The London Borough of Merton

The Health and Wellbeing of the People of Merton:

Joint Strategic Needs Assessment 2013
Foreword

We are delighted to present the Merton Joint Strategic Needs Assessment (JSNA) for 2013. Within this website resource you will find comprehensive data and analysis of all aspects of the population of Merton's health, care and wellbeing needs, the inequalities that exist and ways we can continue to tackle them together.

NHS Sutton and Merton Public Health Directorate worked with the Director of Community and Housing and the Director of Children, Schools and Families in the London Borough of Merton and with Merton Clinical Commissioning Group to produce this Joint Strategic Needs Assessment. As well as a wealth of relevant statistics, the JSNA includes a detailed commentary that describes the changing needs of our local communities and implications for commissioning and service delivery.

The Merton JSNA focuses on both the health and social care needs of the population and takes into account some of the wider determinants of health and wellbeing. We have employed a range of data collection methods and analyses that draw on a wide variety of national and local data sources and epidemiological methods to describe the health status of the population, as well as reviewing the effectiveness and cost-effectiveness of relevant health and social care interventions where available. Further, we present comparative information about the levels of service provision and utilisation by different sub-groups.

In 2012, Merton continued to be “healthy” in comparison with much of London, but within the borough there are unacceptably wide differences in life expectancy and death rates for some of the major causes of death. These inequalities are reflected in key predictors of health and wellbeing such as obesity prevalence, smoking prevalence and teenage conceptions. Strong partnerships and innovative ways of working are central to improving health and reducing inequalities.

2013 is a key year for change in Health and Local Government:

- Merton Council and Merton Clinical Commissioning Group take on wide ranging new responsibilities for commissioning services and improving the health of the population;
- The Council and Clinical Commissioning Group will have a statutory duty to both produce a JSNA and take account of its findings in their commissioning priorities and plans;
- The Merton Health and Wellbeing Board will become a statutory body and has produced a Health and Wellbeing Strategy for the Borough, which has been informed by the evidence set out in the JSNA.

We hope that bringing together this broad range of information into one resource will make it accessible to all those with either a professional interest or use for such data, or who live in Merton and are users of its services.

Please note – the ‘Voice’ section of the JSNA has not yet been updated and will be by Summer 2013. This
section will include the results of recent engagement with residents, including consultations, resident surveys and social marketing research.

Developing the Joint Strategic Needs Assessment is a continuous process. Over the course of time we will continue to add new information and findings from more detailed pieces of work to enhance our understanding of the health and wellbeing of our local population. The JSNA website is easy to use and largely self explanatory, however we have produced a short guide to the use and content of the JSNA and you can also try the search function (driven by Google analytics).

If you have any suggestions on how to improve both the format and the information sources please contact us.

Acknowledgements

A resource like this is only possible through the help and dedication of many people:

**Lead authors and editors**

- Julia Groom, Consultant in Public Health (Merton)
- Sylvia Godden, Principal Public Health Intelligence Specialist
- Susan Mubiru, Public Health Intelligence Specialist

**Partner contribution from:**

- Sarah Bennett-Jones
- Tara Butler
- Ian Callaghan
- Catrina Charlton
- Naheed Choudhry
- Angela Chu
- Ann Maria Clarke
- Helen Cook
- Catherine Croucher
- Lynne Doyle
- Kate Jezernick
- Samantha Green
- Kelly Marshall
- Ian Murrell
- Christine Parsloe
- Michael Pierce
We are grateful to all those who contributed and advised us and hope that the data and analysis will help to bring about improvements to the health and wellbeing of local people and to reduce the health inequalities experienced by residents of Merton.

Dr Val Day

Interim Director of Public Health – NHS SW London (Sutton and Merton)

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What People are Telling Us

Introduction

Please note – this section has not yet been updated, but is expected to be in Spring 2013. It will include the results of recent engagement with residents including consultations, resident surveys and social marketing research.

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 a much better idea 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 took place in the financial year 2009/10 and where possible we have included what is happening in response. It includes activity carried out by the the London Borough of Merton in relation to social care services for children, young people and adults. It also covers the ways in which local health services involved patients and the public.

Links are included to the engagement strategies for local councils and the PCT, and to other reports for further information.

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
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• Kelly Marshall
• Ian Murrell
• Christine Parsloe
• Michael Pierce
• Eben Van der Westhuizen
• Sara Williams
• Shamal Vincent

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Community Engagement is the action taken to consult, involve, listen and respond to communities through ongoing relationships and dialogue. Communities participate to develop solutions, 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, consultation, survey, interview and focus groups. These activities can be conducted face-to-face, via telephone, by the provision of hardcopy written information or online.

The engagement strategies for the PCT and Boroughs can viewed at:

**NHS Sutton and Merton**

**Merton Partnership** (51kB)

**Duty to Involve 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.

These consultations are summarised [here](#). (101kB)

More details are available in the report itself which can be accessed [here](#).

**How do we hear the views of patients and communities?**

**Local Involvement Networks (LINks)**

Local Involvement Networks (LINks) are networks set up all over England to help people and groups have more of a say in how local health and adult social care services are delivered. This may involve talking directly to health and social care staff about gaps in services, or suggesting ways that an existing service could be made better. Below are examples of some of the activities that Merton LINk members have been involved in during 2009/10:

- A wide range of projects with St Helier hospital aimed at improving patient experience including food, cleanliness, privacy and dignity, patient information and supporting during hospital discharge
• Input into the design and delivery of Older People’s services including reducing the number of falls within community settings and footcare services
• Exploring access to early intervention and prevention mental health services and working with the local Trust to improve early take up of day care services
• Involvement in a range of programmes relating to transforming healthcare, e.g. Better Healthcare Closer to Home, procurement of community services and changes to paediatric surgical services at St Helier
• Enabling the community, through regular meetings and special events, to understand and influence the personalisation of social care (Self-Directed Support)

Oil UK Annual Report 2009–10

Community Engagement Networks

INVOLVE 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. Health and social care topics discussed in 2009/10 include:

• Plans for the development and future use of Nelson Hospital
• Personalisation of social care, moving towards people creating their own care packages and receiving direct payments to pay for them
• Proposed relocation of GP surgeries in Merton

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, Black and Asian Minority Ethnic (BAME) networks, learning and physical disability partnerships, faith-based forums, patient groups, and carers forums and partnerships.

Consultation

When commissioners are considering significant changes to local services, formal public consultations are carried out to seek the views of local people. The details of consultations carried out by the PCT and borough (101kB) are given here.
Other engagement activities

As well as consultation there are also a variety of other ways to empower, involve, listen and respond to patients and communities. Examples of some of these activities are in What our Communities Are Saying.

Patient Advice and Liaison Service (PALs) and Complaints

PALs provides a point of contact to resolve concerns or any difficulties experienced with health services. The PCT also regularly monitors and reviews complaints concerning PCT and Community Services issues. More information on these areas is can be found in the attached Complaints (88kB) and PALs (69kB).

National Surveys

There are several surveys carried out on a national basis by both the PCT and the Boroughs. The key results of these surveys and actions arising from them are in National Surveys.

Key Commissioning Implications for improving services 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 the 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, both national and local, qualitative and quantitative, to support this process.

Commissioners also need to consider what is the appropriate involvement approach for different projects. 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’.
Our Living Environment - The Wider Determinants of Health

Key Facts on the Wider Determinants of Health: Our Life Chances

The health of individual people and local communities is affected by a wide range of factors such as where and how people live and what is happening and what has happened to them.

The factors that can contribute towards our good or bad health include:

• Genetic makeup
• Lifestyles (how we live and what we do)
• Housing and community
• Income
• Education
• Relationships with friends and family
• Economy and society (where we live and what is around us)

Some of these can be controlled, some can be influenced, but some can't. Factors outside of our control include:

Gender - men and women are susceptible to some different diseases, conditions and physical experiences which play a role in our general health.

Genetic makeup - people's longevity, general health, and propensity to certain diseases are partly determined by their genetic makeup.

The factors that are generally outside an individual's personal control (to at least some extent) but which can be improved with support from organisations such as the Government, local Councils, the NHS and Police include:

Socioeconomic status - the higher a person's socioeconomic status, the more likely he/she is to enjoy good health. The link is a clear one. Socioeconomic status affects all members of the family, including newborn babies

Education - people with lower levels of education generally have a higher risk of experiencing poorer health (this is also linked to socioeconomic status).

Job prospects and employment conditions - statistics show that people in employment are more likely to enjoy better health than people who are unemployed. If you have some control over your working conditions your health will benefit too.
Physical Environment - if water supplies are clean and safe, the air clean, workplaces are safe and healthy, housing and homes are comfortable and safe, then people are more likely to enjoy good health compared to others whose water supply is not clean and safe, who are exposed to air that is contaminated, and whose workplace is unsafe or unhealthy.

Social Environment - where people have support from family as well as from friends and the local community then their chances of enjoying good health, especially good mental wellbeing, are far greater than where people are isolated and lonely.

Access and use of health services - a society that has access to and uses good quality health services is more likely to enjoy better health than one that doesn't. For example, the population of developed countries that have universal health care services like the NHS have longer life expectancies compared to developed countries that don't (UK vs. USA).

Factors that affect our health that are much more within our control (although not necessarily all the time) include;

What we do and how we manage (our lifestyles) - factors such as what people eat, how physically active they are, whether or not they smoke or drink alcohol excessively or take drugs, and how they cope with stress all play an important role in physical and mental wellbeing.

Our Living Environment and Health Inequalities

There is a strong relationship between health inequalities, deprivation and poverty that starts at conception and continues throughout life. A child's health is significantly influenced by the socioeconomic status of it's parents and there is a wide gap in health status between the most affluent and deprived families. Babies born to poorer families are more likely to be born prematurely, are at greater risk of dying in childhood, of having impaired development and of developing long term conditions such as circulatory disease later in life.

Poor health is both a cause and a consequence of disadvantage. While individual behaviours may seem the most amenable to change through 'informed choice', in reality many apparently free choices are strongly influenced by socioeconomic, cultural and environmental factors. Employment can have a significant impact on health whereby those in employment enjoy better levels of health than the unemployed. Unemployed people are significantly more likely to have poorer mental and physical health including depression, anxiety and long term conditions such as circulatory disease. Supporting local people to be productive either in paid or unpaid work to support the transfer towards future employment will have a beneficial effect on demand for health and social services in the future.

Ensuring fair access to health services is a founding principle and purpose of the National Health (NHS). The National Cross Cutting Review of Health Inequalities (2002) emphasised the impact of differential access to
public services, including health services and local authority services, on health inequalities. More recently, the Marmot Review 'Fair Society, Healthy Lives' (2010) identified strengthening the role and impact of ill health prevention as one of six policy objectives for reducing health inequalities in health.

Tackling the inter-generational cycle of inequalities and improving people's health requires interventions across a range of sectors. The association between health behaviours or 'need' for health improvement action and measures of socioeconomic deprivation is illustrated throughout these reports.

This section focuses on the impact of the wider determinants of health:

- **Economic Wellbeing**
- **Crime**
- **Deprivation**
- **Housing**
- **Physical Environment**
- **Education**
- **Access to health services**
- **Access to Social Care Services**

**Key Commissioning Implications for Improving Life Chances**

Policies and programmes that increase levels of employment and educational attainment are likely to have a significant health benefit for individuals and for the local community. Local Partners need to work together to develop joint policies to directly and indirectly improve work opportunities. In particular, education, training, volunteering and development of social enterprises can improve the chances of obtaining employment.

In terms of health; fear of crime and the effects of crime can have a major impact on long term mental and physical wellbeing. To tackle some of the root causes and to find solutions needs close partnership working. There is an opportunity to link the approaches being taken towards teenage parenthood and pregnancy, offending behaviour, truancy, and alcohol and drug misuse to look more holistically and take a whole system approach to tackling these issues. 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 things that can be prevented from going wrong. Partnership working structures need to reflect this approach.

Where people live and their type of accommodation can have a profound effect on health, wellbeing and quality of life and the ability to be independent. The challenge for commissioners is to be able to predict future housing needs, to inform potential providers of what is required and to feed into and underpin the borough Housing Strategies, linking into initiatives and services that support people having healthier lifestyles and preventative services to support people to live independently for as long as possible.
This page was last updated on Friday 19 July 2013
Where are Our Inequalities?

Key Facts on our Inequalities

There are benefits for everyone if we stay fit and healthy. Healthy people tend to have a better quality of life, more independence, are able to make more of their own choices and have better life chances.

There are a wide number of factors that influence and determine good health, so there is no single definitive measure to tell us if we or our communities are healthy. However, birth weight, infant mortality and life expectancy are good indicators of long term health and are often used as measures of comparative health and therefore of the inequalities between different communities. The links between deprivation and health inequalities are strong, with the most deprived areas broadly correlating to the areas with lowest life expectancy. These areas also tend to have a higher prevalence of smoking, obesity, unhealthy eating and risky drinking behaviour. The schools with a higher proportion of children eligible for free school meals are located in the most deprived electoral wards.

Health outcomes for people in Merton are generally better than those in London and largely in line with or above the rest of 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 but there is a stark difference between some of the most deprived communities in the east of the borough compared to the communities in the west.

Overall, life expectancy at birth in Merton is higher than the England average, and has increased by 5.2 years for men and 3.8 years for women (from 1994-96 to 2008-10) compared to an average across London of 5.1 years for men and 3.6 years for women. Estimates suggest life expectancy will continue to increase.

However, there is a difference between the most and least deprived areas within the borough of about 9 years for men and about 13 years for women. Between 2005-09 to 2006-10 this gap has remained the same for men, but has increased by about 2 years for women. This is because for women life expectancy has increased at a faster rate in the least deprived areas compared to the most deprived areas of the borough.

Low birth weight is an important predictor of future health; a child with a low birth weight is more likely to die early or have poorer life outcomes than a child with an average birth weight. In Merton there are generally fewer babies who are born with a low birth weight and relatively low levels of infant mortality, but again this masks inequalities within the borough with the more deprived areas having higher numbers of babies born with low birth weight and higher levels of infant mortality.

Ethnicity is also a key factor for infant mortality and low birth weight, Pakistani and Caribbean groups have particularly high infant mortality rates, 7.6 and 9.7 deaths per 1,000 live births respectively. This is double the rate of babies born in the White British group which is 4 deaths per 1,000 live births (ONS, 2011). This is of
particular significance in Merton, where some wards in the east of the borough have ethnic minority populations exceeding the Borough average of 35%.

Key Commissioning Implications for Services to Help Reduce Inequalities

There are clear inequalities in terms of life expectancy for both gender and according to where people live. A major report, the Marmot Review-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 level. 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, 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 needs to be in proportion to the level of disadvantage.

Action to reduce health inequalities will benefit society in many ways, including increasing economic benefits, and tackling social inequalities in health and tackling climate change should go together.

Marmot set 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, NHS, Voluntary and Community Sector and 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.

Differences in the populations within Merton mean differences in need and the need for services. With limited resources a much more targeted approach will be required. Merton will need a greater focus on services for younger people and ethnic diversity.

Existing inequalities need to be addressed through ongoing service improvement and development to target
existing needs more effectively. Commissioners need to work with providers to ensure more robust data is captured on the population accessing services and better use of this data needs to be made in planning and commissioning services. A robust programme of Equality Impact Assessments and Health Equity Audits would support understanding this need.

Commissioners need to look at commissioning more targeted services to reduce future need. These services should be aimed at reducing risk factors such as smoking, obesity and risky drinking behaviour. Reducing smoking and exposure to tobacco will have a great single impact on inequalities in infant mortality and life expectancy. However, although deprived populations are more at risk of poor health and well-being, ill-health exists within all social groups and across the whole community regardless of deprivation. Therefore efforts need to be spread proportionally by need across all social groups and not just targeted to a single social group or geographical area.

Partnerships need to focus on approaches to support people of all ages across all communities making healthy life choices. For instance, supporting or enabling people to stop smoking, maintain a healthy weight and reduce risky drinking behaviour is more likely to be achieved through working with partners including local businesses to improve access to affordable healthy food, improve uptake of physical activity and reduce availability of cut price alcohol. Services aimed at prevention of the major killers (circulatory diseases and cancer) to the over 50’s will have the greatest short-term impact.

Although levels of infant mortality and low birth weight remain below the regional average, the inequality that exists within Merton require commissioners to focus on key interventions to reduce infant mortality and low birth weight. These include:

- Improving the quality and accessibility of antenatal care and support during the first year of life, particularly in disadvantaged areas
- Reducing smoking in pregnancy
- Improving nutrition in pregnancy and infancy, including increasing the number of mothers who breastfeed
- Preventing teenage pregnancy where possible and supporting teenage parents to remain in education or in employment
- Improving housing conditions, especially for children in disadvantaged areas
- Making services culturally sensitive to meet the needs of ethnic minority women and families
The Major Killers and Causes of Poor Health

Key Facts on the Health of the People living in Merton

Merton has a young age profile with the highest proportion of its residents around the late 20’s to early 40’s age range and with an ethnically diverse population, which is similar to the population structure of inner London Boroughs.

There are clear inequalities across Merton in terms of mortality and ill-health. These inequalities can be seen in 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.

The wards 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.

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. Access to screening (the opportunity for early diagnosis) is below regional and national uptake.

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.

Measures of the Causes of Poor Health in Merton

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 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 the CCG overall, but ranges from 2% to nearly 10% by Practice. Comparing modelled to recorded prevalence of Diabetes suggests a proportion remains undiagnosed.

• **Cancer:** rates of deaths 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 most deaths in the eastern wards.
• **Respiratory Diseases:** deaths from Respiratory Diseases have declined, but there are wide variations in hospital admissions by area.

• **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 England and London. This needs to be monitored in light of the potential impact of the recession on mental health and wellbeing.

• **Sexual Health:** Late diagnosis for HIV has increased to 46% in 2010, this is of concern particularly for Black African Communities and Men who have Sex with Men (MSM).

• **Dementia:** It is estimated that the rate of diagnosis of dementia in Merton is only 39%, which means that a proportion of older people are living with undiagnosed dementia.

**Key Commissioning Implications for the Major Killers and Causes of Poor Health**

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 for cervical and breast cancers are below regional and national levels. Improvement in the uptake of all screening services is needed for early identification, to prevent cancers becoming untreatable and improve outcomes. 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 work with GP Practices to improve the systems to identify patients for screening services. Vulnerable 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. 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 co-ordinated 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 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 wide variations in the prevalence of diseases identified through Primary Care Practices across
Merton. Merton Clinical Commissioning Group 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 though planning responsibilities, would help to support people to achieve healthy lifestyles and would be of significance in reducing 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 focussing 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 to secondary prevention in primary, (community and secondary health care services), and that these services work in close partnership with social services. There is a real opportunity afforded by the development of Clinical Commissioning Groups and the partnership in the Health and Wellbeing Boards in taking this work forward. Taking any new developments outside of the current national tariff for acute care would allow greater flexibility in how the pathways are designed.

In terms of treatment services for mental health, Commissioners should focus on:

- Developing a whole system approach to mental health with more joined up services to improve experience and outcomes. There should be a 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, and a health equity audit for mental health services would be useful to support this.

In terms of sexual health:

- The growing incidence of HIV, late diagnosis of HIV and Sexually Transmitted Infections (STIs) is a priority. Commissioners should focus on the systematic introduction of health promotion, screening, STI testing, and prompt follow-up for both patients and their partners throughout the borough, with a targeted approach to areas of high prevalence.

Given the predicted increase in older people, and in particular the increase in people over 85 years (40% increase by 2021), Commissioners need to consider:

- The potential impact on social and health services of the ageing population and to the type of support services that will be required to support people with dementia to remain independent for as long as possible. Work is taking place in the borough to implement dementia strategies focussing on raising awareness and understanding of dementia, and ensuring early diagnosis and support.
• A multi-faceted approach to falls prevention including home exercise programmes; medication review; assessment of balance, gait, and blood pressure; and addressing environmental risk factors to reduce falls.
How we Live - Our Lifestyles

Key Facts on How We live Our Lives

How we live our lives has a significant impact on our health. There have been major improvements in health over the last century with people living longer than ever before. Boys born between 2008 and 2010 can expect to live to the age of 79, compared with a life expectancy of 45 in 1900 and 66 in 1948, and girls born at the same time are expected to live to 83, compared with 50 in 1900 and 71 in 1948. A child born today is therefore likely to live 12 and a half years longer than a child born when the NHS was established in 1948.

A number of things have contributed to these improvements. Economic growth has contributed to rising standards of living, improved education, better nutrition and better housing for many. Most of these improvements have been achieved as a result of actions taken by services other than health, for instance local authorities, educational authorities and the police. But while the main causes of death in the last century (infectious diseases) have been largely eradicated and death in childhood is now rare, potentially avoidable deaths from Cancers, Coronary Heart Disease (CHD) and Stroke caused by how we live our lives have risen. These diseases account for around two thirds of all deaths, are the major causes of ill health, and can prevent people from living their lives to the full causing avoidable disability, pain and anxiety.

Lifestyles - Smoking, Healthy Weight, Alcohol

The factors that have been driving the rise in heart disease and cancer are lifestyle choices such as smoking, rises in obesity, a reduction in physical activity and drinking harmful amounts of alcohol.

In recent years there has been a fall in deaths due to Coronary Heart Disease mainly because of a reduction in smoking rather than improvements in medical and surgical treatments (although these have contributed). Smoking rates have fallen since the 1970s but the rate of decline has now slowed. Survey data show a continuing slow decline in smoking rates of around 0.4% per year but smoking still remains the single biggest cause of preventable ill health. The impact of smoke free legislation has been positive in reducing exposure to second hand smoke and changing behaviour, with smokers cutting down on tobacco consumption. But there is still more we can do. Even modest reductions in smoking (beyond what has already been done) and a reduction in cholesterol levels could halve national heart disease death rates.

Obesity has become one of the major public health challenges for the 21st Century, as rates of obesity continue to increase. The cause of obesity is complex having behavioural, genetic, environmental and social components. This makes it a key health inequality. 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.

Lifestyles: Alcohol, Sexual Health
It is not just smoking and obesity that can impact on our health. Other lifestyle choices such as drinking too much alcohol and not taking sufficient precautions in our sexual behaviour can also have an impact.

Alcohol is causally related to cancers of the oral cavity and pharynx, larynx, oesophagus and liver and heart disease, and misuse can be directly linked to ill-health and death from liver cirrhosis. Consuming harmful amounts of alcohol is also associated with a wide range of criminal offences including drink driving, being drunk and disorderly, criminal damage, assault and domestic violence. In young people alcohol misuse, including binge drinking, is associated with anti-social behaviour and teenage conceptions. Socio-economic status, geographical area of residence as well as age and sex, are among the factors linked to levels and patterns of harmful alcohol consumption.

Sexual health in the UK has deteriorated over recent years, with increases in many sexually transmitted infections (STIs) and nationally teenage pregnancy rates being among the highest in Western Europe. Research indicates sexual risk taking behaviour is increasing. Poor sexual health can lead to long term health conditions such as HIV or infertility. The burden of sexual ill health is disproportionately distributed in the population among young people, women, gay men, black and minority ethnic groups, and lower socio-economic groups.

Vulnerable groups including sex workers, young people excluded or truanting from school, homeless people, looked after children (children under the care of social services), children whose parents misuse drugs and offenders are at greater risk of developing problematic drug use. Alcohol, tobacco and cannabis use are 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.

Lifestyle choices can have a very significant impact on future health and well-being. However, trying to find out about how we live our lives is not easy. We don’t routinely collect information for most of our population on how we live; whether we smoke or eat healthily or are active. Therefore we often have to use estimated figures, but information from other sources can either support or refute these estimates and help to build up the picture of whether as a community we are healthy. In general terms our local communities are seen as "healthy" but the profile of how we live our lives suggests that this may not necessarily be the case in the future.

Measures of How We are Living Now in Merton

The measures of how we are living now in Merton are of concern:

- **Smoking**: Overall in Merton there appears to be lower than average levels of smoking, but some areas within the borough are significantly higher than regional and national averages suggesting that in future we are likely to have increased numbers of people with circulatory diseases and cancer that are potentially avoidable.
• **Healthy Weight:** Overall there appear to be lower levels than average of excess weight (overweight and obesity) among adults than nationally, but some areas within the borough are significantly higher. For children there is a significant increase in excess weight between 4/5 year olds and 10/11 year olds, and the proportion of children with excess weight by age 10/11 is higher than England.

• **Physical Activity:** Less than 8% of adults are physically active enough to benefit their health, and over half of adults do no physical activity. This is lower than regional and national averages, although for children levels are above regional and national averages (physical inactivity and being overweight increases the risks of diabetes, cardiovascular disease and cancer).

• **Alcohol:** The levels of risky drinking are higher than both regional and national levels; although these figures are estimated levels, they are supported by the increases we are seeing in hospital admissions for alcohol related harm.

• **Drugs misuse:** Overall estimated levels of Opiate and Crack Cocaine use are lower in Merton than London or England, but 65% of estimated users are not or have never been in treatment. Once in treatment however outcomes are good.

• **Dental Health:** In Merton, 1 in 5 5 year olds and 1 in 4 12 year olds have experience of tooth decay. This is slightly better than England, however children from lower socioeconomic backgrounds are disproportionately affected.

• **Teenage Pregnancy:** Overall in Merton, the under 18 conception rate is below that of London and England and there has been a significant reduction since 1998. However, this masks significant variation across the Borough with the rates of some wards in line with inner London.

The good news is that the impact on our health of our lifestyle choices are factors we can positively influence. Local Insight research in 2010 asked what is important to local people in terms of being healthy and how they can be supported to make positive lifestyle changes to live healthier lives. This research supported the development of a co-ordinated programme of personalised advice and support to help people make healthy lifestyle choices. The Service, LiveWell, was launched in September 2011 and has been recommissioned in 2013 for a further three years to support and enable people to make healthy lifestyle choices. The specific focus for LiveWell is on supporting people to eat well, manage their alcohol intake and be more active and from 2013 it will be integrated with the Stop Smoking Service. For more specialist services such as contraceptive and sexual health services and mental well-being, LiveWell, has links into existing services. Further in-depth social marketing research is taking place locally on healthy eating and physical activity.

**Key Commissioning Implications for Services to Support People Living Healthy Lives**

Services and/or interventions need to be in place to support individuals to reduce risk factors for long term conditions and should be targeted effectively at those people who are in greatest need. These approaches also need to harness the assets already in the community, building on what local people are telling us about what best motivates and supports them. All local partners should be active in promoting healthy lifestyles and
health and other professionals should be enabled to deliver consistent messages and support as part of their day to day work.

Commissioners of Health and Social Care services need to ensure that services deliver positive health outcomes and benefits to individuals as well as improving the health of local communities. As well as ensuring that treatment services are effective, Commissioners must also focus on primary prevention to ensure that the right support is in place to prevent or reduce the risk of future disease. More must be done to support children who may be at risk in the future, and a whole family approach is required to support healthier lives.

To tackle some of the root causes and to find solutions to prevent harm from drug and alcohol misuse requires tight partnership working. There is an opportunity given the link with teenage pregnancy and parenthood, offending behaviour, truancy, and alcohol and drug misuse to look more holistically and take a whole system approach.

While individual lifestyle choices may seem most amenable to change through ‘informed choice’ in reality many apparently free choices are strongly influenced by socioeconomic, cultural and environmental factors. Tackling inequalities requires partnership work with communities and an integrated approach to prevention and health improvement.
Who Makes up the Population - Demographics

Key Facts

Results from the 2011 census and population projections based on the census for the next ten years suggest:

• There are 199,693 people living in Merton, which is projected to rise to 243,164 by 2021 (ONS projections).
• Although most age groups are proportionally likely to remain fairly constant over time to 2021, absolute numbers will increase as the population size increases by 42,600 residents.
• The population aged under 5 years accounts for around 7.4% in Merton, compared to 7.2% in London. This is projected to remain similar (7.3%) to 2021.
• The population aged 5-19 years accounts for 16%, compared to 17% in London, and is projected to remain constant over time to 2021.
• The population of working age (20-64 years) accounts for 64.7%, compared to 64.4% in London and is projected to remain fairly constant over time to 2021.
• The population aged 85 and over accounts for 1.6% in Merton compared to 1.5% in London and is projected to rise by nearly 41%.
• This suggests that although the Merton population will remain relatively young compared to the national profile and more in line with what is expected in London, there is an expected increase of the very elderly population that is more in line with the national profile.
• The Black, Asian and Minority Ethnic (BAME) population accounts for 35% of the population in Merton (2011 census, non white population).
• 16% of the population were from non-British White groups (mainly South African and Polish) and White Irish. When combined with the BAME population this totals 51% of the population from ethnically diverse communities in Merton.
• At the end of September 2012 the registered population for GPs in Merton was 216,539.

Merton's older people are predominantly living in the Village, Cannon Hill, St. Helier, Merton Park and Lower Morden. However, the more deprived older people are predominantly living in Abbey ward (See Inequalities).

Merton's young population predominately live in Cricket Green, Pollards Hill and Figge's Marsh.

Population figures from previous studies indicate that people with learning disabilities are tending to live longer than expected and this trend is projected to continue.

It is estimated that there are over 7,000 people aged over 65 years with either a physical or visual disability in
Merton and projections suggest this will increase by around an additional 3,000 people by 2030 if no action is taken to try to prevent avoidable impairment.

Key Commissioning Implications for the People of Merton

The population is predicted to increase in size through increasing birth rates and migration, and will remain relatively young compared to the national profile and more in line with what is expected in London. However, there is an expected increase of the very elderly population that is more in line with the national profile.

As people are living longer they are more likely to develop long term conditions. These conditions are likely to become increasingly complex as people age, requiring additional support either in peoples own homes or in residential or nursing accommodation if preventative services (primary and secondary) are not in place early to avoid this. Commissioners for health and social care need to work in partnership to ensure prevention and early intervention services are in place and accessible for all.

The increase in birth rates is of significance, not only for health services planning including the provision of Health Visiting, but also for the Local Authority and schools.

Differences between populations within the borough will also have an impact on the types of health conditions being seen and the services required. Given the projected increase in the population overall, at a time when finances are becoming more scarce, commissioning needs to focus on preventative services and early interventions to control increasing demand in future years and to focus existing services on higher levels of need.

Minority communities generally have a much younger profile which reflects the arrival of people of working age in recent decades and their establishment of families. The older population is therefore less mixed, but this is changing as time goes on. The implication for services is that there will be a continuing and increasing need for sensitivity to cultural diversity and diverse needs among older people. It is important that cultural diversity is addressed in the delivery of mainstream services, however, specific culturally tailored services may be necessary to ensure equal access for all residents in light of the increase in people of different ethnic origin.

The change in Merton’s ethnic structure and cultural diversity over the last 10 years is likely to continue over the next 10 to 20 years. In order to gain a better understanding of the ethnic and cultural diversity in Merton and different specific needs, it is essential that continuous analysis is carried out. Furthermore, it is vital that the changing social and income trends of communities are monitored to support people from more diverse communities to better access and use services.
Definitions to help understand data used in 2011 against 2001 data can be found here:

Definitions 2001 v 2011 data (39kB)

This page was last updated on Monday 15 July 2013
Appendix 1 - Background

Background

The Health and Social Care Act 2012 gives duties to local authorities and clinical commissioning groups (CCGs) to develop a Joint Strategic Needs Assessment (JSNA) and to take account of the findings of the JSNA in the development of commissioning plans. This builds on requirements previously set out in the Local Government and Public Involvement Act 2007.

The aim of the JSNA is to accurately assess the current and future health and care needs and assets of the local population in order to improve physical and mental health and wellbeing of communities and to reduce health inequalities within and between communities. JSNAs underpin Health and Wellbeing Strategies, and these will form the basis of commissioning plans.

The JSNA examines aggregated assessment of needs and should not be used for identifying need at the individual level. Specifically, JSNA is a tool to identify groups where needs are not being met and that are experiencing poor outcomes.

In order to undertake a joint strategic assessment of need, information from a range of sources has to be pulled together. These can include routine data sources such as mortality and hospital episode statistics as well as information from consultation with individuals, professional or community groups.

Since the findings of JSNA inform a number of commissioning plans across health services and the local authority, individual areas use their discretion to update elements of JSNA, responding to local circumstances including the availability of new, strategic, plan-changing, information. Key to updating the JSNA is an understanding of the reliability of available data, including the risks attached to using them. The greater the uncertainty surrounding the data, the more frequently they will need to be re-assessed and a decision made on when to refresh parts, or all, of the JSNA.

It is important that everyone has a common understanding of what they mean by JSNA, and the term is sometimes used interchangeably to mean:

- process,
- an overview report /document,
- an individual population/disease specific needs assessment that is undertaken jointly with the local authorities, and
- to refer to the underlying datasets that inform the assessment of need

Progress to date

In Merton the recommended JSNA core datasets have been developed to inform commissioners giving an
overview of the population's health and social care needs across the borough.

The 2013 refresh of the JSNA core data set builds on the previous JSNA and latest guidance. The JSNA has been used to inform priorities set out in the new Merton Health and Wellbeing Strategy. In addition to the core data set information from in-depth needs assessments on priority issues have been included:

In 2008/09

- People with Learning Disabilities
- Older People
- Stroke Rehabilitation

In 2009/10

- Housing Regeneration
- Child and Adolescent Mental Health Services
- The use or misuse of Alcohol

In 2010/11

- Deprivation

In 2013 a Merton Health and Wellbeing Strategy Group will be established which will be accountable to the Merton Health and Wellbeing Board and have strategic oversight of the development of the JSNA. The Group will comprise of senior officers from the Local Authority, Clinical Commissioning Group and Voluntary Sector. This reflects the new partnership structures in Merton and will replace the previous JSNA Steering Group.

Appendix 2 - Sources and references

Who Makes up the population - Demographics

- National Census 2011 and 2001
- ONS population projections based on the 2011 Census
- Primary Care Population: Exeter GP Registration data
- School census 2012 data
- London Health Programmes: Health Needs Assessment Toolkit: birth data, census data
- LHO Practice Profiles
- ONS Annual District Birth data
- ONS Annual District Mortality data
- NHS Information Centre
- IMD 2010 data by LSOA
- Estimating the current need/demand for supports for people with learning disabilities in England (2004); Emerson, E & Hatton, C, Institute for Health Research, Lancaster University, UK
- GLA 2007 Round Ward Population Projections
- Department of Health. Projecting Older People Population Information System (POPPI)
- I COUNT © disability register for Children with Disabilities

How we Live - Our Lifestyles

- London Health Observatory Local Tobacco Control Profiles
- Association of Public Health Observatories: Health and Lifestyles data
- London Health Programmes: Health Needs Assessment Toolkit: smoking, sport
- NHS Information Centre: smoking data, dentistry
- Sutton and Merton Stop Smoking Service
- NHS Sutton and Merton Performance Team
- North West Public Health Observatories: Local Alcohol Profiles for England (LAPE)
- Secondary Uses Services hospital admissions data
- National Drug Treatment Monitoring System
- British Association for Study of Community Dentistry (BACSD) Survey Report for Decayed, Missing or Filled Teeth
- Secondary Uses Service (SUS) for teenage deliveries
Breaking the Cycle of Inequalities in Merton

- Government Office for London
- ONS NOMIS – Official labour market statistics
- London Health Programmes: Health Needs Assessment Toolkit for employment statistics
- IMD 2010 at Lower Super Output Area
- Place Survey 2009
- National census 2001
- Communities and Local Government
- DH Projecting Older People Population Information System (POPPI)
- NHS Information Centre, Healthy Lifestyle Behaviours, Model Based Estimates, National Centre for Social Research (NatCen)
- London Health Programmes: Health Needs Assessment Toolkit: for smoking, alcohol, obesity, sport, breastfeeding data
- NHS Sutton and Merton Performance Team
- National Drug Treatment Monitoring System
- Teenage Pregnancy Unit, Teenage Conception data
- Secondary Uses Service (SUS) for teenage deliveries

The Major Killers and Causes of Poor Health

- London Health Programmes: Health Needs Assessment Toolkit: CHD, Circulatory, Hypertension, Stroke, Diabetes, Cancer, COPD, HIV, TB
- UK Prospective Diabetes Study
- NHS Information Centre
- GP register data (Quality and Outcomes Framework)
- Department of Health Programme Budget Spend
- South West London St George’s Mental Health Trust data
- National Indicator Set from the TellUs4 Survey
- North East Public Health Observatory (NEPHO) 2006 for mental illness prevalence
- Alzheimer’s Society 2007
- The National Suicide Prevention Strategy
- SOPHID 2009, Health Protection Agency
- Secondary Uses Service data for hospital admissions

Our Living Environment-The Wider Determinants of Health

- Department of Health: Equity and Excellence; Liberating the NHS.2010
• Department of Health: Putting People First 2007
• Department of Health: NHS Next Stage Review: Vision for Primary and Community Care July 2008
• Department of Health: Our health, our say: a new direction for community services. 2006.
• Yorkshire and Humber Public Health Observatory (YHPHO) Spend and Outcome tool (SPOT) for CCGs
• NHS Information Centre: flu, cervical screening, emergency admissions
• London Health Programmes: Breast cancer screening, Social Services data
• Audit Commission: PbR Assurance Portal – National Benchmarker
• IMD 2010 at Lower Super Output Area
• NASCIS
• Department of Health. Projecting Older People Population Information System (POPPI)
• Department of Health. Projecting Older People Population Information (PANSI)
• IMD 2010
• Crime Survey for England and Wales (CSEW)
• My Place Survey 2009
• Local Alcohol Profiles for England (LAPE)
• London Health Observatory: Child poverty
• London Health Observatory: Practice Profiles
• Department for Education
• NOMIS: Official Labour Market Statistics
• ONS Neighbourhood Statistics: Dwelling Stock

Understanding the Health of Our Population - Where are our Inequalities

• NHS Information Centre for borough and national life expectancy at birth statistics, for causes amenable to healthcare, infant mortality
• Office for National Statistics, Health Statistics Quarterly for Life Expectancy at 65 years
• London Health Programmes: Health Needs Assessment Toolkit: data for life expectancy, mortality statistics, low birth weight
• ONS Public Health Mortality File
• London Health Programmes: Health Needs Assessment Toolkit: for causes amenable to healthcare
• London Health Observatory: Life Expectancy
• Association of Public Health Observatories (APHO): Life Expectancy, Slope Index

If there are any queries about data sources or you would like further information please contact us.
Appendix 3 - Glossary of terms

95% Confidence Interval

This is a measure of whether a result that differs from the average is likely to be real or merely a chance fluctuation. (95% CI is the range within which the true value is likely to occur).

Age-specific mortality

Death rate in a specified age-group (number of deaths per 100,000 people in that age-group).

Age- and sex-specific mortality

Death rate in a specified age-group (number of deaths per 100,000 men or women in that age-group).

Age- (or age- and sex-) standardised mortality

Death rate calculated to enable fair comparison with another area allowing for the difference in age (or age and sex) composition of the population.

All-cause mortality

Deaths from all (any) cause.

Cancer

A term used to describe a group of diseases that affect different parts of the body but generally involve abnormal growth of a group of cells to form a 'malignant tumour'. Other terms used are 'neoplastic disease' or 'malignancy'.

Cardiovascular diseases (CVD)

Diseases of the heart or blood vessels, also called circulatory diseases.

Circulatory diseases

Diseases of the heart or blood vessels, also called cardiovascular diseases. The commonest are coronary heart disease (see below) and stroke.

Clinical Commissioning Group (CCG)

The NHS organisations responsible for commissioning the majority of local health services (including
community services, acute hospital services and mental health services), led by GPs and other Clinical leaders.

**Coronary heart disease (CHD)**

Disease causing angina (chest pain on exertion), heart attacks, and heart failure. They are caused by atheroma ('furring') of the coronary arteries that supply oxygen to the heart muscle.

**Health inequality**

Differences in health experiences and health outcomes between different population groups.

**Health inequity**

Differences in opportunity for different population groups which result in unequal life chances, access to health services, nutritious food, adequate housing, education, and so on.

**Incidence**

Rate of occurrence of new cases of disease (within a given population over a given time period).

**Interquartile range**

The range within which the middle 50% fall. One-quarter of the values are below this range and one-quarter above. (see quartile).

**Ischaemic heart disease (IHD)**

Another term for coronary heart disease.

**Life expectancy**

The theoretical time an average person born today would live if he or she had the same rate of death at each age as people who are alive at the moment.

**Morbidity**

Rate of ill health.

**Mortality**

Death rate.

**Myocardial infarction**
Heart attack.

NHS Commissioning Board

The organisation responsible for ensuring that money spent on the NHS delivers best possible care for patients. It will directly commission primary care provided by local GPs and some specialist national services.

Prevalence

Proportion of the population with existing disease.

Prognosis

 Likely outcome.

Quartile

When results are ranked in order from lowest to highest, they can be divided into equal-sized groups. If divided into four groups, these are called 'quartiles'. (see interquartile)

Quintile

When results are ranked in order from lowest to highest, they can be divided into equal-sized groups. If divided into five groups, these are called 'quintiles'.

Routine and manual groups

This refers to a grouping within the National Statistics Socio-economic Classification (NS-SEC). The NS-SEC is an occupationally based classification and has been constructed to measure employment relations and conditions. Included in this group are those in lower supervisory, lower technical, semi-routine and routine occupations.

Standardised mortality ratio (SMR)

Death rate calculated to enable fair comparison with another area allowing for the difference in age (or age and sex) composition of the population. Expressed as a ratio to the average value - in this case England and Wales whose SMR is set to 100. Values greater than 100 indicate higher than average mortality. Values less than 100 indicate lower than average mortality.

Source: London Health Observatory (LHO)