Merton Council

Healthier Communities and Older People Overview and Scrutiny Panel

Date: 6 September 2017

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.

For more information about the work of this and other overview and scrutiny panels, please telephone 020 8545 3390 or e-mail scrutiny@merton.gov.uk. Alternatively, visit www.merton.gov.uk/scrutiny

Press enquiries: press@merton.gov.uk or telephone 020 8545 3483 or 4093

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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
Brenda Fraser
Suzanne Grocott
Sally Kenny
Abdul Latif

Substitute Members:
Stephen Crowe
Joan Henry
Najeeb Latif
Ian Munn BSc, MRTPI(Rtd)

Co-opted Representatives
Diane Griffin (Co-opted member, non-voting)
Saleem Sheikh (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

27 JUNE 2017

(7.15 pm - 9.00 pm)

PRESENT Councillors Councillor Peter McCabe (in the Chair), Councillor Brian Lewis-Lavender, Councillor Laxmi Attawar, Councillor Mary Curtin, Councillor Brenda Fraser, Councillor Suzanne Grocott and Councillor Abdul Latif, Councillor Joan Henry

Professor Andrew Rhodes, Acting Medical Director St George's NHS Foundation Trust. David Bradley South West London and St George's Mental Health NHS Trust, Jeremy Walsh Head of Service Delivery, South West London and St George's Mental Health NHS Trust. Stella Akintan Scrutiny Officer.

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Councillor Sally Kenny gave apologies and Councillor Joan Henry attended as a substitute.

Diane Griffin, co-opted member gave apologies

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

None.

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The minutes were agreed subject to the following changes:

Page 4: Second line should read; some panel members expressed concern that gluten free products are not widely available and expensive.

Page 3: Second paragraph should read; He also expressed concern that at a recent meeting of diabetic sufferers, there was some confusion about the difference between Type One and Type Two Diabetes.

Page 2: The penultimate sentence should read; services that meet their need.

Page 2: Resolved should read; officers were thanked for their work.

4 ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST - QUALITY IMPROVEMENT PLAN. (Agenda Item 4)

Professor Rhodes said the Panel would be concerned about the Care Quality Commission (CQC) Report received last year in which the Trust was rated as inadequate and placed in special measures. A significant amount of work had taken place to resolve these issues and although progress has been made there was still more to do. Further inspections on the severe regulation notices had taken place a month ago and the Trust is awaiting the results of this.

A panel member expressed concern about reductions in the building maintenance budget as they understood that the wiring and electrics were in poor condition. They also queried provision of dialysis services being held in a truck in the car park and suggested this service could usefully be moved to St Helier hospital.

Professor Rhodes reported that problems with the fixed wiring structure have been resolved. Renal services were considered to be in an inadequate setting as a result of the CQC inspection and the Trust was given two weeks to relocate it. Out-patient dialysis is now provided in mobile wards on site. This is high quality provision and considered to be better than what was previously in place. They are working towards a long term future for this service. Dialysis provision should be near where people live and there is a balance in how far people are willing to travel. St Helier provides their own services.

A panel member asked if the Uro-Gynaecology services at St George's will be re-opened and the current state of the Trust's finances. Professor Rhodes reported that the Uro-Gynaecology services had to be closed due to concerns about safety. A working group was set up with Wandsworth and Merton Clinical Commissioning Group. It was felt that the high level surgery was not required and care could be delivered by physiotherapy. In regards to the finances, The Trust was £78 million in deficit last year, it is hoped to reduce this to £45 million this year. The turnaround is taking longer than anticipated as there is a need to constrain costs and improve quality.

A panel member asked what impact the CQC inspection had on staff morale. Professor Rhodes reported the uncertainty caused by the inspection was upsetting for staff. Other issues affecting staffing levels include Brexit, South West London location and higher staff turnover within the leadership team. Professor Rhodes reported that the staffing structure was good. There are more nurses on the ward and staffing is above safe levels.

A Panel member asked if there are any additional resources for the improvement work which needs to be implemented following the CQC inspection. Professor Rhodes reported that the Trust can apply for emergency funding as they are now in special measures. Capital funding requirements remain an issue.

A panel member asked how many agency staff the Trust employ at any one time. Professor Rhodes reported that approximately 8% of the work force is drawn from agency staff. There are a number of projects being undertaken to reduce this figure and bring staff in-house.

A panel member asked what recent fire inspections had taken place. Professor Rhodes reported that the Secretary of State required all Trusts to carry out inspections over the weekend and St George's buildings did not pose a significant risk.

RESOLVED
Professor Rhodes was thanked for attending the Panel to present the report

5 DRAFT WORK PROGRAMME REPORT 2017-18 (Agenda Item 5)

The scrutiny officer was asked to develop a draft work programme incorporating all the suggested topics
.
The Panel agreed to conduct a task group on schemes to match housing between professionals and older people with spare rooms.

The following panel members agreed to join the task group

Cllr Laxmi Attawar
Cllr Joan Henry
Cllr Suzanne Grocott
Mr Saleem Sheikh

Panel members also asked the scrutiny officer to arrange a visit to the Department for Work and Pensions local medical assessment centres which process personal independent payments. Concerns have been raised about the physical inaccessibility of the centres. Panel members wish to review the situation and report back at the Panel meeting.

RESOLVED
Draft work programme to be presented to the next Panel meeting

6 SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH TRUST - UPDATE REPORT (Agenda Item 6)

The Chief Executive reported that the Trust received a 'Good' rating at their recent CQC inspection. However driving improvement still remains a key priority. The inspectors were particularly impressed by the efficient use of acute beds, there is national pressure on acute mental health beds but the Trust has not sent any patients out of the local area for some months. The Trust is also in a balanced financial position even though it is the lowest funded Mental Health Trust in South West London.

The redevelopment of the Springfield site remains a priority. The Trust will sell some of the land and build two new hospitals. A development partner has been selected and work will begin in 2018.

The Chief Executive reported to the Panel that Children and Adolescent Mental Health Services were centralised in 2014. Around seven patients a week were requesting diagnostic services for autism and Attention Deficit Hyperactive Disorder. The demand for this service has risen by 300% to 25 children per week. The Commissioners have asked the Trust to look at the service and has provided re-assurance there will be no changes for the next 12 months.

A panel member asked what will happen to the service in the longer term and why referrals are increasing. The Chief Executive reported that Commissioners will determine the future of the service. The Head of Service Delivery reported that there is greater awareness of mental health issues. A diagnosis can also result in greater support from the school. There is no health treatment given as a result of the diagnosis but people are given advice and support.

A panel member queried the length of waiting times for acute beds. The Chief Executive said there is a national unit at Springfield with adult and children's bed this is always full to capacity with patients coming from all over the country but there are no waiting lists.

A panel member asked if they still have a dedicated Merton ward. It was reported that they have moved away from dedicated wards for geographical areas but they still match community teams with wards.

Panel members asked if the Trust has links with the Dementia Hub and the Court Service. The Chief Executive reported that there are strong working arrangements in both areas.

RESOLVED

The Chief Executive and Head of Service Delivery were thanked for attending the meeting.

Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 6th September 2017

Wards: ALL

Subject: Epsom and St Helier University Hospital NHS Trust – 2020-2030 Vision

Lead officer: Daniel Elkeles, Chief Executive Epsom and St Helier University Hospital NHS Trust

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 members comment on the proposals within the 2020-2030 Vision

B.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The Chief Executive of Epsom and St Helier will provide an overview of the 2020-2030 Vision document which is attached.

2 DETAILS

2.1. This Panel has received a number of reports over the last two years outlining the challenges caused by the poor quality of the Epsom and St Helier Estate. The buildings across all sites are old, physically crumbling and no longer fit for purpose. The consequences of this are wide ranging and effect the quality of care and have financial implications. The location of many of departments means clinicians to have to travel across the sites. This has a significant impact on resources.

2.2. The Trust are considering a range of options to address this within the 2020-2030 Vision and are engaging with local communities to gather their views.

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 2017/18

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

12.1.

NHS
Epsom and St Helier
University Hospitals
NHS Trust

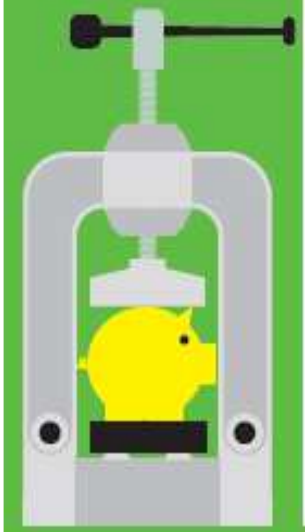
Our future

Epsom and St Helier

2020 - 2030

In the past 12 months:

We kept a firm grip on our finances and drove down our spend on agency staff



We spent £16.7 million on maintaining our buildings and buying new equipment

54,419 patients had elective surgery with us – from hip replacements to cataract surgery

95.3% patients seen within 4 hours

A&E

Our 1,000th dialysis patient recently joined our care

We saw a record-breaking 913,583 patients

Record investments

We are spending record amounts in critical infrastructure backlog circa £80 million

2020 onwards

We have committed to keeping all of acute services on both our sites until 2020

There are 3 significant issues to resolve to secure delivery of acute services into the future

- Our buildings
(latest data shows over 80% are not deemed suitable for delivery of modern healthcare)
- Clinical sustainability
- Financial sustainability

2020-2030 vision

Epsom and St Helier University Hospitals NHS Trust

In summary

- In every scenario 85% of our patients will continue to receive care as they do now from their local hospital

- We need to get the funding for a new acute hospital facility from 2020, which will care for and treat our sickest and most at-risk patients:
  - Major A&E
  - Inpatient paediatrics
  - Babies born in hospital
  - Complex emergency medicine

In summary

- We want to keep this facility on one of our three hospital sites
- We are at an early stage of a lengthy process which will take several years - we genuinely want to know what you think
- It strengthens our case if local people support our vision to keep services locally and our mission to secure a new hospital facility to treat our sickest and most at-risk patients

What we are asking in the engagement phase

Do you agree with our aim to provide as much care as possible from our existing hospital sites at St Helier and Epsom and do this by working more closely with the other local health and care providers?

Do you think we have made the case that we will improve patient care by bringing together our services for our sickest or most at-risk patients on a new specialist acute facility on one site?

What we are asking in the engagement phase

- We have set out several scenarios on how we can do this. Do you think we should consider any other scenarios?

- How would you like to be involved in these discussions in the future?

- Is there anything else you would like to tell us?

The process

- Engagement - end of Sept
- Analyse and complete Strategic Outline Case – this year
- NHS decision-making
- Public consultation on preferred solution expected autumn 2018
- New specialist acute facility opens 2024

Your questions

NHS
Epsom and St Helier University Hospitals NHS Trust

Thank You

How to contact us
Email: esth2020-2030@nhs.net

write to:
ESTH 2020-2030
Epsom and St Helier University Hospitals NHS Trust
4th Floor Ferguson House
St Helier Hospital
Wrythe Lane
Carshalton
Surrey SM5 1AA.

Website: www.epsom-sthelier.nhs.uk

- Website: www.epsom-sthelier.nhs.uk
- Twitter: @epsom_sthelier
- Facebook: www.facebook.com/epsomsthelier

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Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 06 September 2017

Wards: ALL

Subject: Personal Independent Payments Assessment Process

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 discuss the reports from Merton Centre for Independent Living and the Department for Work and Pensions on the Personal Independent Assessment process

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of the attached reports is to provide an overview of the Personal Independent Payment application process and some challenges that people with disabilities have faced. Reports from the Centre for Independent Living and Department for Work and Pensions are attached

2 DETAILS

2.1. The Chief Executive of Merton Centre for Independent Living will attend the Panel to provide an overview of their report and answer questions.

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 2017/18

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

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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

- Merton Centre for Independent Living Report
- Department for Work and Pensions Report.

12 BACKGROUND PAPERS

Merton CIL Briefing on PIP Assessment Challenges

Revised August 2017

Summary

Background

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 with local Disabled people, we have gathered evidence of significant issues facing Disabled people who apply for benefits, and this briefing focuses on Personal Independence Payment (PIP) issues. This is in addition to the fact that Disabled people are facing disadvantage across key areas of their lives[1], and are experiencing health inequalities as a consequence[2].

This is an undated paper following on from work we first carried out in October 2016. In that time, we have seen an increasing number of people struggling with the PIP process.

It is not our intention to try to address or highlight all the issues with PIP which exist and which have been well-documented elsewhere[3],[4], including in Parliament during an Adjournment debate with MP Siobhain McDonagh[5]. Our intention is to focus on specific local challenges and, where appropriate, show these within a national context.

[1] The Equality Act 2010: The Impact on Disabled People, House of Lords Select Committee on the Equality Act 2010 and Disability, 2016
[2] Is Britain Fairer? Equalities and Human Rights Commission, 2015
[3] https://www.gov.uk/government/publications/personal-independence-payment-pip-assessments-first-independent-review
[4] https://www.gov.uk/government/publications/personal-independence-payment-pip-assessment-second-independent-review
[5] http://www.siobhainmcdonagh.org.uk/newsroom/news.aspx?p=105231

What are Personal Independence Payments (PIP)

PIP is a benefit that helps with some of the extra costs caused by long term ill-health or disability. It is a replacement for Disability Living Allowance (DLA) and has different eligibility criteria, ie it is the benefit which has changed, and not people's impairments.

PIP is for those aged 16-64 and has 2 components, Daily Living and Mobility. There are 10 questions in Daily Living and 2 in the Mobility section. Each section is divided up into descriptors with points attached to each one ranging from 0-12. A claimant has to score a minimum of 8 points to receive standard rate or 12 points for enhanced in either component. It can be paid for one single component or both if the claimant satisfies the points tally in the descriptors.

The value of the benefit ranges from £22 to £141.10 per week

- At the start of a claim a form is completed and then sent to the DWP who pass this to ATOS to arrange an assessment.
- ATOS use what are deemed Health Professionals (usually nurses or Physiotherapists) who will carry out an assessment and send a report to the DWP Decision Maker with recommendations for a score to be awarded.
- The DWP will advise the claimant whether or not the claim was successful
- Once a person has been denied PIP and they wish to appeal, they first have to go through a Mandatory Reconsideration (MR) process which was introduced for PIP in April 2013. But since its introduction, 85% of decisions for new claims - and 78% of DLA/PIP reassessment decisions - have remained unchanged.[6] This stage usually takes 4-8 weeks.
- The claimant then has to appeal to HMCTS Bradford on an SSCS1 form and await a hearing which is often many months.
- The proportion of appeals awarded in favour of the claimant has been increasing significantly, reaching 65% in the most recent figures for the first 3 months of 16/17.[7] This means that 2/3 people are being forced to undergo hardship and wait months

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577399/pip-statistics-to-october-2016.pdf

[7] https://www.gov.uk/government/collections/tribunals-statistics

longer in order to access a benefit to which they were entitled in the first place.
- Following the hearing, if a Claimant is successful in receiving the benefit, the Tribunal can recommend that they are not reassessed for a period of time (eg 2 years) however, this is not binding on DWP and in some cases we have seen people having to go through the whole experience again very quickly. In one case, someone who was awarded the benefit in May 2016 following MR, has had to start the reassessment process again already, even though their benefit is dated to June 2018.

Specific Issues with Personal Independence Payment (PIP) Benefits Assessments

Our work with local Disabled people has identified three key issues with assessments for PIP:

1. Inaccessible assessment centres. This includes centres which are physically inaccessible, or those located far away from the person's home

2. Overbooking of assessment centres. This leads to last minute cancellations or excessively long waits at assessment centres

3. Inaccurate Assessments. Many Disabled people are wrongly being found ineligible for PIP at assessment stage, and are being forced to go to tribunal

The scale of the issue

There are 2,638 working age people currently claiming DLA in Merton.[8] All of these people will be told to reapply for PIP if they want to keep receiving a benefit, even people who previously received lifetime DLA awards.

Of the 1,352 people who were previously on DLA and have attempted to transfer to PIP since its introduction, 28% (394 people) have been

[8] DWP Statistics February 2017 https://stat-xplore.dwp.gov.uk/webapi/jsf/dataCatalogueExplorer.xhtml

denied the benefit completely[9]. This is significantly higher than the UK average of 25%[10]

A further 311 people are estimated to have seen their benefit decreased in the changeover from DLA to PIP[11].

In addition to the 705 people who have lost their benefit or seen it reduced already, it is expected that **at least a further 1,345 Disabled people in Merton are going to lose out** in the transfer from DLA to PIP over the next few months. This is in addition to new claimants deemed ineligible, of whom there have already been 1,815 people (54% of new applicants).

It should be noted that people who are turned down for the benefit can appeal, and many of these people are being wrongly turned down for the benefit and awarded it on appeal. Our own data shows that of the people who appeal this decision and reach the first "Mandatory Reconsideration" stage, nearly 9 in 10 will still be refused the benefit. This is in line with the national average and DWP targets for refusal at Mandatory Reconsideration stage.[12] However, once people reach the Tribunal stage, 86% of them will be awarded the benefit, and were **therefore entitled to it all along** (this is ahead of the national average of 64%[13]).

It was highlighted at the Sutton Tribunal User Group by Tribunal Judge Jeremy Bennett that the percentage rate of DWP decisions being overturned at tribunal suggested something was clearly not right with the assessment and decision making process."The Tribunal is overturning 60% of all appeals. This appears to be wrong. DWP should be making a greater effort to get the decision right first time. However DWP often quote that only 3 to 4% of their overall caseload is overturned at appeal. That is the wrong way to look at the issue. 3 to

[9] DWP Statistics April 2017 https://stat-xplore.dwp.gov.uk/webapi/jsf/dataCatalogueExplorer.xhtml

[10] https://www.gov.uk/government/statistics/personal-independence-payment-april-2013-to-october-2016

[11] Based on national decrease rate of 23% https://www.gov.uk/government/statistics/personal-independence-payment-april-2013-to-october-2016

[12] http://www.independent.co.uk/news/uk/politics/dwp-benefit-appeals-target-reject-80-per-cent-outrageous-pip-jobseekers-allowance-department-work-a7740101.html

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/621515/tribunal-grc-statistics-q4-2016-2017.pdf

4% is still upwards of 100,000 Appellants even when we were at the lowest number of appeals."[14]

The impact of losing PIP

Individuals in receipt of DLA/PIP are exempt from a number of other welfare changes: the single room rate change, the overall benefit cap and in some boroughs, council tax support. If entitlement to DLA/PIP is lost, not only will individuals lose their DLA/PIP income, but they could also lose income from other benefits.[15] This includes some Housing Benefit, some disability premiums on types of Income Support, Job Seekers Allowance, Employment Support Allowance and Working Tax Credits. Somebody caring for the individual can lose their Carers Allowance, and the individual will also often lose 'passported' benefits such as blue badge and concessionary travel.[16] Overall, loss of PIP can also entail the loss of thousands per year in associated benefits, depending on the person's circumstances. Even though a high proportion of people who go to appeal are successful in getting the benefit back, this is a lengthy process and in many cases a lot of damage has already been done, such as the loss of a Motability car which someone might have used to get to work, or possession proceedings started and they risk losing their home.

These losses will have a knock-on effect on eg people's housing, livelihoods and incomes and impact people's health and wellbeing. There is a growing body of evidence that assessments themselves are having a negative impact on people's mental health[17].

In addition to the stress and anxiety caused to the individual from having to go to all the way to Tribunal for something they are entitled to, there is a cost to the state, such as Tribunal costs, increased healthcare costs, cost of possession proceedings, etc. There is an impact

[14] Minutes of the Tribunal User Group Meeting, held at Sutton on 20 December 2016 at 2pm, Jeremy Bennett, Regional Tribunal Judge Sutton

[15] http://www.londonspovertyprofile.org.uk/indicators/topics/receiving-non-work-benefits/dla-caseload-by-care-award-type/

[16] Welfare Benefits and Tax Credits Handbook 2017/18, Child Poverty Action Group

[17] http://www.independent.co.uk/news/uk/politics/fit-to-work-wca-tests-mental-health-dwp-work-capability-assessment-benefits-esa-pip-a7623686.html?utm_content=buffer5a87e&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer

on organisations supporting the individual too. For example, Council staff from Social Services may end up attending Tribunals with some Disabled people, and for Merton CIL, there is an organisational impact as every appeal takes on average an additional 20+ hours work, which is time taken away from other people who also need support.

In Detail

1. Inaccessible Assessment Centres

At Merton CIL we regularly get calls from Merton residents who are being asked to attend assessment centres which are difficult for them to get to. This includes being told to travel to Deptford, East London or Vauxhall, all of which require independent travel skills, and the ability to make lengthy journeys with multiple changes. Even closer assessment centres can be difficult to get to, with typical centres being located in Wandsworth and Croydon, neither very easy to get to for Merton residents.

PIP assessment centres appear to have been set up with little consideration for the access needs of the people visiting them. For example, in a Wandsworth[18] centre, there is no parking. The nearest disabled parking spaces are over 200 meters away, and the nearest general car park requires you to walk through a shopping centre before reaching the assessment centre (see pictures 1 and 2). We have had to resort to asking people to get dropped off outside the centre, even though this requires them to drive into a private road and wait on yellow lines and is in direct conflict with the information provided by the centre which tells people not to do this. In addition, this particular centre is very poorly marked and signposted and almost impossible to find unless you have been before. Another example is when assessment centres have wheelchair inaccessible buildings, as described in our case study below.

Inaccessible centres are also those which fail to take into account the communication, health or support needs of people attending the centres. For example, one particular centre[19] has very poor support for people waiting for appointments and we have frequently witnessed people crying in the waiting room, which is distressing for everyone else

[18] PIP Consultation Centre, Unit 4 & 5 Ground Floor, The Filaments, Buckhold Road, London SW18 4AT

[19] 1st Floor, Stephenson House, 2 Cherry Orchard Road, Croydon, Surrey, CR0 6BA

too, and on occasion distressed individuals displaying aggressive or challenging behavior. In one case we witnessed an individual repeatedly banging their head against the wall, which was ignored by staff at the centre. Our advocate was with someone with support needs, otherwise we would have intervened.

Case Study 1 – An Inaccessible Centre

A woman with severe learning difficulties had been invited to an assessment for PIP in Croydon[20]. Before her involvement with Merton CIL she had to rearrange her appointment twice[21] due to 1. As she was unable to get support to go to this appointment. 2. For a hospital appointment.

When she came to Merton CIL to prepare for her assessment her assigned worker noticed that the centre she had been asked to go to was one that Merton CIL knows not to be accessible. Since her assigned worker is a wheelchair user they rang the provider to request that the appointment be moved.

The worker explained that the lady could not attend alone as she is unable to communicate without prompting. She cannot remember the names of her conditions. She is fearful of new places. The worker explained that a wheelchair user would therefore be attending the appointment with her.

The worker was told that the appointment could not be rearranged as it had been moved twice already. The worker said she was aware of that and the guidelines however she would like them to be clear that the inaccessibility of the property was not the fault of the claimant. The rep said he would speak to his manager. After a period on hold the rep can back online and explained that the building was accessible. The worker stated that both she had her colleagues had been to this building and that it was not. After the worker explained the multiple problems with the building the rep admitted her had not been there himself and was not aware of these problems. The rep at one point suggested the wheelchair user could fold up their wheelchair to access the assessment room. The worker explained that it was unacceptable to expect any wheelchair user to do this particularly without ever inquiring whether it was physical possible or safe to do so.

[20] Synergy Centre, 1D Church Road, Croydon, CR0 1SG

[21] People are now only allowed to rearrange an appointment once

The worker was told that herself and the claimant would have to wait for the only accessible room in the building to become available to have the assessment. The worker suggested that this was impractical and asked why the provider could not book appointments based upon access needs. The worker explained that this was not the first time that this problem had occurred and that previously Merton CIL and their service users had had to wait hours for the accessible room to become available despite turning up at their appointment times. The worker suggested it might be more supportive for the Centre staff and claimants if the centre could ensure that access needs were accounted for before claimants turn up for their appointments. The rep said that the person should attend the centre at the time booked and wait for the accessible room to become available if she wanted to continue with the claim (see picture 3 for waiting room).

This is a clear example of centres adding needless stress to an already daunting process.

2. Overbooking of Assessment Centres

We have identified that assessment centres appear to have moved in the last 24 months to a model that we compare to budget airline bookings, ie, they are overbooking appointments in the assumption that some people will not turn up. This was confirmed by one of the assessors who told us that she had 20 assessments on her list per shift, but that she could only reasonably do 6 in the time available. This means that a number of our service users are seeing last minute cancellations by the assessment centres – sometimes while they are en route or just as they are getting ready to leave. This is clearly distressing for people who have prepared for the assessment and may already have faced a lengthy wait to get to this point. For those who do get to the assessment centre we have seen long waits at the centres causing distress and anxiety for our service users. For example, we have had people vomiting at the centre due to anxiety over the wait.

Practical issues also arise such as people unable to take their medication or having difficulty with childcare arrangements.

Case Study 2 – Long Wait results in Cancelled Assessment

A mother of a toddler had had to change her initial assessment as she had no one to go with. When she re-booked her assessment[22] she made it clear that she would only be able to attend with support as she suffers from pain, exhaustion and panic attacks.

Despite this, when she arrived for her assessment, she waited from 1.30pm until 3.55pm. Her booked appointment time was at 1.45pm. During the wait she kept asking the receptionist how long she would have to wait and kept being told she was next. She was with a friend, but struggling with exhaustion and the seating was uncomfortable. She has fibromyalgia and sores, so the long wait on uncomfortable seating caused significant pain and distress.

When she was finally called in she had almost no time left as she had to collect her child from nursery, as no one else was available to pick them up.

She was told to come back for an assessment on another day, which was eventually booked 2 months later. She felt that the wait and cancellation had caused her stress and exhaustion, she hadn't slept for days in anticipation, and she subsequently became ill too.

3. Inaccurate Assessments

PIP works on a points system[23] and at Merton CIL we are witnessing a growing number of assessments where people are being assessed as having zero or very few points at assessment, which is later overturned in tribunal. In a number of cases, people felt their assessment reports were so far removed from their situation and what had been discussed at the assessment itself, that they thought their details had been mixed up with someone else. Assessments for people with mental health needs or for people with fluctuating conditions seem particularly poorly done. Our observations about inaccurate assessments is backed up by the

[22] The Quadrant, 213-217 The Broadway, Wimbledon, London, SW19 1NL
[23] https://www.citizensadvice.org.uk/benefits/sick-or-disabled-people-and-carers/pip/appeals/how-decisions-are-made/

NAO report which highlights that only 13% of PIP and ESA assessment reports reached the necessary standard. [24]

Despite these known issues, in some cases our advocates have been stopped from taking notes during the assessment or stopped from asking the person clarifying questions when they feel an issue hasn't been properly explored, in contravention of DWP guidelines[25]. In one case the Disabled person said they had felt very uncomfortable throughout the assessment and that they had been frightened of the assessor who they felt had spoken to the advocate in an aggressive manner. They person felt they had not been listened to and in fact were denied the benefit, which on appeal was overturned and they were awarded PIP. In another case, a former DLA recipient was denied PIP despite having cancer, diabetes, physical impairments and a home resuscitation kit to help manage their health. We supported the person through Tribunal and they got the enhanced rate for both components of the benefit and the Tribunal recommended the award was given for 5 years.

Case Study 3 - One point to 28 points

A local Disabled mum was referred to Merton CIL support with an upcoming appeal PIP claim. Following the initial claim and mandatory reconsideration, she had been awarded just 1 point and was told she was not eligible. This was despite the fact that she lives with bipolar disorder, depression and borderline personality disorder. Her day-to-day challenges mean that she does not leave her home, answer her phone or read her post. She does not eat, cook, wash or change her clothing regularly due to her depression. She has to be supported to take medication and maintain her health, and she is unable to manage her finances.

The tribunal judges over-turned the original DWP decision and awarded 28 points and the enhanced rate for both daily living and mobility components of the benefit.

[24] https://www.nao.org.uk/wp-content/uploads/2016/01/Contracted-out-health-and-disability-assessments.pdf

[25] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/547146/pip-assessment-guide.pdf

Case Study 4: The knock-on effect of changing from DLA to PIP
Mo got in touch for support with a benefits Health Assessment for PIP, having previously had DLA. Normally we offer people one or two sessions to prepare them for a Health Assessment so that they know what to expect, and we go along to the Health Assessment with them. When Mo got in touch with us before the assessment, we were fully booked. What we did do was explain his right to ask for an assessment closer to home – he had been told to go to Barking – and we signposted him to some guidance, which we also posted to him.

We stayed in touch with Mo and following the Health Assessment, Mo let us know that he was awarded PIP but only for the Daily Living component and not for the Mobility component. He said the assessor hadn't given him time to explain the impact of his different impairments properly, and had prevented his friend, who went with him, from making any notes. The decision was a real cause for concern for Mo because under DLA he had been entitled to the Mobility component and had used that money to lease an adapted car under the Motability scheme. Mo's disability had not changed, but the benefit had. Now Mo was in a situation where he was no longer entitled to lease his adapted car, and was going to be forced to return it. He used that car to get to work, and Mo wasn't sure how he would get to work without it.

We supported Mo through the Mandatory Reconsideration process. The DWP decided to uphold their initial decision, so Mo went to appeal. This was a difficult decision for Mo because at tribunal, there is always the possibility that the whole award will be looked at again, and there is the risk that the award will be reduced or refused altogether, as well as the possibility of getting a higher award, which Mo was asking for. However, Mo felt that he had been unfairly assessed so he went ahead with the appeal. We supported Mo with a preparation session to go through what he could expect at the Tribunal, and we supported Mo to speak up at the Tribunal. The Tribunal found that Mo was eligible for the Mobility component at the standard rate. This outcome meant that Mo was not entitled to re-access the Motability scheme, but was entitled to access a range of other benefits such as Blue Badge and Freedom Pass, as well as seeing his award increase by £22 a week. Because of the long gap (about 7 months) between having his entitlement removed and it being reinstated, Mo had already had to leave the Motability scheme as there was a 7-week window in which you have to either hand back, or buy the leased car (this was extended to 26 weeks in April 2017). Following our

advice around the Motability Transfer package, Mo was able to buy the car outright, rather than losing it. Now Mo is sorting out his road tax liability, which had been affected by the loss and reinstatement of his benefit.

In Conclusion – Significant Risk Factors for Disabled Merton Residents

There is a growing body of evidence indicating that the very process of forcing Disabled people to undergo an assessment is damaging to their wellbeing. Many Disabled people are not only being assessed for PIP, but also for Employment Support Allowance (ESA) and for Social Care, and in many instances being reassessed annually and, in the words of one of our service users, "being asked to prove I am needy enough all the time". In one example, we supported a man at a PIP assessment[26] which was quite lengthy because of the range of issues being discussed. During the assessment, he needed to take numerous breaks as he felt a seizure may be coming on. At the end of the assessment it was our advocate who had to accompany him home (something we don't typically do) as we were so worried about his health.

In several other examples, people have told us about how they feel disbelieved and how they feel they are being accused of being liars following assessments. This is backed up by recent press coverage highlighting how negative the assessment experience can be.[27],[28]

Sadly, our experience is by no means unique. Discussions at the Merton Health and Social Care Forum make it clear that other support agencies are seeing the same issues arising for the people they are supporting. This shared experience is further verified by recent national reports on PIP by Inclusion London[29] and Citizens Advice.[30]

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[26] PIP Consultation Centre, Unit 4 & 5 Ground Floor, The Filaments, Buckhold Road, London SW18 4AT

[27] https://www.theguardian.com/commentisfree/2016/sep/26/i-feel-ashamed-in-a-way-i-never-did-before-your-stories-of-pip-assessment

[28] https://www.theguardian.com/commentisfree/2016/sep/22/we-cant-help-being-disabled-reassessment-hysteria-scroungers-cheating-system

[29] https://www.inclusionlondon.org.uk/campaigns-and-policy/facts-and-information/welfare-reform/evidence-pip-review/

[30] https://www.citizensadvice.org.uk/Global/CitizensAdvice/welfare%20publications/CitizensAdviceresponsetoPIPSecondIndependentReview.pdf

However, while the aims of PIP, and the eligibility criteria are national issues, we can challenge problems with the local experience and implementation of PIP in order to get a better and more accurate assessment process for local Disabled people. This is important because of the negative affect the PIP assessment process is having on Disabled people financially, and in terms of their wellbeing. It is important also because of the sheer numbers involved.

Suggestions for Next Steps

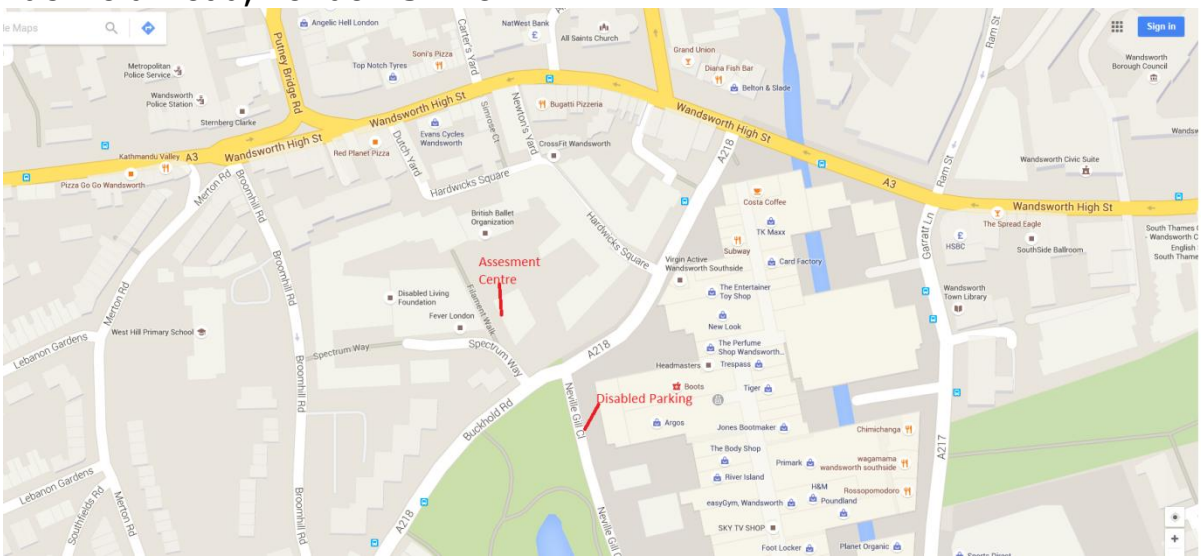
1) Establish the reasons for a significantly higher number of Merton residents being denied PIP in the changeover from DLA
2) Establish the full financial impact of the loss of PIP/DLA
3) Inspect Assessment Centres and insist on local and accessible assessments for local people
4) Challenge the practice of overbooking at Assessment Centres
5) Investigate the quality of local assessments and whether they are fit for purpose

Picture 1 – Assessment centre on unmarked entrance on private road

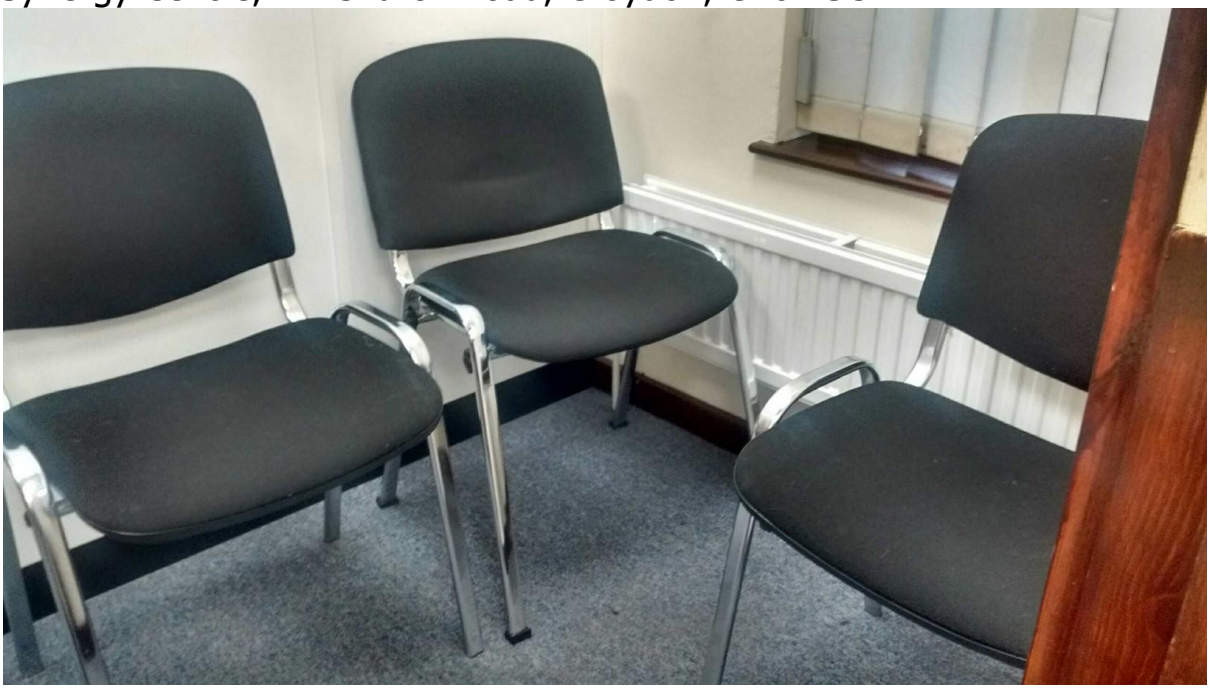
PIP Consultation Centre, Unit 4 & 5 Ground Floor, The Filaments, Buckhold Road, London SW18 4AT

Picture 2 – Map showing distance between centre and parking

PIP Consultation Centre, Unit 4 & 5 Ground Floor, The Filaments, Buckhold Road, London SW18 4AT



Picture 3 – Small and uncomfortable waiting room
Synergy Centre, 1D Church Road, Croydon, CR0 1SG



For more information contact:
Lyla Adwan-Kamara
CEO
Merton Centre for Independent Living
Email: lyla@mertoncil.org
Telephone: 0744 936 2233
www.mertoncil.org.uk

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Department for Work and Pensions

Background

1. Personal Independence Payment (PIP) is a benefit that provides a cash contribution towards the extra costs associated with a long-term health condition or disability.

2. PIP is not awarded on the basis of having a particular health condition or impairment, but on the impact of that condition or impairment on the claimant's everyday life.

3. The PIP assessment provider serving the Merton area is Independent Assessment Services (IAS) delivered by Atos.

Locations and Booking

4. The DWP's requirement is that claimants do not have to travel for more than 90 minutes in a single journey, by public transport to a consultation. However, this limit is an absolute maximum and for the majority of claimants their journey will be less than this.

5. PIP assessment centres available to residents of Merton that meet the above criteria are: - Chertsey, Croydon, Thames Ditton and two in Wandsworth. Details of these assessment centres, maps, travel information and parking can be found on the Independent Assessment Services website at https://www.mypipassessment.co.uk/consultation-centres/
Appointments are booked via an automated booking tool that schedules claimants into the next available appointment slot, at an assessment using the 90 minutes travel time criteria.

6. While this ensures that their appointment takes place sooner than it might at another assessment centre, it does mean that due to availability, appointments will not always be at a site the claimant would prefer to attend, or the nearest.

7. Claimants are sent details of the appointment in advance of their consultation. If they are unable to attend they should contact the assessment provider immediately. Before attending a face-to-face consultation, claimants are given the opportunity to alert their assessment provider of any additional requirements they may have; the providers will meet any such reasonable requests.

Parking and Accessibility

8. IAS must provide sufficient suitable accommodation for face-to-face consultations. DWP has set clear requirements in terms of geography/travel, security and claimant experience in relation to the sites used for PIP consultations.

9. The estate used for PIP has rooms on the ground floor, to ensure claimants who have problems climbing stairs can be accommodated. All assessment centres meet accessibility standards however, there are health and safety implications in the event

of a fire where access to assessment rooms are via a lift and claimants cannot use the stairs.

10. IAS make every effort to identify those claimants who may have problems in accessing their sites. Documentation sent with the appointment letter makes it clear if the centre is not on a ground floor.

11. Claimants who believe they will have problems are offered an appointment at the nearest ground floor assessment centre (within reasonable travelling distance) or a home visit.

12. IAS are also required to consider the needs of claimants regarding their proximity to public transport routes and access to suitable parking, e.g. Blue badge parking. However, there is no requirement for providers to provide on-site parking.

13. All assessment centres currently meet accessibility standards under the Equality Act 2010. Wheelchair access and parking facilities for the sites serving Merton are:-
    - Wandsworth (1) – Step free Access – Free Parking with Disabled Spaces
    - Wandsworth (2) - Step free Access – NCP Parking with Disabled Spaces
    - Chertsey – Step free Access – Onsite or Main Road Parking
    - Thames Ditton – Step free Access – Free Parking with Disabled Spaces
    - Croydon - Step free Access – Pay and Display Parking and Disabled Spaces outside.

Home Visits

14. While face-to-face consultations that allow an in-depth look at how a claimant's condition impacts their daily life, are an important part of the assessment for most individuals, they are not be appropriate in every case. For example, people claiming under the terminal illness provisions are not required to attend face-to-face consultations.

15. Using DWP guidance, IAS review every claimant's circumstances on an individual basis to decide whether their face-to-face consultation will be in one of their assessment centres or in the home.

16. Situations where a claimant may need a home consultation can include where a person's diagnosis suggests a significant disability that would make travel extremely difficult, or where claimants provide evidence from a health care professional that they are unable to travel due to their health condition or impairment.

17. Where enough evidence is already held on which to make an assessment it is inappropriate to require individuals to attend a consultation. Therefore where possible, people are assessed on the basis of paper evidence only.

PIP Application Process

18. New claims to PIP are normally made by phone. For those people who are unable to use the phone somebody else can make the call however, the claimant will need to be there when the call is made. The Department also provides text and video relay

services for those claimants who are deaf or hard of hearing. Full details of the application process are available online.

19. Following the phone call claimants are sent a '*How your disability affects you'* form which gives them the opportunity to explain how their health condition or impairment affects their ability to carry out day-to-day activities.

20. Claimants can also advise who is best placed to provide medical evidence to support their claim, for example a GP or specialist. Claimants are also encouraged to send in any supporting information they already have available such as, care plans, hospital discharge or outpatient clinic letters, reports from professionals such as a hospital doctor, specialist nurse, support worker. Full details are provided in the information booklet that accompanies the PIP form to help claimants with completion.

21. On receipt of the form and any supporting evidence, the information is sent to the assessment provider. A Health Professional reviews the case and considers whether any further evidence is required. If it is needed, the Health Professional will request the evidence, such as a GP report and, where appropriate, pay for it.

22. Based on all the available information, the health professional will decide whether a report can be completed based upon the strength of the paper evidence, or whether the claimant will need to be seen at a face-to-face consultation in order to assess fully how their condition/disability impacts their daily life.

PIP Assessment

23. The PIP assessment looks at people as individuals – and how their impairment or health condition impacts on their ability to live an independent life. It does this by assessing a person's ability to carry out a series of key everyday activities, such as washing, dressing, cooking, communicating and getting around.

24. The PIP assessment does not just consider whether an individual can complete an activity, but the manner in which they do so. The PIP Regulations make clear that consideration must be given to whether individuals can complete activities "safely, to an acceptable standard, repeatedly and in a reasonable time period".

25. The PIP assessment is not a medical assessment requiring the Health Professional to diagnose a condition and to recommend treatment options. Instead the Health Professionals are experts in disability analysis, focusing on the effects of the health condition and impairment on a claimants' daily life.

26. The assessment does not focus on an individual's 'best days' but considers the impact of a claimants condition over a 12 month period and considers functions which are impacted on over 50% of days in the 12 month period.

26. PIP Assessments require specialist skills which is why they are undertaken by qualified health professionals. All Health Professionals undertaking assessments on behalf of DWP must be registered practitioners who have also met requirements around training and competence.

27. They must be: an occupational therapist, level 1 nurse, physiotherapist, paramedic or doctor. They must also be fully registered and have at least 2 years post full-registration experience.

28. IAS is required to ensure that the Health Professionals carrying out assessments have knowledge of the clinical aspects and likely functional effects of a wide range of health conditions and impairments.

29. Health professionals are asked to adopt a holistic approach, assessing all the evidence available to them, including their own clinical knowledge, to provide advice on the claimant's level of function and ability across all assessment criteria. This combines clinical knowledge with a modern understanding of disability and the fact that not everyone with the same disability is impacted in the same way.

30. DWP guidance for Health Professionals carrying out assessments is contained in the PIP Assessment Guide (PIPAG) which is available on GOV.UK. Section 2 covers carrying out PIP assessments. Section 3 explains the assessment criteria. The guide can be found at: - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210722/pip-assessment-guide.pdf

    DWP routinely revises the PIPAG, discussing any proposed revisions with a wide range of stakeholders to ensure that the guidance remains current and clear.

31. Companions are encouraged to attend and can play an active role in the assessment. This is particularly helpful for claimants with mental, cognitive or intellectual impairments who cannot provide an accurate account of their condition due to a lack of understanding or unrealistic expectations of their ability.

32. Following the assessment, the Health Professional will write a detailed report and select the appropriate descriptors that best describe the impact of the claimant's condition.

33. The report is returned to the DWP where a Departmental Decision Maker reviews the claim, the assessment report and all evidence before making their decision. If, at this stage, the Decision Maker feels the case would benefit from further evidence, they can return the case to IAS. It is the DWP Decision Maker who decides on entitlement to PIP, not the IAS Health Professional.

Mandatory Reconsideration/Appeals

34. If a claimant feels the original DWP is incorrect they can ask the Department to review the decision again, this is known as a Mandatory Reconsideration (MR). A different DWP decision maker will review the case again, taking into consideration any new additional evidence supplied by the claimant.

35. If the original decision is maintained, the claimant is notified in writing and advised that they can lodge an appeal direct with the Her Majesty's Courts and Tribunal Service (HMCTS) if they still feel that the DWP decision is incorrect.

36. Of the 2.52 million cases cleared to April 2017, only 23% have been challenged at the Mandatory Reconsideration stage, of which 18% have had a change to the original award. This indicates that in the vast majority of cases, the initial decision was the correct decision.

37. PIP Appeal statistics published by the Ministry of Justice on 8th June 2017, showed that 64% of PIP decisions were overturned during the quarter January to March 2017. This is a 1% reduction on the previous quarter.

38. It is important to stress that it is 64% of decisions that have been appealed which are overturned, rather than 64% of all decisions made. The vast majority of PIP decisions do not go to appeal. Between April 2013 to April 2017, over 2.4m PIP decisions were made, of these just 8% have been appealed and only 3% have been overturned.

39. When a decision is overturned (either at MR or Appeal) it does not necessarily mean the decision was wrong. Many claimants provide additional written evidence not available to the original DWP decision maker. Tribunals also have the added benefit of hearing oral evidence from the appellant.

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Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 6th September 2017

Wards: ALL

Subject: Report and Recommendations arising from the Tackling Loneliness in Merton Task Group

Lead officer: Stella Akintan, Scrutiny Officer

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 report and recommendations arising from the 'Tackling loneliness in Merton' task group.

B. That Panel send the report to Cabinet and Merton Clinical Commissioning Group for final agreement.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This Panel commissioned a task group to consider how to reduce the levels of loneliness amongst older people. The task group focussed on ways to ways to re-connect hidden citizens to communities. There are people who are not in contact with main stream services and most likely to be isolated.

1.2.

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 2017/18

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

- Report and Recommendations arising from the 'Tackling loneliness in Merton' task group report

11 BACKGROUND PAPERS

11.1.

Tackling loneliness in Merton

Task Group members:
Councillor Sally Kenny (Chair)
Councillor Laxmi Attawar
Councillor Mary Curtin
Councillor Joan Henry
Councillor Brian Lewis Lavender

Draft Recommendations

1. To ensure loneliness is included within other strategies such as Falls Strategy, Hoarding Protocol and Volunteering Strategy.

2. Merton Health and Wellbeing Strategy and the East Merton Model of health to make reference to current work connecting communities which will address loneliness.

3. Public Health and Merton Clinical Commissioning Group (utilising existing infrastructure e.g. social prescribing and directories) develop an agreed list of voluntary and community sector groups who provide services to tackle loneliness and provide community activities for older people.

4. Merton Clinical Commissioning Group to use the Practice Manager's forum to have a session to highlight the issues around loneliness

5. Public Health Team to lead discussions with partners such as the Chamber of Commerce on innovative ways to connect local communities to reduce loneliness. These discussions could draw on examples set out in this report. New approaches could use existing resources such as training material from Making Every Contact Count initiative and the Campaign to End Loneliness.

6. An Article in My Merton to profile the agreed list of community activities and services that lead to greater connectivity for older people with case studies from people who have benefitted from them.

7. Public Health to host lunchtime seminar for councillors on 'connecting communities with the aim of tackling loneliness' highlighting key issues and good practice.

Chair's Foreword

The Task Group considering how to alleviate loneliness in later years involved Councillors; Joan Henry, Laxmi Attawar, Mary Curtin and Brain Lewis Lavender. We wanted to achieve the best understanding of approaches to alleviate this, as well as what was already being undertaken in Merton. We liaised with various groups including Age UK, Merton & Wimbledon Guilds, Street Pastors and The British Red Cross. It was especially good to liaise with Abbotsbury Primary School and hear their excellent contributions. To have young school children so interested and full of ideas was invigorating. The meetings involved reaching out to groups as well as inviting them to the Civic Centre.

The group met over a period of about eight months. Interesting strategies were presented and thoughtful ideas put forward. We heard about approaches that highlighted the role of volunteers. We also gave some thought to safeguarding as a vital aspect of this work. The group appreciates the involvement, contribution and effort of all the groups involved, in particular the organisation arranged and administered by Stella Akintan, who collated and recorded the work.

Councillor Sally Kenny

Chair Loneliness Task Group.

Introduction

Merton is fortunate to have a vibrant voluntary and community sector which provides a wide range of services and support to those affected by loneliness. Councillors on this task group also work on the frontline within their local communities to make a difference in the lives of those who are experiencing this issue.

The topic was put forward by the school council at Abbotsbury Primary School. Pupils had seen the impact of loneliness within their community and wanted to take action to tackle it. Merton Councillors went to meet with them to discuss the issue and were highly impressed by their concern for wellbeing amongst senior citizens and for the well thought out and practical suggestions they put forward.

Loneliness is a wide ranging and complex area in terms of its definition, who it affects and most importantly how to tackle it.

Loneliness has been defined as a negative experience that involves painful feelings of not belonging and disconnectedness from others. It occurs when there is a discrepancy between the quantity and quality of social relationships that we want, and those that we have. [1]

Therefore the challenge for professionals is more than simply increasing the number of daily social interactions. It involves helping people to build meaningful relationships and social connections. This alleviates loneliness and contributes to an overall sense of happiness and contentment with life. [2]

The impact of loneliness is also a major public issue. It is known to have detrimental impact on health and wellbeing causing depression, increasing the risk of premature death. It can exacerbate existing mental health issues and lead to additional ones such as anxiety and depression. Lonely adults are more likely to be overweight and less likely to do exercise. Feeling lonely has been shown to increase blood pressure and risk of cardiovascular diseases. Overall loneliness can increase the risk of premature death by 30 per cent [3]

This review will focus on loneliness amongst older people and specifically ways to identify 'hidden citizens'; those who are lonely but not connected or known to services in their community. Loneliness is a personal and stigmatised experience therefore it can be difficult to identify people suffering from it. This group may face a number of barriers that may prevent regular contacts within their local communities including a lack of confidence in unfamiliar surroundings.

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[1] Hidden citizens: How can we identify the most lonely older adults. Campaign to End Loneliness, .2015.

[2] Trapped in a bubble: An investigation into triggers for loneliness in the UK, Co-op British Red Cross, December 2016.

[3] Loneliness and Social Isolation in older people Policy Briefing, Local Government Information Unit.

Those who provide services for older people agreed that attracting people to services, especially those who may not come through a traditional referral process, is an important area to review. With an ageing population it is important that councillors with their knowledge of local communities review this issue and put forward suggestions for change.

Why the task group chose to focus on older people

Loneliness is an experience that can be exacerbated by different life events such as being a young parent, having health or mobility issues. Loneliness can occur at different critical junctures across the age ranges and may only persist for a short period. This report will focus on loneliness amongst older people for whom it is thought to be the most acute.

Risk factors for loneliness amongst the over 80s includes those on low income, poor physical or mental health, living along or in or in poor rural isolated areas or deprived urban areas.

Research by Age UK has highlighted the extent of loneliness. Over a million older people say that they always or often feel lonely – with those over 80 almost twice as likely to report feeling lonely most of the time compared to their younger counterparts (14.8% of 16-64s report this, compared to 29.2% over the over 80s) Around a fifth of older people (17%) are in touch with family, friends and neighbours less than once a week. Around 2 million people over 75 live alone and 1.5 million of these are women.7 12% of older people report feeling trapped in their own homes, 6% leave their homes less than once a week. [4]

As the population continues to age, so too will these particular sub-groups most at risk of feeling lonely. For example, increasing numbers of older people will be living longer with multiple health conditions, while the number of people living into their 80s and 90s (the “older old”) is set to increase dramatically, with the number of people over 85 projected to double within the next 23 years, to more than 3.4 million by 2040.

Reasons for the rise in loneliness

A number of reasons have been put forward for the rise of acute loneliness which affects health. Some research has found that British society has become more geographically and demographically segregated since the 1960s, and as a result, people are experiencing stronger feelings of isolation and weaker feelings of “belonging”. The UK has also experienced greater prosperity and better access to transport, which has made it easier for people to move for employment, retirement, and a better quality of life. The decline in marriage, increasing divorce, immigration and a growing student population were also cited as having contributed to the segregation.

[4] DEMOS: Building Companionship: how better design can combat loneliness in later life, April 2016.

There has also been a deterioration of old-style communities where local services such as the post office and local pub provided a focus point for the area. The loss of these services is thought to contribute to the decline in the community spirit. [5]

The role of the local authority to tackle loneliness

The LGA working with Age UK and the Campaign to End Loneliness produced guidance for local authorities on how to tackle loneliness[6]. It recognises that no organisation can deal with this challenge alone, but calls on councils to lead a co-ordinated strategy involving other local partners such as health and voluntary sectors, those experiencing or at risk of loneliness. Councils are encouraged to adopt clear mechanisms to identify and address loneliness in their services.

The report highlights that measures to tackle loneliness are cost effective in comparison to the potential costs of providing health, social care services to lonely people.

The Joint Strategic Needs Assessment is identified as an important tool to understand the nature and extent of loneliness in the local area, as it can identify those at risk and include outcome measures for the Joint Health and Wellbeing Strategy.

The report has set out a framework for tackling loneliness, this identifies key points of intervention:

Foundation Services: reach out to lonely individuals and connect them to existing services.

Gateway Services: provide the mechanisms to bring people together such as transport and technology and social media platforms.

Direct Interventions: these are the local services in place to support lonely people. this can be the lunch clubs and activities provided by voluntary and community sector organisations, or it can be informal gatherings taking place in communities for example a local councillor setting up a domino club to engage potentially lonely older men in the area.

Structural Enablers: create the right environment to reduce loneliness. This includes neighbourhood approaches, volunteering and positive ageing programmes.

Loneliness in Merton

Merton Public Health Team estimates there are at least 8,000 lonely people in the borough. London's older people population has been identified as having one of highest levels of loneliness in the country, reporting that more than four out of five (87%) felt lonely at least some of the time. London and the North West also score

[5] DEMOS: Building Companionship: how better design can combat loneliness in later life, April 2016.

[6] Combatting loneliness: A guide for local authorities. Local Government Association, Age UK

poorly for having adequate opportunities to socialise and having adequate social events for the over 55s, which may be a contributing factor in their high loneliness scores.[7] Age UK Merton said there are particular problems in tackling loneliness amongst older men and some ethnic minority groups. Although the task group are aware that local groups provide services for ethnic minority groups and Merton's diverse population.

Social class can be an influencing factor in levels of loneliness as wealthier people are seen as able to alleviate loneliness through using their financial resources to participate in a wide range of activities. However the Age UK heat map (attached at Appendix A) for Merton shows that there are hot spots across Merton's wealthy west of the borough as well as the more deprived east. Colleagues from Merton and Morden Guild told the task group that they believe there are high levels of loneliness in the Merton Park area. The task group felt this is likely to be a common thread and there will be pockets of loneliness throughout the borough.

Current services to address loneliness in Merton.

The task group spoke to a wide range of local organisations supporting people who may have otherwise been lonely. These evidence gathering sessions helped to build a comprehensive picture of the services available in Merton and the main issues and challenges they are facing in tackling this issue.

Merton Councillors

Merton councillors play an important role in building strong cohesive communities and connecting vulnerable people to local activities. Within the task group members have:

- Set up and facilitated lunch clubs and activity groups for older people
- Set up domino clubs for local residents
- worked with community groups and faith organisations to provide services

Merton Public Health Team

The Public Health team conducted research in 2016 to look at the range of evidence based interventions available to tackle loneliness. As a result they invested in a befriending pilot. The service ran in collaboration with Age UK Merton, Wimbledon Guild, Positive Network, and Carers Support. This pilot was completed in February 2017. The project sought to identify the most isolated and establish telephone or face to face contact.

Age UK Merton

All services provided by Age UK Merton tackle loneliness. They serve 2,500 clients a year. Services are available to residents across the the whole of the borough, however clients usually come from the more deprived east because this is where most activities are located. The age range of clients is between 65-100 years old.

[7] DEMOS: Building Companionship: how better design can combat loneliness in later life, April 2016.

Activities include; holistic massage, art and craft, exercise classes, information and advice, befriending and continence services.

Merton Clinical Commissioning Group

Merton Clinical Commissioning Group (MCCG) recognises the important role of primary care in identifying loneliness and signposting people to the appropriate services. They informed the task group that they are moving towards a new model of supported self care as GPs only spend a limited time with patients and they are not aware of the breath of non medical services available in the community. Therefore MCCG is running a social prescribing pilot in four practices.

Social prescribing presents the most exciting opportunity for tackling the loneliness agenda. It enables GPs to consider patients needs in a holistic way and rather than dispense medication they can refer people to activities in the voluntary and community sector. There is currently a pilot in two GP surgeries in East Merton. If people meet the criteria for social prescribing which includes loneliness and social isolation, their GP will link them to a community co-ordinator, who find more appropriate services in the voluntary and community sector.

Community Co-ordinators hold expertise on a statutory, community and voluntary services across the borough. They sign post and act as advocates for local people. Frontline workers such as social workers can seek advice from Community Co-ordinators to refer people to appropriate services. Community Co-ordinators can also spend some time working in the community

Libraries

Libraries are accessible open spaces and attract a diverse range of people. Library staff come into contact with a wide range of issues including people who have not had any conversations, human contact with anyone that week, homelessness, depression and other mental health issues. They provide a range of training for library staff to help signpost people informally and refer them to agencies. Merton library service has the most successful volunteering scheme in England.

Adult Social Care

The council has a good understanding of the impact of loneliness on physical and mental health and recognises its important role in referring people to appropriate services within partner organisations. Two members of staff from the adult social care team work in the Merton Civic Centre reception Link in a weekly session to signpost and navigate people to appropriate services. This started in July 2017 and at least 300 people have been supported. The services refer people to activities and helps with transport costs.

The department commissioned an ageing well grants programme. Four local organisations were selected to run specific projects; Friends of St Helier, Age UK, Wimbledon Guild, Merton and Morden Guild. It is recognised that there are a plethora of local organisations across Merton running services, many with little or no external funding.

Carers Support Merton has been commissioned to run a carers hub; this began on the 1st July 2016 and had referred 200 people by February 2016.

Wimbledon Guild

Wimbledon Guild (WG) run a wide range of services focussing on ageing well. They give small grants, offer counselling, chiropody, befriending, holistic therapy service. They have a person centred approach and meet with clients to identify their needs. WG have a charity shop in Mitcham Green. Referrals come from hospitals, adult social care, faith groups, families and word of mouth. WG refer people to other local services.

Merton and Morden Guild

Merton and Morden Guild (MMG) run a wide range of services in the community including a falls prevention course. The exercise programme is very popular and is attractive to those who may be lonely. As these activities do not have specific funding streams they remain under the threat of closure. MMG also work with Raynes Park High School providing intergenerational work helping older people set up their devices so they can Skype their families. Fire, Ambulance, PCSO services attend MMG to speak to service users and provide information and advice.

Street Pastors

Street pastors patrol the Wimbledon area late at night to provide reassurance and support to local residents. They hand out flip-flops to prevent accidents caused by wearing high heels when intoxicated, blankets for rough sleepers, help people who have collapsed on the street, help people to get transport home and offer a listening ear. Street Pastors maintain an up to date list of local services and have a referral list. Sometimes they engage in further follow up and attend agencies with people. They also work closely with the police and the council.

British Red Cross

British Red Cross are not currently providing Independent services in Merton[8] but met with the task group to provide an overview of their work. BRC are working with the Co-op on a project to tackle loneliness, this started in May 2017. It recognises all types of loneliness. The project will use community connectors who will be recruited to work for 3 days. Their role will include recruitment and training of volunteers in the community. Volunteers will go into local areas to identify people and re-connect them to their communities so they don't feel isolated. The aim is to connect people to existing services or community groups that help to reduce feelings of isolation. If a

[8] BRC do have a Memorandum of Understanding with Merton Council Emergency Planning Team which means BRC will provide emergency support to vulnerable people in crisis if called upon by the Council. This supports people during things like UK Power Networks power outages, floods and in any instance a humanitarian assistance centre needs to be opened within the community.

community group does not exist already, BRC will work with councils partners and community groups to establish new ones. The current funding will last for two years. The aim is to move away from traditional methods and not just signpost people into services.

Feedback from Abbotsbury Primary School

Some of the task group met with a group of school ambassadors who were working on a project looking at how to make improvements in their local community. The school ambassadors came up with ideas on how to tackle loneliness and shared them with councillors during the visit.

Task group members reflected on the responses from the school ambassadors throughout the review. Some of the suggestion which were particularly pertinent included:

The pupils highlighted that impact of low self esteem on older people and suggested that a ‘pampering service which would help to build their confidence. The task group found that pampering sessions which are provided by Age UK Merton and Wimbledon Guild.

A pupil said….

“maybe it’s possible to make elderly people feel good about themselves and have days where they go out and meet new people and get their nails done and hair done and maybe some massage but not only for women but with men too. Some people need encouragement to eat healthily and feel good about themselves and get out of the house.”

They highlighted the benefit of social activities such as eating meals in a group. This is beneficial for both social activity to alleviate loneliness and can also encourage healthy eating. This is a core provision within many services such as Asian Elderly, Friends of St Helier and Wimbledon Guild, which has its own café.

Transport and financial issues were also raised as barriers to tackling loneliness.

“ some elderly people cannot afford cars because they might have financial issues or something so we could provide special transport for those elderly people who can’t drive.”

The school ambassadors also offered to do some fund raising to resolve the financial issues.

Findings of the task group

The task group spent a considerable amount of time deliberating on how to tackle loneliness. They found that a new landscape is emerging with the council increasingly taking on the role of an enabler rather than provider of non statutory services. For example the Adult Social Care team explained that they do not specifically provide services to people who are lonely. Therefore they refer people to appropriate partner organisations in the voluntary sector.

The task group also found that the future shape of health services has a stronger focus on connecting communities and tackling the wider determinants of health and wellbeing and moving away from the medical model of health. For example the East Merton Model of health and the new Wilson health facility which is in the early stage of development will be a health and wellbeing campus, with involvement from the community. It will be a dementia friendly environment and the needs of older people will be central.

A holistic approach

The task group are keen to see a holistic approach to tackling loneliness rather it being looked at in isolation. It is important that our understanding of loneliness is reflected and embedded within in all the relevant strategies. The Public Health Team highlighted that there is a link between dementia, loneliness and falls. All these impact upon each other as dementia and being at risk of falling can cause isolate and make it difficult to maintain relationships.

The task group believes that we must recognise that loneliness is not only about providing services to people. Many people who are lonely would benefit from opportunities to volunteer. Building resilience is an important tool in tackling loneliness, therefore it is important to promote independence and look at existing resources within communities to support the vulnerable. The review of Loneliness from the City of London which highlights that it is important not to see communities as a repository of needs but rather a source of opportunity and strength. People are not only seen as recipients of services but rather those who something to offer and capacity to develop their own potential. [9]

Task Group members would also like the Health and Wellbeing Strategy to make reference to loneliness, highlighting the important work taking place and their aspirations to tackle this issue.

Recommendation

1 To ensure loneliness is linked to other strategies such as Falls Strategy, Hoarding Protocol and Volunteering Strategy.

2 Merton Health and Wellbeing Strategy and the East Merton Model of Health to make reference to current work on connecting communities which will address loneliness.

Relationship between the Community and Voluntary and statutory medical sectors

The task group welcome the new social prescribing pilot; it addresses many of the challenges that were highlighted during the review. A major concern was relationship between the voluntary sector and GPs. Witnesses told task group members that GP's can be reluctant to refer people to voluntary services. When the voluntary sector had the opportunity to discuss this with GPs they found that their hesitancy stemmed from their lack of knowledge about the credibility of these organisations. This came as a surprise to the task group particularly given that national recognised organisations such as Age UK Merton told us they experienced the same problem.

There are similar concerns in relation to information material as surgeries can be hesitant to display voluntary sector leaflets in their surgeries. Merton Clinical Commissioning Group told councillors that the practice managers have a responsibility to act as gate keepers regarding the information on display to protect patients. It was highlighted that the surgeries are very busy and receive many requests to display information. MCCG told the task group that they hold a regular

[9] Improving Social Wellbeing in the City of London. Reducing loneliness and building communities. City of London

forum with Practice Managers and they could have a session to discuss all the issues surrounding loneliness in this setting.

It is clear to the task group that there is a necessity to build a relationship between the medical professions and the voluntary sector. One based on trust and mutual appreciation of their important contributions to health and wellbeing. The Health and Wellbeing Board is already playing an important role in this regard, as will the social prescribing pilot. It is also important to build relationships on the ground. The task group believes MCCG and the Public Health team should work together to develop an agreed list of voluntary and community sector organisations who are recognised for their work on tackling loneliness. These recommended groups can then receive referrals from GP's and Community co-ordinators and can build stronger relationships with GP Surgeries.

Recommendation

3 Public Health and Merton Clinical Commissioning Group (utilising existing infrastructure e.g. social prescribing and directories) develop an agreed list of voluntary and community sector groups who provide services to tackle loneliness and provide community activities for older people.

4 Merton Clinical Commissioning Group to use the Practice Manager's forum to have a session to highlight the issues around loneliness.

Increased role for front line organisations

The task group considered how front line organisations can contribute to the loneliness agenda. These organisations work directly within neighbourhoods; therefore they tend to know the local residents well and could potentially, with training and support, refer people to appropriate services or professionals.

Street pastors have regular contact with vulnerable members of the community and may be able to help identify lonely people and refer them to appropriate services. However to perform this role they will need further training on recognising signs of loneliness. They can also add recommended groups to their list of referral services.

The task group also spoke to colleagues who support neighbourhood watch and local high street businesses. Both officers informed the task group that these groups could be well placed to refer people who may be lonely, as they have a good links with the community.

The task group understand that Neighbourhood Watch Co-ordinators are very active and know who is vulnerable in the local area; they have good local knowledge as well as sit on ward panels.

The task group would like there to be more collaboration between different agencies in identifying and referring people to loneliness services. Some of whom have not

traditionally had tackling loneliness within their remit. We need to develop or use existing tools to recognise loneliness.

Both Wimbledon and Merton and Morden Guilds suggested that there could be an important role for supermarkets and local shops in signposting local people to existing services. The task group met with the British Red Cross who reported that the Co-op worked with BRC to fundraise for the social isolation work the charity was now delivering and have continued to support with promotion of the services in the community the service was operating in.

Again the task group found that there are structures in place that can be utilised to make links with supermarket managers to display information and identity. There are town centre officers in Mitcham and Colliers Wood ward shops. There is a business improvement district in Wimbledon Park that has a town centre forum managed through the chamber of commerce. The task group also believes the borough would benefit from the services provided by the British Red Cross.

The Campaign to End Loneliness has produced a number of resources that could be helpful with training and awareness raising:

https://www.campaigntoendloneliness.org/wp-content/uploads/The-Missing-Million-report-FINAL.pdf

https://www.campaigntoendloneliness.org/wp-content/uploads/CEL-Missing-Millions-Guide_final.pdf

Recommendation

5 Public Health Team to lead discussions with partners such as the Chamber of Commerce on innovative ways to connect local communities to reduce loneliness. These discussions could draw on the examples set out in this report. New approaches could use existing resources such as training material from Making Every Contact Count initiative and the Campaign to End Loneliness.

New and Innovative ways to identify hidden citizens

All witnesses informed the task group that identifying lonely people is one of the most challenging aspects of the work. Although there are many people in the communities who may be experiencing loneliness a number of barriers will mean that many will not access services that can support them. Given the stigma attached to loneliness and potential embarrassment they may feel in admitting they have a problem many people may not wish to approach organisations directly. They may

also lack confidence in doing so. This is also coupled with the fact that many lonely older people may not be known to other services such as social care, or their loneliness may not have been identified by professionals.

A strong theme emerging from the evidence on how to reach hidden citizens is to adopt the NHS approach to make every contact count. This means making the right information available where people will visit on a periodic basis such as doctors, dentist and hairdressers, local supermarkets.

Adult Social Care is well placed to pick up the trigger points; such as bereavement, they could provide information to the registrar. They could also provide information and support to carers when they lose the person they are looking after.

The Hidden Citizens report[10] states that council funded magazines could be a good source of information because they go to every household. Special features could be run on special events such as international older people day. The task group considered the resources available within the council to identify hidden citizens and believe that My Merton, which goes to every household in the borough could highlighted those organisations which are tackling loneliness.

Evidence within the Hidden Citizens report argues that mailings and leaflets can be a good way to reach people; the task group found that some organisations found mass mailings to have mixed results. Age UK Merton found that mass mailings were not always successful. The public health team felt that more sustainable ways to reach people should be used. Mass mailings and campaigns are only successful while they are running.

Although the task group are aware that word of mouth, leafleting could exclude the most isolated who are least likely to engage with these methods due to complex barriers such as lack of confidence, discomfort in an unfamiliar environment.

The task group also found that organisations working together can be exacerbated by data protection regulations which mean that information about various groups or individuals cannot be shared between agencies.

Also Merton councillors already play an important role in the community and have a good knowledge of their local wards, therefore highlighting the issues around loneliness, especially for the new cohort of councillors after May 2018, could assist them in this role.

[10] Hidden citizens: How can we identify the most lonely older adults. Campaign to End Loneliness, .2015

Recommendation:

6. An Article in My Merton to profile the agreed list of community activities and services that lead to greater connectivity for older people with case studies from people who have benefitted from them.

7. Public Health to host a lunchtime seminar for councillors on 'connecting communities' with the aim of tackling loneliness highlighting key issues and good practice.

Use of religious venues

A report by the City of London Corporation[11] looking at loneliness and social isolation found that faith venues can help to tackle loneliness. Faith venues foster a strong sense of belonging it is a familiar environment where people can often meet trusted friends or others with a similar viewpoint or share their faith.

A wide range of coffee mornings and outreach activities are happening within faith groups on a regular basis which could offer support to those experiencing loneliness.

This task group were told many faith groups in Merton provide services that support those who are lonely however this service may not be widely advertised and make only be attractive to people of that faith group. The task group believes there could be opportunities to harness these resources for the benefit of the wider community but is beyond the scope of this review. Therefore councillors suggest that the relationship between the council and faith organisations could potentially be a future topic for scrutiny.

Conclusion

Although the task group came across a wide range of innovative and high quality services to tackle loneliness, some challenges still remain. The voluntary and community sector has experienced a significant loss of funding in recent years. Age UK told the task group that the centre used to be for traditional day services but this has now been changed to a social centre, this means that people pay for services. Also both Age UK Merton and Merton and Morden Guild no longer have dedicated bus service and people either make their own way or use Dial a Ride. It can create a challenging environment when the voluntary and community sector are increasingly being called upon to provide services while their funding is in decline.

[11] Improving Social Wellbeing in the City of London. Reducing loneliness and building communities. City of London

However many promising changes are being implemented such as social prescribing and East Merton Model of Heath. The Healthier Communities and Older People Overview and Scrutiny Panel will take a keen interest in how these services help to reduce levels of loneliness in the borough.

The Director of Public Health also highlighted that we should not be on seeking to address loneliness by providing more services. We need to be more holistic and look at connecting communities and creating an environment for people from all walks of life to come together and enjoy mutual support. We must create spaces for people to interact. This is a long term goal and should be a central feature within regeneration and the re-design of local areas.

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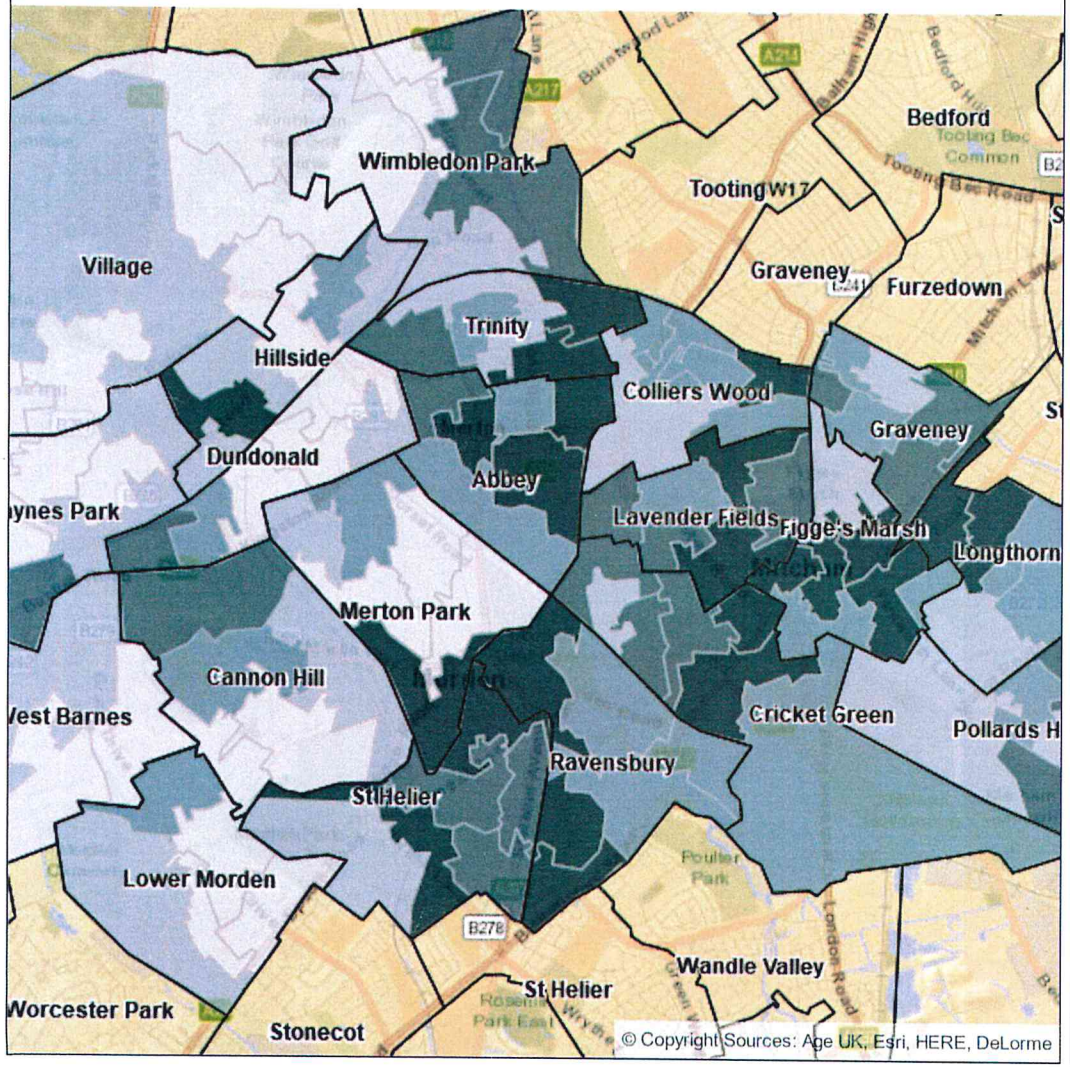
Age UK
Love later life

Age 65 + >> Risk of Loneliness



The map shows the risk of loneliness at neighbourhood level within the local authority. Read more on our website.

The Ward boundaries are outlined in black. Zoom in and the Ward names will appear.

Risk within this authority

- Very low risk
- Low risk
- Medium risk
- High risk
- Very high risk

The table and chart below show how each neighbourhood ranks within England; click on individual areas to see their ranks and which quintile they fall in. 1 = highest risk, 32,844 = lowest risk.

Indicator	Rank in En...	Quintile in England
Age 65 +		
Risk of Loneliness		

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Healthier Communities and Older People Work Programme 2017/18

This table sets out the draft Healthier Communities and Older People Panel Work Programme for 2017/18. 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)
Tel: 020 8545 3390; Email: stella.akintan@merton.gov.uk

For more information about overview and scrutiny at LB Merton, please visit www.merton.gov.uk/scrutiny

Meeting Date 27 June 2017

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Performance Monitoring	St George's University Hospitals NHS Foundation Trust.	Verbal update at the Panel	Dr Andrew Rhodes, Acting Medical Director, St George's Hospital	Panel to receive an update on the improvements since the recent CQC inspection.
Performance Monitoring	South West London and St George's Mental Health NHS Trust	Verbal update at the Panel	David Bradley, Chief Executive, SWLST Mental Health Trust.	Panel to receive update on proposed changes to Autistic services.
	Work programme report	Report to the Panel	Cllr Peter McCabe, Chair Stella Akintan, Scrutiny Officer	To agree the work programme for 2017-18

Meeting date – 06 September 2017

Scrutiny category	Item/Issue	How	Lead Member/ Lead Officer	Intended Outcomes
Consultation	Epsom and St Helier University NHS Trust – Update on current priorities	Report to the Panel	Daniel Elkeles, Chief Executive, Epsom and St Helier	Panel to receive an update on the Trust Estate Strategy
Performance Review	Access to local assessment Centres and the assessment process	Report to the panel		
Scrutiny Review	Loneliness Task Group – Final Draft Report.	Report to the Panel	Councillor Sally Kenny	To consider the report and recommendations arising from the review

Meeting Date – 07 November 2017

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Policy Development	Services for people who have experienced brain injury	Report to the Panel	Specialised Commissioning Group	To review the services available for this group
Policy Development	Services for people with Sickle Cell disease in Merton	Report to the Panel and representation from the Sickle Cell Society	Merton Clinical Commissioning Group	To review the services available for this group

Meeting date – 11 January 2018

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Performance Monitoring	Budget	Report to the Panel	Caroline Holland, Director of Corporate Services	To comment on the council's draft budget
Policy Development	MCCG Primary Care Strategy	Report to the Panel	Dr Andrew Murray, Chair, Merton Clinical Commissioning Group.	Update on the work of MCCG

Meeting date – 02 February 2018 (date to be changed as it is a Friday)

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Policy Development	Preventing the rise in Tuberculosis	Report to the Panel	MCCG, Public Health, local charities	To review the services available for this group
Policy Development	Sexual transmitted infections	Report to the Panel	MCCG, Public Health, local charities	To review the services available for this group
Scrutiny Review	Preventing Loneliness in	Report to the Panel	Councillor Sally Kenny,	The Panel to agree the

	Merton Task Group – Draft Final Report		Task Group Chair.	findings and recommendations arising from the report.

Meeting Date – 13 March 2018

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Performance Monitoring	Update from the Health and Wellbeing Board	Report to the Panel		
Performance Monitoring	Review of Health and Wellbeing Strategy	Report to the Panel		
Performance Monitoring	Update on Healthwatch	Report to the Panel		