while the Merton EWDI for all respiratory diseases is not statistically significantly different from England and London (see Table 9.4 below), Merton is ranked second worst out of all London boroughs. For specifically chronic lower respiratory diseases, the EWDI for Merton is significantly different from London and England, and is ranked the worst in London (see Table 5 below).

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<table>
<thead>
<tr>
<th>Excess winter deaths. Data of 2010-2011</th>
<th>Observed (Excess)</th>
<th>Excess Winter Deaths Index (%) (EWDI)*</th>
<th>Lower CI** Limit 95%</th>
<th>Upper CI Limit 95%</th>
<th>Ranking of EWDI in London boroughs (1= worst)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England</strong></td>
<td>22,960</td>
<td>15.8</td>
<td>15.6</td>
<td>16.0</td>
<td></td>
</tr>
<tr>
<td><strong>London</strong></td>
<td>2,800</td>
<td>18.8</td>
<td>18.1</td>
<td>19.5</td>
<td></td>
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<tr>
<td><strong>Merton</strong></td>
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<td>15.0</td>
<td>11.1</td>
<td>18.9</td>
<td>24</td>
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<tr>
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<td>21.7</td>
<td>18.3</td>
<td>25.1</td>
<td>2</td>
</tr>
<tr>
<td>Croydon</td>
<td>130</td>
<td>17.0</td>
<td>14.1</td>
<td>19.9</td>
<td>19</td>
</tr>
<tr>
<td>Ealing</td>
<td>160</td>
<td>27.6</td>
<td>23.3</td>
<td>31.9</td>
<td>3</td>
</tr>
<tr>
<td>Harrow</td>
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<td>13.9</td>
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<tr>
<td>Hounslow</td>
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<td>13</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
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<td>Redbridge</td>
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<tr>
<td>Richmond upon Thames</td>
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<td>8.2</td>
<td>15.0</td>
<td>29</td>
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<tr>
<td>Sutton</td>
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<td>11.9</td>
<td>19.3</td>
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</tr>
<tr>
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<td>27.2</td>
<td>22.4</td>
<td>31.9</td>
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</tbody>
</table>

Source: Atlas produced by the West Midlands Public Health Observatory on behalf of the Public Health Observatories in England, November 2013

* Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths expressed as a percentage.

** CI stands for confidence interval, which is the range of values in which the true population value of EWDI lies. This allows us to estimate statistically the precision of the value. The narrower the interval between the lower and upper confidence intervals, the more precise the estimate. When comparing values between Merton and other places, if the intervals overlap this tells us that the observed differences are not statistically significant and vice versa.
Table 9.4: Excess winter deaths due to all respiratory diseases, 2004-11 for Merton, London and England.

<table>
<thead>
<tr>
<th>Excess winter deaths. Data of 2004-2011 All Respiratory Diseases</th>
<th>Observed (Excess)</th>
<th>Expected</th>
<th>Excess Winter Deaths Index (%) (EWDI)*</th>
<th>Lower CI** Limit 95%</th>
<th>Upper CI Limit 95%</th>
<th>Ranking of EWDI in London boroughs (1= worst)</th>
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<tbody>
<tr>
<td>England</td>
<td>66,002</td>
<td>129,552</td>
<td>51</td>
<td>50</td>
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<td>London</td>
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<td>14,037</td>
<td>48</td>
<td>46</td>
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<tr>
<td>Merton</td>
<td>202</td>
<td>322</td>
<td>63</td>
<td>45</td>
<td>83</td>
<td>2</td>
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</tbody>
</table>

Table 9.5: Excess winter deaths due to chronic lower respiratory diseases, 2004-11 for Merton, London and England.

<table>
<thead>
<tr>
<th>Excess winter deaths. Data of 2004-2011 Chronic Lower Respiratory Diseases</th>
<th>Observed (Excess)</th>
<th>Expected</th>
<th>Excess Winter Deaths Index (%) (EWDI)*</th>
<th>Lower CI** Limit 95%</th>
<th>Upper CI Limit 95%</th>
<th>Ranking of EWDI in London boroughs (1= worst)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>23,502</td>
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<td>48</td>
<td>47</td>
<td>50</td>
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<td>London</td>
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<td>5,316</td>
<td>43</td>
<td>39</td>
<td>48</td>
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<tr>
<td>Merton</td>
<td>93</td>
<td>107</td>
<td>87</td>
<td>54</td>
<td>127</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Atlas produced by the West Midlands Public Health Observatory on behalf of the Public Health Observatories in England, January 2013

* Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths expressed as a percentage.

** CI stands for confidence interval, which is the range of values in which the true population value of EWDI lies. This allows us to estimate statistically the precision of the value. The narrower the interval between the lower and upper confidence intervals, the more precise the estimate. When comparing values between Merton and other places, if the intervals overlap this tells us that the observed differences are not statistically significant and vice versa.

In general deaths from respiratory diseases are responsible for much of the increases seen during winter months, and in Merton this seems to have been significantly higher than almost all London boroughs over the period from 2004 to 2011. However the numbers are still small, as on average this equates to approximately 25 excess winter deaths per year on account of all respiratory disease for the period 2004-11. But some of these deaths would have been preventable.
Key facts on services

Merton

- Guidance, advice and uptake of benefits all help to increase people’s awareness of the risks associated with winter temperatures. The Merton Health and Warmth Partnership produces an Annual Energy Saving Guide, in partnership with Merton Seniors Forum, Age UK Merton and Merton Council.
- Other local initiatives include the Wandle Valley Low Carbon Zone, which visit homes in Phipps Bridge and Cherry Tree estates offering energy saving advice. This includes an energy survey of the home, discussion, advice and information about energy use, suppliers, tariffs, grants; and fitting of free devices (worth up to £85) to help save energy and water.
- Merton Council’s Environmental Health Team has successfully worked with a number of energy companies over the past few years to secure investment in the heating and insulation of private homes across the borough.
- Work is under way to secure significant further funding from energy companies through their ‘ECO’ (Energy Company Obligation) funds in order to replace old and inefficient boilers and provide solid wall insulation for the benefit of older and disabled households on low incomes who are most likely to be in fuel poverty.
- The Department of Health has provided funds to run ‘Warm Homes Healthy People’ programmes over the winters of 2011-12 and 2012-13. Merton was awarded £174,000 for 2011-12 and £312,000 for 2012-13, more than any other London borough. It used these funds to provide extreme temperature sensors and carbon monoxide detectors for MASCOT Telecare clients across the borough, to provide energy-saving home visits and additional insulation and heating to private homes, to publish and distribute the energy saving guides, and to train outreach workers from across the borough, volunteers and the health sector to help identify those at risk of excess cold.

Cold weather related heating and housing benefits

The Government provides heating and housing benefits in relation to cold weather:

- **Cold Weather Payment** – eligible individuals could get a payment of £25 for each seven-day period of very cold weather between 1 November and 31 March. ([https://www.gov.uk/cold-weather-payment](https://www.gov.uk/cold-weather-payment))
- **Green Deal scheme: Energy saving for homes and businesses** – The Green Deal scheme can help individuals make energy-saving improvements to their home or business, such as insulation, heating, draught-proofing, double glazing, renewable energy generation. ([https://www.gov.uk/green-deal-energy-saving-measures](https://www.gov.uk/green-deal-energy-saving-measures))
- **The Warm Home Discount Scheme** – eligible individuals can get a £135 discount on electricity bills for the winter. ([https://www.gov.uk/the-warm-home-discount-scheme/eligibility](https://www.gov.uk/the-warm-home-discount-scheme/eligibility))
- **Winter Fuel Payment** – eligible individuals can get between £100 and £300 tax-free to help pay heating bills if they were born on or before 5 January 1952. This is known as a ‘Winter Fuel Payment’. ([https://www.gov.uk/winter-fuel-payment](https://www.gov.uk/winter-fuel-payment))
What works and best practice

Excess Winter Deaths are an important public health issue because research evidence suggests that a proportion of winter deaths could be avoidable. Excess seasonal mortality has the greatest impact on those on low incomes, those living alone, older people, disabled people and those living in care homes, and also on women due to their longer life expectancy.

A recent review of evidence of the direct and indirect effects of fuel poverty and cold housing found that\textsuperscript{162}:

- Countries that have more energy-efficient homes have lower EWDs. There is a relationship between EWDs, low thermal efficiency of housing and low indoor temperatures. EWDs are almost three times higher in the coldest quarter of housing than in the warmest quarter.
- Around 40\% of EWDs are attributable to cardiovascular disease, and 33\% attributable to respiratory diseases. There is a strong relationship between cold temperatures and cardiovascular and respiratory diseases.
- Cold housing increases the level of minor illnesses such as colds and flu and exacerbates existing conditions such as arthritis and rheumatism.
- Addressing energy-inefficient housing and bringing all homes up to a minimum standard of thermal efficiency would have the strongest positive impact on the poorest households, even though households from a variety of socio-economic backgrounds are likely to be residents of such properties.

In addition to the above, the links between cold housing and increased incidence of strokes, respiratory diseases and falls are well established.

The Government has a standard methodology for home energy rating called ‘SAP’, which stands for Standard Assessment Procedure, also known as Energy Ratings. Houses are rated from 0-100, 0 being very inefficient and 100 being highly efficient. SAP ratings are used by local authorities and housing improvement programmes to assess the energy efficiency of both new and old housing. The Building Regulations require a SAP assessment to be carried out on all new dwellings.

Data on energy efficiency in Merton’s private sector housing stock (excluding Merton Priory Homes’ properties) demonstrates that 12.5\% of homes have a poor SAP rating of less than 40 and that 72\% of stock is rated as having a SAP rating of below 60.

Both short-term and long-term strategies and plans need to be in place to support local people to avoid seasonal winter deaths.
- The NHS supports the Department of Health annual Keep Warm, Keep Well campaign, where people are urged to take measures to ensure they stay healthy during the cold weather. The campaign offers tips to help people stay healthy in winter.

\textsuperscript{162} Marmot Review Team (2011). \textit{The Health Impacts of Cold Homes and Fuel Poverty}; Marmot Review Team written for Friends of the Earth.
• Immunisation to protect older people and those with long-term conditions against seasonal flu and advice about managing long-term conditions contribute to reducing the risk of death in winter.

• A Met Office initiative supported by the NHS to text severe weather warnings to people with specific long-term conditions such as cardiovascular and respiratory diseases has shown some benefit in protecting vulnerable people from the effects of severe seasonal temperatures.

**Cold Weather Plan**
The Department of Health produces a Cold Weather Plan each winter season, which is cascaded to all local authorities, CCGs, public health teams, emergency planners and teams nationally, regionally and locally. This Cold Weather Plan for England helps to raise the public’s awareness of the harm to health from cold, provides guidance on how to prepare for and respond to cold weather, which can affect everybody’s health, and triggers actions in the NHS, public health, social care and other community organisations to support vulnerable people who have health, housing or economic circumstances that increase their risk to harm. It aims to prevent the major avoidable effects on health during periods of cold weather in England by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately.

**Getting the measure of fuel poverty, John Hills, March 2012**
(http://sticerd.lse.ac.uk/dps/case/cr/CASEreport72.pdf)
This independent review sets out an alternative measurement framework which, by separating out the extent and depth of the problem faced by households, is designed to lend itself to better application, improved policy development and more effective policy delivery. It pinpoints those who, alongside the most vulnerable, are priorities for action – those most deeply in fuel poverty. It also embeds a concern for distributional equity and improving standards, with sustained improvements to energy efficiency levels – the most effective long-term approach by virtually every indicator.

**Fuel Poverty: a Framework for Future Action, July 2013**

**NICE guidance**
NICE is in the process of developing Public Health Guidance on excess winter deaths and illnesses, expected to be issued in January 2015.
Key commissioning recommendations to fill the gaps

The Environmental Health (Housing) Team has legal powers through the Housing Act 2004 to require private landlords to improve cold housing and reduce ‘excess cold’ hazards by serving improvement notices.

Current levels of resources limit the team to responding to complaints from the tenants of rented properties. However, a proactive approach could be adopted using additional resources to target rented homes in the more deprived parts of the borough and use formal and informal approaches to secure insulation and heating improvements to homes, reducing the risk of EWDs and fuel poverty.

The successful ‘Warm Homes Healthy People’ activities should be continued and further developed over forthcoming winters.
End of Life Care

Key facts on end of life care (EoLC)

A definition of end of life care services

‘End of Life Care services support people with advanced, progressive and incurable illnesses to live as well as possible until they die. This enables the supportive and palliative care needs of both patient and carers to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and the provision of psychological, social, spiritual and practical support.’ (National Council for Palliative Care 2006 and adopted in the Department of Health’s national End of Life Care Strategy, 2008, DH)

End of life (EoLC) affects all people regardless of cause. Good EoLC ensures all residents have a dignified, controlled and peaceful end to their life regardless of age and cause of death, ensuring that their choices and wishes are met. In order to achieve a good outcome, the needs of the patient, carer and family should be identified and services provided to meet these needs throughout the last phases of life and into bereavement. EoLC should include management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

The VOICES Survey showed that 71% of patients wished to die at home, so the proportion of deaths at home is used as a proxy indicator for the provision of EoLC. A higher proportion of deaths at home is considered to be desirable. While this is a proxy measure, the home death rate in Merton increased from 12.3% to 16.6% between 2004 and 2009. The measurement was changed to include usual place of residence in 2010 (to include care homes) and the current rate is approximately 36% with over 67.5% of patients with a CMC record achieving their preferred place of care and death (see Figure 9.12 below).

A recent report published by Public Health England in June 2013, Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK shows that there is growing evidence that ethnic and cultural differences can influence patterns of advanced disease, illness experiences, healthcare seeking behaviour, and the use of healthcare services. The End of Life Care Strategy highlights that although much has been done, inequalities still exist in the care that different groups of people receive at the end of life.

Key facts on EoLC services

Nationally

The Department of Health’s national End of Life Care Programme made significant progress working with health and social care staff, providers, commissioners and third sector


Working with a network of healthcare facilitators and social care champions, the national programme worked to:
- promote high-quality, person-centred care for all adults at the end of life, across all care settings and health conditions
- support people to live and die well in their preferred place.

On 1 April 2013, NHS Improving Quality (IQ) was established to bring together the wealth of knowledge, expertise and experience of a number of NHS improvement organisations. As a consequence the national End of Life Care Programme closed.

While elements of the programme's work have finished, some continue within NHS IQ. The continuing workstreams are:
- Transforming end of life care in acute hospitals
- Electronic palliative care coordination systems
- Health care facilitators and social care champions’ network.

The National End of Life Care Intelligence Network continues to operate as part of Public Health England since 1 April 2013.

**Merton**

*Health and Wellbeing Strategy Priority 3*

Priority 3 (Enabling people to manage their own health and wellbeing as independently as possible) of Merton’s Health and Wellbeing Strategy includes increasing the preferred place of care and death for those who need end of life care services as an outcome. This will be achieved by increasing professional and patient awareness of non-acute care and making more people aware of the CMC electronic record and its benefits.

*Merton EoLC strategy ‘A Good End to Life’*

Merton’s EoLC Services are underpinned by its EoLC strategy ‘A Good End to Life’ that was developed in 2007 by the then Sutton and Merton NHS Primary Care Trust (SMPCT). This strategy was subsequently revised in 2011. There are plans to refresh this strategy over the next year.

The aims of the strategy are to:
- improve quality of EoLC
- increase percentage of people achieving preferred priorities of care and preferred place of death
- improve communication using CMC electronic records.

*End of life multi-disciplinary network*

An end of life multidisciplinary network is in place for Sutton and Merton constituted by secondary and tertiary care clinicians, representatives from hospices, social care, commissioning and patient representatives. Established in 2007 this network meets every
two months and advises Sutton and Merton joint commissioning on the EoLC provision across Sutton and Merton, to optimise effectiveness. This is only one of two such local networks currently existing in England and London-wide networks and alliances are currently being developed.

**Sutton and Merton Community Services EoLC team**  
The team is lead by a nurse consultant and provides:
- general EoLC support and advice to GPs, primary care teams, community nursing teams and nursing homes
- regular rounds in care homes to support nursing home staff
- support and education in use of CMC in community settings.

**Coordinate My Care (CMC)**  
SMPCT was a pilot site for CMC. CMC is an electronic palliative care coordination system (EPaCCS) that gives people with life-limiting illnesses the means to consent to sharing their EoLC records with community nurses, OOH services, LAS and secondary care. It has been developed to enable users' wishes and preferences for how and where they are treated and cared for as they near the end of their life to be shared. Most importantly it ensures that the appropriate health professional, such as the GP, community nurse, out-of-hours GP and secondary care professional legitimately involved in their care has access to advance care plans and clinical management plans, out of hours.

As of September 2013:
- 1,062 Merton residents have a CMC record.
- 47% of Merton patients with a CMC record have cancer and 53% have non-malignant conditions.
- 79% of patients with a CMC record achieved their preferred priorities of care (PPC) and 67.5% their preferred place of death (PPD).
- 26% of patients with a CMC record died in hospital compared with 54% nationally.

**Best practice EoLC services**  
The following best practice EoLC services are now provided in Sutton and Merton following investment by Sutton and Merton PCT and now by the CCGs in this strategy:

- **Hospice at Home Service provided by St Raphael's Hospice:**  
  This service aims to enable patients in the last few weeks of life to be cared for at home, and to die at home if this is their preference. Care may be provided to prevent admission to an inpatient unit, for respite, or crisis management, or for longer periods of time. The Hospice at Home Service became operational in May 2009; with the aim of providing quality EoLC and also increasing the percentage of people who want to die at home. From April 2010-November 2010 the service saw 143 referrals for patients with varying conditions, both cancer and non-cancer. Evaluation of the pilot service from May to December 2009 shows that 68 patients were referred into the service, the preferred place of death was identified for 59 patients and 93% achieved their preference. Out of all referrals 22% were for non-cancer patients. The average cost of a Hospice at Home visit (three hours) is approximately £120.00 (daytime) and £173.00 (night time) compared with the cost of an inpatient episode at £361 per day plus costs of £130 per
contact for the hospital support team and £80 per contact for palliative medicine input; or a hospice inpatient episode at £550 per day (source: Hospice at Home End of Life Care Pilot Evaluation Report, May-December 2009).

- **Fast-track discharge at St George’s Hospital:**
  End of Life Discharge Home Service from St George’s Hospital (SGH), established in June 2009. The main features of this fast-track service at SGH are:
  
  o 24-hour, seven days per week specialist palliative care advice available from SGH (meeting the NICE requirements)
  
  o a Specialist Palliative Care Nurse from the Palliative Care Team escorts the patient in the ambulance and hands over care to community staff in the patient’s home
  
  o the service is evaluated, including carers’ views
  
  o of those patients referred to the service who stated a preference to die at home, the proportion achieving their wish increased from 39% in 2008-09 to 82% in 2009-10.

- **Seven-day palliative care nursing at St Helier Hospital.**

- **Gold Standards Framework (GSF) in care homes and primary care:**
  GSF is a systematic common-sense approach to formalising best practice, so that quality EoLC becomes standard for every patient. It helps clinicians identify patients in the last year of life, assess their needs, symptoms and preferences and plan care on that basis, enabling patients to live and die where they choose. GSF embodies an approach that centres on the needs of patients and their families and encourages inter-professional teams to work together. GSF can help coordinate better care provided by generalists across different settings.

- **Marie Curie nursing services.**

- **Social care services.**

- **General practice services.**

**New services commissioned**

- Hospice at Home provides specially trained health care assistants supporting care at home.

- Fast-track discharge teams based at St Helier Hospital and SGH.

- EoLC/dementia project, provides training to GPs and care homes.

- Community EoLC nursing team to support nursing homes, GPs and community nurses.

- EoLC training course for care home staff.

**Services decommissioned**

- Liverpool Care Pathway (LCP): This will be phased out in favour of individual care plans following the LCP review. It has not been used in community settings since April 2013.

- Bereavement support: A telephone service was previously commissioned from a large bereavement charity, but this service was not able to meet the needs of the population and was therefore decommissioned. The reprovision of a service to meet the needs of people in Merton is being reviewed.
Figure 9.12: Quarterly percentage of deaths that take place at home in Merton, December 2009 to September 2012. The thick blue line indicates the Merton average over this period and the graph shows that the percentage has increased over time.

The thick blue line indicates the Merton average over this period and the graph shows that the percentage has increased over time.

The two graphs in Figures 9.13 and 9.14 below show that in Merton there was a greater percentage of males (20.5%) than females (16.1%) that died at home in the period 2008-10, however, in both cases, this was lower than the London and England averages. There are therefore differences by sex for this metric.

Figure 9.13: Percentage of deaths at home from all causes for males in Merton compared with London, England, and statistical and geographical neighbours, 2008-10.
Figure 9.14: Percentage of deaths at home from all causes for females in Merton compared with London, England, and statistical and geographical neighbours, 2008-10.

What works and best practice

Sutton and Merton Strategy for End of Life Care, A Good End to Life, April 2011
The Sutton and Merton End of Life Care Strategy was first published in July 2007, following engagement events with local people, patients and professionals from both the statutory and non-statutory sectors. It was updated in 2008 to take account of the new national End of Life Care Strategy – promoting high-quality care for all adults at the end of life, published by the Department of Health (DH) (see below). Since 2007 considerable progress has been made in implementing and realising the benefits of many of the service priorities first set out in 2007 and a refresh of the strategy was published in 2011.

End of Life Care Strategy: Promoting high quality care for all adults at the end of life, Department of Health July 2008
In 2008 the Department of Health published its End of Life Care Strategy, which sets out 12 key priorities, with the related actions and recommendations. These key priorities are summarised below, [except the one in relation to the Liverpool Pathway, which has been omitted as it has been phased out].

Raising the profile
Improving end of life care will involve NHS and Local Authorities (LAs) working in partnership to consider how best to engage with their local communities to raise the profile of EoLC. This
may involve engagement with schools, faith groups, funeral directors, care homes, hospices, independent and voluntary sector providers and employers amongst others. At a national level, the Department of Health will work with the National Council for Palliative Care to develop a national coalition to raise the profile of EoLC and to change attitudes to death and dying in society.

**Strategic commissioning**
As the services required by people approaching the end of life span different sectors and settings, it is vital that an integrated approach to planning, contracting and monitoring of service delivery should be taken across health and social care. A strategic approach to commissioning led by NHS and LAs is vital and commissioners are reminded of the requirement to conduct equality impact assessments of any planned changes to services. All relevant provider organisations should be involved in the commissioning process.

**Identifying people approaching the end of life**
Caring for those approaching the end of life is one of the most important and rewarding areas of care. Although it is challenging and emotionally demanding, if staff have the necessary knowledge, skills and attitudes, it can also be immensely satisfying. However, many health and social care staff have had insufficient training in identifying those who are approaching the end of life, in communicating with them or in delivering optimal care. To address this, a major workforce development initiative is now needed, with particular emphasis on staff for whom EoLC is only one aspect of their work.

This will include the provision of communications skills training programmes and other programmes based on the competences needed by different staff groups. Professional regulatory bodies and higher educational institutions will need to be engaged in this endeavour.

**Care planning**
All people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan. In some cases people may want to make an advance decision to refuse treatment, should they lack capacity to make such a decision in the future. Others may want to set out more general wishes and preferences about how they are cared for and where they would wish to die. These should all be incorporated into the care plan. The care plan should be subject to review by the multidisciplinary team, the patient and carers as and when a person’s condition, or wishes, change. For greater effectiveness, the care plan should be available to all who have a legitimate reason to access it (e.g. out of hours and emergency services).

**Coordination of care**
Within each local health economy mechanisms need to be established to ensure that each person approaching the end of life receives coordinated care, in accordance with the care plan, across sectors and at all times of day and night.

**Rapid access to care**
As the condition of a person may change rapidly, it is essential that services are marshalled without delay. If a person is likely to live for only a matter of weeks, days matter. If the
prognosis is measured in days, hours matter. Therefore, NHS and LAs will wish to consider how to ensure that medical, nursing and personal care and carers’ support services can be made available in the community 24/7, including in care homes, sheltered and extra care housing and can be accessed without delay. It is evident that provision of 24/7 services can avoid unnecessary emergency admissions to hospital and can enable more people at the end of their life to live and die in the place of their choice.

Delivery of high-quality services in all locations
Commissioners will wish to review the availability and quality of EoLC services in different settings. These will include services provided in hospitals, in the community, and in care homes, sheltered and extra care housing, in hospices and by ambulance services. Also, commissioners will wish to refer to the NICE quality standards which set out what is needed to deliver high-quality care at the end of life, adopting a care pathway approach.

Involving and supporting carers
The family, including children, close friends and informal carers of people approaching the end of life, have a vital role in the provision of care. They need to be closely involved in decision making, with the recognition that they also have their own needs. For many this will have been the first time they have cared for someone who is dying. They need information about the likely progress of the person’s condition and information about services which are available. They may well also need practical and emotional support both during the person’s life and after bereavement. Carers already have the right to have their own needs assessed and reviewed and to have a carer’s care plan.

Education and training and continuing professional development
Ensuring that health and social care staff at all levels have the necessary knowledge, skills and attitudes related to care for the dying will be critical to the success of improving EoLC. For this to happen, EoLC needs to be embedded in training curricula at all levels and for all staff groups. EoLC should be included in induction programmes, in continuing professional development and in appraisal systems.

The health and social care workforce can be segmented into three broad groups in relation to EoLC. Staff who spend the whole of their time caring for those at the end of life; those who frequently deal with EoLC as part of their role; and those who care for people at the end of life infrequently. Commissioners will wish to consider how training can best be commissioned and provided to ensure that the relevant staff have the necessary competences.

Measurement and research
Good information on EoLC is needed by patients, carers, commissioners, clinicians, service providers, researchers and policy makers. Each group will have somewhat different questions to ask and therefore different priorities for information. The NHS Choices website contains information which may be helpful.

Measurement of EoLC provision is a key lever for change and is essential to monitor progress. This will require measurement of structure, process and outcomes of care. Structures and processes will largely be measured through self-assessment by organisations against the quality standards, on which consultation will commence shortly.
In addition to information on place of death, which is available through the Office for National Statistics (ONS), outcomes of EoLC will in future be monitored through surveys of bereaved relatives, national audits and regular reviews of complaints.

**Funding**

It is difficult, if not impossible, to calculate the cost of EoLC in this country. This is partly because of the difficulty in defining exactly when EoLC starts. However, the key elements of expenditure can be identified.

These are:
- Hospital admissions
- Hospices and specialist palliative care services
- Community nursing services
- Care homes.

Across health and social care, the overall cost of EoLC is large (measured in billions of pounds) and there is widespread agreement that these resources are not all being used as well as they might be. In addition, there are costs met by other government departments, such as the Attendance Allowance and Disability Living Allowance. There are also costs to unpaid carers.

Many of the improvements envisioned can be achieved by better use of existing health and social care resources. It is likely, for example, that at least part of the additional costs of providing improved care in the community and in care homes will be offset by reductions in hospital admissions and length of stay. Further work on the cost impact of new EoLC service models, developed through the Marie Curie Cancer Care Delivering Choice Programme, is encouraging, showing a reduction in hospital admissions and increase in home deaths with stable overall costs.

However, in reviewing local areas, commissioners will need to consider the financial implications of:
- establishment of coordination centres/facilities
- provision of 24/7 home care services
- improved ambulance transport services for people near the end of life
- additional specialist palliative care outreach services to provide advice and care for non-cancer patients and to increase input into care homes and community hospitals
- improved education and training of existing staff.

**NICE quality standard for end of life care for adults – QS13, 2011**


This quality standard covers all settings and services in which care is provided by health and social care staff to all adults approaching the end of life. This includes adults who die suddenly or after a very brief illness. The quality standard does not cover condition-specific management and care, clinical management of specific physical symptoms or emergency planning and mass casualty incidents. It sets out markers of high-quality care for adults aged 18 years and older with advanced, progressive, incurable conditions; adults who may die
within 12 months; and those with life-threatening acute conditions. It also covers support for the families and carers of people in these groups.

It is not expected that each quality statement will apply to all groups. Similarly, some quality statements may need special consideration when applied to certain groups. For example, people with dementia may need to participate in advance care planning significantly earlier in the pathway than people with cancer.

The quality standard is also expected to contribute to the following overarching outcomes for people approaching the end of life:

- The care that people approaching the end of life receive is aligned to their needs and preferences.
- Increased length of time spent in preferred place of care during the last year of life.
- Reduction in unscheduled care hospital admissions leading to death in hospital (where death in hospital is against their stated preference).
- Reduction in deaths in inappropriate places such as on a trolley in hospital or in transit in an ambulance.

Figure 9.15: The End of Life Care Pathway, as set out in the End of Life Care Strategy (DH 2008), comprises of six steps and was developed to help anyone providing health and social care to people nearing the end of life.

Care in the last few days of life
The Liverpool Care Pathway (LCP) has not been used in community or secondary care settings in Merton since 2012 and is being phased out nationally. In Merton, recognising that one size does not fit all, the emphasis is on the development of individual care plans and pathways for patients.

Following a series of instances of poor care, the Department of Health announced in January 2013 that an independent review into the use of the LCP would be undertaken. Chaired by Baroness Julia Neuberger, the review findings were published on 15 July 2013.164

The report sets out 44 recommendations regarding the Liverpool Care Pathway and EoLC, including:
- phasing out the LCP and replacing it with an individual EoLC plan
- a general principle that a patient should only be placed on the LCP or a similar approach by a senior responsible clinician in consultation with the healthcare team
- unless there is a very good reason, a decision to withdraw or not to start a life-prolonging treatment should not be taken during any 'out of hours' period
- an urgent call for the Nursing and Midwifery Council to issue guidance on EoLC
- an end to incentive payments that are based on the numbers of people who die supported by an integrated care pathway
- a new system-wide approach to improving the quality of care for the dying.

What are the gaps?

Gaps in terms of BAME access
The 2013 Public Health England report, Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK, identified the following gaps based on a review of the evidence nationally and internationally:

Access to palliative and end of life care
In terms of access to care, BAME groups had lower access to palliative and EoLC services when compared with white British people. This was associated with lack of referrals, lack of awareness of relevant services, previous bad experiences when accessing care, a lack of information in relevant languages or formats and family/religious values conflicting with the idea of hospice care. A number of authors stated that BAME groups are usually younger and consequently experience different types of cancer compared with the majority of the white population. However, they also stated that these trends are likely to change and this should not be seen as the only explanation to account for lower rates of service use.

Receipt of palliative and end of life care
Disparities and unmet needs when receiving care were also examined, especially issues regarding communication, end of life decision making and health outcomes (e.g. pain). The most discussed issue was poor communication between the healthcare professional and the patient/family. This was associated with lack of sensitivity to cultural/religious differences,

lack of availability or translators and low availability of training for healthcare professionals. Evidence on disparities on end of life decision making was more common in studies from the US, with minority ethnic patients less likely to complete advance care planning documents and more likely to desire life-sustaining treatment (such as intubation and artificial feeding) than the majority white population.

**Gaps in Merton**
An important gap is in relation to the capacity of EoLC services to spend adequate time with patients and use advanced communication skills to identify the right groups of patients for the services. In addition to capacity, this is also a training issue for community generalists in the EoLC team and carers.

If a patient has a CMC record and opts to have care at home, this has implications on capacity and will increase the number of visits required by community professionals in order to support this to happen. There needs to be a corresponding shift in resources to community care to address this increased demand on capacity.

A telephone service was previously commissioned from a large bereavement charity to provide bereavement support at home, but this service was not able to meet the needs of the population and was therefore decommissioned. While the reprovision of a service to meet the needs of people in Merton is being reviewed, until a suitable provider is found or alternative ways of providing this service are developed, bereavement support at home remains a gap.

Accessibility to and adaptability of EoLC services to different faiths have been raised through a Community meeting. Faith Group Leaders are now helping to inform the training of EoLC service staff.

**Key commissioning recommendations**

**BAME access**
A health needs assessment of BAME groups in EoLC services in Merton is suggested as a means of understanding the unmet need in our communities in relation to EoLC services and access by BAME groups. In the absence of detailed local analysis, the recommendations below are from the 2013 Public Health England report, *Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK*. This report made the following recommendations for practice in relation to EoLC in BAME groups, which should be kept in mind when addressing any commissioning gaps, recognising that some of these are already being met in our local provision:

**Staff training**
- Training for bilingual support workers, advocate and link workers to be sources of information.
- Cultural competency training for medical/nursing students and palliative care staff.
- Communication skills training for palliative and end of life care staff and interpreters.
- Interdisciplinary learning for health and social care workers, attorneys, and clergy providing palliative care.
• Two-way education between specialists and generalists to provide better access to palliative care.

**Open, non-judgemental and ongoing communication**
• Carefully listen to patients and families; ask how they wish to hear and discuss medical information; be respectful when practices are not acceptable to them; respond to their views, and provide necessary support (dietary, religious, family involvement).
• Address each patient and family individually, but apply general principles of good practice to all, regardless of ethnicity.
• Provide advocacy, intervention and support for family/friends.
• Beware of stereotypes, and be aware of differences within the same group and of own personal biases.
• Establish anti-racism/anti-discriminatory policies and create a code of conduct for staff and patients.

**Reaching, listening to and involving BAME communities**
• Develop outreach measures to provide information about services: seek out agencies providing services to BAME communities, conduct presentations about hospice care; develop community-based partnerships and encourage BAME communities and volunteer organisations to participate.
• Recruit individuals from BAME communities, including bilingual volunteers, and have BAME representatives in the board of directors, advisory councils and management committees.
• Provide information using various media to address all literacy levels.
• Have pain charts, dictionaries and phrase books for use in the absence of interpreters.

**Building and sharing knowledge**
• Use robust research findings to inform practice and ensure appropriate capture of ethnicity data to support research
• Share experiences of good practice and recommendations with others
• Develop a system of information provision for hospital consultants and GPs about available palliative care services for BAME communities

The 2008 Department of Health End of Life Care Strategy sets out 12 key priorities described earlier, apart from the one concerning the Liverpool Pathway, which has been phased out. The strategy makes some recommendation to commissioners as set out below.

**Strategic commissioning**
As the services required by people approaching the end of life span different sectors and settings, it is vital that an integrated approach to planning, contracting and monitoring of service delivery should be taken across health and social care. A strategic approach to commissioning led by the NHS and LAs is vital and commissioners are reminded of the requirement to conduct equality impact assessments of any planned changes to services. Relevant provider organisations should be involved in the commissioning process.

**Staff education, training and continuing professional development**
Many health and social care staff have had insufficient training in identifying those who are approaching the end of life, in communicating with them or in delivering optimal care. To
address this, a major workforce development initiative is now needed, with particular emphasis on staff for whom EoLC is only one aspect of their work. This will include the provision of communications skills training programmes and other programmes based on the competences needed by different staff groups. Professional regulatory bodies and higher educational institutions will need to be engaged in this endeavour. Commissioners will wish to consider how training can best be commissioned and provided to ensure that relevant staff have the necessary competences.

**Delivery of high-quality services in all locations**
Commissioners will wish to review the availability and quality of EoLC services in different settings. These will include services provided in hospitals, in the community, and in care homes, sheltered and extra care housing, in hospices and by ambulance services. Also, commissioners will wish to refer to the NICE quality standards which set out what is needed to deliver high-quality care at the end of life, adopting a care pathway approach.

**Measurement and research**
Measurement of EoLC provision is a key lever for change and is essential to monitor progress. This will require measurement of structure, process and outcomes of care. Structures and processes will largely be measured through self-assessment by organisations against the quality standards, on which consultation will commence shortly.

**Economic implications**
In reviewing local areas, commissioners will need to consider the financial implications of:
- establishing coordination centres/facilities
- providing 24/7 home care services
- improving ambulance transport services for people near the end of life
- providing Additional specialist palliative care outreach services to provide advice and care for non-cancer patients and to increase input into care homes and community hospitals
- improving education and training of existing staff.

**Merton-specific recommendations**

Commissioners should continue to ensure that services continue to raise the population’s awareness of options for care and place of death and dying across our population, and also to raise awareness of the CMC register so as to increase the number of people with CMC records.

There are plans to review the 2011 EoLC strategy in 2014-15 and it is important that this is undertaken.

Currently there is a gap in providing bereavement support services in Merton. Commissioners should consider the reprovision of the service through a suitable provider or developing alternative models for providing this service.
Commissioners are recommended to examine the size and nature of the gap in relation to the capacity of EoLC services to spend adequate time with patients and use advanced communication skills to identify right groups of patients for the services. In addition to capacity, there is also a training issue for community generalists in the EoLC team and for carers. It is also recommended that commissioners consider how Merton performs in this area compared with other similar boroughs and perhaps learn from best practice in such boroughs that perform better.

Furthermore, commissioners should consider the implications on capacity when patients on CMC increasingly opt for care at home, as this will result in an increase in the number of visits required by community professionals. Consideration should be given as to how to resource this additional work for community services and primary care services to address this potential surge in demand.
MERTON
JOINT STRATEGIC
NEEDS ASSESSMENT
(JSNA)
2013-14

THEME 10:
SEXUAL HEALTH AND INFECTIOUS
DISEASES IN MERTON
Sexual health abbreviations

**STIs** – sexually transmitted infections  
**CASH** – Contraception and Sexual Health  
**GUM** – genito-urinary medicine  
**HIV** – human immunodeficiency virus  
**MSM** – men who have sex with men  
**HSV** – herpes simplex virus  
**NCSP** – National Chlamydia Screening Programme  
**LARC** – long-acting reversible contraception
Summary

HIV

Key facts on HIV

The human immunodeficiency virus is commonly known as HIV. It is a disease of the immune system primarily transmitted through unprotected sexual intercourse with an infected person. This includes vaginal, anal and oral sex. It can also be caught by sharing infected needles, or less commonly through contaminated blood transfusions and mother-to-child transmission in pregnancy.

Prevalence refers to the proportion of individuals within a defined population who are infected at a given time. In 2011, there were 561 people known to have HIV in Merton. This equates to a prevalence rate in Merton of 3.8 per 1,000 population aged 15-59 years (ONS, 2011). This was lower than the London rate (5.4 per 1,000) but higher than the England rate (2.0 per 1,000). In 2011, 29 adult residents (aged between 15 and 59 years) of Merton were newly diagnosed with HIV.

Prevalence varies across Merton, with the five wards with the highest rates accounting for 42% of all people diagnosed with HIV in Merton. These wards are Pollards Hill, Figgies Marsh, Lavender Fields, Colliers Wood and Abbey. The prevalence rate ranges from 5.7 per 1,000 in the former to 4.1 per 1,000 in the latter.

The majority of those diagnosed in 2011 were men (60%, 334). In terms of age, those aged 35-44 years old followed by those aged 44-54 years made up the biggest contribution to HIV diagnoses in Merton in 2011 (177,32% and 173,31% respectively).

Data analysis by ethnicity shows that two ethnic groups accounted for the majority of known HIV infections diagnosed in Merton: black African (276) and white (201). Given the ethnic diversity of the Merton population, BME groups appear to be disproportionately affected by HIV, which reflects the London trend.

In Merton, in 2011 heterosexual contact accounted for the largest proportion of residents diagnosed with HIV (324, 58%). This was higher than London and South West London at 46% and 53% respectively. Whilst MSM accounted for a significant proportion of HIV diagnoses in Merton (194, 35%), this was lower than London and South West London.

Late diagnosis of HIV

Data from 2011 estimates that 1 in 5 Londoners with HIV was unaware of their HIV status. The earlier people are diagnosed the better as they can access effective treatment, which greatly improves their health, and can reduce their chances of infecting others. It has been estimated that over half of overall HIV transmissions are due to people who are unaware that they have the disease. Late diagnosis is one of the biggest contributing factors to morbidity and mortality of people with HIV and has significant implications for health and social care services. Reducing late diagnosis is used as an indirect performance measure for HIV prevention and is one of the Public Health Outcomes Framework indicators.

Late diagnosis is defined as people who have a CD4 count of less than 350 per cubic millimetre of blood at diagnosis. In 2011, 32% of people with HIV in Merton were diagnosed with a CD4 count of less than 350, compared with 44% in London overall. 10% of MSM were diagnosed late (compared to 31% in London) and 50% of heterosexuals were diagnosed late (compared with 61% in London).
What are the gaps?

- There is a need for more widespread HIV testing in primary care settings, in general medical admissions at Epsom and St Helier Hospitals and through the CASH service.
- There is a gap in knowledge on HIV testing in pregnancy and work around mother-to-child transmission. There is a need to work with St George's and St Helier Hospitals to investigate surrounding issues since most of Merton mothers attend there.
- Further understanding, including robust local data and a strategy for engaging effectively with MSM and black African communities is required.
- There is a need for greater involvement of service users and those at risk of HIV in local commissioning and the development of effective interventions.

Key commissioning recommendations

- Reducing late HIV diagnosis in Merton should be a continuing public health priority. Twelve out of 20 wards in Merton have a prevalence of above 2.0 per 1,000 of the population.
- HIV testing should be offered more widely through primary care and through the CASH service.
- A pilot offering ‘opt out’ HIV testing in general medical admissions at Epsom and St Helier Hospitals should be considered.
- More targeted interventions aimed at MSM and black African communities need to be explored and commissioned.
- A South West London HIV forum and other ways to engage regularly with Black African communities need to be considered with key partners.
- Decisions need to be made, in partnership with South London colleagues; about the future commissioning of HIV prevention and support work provided through the South London and South West London partnerships.

Sexually transmitted infections (STIs) excluding chlamydia

Genital human papillomavirus (Genital Warts)

Genital warts are the second most commonly diagnosed STI after chlamydia. Infections are extremely common among the sexually active population especially in the first few years after starting sexual intercourse.

They are the result of a viral skin infection caused by the human papillomavirus (HPV). There are more than 100 types of HPV, 40% of which can infect the genital tract and are sexually acquired. These infections don’t usually cause a serious threat to health but they can be difficult to treat with frequent recurrent symptoms.

Data from GUM clinics shows the number of genital wart infections diagnosed in Merton residents has reduced by 10%, with the rate similarly reducing. This contrasts with London and England, where the rate is more stable.

Gonorrhoea

Gonorrhoea is caused by bacteria called Neisseria gonorrhoeae or gonococci. These bacteria are found in the vaginal fluid or discharge of the penis of infected women and men, therefore gonorrhoea is mainly contracted through unprotected sex.

The rate of diagnosis of gonorrhoea in Merton in 2011 was 76.6 per 100,000, significantly higher than the England rate of 39.1 per 100,000 but lower than the London rate of 109.2 per 100,000. The rate and number of gonorrhoea infections are increasing in Merton (see Figure 10.6 below). This increase is in line with that seen in London and England. These changes may simply be due to increased incidence, but it is likely that other factors such as
more complete reporting, increased testing and better coding have impacted on the recorded rates.

Gonorrhoea diagnoses in Merton are concentrated in specific population subgroups, including males, MSM and those aged 25 and above. The local picture largely mirrors that for England.

**Genital herpes**
Genital herpes is an incurable but generally manageable infection caused by the herpes simplex virus (HSV). There are two types of the virus, with one being genital herpes. The virus is highly contagious and can be easily passed from person to person. Many infections are asymptomatic or present only mild symptoms, and as a consequence 80% of people are unaware of being infected.

The rate of HSV diagnosis in Merton in 2011 was 78.5 per 100,000, higher than the England rate (58 per 100,000) but lower than London (92 per 100,000). Between 2009 and 2011 the number and rate of HSV infections in Merton showed no consistent pattern in contrast to the increase in London and England during the same period.

**Syphilis**
Syphilis is caused by a bacterium called Treponema Pallidum, which can be passed on through close contact with an infected sore, normally during vaginal, anal or oral sex. Pregnant women can pass syphilis on to their unborn child causing stillbirth or death shortly after birth. Injecting drug users can also contract it by sharing needles with someone who is infected.

In Merton, in 2011, the rate of syphilis was low at 8 per 100,000, lower than London (17.5 per 100,000) but higher than England (5.4 per 100,000). Males accounted for 90% of cases and the majority of cases in Merton (71%) were in MSM.

**What are the gaps?**
- STI testing is particularly low in men even though the prevalence of chlamydia, gonorrhoea and HIV is high in this group. There is a need to work with men to understand effective ways to engage with them to increase the acceptability of using sexual health services and increase the uptake of STI testing.
- The CASH service in Merton and Sutton is not providing an integrated service at present so only offers contraceptive provision. It has begun offering HIV testing since November 2013 but steps need to be made towards further integration.
- There is a lack of robust data relating to the activity, outcomes and service user experience of the GUM and CASH services. This is needed to inform future commissioning.
- General practice is an underutilised resource for sexual health service provision. Although general practices in Merton have seen an increase in STI testing, the numbers are still low and rates of testing vary considerably across the borough. Successful pilots in London and other areas support both the feasibility and acceptability of HIV testing in primary care (HPA, 2011). There is potential in Merton to engage with GPs to discuss implementation of sexual health service provision.

**Key commissioning recommendations**
- There is a need to work towards the development of an integrated sexual health and contraceptive service.
- The barriers to accessing the condom distribution scheme need to be identified and solutions developed to enhance distribution.
• There is a need to ensure that people, especially young people, are aware of local sexual health services and how to access them. In particular, investment in further advertising of www.gettingiton.org.uk.

• An independent review of the CASH service should be commissioned in order to fully understand accessibility, service user experience, what works, and any gaps or barriers.

• Data reporting for GUM and CASH services need to be strengthened and commissioner/provider relationships further developed so effective monitoring and management can take place.

• Good practice models of working with men need to be explored and local insight gained, so effective interventions can be commissioned which increase safe sexual health practice and STI testing and treatment.

• Opportunities to increase STI testing in GP practices need to be explored.

Chlamydia

Key facts on disease
Genital Chlamydia trachomatis is the most commonly reported bacterial STI in England. Over 186,000 new cases were diagnosed in England in 2011 (HPA) representing a substantial public health problem. Infection is asymptomatic in at least 70% of women and 50% of men and as a result the majority of infections remain undiagnosed.

Untreated, chlamydia infection has significant health consequences. It is associated with considerable reproductive morbidity in women including pelvic inflammatory disease, ectopic pregnancy and blocked fallopian tubes causing infertility. In men complications include urethritis, epididymitis and Reiter’s syndrome.

In Merton, the rate of chlamydia diagnosis in 2011 was 335.7 per 100,000 of the population, which was lower than England (351.2 per 100,000).165 The National Chlamydia Screening Programme (NCSP), which started locally in Merton in 2008, specifically targets 15-24 year olds. In 2011, 5,419 chlamydia tests were undertaken by Merton residents aged 15-24. The number of tests was equivalent to coverage of 24% of the Merton 15-24 year old population, with a rate of positivity of 8%. This compares with coverage of 30% nationally, with a 7% positivity rate. The rate of positive chlamydia diagnoses in Merton in 2011 amongst 15-24 year olds was 1,987.8 per 100,000 population.

What are the gaps?
• The National Chlamydia Screening Programme for 15-24 year olds is still a long way from being embedded effectively into core services, many of which are being paid additional money to offer this service.

• Primary care providers would prefer a more integrated model of sexual health where training is offered on the whole range of services together e.g. EHC, c-card condom scheme.

• Chlamydia screening needs to be made more accessible to the over 25s as well as the under 25s. At present, the only place someone over the age of 25 can be tested is at a GUM clinic.

Key commissioning recommendations to fill the gaps
• There needs to be a further focus on embedding chlamydia screening into core services especially the CASH service and in GP practices, as recommended by the NCSP.

• Commissioning models which address a whole range of health concerns and risk taking behaviour need to be explored rather than chlamydia being considered separately.

165 PHE, 2012.
Increasing access to chlamydia screening to the over 25s needs to be considered so that GUM is not the only provider.

Work needs to be undertaken to ensure that key preventative messages are given to those receiving a negative result.

Sex and relationships education and information sources for young people need to be reviewed and considered to ensure that ‘myths’ are dealt with, and they have the knowledge and skills they need to make informed decisions about their sexual health.

**Contraception**

GPs are instrumental in contraception provision. It is estimated nationally that three quarters of all access to contraception is through general practice. There are 26 GP practices in Merton.

Oral contraception is the most common form of contraception prescribed by GPs. In 2011-12, the rate of prescribing in general practice was 42.8 prescriptions per 100 women (aged 15-49 years). Oral contraceptives accounted for 89% of all GP prescriptions. However, this does vary from practice to practice, ranging from 21.4 to 62.4 prescriptions per 100 women aged 15-49.

The average LARC prescription rate in GP practices in Merton was 46.2 prescriptions per 1,000 women aged 15-49. Due to the recent NHS transition, data reflecting the new organisations is not yet available. The LARC prescribing rate is low generally, but only lower than 10 PCTs in London. The LARC prescription rate varies from practice to practice across Merton. In 2011-12 this varied from 0.4 to 15 per 100 women aged 15-49 years. Injections were the most common type of LARC prescribed.

There were 460 women recorded as having been prescribed EHC in Merton GPs in 2011/12, an 11% reduction from the previous year. Eight out of nine of those women had been given information on LARC in the previous 15 months.

What are the gaps?

- There is a need to understand the reasons underlying the low prescribing rates for LARC in GP practices. The reasons could be due to training issues where nurses and GPs lack the necessary training to fit LARC confidently and competently or a lack of knowledge and acceptance of LARC amongst women. Although most practices are offering information on LARC, the timeliness and depth of the information as well as service pathways impact on uptake and need to be standardised.
- Data available on the uptake of sexual health services in general practice is poor and often unreliable. There are gaps in critical information, for instance the demographics of those attending, creating difficulty in identifying unmet needs and inequalities in access.
- The CASH service in Merton and Sutton is not providing an integrated service at present. It only offers contraceptive provision, and dual testing for chlamydia/gonorrhoea to the under 25s. It will begin offering HIV testing this year but steps need to be made towards further integration.
- There is a lack of robust data relating to the activity, outcomes and service user experience of the CASH service. This is needed to inform future commissioning.

**Key commissioning recommendations**

- Opportunities for promoting the use of LARC and increasing uptake in GP surgeries need to be explored.
- An independent review of the CASH service should be commissioned in order to fully understand accessibility, service user experience, what works, and any gaps or barriers.
• Data reporting for the CASH service need to be strengthened and commissioner/provider relationships further developed so effective monitoring and management can take place.
• There is a need to ensure that people, especially young people, are aware of local sexual health services and how to access them. In particular, investment in further advertising of www.gettingiton.org.uk.

Infectious diseases

‘Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another.’

(World Health Organization)

Although the effect on mortality of infectious diseases is greater in the developing world, infectious diseases in England generate a significant cost financially, socially, and on health and wellbeing.\textsuperscript{166} In the UK, infectious diseases have been estimated to account for half of GP consultations for children, and over a third of GP consultations for adults.\textsuperscript{175} Direct costs to the NHS were estimated in 2005 to be £6 billion, one tenth of the NHS budget.\textsuperscript{175,167} The majority of this cost is in primary care.

Vaccine-preventable diseases

Measles/Mumps/Meningococcal disease

Measles in Merton:
• In the previous three years (2010-12), there were 10 reported cases of measles in Merton.
• The measles rate for 2012 (per 100,000 population) was 1.0 per 100,000 population.
• In 2012, Merton’s measles rate was ranked fourth out of the six South West London Local Authorities (SWL LAs).

Mumps in Merton:
• Over the same period (2010-12), there were 27 reported cases of mumps in Merton.
• The mumps rate for 2012 per 100,000 population was 3.5 per 100,000 population.
• In 2012, Merton’s mumps rate ranked second of the six SWL LAs.

Meningococcal disease in Merton
Meningococcal disease is a bacterial infection, potentially leading to serious sequelae such as: meningitis or inflammation of the lining of the brain; and septicaemia, or bloodstream infection.\textsuperscript{178} Vaccination is available for particular strains of meningococcal disease.
• From 2010-2012, there were 17 cases of meningococcal disease in Merton.
• The rate of meningococcal disease for 2012 was 3.5 per 100,000 population.
• This ranked highest of the six SWL LAs.

Hepatitis
• Over the period from 2010-12, there were six cases of hepatitis A in Merton, and six cases of acute hepatitis B.
• The rate of hepatitis A and acute hepatitis B in Merton ranked fifth out of the six SWL LAs in 2012.

\textsuperscript{167} HPA (2005). Health Protection in the 21\textsuperscript{st} Century: Understanding the Burden of Disease; preparing for the future.
Key commissioning recommendations
The NICE Pathway – Immunisation for children and young people includes a specific pathway and recommendations for immunisation strategy, policy and commissioning (see Figure 10.14 below). Specific advice in strategy, policy and commissioning for immunisation programmes, is outlined in the document as can be found in Box 10.1 below.

Tuberculosis (TB)

Key facts on tuberculosis
In 2011, London had the largest proportion of TB cases in the UK, close to 40% of all cases.168 London also had the highest incidence of TB of any western European capital.181 Mortality from TB has continued on a decreasing trend, however deaths from TB – a treatable disease – continue. In London from 2001-10, 1,348 people died as the result of TB.79,169 TB disproportionately affects certain groups and individuals, and rates vary according to ethnicity, migrant status, gender, and social risk factors (such as homelessness, drug and alcohol misuse, imprisonment and mental health issues).180,181 Drug resistance in TB and co-infection of TB and HIV are also of particular concern.

In Merton, both the number and rate of TB cases have been increasing over the past several years.

- The TB rate in Merton increased to 37/100,000 in 2012, the highest seen in recent years, and just below the London average.
- Patients were predominantly male, and aged 20-49 years old.
- While most were born outside the UK, 27% had been in the UK over ten years.
- The most common ethnic group was mixed/other; the most common countries of birth outside the UK were India, Sri Lanka and Pakistan.
- More than half had pulmonary TB, a rate of 21/100,000: a lower than average proportion of these were confirmed by culture.
- Merton residents had similar levels of isoniazid resistance and higher multi-drug resistance, compared to the London average.
- Treatment completion was similar to the London average at 87%.

Source: Local Authority TB Profiles (2012 data)

Cases
- From 2010-12, there were 194 notified cases of TB in Merton.
- In 2012, there were 74 cases of TB, higher than in the previous three years.
- The rate of TB per 100,000 population in 2012 (36.6), was the highest of all SWL LAs..
- One third of cases in 2012 were diagnosed in 20 to 29 year olds.
- 13.5% of cases were born in the UK.

What are the gaps?

- TB rates are increasing for Merton, and remain high for London overall. Commissioning is fragmented at present between CCGs (non-specialist care) and NHS England (specialist care).
- TB teams in South West London require skilled staff resources for awareness raising and management of hard-to-reach groups.
- A needs assessment in 2008 identified the gaps outlined below. An updated needs assessment and input from continued cohort reviews are required.

*From Review of TB Services in South West London, September 2008*

Clinical gaps

- At some centres TB nurses have responsibility for both respiratory and TB patients; given the volume and complexity of TB patients, these services should be separated and funded appropriately.
- Agreement is needed on minimum standards of clinical care to ensure equitable service provision; this could be achieved through the design of an effective integrated care pathway.
- Introducing an opt-out HIV testing programme would increase the provision of HIV testing for TB patients.
- Directly Observed Therapy (DOT) for the treatment of TB is used variably across South West London. Agreed criteria for commencing a patient on DOT should be introduced. This should be allied to an effective risk assessment process to identify the case mix more effectively.
- Variability in levels of chemoprophylaxis may be due to capacity or practice and agreed criteria for chemoprophylaxis should be agreed.

Commissioning and funding gaps

- Active commissioning will cost more in the short term but will improve outcomes of care and achieve a saving in the medium to long term.
- The service provided to a PCT’s resident varies significantly dependent on the provider; allied to this is significant cross-border movement of TB patients.
- Almost all funding currently enters the trusts through Payment by Results (PbR); it is difficult to identify if non-PbR funding has been added at any point. The existing PbR expenditure is variable dependent on the acute trust providing care. PbR needs to be managed more effectively to ensure value for money.
- There are no discrete contracts in place for TB; existing TB services are commissioned as part of the global sum service level agreement (SLA). This means that it is virtually impossible to track funding and investments. PCTs, as recommended in the national TB commissioning toolkit, should introduce a discrete section to the acute contracts for the TB service.
- TB services provide variable community and outreach services, and there is little or no identified funding in place to deliver additional community and outreach work. PCTs should invest in community/outreach services in 2009-10.
- PCTs should not demand-manage TB and it should not be subject to choice as per national guidance.

Management and coordination gaps

Coordination: this is a challenging and ambitious agenda and the work should be taken forward by the network manager, when appointed. This person will need to support PCTs to commission TB services but also will have a significant role in stimulating the market and developing providers.
Key recommendations for commissioners

- Coordination:
  There is a need for increased coordination within South West London, but also more broadly within London, and nationally. This has been repeatedly highlighted, particularly the need for a national strategy and quality national data. This is even more important now that the commissioning of services is divided between CCGs (non-specialist care) and NHS England (specialist care).

- Funding:
  Designated funding for TB services should be maintained within acute trust contracts. Funding should also be designated for community and outreach services, particularly important for accessing hard-to-reach groups.

- Information:
  Regular needs assessments, including regular cohort reviews, should continue to inform local commissioning of services.

Local recommendations: findings and recommendations from South West London TB services review (2008)

The following areas were consistently highlighted in discussions with the TB teams:

- Increasing current capacity to work in the community rather than just in secondary care.
- Increasing education and awareness for primary care staff and community groups.
- A shortage of medical sessions to compete TB work.
- The level of DOT coverage and the capacity of teams to deliver this.
- A need to be more assertive in identifying new cases in high-risk groups.
- A need to be more assertive in terracing defaulters from TB care.

The following actions could support some of these issues:

- A formal development programme should be devised for TB nurses, in terms of career and educational development. This is a process that should be led by nurses.
- All senior staff within TB should be supported in developing management and leadership skills.
- Gaps in provision identified through the needs assessment should be filled using appropriately skilled staff.
- Nursing services should consider the introduction of timetabled sessions to ensure that time is given to essential activities such as outreach and health promotion.
- A case review board could be established to provide expert advice on complex cases management. The membership of this board could be flexible dependent upon the case. Similar groups could exist for multidrug resistant TB (MDRTB), case management, screening and incident management if required.
- Greater standardisation of assessment and data collection should occur, based upon the data requirements of the London standards and the suggested Health Protection Agency (HPA) enhanced surveillance requirements.
- Better reporting of data and performance against London and national standards.
- All TB services should have a dedicated budget.
- PCTs should identify a TB lead, lead clinician and commissioning lead.
- Budgets should reflect the need for funding items other than staffing.
- Investment in additional non-clinical staff to support enhanced case management and outreach.


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HIV

Key facts on disease

Human immunodeficiency virus is commonly known as HIV. It is a disease of the immune system primarily transmitted through unprotected sexual intercourse with an infected person. This includes vaginal, anal and oral sex. It can also be caught by sharing infected needles, or less commonly through contaminated blood transfusions and mother-to-child transmission in pregnancy.

HIV is a major public health issue for London. The number of people living with HIV in Merton has increased by 26% in the past five years (compared with 30% for England). It can affect anybody but the high-risk groups are MSM and black Africans. The latter accounted for 30% of people diagnosed with HIV in London in 2011.

HIV prevalence

Prevalence refers to the proportion of individuals within a defined population who are infected at a given time. In 2011, there were 561 people known to have HIV in Merton. This equates to a prevalence rate in Merton of 3.8 per 1,000 population aged 15-59 years (2011 ONS). This was lower than the London rate (5.4 per 1,000) but higher than the England rate (2.0 per 1,000). In 2011, 29 adult residents (aged between 15 and 59 years) of Merton were newly diagnosed with HIV.

Prevalence varies across Merton, with the five wards with the highest rates accounting for 42% of all people diagnosed with HIV in Merton. These wards are Pollards Hill, Figges Marsh, Lavender Fields, Colliers Wood and Abbey. The prevalence rate ranges from 5.7 per 1,000 in the former to 4.1 per 1,000 in the latter.

The majority of those diagnosed in 2011 were men (60%, 334) as shown in Figure 10.1 below. In terms of age, those aged 35-44 years old followed by those aged 44-54 years made up the biggest contribution to HIV diagnoses in Merton in 2011 (177,32% and 173,31% respectively).
Data analysis by ethnicity shows that two ethnic groups accounted for the majority of known HIV infections diagnosed in Merton: black African (276) and white (201) as shown in Figure 10.2 below. Given the ethnic diversity of the Merton population, BME groups appear to be disproportionately affected by HIV, which reflects the London trend.
In Merton, in 2011, heterosexual contact accounted for the largest proportion of residents diagnosed with HIV (324, 58%). This was higher than London and South West London at 46% and 53% respectively. Whilst MSM accounted for a significant proportion of HIV diagnoses in Merton (194, 35%), this was lower than London and South West London Sector as shown in Figure 10.3 below.

**Figure 10.3: HIV diagnoses by probable route of transmission.**

Late diagnosis of HIV

Data from 2011 estimates that 1 in 5 Londoners with HIV was unaware of their HIV status. The earlier people are diagnosed the better as they can access effective treatment, which greatly improves their health, and can reduce their chances of infecting others. It has been estimated that over half of overall HIV transmissions are due to people who are unaware that they have the disease.

Late diagnosis is one of the biggest contributing factors to morbidity and mortality of people with HIV and has significant implications for health and social care services. Reducing late diagnosis is used as an indirect performance measure for HIV prevention and is one of the Public Health Outcomes Framework indicators.

HIV infects cells in the body called CD4 cells that are found in the blood and are responsible for fighting infection. Late diagnosis is defined as people who have a CD4 count of less than 350 per cubic millimetre of blood at diagnosis. In 2011, 32% of people with HIV were diagnosed with a CD4 count of less than 350 in Merton, compared with 44% in London overall. 10% of MSM were diagnosed late (compared with 31% in London) and 50% of heterosexuals were diagnosed late (compared with 61% in London).
Key facts on services

HIV testing
Free HIV testing is offered to all ages through genito-urinary medicine (GUM) clinics, The Wilson Hospital walk-in clinic and in some GP surgeries. In the past three years uptake of HIV testing in GUM clinics has increased, with a 5% increase in tests offered and 14% increase in uptake, compared with a 6% in offered tests and 9% increase in uptake for England. London has seen a 12% increase in tests offered and 14% increase in uptake (see Figure 10.4 below).

Figure 10.4: Trends in HIV testing in Merton (2009-11).

![HIV testing uptake in Merton (2009-2011)](image)

All patients who test positive at a walk-in centre or in a GP surgery are referred to their nearest GUM clinic for a repeat/confirmatory test. The walk-in centre or GP surgery will send the patient’s preliminary test result to the GUM clinic via confidential fax or phone call and support the patient to attend. The GUM clinic will see the client within 48 hours and repeat the HIV test alongside a full screen for other STIs. The clinic will then obtain consent to refer to specialist services for support and signposting. When the patient comes back to obtain their results they will meet with a health advisor and be offered advice and counselling, and partner notification will be discussed. They will then meet with a consultant/registrar for their first medical visit.

South London HIV Partnership
The South London HIV Partnership (SLHP) is a consortium of South London councils. The partnership commission voluntary sector services for people diagnosed with HIV. The London Borough of Croydon currently hosts the commissioning of services on behalf of all participating members.
The partnership allows for a seamless and individualised system of services for HIV-positive people across geographical boundaries, allowing them to live independently. By being supported and well informed, these HIV-positive individuals will improve their ability to shape their lives positively and reduce risk-taking behaviour, including the onward transmission of HIV.

The service commissioned under this partnership acts as a first point of contact and referral for anyone diagnosed with HIV, and offers advice and advocacy, counselling and peer support.

South West London HIV Consortium
This is a partnership of South West London boroughs which commission voluntary sector services to deliver HIV prevention initiatives to black African communities. As with the South London Partnership, the London Borough of Croydon hosts the commissioning on behalf of all participating members.

Services currently offered are: targeted condom distribution, health promotion advice, referral to community services for HIV testing, awareness-raising courses on HIV/STIs, community engagement in the design of local HIV services and a clinical network that maintains collaboration and coordination between the provider organisations and professional groups.

Pan-London HIV Prevention Programme
From 1 April 2008, all London PCTs have funded what was then intended to be a three-year programme of HIV prevention for gay men and African communities. Funding is weighted according to HIV prevalence per borough. In 2013-14, many of the contracts were discontinued whilst the programme is reviewed. All services currently available are offered to MSM only and include: targeted condom scheme, counselling and mentoring, group work, and sexual health promotion, including 1:1 interventions.

What works and best practice

Public Health England (PHE) recommends that routine HIV testing should be a priority for all general medical admissions at hospitals in areas of high prevalence. It also recommends that Point of Care HIV testing be promoted to all GPs in high prevalence areas (with a rate of 2.0 per 100,000 or more), and offered on an ‘opt out’ basis to all patients as part of new registration checks or based on clinical indicators.

Two pieces of guidance from NICE were issued in 2011: the first on ‘increasing HIV testing in men who have sex with men’ and the second ‘increasing the uptake of HIV testing to reduce undiagnosed infection among Black African communities living in England’. They recommend:

- planning services, using local data to assess need and developing a strategy to address this need
- promoting HIV testing amongst these groups whilst addressing any barriers, particularly cultural issues
ensuring clear referral pathways
offering and recommending HIV tests through primary care for MSM
providing rapid point-of-care tests through outreach to MSM
engagement and involvement of black African communities.

In line with the British HIV Association (BHIVA) guidelines, all health professionals should routinely offer and recommend an HIV test to:

- men and women known to be from a country of high HIV prevalence
- men and women who report sexual contact abroad or in the UK with someone from a country of high HIV prevalence
- patients who have symptoms that may indicate HIV or where HIV is part of the differential diagnosis
- patients diagnosed with a sexually transmitted infection
- the sexual partners of men and women known to be HIV positive
- men who have disclosed that they have sexual contact with other men
- the female sexual contacts of men who have sex with men
- patients reporting a history of injecting drug use
- all patients attending: genito-urinary medicine or sexual health clinics, antenatal services, termination of pregnancy services, drug dependency programmes, tuberculosis, hepatitis B, hepatitis C and lymphoma services.

In February 2013, the Leaders’ Committee at London Councils agreed that there should be a robust, London-wide needs assessment to inform decisions on whether there was any merit in commissioning HIV prevention at a pan-London level in the future, rather than in boroughs or locally-initiated clusters, and what those interventions should be according to the evidence. The results of this are being used to inform future commissioning of HIV prevention and support services, alongside a review of the South London and South West London programmes, which has also been completed.

What are the gaps?

There is a need for more widespread HIV testing in primary care settings, in general medical admissions at Epsom and St Helier Hospitals and through the Contraception and Sexual Health (CASH) service.

There is a gap in knowledge on HIV testing in pregnancy and work around mother to child transmission. There is a need to work with St George’s and St Helier Hospitals to investigate surrounding issues since most of Merton mothers attend there.

Further understanding, including robust local data and a strategy for engaging effectively with MSM and black African communities is required.

There is a need for greater involvement of service users and those at risk of HIV in local commissioning and the development of effective interventions.
Merton Voice

An independent review of the South London and South West London HIV partnerships involved consultation with key stakeholders. Although not all participants were Merton residents, there was representation from Merton. The key feedback from stakeholders was that:

- there is awareness of condom distribution but not of the other services commissioned under these partnerships
- there is a need for further understanding of the diversity within African communities rather than a ‘one size fits all’ approach
- there is a need to take the time to build trust with certain communities in particular e.g. Somali communities
- there is a need for more joined-up working between GPs and community organisations as many people don’t want to access GPs; but community organisations don’t have the necessary resources
- more development work is needed to understand the health and social care needs of people living with or at risk of HIV
- there is a need to involve users and communities identifying service gaps by reaching out to communities who could not be reached through the traditional engagement schemes used to assess local health needs
- there is a time lag between HIV testing & receiving results which needs to be addressed in order to encourage widespread testing.

Key commissioning recommendations

- Reducing late HIV diagnosis in Merton should be a continuing public health priority. Twelve out of 20 wards in Merton have a prevalence of above 2.0 per 1,000 of the population.

- HIV testing should be offered more widely through primary care and through the CASH service.

- A pilot offering ‘opt out’ HIV testing in general medical admissions at Epsom and St Helier Hospitals should be considered.

- More targeted interventions aimed at MSM and Black African communities need to be explored and commissioned.

- To work with key partners to consider a South West London HIV forum and other ways to engage regularly with black African communities.

- Decisions need to be made, in partnership with South London colleagues, about the future commissioning of HIV prevention and support work provided through the South London and South West London partnerships.
Sexually Transmitted Infections (STIs) excluding Chlamydia

Key facts on disease

STIs are among the most common infectious diseases in the UK, with London having the highest rates of STIs in the country. High levels of unsafe sexual behaviour are likely to be the most contributory factor, but also the increased use of screening and asymptomatic testing such as through the National Chlamydia Screening Programme.

In Merton, there were 2,080 cases of acute STIs diagnosed in 2012, a rate of 1,037.2 per 100,000 population. Merton ranks 40 out of 326 local authorities in England (where 1st is the highest rate) for STI diagnosis rate.

Genital human papillomavirus (genital warts)

Genital warts are the second most commonly diagnosed STI after chlamydia. Infections are extremely common among the sexually active population especially in the first few years after starting sexual intercourse.

They are the result of a viral skin infection caused by the human papillomavirus (HPV). There are more than 100 types of HPV, 40% of which can infect the genital tract and are sexually acquired. These infections don’t usually cause a serious threat to health but they can be difficult to treat with frequent recurrent symptoms.

Data from GUM clinics shows the number of genital wart infections diagnosed in Merton residents has reduced by 10%, with the rate similarly reducing. This contrasts with London and England where the rate is more stable.

Figure 10.5: Genital warts diagnoses trends, 2009-11.

![Rate of Genital warts diagnoses in Merton (2009-2011)](source: HPA, 2012)
Gonorrhoea

Gonorrhoea is caused by bacteria called Neisseria gonorrhoeae or gonococci. These bacteria are found in the vaginal fluid or discharge of the penis of infected women and men, and therefore gonorrhoea is mainly contracted through unprotected sex.

The rate of diagnosis of gonorrhoea in Merton in 2011 was 76.6 per 100,000, significantly higher than the England rate of 39.1 per 100,000 but lower than the London rate of 109.2 per 100,000. The rate and number of gonorrhoea infections are increasing in Merton (see Figure 10.6 below). This increase is in line with that seen in London and England. These changes may simply be due to increased incidence, but it is likely that other factors such as more complete reporting, increased testing and better coding have impacted on the recorded rates.

Gonorrhoea diagnoses in Merton are concentrated in specific population subgroups, including males, MSM and those aged 25 and above. The local picture largely mirrors that for England.

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<th>Source: HPA, 2012</th>
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Figure 10.6: Gonorrhoea diagnoses trends (2009-2011).

Genital herpes

Genital herpes is an incurable but generally manageable infection caused by the herpes simplex virus (HSV). There are two types of the virus, with one being genital herpes. The virus is highly contagious and can be easily passed from person to person. Many infections are asymptomatic or present only mild symptoms, and as a consequence 80% of people are unaware of being infected.

The rate of HSV diagnosis in Merton in 2011 was 78.5 per 100,000, higher than the England rate (58 per 100,000) but lower than London (92 per 100,000). Between 2009 and 2011 the number and rate of HSV infections in Merton showed no consistent pattern in contrast to the increase in London and England during the same period.
Genital herpes infections were higher locally in women (68%) than men, and young people aged 15-24 accounted for 41% of all genital herpes infections diagnosed in 2011.

**Syphilis**

Syphilis is caused by a bacterium called Treponema pallidum, which can be passed on through close contact with an infected sore, normally during vaginal, anal or oral sex. Pregnant women can pass syphilis on to their unborn child causing stillbirth or death shortly after birth. Injecting drug users can also contract it by sharing needles with someone who is infected.

The symptoms develop in three stages. The first stage is the development of a painless but highly infectious sore which lasts two to six weeks before disappearing. Secondary stage symptoms can vary but can include a skin rash and sore throat. These become latent after a few weeks and can remain so for many years until the third and most dangerous stage develops, which can cause serious harm to the body.

Although syphilis accounts for the lowest proportion of STIs diagnosed in the UK, the number of diagnoses has been increasing since 1997, after having previously reduced for many years. There have also been a series of outbreaks, notably one in London in 2001, and syphilis infections have risen steeply since then, especially in MSM.

In Merton, in 2011, the rate of syphilis was low at 8 per 100,000, lower than London (17.5 per 100,000) but higher than England (5.4 per 100,000). Males accounted for 90% of cases and the majority of cases in Merton (71%) were in MSM.
Key facts on services

STI testing

Merton residents can access GUM clinics for free testing and treatment for the whole range of STIs. GUM clinics are open access so residents can go anywhere in London or indeed England. The biggest providers for Merton residents are St George’s Healthcare NHS Trust, Kingston Hospital, Epsom and St Helier Hospitals and Chelsea and Westminster Hospital. The local authority is cross-charged for any of their residents apart from Epsom and St Helier, which is a block contract. GUM is the only service Merton residents of all ages can access to get tested and treated for STIs. This is apart from providers offering chlamydia and gonorrhoea screening to 15-24 year olds as part of the national programme.

Residents can also access their GP for STI testing. In 2012-13, there were 2,439 STI tests in people registered with Merton general practices as shown in Table 10.1 below. It is noteworthy that some of these could be patients who are not residents of Merton. National Chlamydia Screening Programme tests for the under 25s have also been excluded from the 2,439 figure. The most common STI tested for in general practice was chlamydia – 1,249 tests were processed, which were likely to be for patients aged over 25. This was followed by HIV (1,053 tests) and syphilis (139 tests). For all conditions, the number of tests was significantly higher in females (74%) than males (26%). This is in keeping with information that women are more likely to engage with GPs. However, although fewer tests were seen in males, 8 out of 10 of them were for HIV.
Table 10.1: STI testing in general practices in Merton 2012-13.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
<th>Person</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>70</td>
<td>11%</td>
<td>1,179</td>
<td>65%</td>
<td>1,249</td>
<td>51%</td>
</tr>
<tr>
<td>HIV</td>
<td>501</td>
<td>79%</td>
<td>549</td>
<td>30%</td>
<td>1,053</td>
<td>43%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>62</td>
<td>10%</td>
<td>76</td>
<td>4%</td>
<td>139</td>
<td>6%</td>
</tr>
<tr>
<td>All STIs</td>
<td>633</td>
<td>26%</td>
<td>1,802</td>
<td>74%</td>
<td>2,439</td>
<td></td>
</tr>
</tbody>
</table>

Source: Epsom and St Helier Laboratories, 2012

With regards to STI prevention, free condoms are available to all ages from GUM clinics or CASH clinics. Both services are open access so residents can choose where they would prefer to go. At present the CASH service does not offer STI testing or treatment (apart from via the Chlamydia Screening Programme).

Merton and Sutton are also part of the pan-London condom distribution scheme, which offers free condoms to 13-25 year olds in a range of youth friendly settings such as youth clubs and colleges. The scheme has made slow progress to date.

What works and best practice

NICE guidance published in 2007 recommends the following to prevent sexually transmitted infections:

- use an individual’s sexual history to identify those at high risk: during consultations on contraception, pregnancy or abortion, when carrying out a cervical smear test, offering an STI test or providing travel immunisation; risk assessment could also be carried out during routine care or when a new patient registers
- offer one-to-one structured discussions with individuals at high risk of STIs focused on behaviour change
- ensure sexual health services, including contraceptive and abortion services, are in place to meet local needs; all services should include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI (partner notification)
- support patients with an STI to notify their partners that they need to get tested and treated (partner notification)
- provide one-to-one sexual health advice for under 18s on: how to prevent and/or get tested for STIs and prevent unwanted pregnancies, all methods of reversible contraception, including long-acting reversible contraception (LARC), how to get and use emergency contraception, and other reproductive issues and concerns.

The Department of Health’s Sexual Health and HIV strategy (2001) recommended as good practice commissioning integrated level 2 sexual health services, meaning people only need to visit one clinic for all their sexual health needs. This improves outcomes for patients and is more cost effective for service commissioners. Most areas are now working towards this kind of provision, many on a payment by results basis.
What are the gaps?

STI testing is particularly low in men even though the prevalence of chlamydia, gonorrhoea and HIV is high in this group. There is a need to work with men to understand effective ways to engage with them to increase the acceptability of using sexual health services and increase the uptake of STI testing.

The CASH service in Merton and Sutton is not providing an integrated service at present so only offers contraceptive provision. It will begin offering HIV testing this year but steps need to be made towards further integration.

There is a lack of robust data relating to the activity, outcomes and service user experience of the GUM and CASH services. This is needed to inform future commissioning.

General practice is an underutilised resource for sexual health service provision. Although general practices in Merton have seen an increase in STI testing, the numbers are still low and rates of testing vary considerably across the borough. Successful pilots in London and other areas support both the feasibility and acceptability of HIV testing in primary care (HPA 2011). There is potential in Merton to engage with GPs to discuss implementation of sexual health service provision.

Merton Voice

Young People
A sexual health and substance misuse needs assessment of under 18s carried out in January [2012] highlighted that young people felt:
- There was not enough access to free condoms in different settings where they would feel comfortable asking for them.
- There needs to be increased access to free emergency hormonal contraception.
- Clinic settings in Merton are not very accessible, and they want more privacy.
- Contraception should be available more widely in different settings, and a youth club setting would be acceptable if private.
- They need more information on sexual health and where to access services.

When asked if they knew where to get support if they needed any information, advice or support regarding sexual health: 62.7% of those questioned through a targeted youth support survey said no and 81% of those questioned through a schools/academies/college survey said no.
Key commissioning recommendations

There is a need to work towards the development of an integrated level 2 sexual health service.

The barriers to accessing the condom distribution scheme need to be identified and solutions developed to enhance distribution.

There is a need to ensure that people, especially young people, are aware of local sexual health services and how to access them. In particular, investment in further advertising of www.gettingiton.org.uk.

An independent review of the CASH service should be commissioned in order to fully understand accessibility, service user experience, what works, and any gaps or barriers.

Data reporting for GUM and CASH services need to be strengthened and commissioner/provider relationships further developed so effective monitoring and management can take place.

Good practice models of working with men need to be explored and local insight gained, so effective interventions can be commissioned that increase safe sexual health practice and STI testing and treatment.

Opportunities to increase STI testing in GP practices need to be explored.
Chlamydia

Key facts on disease

Genital Chlamydia trachomatis is the most commonly reported bacterial STI in England. Over 186,000 new cases were diagnosed in England in 2011 (HPA) representing a substantial public health problem. Infection is asymptomatic in at least 70% of women and 50% of men and as a result the majority of infections remain undiagnosed.

Untreated, chlamydia infection has significant health consequences. It is associated with considerable reproductive morbidity in women, including pelvic inflammatory disease, ectopic pregnancy and blocked fallopian tubes causing infertility. In men complications include urethritis, epididymitis and Reiter’s syndrome.

Figure 10.9 below shows that chlamydia rates are highest in women aged 15-20 years but decline rapidly thereafter. In men, the peak is slightly later with the highest rates at 20-25 years.

Figure 10.9: Chlamydia diagnoses rates by age and sex, 2011.

In Merton, the rate of chlamydia diagnosis in 2011 was 335.7 per 100,000 population, which was lower than England (351.2 per 100,000).\textsuperscript{171}

The National Chlamydia Screening Programme (NCSP), which started locally in Merton in 2008, specifically targets 15-24 year olds. In 2011, 5,419 chlamydia tests were undertaken by Merton residents aged 15-24. The number of tests was equivalent to coverage of 24% of the Merton 15-24 year old population, with a rate of positivity of 8%. This compares with coverage of 30% nationally, with a 7% positivity rate.\textsuperscript{171}

The rate of positive Chlamydia diagnoses in Merton in 2011 amongst 15-24 year olds was 1,987.8 per 100,000 population.\textsuperscript{171}

\textsuperscript{171} PHE (2012).
Key facts on services

The main focus on chlamydia screening and treatment is 15-24 year olds, as recommended by the NCSP coordinated by Public Health England. It is a control and prevention programme offering free, opportunistic screening and treatment to sexually active people in this age group who are asymptomatic. In Merton, dual testing for chlamydia and gonorrhoea is now offered.

In 2011-12, the focus for the programme shifted from the number of people screened to the number of positive diagnoses. The current expectation of the NCSP is to work towards achieving 2,300 diagnoses per 100,000 young people aged 15-24 years. This is a Public Health Outcomes Framework indicator.

In Merton, the programme has a target of working towards 2,200 diagnoses per 100,000, which is 504 positive diagnoses per year (based on the 2011 population census estimates). Table 10.2 below shows progress towards this target over the past three years. There were 820 positives in 2012-13.

<table>
<thead>
<tr>
<th>Diagnosis target (per 100,000 15-24 year olds)</th>
<th>Merton</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,000 (increased to 2,200 in 2012-13)</td>
<td></td>
</tr>
<tr>
<td>Positives needed to achieve target (GUM included)</td>
<td>918 (975 from 2012-13)</td>
</tr>
<tr>
<td>Performance 2011-12</td>
<td>1,939</td>
</tr>
<tr>
<td>Performance 2012-13</td>
<td>1,628</td>
</tr>
<tr>
<td>Performance 2013-14 (Q1 data only)*</td>
<td>1,685</td>
</tr>
</tbody>
</table>

*This is an indication of the diagnostic target which will be achieved if activity continues as in Q1

The NCSP estimates that at least 70% of screening should be achievable through core services such as primary care, contraception and sexual health clinics, pharmacy and termination of pregnancy services. In Merton, in 2012-13, there was over-achievement on this target with 78.8% being screened in core services.

The local programme is currently run by Terrence Higgins Trust (THT), as part of a partnership arrangement with the London Boroughs of Croydon, Richmond, Sutton and Wandsworth. THT is responsible for building capacity and embedding screening provision within core services. It also undertakes the management of the laboratory contract, health promotion campaigns, advertising, training, outreach activity and website management. An independent evaluation of the service being offered has been carried out and will inform future commissioning.
As well as screening in genito-urinary medicine (GUM) clinics, tests take place in a wide range of other settings as shown in Figure 10.10 below. In addition, home testing kits can also be ordered online via www.checkursef.org.uk and http://freetest.me.uk/. The online service is very popular with young people. In 2012-13, 173 Merton residents returned chlamydia testing kits via the www.checkursef.org.uk website, of which 6% of the returned kits tested positive, while 287 tests were returned via the http://freetest.me.uk website with 7% positivity.

Figure 10.10: Non-GUM site for chlamydia screening across Sutton and Merton, 2011-12.

In 2012, there were 95 tests done in Merton pharmacies with 5% of the patients testing positive. Some pharmacies also offer other services to this age range including condom distribution and emergency hormonal contraception (EHC). A few will soon be offering chlamydia treatment as well as testing, as part of a pilot initiative.

Aside from the NCSP, both under 25s and over 25s can access free testing at GUM clinics. In 2011, there were 7,752 chlamydia tests provided to Merton residents through GUM: 39% were to 25-34 year olds and 37% were to 15-24 year olds. Of these, 595 tests were positive with 58% (344) of the positives in people aged below 25 years and 51% in men.

**What works and best practice**

The National Audit Office report (2009) on cost effectiveness within the NCSP suggested that embedding chlamydia screening within mainstream sexual health service provision could generate efficiencies, and would make screening a routine part of a sexual health consultation.

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172 National Chlamydia Screening Programme (2013).
The NCSP advocates that testing is completely integrated into existing primary and community sexual health and GUM services, so there is no longer stand-alone chlamydia specific activities.

It is advised that commissioners review the use of all resources in the community and care pathways into GUM services.

**What are the gaps?**

The Chlamydia Screening Programme for 15-24 year olds is still a long way from being embedded effectively into core services, many of which are being paid additional money to offer this service.

Primary care providers would prefer a more integrated model of sexual health where training is offered on the whole range of services together, e.g. EHC, c-card condom scheme.

Chlamydia screening needs to be made more accessible to the over 25s as well as the under 25s. At present, the only place someone over the age of 25 can be tested is at a GUM clinic.

**Merton Voice**

An independent evaluation of the Chlamydia Screening Programme was carried out in 2013. As part of this evaluation, 15-24 year olds were consulted. Although numbers were small the findings were:

- All the young people had heard of chlamydia, but their knowledge of transmission, symptoms and testing indicated knowledge gaps, even though 50% of them had been tested.
- They expressed a preference for being tested by GPs and nurses.
- GUM clinics were reported as the sites most used for testing. Only nine people responded but of these 50% had a positive experience of testing and rated their experience as ‘good’, and 16.7% as ‘very good’. Texting was the most used method of receiving a test result and all young people were satisfied about the way they received their results.
- Three young people reported receiving no further information following a negative result. This probably reflects the fact that over 57% received their results by text, however there is a need to ensure that health promotion messages and the importance of re-testing is communicated at this vital time.
- Fifty per cent of the young people with a positive result received treatment, all reporting a positive experience, with an emphasis on helpful staff.
- There were lots of ‘myths’ about sexual practice that hadn’t been addressed through sex and relationships education in school or contact with sexual health services.
- There was still a lot of ‘embarrassment’ surrounding testing for both males and females. Possible solutions suggested were role models/celebrities promoting the importance of
testing, or a young person sharing their experience, but they were not sure if anyone would volunteer.

- The main reason for seeking a test was unprotected sex for which the main reasons were ‘being drunk’, and ‘being in a relationship’. They felt that sexual health shouldn’t be discussed in isolation.

**Key commissioning recommendations to fill the gaps**

- There needs to be a further focus on embedding chlamydia screening into core services especially the CASH service and in GP practices, as recommended by the NCSP.

- Commissioning models which address a whole range of health concerns and risk-taking behaviour need to be explored rather than chlamydia being considered separately.

- Increasing access to chlamydia screening to the over 25s needs to be considered so that GUM is not the only provider.

- Work needs to be undertaken to ensure that key preventative messages are given to those receiving a negative result.

- Sex and relationships education and information sources for young people need to be reviewed and considered to ensure that ‘myths’ are dealt with, and they have the knowledge and skills they need to make informed decisions about their sexual health.
Contraception

Key facts on services

General practices
GPs are instrumental in contraception provision. It is estimated nationally that three quarters of all access to contraception is through general practice. There are 28 GP practices in Merton.

Oral contraception is the most common form of contraception prescribed by GPs. In 2011-12, the rate of prescribing in general practice was 42.8 prescriptions per 100 women (aged 15-49 years). Oral contraceptives accounted for 89% of all GP prescriptions. However, this does vary from practice to practice, ranging from 21.4 to 62.4 prescriptions per 100 women aged 15-49.

The average LARC prescription rate in GP practices in Merton was 46.2 prescriptions per 1,000 women aged 15-49. Due to the recent NHS transition, data reflecting the new organisations is not yet available. Figure 10.11 below presents PCT data as a proxy in the absence of CCG data, showing how Sutton and Merton LARC prescribing compares with the rest of London and England. The LARC prescribing rate is low generally but only lower than [8] PCTs in London.

Figure 10.11: LARC prescribing rate per 1000 women aged 15-44, 2011-12.

Source: APHO sexual health balanced scorecard

Like oral contraception, the LARC prescription rate varies from practice to practice across Merton. In 2011-12 this varied from 0.4 to 15 per 100 women aged 15-49 years. Injections were the most common type of LARC prescribed.
Figure 10.12 below shows spend on contraception over time (LARC, pills and other forms of contraception like patches). More than 70% of all spend on contraception in general practices is generated by prescriptions for pills. Although there has been an increase in spend on LARC since 2008, the proportion of spend is still low.

Figure 10.12: Proportion of spend by contraception type in Merton general practices, 2008-13.

There were 460 women recorded as having been prescribed EHC in Merton GP practices in 2011-12, an 11% reduction from the previous year. Eight in nine of those women had been given information on LARC in the previous 15 months.

It is worth noting when considering all the GP data above that it is only indicative of people registered with Merton general practices and general practices using Epsom and St Helier hospital laboratories. There could be a cohort of Merton residents registered with GPs outside the borough and GPs using St George’s Hospital laboratories for whom we have no access to data.

**Contraception and Sexual Health Clinics (CASH)**

CASH is a rebranding of the former family planning clinics. The contract for this service, which is jointly commissioned between Merton and Sutton, is currently provided by the Royal Marsden NHS Foundation Trust. The service provides cost-effective, high-quality provision of contraceptive services and onward referral for treatment of STIs. Chlamydia screening and treatment are currently offered only as part of the NCSP, and HIV testing is due to commence shortly. The service is working towards providing an integrated service – level 2 STI testing, screening and treatment and HIV testing.

The service went through a redesign in 2012 and now operates a hub and spoke model. In Merton, the hub is Patrick Doody Clinic in Wimbledon and Wide Way Clinic in Pollards Hill is
the satellite. The service is characterised by being open access, so it is available to anyone requiring care, irrespective of their place of residence, without referral.

Data quality has been an issue for the service; therefore this should be considered with caution. The data that is available for 2012-13 shows 6,053 attendances in Merton with approximately 15% of these being under 20 year olds and 2.5% being male. The data also shows that 75% of these contacts were for contraception. Of the contacts for contraception: 2,665 were for oral contraception; 1,731 for LARC; and 1,863 for condoms. Of the patients who took up LARC, 85% were 21 years or over and 15% were 20 years or under.

**Pharmacies**

A number of sexual health services are provided in pharmacies in Merton, in line with the direction for community services set out in the Government’s White Paper: *Our health, Our care, Our say*.¹⁷³

EHC is provided free to 13-25 year olds presenting at a pharmacy. In 2012-13, 545 women residents in Merton were given EHC of which 50% (274) were aged 20-24 years and 44% (239) were 15-19 year olds. Condoms are provided to community pharmacies participating in the EHC scheme to distribute to patients after their emergency contraception consultation. Chlamydia screening is also offered in many pharmacies across the borough.

**Check It Out (under 20s sexual health service)**

This service was commissioned in 2009 to address the low numbers of young people being seen in mainstream CASH clinics, to increase access to contraceptive and sexual health services for the most vulnerable young people and to contribute to a reduction in teenage conceptions. The current provider is the Royal Marsden NHS Foundation Trust.

Service delivery is a mixture of ‘clinic in a box’ in schools, one-to-one support, education and outreach sessions. A range of contraceptive methods, including condoms, contraceptive pills, LARC and EHC, are offered. Other services include chlamydia screening, pregnancy testing and referral for termination.

Data for 2012-13 shows the following performance headlines:

- 721 young people in Merton accessed clinic in a box sessions with a 50/50 split in gender.
- The age range of young people seen ranged from 12 to 19 years with the majority aged 15 to 17 years.
- A range of contraceptive methods were provided through ‘clinic in a box’ sessions including: 356 clients seen for oral contraception (28% of provision), 820 for condoms (65%), 52 for LARC (4%), and 42 for EHC (3%). Some clients will have received more than one method.
- Uptake of oral contraception, LARC and EHC was fairly low.
- There were 21 one-to-one responsive sessions provided, with concerns raised including poor self-esteem, multiple risky behaviours, young people with sexual health needs included in their child protection plans, and repeat pregnancy scares. Many were supported to attend GUM and several commenced LARC after discussion.

• Education sessions were carried out in Merton at The Prince’s Trust, the Acacia Centre (St Mark’s students), the New Horizon Centre (Pollards Hill), Commonside (Young Mums Group), and Muschamp (Antenatal Group).

What works and best practice

NICE recommends that ‘women requiring contraception should be given information and offered a choice of all methods, including LARC methods’.

What are the gaps?

There is a need to understand the reasons underlying the low prescribing rates for LARC in GP practices. The reasons could be due to training issues where nurses and GPs lack the necessary training to fit LARC confidently and competently or a lack of knowledge and acceptance of LARC amongst women. Although most practices are offering information on LARC, the timeliness and depth of the information as well as service pathways impact on uptake and need to be standardised.

Data available on the uptake of sexual health services in general practice is poor and often unreliable. There are gaps in critical information, for instance the demographics of those attending, creating difficulty in identifying unmet needs and inequalities in access.

The CASH service in Merton and Sutton is not providing an integrated service at present. It only offers contraceptive provision, and dual testing for chlamydia/gonorrhoea to the under 25s. It will begin offering HIV testing [in 2014] but steps need to be made towards further integration.

There is a lack of robust data relating to the activity, outcomes and service user experience of the CASH service. This is needed to inform future commissioning.

Merton Voice

An independent review of the Check It Out service was carried out this year. Engagement with under 20s found the following:

• The majority of feedback indicated that they were ‘moderately to extremely’ satisfied with the service.
• The need for more awareness and information on sexual health was highlighted. Although there is information on www.gettingiton.org.uk and through comments related to where this should be more available and in different formats e.g. posters, website, apps and Facebook.
• They wanted sexual health information and treatment to be brought to them in schools and colleges, or other settings young people visit e.g. youth centres, nightclubs.
• They stressed the need for privacy especially in schools when receiving contraception and STI testing.
• They wanted Check It Out, school nurses, GPs, specialist youth workers and pharmacists to provide services.
• They requested better opening times for the CASH service after school and at the weekend.

Key commissioning recommendations

• Opportunities for promoting the use of LARC and increasing uptake in GP surgeries need to be explored.

• An independent review of the CASH service should be commissioned in order to fully understand accessibility, service user experience, what works, and any gaps or barriers.

• Data reporting for the CASH service needs to be strengthened and commissioner/provider relationships further developed so effective monitoring and management can take place.

• There is a need to ensure that people, especially young people, are aware of local sexual health services and how to access them. In particular, investment in further advertising of www.gettingiton.org.uk.
Infectious Diseases

Overview

‘Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another.’

(World Health Organization)

Infectious diseases continue today to pose a significant burden to health and society. The increased mobility of people and goods has contributed to the persistent and ever-changing impact of infectious diseases. In the UK, infectious diseases have been estimated to account for half of GP consultations for children, and over a third of GP consultations for adults. Direct costs to the NHS were estimated in 2005 to be £6 billion, one tenth of the NHS budget. The majority of this cost is in primary care.

The sections below will outline key infectious diseases; including background information, trends in the local population and regional comparisons. This will be followed by a description of services available locally, gaps, and recommendations. Please note that sexually transmitted infections are discussed in the section above (Sexual Health); childhood vaccinations are discussed in the Children and Maternal Health Theme.

Unless otherwise specified, the infectious disease surveillance information below comes from Public Health England (PHE); specifically from the South West London Health Protection Team within PHE. Available surveillance data and epidemiology of diseases are influenced by the designation of diseases as notifiable as per the Health Protection (Notification) Regulations 2010. Please see Appendix 2 to this Theme 10 for the list of notifiable diseases.

Overview: Immunisation, treatment, and surveillance of infectious diseases

The Health and Social Care Acts of 2008 and 2012 brought about changes in the division of responsibilities and roles in providing services in infectious diseases. For example, commissioning, delivery, and regulation of immunisation services are now shared at national level between NHS England, Public Health England (PHE), and the Department of Health (DH); the local operating model divides responsibilities between NHS England, PHE, and local government.

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Immunisation (both routine and for groups at risk) is provided largely in primary care from GPs, although vaccinations can be provided in other community settings (such as pharmacies and schools) or in acute settings if appropriate.

Treatment of infectious diseases is provided at primary, secondary, and tertiary levels depending on individual choice and clinical presentation. If the condition is notifiable, healthcare professionals at these sites should contact PHE.

The Health Protection Team (HPT), within PHE, collects information for surveillance and monitoring, and also provides support and advice on infectious disease prevention, treatment and control. For example, focusing on vaccine-preventable illnesses, South West London HPT advises on contact tracing and treatment of vaccine-preventable diseases such as hepatitis and meningococcal disease.

Vaccine-preventable diseases

Measles/Mumps/Meningococcal Disease

<table>
<thead>
<tr>
<th>Measles and Mumps are vaccine preventable diseases for which there is a national immunisation programme in the UK.</th>
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</thead>
<tbody>
<tr>
<td>Meningitis is the inflammation of the linings of the brain and spinal cord, while sepsicaemia is the blood poisoning form of the disease. These two conditions have different sets of symptoms and may occur separately or together. Additionally, they may be caused by a variety of different organisms, including bacteria, viruses and fungi. When caused by meningococcal bacteria, these two conditions together are known as meningococcal disease.</td>
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Adapted from HPA: http://www.hpa.org.uk/

Measles and mumps are both acute viral illnesses, prevented by the MMR vaccine. Measles is a highly infectious viral illness; the illness can be more severe in certain groups, such as infants, pregnant women, and the immunocompromised. Mumps is an acute viral illness that can cause serious complications such as meningitis, although it is rarely fatal. The number of cases of measles in England and Wales in 2012 was at its highest level in 18 years, which underscores the importance of increasing immunisation rates.

Measles in Merton:
- In the previous three years (2010-12), there were 10 reported cases of measles in Merton.
- The measles rate for 2012 (per 100,000 population) was 1.0 per 100,000 population.
- In 2012, Merton's measles rate was ranked fourth out of the six SWL LAs.

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Mumps in Merton

- Over the same period (2010-12), there were 27 reported cases of mumps in Merton.
- The mumps rate for 2012 per 100,000 population was 3.5 per 100,000 population.
- In 2012, Merton’s mumps rate was ranked second out of the six SWL LAs.

Meningococcal disease in Merton:
Meningococcal disease is a bacterial infection, potentially leading to serious sequelae such as: meningitis, or inflammation of the lining of the brain; and septicaemia, or bloodstream infection. Vaccination is available for particular strains of meningococcal disease.

- From 2010-12, there were 17 cases of meningococcal disease in Merton.
- The rate of meningococcal disease for 2012 was 3.5 per 100,000 population.
- This ranked highest of the six SWL LAs.

Hepatitis

- Over the period from 2010-12, there were six cases of hepatitis A in Merton, and six cases of acute hepatitis B.
- The rate of hepatitis A and acute hepatitis B in Merton was ranked fifth out of the six SWL LAs in 2012.

Key services

Vaccination of appropriate groups and individuals (prevention) is central to addressing vaccine-preventable illness.

National immunisation campaigns cover the following illnesses:

- Neonatal hepatitis B immunisation programme
- Neonatal BCG immunisation programme
- Respiratory syncytial virus (RSV) immunisation programme
- Immunisation against diphtheria, tetanus, poliomyelitis, pertussis, and Hib
- Meningitis C (MenC) immunisation programme
- Hib/MenC immunisation programme
- pneumococcal immunisation programme
- DTaP/IPV and dTaP/IPV immunisation programme
• Measles, mumps and rubella (MMR) immunisation programme
• Human papillomavirus (HPV) immunisation
• Td/IPV (teenage booster) immunisation programme
• Seasonal influenza immunisation programme.

New programmes:
• Rotavirus
• Shingles
• Childhood influenza programme
• Continuation of the temporary pertussis programme for pregnant women.

As stated above, responsibility for immunisation programmes is divided between DH, NHS England, PHE, and local government. The framework of division of roles and responsibilities is as follows, with the addition of Expert Committees contributing to policy development:177

• **DH**: national strategic oversight, policy and finance for the national screening and immunisation programmes.
• **NHS England**: the routine commissioning of national screening and immunisation programmes.
• **PHE**: supporting both DH and NHS England, with system leadership, national planning and implementation of immunisation programmes.
• **Local government (including local public health teams)**: improving and protecting the health of local people and communities.

**Note that local public health teams are not directly involved in immunisation programme delivery; also that service providers will continue delivering programmes under existing contracts.** 177

**What works and best practice**

Best practice is to give vaccinations according to the ‘Green Book’ (*Immunisation against Infectious disease*) guidelines, published by the Department of Health in collaboration with the [PHE]HPA and the Joint Committee on Vaccination and Immunisation (JCVI).179 Vaccinations in Merton should be delivered according to Green Book guidelines. Please see Appendix 1 to this Theme 10 for the full 2013-14 vaccine schedule. For further information regarding vaccination in children, please see Theme 6 (*Children and Young People, and Maternal Health in Merton*).

NICE guidance on increasing vaccination rates, particularly reducing differences in the uptake of immunisations in children and young people, and ensuring vaccination of babies born to mothers with hepatitis B, was issued in 2009 (and updated in 2011).

A linked NICE Pathway on immunisation for children and young people was updated in June 2013. Please see Figure 10.13 below for an overview of this pathway (NICE 2009; updated

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Guidance recommendations cover six areas:

- immunisation programmes
- information systems
- training
- contribution of nurseries, schools, colleges of further education
- targeting groups at risk of not being fully immunised
- hepatitis B immunisation for infants.

Specific advice included is (see NICE Pathway for full recommendations):

- improve access to immunisation services e.g. by extending clinic times and making sure clinics are ‘child-friendly’
- provide parents and young people with tailored information and support and an opportunity to discuss any concerns
- check children and young people’s immunisation status during health appointments and when they join nurseries, playgroups, schools and further education colleges, and offer them vaccinations
- ensure babies born to hepatitis B-positive mothers are given all recommended doses of the vaccine on time, a blood test to check for infection and, where appropriate, hepatitis B immunoglobulin.

Figure 10.13: NICE Pathway – immunisation for children and young people.

Source: NICE Pathways http://pathways.nice.org.uk/
Key commissioning recommendations

The NICE Pathway referred to above includes a specific pathway and recommendations for immunisation strategy, policy and commissioning (see Figure 10.14). Specific advice given in this pathway – strategy, policy and commissioning for immunisation services – is outlined in Box 10.1 below.

Figure 10.14: NICE Pathway – strategy, policy and commissioning for immunisation services.

Source: NICE Pathways http://pathways.nice.org.uk/
Box 10.1: Recommendations from NICE pathway: strategy, policy and commissioning for immunisation programmes (http://pathways.nice.org.uk/)

Implementing the routine childhood immunisation programme for those aged under 19

- Directors of public health and others who commission immunisation services should ensure Department of Health (DH) guidance and updates on immunisations (including official letters from the Chief Medical Officer, Chief Nursing Officer and Chief Pharmaceutical Officer) are disseminated to relevant professionals and implemented.

- They should also ensure a multifaceted, coordinated programme is adopted across different settings to increase timely immunisation among groups with low or partial uptake. The programme should form part of the local child health strategy and should include the following actions:
  - Monitor vaccination status as part of a wider assessment of children and young people's health.
  - Ensure there is an identified healthcare professional in every GP practice who is responsible — and provides leadership — for the local childhood immunisation programme.
  - Ensure all staff involved in immunisation services have access to the Green book. Also ensure updates to the childhood immunisation programme and schedule are monitored and services adapted appropriately.

Developing information systems to support effective immunisation services

- Public health commissioners and GPs should ensure there is a structured, systematic method for recording, maintaining and transferring accurate information on the vaccination status of all children and young people. Vaccination information should be recorded in patient records, the personal child health record and the child health information system. The same data should be used when reporting vaccinations to the child health department and when submitting returns for GP and practice payments. This will ensure records in both systems are reconciled and consistent.

- Public health commissioners should encourage and enable private providers to give the relevant GP practice or public health commissioners details of all vaccinations administered to children and young people, so they can be recorded in the appropriate information system.

- Those responsible for databases used to record the immunisation status of children and young people should regularly update and maintain them. For example, ensure records are transferred when a child or young person moves out of the area, ensure information is not duplicated and follow up on any missing data.

- Information system providers and immunisation coordinators and leads should ensure up-to-date information on vaccination coverage is available and disseminated to all those responsible for the immunisation of children and young people. This includes those who are delivering the vaccinations.

- Public health directors and commissioners should use recorded information on immunisation, together with surveillance data on the incidence of infection, to inform local and joint strategic needs assessments and health equity audits. These data should also be used to support delivery of an immunisation programme for children and young people.

- Immunisation leads and coordinators should monitor the age composition of the practice population so that there is enough capacity to provide timely immunisations. Waiting lists are unacceptable.

Implementing the hepatitis B immunisation programme for infants born to hepatitis B-positive mothers:

Providing information on, and access to, immunisation services: What action should be taken?

- Commissioners of children's services in primary care, Sure Start children's centres and immigration services should improve access to immunisation services for those with transport, language or communication difficulties, and those with physical or learning disabilities. For example, provide longer appointment times, walk-in vaccination clinics, services offering extended hours and mobile or outreach services. The latter might include home visits or vaccinations at children's centres.

- They should consider using pharmacies, retail outlets, libraries and local community venues to promote and disseminate accurate, up-to-date information on childhood immunisation.

Source: NICE Pathways http://pathways.nice.org.uk/
Tuberculosis

Key facts on tuberculosis

Tuberculosis (TB) is an infectious disease caused by bacteria belonging to the Mycobacterium tuberculosis complex. Only the pulmonary form of TB disease is infectious, following prolonged close contact with an infectious case. TB is curable with a combination of specific antibiotics, treated for at least six months. TB is the leading cause of death among curable infectious diseases. The World Health Organization declared TB a global emergency in 1993.

Adapted from HPA: http://www.hpa.org.uk/

TB is a key national priority for PHE, as well as being a key priority for London.\textsuperscript{180,181}

While rates of TB in the UK have been stable since 2005,\textsuperscript{181} TB rates in the UK (and London in particular) remain among the highest in Western Europe.\textsuperscript{181} In 2011, London had the largest proportion of TB cases in the UK, close to 40\% of all cases.\textsuperscript{182} London also has the highest incidence of TB of any western European capital.\textsuperscript{181}

Mortality from TB has continued on a decreasing trend, however deaths from TB – a treatable disease – continue. In London from 2001-10, 1,348 people died as the result of TB.\textsuperscript{79,183}

\textsuperscript{182} Health Protection Agency (PHE) (2012). London Regional Epidemiology Unit.
\textsuperscript{183} Health Protection Agency (PHE), (2013). Tuberculosis Update.
TB disproportionately affects certain groups and individuals, and rates vary according to ethnicity, migrant status, gender, and social risk factors (such as homelessness, drug and
alcohol misuse, imprisonment and mental health issues).\textsuperscript{180,181} Drug resistance in TB and co-infection of TB and HIV are also of particular concern.

**TB in London overall**

- From 2010-12, there were 10,147 cases of TB in London.
- The overall rate in London in 2012 was 41.9 per 100,000 population.
- Rates are highest in 20-29 year olds; rates are higher in males.
- The majority of cases were born outside the UK.
- Most (89%) of under 5 year old cases were born in the UK – they make up only 1% of cases.

  \textit{Source: PHE 2013}

**TB in Merton:**\textsuperscript{184}

In Merton, both the number and the rate of TB cases have been increasing over the past several years.

- The TB rate in Merton increased to 37/100,000 in 2012, the highest seen in recent years, and just below the London average.
- Patients were predominantly male, and aged 20-49 years old.
- While most were born outside the UK, 27\% had been in the UK over ten years.
- The most common ethnic group was mixed/other; the most common countries of birth outside the UK were India, Sri Lanka and Pakistan.
- More than half had pulmonary TB, a rate of 21/100,000: a lower than average proportion of these were confirmed by culture.
- Merton residents had similar levels of isoniazid resistance and higher multi-drug resistance, compared to the London average.
- Treatment completion was similar to the London average at 87\%.

\textit{Source: Local Authority TB Profiles (2012 data)}

**Cases**

- From 2010-12, there were 194 notified cases of TB in Merton.
- In 2012, there were 74 cases of TB, higher than in the previous three years.
- The rate of TB per 100,000 population in 2012 (36.6), was the highest of all SWL LAs.
- One third of cases in 2012 were in 20 to 29 year olds.
- 13.5\% of cases were born in the UK.

Figure 10.17: TB rates in Merton by year 2010-12.

Merton TB Rates by year 2010-2012
Source: Merton Local Area Health Protection Profiles 2010-12, SWLHPU

Source: HPA/PHE Surveillance data

Figure 10.18: London TB Notification Rates 2009-11, Merton in comparison with geographical and statistical neighbours.

TB Notification Rates, 2009-11
Source: London Health Programmes HNA Toolkit

Key facts on services

TB services for South West London are centred at four acute trusts:
- St George’s Healthcare NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
TB Services aim to provide the following elements of care:

- Investigation of suspected but unconfirmed TB
- Case management of TB patients
- Contact tracing and screening of individuals exposed to TB
- Community home visiting
- Multidisciplinary TB clinics
- Nurse-led hospital and community TB clinics
- Outreach work
- Reactive outbreak screening
- Directly observed therapy (DOT) for patients identified as at risk of treatment failure.

Additional services and structures provide:

- Awareness raising
- Services targeting specific populations
- Find-and-treat teams.

**Coordination of TB services in South West London**

Historically, only an informal network and communication have existed between TB service providers in South West London (and London-wide). No pan-London TB services exist at present. The find-and-treat team is the only pan-London service aspect at present. However, formal cohort reviews are now being held regularly; there is also a TB sector group that meets quarterly (TB team).

Pan-London reporting and standards are in use (London Model of Care; London TB Register), and there is acknowledgement of the need for a strong response to the high rates of TB in London. However, no funding or commissioning services have been allocated to this aim.

**What works and best practice**

There is extensive published NICE guidance on the management of TB (NICE 2006; 2011) which covers:

- Diagnosis
- Management of respiratory TB
- Management of non-respiratory TB
- Monitoring, adherence and treatment completion
- Risk assessment and infection control in drug-resistant TB
- Management of latent TB
- BCG vaccination
- Active case finding

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• Preventing infection in specific settings.

The updated NICE Pathway for tuberculosis (see Figure 10.19 below) includes guidance on:
• commissioning tuberculosis services
• preventing the spread of tuberculosis
• diagnosing and managing active tuberculosis
• identifying and managing tuberculosis among hard-to-reach groups.

**Figure 10.19: Overview of NICE Pathway – Tuberculosis.**


In 2007, following a review of TB, the Chief Medical Officer (CMO) recommended that the schools immunisation programme be terminated in favour of a programme of immunisation of newborn babies in areas where the prevalence of the condition was more than 40/100,000 and for babies where the parents are first-generation immigrants from areas with high levels of circulating TB.

**What works to improve identification and management of tuberculosis**

NICE has produced guidance on what works to improve the way TB is identified and managed in hard-to-reach communities (2012). The hard-to-reach groups considered in the guidance were:
• people who are homeless
• substance misusers
• prisoners
• vulnerable migrants.

Improving identification and management of TB in these groups will benefit the wider community, by helping to reduce onward transmission of TB among the general population. Recommendations include:
• raising and sustaining awareness of TB among health professionals and those working with hard to reach groups, and among the hard-to-reach groups themselves
• local needs assessment
• community multidisciplinary TB support
• identifying and managing TB (including contact investigation)
• rapid-access TB services and enhanced case management
• provision of accommodation during treatment.

Follow the link for further information on the guidance: http://pathways.nice.org.uk/pathways/tuberculosis#

What are the gaps?

TB rates are increasing for Merton, and remain high for London overall. Commissioning is divided at present between CCGs (non-specialist care) and NHS England (specialist care).

TB teams in South West London require skilled staff resources for awareness raising and management of hard-to-reach groups.

A needs assessment in 2008 identified the gaps outlined below. An updated needs assessment and input from continued cohort reviews are required.


Clinical gaps
• At some centres TB nurses have responsibility for both respiratory and TB patients; given the volume and complexity of TB patients, these services should be separated and funded appropriately.
• Agreement is needed on minimum standards of clinical care to ensure equitable service provision; this could be achieved through the design of an effective integrated care pathway.
• Introducing an opt-out HIV testing programme would increase the provision of HIV testing for TB patients.
• Directly Observed Therapy (DOT) for the treatment of TB is used variably across South West London. Agreed criteria for commencing patient on DOT should be introduced. This should be allied to an effective risk assessment process to identify the case mix more effectively.
• Variability in levels of chemoprophylaxis may be due to capacity or practice and agreed criteria for chemoprophylaxis should be agreed.

Commissioning and funding gaps
• Active commissioning will cost more in the short term but will improve outcomes of care and achieve a saving in the medium to long term.
• The service provided to a PCT’s resident varies significantly dependent on the provider; allied to this is significant cross-border movement of TB patients.
• Almost all funding currently enters the trusts through payment by results (PbR); it is difficult to identify if non-PbR funding has been added at any point. The existing PbR expenditure is variable dependent on the acute trust providing care. PbR needs to be managed more effectively to ensure value for money.
There are no discrete contracts in place for TB; existing TB services are commissioned as part of the global sum service level agreement (SLA). This means that it is virtually impossible to track funding and investments. PCTs, as recommended in the national TB commissioning toolkit, should introduce a discrete section to the acute contracts for the TB service.

TB services provide variable community and outreach services, and there is little or no identified funding in place to deliver additional community and outreach work. PCTs should invest in community/outreach services in 2009-10.

PCTs should not demand manage TB and it should not be subject to choice as per national guidance.

Management and coordination gaps

 Coordination: this is a challenging and ambitious agenda and the work should be taken forward by a network manager. This person will need to support PCTs to commission TB services but also will have a significant role in stimulating the market and developing providers.

Key recommendations for commissioners

 Coordination

There is a need for increased coordination within South West London, but also more broadly within London, and nationally. This has been repeatedly highlighted, particularly the need for a national strategy and quality national data. This is even more important now that the commissioning of services is divided between CCGs (non-specialist care) and NHS England (specialist care).

 Funding

Designated funding for TB services should be maintained within acute trust contracts. Funding should also be designated for community and outreach services, particularly important for accessing hard-to-reach groups.

 Information:

Regular needs assessments, including regular cohort reviews, should continue to inform local commissioning of services.

Locally, the recommendations outlined following the NICE commissioning recommendations were identified by the Review of TB Services in SW London, September 2008. In the future, needs assessments and cohort reviews should continue to update this information and inform the JSNA.

Nationally, there are detailed NICE commissioning recommendations (outlined below).

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NICE recommendations for commissioning TB services (Adapted from NICE Pathway 2013)

1) Adopting a national, strategic approach:
   - The NHS Commissioning Board, in partnership with Public Health England, should take responsibility for national oversight of TB prevention and control activities.
   - Public Health England and commissioners should:
     - consider collaborative commissioning.
     - ensure TB prevention and control programmes are led by a director of public health or another nominated public health consultant.
     - ensure TB prevention and control programmes set up multidisciplinary TB teams to provide all TB services.
     - ensure the TB prevention and control programme is informed by relevant NICE guidance, local needs assessment and service audit, and developed in collaboration with relevant clinical services.
     - ensure the TB prevention and control programme targets all ages, and all aspects of TB prevention and control.
     - ensure TB prevention and control programmes take account of the need to work with other programmes targeting hard-to-reach groups.

2) Needs assessment
   - Directors of public health and others who lead TB prevention should use cohort review and other methods to collect data to inform local needs assessment.
   - TB prevention and control programme commissioners should be provided with local needs assessment information on an annual basis.
   - TB should be part of the joint strategic needs assessment in areas of high need.
   - Commissioners of TB prevention and control programmes should ensure services reflect the needs of their area, as identified by needs assessment.

3) Supporting vulnerable migrants
   - The NHS Commissioning Board should ensure primary care services are fulfilling their obligation to register vulnerable migrants.
   - TB prevention and control commissioners should ensure services take into account the barriers facing vulnerable migrants who may need treatment, and, in particular, the stigma they may face.

4) Developing multidisciplinary teams
   - Commissioners of TB prevention and control programmes should ensure multidisciplinary tuberculosis (MDTB) teams are skilled and resourced.

5) Active case-finding
   - Identifying active pulmonary TB among those using homeless or substance misuse services
     - Action required from commissioners of TB prevention and control programmes, commissioners of services for homeless groups and commissioners of substance misuse services.
   - In areas of identified need, commissioners should:
Ensure there is a programme of active case-finding using mobile digital radiography in places where homeless people and substance misusers congregate.

- **Identifying and managing latent TB among substance misusers and prison populations**
  - Commissioners of TB prevention and control programmes should ensure arrangements are in place to provide latent TB testing for substance misusers and prisoners.

**6) Providing accommodation during treatment**

- Commissioners of TB prevention and control programmes should fund accommodation for homeless people diagnosed with active TB who are otherwise ineligible for state-funded accommodation. Health or public health resources should be used.

**Local recommendations: Findings and recommendations from South West London TB services review (2008)**

The following areas were consistently highlighted in discussions with the TB teams:

- Increasing current capacity to work in the community rather than just in secondary care
- Increasing education and awareness for primary care staff and community groups
- A shortage of medical sessions to complete TB work
- The level of DOT coverage and the capacity of teams to deliver this
- A need to be more assertive in identifying new cases in high-risk groups
- A need to be more assertive in terracing defaulters from TB care.

The following actions could support some of these issues:

- A formal development programme should be devised for TB nurses, in terms of career and educational development. This is a process that should be led by nurses.
- All senior staff within TB Services should be supported in developing management and leadership skills.
- Gaps in provision identified through the needs assessment should be filled using appropriately skilled staff.
- Nursing services should consider the introduction of timetabled sessions to ensure that time is given to essential activities such as outreach and health promotion.
- A case review board could be established to provide expert advice on complex cases management. The membership of this board could be flexible dependent upon the case. Similar groups could exist for Multidrug Resistant TB (MDRTB), case management, screening and incident management if required.
- Greater standardisation of assessment and data collection should occur, based upon the data requirements of the London standards and the suggested HPA enhanced surveillance requirements.
- Better reporting of data and performance against London and national standards.
- All TB services should have a dedicated budget.
- PCTs should identify a TB lead, lead clinician and commissioning lead.
- Budgets should reflect the need for funding items other than staffing.
• Investment in additional non-clinical staff to support enhanced case management and outreach.

Gastrointestinal Infections, Legionnaire’s Disease and Healthcare Associated Infections (HCAIs)

Key facts on gastrointestinal infection, Legionnaires’ disease and healthcare associated Infection (HCAI)

Gastrointestinal infection (infecous intestinal disease) affects as many as 1 in 5 members of the population each year. Symptoms of gastrointestinal infection, which are not necessarily confined to diarrhoea and vomiting, are caused by the organisms themselves or by the toxins that they produce.

Adapted from HPA factsheet: http://www.hpa.org.uk/

In 2012:
- The gastrointestinal disease rate in Merton (laboratory confirmed and not associated with travel) was lower than the national average.
- In Merton (and South West London) the most common organism isolated in laboratories was Campylobacter.
- The majority of outbreaks of gastroenteritis in establishments in Merton in 2012 (total 15) were caused by norovirus; no commercial food poisoning incidents were reported.

Source: SW London Health Protection Team

Table 10.3: Gastrointestinal diseases in Merton.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Cases 2010-12</th>
<th>Rate per 100,000 population (2012)</th>
<th>Ranking of SW London LAs (2012 Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VTEC</td>
<td>8 cases</td>
<td>1.5</td>
<td>2</td>
</tr>
<tr>
<td>Norovirus</td>
<td>3 cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enteric fever</td>
<td>11 cases</td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>Campylobacter</td>
<td></td>
<td>160.2</td>
<td>2</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td></td>
<td>8.9</td>
<td>5</td>
</tr>
<tr>
<td>Giardia</td>
<td></td>
<td>13.8</td>
<td>4</td>
</tr>
<tr>
<td>Shigella</td>
<td></td>
<td>4.9</td>
<td>4</td>
</tr>
<tr>
<td>Salmonella (excluding Typhoid and Paratyphoid)</td>
<td></td>
<td>51.9</td>
<td>1</td>
</tr>
<tr>
<td>Typhoid or Paratyphoid fever</td>
<td>11</td>
<td>1.0</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: SW London Health Protection Team
Legionnaire’s disease

**Legionnaires’ disease** is an uncommon form of pneumonia caused by the legionella bacterium. The majority of cases are reported as single (isolated) cases but outbreaks can occur. All ages can be affected but the disease mainly affects people over 50 years of age, and generally men more than women. Smokers and the immunocompromised are at a higher risk.

Adapted from HPA factsheet: http://www.hpa.org.uk/

- Over the period from 2010-12, there were three cases of Legionnaire’s disease in Merton, ranking it third of the six SWL LAs.

Healthcare Associated Infections (HCAIs)

**HCAI** are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

Adapted from HPA factsheet: http://www.hpa.org.uk/

In the financial year 2012-13, for Sutton and Merton PCT:

- There were 3.8 cases of MRSA bacteraemia per 100,000 population; this is an increase since the previous year; this compares with a rate of 1.7 in England overall.
- The rate of Clostridium difficile (C. difficile) infection in people aged 2 years and over was 22.5 per 100,000 population; this is a decrease since the previous year; it compares with a rate of 27.7 per 100,000 in England overall.

Key facts on services

**Overview**

As with other infectious diseases, treatment is provided at primary, secondary, and tertiary levels depending on individual choice and clinical presentation. Individuals may present and be clinically treated in primary, secondary, or tertiary care facilities.

**Health and Social Care Act 2008**

The Health and Social Care Act 2008 set up the Care Quality Commission (CQC). A code of practice was also set up, with the following aims:

The main purposes of the code of practice (the Code) are:

- to make the registration requirement for cleanliness and infection control clear to providers of health and social care services so that they know what they need to do to comply
- for use by the CQC’s staff who will be judging compliance with the Code

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for use by people who use the services of a registered provider
for use by commissioners of services (primary care trusts and councils); and for use by the general public.

Additional drivers for reduction of HCAIs include:

- CQC registration
- Commissioning for Quality and Innovation (CQUIN)
- the Operating Framework for the NHS in England 2012-2013 (DH, 2011)
- compliance with National Health Service Litigation Authority (NHSLA) criteria
- Health Building Notes and Health Technical Memoranda, and Choice Frameworks for local Policies and Procedures (CFPP)
- Quality Innovation Productivity and Prevention (QIPP) initiatives
- National Institute for Health and Care Excellence (NICE) standards or quality statements.

Specific service structures and regulations in place
Table 10.4 below outlines the framework governing the division of infection prevention and control responsibilities in the provision, commissioning and regulation of services.

Table 10.4: Infection prevention and control.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Regulation</th>
<th>Commissioning of Services provider</th>
<th>Other; from April 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Provider</td>
<td>Monitor, NDTA</td>
<td>CCG</td>
<td></td>
</tr>
<tr>
<td>Community Provider</td>
<td>CQC</td>
<td>CCG</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Monitor, CQC</td>
<td>CCG</td>
<td></td>
</tr>
<tr>
<td>Independent Contractors</td>
<td>CQC</td>
<td>NHS England</td>
<td></td>
</tr>
<tr>
<td>Intermediate Services</td>
<td>CQC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care homes (LA)</td>
<td>CQC</td>
<td>Local Authority</td>
<td></td>
</tr>
<tr>
<td>Care homes (independent)</td>
<td>CQC</td>
<td>Local Authority</td>
<td></td>
</tr>
<tr>
<td>Continuing care beds</td>
<td>CQC</td>
<td>Local Authority</td>
<td></td>
</tr>
<tr>
<td>Care agencies</td>
<td>CQC</td>
<td>Local Authority</td>
<td></td>
</tr>
<tr>
<td>Schools and nurseries</td>
<td>Local Authority</td>
<td>Ofsted</td>
<td></td>
</tr>
<tr>
<td>Primary Care NHS estates</td>
<td>Local Authority</td>
<td>NHS PS</td>
<td></td>
</tr>
</tbody>
</table>

Source: South London Commissioning Support Unit

### Table 10.5: Responsibility for leading outbreaks and investigations.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Regulation</th>
<th>Commissioning of Services (commissioned responsible)</th>
<th>Other; from April 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Provider</td>
<td></td>
<td></td>
<td>Provider ICT</td>
</tr>
<tr>
<td>Community Provider</td>
<td></td>
<td></td>
<td>Provider ICT</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td>Provider ICT</td>
</tr>
<tr>
<td>Independent Contractors</td>
<td></td>
<td></td>
<td>CCG</td>
</tr>
<tr>
<td>Intermediate Services</td>
<td></td>
<td></td>
<td>CCG</td>
</tr>
<tr>
<td>Care homes (LA)</td>
<td></td>
<td></td>
<td>Local Authority</td>
</tr>
<tr>
<td>Care homes (independent)</td>
<td></td>
<td></td>
<td>Local Authority</td>
</tr>
<tr>
<td>Continuing care beds</td>
<td></td>
<td></td>
<td>Local Authority</td>
</tr>
<tr>
<td>Care agencies</td>
<td></td>
<td></td>
<td>Local Authority</td>
</tr>
</tbody>
</table>

* For outbreaks/serious incidents all are/can be involved
* MRSA bacteraemia post-infection review & C. difficile root cause analysis

Source: South London Commissioning Support Unit

### Key recommendations for commissioners

**IPS/RCN Guidance (Infection Prevention Society and Royal College of Nursing), 2012**

- **Aim:** Commissioning organisations will support providers, whilst holding them to account for their performance, in the surveillance of infections and in the implementation and sustained improvement of infection prevention and control practices and procedures to reduce HCAIs.

- **Actions:**
  - Commissioning teams will systematically review local objective setting across the organisations from which they commission services. This will include the review of surveillance data to monitor progress against nationally set trajectories for specific organisms and other agreed indicators.
  - Commissioning organisations are obliged to be sufficiently assured that all services, commissioned or contracted by them or on their behalf are compliant with:
    - NHSLA risk management standards
    - reduction of HCAIs in line with nationally set objectives and reporting of deaths where an HCAI is noted on any part of the death certificate according to local policy and procedures
    - ensuring lessons learned from any associated root cause analysis (RCA) are completed in a timely way
    - contractual requirements relating to quality standards, NICE guidelines and other national policies
    - CQC requirements (Outcome 8). Notably, if concerns are identified by the CQC it can lead to regulatory enforcement activities, including suspension of services.

- **Toolkit:**
  - The IPS and the RCN have developed a toolkit for commissioning organisations to support the commissioning of infection prevention and control, along with the development and implementation of the commissioning framework in practice.
  - The toolkit consists of a ‘basket’ of indicators for consideration for inclusion in the commissioning contract and an example of a local HCAI reduction plan.

**NICE guidance**

NICE has produced guidance and pathways on prevention and control of HCAIs in primary and secondary care (see Figure 10.20 below and as set out below).

As emphasised above, there has been a great deal of recent change in responsibilities within local infection control. This should serve as an opportunity, rather than a setback, to prompt stakeholders (such as CCGs and local public health teams) to work together to improve priorities in dissemination of information, regulation and oversight of quality, and use of evidence to support infection prevention and control strategies.

Figure 10.20: NICE pathway on prevention and control of healthcare-associated infections in primary and secondary care.

![NICE Pathway](http://pathways.nice.org.uk/)

**Source:** NICE Pathways [http://pathways.nice.org.uk/](http://pathways.nice.org.uk/)

NICE has published a quality improvement guide on the prevention and control of healthcare-associated infections for secondary care settings that comprises 11 quality improvement statements:

1. Board-level leadership to prevent HCAIs
   Trust boards demonstrate leadership in infection prevention and control to ensure a culture of continuous quality improvement and to minimise risk to patients.

2. Be a learning organisation
   Trusts use information from a range of sources to inform and drive continuous quality improvement to minimise risk from infection.

3. HCAI surveillance
   Trusts have a surveillance system in place to routinely gather data and to carry out mandatory monitoring of HCAIs and other infections of local relevance to inform the local response to HCAIs.

4. Workforce capacity and capability
   Trusts prioritise the need for a skilled, knowledgeable and healthy workforce that delivers continuous quality improvement to minimise the risk from infections. This includes support staff, volunteers, agency/locum staff and those employed by contractors.

5. Environmental cleanliness
   Trusts ensure standards of environmental cleanliness are maintained and improved beyond current national guidance.

6. Multi-agency working to reduce HCAIs
   Trusts work proactively in multi-agency collaborations with other local health and social care providers to reduce risk from infection.

7. Communication
   Trusts ensure there is clear communication with all staff, patients and carers throughout the care pathway about HCAIs, infection risks and how to prevent HCAIs, to reduce harm from infection.

8. Admission, discharge and transfer
   Trusts have a multi-agency patient admission, discharge and transfer policy which gives clear, relevant guidance to local health and social care providers on the critical steps to take to minimise harm from infection.

9. Patient and public involvement
   Trusts use input from local patient and public experience for continuous quality improvement to minimise harm from HCAIs.

10. Trust estate management
    Trusts consider infection prevention and control when procuring, commissioning, planning, designing and completing new and refurbished hospital services and facilities (and during subsequent routine maintenance).

11. New technology and innovation
    Trusts regularly review evidence-based assessments of new technology and other innovations to minimise harm from HCAIs and antimicrobial resistance (AMR).

Source: NICE public health guidance 36; NICE Pathways 2013 http://pathways.nice.org.uk/
**Gastrointestinal disease**
The investigation of cases and outbreaks of gastrointestinal disease in Merton is jointly undertaken by SWLHPU and the Environmental Health Department of LBM.

**Legionnaire’s disease**
As legionnaire’s disease is transmitted largely through water and cooling systems, landlords and employers have statutory responsibilities in this area. This includes the responsibility to:

- Prepare a scheme for preventing or controlling the risk
- Implement, manage and monitor precautions
- Keep records of the precautions
- Appoint a person to be managerially responsible.

*Source: Merton factsheet; HSE 2000*

**Further sources**


# Appendix 1

## The complete routine immunisation schedule 2013/14

<table>
<thead>
<tr>
<th>When to immunise</th>
<th>Diseases protected against</th>
<th>Vaccine given</th>
<th>Immunisation site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two months old</td>
<td>Diptheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib)</td>
<td>DTaP/IPV/Hib (Pediacel)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>PCV (Prevenar 13)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Rotavirus</td>
<td>Rotavirus (Rotarix)</td>
<td>By mouth</td>
</tr>
<tr>
<td>Three months old</td>
<td>Diptheria, tetanus, pertussis, polio and Hib</td>
<td>DTaP/IPV/Hib (Pediacel)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Meningococcal group C disease (MenC)</td>
<td>MenC (MenVac-C or Menjugate)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Rotavirus</td>
<td>Rotavirus (Rotarix)</td>
<td>By mouth</td>
</tr>
<tr>
<td>Four months old</td>
<td>Diptheria, tetanus, pertussis, polio and Hib</td>
<td>DTaP/IPV/Hib (Pediacel)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>PCV (Prevenar 13)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 12 and 13 months old – within a month of the first birthday</td>
<td>Hib/MenC</td>
<td>Hib/MenC (Menitorix)</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td></td>
<td>Meningococcal disease</td>
<td>PCV (Prevenar 13)</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella (German measles)</td>
<td>MMR (Prioxx or MMR Nvax/QRO)</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td>Two and three years old</td>
<td>Influenza (from September)</td>
<td>Flu nasal spray (Fluenz) annual (if Fluenz unsuitable, use inactivated flu vaccine)</td>
<td>Nostrils</td>
</tr>
<tr>
<td>Three years four months old or soon after</td>
<td></td>
<td></td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>Diptheria, tetanus, pertussis and polio</td>
<td>DTaP/IPV (Repevax) or DTaP/IPV (Infanrix-iPV)</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella</td>
<td>MMR (Prioxx or MMR Nvax/QRO) (check first dose has been given)</td>
<td>Upper arm</td>
</tr>
<tr>
<td>Girls aged 12 to 13 years old</td>
<td>Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)</td>
<td>HPV (Gardasil)</td>
<td>Upper arm</td>
</tr>
<tr>
<td>Around 14 years old</td>
<td>Tetanus, diphtheria and polio</td>
<td>Td/IPV (Revisax), and check MMR status</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>MenC</td>
<td>MenC (Meningitec, Menjugate or NeVac-C)</td>
<td>Upper arm</td>
</tr>
<tr>
<td>65 years old</td>
<td>Pneumococcal disease</td>
<td>PPV Pneumococcal polysaccharide vaccine (Pneumovax II)</td>
<td>Upper arm</td>
</tr>
<tr>
<td>65 years of age and older</td>
<td>Influenza</td>
<td>Flu injection (annual)</td>
<td>Upper arm</td>
</tr>
<tr>
<td>79 years old</td>
<td>Shingles (from September)</td>
<td>Shingles (Zostavax)</td>
<td>Upper arm (subcutaneous)</td>
</tr>
</tbody>
</table>

## Immunisations for those at risk

<table>
<thead>
<tr>
<th>At birth, 1 month old, 2 months old and 12 months old</th>
<th>Hepatitis B</th>
<th>Hep B</th>
<th>Thigh</th>
</tr>
</thead>
<tbody>
<tr>
<td>At birth</td>
<td>Tuberculosis</td>
<td>BCG</td>
<td>Upper arm (intradermal)</td>
</tr>
<tr>
<td>Six months up to two years</td>
<td>Influenza4</td>
<td>Inactivated flu vaccine (annual)</td>
<td>Upper arm/high</td>
</tr>
<tr>
<td>Two years up to under 65 years</td>
<td>Pneumococcal disease</td>
<td>PPV Pneumococcal polysaccharide vaccine (Pneumovax II)</td>
<td>Upper arm</td>
</tr>
<tr>
<td>Over two up to less than 18 years</td>
<td>Influenza4 (from September)</td>
<td>Flu nasal spray (Fluenz2) annual (if Fluenz unsuitable, use inactivated flu vaccine)</td>
<td>Nostrils</td>
</tr>
<tr>
<td>18 up to under 65 years</td>
<td>Influenza4</td>
<td>Inactivated flu vaccine (annual)</td>
<td>Upper arm</td>
</tr>
<tr>
<td>From 28 weeks of pregnancy1</td>
<td>Pertussis</td>
<td>DTaP/IPV (Repevax)</td>
<td>Upper arm</td>
</tr>
</tbody>
</table>

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Source: Department of Health Green Book (2013)
Appendix 2

List of notifiable diseases

Diseases notifiable (to Local Authority Proper Officers) under the Health Protection (Notification) Regulations 2010:

- Acute encephalitis
- Acute infectious hepatitis
- Acute meningitis
- Acute poliomyelitis
- Anthrax
- Botulism
- Brucellosis
- Cholera
- Diphtheria
- Enteric fever (typhoid or paratyphoid fever)
- Food poisoning
- Haemolytic uraemic syndrome (HUS)
- Infectious bloody diarrhoea
- Invasive group A streptococcal disease
- Legionnaire’s Disease
- Leprosy
- Malaria
- Measles
- Meningococcal septicaemia
- Mumps
- Plague
- Rabies
- Rubella
- SARS
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhus
- Viral haemorrhagic fever (VHF)
- Whooping cough
- Yellow fever

These and other diseases that may present significant risk to human health may be reported under Other significant disease category.

Source: Department of Health, Health protection regulation guidance (2010)