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Merton Council
Healthier Communities and Older People Overview and Scrutiny Panel

Date: 17 March 2014
Time: 19:15
Venue: Committee rooms B & C - Merton Civic Centre, London Road, Morden SM4 5DX

AGENDA

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1.	Declarations of Pecuniary Interest	
2.	Apologies for Absence	
3.	Minutes of the meeting held on the 12 February	1 - 4
4.	Matters arising from the minutes	
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9.	Draft task group review on Physical Activity for the fifty five plus	73 - 86
10.	Scrutiny topic suggestions for the new municipal year	

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

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Healthier Communities and Older People Overview and Scrutiny Panel membership

Councillors:
Logie Lohendran (Chairman)
Richard Chellew
Caroline Cooper-Marbiah
Brenda Fraser
Maurice Groves
Peter McCabe (Vice-Chair)
Debbie Shears
Gregory Patrick Udeh

Substitute Members:
Laxmi Attawar
John Dehaney
Gilli Lewis-Lavender
Suzanne Grocott

Co-opted Representatives
Myrtle Agutter
Laura Johnson
Sheila Knight
Saleem Sheikh

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

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HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL
12 FEBRUARY 2014
(19.15 - 21.00)

PRESENT Councillors Councillor Logie Lohendran (in the Chair), Councillor Caroline Cooper-Marbiah, Councillor Brenda Fraser, Councillor Maurice Groves, Councillor Peter McCabe, Councillor Debbie Shears, Councillor Gregory Udeh, Myrtle Agutter, Laura Johnson, Sheila Knight and Saleem Sheikh,

Also Present: Councillor Linda Kirby, Councillor Margaret Brierly

Simon Williams, Director of Community and Housing, Julie Phillips, Safeguarding Manager, Jenny Kay, Director of Quality, Merton Clinical Commissioning Group, Anjan Ghosh Assistant Director and Consultant in Public Health, Catrina Charlton, Commissioning Manager, Merton Clinical Commissioning Group, Stella Akintan, Scrutiny Officer.

1. DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 1)

There were no declarations of pecuniary interests

2. APOLOGIES FOR ABSENCE (Agenda Item 2)

Apologies for absence were received from Councillor Richard Chellew

3. MINUTES OF THE MEETING HELD ON THE 15 JANUARY (Agenda Item 3)

A panel member pointed out that the resolution regarding the discussion with South West London and St Georges NHS Trust should be amended to reflect what the report asked the panel to agree; therefore the recommendation should read; the panel supports the Trust's proposed governance arrangements.

4. MATTERS ARISING FROM THE MINUTES (Agenda Item 4)

There were no matters arising from the minutes

5. LONG TERM CONDITIONS IN MERTON (Agenda Item 5)

The Panel received an overview of the main provisions in the report

A panel member asked about screening for people who do not go to the GP. The Assistant Director and Consultant in Public Health, reported that the health check needs to be conducted by health professionals. We are looking at other ways of conducting the health checks like libraries, and increasing the number of pharmacies.
A panel member said that brain injury should be included in long term conditions. This is a serious problem which causes isolation and relationship breakdown and homelessness. There needs to be a comprehensive strategy to deal with it.
The MCCG reported that facilities for rehabilitation need to be improved; this includes Epilepsy Multiple Sclerosis, however accidents and injuries are mentioned within the priorities.
A panel member asked if we are targeting the East of the borough where these issues are more prevalent also are we educating people about how to manage their conditions
The Assistant Director and Consultant in Public Health, said the expert patient programme helps to educate people and put them in charge of their own condition however there are still challenges around managing medication. The Director for Quality said Merton Clinical Commissioning Group are very aware of the equalities issues. Health Champions will play an important role as will the Mitcham and Nelson care centres.
A panel member asked what is being done regarding those who refuse to engage?
The Assistant Director and Consultant in Public Health, said that health champions and the voluntary sector will play an important role in reaching out to communities.
A panel member said that mental health had not been included as a long term condition even though they experience higher rates of diabetes, alcohol, drugs and the NHS spends the largest proportion of its budget in this area.
The Director of Quality said that they are increasing liaison psychiatry and reviewing the IAPT service and due to changes there has been an improvement in physical health in the mental health service.
The Assistant Director and Consultant in Public Health, Public health are leading on a review of mental health services this includes a review of services, writing a mental health assessment and an adult mental health strategy, which is likely to be ready in April.
A panel asked how the Merton Clinical Commissioning Group is tackling health inequalities in the East of the borough.
The Director of Quality said the organisation were aware of the disparities and this is fully addressed in the Joint Strategic Needs Assessment
The Panel were concerned about varying quality within GP practices. The Director for Quality said that Care Quality Commission is inspecting many GP practices. Merton GP's do not rank badly in the health standards. Patients can also use the complaints process if they are unhappy.

6. SAFEGUARDING ADULTS IN MERTON (Agenda Item 6)

A panel member asked if the council is protecting whistle blowers?
The Safeguarding Manager said the council goes to great lengths to protect whistle blowers and investigates all issues that are raised.
A panel member asked why there were more alerts raised over the holidays, The Safeguarding Manager said this may be that staff have a backlog of complaints that

need to be input into the system after the holiday period. Furthermore holidays are a time when families come together causing increased tension and arguments.

7. REVIEW OF HEALTH SERVICES IN SOUTH WEST LONDON - VERBAL UPDATE (Agenda Item 7)

This item was deferred until the next meeting

8. HEALTH AND WELLBEING BOARD - VERBAL UPDATE (Agenda Item 8)

Councillor Kirby gave an overview of the last meeting and work of the Board saying that joint working with the Clinical Commissioning Group remained strong.

9. WORK PROGRAMME (Agenda Item 9)

There were no comments on the work programme

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Committee: Healthier Communities and Older People Overview and Scrutiny Committee

Date: 2014

Agenda item:

Wards: ALL

Subject: NHS England Immunisations and Screening in Merton

Lead officer:

Lead member: Councillor Logie Lohendran, 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 NHS England's Childhood Immunisations and Diabetic eye screening programme

B. That the Panel identify issues to be included in the future work programme

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of the report is to provide the panel with work of NHS England's immunisation and screening programme. This report will focus on Child Immunisations and Diabetic Eye Screening Programme. Which are attached to this report. The Panel may wish to look at other areas of this programme in future.

2 DETAILS

2.1. From April 2013, NHS England took responsibility for the local immunisation and screening programme.

2.2. Members of the Children and Young People Panel will be invited to join the discussion on Child Immunisations.

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 2013/14

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.

Scrutiny Report on Childhood Immunisations in Merton

PURPOSE OF THE REPORT

The aim of this paper is to provide the Overview and Scrutiny Committee with information on:

- Roles and responsibilities of organisations in improving coverage of childhood immunisations across London since April 1st 2013
- The local picture of childhood immunisations in Sutton & Merton
- Vaccine Preventable Diseases in Merton
- NHS England's plans to improve reported rates of childhood immunisations across London
- NHS England's Action Plan for Sutton & Merton 2013/14

INTRODUCTION

- Since April 1st 2013, a number of public health functions are the responsibility of NHS England (NHSE) under Section 7a of the Health & Social Care Act 2012. These comprise of screening, immunisations, Health in the Justice System (i.e. prisons, Sexual Assault Centres, places of detention) and military health.

- In London, the NHS England (London) Public Health, Health in the Justice System and Military Health team is responsible for commissioning immunisation programmes. This team comprises of a central team who work closely with immunisation commissioners situated within the 3 patch teams: North East London, North West London and South London.

- The central team consists of the Head of Early Years, Immunisations & Military Health, Dr Kenny Gibson and he is supported by two Public Health England embedded staff – Dr Catherine Heffernan (Principal Advisor for Early Years Commissioning, Immunisation & Vaccinations) and Ms Thara Raj (Immunisation Manager for London). These personnel provide accountability and leadership for the commissioning of the programmes and system leadership. The team also have responsibility for the quality assurance of training of immunisers and oversight of serious incident and incident investigations involving vaccinations. The borough of Merton falls under South London patch area which is headed by Johan Van Wijgerden and his team of screening and immunisation commissioners.

- The new emphasis on commissioning immunisations and vaccinations provides new opportunities to improve uptake of immunisations which were not previously available in the old world of public health immunisation co-ordinators in Primary Care Trusts. NHSE plans to utilise these opportunities will be discussed below. The paper will also outline the roles and responsibilities of different organisations in improving uptake of immunisations. It can be seen that improving uptake incorporates partnership work across a number of different bodies.

- This report focuses on the immunisation uptake in 0-5s age group. Apart from the over 65s, this group are the most vulnerable to communicable diseases and the National Routine Childhood

Immunisation Schedule is timed to give the vaccinations at optimal times to protect them and to protect others by reducing the spread of communicable diseases within the wider population.

ROLES AND RESPONSIBILITIES OF ORGANISATIONS IN IMPROVING COVERAGE OF CHILDHOOD IMMUNISATIONS ACROSS LONDON SINCE APRIL 1ST 2013

NHS England (NHSE)

- Commissioning of all national immunisation and screening programmes described in Section 7A of the Mandate
- Commission immunisation and vaccination services from primary care, community providers (e.g. school nursing teams) and other providers which are specified to national standards
- Monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required
- Accountable for ensuring those local providers of services will deliver against the national service specifications and meet agreed population uptake and coverage levels as specified in Public Health Outcome Indicators and KPIs
- Work with Department of Health and Public Health England in national planning and implementation of immunisation programmes and in quality assurance
- Emergency Planning Response and Resilience (EPRR) where this involves vaccine preventable diseases

Public Health England (PHE)

- Lead the response to outbreaks of vaccine preventable disease and provide expert advice to NHS England in cases of immunisation incidents. They will provide access to national expertise on vaccination and immunisation queries.
- Professional support to the PHE staff embedded in the NHSE Area Teams including access to continuing professional appraisal and revalidation system
- Provide information to support the monitoring of immunisation programmes
- Publishes Cohort of Vaccination Evaluated Rapidly (COVER) data

Clinical Commissioning Groups (CCGs)

- Have a duty of quality improvement (including immunisation services delivered in GP practices)
- Commission maternity services (which are providers of neonatal BCG and infant Hepatitis B)

Local Authorities

- Provide information and advice to relevant bodies within its areas to protect the population's health (whilst not explicitly stated in the regulations, this can reasonably be assumed to include immunisation)
- Provide local intelligence information on population health requirements e.g. JSNA
- Independent scrutiny and challenge of the arrangements of NHSE, PHE and providers.
- Local authorities will need to work closely with Area Teams including arrangements for the NHS response to the need for surge capacity in the cases of outbreaks.

Commissioning Support Units (CSUs)

- Although not statutory, CSUs have a role to play in supporting CCG member practices in enabling them to carry out their immunisation work, e.g. IT support to help with call/recall

General Practitioners (GPs)

- General practices are contracted by NHSE to delivery the Childhood Routine Immunisation Schedule to their registered child population. They are the main mode of delivery in England.

Community Services Providers

- Child Health Information System (CHIS) is housed within community service providers and incorporates the child health records department which holds clinical records on all children and young people. COVER data is submitted from CHIS to PHE.
- The community provider may have an immunisation team that provides outreach or 'catch-up' for childhood immunisations (e.g. for unregistered populations) and for BCG.
- Health visitors have a role to play in promoting the importance of vaccinations to parents.
- Many community services providers have immunisation clinical leads or co-ordinators who provide clinical advice and input into immunisation services locally.

THE LOCAL PICTURE OF CHILDHOOD IMMUNISATIONS IN SUTTON & MERTON

- Immunisation rates for children aged 0-5 years are reported by Primary Care Trust (PCT) areas. This means that for Merton, the immunisation rates are combined with Sutton. As of March 2014, no public announcement has been made on whether this will change in the near future.

- Figures 1-6 illustrate the uptake of vaccinations in 0-5 year olds as recorded by Cohort of Vaccination Evaluated Rapidly (COVER). The figures are grouped into the Age 1 primaries, Age 2 (boosters and first dose of MMR) and Age 5 vaccinations (2nd dose of MMR and the preschool booster).

- COVER monitors immunisation coverage data for children in UK who reach their first, second or fifth birthday during each evaluation quarter – e.g. 1st January 2012 to 31st March 2012, 1st April 2012 – 30th June 2012. Children having their first birthday in the quarter should have been vaccinated at 2, 3 and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.

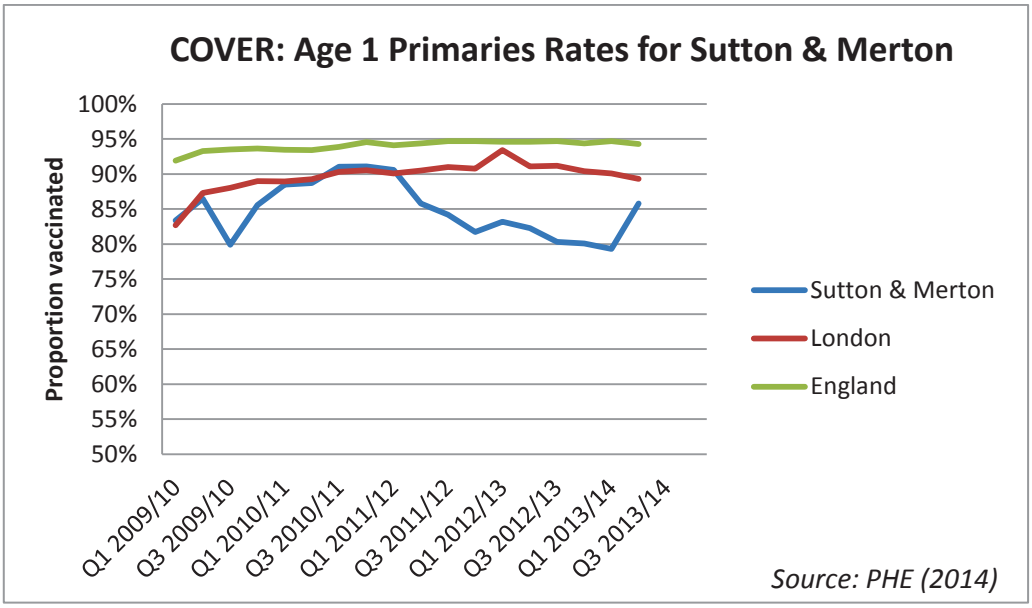
- London has in recent years delivered significantly poorer uptake than the remainder of the country. Reasons provided for the low coverage include the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices, London's high population mobility, difficulties in data collection particularly as there is no real incentive for GPs to submit data for COVER statistics and large numbers of deprived or vulnerable groups. In addition, there is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions, which in Sutton & Merton's case inflates the denominator (i.e. number of children requiring immunisation) resulting in a lower uptake percentage. Like many other London boroughs, Sutton & Merton has not achieved the required 95% herd immunity (i.e. the proportion of people that need to be vaccinated in order to stop a disease spreading in the population).

- Figure 1 illustrates the quarterly COVER statistics for the uptake of primaries for the age 1 cohort. Quarterly rates vary considerably more than annual rates but are used here so that Quarter 2 data from 2013/14 could be included.

- Similar to other London boroughs, Sutton & Merton has consistently been lower than England averages since April 2009. Looking at Figure 1, rates dipped between Q1 2011/12 and Q1 2012/13. Since then there has been one quarter of recovery. It is likely that the recovery is due to the implementation of the data extraction methodology and improvements in reporting mechanisms and so is a data quality issue rather than any real increase in uptake of vaccination

in the age 1 age-group. It is projected that Sutton & Merton will achieve the 95% level in the next 18 months.

Figure 1



- Figures 2 and 3 depict the COVER rates for the two boosters – PCV and Hib/MenC – for the age 2 cohorts. Again rates are lower in Sutton & Merton when compared to England averages but there appears to have been a recovery over the last six quarters and the rates are now similar though slightly lower compared to the overall London rates.

Figure 2

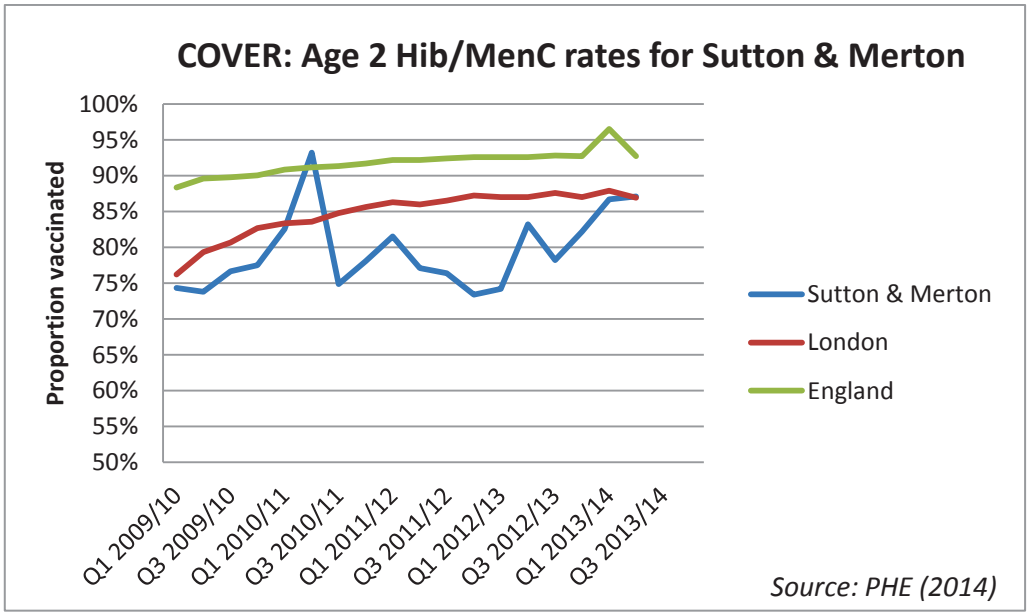
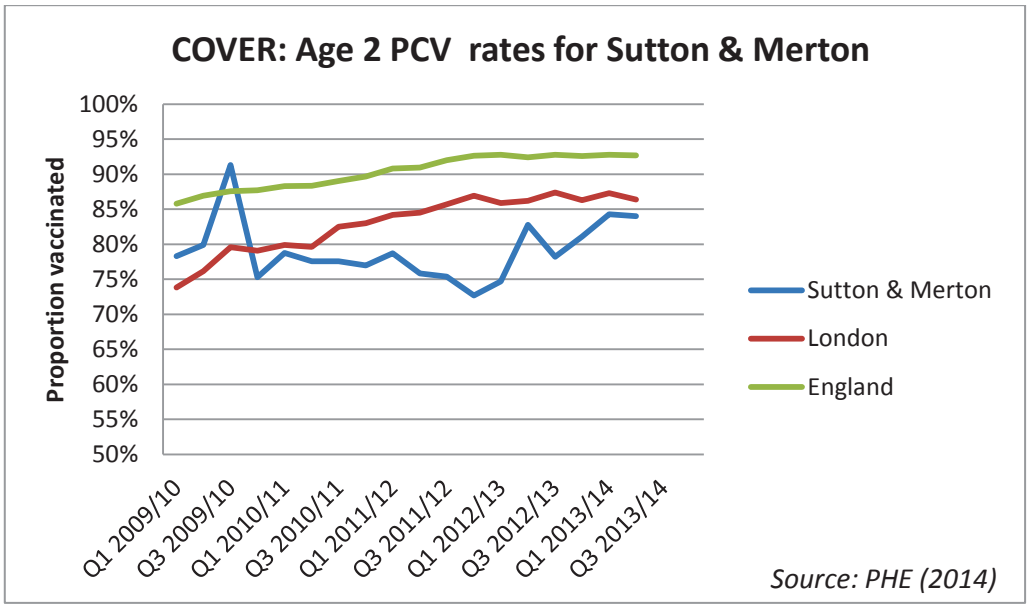


Figure 3



- Figures 4 and 5 demonstrate the uptake for 1st dose of MMR and 2nd dose of MMR for the age 2 and age 5 cohorts in Sutton & Merton. Proportion of children vaccinated with the first MMR is around 5% higher compared to similar to that of the 2nd MMR at age 5. Again there has been a marked improvement over the last six quarters. It should also be pointed out that if the true rate of uptake of MMR is as the figures suggest (e.g. 77.1% of age 5 children for 2nd dose in Quarter 2 2013/14), we would be seeing more measles, mumps and rubella cases than are actually seen for Sutton & Merton. This suggests coverage rates are affected more by data management issues than poor uptake of immunisations.

Figure 4

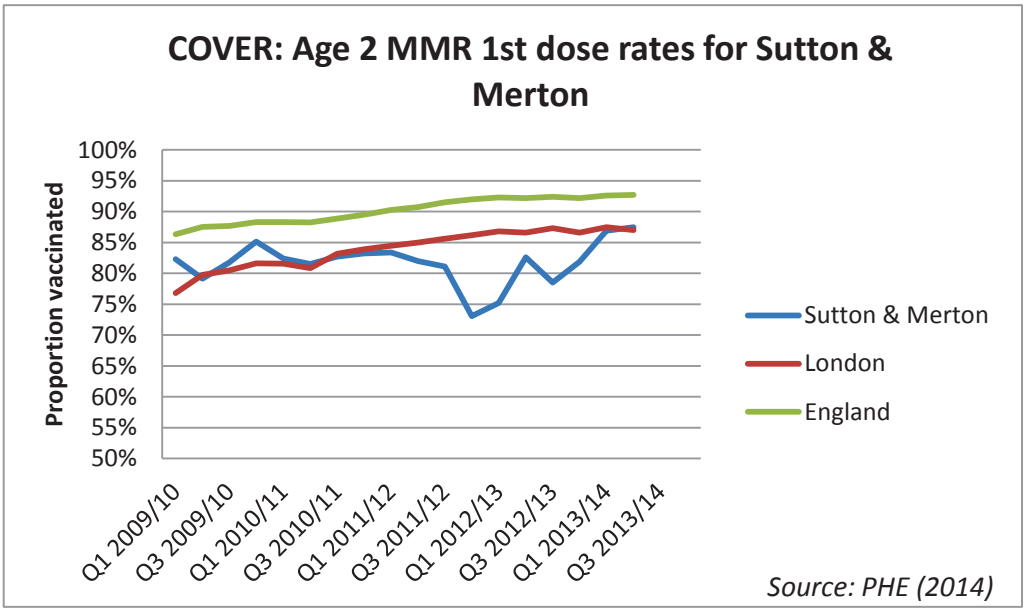
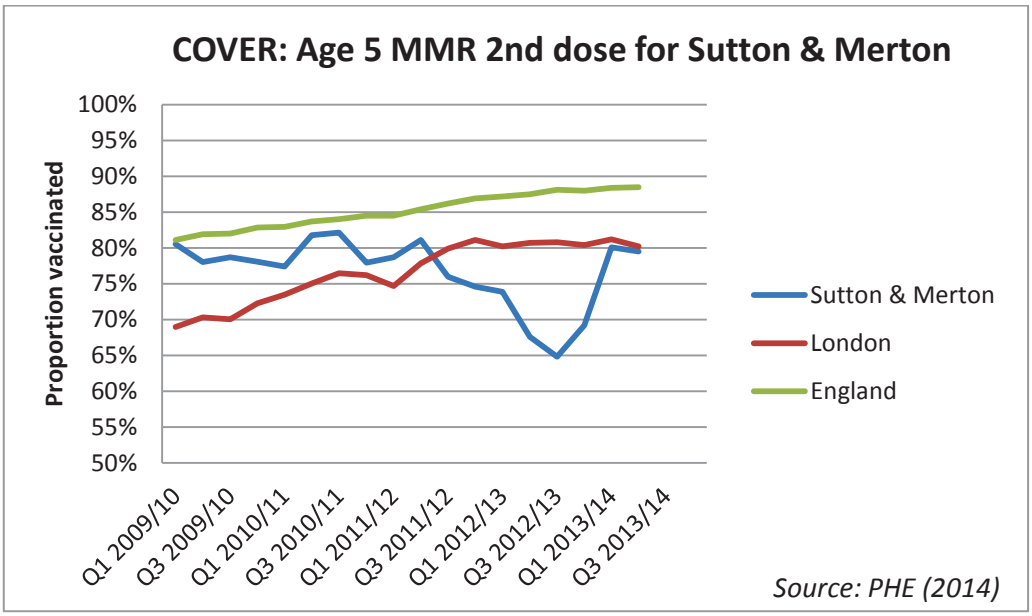
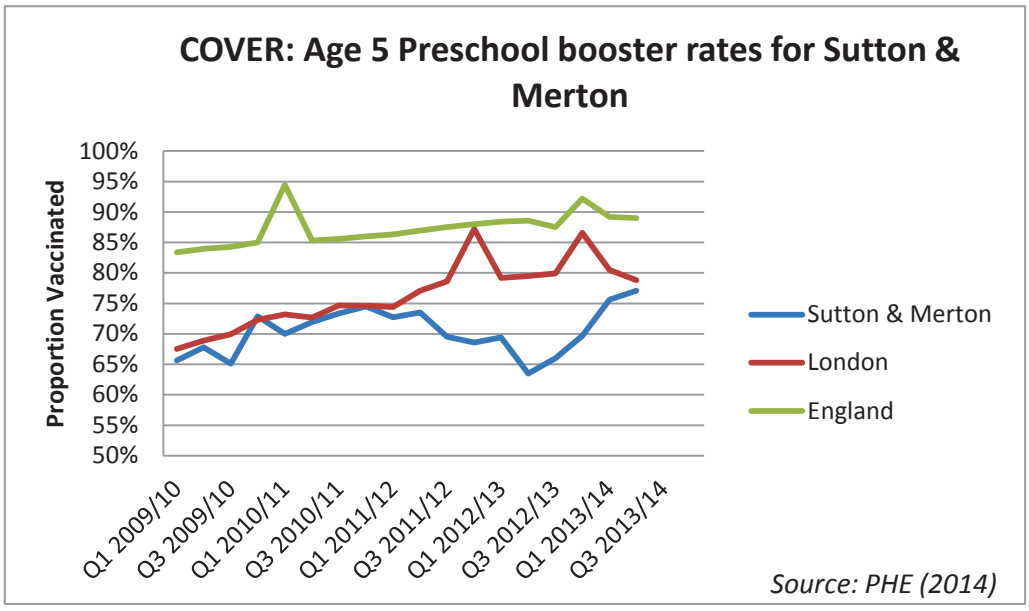


Figure 5



- Figure 6 depicts the preschool booster for age 5 – which can be used as an indicator of the number of children with completed immunisation schedules. Sutton & Merton is slightly lower than London average. As previously explained, reported rates of uptake drop as age group increases in London. Since Q1 2012/13, Sutton & Merton rates have improved to 79.5%. There are fluctuations between quarters which is indicative of data quality issues such as data flow between GP systems, population mobility and lack of adequate call-recall procedures.

Figure 6



- Overall, the current rates in Sutton & Merton are similar to its neighbouring South West London boroughs and similarly are affected by quality of data flows. Data flows and information management has the biggest impact upon COVER rate. Production of COVER rates are the responsibility of the Child Health Information system (CHIS) provider and the rates reflect how good the information is on the CHIS. Accurate and complete data are dependent upon good flows of data

between GP systems and CHIS and ensuring that CHIS is regularly updated with movers in and transfers out (i.e. population mobility). Immunisation statistics depend on accurate assessment of the numerator (children immunised) and denominator (population of children requiring immunisation). The CHIS in Sutton & Merton previously used Informatica to facilitate data extraction from GP systems but this has been replaced by the Practice Focus data extract tool, giving standardised extraction across London. Work is on-going to gain acceptance from all users involved.

- The drop between age 1 and age 2 cohorts and the age 5 cohort indicates a need for better call-recall systems (i.e. calling parents/guardians for appointments and chasing those who do not attend). This is not unique to Sutton & Merton and is common across London boroughs. There is also some anecdotal evidence from practice managers that it is difficult to get parents to return after 12 months as there has been a considerable gap since the last vaccination and many parents feel that these 'boosters' are not important.

VACCINE PREVENTABLE DISEASES IN MERTON

- There have not been any major outbreaks of vaccine preventable diseases in Merton between 2010 and 2012. Most of the infections have been single sporadic cases.

- There were 10 cases of confirmed measles in Merton between 2010 and 2012, ranking fifth of the six Local Authorities (LAs) in the South West London (SWL) sector[1]. The highest number of confirmed cases in this period was during 2010 when there were five[1]. The rate of confirmed measles per 100,000 population in 2012 was 1.0 (n=<5), ranking fourth of the six LAs in SWL[1]. Provisional data indicates that there were <5 cases of confirmed measles in Merton during 2013[1].

- South West London is not a measles 'hot-spot'. Over the past 10 years, Lambeth, Southwark & Lewisham, East London and City of London have consistently had clusters. These were contained outbreaks in their gypsy/traveller communities or in their Orthodox Jewish communities. In 2012, South London's rate was 0.91 per 100,000 person years, lower than North West London's 1.21 and North East London's 2.77.

- There were 28 cases of confirmed mumps in Merton between 2010 and 2012, ranking lowest of the six LAs in SWL[1]. The highest number of confirmed cases in this period was during 2010 when there were 14[1]. The rate of confirmed mumps per 100,000 population in 2012 was 3.5 (n=7), ranking second of the six LAs in SWL[1]. Provisional data indicates that there were eight cases of confirmed mumps in Merton during 2013[1]. The rise in mumps has been ongoing in England and Wales for five years relating to lack of immunity in the teenage/young adolescent population who were given measles and rubella (MR) vaccine in 1994 when there was a threatened measles outbreak.

- There were six cases of acute hepatitis B in Merton between 2010 and 2012, ranking fourth of the six LAs in SWL[1]. In 2012 there were 0.5 cases of acute hepatitis B per 100,000 population in Merton, (n=<5) ranking fifth of the six LAs in SWL[1]. Provisional data indicates that there were <5 cases of acute hepatitis B in Merton during 2013[1].

- There were six cases of hepatitis A in Merton from 2010 to 2012, ranking third of the six LAs in SWL[1]. In 2012 there were 0.1 cases of hepatitis A per 100,000 population in Merton (n=<5) ranking fifth of the six LAs in SWL[1]. Provisional data indicates that there were <5 cases of hepatitis A in Merton during 2013[1]

- There were 17 cases of probable or confirmed meningococcal disease in Merton from 2010 to 2012, ranking second of the six LAs in SWL[1]. In 2012 there were seven cases, a rate of 3.5 cases per 100,000 population, ranking highest of the six LAs in SWL[3]. Provisional data indicates that there were <5 cases of probable or confirmed meningococcal disease in Merton during 2013[1]

- There were 50 cases of confirmed whooping cough in Merton between 2010 and 2012, ranking third of the six LAs in SWL[1]. In 2012 there were 22.3 cases of whooping cough per 100,000 population in Merton, (n=45) ranking third of the six LAs in SWL[1]. Provisional data indicates that there were 23 cases of confirmed whooping cough in Merton during 2013[1].

- The rankings are based on descending order, a ranking of first for rate or number of cases of disease indicates an undesirable higher burden of illness.

Data Source
[1]South West London Health Protection Team, Enhanced Surveillance (2014)

NHS ENGLAND'S IMMUNISATION PLAN FOR LONDON

- Across London there are 5 areas that need to be improved in order to achieve the World Health Organisation's recommended herd immunity level of 95%:
    - Active information management
    - Active performance management
    - Active patient management
    - Competency of staff in delivering vaccinations (training)
    - Public education and acceptability

  These issues are relevant to Sutton & Merton and resolving them will consist of regional and local efforts.

- For 2013/14, NHSE's central team are working to:
    - Introduce an immunisation strategy for London on attaining 95% herd immunity for routine childhood immunisations including trajectories and interventions to improve borough level outcomes
    - Develop and implement an immunisation action plan for London 2013 – 2015 – this focuses on improving data management, targeting specific communities (i.e. known groups of poor uptake) and widening access to immunisation services by commissioning a range of alternative providers to complement existing GP practice and community health service delivered immunisations
    - Produce and implement action plans for the new regimes e.g. rotavirus, child 'flu for 2-3 year olds and pilots of child flu programmes in primary schools
    - Develop a London-wide model for the delivery of school age immunisations for 2014 onwards
    - Develop London-wide models for BCG & Hepatitis B vaccination in infants and 'at risk' children for 2014 onwards
    - Commission integrated health information strategy for Public Health (e.g. improving Child Health Information Systems across London, introduction of minimum child health dataset on 1st September 2013, data linkage systems between GP practices and CHIS)

- Develop more detailed immunisation reports that show variation in immunisation uptake by GP practice and illustrate geographical differences and other inequalities in uptake of immunisations. This collection commenced in September 2013 and it will be at least six months before the data will be meaningful to depict trends and patterns across practices.

- Improving uptake of childhood immunisations is driven through the following mechanisms:

  London Immunisation Programme Board

  - Responsible for the strategic direction for all immunisations in London including development of immunisation strategies
  - The board is accountable to the Director of Operations and Delivery at NHS England (London) and to the National Public Health Oversight Group
  - The board provides quarterly reports to the London's Health Board, directors of public health and Health and Well-Being Boards

  London Immunisation Business Meeting (Sub-group of the Immunisations Programme Board)

  - Consists of PHE and NHSE central and patch teams
  - Leads the operational component of the Immunisation Programme Board - i.e. put strategies into action and work to improve coverage of immunisations across London

  Patch Quality and Performance Groups

  - Each patch (i.e. North West London, North East London and South London) will have a Quality and Performance Group
  - Each group is responsible for quality assuring and monitoring of performance of immunisations in the respective patches
  - Each group will derive and drive the patch's annual immunisation action plans from the London Immunisation Programme Board's strategies
  - Membership consists of representatives from directors of public health and CCGs, patch commissioners and are chaired by NHS England's population health leads
  - To date the North West London group is in operation and the other groups will be in place by end of March 2014

NHS ENGLAND'S ACTION PLAN FOR SUTTON & MERTON 2013/14

Outcome	Objective	Actions	Impact	Due Date	Risks to delivery	Mitigation
To stabilise immunisation reported rates in Sutton & Merton and increase reported rates through improvements in information management systems	To improve the recording of immunisation data in order to have as accurate a reflection as possible for COVER submissions	• Update and implement a standard data collection template in GP practices to reduce the risk of data entry errors.	More accurate data recording of vaccinations given in GP systems leading to increased vaccination rates	1st April 2014	Lack of GP engagement, poor implementation	Raise practice awareness of need for accurate data entry
		• Confirm Rio to Rio is switched on • Process map the flow of information for children who transfer in and out of the Borough in terms of keeping Rio records up to date • Process map data flow between practices, internal and external	Increased vaccination rates	1st April 2014 1st June 2014 1st June 2014	Poor practice understanding Capacity issues	NHSE CHIS events which offers CHIS to CHIS support and sharing of best practice
		• Develop clear actions to improve call-recall management in GP practices	Increased numbers of children vaccinated	1st May 2014	GP practices fail to commit to actions for improvement	Highlight the outcomes of engagement with improved recall process
		• Visit three high performing practices and three low performing practices to identify best practice and areas for improvement. • Disseminate learning to	Improvements of call and recall in practices.	1st June 2014	Practices will not use the guidance.	NHS England to liaise with CCG and promote through CCG networks.

		Sutton & Merton practices				
	Strengthening of governance arrangements between NHSE, providers and CCG	• Commencement of South London Quality and Performance Group	Higher quality and performance of the immunisation programme	1st April 2014	Refusal by providers and CCGs to attend	NHSE Immunisation Team communication and engagement with providers and CCGs

CONCLUSIONS

- Sutton & Merton's COVER rates have consistently been below the World Health Organisation (WHO) recommended herd immunity level of 95%.

- NHS England is responsible for the commissioning of all national immunisation programmes and has set about improving COVER rates in London through its governance framework of the London Immunisation Programme Board and patch level quality and performance groups. This includes partnership work with CCGs to improve quality of GP performance and local authorities to promote uptake in boroughs. Work by the groups will be guided by NHS England's 5 year strategy and 2 year action plan for immunisations and vaccinations in London.

- Given the low numbers of cases of communicable diseases amongst children in Sutton & Merton and the fluctuation of rates between quarters, Sutton & Merton's rates are affected by issues in information management such as data linkage between CHIS and GP systems. In addition, the drop between age 2 and age 5 rates illustrate that the rates are further affected by population mobility and lack of proactive reminding of parents/guardians to complete the immunisation schedule. These issues are not unique to Sutton & Merton and can be addressed through the new commissioning arrangements between NHS England and its providers – GPs and CHIS. This system of commissioning immunisations and vaccinations offers new opportunities to improve immunisation rates across London including the borough of Sutton & Merton.

Authors

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Scrutiny Report on the Diabetic Eye Screening Programme (DESP) in Merton

PURPOSE OF THE REPORT

The aim of this paper is to provide the Overview and Scrutiny Committee with information on:

- Roles and responsibilities of organisations in managing the Diabetic Eye Screening Programme across London since April 1st 2013
- What is the Diabetic Eye Screening Programme
- The local picture of the NHS Diabetic Eye Screening Programme in Merton
- NHS England's plans to improve the NHS Diabetic Eye Screening Programme across London (including Merton).

INTRODUCTION

- Since April 1st 2013, a number of public health functions are the responsibility of NHS England (NHSE) under Section 7a of the Health & Social Care Act 2012. These comprise of screening, immunisations, Health in the Justice System (i.e. prisons, Sexual Assault Centres, places of detention) and military health.

- In London, the NHS England (London) Public Health team is responsible for commissioning screening programmes. This team comprises of a central team who work closely with screening commissioners situated within the three patch teams: North East London, North West London and South London.

- The central team consists of the Head Screening, Dr Kathie Binysh supported by two Public Health England embedded staff – Dr Bonny Rodrigues (lead for the Adult Screening programmes) and Dr. Josephine Ruwende (lead for the cancer screening programmes). The commissioning manager for London Adult Screening programmes is Ms Sarojini Ariyanayagam. These personnel provide accountability and leadership for the commissioning of the programmes and system leadership. The team also have responsibility for the quality assurance and oversight of serious incident and incident investigations involving screening. Diabetic Eye Screening for Merton patients is provided as part of the Sutton and Merton Diabetic Eye Screening Programme which falls under South London patch area, headed by Mr Johan Van Wijgerden and his team of screening and immunisation commissioners.

- The new emphasis on commissioning the adult screening programmes provides new opportunities to improve those programmes which were not previously available in the old world of public health screening co-ordinators in Primary Care Trusts. NHSE plans to utilise these opportunities will be discussed below. The paper will also outline the roles and responsibilities of different organisations in improving the Diabetic Eye Screening Programme (DESP). It can be seen that improving the DESP incorporates partnership work across a number of different bodies.

WHAT IS THE DIABETIC EYE SCREENING PROGRAMME

- The Diabetic Eye Screening Programme is a systematic national population-based screening programme that aims to reduce the risk of sight loss among people with diabetes through the early detection and appropriate treatment of diabetic retinopathy.

- Diabetic retinopathy is caused when diabetes affects the small blood vessels in the retina, the part of the eye that acts rather like a film in a camera.

- The screening care pathway begins with referral from the patient's GP to the screening service upon diagnosis with diabetes. Annual screening is offered to all eligible patients using digital retinal photography, with any patient requiring treatment being referred from the screening service to secondary care

- Diabetic retinopathy progresses with time but may not cause symptoms until it is quite advanced and affects a person's sight.

- Diabetic retinopathy is the most common cause of sight loss in people of working age.

- It is estimated that in England every year 4,200 people are at risk of blindness caused by diabetic retinopathy and there are 1,280 new cases of blindness caused by diabetic retinopathy.

- Screening is an effective way of detecting diabetic retinopathy as early as possible

- All eligible people aged 12 and over with diabetes (type 1 and 2) are offered annual screening appointments

- Laser treatment is the most common treatment for diabetic retinopathy and is most effective when the condition is detected early

- Laser treatment can reduce the risk of severe visual loss by 50% or more within a two-year period

ROLES AND RESPONSIBILITIES OF ORGANISATIONS IN THE DIABETIC EYE SCREENING PROGRAMME ACROSS MERTON SINCE APRIL 1ST 2013

NHS England (NHSE)

- Commissioning screening services from primary care, community providers and other providers which are specified to national standards
- Monitoring providers' performance and supporting providers in delivering improvements in quality and changes in the programme when required
- Accountable for ensuring those local providers of services will deliver against the national service specifications and meet agreed population uptake and coverage levels as specified in Public Health Outcome Indicators and KPIs
- Work with Department of Health and Public Health England in national planning and implementation of screening programmes and in quality assurance

Public Health England (PHE)

- Provides access to national expertise on screening
- Professional support to the PHE staff embedded in the NHSE Area Teams including access to continuing professional appraisal and revalidation system
- Provide information to support the monitoring of screening programmes
- Publishes screening programmes key performance indicators
- Host the Quality Assurance (QA) team for the London Region
- Hosts the National Diabetic Eye Screening Programme Office

Clinical Commissioning Groups (CCGs)

- Commissioning the treatment part of the screening pathway

Local Authorities

- Provide information and advice to relevant bodies within its areas to protect the population's health
- Provide local intelligence information on population health requirements e.g. JSNA
- Independent scrutiny and challenge of the arrangements of NHSE, PHE and providers.

Commissioning Support Units (CSUs)

- Although not statutory, CSUs have a role to play in supporting CCG member practices in enabling them to carry out their screening work, e.g. IT support to help with transfer of information

General Practitioners (GPs)

- Responsible for referring patients to the screening service and for the diabetic care of their registered patients with diabetes.

Community Service Providers

- Provide screening from community based locations including the programme administration and management

Secondary Care Providers

- Provide the ophthalmology service associated with the screening programme offering assessment and treatment to patients referred from screening

THE LOCAL PICTURE OF THE DIABETIC EYE SCREENING PROGRAMME IN MERTON

- The Sutton and Merton DESP was established in 2004 and is part of the National DESP serving patients with diabetes registered to a GP in the London boroughs of Sutton and Merton.

- The service is provided by Sutton and Merton Community Services (delivered by The Royal Marsden NHS Foundation Trust) from four community based locations; two in Merton, two in Sutton. Screening in Merton is offered from Morden Road Clinic, Morden and Birches Close Polyclinic, Mitcham although patients may opt to receive screening at any of the programme locations according to personal preference. Screening venues are co-located with other community diabetes services offering patients the opportunity to receive their diabetes care in one location.

- Patients requiring further examination or treatment for diabetic retinopathy are referred to the ophthalmology service of Epsom and St. Helier NHS Trust which offers assessment at two locations; Morden Road Clinic and Sutton Hospital. Laser treatment is offered at Sutton Hospital with plans for this to be relocated to St. Helier Hospital in the near future. Merton patients may also choose to be referred to another ophthalmology service, for example St. George's Hospital, via their GP.

- The programme is lead by a consultant ophthalmologist clinical lead and dedicated programme manager supported by a twelve strong team. A multidisciplinary programme board chaired by NHS England oversees operation of the programme and compliance against national quality standards. The programme board comprises representation from CCG's, NHS England, provider Trusts, Diabetes UK, service users and the National DESP.

- The programme was suspended in July 2009 until May 2010 following an External Quality Assurance (EQA) from the National DESP. During this period the then Primary Care Trust (PCT) and Epsom and St. Helier NHS Trust worked closely with the National DESP to redesign the screening service and associated ophthalmology provision in line with best practice guidance and national standards.

- Since this time the redesigned programme has received both local and national recognition and continues to work in partnership with NHS England and other stakeholders to continually improve outcomes. Recent work has focused on reducing health inequalities within the population, particularly those that have never received screening. In addition, the programme is currently pioneering a number of initiatives such as using experienced based design to collect patient feedback and providing patients with the option to receive all their correspondence in an electronic format.

NHS ENGLAND KEY PERFORMANCE INDICATORS (KPI'S) FOR THE SUTTON AND MERTON DIABETIC EYE SCREENING PROGRAMME

NHS England receives quarterly data returns from each local DESP with the aim of capturing quality and performance across the patient pathway against national standards provided by the National DESP. Given below is the most recent data available from the Sutton and Merton DESP for the quarter ending December 2013. The originating provider is shown next to each objective. Data is provided for Merton patients only, with London regional comparators where available from the National Screening Committee.

A recognised challenge when evaluating data from local DESP's is the current variation in local programme delivery and software in use across the country which can have a significant effect on the ability to draw conclusions. This is currently being addressed through the new national common screening pathway and other measures as described later in this paper.

Objective 1: Primary Care (GP Practices within Merton)

Objective 1	Criteria	Standard	Merton
Maximise Coverage	The proportion of GP Practices returning full patient lists to the screening programme each quarter	100%	96.20%

Objective 2: Sutton and Merton DESP (The Royal Marsden NHS Foundation Trust)

Objective 2	Criteria	Standard	Merton
Maximise Invitation	The proportion of patients invited for screening in the previous 12 months	=>100%	104.40%

Commentary: Objective 1 and 2 combine to give an indication of the screening programme coverage and aim to ensure all patients with diabetes are referred to the screening programme and invited for screening. All eligible patients known to the screening programme were invited for screening in the preceding 12 months. The programme patient register requires regular electronic uploads from each GP practice to comply with national guidance on maintaining database accuracy. One practice within Merton has declined this method of data transfer (preferring to make ad hoc manual referrals). NHS England is currently liaising with this practice to understand any concerns with a view to finding a mutually agreeable method of data transfer that meets national guidance.

Note: *It is possible for objective 2 to exceed 100% due to the way this metric is measured (a patient maybe invited during the previous 12 months but then go on to be ineligible therefore including them in the number of patients invited but removing them from the final number of eligible patients).*

Objective 3: Sutton and Merton DESP (The Royal Marsden NHS Foundation Trust)

Objective 3	Criteria	Standard	Merton
Maximise Uptake	The proportion of invited patients attending for screening in the previous 12 months	Minimum=>70% Achievable=>80%	84.40%

Objective 4: Sutton and Merton DESP (The Royal Marsden NHS Foundation Trust)

Objective 4	Criteria	Standard	Merton
Minimise Exclusion	The proportion of patients excluded from screening on the last day of the quarter	=<15%	13.30%

Commentary: Uptake of screening in Merton compares favourably with the most recent published London average of 78.8% (Q1 2013/14)[1]. Patients unsuitable for screening maybe excluded in line with guidance from the National DESP. Levels of exclusion are monitored by NHS England and subject to annual audit presented to the programme board.

Objective 5: Sutton and Merton DESP (The Royal Marsden NHS Foundation Trust)

Objective 5	Criteria	Standard	Merton
Quality of Screening	The proportion of ungradable images during the quarter	Minimum<7% Achievable=>2.5%<7%	2.30% (quarter) 3.3%(12 months)

Commentary: Objective 5 gives the proportion of images captured during screening that were later deemed to be of insufficient quality to permit assessment to national standards. The National DESP has recently recommended any quarterly figure should be considered alongside a rolling 12 month measure to reduce the effect of quarter on quarter fluctuations. This measure may also affected by the local pathway in use.

Objective 6: Sutton and Merton DESP (The Royal Marsden NHS Foundation Trust)

Objective 6	Criteria	Target	Merton
Timely Results	The proportion of results issued within 3 weeks	Minimum=>70% Achievable=>95%	98.40%

Objective 7: Sutton and Merton DESP (The Royal Marsden NHS Foundation Trust)

Objective 7	Criteria	Target	Merton
Timely Referral	The proportion of urgent patients referred within 2 weeks	Minimum=>95% Achievable=>98%	100.00%

Commentary: The screening service employs a dedicated fast track pathway within its software to ensure patients at a higher risk of sight loss are prioritised and referred urgently. The most recent available comparative data for objective 6 (Q1, 2013/14)[1] shows a London average of 97.2%.

Objective 8: Epsom and St. Helier NHS Trust

Objective 8	Criteria	Target	Merton
Timely Consultation	The proportion of urgent patients seen within 4 weeks of referral	Minimum=>80%	97.50%

Objective 9: Epsom and St. Helier NHS Trust

Objective 9	Criteria	Target	Merton
Timely Treatment	The proportion of urgent patients receiving treatment within 6 weeks of referral	Minimum>70% Achievable>95%	88.90%

Commentary: Objectives 8 and 9 relate to the time taken to assess and treat patients referred urgently to ophthalmology for active disease. These patients are at a higher risk of sight loss and have a dedicated fast track pathway within ophthalmology. The indicators above should be viewed with the knowledge that there is no allowance made for patients who do not receive assessment or treatment for reasons beyond the control of the NHS (e.g. patients who cancel their appointments due to other illness or patients who move out of the area / country). The DESP programme board receives a detailed quarterly report from the programme manager providing further information on why patients did not receive assessment or treatment. The most recent available comparative data for objective 8 (Q1, 2013/14)[1] shows a London average of 76.4%.

CURRENT CHALLENGES

Data quality in the DESP

Diabetic eye screening programmes are heavily reliant on software information systems, perhaps more so than any other screening programme. There are number of nationally recognised data quality issues affecting diabetic eye screening programmes which have arisen due to the variety of different software packages and local delivery models currently in use. This makes measurement

against some standards and comparison between local programmes problematic. Many of these issues are addressed in the new national common screening pathway due to be rolled out to Merton in April 2014.

Capacity within secondary care

The current screening care pathway results in many patients not requiring treatment being referred to ophthalmology services when this may not be required to monitor these patients safely. The resultant demand on ophthalmology services currently exceeds capacity. Although not captured in the above indicators for urgent patients, ophthalmology waiting times for routine patients are presently exceeding clinically recommended intervals and have recently been escalated to NHS England to be managed under the incident framework. The programme board recently endorsed a proposal where patients who do not require treatment could be monitored within the community screening service in line with national guidance. This has the potential to relieve capacity demands on the ophthalmology service and reduce waiting times. Implementation of the proposed pathway is outside of NHS England or provider control but has been presented to Merton CCG for consideration.

Screening during pregnancy

Diabetic retinopathy may progress more quickly during pregnancy. National guidance recommends screening should be offered to patients within the first three months of the pregnancy and more frequently thereafter until the patient gives birth. In common with other London areas, the Sutton and Merton DESP has noted difficulty meeting this requirement as the screening programme is often not notified of the pregnancy in time. Patients may choose to receive ante natal care outside of the area and may not notify their GP of the pregnancy resulting in a complex referral pathway particularly if the patient chooses to receive care outside London. NHS England is currently working with the DESP and providers of ante natal care to establish robust systems promptly notify the screening service of any pregnancy. The local service is shortly about to undertake a mailing campaign to raise awareness in women of child baring age of the need to receive screening more frequently during pregnancy.

NHS ENGLAND'S DIABETIC EYE SCREENING PROGRAMME PLAN FOR LONDON

- For 2013/14, NHSE's central team are working to:
  - Introduce an Diabetic Eye Screening Programme five year strategy for London including interventions to improve borough level outcomes
  - Develop and implement an Diabetic Eye Screening Programme action plan for London 2013 – 2015 with a focus on:
    - Rolling out the new national common screening pathway which addresses many of the variations in local delivery and associated difficulties in comparing performance between local programmes that currently exist
    - Improving data quality and management
    - Targeting specific communities with known health inequalities to improve access to DESP services

- Implementing a common approach across south London for the referral of patients to diabetic eye screening employing a robust electronic method of data transfer from primary care to improve coverage and reduce data transcription errors

- Improvement of Diabetic Eye Screening Programmes is driven through the following mechanisms:

London Screening Programme Board

- Responsible for the strategic direction for all screening programmes in London including Diabetic Eye Screening Programme strategies
- The board is accountable to the Director of Operations and Delivery at NHS England (London) and to the National Public Health Oversight Group
- The board provides quarterly reports to the London's Health Board, directors of public health and Health and Well-Being Boards

London Adult Screening Meeting (Sub-group of the London Screening Programme Board)

- Consists of PHE and NHSE central and patch teams
- Leads the operational component of the Adult Screening Programme Board - i.e. put strategies into action and work to improve the Diabetic Eye Screening Programmes across London

Programme Specific Diabetic Eye Screening Boards

- Each patch (i.e. North West London, North East London and South London) will have a number of programme specific DESP Boards
- Each group is responsible for quality assuring and monitoring of performance of the DESP programmes in the respective patches
- Each group will derive and drive the patch's annual screening action plans from the London Screening Programme Board's strategies
- Membership consists of representatives from directors of public health and CCGs, patch commissioners and are chaired by NHS England's population health leads

CONCLUSIONS

- NHS England is now responsible for the commissioning of all national screening programmes and has set about improving Diabetic Eye Screening Programmes in London through its governance framework of the London Screening Programme Board and patch level programme boards. This includes partnership work with CCGs to improve quality and local authorities to promote diabetes health in boroughs. Work by the groups will be guided by NHS England's five year strategy and two year action plan for screening programmes in London.

- Following the programme redesign in 2009/10, Merton is now served by a well-developed and administered Diabetic Eye Screening Programme which is highly regarded as one of the leading programmes for adherence to national quality standards. This position of strength should be commended and seen as a solid foundation for future development.

- The national common diabetic eye screening pathway due to be implemented in Merton by the end of April 2014 provides a number of opportunities to improve data collection and standardise care delivery across London

Authors
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Mr Alain du Chemin, Programme Manager, Diabetic Eye Screening Programme, Sutton and Merton Community Services

References:

1. 2013/14 Quarter 1 Diabetic Eye Screening KPI's available from http://www.screening.nhs.uk/kpi/reports/2013-14/q1 Accessed March 2014

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Committee: Healthier Communities and Older People Overview and Scrutiny Committee

Date: 17 March 2014

Agenda item:

Wards: ALL

Subject: Public Health in its first year following transition.

Lead officer: Kay Eilbert, Director of Public Health

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

Forward Plan reference number:

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

Recommendations:

A. That members of Healthier Communities and Older People Overview and Scrutiny Committee note the progress made in public health during the first year of transition to the local authority.

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report provides an overview of the first ten months of Public Health following transition into the London Borough of Merton

2. DETAILS

2.1 Introduction

2.1.1 Public health is about what we do as a society to create opportunities for people to be healthy. The factors that influence health start early in life and range from early child development, school achievement, work readiness and good work through to a thriving retirement. Health care services are a key factor but only come into play once a health problem occurs, often resulting from unhealthy habits that lead to long term conditions and disabilities. The return of Public Health to local government provides opportunities to address these influences through the work of the Council.

2.1.2 Since the transition of Public Health in April 2013, the Public Health team has been forging new partnerships, seeking opportunities to address the significant health inequalities in Merton and to embed prevention in everyone's work in the Council and beyond.

2.1.3 Public Health was established as a new team specific to Merton, having previously been a shared service with Sutton. Merton Council inherited a relatively small team and budget which has worked in ways to make public health robust, while realising that we have to work differently and more effectively within limited resources.

2.1.4 The initial focus of our work has been two fold: ensuring contracts that we inherited are robust and on identifying new opportunities in the Council, and with partners, to embed public health.

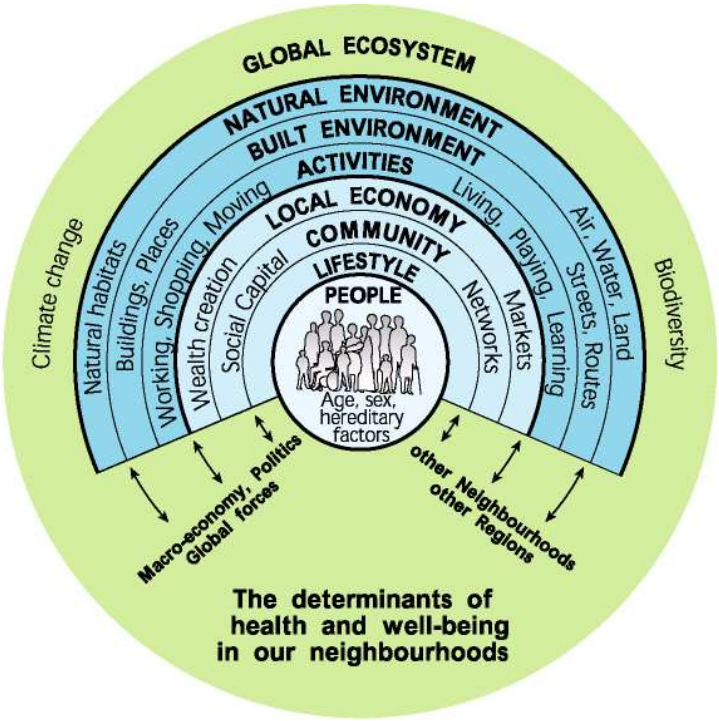
Work has taken place on the mandatory services (NHS health checks, national school measurement programme, sexual health services, expertise and support to Merton Clinical Commissioning Group and assurance of health-related emergency planning), along with universal services such as Stop Smoking and assurance for childhood immunisations and screening services. All contracted services are being reviewed to ensure that they are effective and meet the needs of our residents.

2.2 The Public Health Approach

2.2.1 Our vision for people's health in Merton over the next five years is to stem the increase in the significant inequalities in health outcomes between the East and West of Merton, providing more equal opportunities for all residents of Merton to be healthy.

2.2.2 Following this the Public Health team works to make health everyone's business. We work with partners, in the Council, Merton Clinical Commissioning Group and the voluntary sector, to build each of our contributions to reducing health inequalities.

2.3 What is health?



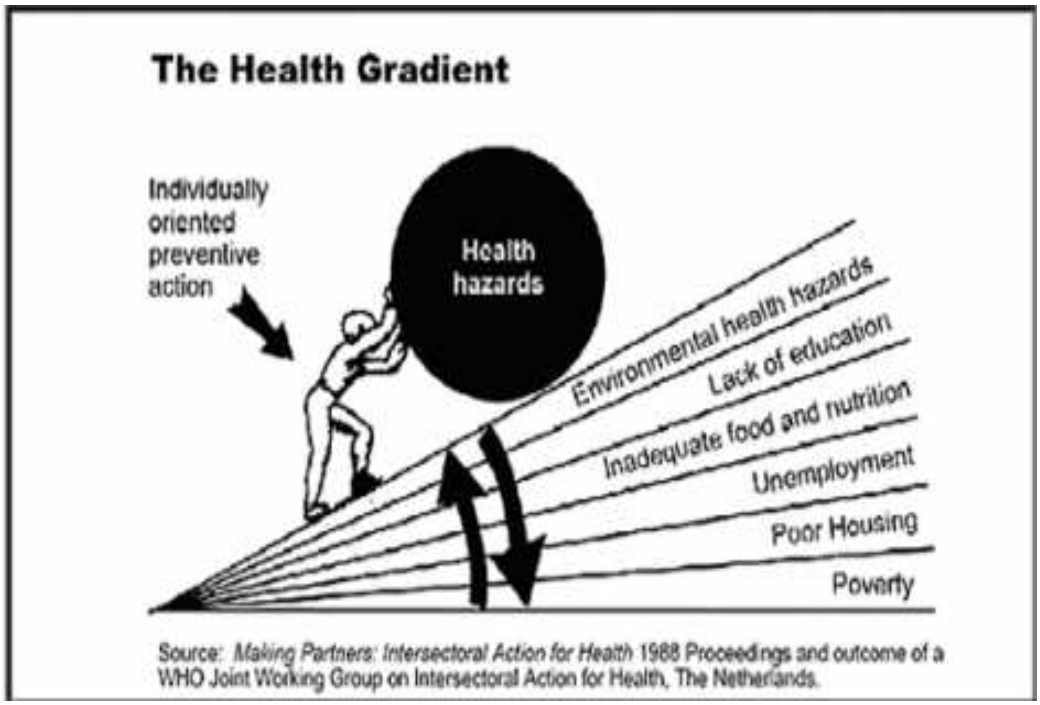
2.3.1 The above figure shows that health is about putting in place the conditions in which people can be healthy. People's health and wellbeing is strongly influenced by the conditions in which they live and work. Health inequalities are created by inequalities in wider society, for example in unequal opportunities for a good education and a good job.

2.3.2 Lying at the heart of shorter life expectancy are poverty and low education levels, the largest influences on health. In fact, health care and social care services and our biology only account for about 20-30% of our health and wellbeing. While these services are important to help those who become ill or disabled to re-establish their independence as far as possible, the rest is mainly determined by the social and physical environments in which we live. This includes our ability to take responsibility for our lifestyle choices.

2.3.3 The 2010 Marmot review of health inequalities recommended working across the life course - prioritising the early years, through working age to a thriving retirement. We have adopted this approach, focusing on reducing the significant health inequalities that exist within Merton and the social determinants which influence this**.**

2.3.4 The move of Public Health to the local authority has provided an opportunity to expand the traditional focus on health care and lifestyles to a broader approach to prevention.

The figure below shows that we must combine efforts to provide information and services to enable individuals to take responsibility for their own lifestyle choices but they can only make healthy choices if these options are available. The Council has numerous levers to improve availability of healthy options, through for example planning and licensing.



2.4 Public Health Work in the first ten months

Mandatory Work

2.4.1 Local authority responsibilities for public health leadership, commissioning and delivery include specific mandatory functions and services which must be delivered:

- Production of the Joint Strategic Needs Assessment (JSNA), jointly with the Clinical Commissioning Group. Merton Joint Strategic Needs Assessment (JSNA) sets out the health and social care needs of our residents. In partnership with colleagues and in consultation with the voluntary sector Merton JSNA has been refreshed for 2014 involving significant consultation with partners.

  The JSNA confirms that there are significant differences in health and wellbeing across Merton and that people in the west of borough live longer than those in the east. This inequality is seen across all areas relating to 'a good life' in Merton

- Leadership of the Health and Wellbeing Board and production of the Joint Health and Wellbeing Strategy. Public Health has led on reporting progress on the Strategy and will lead on the refresh following its first year.

- Responsibility for assuring health protection functions, including the planning and response to emergencies that involve a risk to public health and delivery of robust clinical prevention services such as childhood immunisation and screening programmes.

- The Director of Public Health must produce an annual report on the health of the people in the area of the local authority, which will be published later this year.

- Commissioning of local mandatory services, including:
  - Access to sexual health services
  - The National Child Measurement Programme
  - NHS Health Check assessment

  (See Appendix 1 for list of services inherited)

2.4.2 Public Health is also required to provide public health advice to Merton Clinical Commissioning Group (MCCG), and we are expected to ensure that we have the appropriate resources in place to deliver this. The Director of Public Health also contributes to the governance and decision making of the CCG. Merton CCG has developed a governance structure that includes the Director of Public Health as a full member of the governing body.

2.5 Further Public Health Work

2.5.1 In addition to the mandatory work that public health must deliver, a wider programme of initiatives has been developed in the first 10 months, largely in

partnership with Council colleagues and other organisations, to address health inequalities and deliver prevention. These include:

- Children and families
- Adults
- Prevention

This programme of work which is progressing reflects the desire to work on the determinants of health and across the life course. Some examples are set out below and further details are included in the appendices to this report. See appendix 2.

2.5.2 Children and Families

- Children's Centres Review

  In partnership with Children, Schools and Families we intend to prioritise the early years to ensure that children have 'the best start in life' and are prepared to enter school. A review has been completed to determine gaps in provision in children's centre services, especially around early parenting and join up services across the early years. Actions are currently being put in place which respond to the findings of the review.

- Healthy Schools

  Public Health is working with secondary and primary head teachers in the more deprived east of the borough to identify priority areas to build on existing successful efforts such as family weight management, prevention of smoking, drugs and excessive alcohol, and early detection of difficulties in child wellbeing.

- Young People drugs and alcohol service

  Has been reviewed and will result in a service based on best practice and opportunities for improved long term efficiencies by linking to other appropriate services, such as sexual health.

2.5.3 Adults

- Improved planning

  Public health is supporting a review of adult mental health services and development of a joint strategy and action plan with Merton Clinical Commissioning Group using a needs assessment and evidence of best practice.

- English as a Second Language (ESOL)

  To improve wellbeing and community cohesion by reducing isolation resulting from being unable to communicate with the general population we are investing in a series of ESOL materials and classes that use practical health information to increased health awareness of selected topics.

- LiveWell

Our service to provide behaviour modification support is being broadened to provide an outreach service working through community groups and organisations. The outreach work will encourage residents, mainly in deprived areas to take up prevention opportunities, such as NHS Health Checks and to work with an 'adult health book' to set health improvement objectives.

- Tier 2/3 Weight Management service

  Under development - weight management an exercise as per NICE guidance in collaboration with Merton Clinical Commissioning Group.

- Healthy Workplace

  We are working with the Council as the largest employer in the borough to encourage participation in a London Workplace Charter scheme, which brings together existing health promotion activities and best practice HR policies for the Council to work toward becoming an exemplar healthy employer.

- Drugs and Alcohol

  An agreement has been reached to transfer the Drug and Alcohol resource in the Council to Public Health (staff move from 1.4.14). The contract to deliver this service was also recently reviewed and will be extended to include prevention, lacking from the current approach, which focuses on treatment.

2.5.4 Influences on Health and Healthy Behaviours

- East Merton Model of Care

  Starting with a health needs assessment of East Merton, we are working in partnership with Merton Clinical Commissioning Group to deliver a new model of care including a community health centre.

- Health Impact Assessment

  A pilot to review developing policies and other work in terms of their influence on health with a view to mitigate any negative influences. Examples include the workforce strategy and Social Value procurement work.

- Joint work on prevention with Environment and Regeneration

  Ongoing discussions with Environment and Regeneration (e.g. planning and licensing) to use Council levers to influence the built environment, to increase provision of healthy options, starting with the issue of alcohol.

- Action on Smoking

  Litter enforcement officers dedicate a few days a year to offer smokers who litter cigarette butts an option for referral into smoking cessation service, instead of being fined.

2.5.5 Voluntary Sector

- Partnership with Fire Brigade

  London Fire Brigade has embedded smoking cessation in its work to install fire alarms. Reciprocal work with smoking cessation, to refer smokers to the fire service for installation of fire alarms. This work is being expanded to include alcohol, another major cause of fires.

- Partnership with the voluntary sector

  Public Health has partnered with MVSC to develop the outreach service for LiveWell, working through community groups representative of more deprived residents and to build capacity in those groups.

- Pollards Hill Community Audit

  A community audit will take place in Pollards Hill in partnership with local voluntary organisations as the start of an initiative to develop a community development initiative and increase engagement of residents in their local communities.

The 2013/14 public health work plan is at Appendix 3.

2.6 Challenges to Public Health

2.6.1 Though significant progress has taken place in the first 10 months, transition did not in fact end on 1 April 2013. There are still uncertainties in the overall public health system about where public health functions are delivered, about relevant budgets that were transferred and about data sharing. These risks affect our ability to develop definitive budgets.

As mentioned earlier the Council inherited a small Public Health team and budget. The Council argued successfully for a small increase in the allocation for public health to £8.9 million 2013/14, which will increase to £9.2 million 2014/15.

Our early work in Public Health pointed to some gaps in provision of services, highlighting limited capacity in the public health team. The team inherited from the split of the NHS Sutton and Merton joint team consists of the equivalent of seven WTE professionals and 1 PA compared to Croydon (40+), Kingston (30+), Richmond (20), Wandsworth (35+), and Sutton (8). Appendix 4 sets out the current structure.

2.6.3 It has now been agreed to create 4 new posts to strengthen public health intelligence and prevention. Two of the posts will be shared with Merton Clinical Commissioning Group. Structure charts showing these new posts is provided in Appendix 5.

This will bring the total to 12 professional staff and bring the total investment for staff to about 10% of the total £9m public health budget, up from about 6.7%. This increased capacity will provide additional public health expertise to support Council work and foresee the addition of health visiting from 2014, while remaining well below other public health directorates elsewhere.

2.7 Health and Wellbeing Peer Challenge

2.7.1 Though relatively early following transition, Merton took the opportunity to put itself forward as a pilot in the Health and Wellbeing Peer Challenge - the only London Borough to do so. The purpose of the Challenge was to support the Council in implementing its new statutory responsibilities through a systematic challenge by peers to improve local practice. The challenge particularly focussed on:

- The establishment of effective health and wellbeing boards
- The operation of the public health function
- The establishment of a local HealthWatch

2.7.3 The Peer Challenge concluded with a feedback session which included many positive and constructive comments.

- Clear strategy, enthusiasm and commitment to improving health and wellbeing of residents.
- Some good engagement to inform the health and wellbeing strategy and the priorities.
- Relationships between people who form part of the health, care and wellbeing system are strong.
- Early days with good progress from some difficult legacy issues.
- Widespread recognition of the energy and drive of the DPH and her team.
- Opportunity for the Health and Wellbeing Board to drive change across partnerships with focus and pace.
- Pursue further opportunities for joint commissioning and working to drive integration and prevention.
- Look beyond Merton to maximise resilience given likely changes in health and social care economy.
- Exemplar of excellence and maturity in working with the voluntary sector through MVSC
- Engaged and motivated staff.

2.7.4 The recommendations speak of a need for the Health and Wellbeing Board to maintain a focus on delivery with pace and highlights specific actions for consideration. It also states the need for public health to be fully embedded in Council service plans. A plan of action responding to the findings will form part of the evaluation of the Health and Wellbeing Strategy and its Delivery Plan and the Annual Public Health Report.

2.8 Merton Partnership Conference on Health Inequalities

2.8.1 Merton Partnership asked Public health to organise the annual conference focusing on health inequalities. The aim of MP Conference was ‘to commit to new ways of working that will help reduce health inequalities in Merton’.

2.8.3 Participants started with agreement on the main elements of a ‘good life,’ i.e.,

- Good health – preventing illness and accessing health care
- Early years and strong educational achievement
- Community participation and feeling safe
- Life skills training and good work
- A good natural and built environment

2.8.4 All participants were asked to give a written pledge to work in a new way to reduce health inequalities. A total of 74 written pledges were made, which fed into action planning and will contribute to the review of the Health and Wellbeing Strategy.

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.

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

The Panel will be consulted at the meeting

5 TIMETABLE

The Panel will consider important items as they arise as part of their work programme for 2013/14

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None relating to this covering report

7 LEGAL AND STATUTORY IMPLICATIONS

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

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

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

None relating to this covering report

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

Appendix 1 Public Health Budget with Proposals for Use of Uncommitted Funds

Appendix 2 2013/14 Public Health Work Plan

Appendix 3 Public Health Structure Charts

Public Health Budget 2013-14 **Appendix 1**
Existing Commitment & Proposals for Use of Uncommitted Funds

Existing Commitments	**Provider/ Partner**	**Allocated Budget £000**	**%**	**Status**
Sexual Health - Mandatory				
- GUM – acute sexual health services	Acute trusts Open access service	2,025	23%	To be reviewed in 2014/15
- Contraception	RMCS	582	6%	To be reviewed in 2014/15
- Sexual health advice, prevention and promotion	Chlamydia screening. – Terence Higgins Trust Pan-London HIV services	334	4%	One year extension - To be reviewed in 2014/15 London review on-going
NHS Health Checks – Mandatory	GPs plus exploring additional delivery options	226	3%	Looking for alternative providers as GPs not keen; developing spec
National Child Measurement Programme - Mandatory (part of universal school nursing service)	School Nursing RMCS	611	7%	Provided by school nurses, which is under review
Support to MCCG – up to 40% of staff capacity - Mandatory	Public Health team	Staff resource		Under development with MCCG
Assurance of health emergency preparedness - Mandatory	Director of Public Health	Staff resource		Developing understanding of Public Health role – working with borough resilience forum
Drugs and Alcohol	Safer Merton (LBM)	2,086	23%	Developing understanding of services
Smoking – universal service plus Live Well	Hounslow and Richmond	346	4%	Live Well – part of contract being

Existing Commitments	Provider/ Partner	Allocated Budget £000	%	Status
	Community Services			renegotiated to include outreach by health champions through community organisations
Obesity – diet and physical activity	RMCS	339	4%	Dietetics service under review – exclusively clinical service. Negotiating ph content of service
Falls prevention	RMCS	64	1%	Will be reviewed in 2014/15
Public Health Resources	RMCS	15		Will be reviewed in 2014/15
Community services Contract Estates		186	2%	Errors in invoicing being worked through to reflect budgetary amount
Surveillance and Control of Infectious Diseases		63	1%	Available for health protection ad hoc needs
Corporate Overheads		97	1%	LBM
Community Development and Health Course		7		
Public Health Salaries and non-pay		626	7%	
Total Existing Commitments		**£7,607**	85%	

New funding is allocated across the life course to support influences on health (mainly in LBM – Ageing Well, training frontline staff, healthy catering, ESOL), to work in settings (workplace and schools) and to fill gaps in provision such as weight management

Proposed New Investments	**Provider / Partner**	**Amount £000**	**%**	**Status**
Children's Centres	Early child development/ LBM	100		
Healthy Schools	Practical activities to promote healthy students/ Schools, LBM	100		
Young People Drugs and Alcohol	TBD/LBM	From D&A funding		Service being reviewed to include integration/efficiencies
Total Children's Services		**200**	**2%**	
English for Speakers of Other Languages	Language courses with health themes to increase integration and control over one's life/Adult Learning	50		
Community Outreach	LiveWell HRCS/MVSC to manage contracts with community groups	50		
Physical Activity	Most likely GLL	50		
Tier 2-3 weight management	Negotiating joint procurement with MCCG for Tier 3	165		NICE guidance says Tier 1 -4 should be available. Nothing in place for Tiers 3-4

Proposed New Investments	Provider / Partner	Amount £000	%	Status
Ageing Well	TBD	50		
Embedding Prevention and Early detection in primary care	Merton CCG	225		Plus 150 non recurrent from 13-14 underspend
Total Adults Services		**590**	**7%**	
Healthy Workplace	HR and PH	60		
Support to LBM use of Council levers	Directorates and PH			Staff resource – to use Council levers re alcohol, betting shops, fast food outlets
Healthy Catering	Environmental Health and PH	50		
Training for frontline staff across Merton	HR and PH	50		
Total Other Services		**160**	**2%**	
Public Health Staff to increase analytical and joint working capacity		278	3%	Total 10% with existing funds
Contingency Fund		150	1%	e.g., Sexual health open access; drugs for LESs
Total Proposed New Investments		**£1,378**	15%	
Total Existing Commitments		**£7,607**	85%	
TOTAL PUBLIC HEALTH		**£8,985**	100%	

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APPENDIX 3

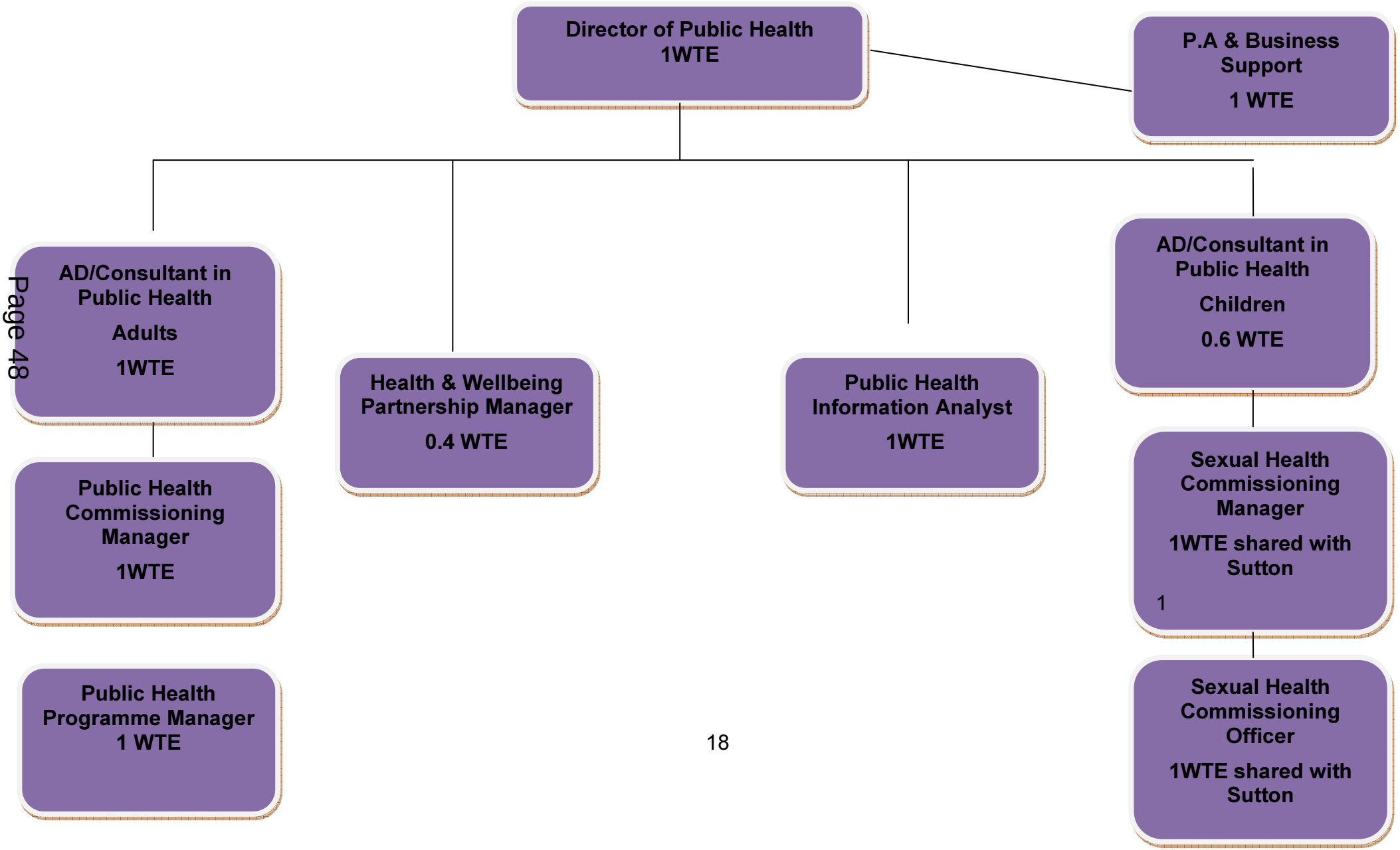
- Public Health Directorate Workplan 2013-14

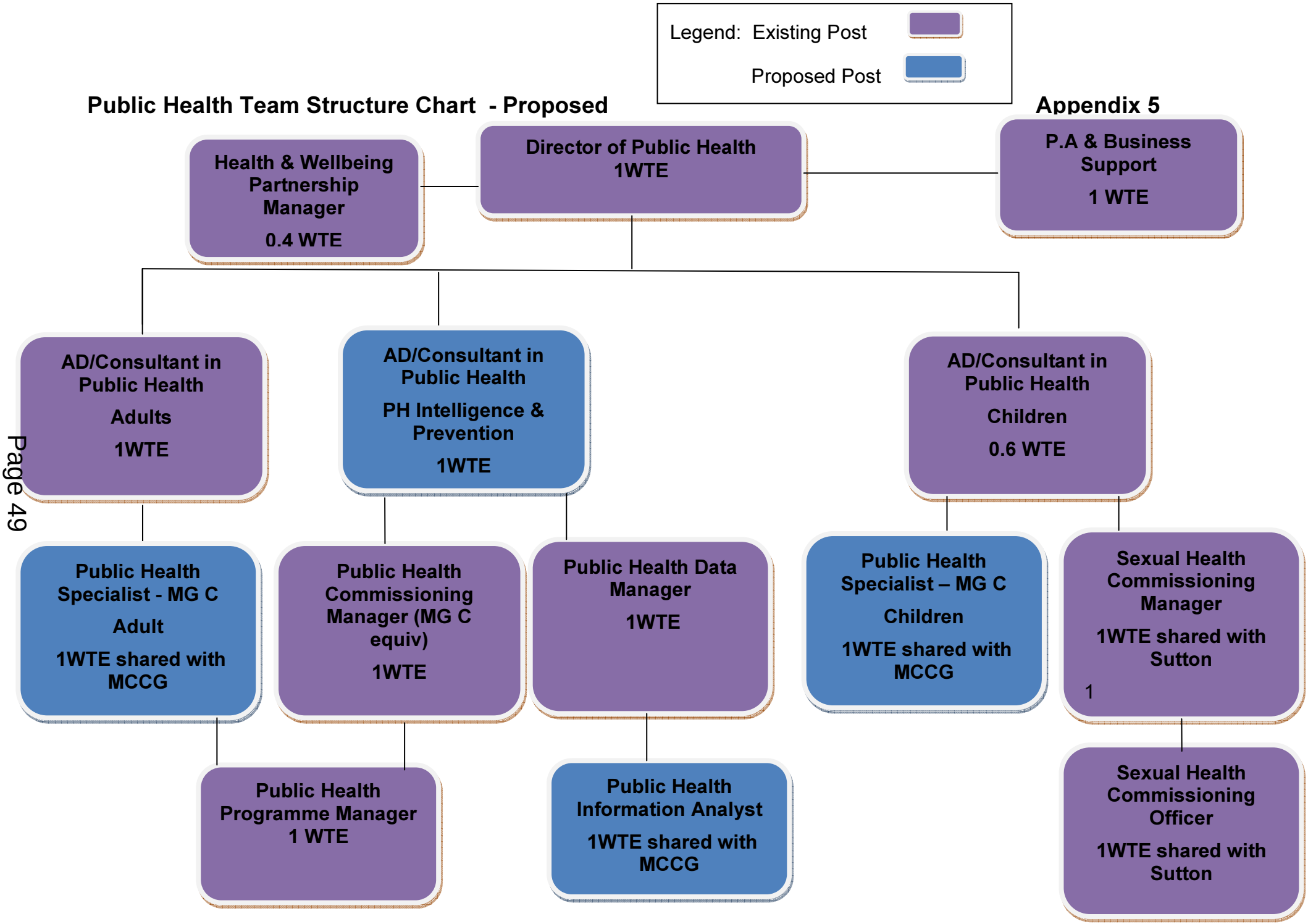
Area	Task	Evidence of Success	Responsibility	Comment
Ensure smooth transition of public health into LBM		Public Health embedded across LBM with ongoing, effective relationships	DPH/LBM	
Review public health team with a view to proposing fit-for-purpose structure within LBM		Options paper – CMT agreed option	DPH in consultation with team and Simon Williams	
Develop annual workplan for public health to deliver the mandated services as a minimum	• Staff in team propose and agree objectives • Discussions with CCG to agree PH inputs • Build objectives into annual workplan	Annual workplan agreed by CMT	DPH - Public health team	
Oversee directorate budget , ensuring expenditure stays within budget	• Finalise 2013/14 budget to reflect full cost of transferred services. • Work with CMT to agree 2014/15 budget for public health services	2013/14 budget agreed 2014/15 budget agreed	DPH - Public health team	
Ensure robust services are contracted for 2013-14 and 2014-15	• Ensure reviews of services inherited from the NHS take place • Develop plan to allocate remaining 2013/14 balance between short and medium-term services. • Using recommendations of reviews, put in place plan and procure services for 14/15 budget.	Reviews finalised with recommendations Pilot services in place 2013/14 2014/15 services procured in timely manner	PH staff for each review DPH with PH team PH team/LBM	

Area	Task	Evidence of Success	Responsibility	Comment
Ensure robust performance management in place for all contracts	• Agree KPIs for each service contract • Agree regular performance management arrangements for each contract • Participate in multi-borough contract monitoring	All contracts are performance managed with robust KPIs	PH staff responsible for each service	
Ensure monitoring data provided as required	• Agree public health monitoring data to be reported to various levels • Provide monitoring data • Make adjustments in delivery as indicated by data	Service delivery is adjusted to reflect monitoring results	PH Intelligence specialist PH team	
Provide leadership for public health across Merton partnerships	• Raise profile and understanding of public health in LBM and across partnership • Propose strategies to embed public health across LBM; e., health impact assessment • Develop strategies to make 'health everyone's business'	Partners understand their contribution to health HIA policy agreed Public health concerns embedded in contracts; e.g., leisure	DPH with PH team DPH with ph trainee DPH with PH team	
Produce annual public health report	Decide theme and prepare report	Annual Public Health Report available	DPH with PH Intelligence Specialist	
Provide Public Health leadership, advice, and support to deliver services	• Agree joint work and provide ongoing support to across LBM directorates • Undertake 3-4 in-depth needs assessment and/or strategy development e.g, mental health and alcohol in partnership with key stakeholders	workplans agreed with each directorate JSNA uses in-depth analysis to set out health needs Evidence-based strategies	DPH Julia Groom – children Anjan Ghosh - adults	

Area	Task	Evidence of Success	Responsibility	Comment
Develop good working relationships with key stakeholders in the Clinical Commissioning Group and voluntary sector	• Agree Memorandum of Understanding and annual workplan with MCCG • Develop partnership with voluntary sector	Public Health providing appropriate support to MCCG Public Health seen as important partner	DPH DPH and PH team	
Support the Health and Wellbeing Board and delivery of the Health and Wellbeing strategy	• Provide public health leadership to HWB • Provide support through agreeing agenda, delivering papers and presentations • Agree mechanism to monitor HWB strategy • Review annually HWB strategy and adjust	Well functioning HWB HWB strategy delivered as per plan	DPH with HWB support officer – Clarissa Larsen	
Ensure Joint Strategic Needs Assessment is updated regularly	Update JSNA	JSNA provides most up-to-date analysis of health needs	Consultant in PH PH Intelligence Specialist	
Provide local assurance for NHS England and Public Health England	• Assure robust plans for immunisations, for example • Support health protection work, as required	Robust local delivery of NHS England and Public Health England work	DPH with PH team	

Appendix 4 Public Health Team Structure Chart - Actual




Legend: Existing Post
Proposed Post
Public Health Team Structure Chart - Proposed
Appendix 5
Health & Wellbeing Partnership Manager
0.4 WTE
Director of Public Health
1WTE
P.A & Business Support
1 WTE
AD/Consultant in Public Health
Adults
1WTE
AD/Consultant in Public Health
PH Intelligence & Prevention
1WTE
AD/Consultant in Public Health
Children
0.6 WTE
Public Health Specialist - MG C
Adult
1WTE shared with MCCG
Public Health Commissioning Manager (MG C equiv)
1WTE
Public Health Data Manager
1WTE
Public Health Specialist – MG C
Children
1WTE shared with MCCG
Sexual Health Commissioning Manager
1WTE shared with Sutton
1
Public Health Programme Manager
1 WTE
Public Health Information Analyst
1WTE shared with MCCG
Sexual Health Commissioning Officer
1WTE shared with Sutton

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Committee: Healthier Communities and Older People Overview and Scrutiny Committee

Date: 17th March 2014.

Agenda item:

Wards: ALL

Subject: Update from Merton Clinical Commissioning Group

Lead officer:

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

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

Recommendations:

A. That Panel members comment on the update from Dr Howard Freeman, Chairman of Merton Clinical Commissioning Group on next steps for health services in South West London

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. To update the panel on the latest position on future strategic reviews of health services in South West London following the demise of the Better Services Better Value Review.

2 DETAILS

2.1. On the 6th January 2014 The Six South West London Clinical Commissioning Groups issued a press release stating that the business case for the Better Services Better Value Review was rendered invalid following the withdrawal of Surrey Downs Clinical Commissioning Group.

2.2. The proposals within the BSBV review had significant implications for Merton residents, including the possible closure of Accident and Emergency and Maternity departments at Epsom and St Helier University Hospital.

2.3. The review was clear that the current configuration of health services in south west London is unsustainable therefore it is expected that a similar review will take place in the future.

2.4. Dr Freeman will attend the panel to discuss next steps for any future strategic reviews for health services in South West London.

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 2013/14

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.

Committee: Healthier Communities and Older People Overview and Scrutiny Committee

Date: 17th March 2014

Agenda item:

Wards: ALL

Subject: Draft report and recommendations arising from the scrutiny review of incontinence amongst women of child bearing age in Merton

Lead officer: Stella Akintan, Scrutiny Officer

Lead member: Councillor Suzanne Evans, Chair of the incontinence amongst women of child bearing age task group review.

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

Recommendations:

A. That the Healthier Communities and Older People Overview and Scrutiny Panel considers and endorses the recommendations arising from the scrutiny review on incontinence amongst women of child bearing age in Merton attached at **Appendix 1.**

B. That the Panel agrees to forward the review report to Cabinet and Merton Clinical Commissioning Group for approval and implementation of the recommendations, by means of an action plan to be drawn up by officers and relevant partners working with the Cabinet Member(s) to be designated by Cabinet.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. In the last municipal year the Healthier Communities and Older People Overview and Scrutiny Panel agreed to undertake a scrutiny review of continence services in Merton. The review came to a close during the transition from the Primary Care Trust to the Merton Clinical Commissioning Group, (MCCG). Therefore the task group decided to allow the time for the organisation to embed before forwarding the report.

1.2. MCCG have received the report and recommendations and will provide a response. However they wish to highlight that since they received first sight of this work in February they have not had the opportunity to incorporate it into their existing work programme.

2 DETAILS

2.1. This review looked at the services available to people suffering from incontinence. Although rarely life-threatening, urinary and/ or faecal incontinence can seriously influence the physical, psychological social well-being of affected individuals.

2.2. The task group decided to focus on women of child bearing age, those between the ages of sixteen and forty four, not least because, urinary incontinence often occurs following pregnancy. This contributes to making it about two to three times more common in women than in men.

2.3. Also the task group felt that if services can be improved for this age group, there will be a direct knock on effect on older age groups where it is more prevalent. This supports the task group's commitment to the prevention agenda – identifying problems at an early stage and addressing them before they become worse, which creates unnecessary suffering and requires more invasive and expensive interventions later on. This review also looked at how to raise awareness of incontinence and tackle the stigma that prevents people seeking help.

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 2013/14

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

- Draft scrutiny review of incontinence amongst women of child bearing age

12 BACKGROUND PAPERS

12.1. .

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Incontinence Amongst Women of Child-bearing Age

A report of the Healthier Communities and Older People Overview and Scrutiny Panel, Chaired by Cllr Suzanne Evans

Foreword by the task group chair

There was tremendous support for investigating this issue among members of the Panel. For many of us it was all too personal: we had either suffered ourselves or seen members of our family struggle to cope with this condition, one which is not only debilitating and distressing but also taboo, especially for women of childbearing age.

My own experience of living with incontinence following the birth of my daughter turned out to be typical. It took me five years to pluck up the courage to go to my doctor to ask for help, and only then after an ‘accident’ I found particularly embarrassing. But once I had done so, and my doctor had assured me the problem could be solved, the relief was immense. I remain incredibly grateful to the staff at St George’s hospital who, to use colloquial terms, gave me my life back.

However, in preparing this report the Panel uncovered many barriers faced by women when it comes to getting access to incontinence services. This is unacceptable, especially given how hard it is for them to report the problem in the first place.

It is also very short-sighted. Incontinence has huge impact on health and social care services. Those who suffer are less likely to lead active, sociable lives. Working may become problematic. In any age group, incontinence is a key factor in relationship breakdown. It can often be a trigger for abuse. As women get older they are more likely to suffer falls and need residential care. Yet if incontinence was addressed earlier, many of these subsequent problems could be avoided.

The panel believes that if our recommendations are followed, more women will come forward for treatment, and sooner. Not only will this dramatically improve their quality of life, the NHS and our social care services will also benefit financially in the longer term.

Suzanne Evans

Chair, Incontinence amongst women of child bearing age task group

Draft Recommendations:

No	Recommendation	To be implemented by:
1.	That midwives and health visitors follow up first, second and third degree tears following childbirth to check for signs of incontinence	**NHS England**
2.	That health visitors ask women 'trigger questions' after childbirth to identify the onset of incontinence.	**NHS England**
3.	That women are warned incontinence may be a problem following childbirth and that pelvic floor exercises are important to help prevent it.	**MCCG**
4,	That women should be given realistic information about the efficacy of pelvic floor exercises and advised what other options may be available in extremis.	**MCCG**
5.	That women are advised they should not hesitate to contact either their GP or the continence service if they experience any problems with incontinence at any time in the future	**MCCG**
6.	NHS Trusts should place greater emphasis on early detection and prevention of continence issues. We suggest perhaps establishing local/regional clinical champions?	**MCCG**
7.	The Director of Public Health should investigate how easily accessible and free training can be rolled out to unpaid carers to help them deal with continence	**Merton Council**
8	Incontinence issues should be prioritised as part of the Falls Prevention Strategy	**MCCG**
9.	Merton Clinical Commissioning Group should develop a clear pathway for unified continence	**MCCG**

	services across the borough.	
10.	That MCCG and local acute NHS Trusts look into what role pharmaceutical companies may be able to take in hosting events to raise awareness on incontinence issues	**MCCG**
11.	That commissioners and the continence service seek to involve patient participation groups in raising awareness of continence issues	**MCCG**
12.	That an information leaflet is produced to advertise continence services	**MCCG**
13.	That e-information leaflets and posters advertising continence services should be distributed in discreet locations such as Lavatory cubicles in local public buildings where women can access them privately.	**MCCG**

Introduction

1. This review looked at the services available to people suffering from incontinence. This is a common condition that can affect people of all ages. Urinary incontinence (UI) is defined by the International Continence Society as 'the complaint of any involuntary leakage of urine' and is wide ranging in its severity and features. Although rarely life-threatening, UI and or faecal incontinence can seriously influence the physical, psychological and social well-being of affected individuals.

2. The impact of the condition on the families and carers of women with incontinence may be profound; it is often cited as a major reason why relationships between carers and the people they are caring for breaks down, and a key cause of admissions to residential or nursing homes; incontinence is second only to dementia as an initiating factor for such moves.[1]

3. The resource implications for the health service are considerable. Figures from 2010 suggest the total incontinence-related expenditure for the UK was more than £420 million; £80 million of which was spent on absorbent products, such as incontinence pads alone (Royal College of Nursing). The Bladder and Bowel Foundation estimates incontinence costs the NHS £7,178 per 1,000 people in England.[2]

4. Incontinence also has a major impact on the quality of life of those who suffer. It restricts employment, educational and leisure opportunities. There may be considerable financial implications because of the soiling of clothes and bedding which; leads to extra laundry and renewal costs.

5. A number of factors led the task group to conduct this review. Incontinence is an issue that resonated amongst the group both from their own experiences as well as those of loved ones. The Chair and cabinet member had both suffered from the condition and had to face not only the challenge of dealing with it but also summoning the courage to seek medical help, such is the level of stigma around the condition in relatively young or middle aged mobile and otherwise healthy women. Another task group member cared for a family member who had the condition.

6. Age Concern UK were concerned about the low level of resources available to support people and a lack of awareness about what help is available to tackle this problem.

[1] Urinary continence service for the conservative management of urinary incontinence in women, NICE Guidance, 2008
[2] Prevention and Early Intervention Continence Services, Health and Social Care Partnership.

7. As members felt this group had been overlooked in previous discussions of the subject and because they were less likely to report symptoms due to shame or embarrassment, the task group decided to focus on women of child bearing age, those between the ages of sixteen and forty four, not least because, urinary incontinence often occurs following pregnancy. This contributes to making it about two to three times more common in women than in men. Also the task group felt that if services can be improved for this age group, there will be a direct knock on effect on older age groups where it is more prevalent. This supports the task group's commitment to the prevention agenda – identifying problems at an early stage and addressing them before they become worse, which creates unnecessary suffering and requires more invasive and expensive interventions later on.

8. This review also looked at how to raise awareness of incontinence and tackle the stigma that prevents people seeking help. As a first step the Chair of this task group and the Cabinet member for adult social care and health spoke jointly about their personal experiences in an article for the local newspaper. (See Appendix A)

The task group's terms of reference were:

- Looking at health pathways for treatment of incontinence amongst women of child bearing age
- Influencing current policies and strategies to increase the priority for this service such as the CCG's public health and the health and wellbeing strategy
- Looking at ways to tackle the stigma associated with continence issues
- Looking at ways to raise awareness of the problem and encourage people to seek help

What the task group did?

The task group held three meetings to consider a wide range of evidence and heard from:

- Continence nurse at St Helier hospital
- Community Nursing Manager, Sutton and Merton Community Services
- Acute Therapies Service Manager, Sutton and Merton Community Services
- Women's Health Physiotherapist, Sutton and Merton Community Services
- Assistant Director, commissioning, NHS South West London

The task group also:

1. Secured an article in the Wimbledon Guardian highlighting the problem with quotes from the Healthier Communities and Older People Scrutiny Panel Chair and the Cabinet Member for Adult Social Care and Health.

2. Conducted an online survey of incontinence in Merton which provided a small sample of people's experiences, while the survey was open to all areas

across London, it was still possible to extrapolate responses from Merton residents. Links to the survey were placed on:

- Mumsnet
- The Bladder and Bowel Foundation
- Merton Council website
- The Pelfix Technique

The findings and deliberations of the task group

Services for people who suffer from incontinence in Merton

9. We spoke to a number of front line clinicians who provide treatment for people suffering from incontinence to get a picture of services available for Merton residents, especially women in our target group. We found there are a range of services available;

10. The Continence Service is part of Sutton and Merton Community Services. There are two part time continence nurses and a senior nurse who works as a continence advisor . Their work includes clinical services such as assessing people for treatment as well as specialist support to individuals and training for other staff. We were told that there is a limited budget of £700,000 for continence services across the two boroughs. We found the team are passionate about their work and do the best they can with the limited resources available.

11. Continence services have been improved following a review in 2010. This led to the employment of the continence advisor who provides specialist advice and training for staff. There is also improved advice and delivery service on incontinence products.

12. There is a part-time continence nurse at Epsom and St Helier hospital who runs a continence clinic providing diagnosis, physiotherapy and advice on managing the condition.

13. The women's health physiotherapist is based within community services and provides exercises to strengthen the pelvic floor muscles for the treatment of incontinence. She sees five new cases a week. The waiting list for this service is currently three months long.

14. St George's hospital which also serves Merton residents has Urologists that treat incontinence problems.

15. In response to questions from us, staff from the continence service were clear that they spend the majority of their time responding to people who request their services and they have very little time and resources to focus on the prevention agenda. Most people who access continence services are elderly, although the service is open to all age groups. Staff are not able to do preventative work or reach out to other groups who may need help due to limited resources.

16. Although we recognise that there have been some improvements to continence services since the review of 2010. We do not believe that many of the fundamental problems have been addressed. Amongst the issues identified in the review were:

- A lack of standardised referral/advice/treatment pathways within primary care to specialist care
- A lack of consistent information to patients
- Specialist physiotherapy continence is patchy and limited
- Insufficient continence education for front line staff
- Poor data from home delivery service of containment products so unable to get a clear picture of current incontinent needs.

17. An NHS Sutton and Merton briefing report presented to the panel[3] states that 'the service review recommended the provision of a comprehensive continence service, supporting screening or urinary and faecal symptoms, assessment management and evaluation of management. This service provision with the correct highly skilled workforce would be promoting continence through accurate assessment rather than containing it through poor assessment.'

18. It also stated that 'the new model of care will challenge the current reactive service which only provides continence products and very little advice and support.'

19. We also found out that the staffing levels for treatment of incontinence across Sutton and Merton are below the recommended guidelines set out by NICE. It was very apparent to the task group that the service is not adequately resourced to meet need within the borough.

Under- reporting of continence problems

20. Existing research, previous reports to scrutiny, anecdotal evidence and personal experiences made it clear that many people do not seek help for

[3] NHS Sutton and Merton - Briefing on the Continence Service – Healthier Communities and Older People Overview and Scrutiny Panel January 2010.

their incontinence. Some studies reveal that it can take the average woman five years to go to her general practitioner for help[4].

21. A report to the health scrutiny committee in 2010 highlighted that accurately quantifying the real need and potential demand for services is difficult because:

- Definitions of incontinence vary
- There is so much stigma and misunderstanding of the condition that people who might benefit from treatment do not seek help
- Some people with continence problems are unaware that anything can be done to help them, and so do not seek help

22. Data from a Leicestershire study has been used to estimate the local need for continence services within the NHS Sutton and Merton area. Over 11,000 people were estimated to have "bothersome" incontinence symptoms, and of these it was estimated that 4,450 would actively want help.

23. Recent figures show that 3,105, individuals are currently receiving incontinence pads from NHS Sutton and Merton, which could mean that there are at least 1,500 people who still need help.

24. The task group concluded that the low priority placed on incontinence needs to change. Incontinence has a huge impact on quality of life and is a major factor in falls amongst older people and those with long term conditions. Women of child-bearing age with young children, may struggle to keep active because of symptoms. It plays a role in mental health issues, leading to problems such as depression, anxiety, agoraphobia etc. If incontinence is left untreated and worsens the cost to the NHS and Adult Social Care becomes even greater.

25. Despite much talk of prevention, task group members concluded that in fact the service was already struggling to cope and probably could not manage if more emphasis was placed on the preventative agenda and more people came forward to get help.

26. We spoke to the Assistant Director for Commissioning at NHS South West London, were informed that commissioners were not aware of an unmet need within the service. Although we spoke to the service as it was going through a major period of transition (February 2013) , this reinforced our conclusions that this service is given a low priority by Commissioners as it is not life threatening.

[4] Graham Allen MP Report to Parliament on incontinence 24 October 2007.

Impact of incontinence on women of child bearing age

27. Urinary incontinence is more prevalent among women after childbirth, because of the damage caused to the pelvic floor during the birth process. One in four women experience it. The level of damage and severity of symptoms varies enormously; often muscles are weakened and women leak small amounts of urine when they cough, sneeze or exercise. At the other end of the spectrum – there can be severe damage resulting in uncontrollable urinary and faecal incontinence.

28. If services are improved for women of child bearing age, the task group felt a good practice model could be developed which could then be extended and applied to other groups. The Continence Nurse agreed that this approach could have a direct impact on reducing incontinence amongst older people, where it is more prevalent.

29. There are some services in place to support women in the six week period after giving birth. For example, women who experience third degree tears in childbirth will receive a check up with the women's health physiotherapist, in accordance with NICE guidelines. We were informed that after such a tear women are at higher risk of incontinence so it is important they are encouraged to do pelvic floor exercises which can improve symptoms in up to 70% of women. This is also in line with guidance from the Royal College of Gynaecologists and Obstetricians, although we were told this is not standard practice across the borough.

30. However the task group heard evidence that incontinence does not only result from third degree tears and limiting access to physiotherapy just for this group is a mistake. Despite the fact the task group was aware this goes beyond the current NICE guidelines, members felt strongly that women who experience first and second degree tears should also be followed up to both identify and pre-empt problems.

31. Although women receive postnatal support from health visitors and midwives, it is clear many are not asked questions about incontinence. Or if they are, the questions are asked too soon after childbirth, when it is not possible to assess whether or not a continence problem will either develop or become long-term due to the fact a woman is still recovering and her body is not yet back to 'normal'. The task group felt frontline professionals need more training and support to ensure that they ask women about incontinence issues, well

after the six week period given the problem can kick in a few years after childbirth.

32. One respondent from our survey has called for *"greater help from midwives. I had a third degree tear and had no information at all either before or after birth on pelvic floor exercises or how to treat incontinence. I had to seek help myself some months after the birth"*

33. The task group also heard that in many cases, pelvic floor exercises alone cannot solve the problem. Our concern is that they can be offered as a panacea 'cure all' by both medical professionals and voluntary sector support groups, and give women the unrealistic expectations about their efficacy. This means women with greater problems which are not resolvable by pelvic floor exercises may a) fail to seek further help and b) blame themselves for their inability to cure the problem. The point should be made very strongly that if pelvic floor exercises fail to solve the problem this is not the end of the line and that other interventions, including surgery are available.

RECOMMENDATIONS:

That midwives and health visitors follow up first, second and third degree tears following childbirth to check for signs of incontinence.

That health visitors ask women 'trigger questions' after childbirth to identify the onset of incontinence.

That women are warned incontinence may be a problem following childbirth and that pelvic floor exercises are important to help prevent it

That women should be given realistic information about the efficacy of pelvic floor exercises and advised what other options may be available in extremis.

That women are advised they should not hesitate to contact either their GP or the continence service if they experience any problems with incontinence at any time in the future

The Prevention Agenda

34. As members of this task group and the Healthier Communities and Older People Overview and Scrutiny Panel we cannot stress enough the importance of the prevention agenda. Time and time again we review health issues and find that resources are concentrated on treating the problem when it has escalated and that not enough emphasis is put on trying to prevent it in the first place or targeting treatment in the early stages.

35. We saw the continence service as being a prime example of this. The condition is clearly not prioritised, nor understood in terms of its wider implications. Current services are stretched and there are no clear treatment pathways. This has a huge impact on those suffering from incontinence and places a significant financial burden on the NHS.

36. An All-Party Parliamentary Group for Continence Care produced a guide for commissioners regarding implementing and monitoring an integrated continence service. The guide argues that the most cost effective continence services are clinically driven, patient sensitive and treatment focussed. This reduces associated complications further down the line such as urinary tract infections, pressure ulcers, and complications leading to hospitalisation. This report calls for one target on incontinence in the Joint Strategic Needs Assessment.[5]
37. The professionals we heard from who work in continence services told us we should target people at risk: those with mental health problems; women aged 16-44; and those with learning disabilities. We need to get healthcare professionals to ask the right questions to find out if people are incontinent and then to know where to send them to.

38. We need to put money into prevention and raising awareness, and recognise that it may take a few years to realise the benefits.

39. We know that as our population ages the impact of incontinence related problems will escalate. It is important to improve the service now not least because we know there is a link between incontinence and falls which can seriously distress and incapacitate the elderly and cause premature death.

40. Given the fact incontinence is a key factor in admissions to care homes and current policy is to continue to allow people to live in their own homes for as long as possible, the task group felt that tying incontinence into the prevention agenda and providing more support to carers would assist in minimising care home admissions.

Recommendations:

NHS Trusts should place greater emphasis on early detection and prevention of continence issues. We suggest perhaps establishing local/regional clinical champions?

The Director of Public Health should investigate how easily accessible and free training can be rolled out to unpaid carers to help them deal with continence

[5] Cost effective Commissioning for Continence Care, All Party Parliamentary Group for Continence Care Report, 2011.

Incontinence issues should be prioritised as part of the Falls Prevention Strategy

Health Pathways and Co-ordination of Continence Services.

41. The panel is unanimous in agreeing that there can be no underestimating the importance of having a clear clinical pathway both in terms of patient experience and identifying issues at an early stage. Professionals need to be able to identify problems quickly and signpost people to the right service.

42. When we investigated what someone reporting an issue with incontinence may experience we found a very fragmented service across South West London, where some health care professionals are not even clear where to refer people to. The treatment that people receive depends upon which service they go to – their GP, the continence clinic at Epsom and St Helier or the Urology department at St George's.

43. The All Party Parliamentary report; *Cost Effective Commissioning for Continence Care* highlights: "There is no doubt that an integrated service saves money, it leads of early identification and treatment of symptoms, agreed referral pathway to specialists , reduced hospital admissions improved patient experience and alleviation of distressing symptoms.

RECOMMENDATION :

Merton Clinical Commissioning Group should develop a clear pathway for unified continence services across the borough.

Raising awareness and tackling stigma

44. Our research highlighted again and again the unfortunate truth that many people do not seek help for their incontinence, either because they do not know where to go or they are too ashamed or embarrassed.

45. We uncovered a number of prevailing and damaging myths around incontinence which; can also act as barrier to those who would otherwise seek help and treatment. Some of these myths include:

- Incontinence can only be corrected by surgery
- If pelvic floor exercises don't work, there is nothing else you can do
- Incontinence is inevitable because it's hereditary

- Health professionals can see it as a ‘normal’ part of ageing
- Health professionals do not take it seriously or they dismiss it
- Having a caesarean rather than a natural birth always prevents the problem

46. We asked our front line practitioners how we could tackle these myths and were told we need to use a combination of training, positive feedback from clients and success stories to dispel myths around incontinence. Proactive treatments such as pelvic floor exercises and bladder retraining should be used much more widely. Also general awareness raising was necessary among the public, families and, indeed, some health professionals, that the condition can be treated and not just contained.

47. The new responsibility for local authorities for public health presents an important opportunity to raise awareness about how to get help for incontinence. We recognise that there are limited resources and tight budgets, so we considered low budget options for raising awareness of services which will also help to tackle the stigma and myths surrounding this issue.

48. We were told that pharmaceutical companies often play a role in offering information and advice on the range of continence products available. We would like Merton Clinical Commissioning Group (MCCG) and the Trusts to consider what role they could play in providing information to the public and training for professionals on continence issues. However we recognise that this needs to be managed with sensitivity and caution, not least because the task group felt strongly that some existing commercial forms of awareness raising can be counter-productive. For example, the well known Tena Lady TV advertisements could lead the uniformed to conclude that incontinence is as natural as menstruation and that pads are the only answer. This is another reason why positive public health messages need to alert women to the range of support options available.

49. In Merton we have a vibrant voluntary and community sector. We feel they could play an important role in raising awareness of incontinence issues and dispelling the myths and promoting success stories. We would like the commissioners and the continence service to take this forward as a matter of urgency.

50. We were surprised to find that there are no leaflets or strategically placed posters advertising the continence service. This is an important way to signpost people and let them know that the service exists and the task group felt that women needed to access such leaflets in places where they will not feel embarrassed about picking them, lavatory cubicles for example.

Recommendations:

That MCCG and local acute NHS Trusts look into what role pharmaceutical companies may be able to take in hosting events to raise awareness on incontinence issues

That commissioners and the continence service seek to involve patient participation groups in raising awareness of continence issues

That an information leaflet is produced to advertise continence services

That e-information leaflets and posters advertising continence services should be distributed in discreet locations such as Lavatory cubicles in local public buildings where women can access them privately.

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Committee: Healthier Communities and Older People Overview and Scrutiny Committee

Date: 2014

Agenda item:

Wards: ALL

Subject: Physical activity for the fifty five plus age group

Lead officer: Stella Akintan, Scrutiny Officer

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

Forward Plan reference number:

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

Recommendations:

A. That That the Healthier Communities and Older People Overview and Scrutiny Panel considers and endorses the recommendations arising from the scrutiny review on physical activity for the fifty five plus in Merton attached at **Appendix 1**

B. That the Panel agrees to forward the report to Cabinet for approval and implementation of the recommendations, by means of an action plan to be drawn up by officers and relevant partners working with the Cabinet Member(s) to be designated by Cabinet.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of the report is to provide Panel members with the draft task group review looking at physical activity for the 55 plus age group.

2 DETAILS

2.1. Last year the Healthier Communities and Older People Overview and Scrutiny Panel agreed to undertake a task group review of physical activity for the fifty five plus. The task group spoke to a wide range of witnesses including Age UK Merton and Pro Active South London.

2.2. The task group identified a number of barriers which exclude people who are fifty five plus from getting involved in physical activity. These include the cost of services and not knowing what local activities are available.

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 2013/14

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

- Draft task group report on physical activity for the fifty five plus age group.

12 BACKGROUND PAPERS

12.1.

Physical Activity for the fifty five plus age group – draft task group report

A report of the Healthier Communities and Older People Overview and Scrutiny Panel, Chaired by Cllr Logie Lohendran

Foreword by the task group Chairman.

The transfer of Public Health to the local authority has presented us with a unique opportunity to increase the focus on to promoting health and wellbeing across all council services. The mortality rate between the East and West is getting wider, and is a big concern within the borough and a key feature in our health and wellbeing strategy. We know that poor diet and lack of physical activity contribute to obesity and coronary heart disease; these seem to fall heavily on those deprived areas. Many of these issues have been clearly identified by this task group which looked at that Sport and Fitness for the fifty five Plus age group.

The task group identified a number of barriers which prevented older people participating in sports and physical activities including the cost of attending sports and exercise classes, for some women the result of having neither female only changing rooms nor female only activities inhibits them for cultural and religious reasons. We found that there here needs to be more information about where activities are held, and what is specifically available to 55 plus age group. We received evidence from Pro Active South London, using the Sport England Market segmentation tool which confirmed what we already knew that the east of the Borough is the worst affected area of groups which lacked physical activities. We made a number of recommendations to address these barriers.

We need to use the evidence and recommendations within this report to work collectively develop the understanding of how to increase physical activity within Merton Communities. I hope that this report will encourage every ward Councilor to ask themselves 'What have we done to progress this important agenda.

Councillor Logie Lohendran

Draft recommendations:

1.That public health teams and the Leisure and Culture Development Team make better use of the communications channels that we know of and direct people to Merton-i and Get Active London link

2. GP's to signpost and refer people to sports groups, and make use of Merton-I and LiveWell behaviour change programme.

3. The Council's Cultural and Sports Framework to include ways and means of developing specific and measurable targets to improve outcomes, including those for the fifty five plus age group.

4. Run a ward pilot, using the market segmentation tool to identify and target services for this group

5. The council to host workshops for sports clubs and others interested in sport and physical activity delivery in Merton on using the market segmentation tool

6. Private sponsorship – explore the possibility for sponsors, which compliment the councils public health responsibilities, to support local sporting activities

Introduction

1. This report will focus on increasing opportunities for residents who are aged fifty five plus to become more physically active. It should be noted that playing sport, using a leisure centre, walking/cycling, group dance classes and outdoor activities such as gardening all count as physical activity and are all as important as each other .

2. The evidence of health gain from an active lifestyle is now well established and the Chief Medical Officer (CMO) has highlighted significant health benefits including reducing the risk of many chronic conditions, including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions.Regular exercise reduces the risk of early death and developing disease by 20-30%.

3. Further guidance from the CMO recommends that adults should aim to be active daily and over a week activity should add up to 150 minutes in bouts of ten minutes or more. Older adults should also undertake physical activity to improve muscle strength on at least two days a week

4. As with previous reviews conducted by this Panel, this work has strong links with the prevention agenda particularly now that LBM has a responsibility to improve the health of its residents through its public health function. The relatively new Public Health team in the council has a vision over the next five years to stem the increase in the significant inequalities in health outcomes between the East and West of Merton, providing more equal opportunities for all residents of Merton to be healthy.,

Activity levels in Merton

5. Data from the Active People Survey (APS6) shows that in Merton only 7% of people in our target age group do enough physical activity to benefit their health. The results of the Health Survey for England highlighted that approximately 39% of men and 29% of women meet the minimum recommendations for physical activity. Activity levels of both men and women generally decreased with age and the higher the BMI the less likely to meet the standard. Encouragingly, the Active People's Survey shows that 60% of people are keen to be more active.
6. While the health of Merton residents is generally better than the national average, many chronic conditions are predicted to be on the increase, therefore improving participation in sport and exercise in some of our most vulnerable groups can help to combat this.
7. There are a number of other pressures which highlight the importance of this review. A report to the Overview and Scrutiny Commission in November 2013 highlighted significant demographic changes in Merton which will impact on service provision from 2017. Drawing upon recent census data it shows that

there will be an increasing proportion of older people; an 11% increase in the over sixty five age group and 25% in those over ninety. As a result of this increase demand for adult social care is likely to increase as well as a general increase in diseases for those over forty five. This increased pressure on resources comes at a time of declining financial resources for councils and individuals who have faced the impact of rising food and energy costs and the impact of welfare reform.

Who the task group spoke to:

- Barry Causer, Public Health Commissioning Manager
- Charmaine Sainsbury, Chief Executive, Age Concern Merton
- Christine Parsloe, Merton Leisure and Culture Development Manager
- Richard Nash, Marketing and Communications Officer, Pro- Active South London
- Conducted a survey amongst Merton Seniors Forum membership

Scope of the review:

- To review services that engages the 55 plus residents in sport and physical activity.
- To speak to local residents and ensure that services are being developed to meet their needs.
- To look at the differences in services and physical activity levels between the East and West of the Borough.

The findings and deliberations of the task group:

What services are available already?

8. We found that there are a wide range of activities for the fifty five plus age group run by the council and other local organisations including; Age UK, Wimbledon Guild , Merton Council for the Voluntary Sector with activities ranging from seated exercise to senior get fit classes and chair based Zumba.

9. The Leisure and Culture Development Manager told us that there are three leisure centres operating in Merton; Wimbledon, Morden and Canon's providing a wide range of services some of which are dedicated to the fifty five plus age group. We were told that the gyms now run integrated sessions and all age groups are encouraged to use the facilities at the same time. Prices vary according to the activity and for some concessionary prices are available for the sixty five plus age group.

10. Merton's parks and open spaces are also used for physical activity with activities including walking, cycling, cricket and football. There are also outdoor sports courts including those for tennis and netball. There are six outdoor gyms and two private golf facilities at Wimbledon and Mitcham Commons as well as crazy golf, pitch and putt and golf driving range all in the borough.

11. We were told about a wide range of activities spread across the borough specifically aimed at our target age group. However participation in some groups is low, for example; a new BMX track opened in 2012, currently only ten people who are fifty five plus participate.

12. The Leisure and Culture Development Manager told us that if more resources were available they could work with partners to generate increased participation in many of the activities.

13. We were also concerned about providing opportunities for people in care homes to participate in activities. The Leisure and Culture Development Manager told us that a project has started in the Woodland House care home which will work with residents to improve their physical and mental wellbeing, programmes include art, story-telling, music and movement. The leisure team are training activity co-ordinators within care homes do so some similar work.

14. We also think that this work has important links to the loneliness agenda. Older people are more likely to be vulnerable and isolated. Encouraging people to get involved in sport and physical activity can alleviate this; however they may be more likely to lack the confidence to join groups on their own. We know that the council's Public health team are developing a network of health champions to support people to get involved in the local community and they will play an important role in helping people to increase their activity levels.

Barriers to older people participating in sport and physical activity

15. Since we are aware that only a small proportion of older people participate in sport and physical activity, the task group sought to identify the barriers this group face and how they can be overcome. Based on their professional experiences a number of suggestions were put forward by our witnesses:

16. The cost of sport and exercise classes was highlighted as a big issue. For example the celebrating age festival is held once a year and involves a wide range of sport and activities, this is a very popular and well attended. There is a significant drop in participation rates at the end of the festival highlighting that many people are keen to get involved but cannot afford the costs involved.

17. The Chief Executive of Age UK told us that many activities are branded for the 'over 50s'. This is a very wide age band and can mean the younger and older people within that spectrum may feel it is not suitable for them.

18. Cultural stereotypes and low expectations of older people need to be challenged. We need to discard the myth that at a certain age people cannot be active anymore. We need to ensure that services for older people are not sedentary which encourages a format in which people sit down and are served and not encouraged to participate.

19. There are also cultural/ religious issues for example; some Muslim women do not participate in mixed gender swimming sessions. Some leisure centres have stopped running 'female only' sessions; therefore these women feel inhibited from participating.

20. Some people find sports clubs elitist and are not confident to go on their own. Clubs need to promote inclusivity for everyone not just those considered to be good at sports. Coaching for sports can often focus on performance with not enough emphasis on sport participation for general well-being.

21. Some older people would be put off from joining walking clubs if there are not adequate public toilets in parks. This highlights the need for a joined up approach to providing services for this group.

22. Sometimes the idea of sport can deter people. We need to promote the importance of physical activity which can be more informal such as walking rather than taking the bus or car. Task Group members challenged some of the results of the Active Peoples Survey as it only emphasised sport. The Public Health Commissioning Manager agreed that it does not take account of activities of daily living and that these activities are just as, if not more important than sport.

Disseminating Information

23. We know there is a good range of sport and physical activities for the fifty plus age group across the borough, however this information is not disseminated widely and many people do not know what services exist. This became apparent through our snapshot survey amongst the membership of Merton Seniors Forum.

24. We asked the Leisure and Cultural Development Manager for her thoughts on mapping existing services and making them available in a single location, The Leisure and Cultural Development Manager told us she agreed that we need to make the information available for people to access. However it is

important not to re-invent the wheel. We need to utilise what we have already such as Merton-I, an information portal available on the Merton Council website and Get Active London Link, which is a London wide website on Sport activity. individuals and Sports Clubs are able to upload their own information directly to the Get Active London Link.

25. We accepted this view and recognise that it is important that in these stringent times, we need all local partners to pay an active role in sharing information that will contribute to this important agenda. We considered which central locations the fifty five plus are most be likely to congregate and could collect information about sport and fitness. Libraries would be a central location as would GP Surgeries. Our snap shot survey found community halls, and adverts in local newspapers are where people access information.

26. We want GP's to play a bigger role in this agenda; they provide a critical link to highlight the importance of physical activity and its overall contribution to wellbeing. A significant number of people are in contact with their GP's and it can be a good central source of information. We believe that GP's should be signposting people to exercise and sharing key messages about its benefits. LiveWell, the council's health improvement support programme, would be an excellent service to support this target group to increase their activity levels.

27. The Leisure and Cultural Development Manager told us that a new Culture and Sport Framework is being developed. There is recognition that there is less money for sport. The priorities within the framework include looking at ways to increase physical activity and how to improve health outcomes for local people. There are specific strands that would relate to activity for the fifty plus age group. We would like to see measurable outcomes attached to these.

Recommendations

1.That public health teams and the Leisure and Culture Development Team make better use of the communications channels that we know of and direct people to Merton-i and Get Active London link

2. GP's to signpost and refer people to sports groups, and make use of Merton-I and LiveWell behaviour change programme.

3. The Council's Cultural and Sports Framework to include ways and means of developing specific and measurable targets to improve outcomes, including those for the fifty five plus age group.

Targeting Services

28. We met with the Marketing and Communications Manager from PRO-Active South London. They use Sport England's market segmentation tool to determine where the target groups live and the type of sport they are likely to participate in. We were provided with a report on the Merton profile. The report found that there are 43,407 people living in Merton who are over 55. This equates to nearly 25% of the total population in the borough.

29. The market segmentation tool creates nineteen characters drawing on information on their behaviour profile to build a portrait of each character. This information provides details on the type of activity that target groups are likely to prefer. The data shows that indoor sport, individual sport, water and sport/leisure hall activities have the highest demand across the 55+ population. Although there are ward variations so other sports could be successful.

30. The Marketing and Communications Manager from PRO-Active South London said that targeting messages to each ward has a big impact as many people do not know what is happening locally. Also the location of services has a big impact on whether people will attend.

31. A number of wards have significantly higher proportions of people from the 55 plus age group. The data also highlights those wards which have significantly low numbers of people from this group and therefore is useful to determine if any services are placed in this ward are best placed for this group.

32. The data shows a higher level of inactivity amongst the 55-64 age range in Merton compared with the national average. Similarly, 78.2% of over 65 years olds in Merton are completely inactive compared with 74.8% nationally. Overall the data shows that almost 70% of the 55+ residents are not currently participating in sport or physical activity.

33. Ravensbury, Pollards Hill, Cricket Green, Lavender Fields, Longthorton, Figge's Marsh and St Helier wards have significantly greater numbers of the fifty five plus populations than the London average and would be ideal for fifty five plus activities.

34. We believe the market segmentation tool can be a vey useful way of targeting services to meet the need of the fifty five plus age group. It can help to identify if services are located in the right place, identify gaps and if messages of communication are appropriate to encourage people to participate. We would like the Leisure and Culture Development Team to make use of this free tool. We recommend that they identify a ward with a high population of the fifty plus residents and review services to see that our target group has access to appropriate sporting activities and that relevant messages are targeted to this

group and they are able to access information and find out what is available.

35. We also think that local community groups and sports clubs would benefit from using the market segmentation tool. We believe the council should host a workshop run by Pro-active South London on how to make use of the market segmentation tool. This will help groups to identify and target services to the right groups.
36. With diminishing resources available for sports, we considered if there could be opportunities for private sponsorship, we need to identify organisations who would be willing to invest in the local community and could perhaps help to advertise activities such as walking groups. We would like the possibilities for private sponsorship to be explored.

Recommendations

4. Run a ward pilot, using the market segmentation tool to identify and target services for this group

5. The council to host workshops for sports clubs and others interested in sport and physical activity delivery in Merton on using the market segmentation tool

6. Private sponsorship – explore the possibility for sponsors, which compliment the councils public health responsibilities, to support local sporting activities

Conclusion

37. The recent changes in demographics, predicted increases in chronic conditions, the financial outlook for local authorities' highlight that services need to need to work very differently in order to support local communities. In this review we have suggested some useful ideas such as looking into private sponsorship and using the market segmentation tool. We have also identified opportunities for improving the use of existing resources through using Merton-I and Get Active London link to promote services. We believe that once these recommendations are agreed and implemented it will have a positive impact on participation in sport and fitness for the fifty five plus age group, which can be measured through the Cultural and Sports Framework.

38. The arrival of Public Health in the Council provides opportunities to improve the links with Leisure and other relevant Council services to improve use of the evidence base and embed prevention.

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