Merton Council

Healthier Communities and Older People Overview and Scrutiny Panel

Date: 20 October 2016

Time: 7.15 pm

Venue: Committee rooms C, D & E - Merton Civic Centre, London Road, Morden SM4 5DX

AGENDA

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

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Healthier Communities and Older People Overview and Scrutiny Panel membership

Councillors:
Peter McCabe (Chair)
Brian Lewis-Lavender (Vice-Chair)
Laxmi Attawar
Mary Curtin
Suzanne Grocott
Sally Kenny
Abdul Latif
Marsie Skeete

Substitute Members:
Stephen Crowe
Najeeb Latif
Ian Munn BSc, MRTPI(Rtd)
Gregory Patrick Udeh

Co-opted Representatives

Saleem Sheikh (Co-opted member, non-voting)
Hayley James (Co-opted member, non-voting)

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

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

Scrutiny's work falls into four broad areas:

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

Scrutiny panels need the help of local people, partners and community groups to make sure that Merton delivers effective services. If you think there is something that scrutiny should look at, or have views on current reviews being carried out by scrutiny, let us know.

For more information, please contact the Scrutiny Team on 020 8545 3390 or by e-mail on scrutiny@merton.gov.uk. Alternatively, visit www.merton.gov.uk/scrutiny

HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL
6 SEPTEMBER 2016

(7.15 pm - 8.50 pm)

PRESENT Councillors Councillor Peter McCabe (in the Chair), Councillor Brian Lewis-Lavender, Councillor Laxmi Attawar, Councillor Mary Curtin, Councillor Suzanne Grocott, Councillor Sally Kenny, Councillor Abdul Latif, Councillor Marsie Skeete and Saleem Sheikh.

Stella Akintan (Scrutiny Officer)

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

None

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

None

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The minutes of the previous meeting were agreed as a true and accurate record.

4 MERTON CLINICAL COMMISSIONING GROUP - VERBAL UPDATE (Agenda Item 4)

Dr Andrew Murray Chair of Merton Clinical Commissioning Group (MCCG) attended the Panel to give an update on the latest priorities, issues and challenges within MCCG.

Dr Murray reported that MCCG are facing a number of concerns including rising demand for services, workforce issues and the need for estate modernisation at some acute hospitals. MCCG is a partner within the South West London Strategic Planning Group which also includes local authorities and NHS England. The partnership is developing a Sustainable Transformation Plan, (STP) a summary has been published. The priorities within the STP are similar to those within MCCG. Dr Murray outlined four main priority areas for MCCG:

Improve Outcomes: working with the Health and Wellbeing Board to reduce health inequalities. The Board is working on integrating health and social care services and developing the East Merton Model of Care for the most deprived areas of the borough.

Balancing Finances: MCCG are currently working to reduce a £6 million deficit and achieve a break even budget position.
Improving Performance Targets: Working closely with the acute sector who account for 50% of MCCG's targets.

Designing services for right care in right settings: The aim is to increase care within community settings. MCCG are developing a strategy on improving primary care and will consult with the community in due course.

A panel member asked if MCCG are looking at best practice from across the country to tackle health inequalities. Dr Murray reported that they recently visited the Bromley by Bow Medical Centre in Tower Hamlets.

A panel member asked if the prevention agenda is being built into plans for the Wilson medical centre. Dr Murray reported that prevention is a priority within the Sustainable Transformation Plans. The Wilson site will include a building purpose built for community use and will provide exercise classes, community gardens and other activities.

A panel member asked how MCCG is tackling the £6 million deficit. Dr Murray reported that they are aiming to prevent people going into hospitals and reducing the use of emergency care. They are also working with GP's to reduce the number of referrals to out- patient clinics as many of this can be dealt with in more appropriate settings.

A panel member asked if GP services are being closed. Dr Murray reported that there is an expectation that they will operate on a larger scale and work in partnership.

A panel member said that health colleagues need to lobby the government to ensure sufficient resources are allocated to the sector especially as Clinical Commissioning Groups around the country are facing similar challenges. Dr Murray agreed that those who work in the sector, including those at senior levels believe that resources to health need to be increased.

RESOLVED
The panel thanked Dr Murray for attending the meeting.

5 EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST (Agenda Item 5)

Daniel Elkeles, Chief Executive of Epsom and St Helier, gave an overview of the performance report stating that the Standard Hospital Mortality Rate still placed the Trust in the best quartile in the country.

A panel member asked what is being done to secure a modern hospital on the St Helier site. Mr Elkeles said he is making the case for four acute sites in South west London which includes Epsom and St Helier. The Trust is seeking support for this from the STP.

Panel members had a discussion about the proposed location of the St Helier Site.

A panel member said health colleagues need to lobby for additional resources for the sector as CCG's around the country are struggling. Dr Murry said there was a strong view even amongst those at senior levels that funding for health needs to be increased.

RESOLVED
The Panel thanked Mr Elkeles for providing the update.

6 FINAL REPORT AND RECOMMENDATIONS ARISING FROM THE DIABETES TASK GROUP (Agenda Item 6)

Councillor Brian Lewis Lavender, Chair of the Diabetes task group presented the report stating it is vital that the recommendations from this review are implemented so the target group can be supported.

The Panel agreed to send the report to Cabinet

RESOLVED
Members of the Diabetes task group were thanked for their work
That the report and recommendations are forwarded to Cabinet for agreement.

7 ADULT LEARNING DISABILITIES - MINI TASK GROUP REVIEW (Agenda Item 7)

The Panel agreed the scope of the review. The following members were appointed to the task group:

Councillor Mary Curtin
Councillor Sally Kenny
Councillor Brian Lewis-Lavender
Councillor Laxmi Attawar

RESOLVED
That the task group conduct the review and report their findings to the Panel in November.

8 WORK PROGRAMME (Agenda Item 8)

The work programme was noted

9 RESPONSE TO THE MOTION FROM THIS PANEL ON THE HANDYMAN SERVICE (Agenda Item 9)

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Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 2016

Wards: ALL

Subject: Cumulative Impact of Welfare Reform on Vulnerable People

Lead member: Councillor Peter McCabe, Chair of the Healthier Communities and Older People overview and scrutiny panel.

Contact officer: Stella Akintan, stella.akintan@merton.gov.uk; 020 8545 3390

Recommendations:

A. That the Panel comment on the reports from local organisations attending the panel

B. Any concerns raised during the discussion to be reported to the Council's Welfare Reform Group

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of the report is to look at the cumulative impact of welfare reform on vulnerable groups. Merton Centre for Independent Living and Faith in Action will attend the Panel to talk about the effect on the communities they support.

1.2. As this is a cross cutting issue, members of the Sustainable Communities Overview and Scrutiny Panel will also attend to contribute to the discussion.

1.3. The council has established a welfare reform group which is looking at ways to mitigate the impact of benefit changes. Feedback from the Panel discussion can reported back to this group who can provide an update at a future meeting.

2 DETAILS

2.1. The Local Government Association produced a report commissioned by the Centre for Economic and Social Inclusion entitled " The local impacts of welfare reform" which was published in 2013.

2.2. The report states that the welfare reform programme which began in 2010 represents the most fundamental change to the Benefit System in a generation. A list of the changes to benefits as outlined in this report is attached at Appendix A. The purpose of this session is to understand the impact at the local level and how the council and its partners can provide assistance. Reports from Faith in Action and Merton Centre for Independent Living are also attached.

3 ALTERNATIVE OPTIONS

The Healthier Communities and Older People Overview and Scrutiny Panel can select topics for scrutiny review and for other scrutiny work as it sees fit, taking into account views and suggestions from officers, partner organisations and the public.

Cabinet is constitutionally required to receive, consider and respond to scrutiny recommendations within two months of receiving them at a meeting.

3.1. Cabinet is not, however, required to agree and implement recommendations from Overview and Scrutiny. Cabinet could agree to implement some, or none, of the recommendations made in the scrutiny review final report.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The Panel will be consulted at the meeting

5 TIMETABLE

5.1. The Panel will consider important items as they arise as part of their work programme for 2016/17

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. None relating to this covering report

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. None relating to this covering report. Scrutiny work involves consideration of the legal and statutory implications of the topic being scrutinised.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. It is a fundamental aim of the scrutiny process to ensure that there is full and equal access to the democratic process through public involvement and engaging with local partners in scrutiny reviews. Furthermore, the outcomes of reviews are intended to benefit all sections of the local community.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None relating to this covering report. Scrutiny work involves consideration of the crime and disorder implications of the topic being scrutinised.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None relating to this covering report

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

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12 BACKGROUND PAPERS

Reforms included in this report

As noted, this analysis seeks to describe the cumulative impact of all reforms to benefits announced since the Coalition Government took office in May 2010. The reforms included in this analysis are listed below, with a brief summary. In all cases, the impact described is the projected saving in the financial year 2015/16 for Great Britain.

- **Changes to tax credits:** including reductions in the basic, 30-hour and childcare elements; increases in the child element; changes to working hours requirements, thresholds, disregards and withdrawal rates – saving **£5,275 million**.
- **Changes to Housing Benefit (HB) for renters in the private sector:** restricting the maximum Local Housing Allowance payment to the thirtieth percentile of average local rents, introducing Housing Benefit caps, restricting Housing Benefit to the "Shared Room Rate" for most claimants aged under 35, and changing the formula for annual increases in benefit – with combined savings of **£1,640 million**.
- **Increases in the deductions taken from Housing Benefit and Council Tax Benefit** in respect of other adults living at the property – saving **£130 million**[2].
- **The restriction of contributory Employment and Support Allowance (ESA) to one year** for claimants in the "Work Related Activity Group" – saving **£1,600 million**.
- **The replacement of Disability Living Allowance (DLA)** with a new benefit called the Personal Independence Payment (PIP) – saving **£1,350 million**.
- **The abolition of Council Tax Benefit (CTB)** and its replacement by locally-determined Council Tax Support schemes – saving **£355 million**[3].
- **The introduction of "size criteria"** for most Housing Benefit recipients in social housing, reducing awards by 14 per cent where tenants are deemed to have one spare bedroom and 25 per cent where they have two spare bedrooms – saving **£465 million**.
- **The introduction of a cap on total benefit receipt** for most households where no adult is in work, of £500 a week for families or £350 a week for single people – saving **£185 million**.
- **The uprating of benefits and tax credits** by 1 per cent instead of the Consumer Prices Index – saving **£2,680 million**.
- **The introduction of Universal Credit**, replacing the main means-tested benefits for those on low incomes in and out of work (Housing Benefit, Jobseeker's Allowance, Income Support, Employment and Support Allowance, Tax Credits) with a single benefit paid to the head of the household. Universal Credit will begin to roll out from late 2013, with existing claimants being reassessed over the following four years. The impact of Universal Credit will be to increase entitlements by £190 per claimant household per year, or around **£1,600 million** by the time it is fully rolled out in 2017/8[4].

2 From households of "working age"

3 This excludes losses from Council Tax localisation that are not passed on to claimants – ie where local and national governments have maintained entitlements for claimants.

4 Source: Universal Credit Impact Assessment, December 2012

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FAITH IN ACTION
helping with homelessness

FIAMHP
c/o Wimbledon Guild
30 – 32 Worple Road
Wimbledon
London
SW19 4EF

Mobile: 07843 280 419
Fax: 020 8296 0042
Email: FaithInAction@wimbledonguild.co.uk
Website: http://www.mertonfaithinaction.org

Paper to the Merton Scrutiny Panel.

The impact of Welfare Reform on Vulnerable Groups – the homeless, and A10 homeless.

Faith in Action is a twice weekly Drop In for the homeless run from the Salvation Army Hall in South Wimbledon. We have been running for 12 years and seen an escalation of those using our service since 2008. Over half our service users are from A10 European countries, and so we have had to develop our service with Polish–speaking staff and volunteers.

1. Since April 2014 A10 service users have been entitled to 13 weeks of Benefits after being in the country for 13 weeks, and then no entitlement until they have worked for 2 years. In our experience, most are not looking for benefits, but work. However, this means they cannot receive the help of some services, such as Drug and Alcohol for detox and rehabilitation, or the Spear Health Service, a support service for the homeless with health problems.

2. The new welfare system of Universal Credit requires all applicants to have their benefits paid into a bank account. Without an address one cannot get a bank account. Therefore those who are homeless are unable to be put on to benefits. We have tried to get access to bank accounts for the homeless, without success so far. We are able to supply a secure mailing address for our service users, but not an accommodation address, as is required.

3. We have observed that some service users who have chronic alcohol issues and are not able to access treatment will go into hospital because of another serious issue, probably related to their alcohol use. While they are there, they may receive an alcohol detoxification. This has been the case for about 10 service users in the last couple of years. On leaving hospital, the follow up services required are not usually put in place; having no benefit entitlement means rehabilitation is not available. We have an example of NS who was admitted with TB and was given a detox from alcohol. He was found accommodation and monitored for his TB, so has thrived and is now working and recently paid us back the cost of his passport (£90) required as ID.

4. Sanctions – The new regime of sanctioning benefit claimants if they are not able to fulfill the requirements of their “claimant commitment” has led to some service users losing benefit and having no money at all to live on for the period of the sanction.

What does FIA do to help with these situations and can other services help?

1. FIA sees work as the way out of homelessness for our service users. We have a volunteer who works to develop CVs and make job applications, and will help with the cost of transport to interviews. We even keep a suit for use at interviews, when required. We have a Polish speaking worker and volunteers, and can buy passports for Merton based people to enable them to have ID for work. Without this they cannot work legally; last year we paid for 17 Passports. Our Polish worker also runs an alcohol awareness group for Polish speakers, previously with the help of Engage Merton, part of the Drug and Alcohol treatment services in Merton. The worker also deals with issues that arise for Eastern Europeans. Her salary is funded by a grant from Merton Housing of £10,000, which is a hugely valuable resource for FIA.

2. We would like to find a bank or credit union in Merton that would allow the homeless to open an account, in particular one that does not allow withdrawing of money that is not in the account, ie no overdraft facilities. We have had contact with the Merton Chamber of Commerce about this, but not as yet solved it. The Job Centre is aware of this problem.

3. The investment in treatment and detoxing alongside seems to us to be a waste of an opportunity and expensive resources. Those who undergo the detox should be referred to ongoing support by drug services. Releasing people from hospital back to rough sleeping means that the period of abstinence is likely to be short.

4. We have an outreach worker from the Job Centre in the Drop In one day a week who can help address Benefits issues. She is able to explain why a service user has been sanctioned and the exact period of the sanction, which gives clarity. Her attendance at the Drop In is under review at the moment by the Job Centre. We have a service user with clear learning difficulties whose work search has to be filled in by our job search volunteer every two weeks to prevent him being sanctioned. We have tried to get him assessed as vulnerable by the Job Centre without success

How could the LB of Merton help?

We are immensely grateful for the support we already receive from the borough. Beyond that, and bearing in mind limited financial and professional resources, we would ask that you consider assisting positively to:

a. Raise the profile of organisations such as FiA, which would help us when seeking funding and other assistance;
b. Press local banks to reconsider their reluctance to allow homeless people to open bank accounts;
c. Lobby government, perhaps through local authorities' national representational organisations, to take more account of the barriers which homeless people face in seeking work and accommodation;
d. Press local housing associations to do more to assist homeless people who do find work, and therefore have the ability to pay for accommodation.

Conclusion

It is more cost effective to help the homeless to change their situation with regard to acceptable welfare restraints than to leave them to become a bigger drain on scarce community and health resources. The adjustments we suggest could have a significant impact.

Summary Review of the Impact of Welfare Reform

Oct 2016

Introduction

Merton CIL are a user-led Disabled people's organisation run by Disabled people, for Disabled people. We deliver a range of services to disabled people in London Borough of Merton, including advice and advocacy services.

Through our case work we gather evidence of significant issues facing local disabled people. This briefing is a short overview of the impact of Welfare Reform. It has been prepared for a Healthier Communities and Older People Overview and Scrutiny Panel[1] and in addition to being based on our casework, builds on initial research undertaken in partnership with the Public Health team.

Overview

The welfare benefit reforms that the government brought in through the Welfare Reform Act 2012 are having a significant and disproportionate negative impact on Disabled people, which seriously jeopardises Disabled people's standard of living and reduces the level of social protection.[2]

Cuts to benefits and Local Government together bear 50% of planned cuts in the Treasury Spending Review. A list of some of the main changes, caps and cuts demonstrates the scale of Welfare Reform[3]:

[1] http://democracy.merton.gov.uk/ieListDocuments.aspx?CId=151&MId=2528
[2] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015, p. 13
[3] http://www.centreforwelfarereform.org/library/categories/disability/farewell-to-welfare.html

Reducing benefits over time so they don't keep pace with the economy (CPI indexation)	Closure of ILF
Child Benefit Changes	Cuts to Tax Credits (not implemented)
Replacing DLA with PIP	Introduction of Mandatory Reconsideration process in benefit appeals
Time-limiting contributory ESA	Cuts to Housing Benefit such as non-dependant deductions and limited backdating
Council Tax Benefit Changes	Household benefit cap
Cuts to Local Welfare Assistance Fund	Freeze to Local Housing Allowance
Spare Room Subsidy (Bedroom Tax)	Continued transfer from IB to ESA
Abolition of Child Trust Fund	Abolition of ESA youth rules
Abolition of Sure Start Maternity grant for second child	Tougher sanctions for JSA and ESA claimants
Abolition of Health in Pregnancy grant	Work Capacity Assessments for ESA claimants
Reductions in Supporting People funding	Reductions in Access to Work funding
Closure of Remploy services	Changes to Mortgage Interest Relief
Universal Credit rollout	Significant cuts to local authority funding

Further planned cuts and changes:

- Transfer of AA to local authorities
- Tax Credits Support for children reduced
- Reduction in payment for ESA Work-Related Activity Group Claimants
- Universal Credit Youth Obligation
- Universal Credit Housing Support removed for young people
- Capping Housing Benefit in the social rented sector
- Support for Mortgage Interest (SMI) payments to become a loan

Other significant changes affecting the people hardest hit by Welfare Reform include:

- Increased VAT to 20%
- Cuts to legal aid
- Increased rents
- Increased cost of basic needs like utilities

Recently, four different reports have concluded that the cuts associated with Welfare Reform have disproportionately impacted on disabled people. One report demonstrates that Welfare Reform targets people in poverty and disabled people, with disabled people who need to access both benefits and social care affected 6 times more than non-disabled people resulting in an annual reduction in income of £6,354 per person[4]. Demos, funded by Scope, have also demonstrated the severe cuts faced by disabled people. They calculated that by 2018 disabled people will have lost a total of £28.3 billion of income by a series of different caps and cuts[5].

Most recently the National Institute of Economic and Social Research, commissioned by the Equality and Human Rights Commission reached the same conclusion. They found "The impacts of tax and welfare reforms are more negative for families containing at least one disabled person, particularly a disabled child, and that these negative impacts are particularly strong for low income families."[6] Finally, a recent report from Just Fair – Dignity and Opportunity for All – concluded that the UK Government was in breach of international law for its unfair treatment of disabled people.[7]

As a consequence, Disabled people are facing disadvantage across key areas of their lives[8], and are experiencing significant health inequalities[9]. Barriers to employment, accessing the community, poverty and homelessness follow.[10]

[4] Duffy S (2014) Counting the Cuts: what the Government doesn't want the public to know. Sheffield, The Centre for Welfare Reform
[5] Wood C (2013) Destination Unknown: April 2013. London, Demos.
[6] Reed H & Portes J (2014) Cumulative Impact Assessment:A Research Report by Landman Economics and the National Institute of Economic and Social Research (NIESR) for the Equality and Human Rights Commission. London, Equality and Human Rights Commission.
[7] Young J (with Nolan A) (2014) (Dignity and Opportunity for All: securing the rights of disabled people in the austerity era. London, Just Fair.
[8] The Equality Act 2010: The Impact on Disabled People, House of Lords Select Committee on the Equality Act 2010 and Disability, 2016
[9] Is Britain Fairer? Equalities and Human Rights Commission, 2015
[10] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015

Welfare Reform has been detrimental to the well-being of disabled people and this creates particular challenges for statutory and voluntary services supporting disabled people.

Summary impact of benefit cuts and changes

The changes to benefits are complex, far-reaching, and inter-linked, so that a change in one benefit frequently has a larger effect than might have been expected.

For example, in the migration from DLA to PIP, about 20% of those entitled to DLA are expected to lose their entitlement to PIP.[11] If entitlement to DLA is lost, not only will individuals lose their DLA income, but they could also lose income from other benefits as they are no longer exempt from bedroom tax, the overall benefit cap and in some boroughs, council tax support.[12] In addition, 148,000 disabled people are expected to lose out on the enhanced rate and their access to a Motability vehicle meaning they will not be able to leave their own homes and participation in the community such as volunteering, employment or social contact will be lost.[13]

In another example, people who lose ESA will automatically lose Housing Benefit, even though this is contrary to DWP guidelines[14]. If loss of Housing Benefit leads to rent arrears then people can be evicted and may additionally be found intentionally homeless by the local authority and therefore not eligible for further support. We have witnessed this happening in Merton.

In a third example, people who struggle to pay their full rent can apply for Discretionary Housing Payments. However, nationally 1 in 3 Disabled people are being refused a DHP [15] and Local Authorities have even rejected DHP applications from Disabled people living in adapted properties who are unable to downsize in the short term. Because DHPs

[11] http://www.londonspovertyprofile.org.uk/indicators/topics/receiving-non-work-benefits/dla-caseload-by-care-award-type/
[12] http://www.londonspovertyprofile.org.uk/indicators/topics/receiving-non-work-benefits/dla-caseload-by-care-award-type/
[13] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015, p. 22
[14] http://www.theguardian.com/society/patrick-butler-cuts-blog/2015/oct/06/dwp-finally-acts-to-end-housing-benefit-maladministration-scandal
[15] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015, p. 24

are short term and temporary they are creating significant instability for disabled people trying to remain in rented accommodation.

Summary impact of Social Care cuts and changes

Social care is the front-line prevention service of the welfare state. When people do not get this practical assistance it can quickly lead to death, health crisis, hospital admission, institutionalisation, fractured families and police action - all of which is more expensive and less effective than early support to stay strong and independent.[16]

Despite this, there have been considerable cuts to local authority funding[17], leading to cuts to Adult Social Care funding, although some local authorities have mitigated this better than others, with 144/152 of English Councils taking up the 2% Social Care Precept in Council Tax[18].

Many Disabled people's care and support has been cut down to a very basic clean and feed model, and as a result full inclusion and participation in the community has become impossible. In a survey with disabled people, over a third (36%) say they were unable to eat, wash or leave their homes due to underfunding,[19] while service providers are significantly concerned that there is insufficient time or funding to ensure people can be supported without risk to their dignity.[20]

The Office for National Statistics found that only 65 per cent of Disabled people said they frequently had choice and control over their lives, a fall of more than 14 per cent (or 11 percentage points) in just six years.[21]

Local authority cuts also impact disabled people in other ways with reductions in other services having an impact too and even a simple cost-cutting measure like moving services online can be detrimental given that only 60% of disabled people access the internet compared to 90% of non-disabled people.[22]

[16] A Fair Society? How the Cuts target Disabled People, Centre for Welfare Reform, 2010, p. 13
[17] ADASS (2014) Budget Survey 2014. ADASS
[18] Only 8 out of 152 Councils in England decided not to take up the 2% Council Tax precept. Source: Local Government Association 26/08/2016
[19] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015, p. 8
[20] Angel C (2012) Care is Not a Commodity. UKHCA
[21] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015, p. 6
[22] Is Britain Fairer? Equalities and Human Rights Commission, 2015, p. 32

Summary cumulative impact of Welfare Reform

Without appropriate support many disabled people face isolation and poverty, unable to assume ordinary roles in society or to contribute socially and economically.[23]

There has been particular concern about the effects of reductions in funding for local authorities, changes to benefits, and the way in which these might interact to restrict independent living.[24]

It seems clear that these changes are creating and compounding inequality which is correlated with[25]:

- Lower levels of life expectancy
- Higher levels of infant mortality
- Worsening mental health[26]
- Greater obesity
- Higher rates of bad health[27]
- Poor educational achievement
- Higher teenage birth rates
- Lower community cohesion

This means that inequality is expensive. However, disabled people are in greater, and increasing, poverty.[28]

Welfare Reform is also correlated with homelessness with a sharp rise in the number Disabled people who have been experiencing evictions and homelessness in the last 2 years because of rent arrears.[29]

[23] Dignity and Opportunity for All: Securing the Rights of Disabled People in the Austerity Area, Just Fair, 2014, p. 3
[24] Implementation of the Right of Disabled People to Independent Living, House of Lords House of Commons Joint Committee on Human Rights, Twenty–third Report of Session, 2010–12, p. 5
[25] A Fair Society? How the Cuts target Disabled People, Centre for Welfare Reform, 2010, p. 26
[26] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015, p. 8
[27] Is Britain Fairer? Equalities and Human Rights Commission, 2015, p. 51
[28] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015, p. 12
[29] Evidence of Breaches of Disabled People's Rights Under the UN Convention on the Rights of Persons with Disabilities, Inclusion London, 2015, p. 17

The impact in Merton

At Merton CIL we work closely with disabled people to navigate the benefits and care systems and directly experience many of the issues described above. Currently we have a service user who has had his Housing Benefit suspended because of a stop to his ESA. We have spoken to DWP and confirmed the stop has been done in error and should be reinstated, but the Council decline to take our word for it and won't reinstate the HB claim until they receive formal notification from DWP, meaning that the individual is currently in rent arrears. In another example, we supported a former ILF user who had his care package cut during the reassessment process but was subsequently hospitalised and is now trying to fight for a reassessment to meet his increased needs, while very unwell.

We estimate that between 950 and 2,000[30] disabled people may lose their entitlement to PIP in Merton. An estimated 100 motability vehicles may be lost as claims are downgraded.

We are still exploring the potential local impact of ESA changes such as increasing sanction rates[31], or Universal Credit changes resulting in less income for disabled people in work.[32]

In January 2016, the council faced protests over its plans to cut £5 million from its adult social care budget, with campaigners comparing these plans to "social cleansing", and accusing it of "treating people no better than animals in Longleat". A report from Healthwatch Merton[33] showed that local people didn't feel they could influence the decision-making process. It also highlighted the fact that the quality of existing services was reducing and that prevention was made impossible by cuts to services. Disabled and older people felt that their wellbeing would be reduced and people's physical health would worsen. Families would be put under immense strain and social connections severed. Disabled and older people would be made vulnerable by these cuts and the ultimate consequence for some was that life was no longer worth living.

[30] We have written to the Job Centre to ask for more accurate assessments but they are unable to provide this information

[31] Hale C (2014) Fulfilling Potential? London, Mind

[32] The Children's Society (2012) Holes in the safety net: the impact of Universal Credit on disabled people and their families. The Children's Society

[33] http://www.healthwatchmerton.co.uk/sites/default/files/hwm_asc_focus_groups_write_up_report.pdf

In conclusion

Local support structures could be put in place to mitigate the impact of Welfare Reform. This could include a range of activities such as more local advice and advocacy services, money management and debt advice, greater scrutiny of poor practices at benefit assessment centres, and improvements to housing support.

However, the local authority has the most control over its Adult Social Care budget. Insufficient funding of social care is creating an unsustainable situation. Merton's own budget plan points out that the cuts to services which are being implemented mean that they can't meet their statutory duties and the local voluntary sector has been vocal in asking for less damaging cuts. It is here that LBM can have the greatest impact on people's lives by adequately resourcing Adult Social Care to the Care Act standard.

Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 20th September 2016.

Wards: ALL

Subject: Sustainability and Transformation Plan for South West London

Lead officer: Dr Andrew Murray, Chairman Merton Clinical Commissioning Group

Lead member: Councillor Peter McCabe, Chair of the Healthier Communities and Older People Overview and Scrutiny Panel.

Contact officer: Stella Akintan, stella.akintan@merton.gov.uk; 020 8545 3390

Recommendations:

A. That Panel members comment on the update from Dr Andrew Murray, Chairman of Merton Clinical Commissioning Group (MCCG) on the progress with developing the Sustainability and Transformation Plan for South West London.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. Dr Andrew Murray will attend the panel to provide update on the progress with developing a Sustainability and Transformation Plan for South West London.

1.2. **DETAIL**

1.3. All regions of the NHS in England are required to publish Sustainability and Transformation Plans (STPs) setting out how they will deliver high quality, sustainable services for their populations in the years ahead . STPs are intended to be developed through a partnership of NHS commissioners and providers, working with their local authorities.

1.4. The scrutiny of the STP has been delegated to the South West London Joint Health Scrutiny Committee (JHOSC). The Chair and Vice-Chair of this Panel are members of the committee and will report back on the discussion at future Panel meetings. A briefing and presentation from the 11th October JHOSC meeting is **attached** for information.

2 ALTERNATIVE OPTIONS

The Healthier Communities and Older People Overview and Scrutiny Panel can select topics for scrutiny review and for other scrutiny work as it sees fit, taking into account views and suggestions from officers, partner organisations and the public.

Cabinet is constitutionally required to receive, consider and respond to scrutiny recommendations within two months of receiving them at a meeting.

2.1. Cabinet is not, however, required to agree and implement recommendations from Overview and Scrutiny. Cabinet could agree to implement some, or none, of the recommendations made in the scrutiny review final report.

3 CONSULTATION UNDERTAKEN OR PROPOSED

3.1. The Panel will be consulted at the meeting

4 TIMETABLE

4.1. The Panel will consider important items as they arise as part of their work programme for 2016/17

5 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

5.1. None relating to this covering report

6 LEGAL AND STATUTORY IMPLICATIONS

6.1. None relating to this covering report. Scrutiny work involves consideration of the legal and statutory implications of the topic being scrutinised.

7 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

7.1. It is a fundamental aim of the scrutiny process to ensure that there is full and equal access to the democratic process through public involvement and engaging with local partners in scrutiny reviews. Furthermore, the outcomes of reviews are intended to benefit all sections of the local community.

8 CRIME AND DISORDER IMPLICATIONS

8.1. None relating to this covering report. Scrutiny work involves consideration of the crime and disorder implications of the topic being scrutinised.

9 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

9.1. None relating to this covering report

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

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11 BACKGROUND PAPERS

11.1.

SWL Sustainability and Transformation Plan

Briefing for South West London Joint Health Overview and Scrutiny Committee
October 2016

Background

Following publication of the NHS Five Year Forward View (5YFV) in 2015, all regions (or 'footprints') of the NHS in England are required to publish Sustainability and Transformation Plans (STPs) setting out how they will meet the challenges set out in the 5YFV and deliver high quality, sustainable services for their populations in the years ahead.

STPs are intended to be developed through a partnership of NHS commissioners and providers, working with their local authorities. This is a significant change to previous NHS change programmes, which have been commissioner-led. The partnership approach is expected to continue in development of the STP: while in the past, different areas of the NHS have in effect had competing interests, the STP process requires 'whole system' accountability. NHS England and NHS Improvement, as regulators of commissioners and providers, are taking an active role in ensuring system-wide accountability for STPs.

South West London STP

The South West London STP is currently going through the final stage of drafting. An initial submission was made to NHS England in June 2016, in line with national requirements. As June submissions were very early drafts, NHS England requested that they were not made public at that stage, but a summary of our early thinking has been shared online and forms our presentation pack for this meeting. The final draft – which will remain an iterative document for discussion with local stakeholders and the public – will be submitted in October 2016. The final document will be similar in essence to the June submission, but is likely to be more specific about financial modelling, whole system working and our approach to the configuration of acute hospital sites.

Leadership and governance

STPs are a partnership between commissioners and providers, working with their local authorities. Our governance reflects this. **Decisions are made by CCG governing bodies and provider trust boards, based on recommendations from our programme board, clinical board and collaborative leadership group.**

Day to day management of the STP process rests with a small leadership team:

- Kathryn Magson – SRO for STP and Chief Accountable Officer for Richmond CCG
- John Goulston – Provider Lead – Chief Executive of Croydon NHS Hospitals Trust
- Kath Cawley – STP Programme Director
- Ged Curran – Local Authority Lead and Chief Executive of the London Borough of Merton.

Local authority leaders and CCG Chairs meet on a quarterly basis in the Collaborative Leadership Group, which is the key partnership forum between local authorities and the programme.

The programme has eight clinical working groups, covering different clinical areas, all of which include more than one patient and public representative. These representatives meet on a quarterly basis and the programme also has a dedicated Patient and Public Engagement Steering Group, which advises us on all aspects of our public engagement.

Content of draft STP

The attached slides summarise content of the June submission. It is important to note that the October submission is still being drafted and is likely to update the initial STP significantly.

The key planks of our STP are likely to remain in place:

- A whole system approach based on collaboration between and across commissioners, providers and local authorities
- More care delivered outside hospital in community settings
- An expansion/transformation of primary care
- Proactive, preventative care based on keeping people well and early intervention
- Parity of esteem for mental and physical healthcare
- The need to consider the best configuration of our acute hospitals and of specialised services in south London.

However, we have carried out further work to improve the estimated savings and further close the financial gap and this will be reflected in the submission. We have also looked in more detail at the question of acute hospital configuration through the lenses of clinical pathways, finance, workforce, and deliverability.

Public engagement

The NHS has been talking to the public and stakeholders about the challenges facing local services for several years. In 2015, we published an Issues Paper setting out the challenges and asking local people and organisations for their views. Large-scale deliberative events were held in each of our six boroughs to discuss these issues and all feedback has been recorded and published. We will shortly publish our response to this feedback, which has informed our thinking on the STP . We also commissioned an Equalities Analysis, to look at how changes to services might impact on groups listed as having protected characteristics under the Equality Act 2010.

During 2016, we have continued to engage with local people on these issues.

- In May, we wrote to **over 1,000 local organisations, sharing emerging thinking on the STP** and asking for their feedback, also offering to attend local meetings to talk through the issues.
- We launched an extensive **grassroots engagement programme** in partnership with local Healthwatch organisations. This programme sponsors enjoyable activities for local grassroots organisations, during which the NHS has a slot to talk to local people about health services and the issues raised in the STP. To date, around 27 events

have been held across all boroughs and extensive feedback has been gathered, with a similar number being planned over the remainder of this financial year.

- We published a **summary of the draft STP online** and again shared this with all of the organisations on our database for comment. We again offered to speak to local groups who wish to discuss the STP further.
- Our Patient and Public Engagement Steering Group has continued to meet and to advise us on all elements of public engagement, while all of our clinical groups, our programme board and our clinical board have patient and public representatives.
- We are now working with local authority communications teams to develop bi-annual **Health and Care Forums in each borough** – this will be a means of continuous engagement with local people on the issues raised by the STP and our developing strategy.

The next steps

When the final draft STP has been submitted, we will undertake further public and stakeholder engagement, as we seek to develop our plans on an iterative basis, in partnership with local authorities and local people. The proposed Health and Care Forums will be one step in this, as will a programme of social media engagement and further attendances at local meetings. We will produce regular 'You Said We Did' updates, summarising all feedback received and our response to it.

Should the STP lead to proposals for significant service change at any of our hospitals, we would hold a full public consultation on these. Current timescales suggest that if public consultation is required, it would take place during 2017.

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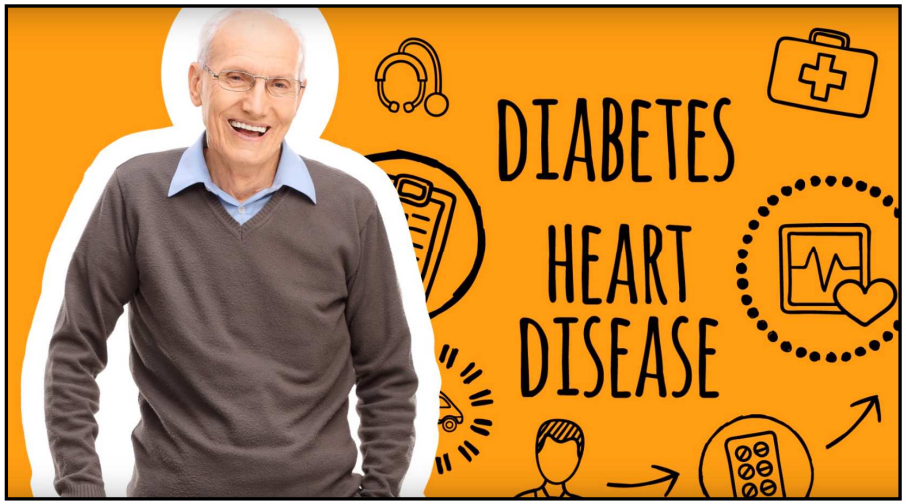
South West London Collaborative Commissioning



Our five year forward plan for south west London

Start well, live well, age well

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England

'Working together to improve the quality of care in South West London'

About our five year forward plan

- Following the NHS Five Year Forward View, all regions of the NHS in England are required to produce five year Sustainability and Transformation Plans (STP)
- Our plan is the product of genuine collaboration between all NHS commissioners and providers in SW London, working with our six local authorities and GP federations
- An initial draft was submitted to NHS England on 30 June - now undergoing assurance from NHS England
- Full draft STP will be shared following assurance and further public and stakeholder engagement will take place. Next draft due to be submitted to NHS England in October 2016

We are clear about the challenges we face

- We have a life expectancy gap of 9.4 years from most affluent areas to most deprived.
- Our population is growing and ageing, with increasingly complex mental and physical healthcare needs – we need to do more to help people live healthy, independent lives for as long as possible
- Services in SWL are not set up to achieve this. Too often people are admitted to hospital in an emergency or to inpatient mental health beds when they could have been treated earlier or elsewhere and not needed to be in hospital
- Quality of care varies enormously across SWL depending on where and when patients access services
- None of our acute hospitals meet all of the London Quality Standards for acute urgent and emergency care and we over-rely on agency staff to support acute services
- These pressures on the NHS are compounded by cuts to local councils and social care budgets
- As a result of these pressures, the cost of providing care are rising far quicker than inflation and the money we are allocated

Our principles

- Doing nothing is not an option – we need to act now to improve standards and outcomes for people in south west London, whilst making sure services are clinically and financially sustainable

- Our draft plan sets out how we can work together across south west London to support people to keep healthy and well – and to intervene early and deliver the right care in the best place to support them if they do become unwell

- To do this we propose to shift more care from hospitals into the community, so we can provide care that is closer to home, tailored to people's individual needs and supports them to stay as well as possible for as long as possible

- We will work with local people and organisations across south west London over the next few months to develop a detailed plan for high quality, sustainable services for our population

The SWL Vision

Our Mission

To help South West London's residents to

Start well, live well, age well

Our Vision

People live longer, healthier lives. They are supported to look after themselves and those they care for. They have access to high quality, joined up health and care services when they need them that deliver better health outcomes at a lower cost of provision to the system

Service Design Principles

1. Care is patient centred & holistic

•Inclusive & recognises the role of family, friends, communities & voluntary organisations

•Joined up and crosses organisational boundaries, encompassing people's physical, mental and social care needs

•Easy to navigate

2. Care is proactive & preventative

•Focussed on enabling people to stay well and avoid healthcare instances

•Prioritises early detection – people have access to early support mechanisms

•Promotes self management – people are encouraged to take responsibility for their healthy lives

3. Care supports the quality of life and the outcomes people value

•People are supported to live life as fully as possible for as long as possible

•People are aware of the choices available and have greater control

4. Care is financially sustainable

5. Our staff and care givers feel supported and able to do their roles

Service Development Principles

1. We focus on **better health outcomes at lower cost of provision to the system**

•We work in partnership across all health and social care organisations including the third sector to design and deliver the solutions

•We make better use of resources, irrespective of the organisation

•We plan for a changing environment

2. We will rapidly adopt **evidence based care** (where possible)

3. We maximise the use of **digital technology,** for the benefit of all stakeholders

The three big challenges we need to meet

Gap 1: Improving health and wellbeing

•Growing and **ageing population**, but also an unusually **young population**.
•**Inequalities** with pockets of deprivation that are linked to poorer health and wellbeing outcomes
•**Prevention in early years** could be improved (focus on childhood obesity)
•The number of **people living with dementia** is rising and embedding high quality dementia care into services is key.

Developing cross partner prevention plans
The development of this plan has been welcomed as an opportunity to improve collaboration between the NHS and local authorities.

Gap 2. Improving care and quality

Our care and quality base case demonstrates:
•We are failing to meet minimum standards for acute urgent and emergency care
•More could be done in the community to reduce the amount of care delivered in hospitals
•We can do more to improve the quality of general practice
•We are not consistently meeting the needs of people who have mental health needs or dementia

Underlying factors
Two main factors underpin these gaps in the quality of our services:
•The lack of an available workforce to provide safe, effective care in the existing configuration of services
•The provision of preventative and proactive care, including primary care and services supporting earlier discharge from hospital, is inadequate.

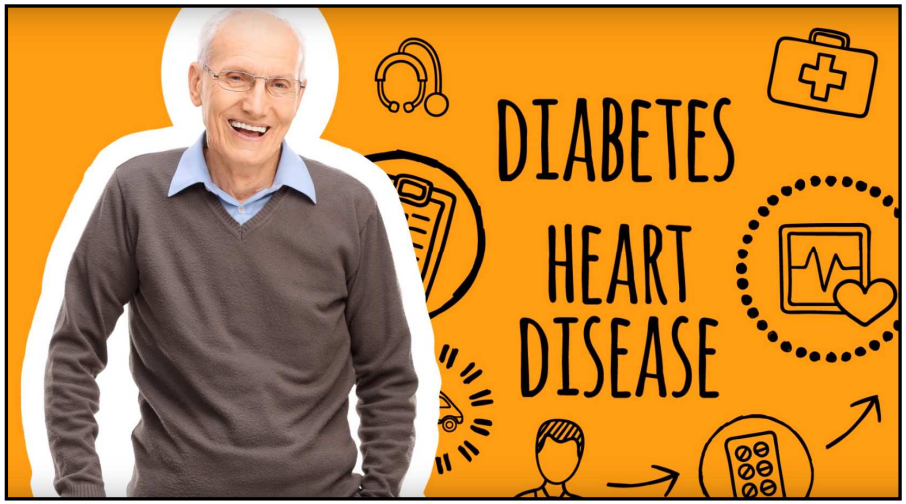
Gap 3: Improving finance and efficiency

•The cost of delivering services is rising much faster than inflation due to rapidly increasing demand; this is creating a financial gap which will make current services unaffordable by 2020/21 if we do not make changes now.
•Our initial analysis suggested that if we do nothing, the financial gap in five years would be £900m.
•We believe that making changes to the way in which services are delivered can deliver changes that improve the quality of care as well as making services more cost-effective to the taxpayer.

Our draft plan suggests we should:

- Set up locality teams across south west London to provide care to defined populations of approximately 50,000 people. The teams would align with GP practice localities and have the skills, resources and capacity to deliver preventative health and support self-care
- Address both mental and physical needs in an integrated way, because we know this improves the wellbeing and life expectancy of people with severe mental illness and reduces the need for acute and primary care services for people with long term conditions
- Introduce new technologies to deliver better patient care (e.g. virtual clinics and apps)
- Use our workforce differently to give us enough capacity in community, social care and mental health services to bring care closer to home and reduce hospital admissions
- Make best use of acute hospital staff through clinical networking and/or consolidating activity on a smaller number of sites
- Review our acute hospitals to ensure that we meet the changing demands of our populations and to ensure that acute providers deliver high quality, efficient care.

South West London Collaborative Commissioning



Summary of suggested changes

Start well, live well, age well

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England

'Working together to improve the quality of care in South West London'

Prevention and early intervention

- We need to better support people to live healthy, active and independent lives for as long as possible: this includes advice and support to stop people getting ill and to help patients to manage their long term conditions
- Where people do get ill, we need to ensure they are diagnosed and supported at an early stage
- Mental and physical health issues must go hand in hand: support for people with long term conditions like diabetes, medically unexplained symptoms and chronic pain should take into account mental as well as physical health needs
- We need to do more to identify people at risk of developing long term conditions and use modern technology and a modernised workforce to develop proactive care to support them at home and in the community
- Much closer work between the NHS and local authorities, who provide social care, is critical to supporting the prevention agenda
- Modern technology can support the prevention agenda – e.g. online, apps and text-based services, Skype consultations
- We need to improve the uptake of health checks

Transforming access to outpatients

- We want to deliver more consistent outpatients services across SWL, stop patients having to attend unnecessary appointments and bring outpatient care closer to home
- We aim to stop unnecessary follow-up appointments by only providing annual reviews when clinically necessary, ideally in a primary care setting, stopping automatic follow-up appointments and making it easier to be re-referred
- We want to reduce variation between GP practices by expanding the use of referral management systems, setting up one-stop clinics and standardising protocols in our diagnostic services
- Better use of technology – eg Skype or telephone appointments, remote monitoring via smartphone apps, online services (eg for sexual health), better sharing of information between GPs and hospitals, text reminders for appointments
- More community-based clinics (e.g. musculoskeletal and dermatology), upskilling primary care work force to support community-based care, more ambulatory care in the community.

New models of care

- **Maternity**: Support women's choice in place of birth, increasing availability of home births and midwife-led care. Safe an sustainable hospital services for women who need obstetric-led care. More personalised antenatal and postnatal care, including reviewing consistency of carer and provision of perinatal mental health support.

- **Children's services:** Most children who are unwell should be treated in primary care and the community; better access to and availability of community-based care will reduce the need for hospital attendances. Children who need hospital care for a short period to be assessed, observed and treated in paediatric assessment units sitting alongside A&Es. Quick access to specialist inpatient care for the small number of children who need it. Increased networking between hospitals and between GPs/primary care and hospitals.
- **Urgent and emergency care**: An integrated service which achieves the core standards is a high priority. 24/7 integrated urgent care access, treatment and advice via an improved 111 service. Priorities include mental health crisis care, self-care support and 'see and treat' models for London Ambulance Service.

New models of care (2)

- **Ambulatory emergency care (AEC)**: Treatments such as deep vain thrombosis or cellulitis are delivered in hospital but need not require hospital admission. AEC provides timely treatment and improved experience for patients, avoiding unnecessary admissions. All 6 CCGs have signed up to further delivery of AEC. We also need to improve support outside hospital for people with mental health conditions, who are three times more likely to attend A&E at present.

- **Care for the frail elderly:** We want to improve care in the community for frail older people, building on existing work, for example in Croydon where acute hospitals work with other NHS and social care providers to support older people. We might consider converting parts of our acute sites to provide specialist elderly care. We know more older patients could be treated in the community, including dementia patients as well as those being treated in acute hospitals.

Primary care

- **Locality teams** to be set up across SWL to support defined populations of approx. 50,000: role will be prevention/public health, early intervention, working closely with the voluntary and community sector, aligning with GP localities and supported by GP federations. There will be a single point of access for professionals.
- Commitment to **accessible, coordinated and proactive** primary care
- **Investment** in primary care will be higher than baseline core contract allocations, to cover cost of developing primary care hubs, continued federation development and increased workforce costs
- **Community Education Provider Networks** (CEPNs) to deliver a range of training to practice staff
- More **Care Navigator** roles; explore recruitment of practice-based clinical pharmacists, mental health therapists and others
- **Sutton Care Home Vanguard** rolled out across SWL
- **GP federations**: 6 established and have formed a collaborative. Kingston & Wandsworth already have contracts in place (eg diabetes, ophthalmology, dermatology and musculoskeletal outpatients); Richmond has 8am-8pm GP access 7 days a week

Acute hospital services

- We want to improve quality and optimise our workforce, in particular meeting the **London Quality Standards** (LQS). Since LQS were introduced, there has been more emphasis on multi-disciplinary teams and drawing on skills of a wide range of staff, so there may be other ways of delivering the outcomes the LQS aim for.

- We need to make the best use of clinicians, increasing **clinical networks** across the trusts OR **consolidate services** on a smaller number of sites.

- We are considering a shared cancer centre, pooling the resources of St George's, Epsom, St Helier and Royal Marsden. We would only look to move routine cancer surgery , with Kingston and Croydon to a new centre if this would deliver demonstrably better outcomes.

- Every hospital does not have to provide every service. We will explore which services are provided on each site and how we might use clinical networks, get remote support from specialists or a lead site providing shared cover at quiet times.

Acute hospital services (2): specialised commissioning

- NHS England has announced a review of specialised services in south London
- We will work with south east London, NHS England and all stakeholders across both areas (providers trusts, CCGs, local councils and the public) as this develops
- South London has some similar services being provided in close proximity – need to consider long term sustainability of specialised services at Guy's and St Thomas', King's College Hospital and St George's. Other providers such as Epsom & St Helier will also be involved in the review.
- Four projects are in development: children's oncology, neuro-rehabilitation, HIV services and Tier 4 child and adolescent mental health services. Work also underway to address local challenges in cardiovascular care and haematology. Cancer was agreed to be out of scope as it was important to follow through on existing proposals
- Formal governance structures being developed for all specialised commissioning across London, including creation of a Specialised Commissioning Planning Board
- Collaboration expected between specialist mental health providers in south London (South London and Maudsley, Oxleas and SWL & St George's) to transform adult secure services

Acute hospital services (3): hospital configuration

- Demand for services is likely to increase by 2020/21, so we need to plan for this. Moving more care into the community will offset growth in demand to some degree: intermediate beds can be delivered in a range of ways in different places. Changes to specialised commissioning may potentially impact the numbers of beds needed in SWL

- All our hospitals have areas of estate that need improvement and investment. St Helier is not currently compliant with modern standards for safe and high quality care and St George's has significant estate problems requiring investment.

- We are awaiting the modelling of bed numbers, the specialised commissioning review and further info on estates costs at St George's before deciding whether we need to consider potential scenarios for configuration of acute sites.

- Transformation of services outside hospital would be a major consideration if acute hospital reconfiguration was proposed; any major service change would also subject to public consultation.

Estates

- Fundamental change is needed in the way we manage SWL health and social care estate
- New models of care will increase primary care provision location of acute and mental health services in primary care/community settings
- 20 multi-specialty community hubs providing an integrated range of services – mainly through repurposing existing premises where possible, with small amount of new build
- Future acute estate will depend on bed audit/bed volumes, future configuration and review of specialised services
- We are working with local authorities and across the local NHS to develop an Estates Strategy for south west London

Workforce

- We need to develop our health and social care workforce across organisational and clinical boundaries, delivering integrated, patient-centred care that is high quality and value for money
- 25,000 NHS staff and 32,000 in social care. Over 18,000 of NHS staff work min acute sector and only 2,500 in community settings. Without improved recruitment and retention, demand will outstrip supply
- National shortage of qualified staff such as GPs, nurses and paediatricians. Currently over-reliant on agency staff. Some staff roles likely to change as services are delivered differently.

Four core priorities to develop our workforce:

- Securing sustainable workforce and improving recruitment and retention
- Capacity and skill mix
- Working differently
- A healthy workforce

Education and training is a key enabler running across all priorities. We will work with local academic institutions/education providers to ensure sustainable workforce and right competencies.

Delivering an information revolution

- Technology is a critical enabler for many of the recommendations set out in our draft plan. It is critical that clinical information about patients follows them between different health and social care services
- **Self-care** for patients can be supported by digital technology, enabling patients to get information about their condition, or provide information such as their record, to help them make informed decisions about managing their health
- Technology such as **video conferencing** can help break down barriers between patients and clinicians and help clinicians get rapid specialist input when needed
- **Information sharing** which combines clinical, operational and financial data can help us take a 'whole system' approach to improving the way services are delivered
- **Digital technology** should be available to all clinicians and care professionals when they need it
- There are pockets of good practice already in SWL: these will need to be expanded significantly if we are to achieve our ambitions

Closing our financial gap

- By organising services better and delivering the initiatives set out in our plan, we can close our financial gap with **no reduction in the quality of care**
- An audit of acute hospital beds suggests that we could substantially reduce the number of days people spend as inpatients by delivering improved models of care
- By changing outpatient services, we could reduce unnecessary appointments by 20%
- By reducing the use of procedures which have limited clinical effectiveness, we could reduce elective surgery by 13%
- Programmes to increase acute provider productivity by sharing non-clinical 'back office' functions are underway: areas being looked at by hospitals include procurement, a shared staff bank, reduction of corporate and administrative costs and more efficient management of our estates
- CCGs have also identified that they can make significant savings by working together more closely, including sharing 'back office' functions internally and with providers or councils.
- Pharmacy teams across SWL are working together to identify opportunities for medicines-related savings: for example by reducing use of medicines that are less clinically effective or significantly more expensive than alternatives

Involving local people

- We published an Issues Paper in 2014 which was widely distributed across SWL and discussed at large scale events with the public and stakeholders in each borough – feedback from these informed our five year forward plan
- In May, we wrote to over 1,000 local voluntary, community and campaigning organisations in SWL setting out our emerging thinking and asking for their views – these views were considered as our plan was being developed
- All feedback received to date and our response to it will be published shortly. We will produce regular 'You Said We Did' reports summarising feedback received and our response
- We plan further public events later in 2016, where we will discuss the content of our draft plan and seek people's views
- We are running a large grassroots engagement programme with local Healthwatch organisations, leading to 7-10 events in each borough for groups whose voices are seldom heard. The feedback will continue to inform our thinking
- Patients and the public are directly involved in each of our clinical workstreams and we have a Patient and Public Engagement Steering Group which oversees our public engagement

Our plan for the next six months

- Our initial draft plan (STP) was submitted to NHSE at the end of June 2016
- Once national assurance is complete, the final plan will be published and further public engagement will take place
- We anticipate a series of public events in the autumn, which will help inform the next iteration of our plan
- Should any proposals emerge that require public consultation we would envisage this would take place in late 2017
- A number of plans are already underway – for example plans to improve primary care, better preventative care, a more joined up approach between services and development of a SWL Estates Strategy.
- Further modelling work, further information and further public engagement will be needed before we can finalise our strategy.

Healthier Communities and Older People Work Programme 2016/17

This table sets out the draft Healthier Communities and Older People Panel Work Programme for 2016/17. This Work Programme will be considered at every meeting of the Panel to enable it to respond to issues of concern and incorporate reviews or to comment upon pre-decision items ahead of their consideration by Cabinet/Council.

The work programme table shows items on a meeting by meeting basis, identifying the issue under review, the nature of the scrutiny (pre decision, policy development, issue specific, performance monitoring, partnership related) and the intended outcomes. The last page provides information on items on the Council's Forward Plan that relate to the portfolio of the Healthier Communities and Older People Panel so that these can be added to the work programme should the Commission wish to.

The Panel is asked to identify any work programme items that would be suitable for the use of an informal preparatory session (or other format) to develop lines of questioning (as recommended by the 2009 review of the scrutiny function).

Scrutiny Support

For further information on the work programme of the Healthier Communities and Older People please contact: -
Stella Akintan (Scrutiny Officer)
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For more information about overview and scrutiny at LB Merton, please visit www.merton.gov.uk/scrutiny

Meeting Date 28 June 2016

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Consultation	Proposed closure of Urogynaecology clinic at St Georges Hospital	Verbal update at the Panel	Dr Andrew Rhodes, Acting Medical Director, St George's Hospital	Panel to receive an update on the future of the clinic.
Performance Monitoring	Merton Improving Access to Psychological Therapies Service	Report to the Panel	Commissioning Team, Merton Clinical Commissioning Group. Director of Addaction.	To provide an update on the service
Budget	Merton Public Health Budget – 2016/17	Report to the Panel	Dagmar Zeuner, Director of Public Health	To review budget decisions

Meeting date – 06 September 2016

Scrutiny category	Item/Issue	How	Lead Member/ Lead Officer	Intended Outcomes
Consultation	Epsom and St Helier University NHS Trust – Update on current priorities	Verbal update to the Panel	Daniel Elkeles, Chief Executive, Epsom and St Helier	Panel to receive an update on the Trust Estate Strategy
Policy Development	Merton Clinical Commissioning Group – Update on current priorities.	Verbal update to the Panel	Dr Andrew Murray, Chair, Merton Clinical Commissioning Group.	Update on the work of MCCG
Scrutiny Review	Diabetes Task Group	Report to the Panel	Councillor Brian Lewis Lavender	To consider the report and recommendations arising from the review
Scrutiny Review	Draft task group scoping document on Learning Disability Day Centres	Report to the Panel	All Panel	To discuss the scope of the review.

Meeting date – 20 October 2016

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Policy Development	Impact of welfare reform	Report to the Panel	Merton Centre for Independent Living, Faith in Action,	To review the impact of welfare reform on vulnerable residents.
Policy Development	Sustainability and Transformation Plan	Report to the Panel	Dr Andrew Murray, Chair Merton Clinical Commissioning Group	To review the progress in developing a Sustainability and Transformation Plan for Merton

Meeting Date – 08 November 2016

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Policy Development	Physical activity for the 55 plus	Report to the Panel	Dagmar Zeuner, Director of Public Health	Review the progress with this work.
Performance monitoring	Budget	Report to the Panel	Caroline Holland, Director of Corporate Services	To review savings proposals.
Scrutiny review	Feedback from the Learning Disability Day Centres review	Report to the Panel	Councillor, Sally Kenny, Task Group Chair	Review the activities in Learning Disability Day Centre

Meeting date – 10 January 2017 BUDGET

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Performance monitoring	Budget	Report to the Panel	Caroline Holland, Director of Corporate	To comment on the council's draft budget

			Services	
Policy Development	Making Merton a dementia Friendly Borough	Report to the Panel	Dagmar Zeuner, Director of Public Health	Review the progress with this work.

Meeting date – 07 February 2017

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Policy Development	Update on Mental Health Services	Report to the Panel		
Policy Development	Care in the community for older people and support when they are released from hospital.	Report to the Panel		
Policy Development	Support for People who have been affected by brain injury	Report to the Panel	Adult Social Care/ Merton CCG	Review services and recommend improvements if/where necessary
Policy Development	Joint working with Citizen's Advice and other local partners to support vulnerable residents	Report to the Panel	Merton and Lambeth Citizen's Advice and Mental Health Services	
Scrutiny Review	Diabetes Action Plan	Report to the Panel		

Meeting Date - 17 March 2017

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes

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