Merton Council
Healthier Communities and Older People Overview and Scrutiny Panel

Date: 9 February 2016
Time: 7.15 pm
Venue: Committee rooms C, D & E - Merton Civic Centre, London Road, Morden SM4 5DX

AGENDA

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1	Apologies for absence	
2	Declarations of pecuniary interest	
3	Minutes of the previous meeting	1 - 6
4	Improving Physical Activity for the 55 plus age group	7 - 14
5	Urogynaecology Services at St George's University Hospital NHS Foundation Trust	15 - 28
6	Work Programme	29 - 34

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

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Healthier Communities and Older People Overview and Scrutiny Panel membership

Councillors:
Peter McCabe (Chair)
Brian Lewis-Lavender (Vice-Chair)
Mary Curtin
Brenda Fraser
Suzanne Grocott
Sally Kenny
Laxmi Attawar
Michael Bull
Caroline Cooper-Marbiah

Substitute Members:
Abdul Latif
Joan Henry
Gregory Patrick Udeh
Jill West

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

Note on declarations of interest

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

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

Scrutiny's work falls into four broad areas:

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

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

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HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL
12 JANUARY 2016

(19.15 - 20.50)

PRESENT Councillors Councillor Peter McCabe (in the Chair), Councillor Brian Lewis-Lavender, Councillor Mary Curtin, Councillor Suzanne Grocott, Councillor Sally Kenny, Saleem Sheikh, Hayley James, Councillor Laxmi Attawar and Councillor Michael Bull, Councillor Joan Henry.

Caroline Holland (Director of Corporate Services) and Simon Williams (Director, Community & Housing Department) Stella Akintan (Scrutiny Officer)

Councillor Mark Allison Deputy Leader and Cabinet Member for Finance, Councillor Caroline Cooper-Marbiah Cabinet Member for Adult Social Care and Health,

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for absence were received from Councillor Brenda Fraser and Myrtle Agutter.

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of pecuniary interest.

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

A panel member pointed out a number of typographical errors from the 10th November minute:

On page 2 row 12 it should read “higher Level” rather than lower level.

On page 4 point 3 it should read “if” rather than “of”

On page 8 row 3 it should read “Manager” rather than Manger

RESOLVED

The minutes were agreed by the Panel

4 MINUTES OF THE MEETING HELD ON THE 22ND OCTOBER (Agenda Item 4)

Agreed by the Panel as a true record of the meeting

5 BUSINESS PLAN UPDATE 2016-2020 (Agenda Item 5)

Caroline Holland gave an overview of the report stating that the paper to cabinet included information in relation to freedom passes, the cut in the public health grant as well as amendments to the February savings. The report was published before the final local government settlement; therefore some of the details are still to be confirmed. There will be an approximate £10 million loss in the revenue support grant for the council by 2020. Departments are trying to identify savings as far forward as possible to plan in the most appropriate way.

The Director of Community and Housing said we need to find £1.6 million of new substitute savings as some of the previous savings were not achievable. It is no longer possible to get below inflation costs from providers. The new replacement savings are in two main areas. We are bringing forward staff savings to 2017/18 and 2018/19 to 2016/17, thus making the total saving in one year 16/17 rather than phasing it over three years. This is challenging and increases delivery risks. The aim continues to be to protect frontline services. The second broad area of savings will be to de-commission services in meals on wheels, Imagine and South Thames Crossroads.

The Director said he had already reported to this panel that we are now moving into the phase where the low to medium impact savings had been realised and subsequent savings are likely to have a significant impact and be even more difficult to deliver. The Cabinet meeting in February will take into account all the comments from scrutiny as well as the results of the Adult Social Care consultation. The Director was also keen to hear the views from this meeting and all feedback would be brought together to develop the most appropriate solutions.

A panel member sought clarification that the most vulnerable people will still receive their care. The Director of Community and Housing said we have a statutory duty to meet needs. We will target scarce resources to meet the needs of the most vulnerable. The Director also highlighted that every individual will be assessed on the basis of individual need, and officers have not been given prior targets to reduce support packages for individual customers. However, across all customers and through following a promoting independence approach, it has been possible to reduce support overall.

A panel member asked if the department has considered sharing services with partners such as the NHS to make savings. The director reported that this is a future possibility but we will not be able to achieve this for 2016/17. In the future we will be exploring options for sharing commissioning and operational delivery.
The Chair allowed members of the public who had submitted a request in advance to address the panel.

George McAdam, Adults First
Mr McAdam said he was terrified at the cuts levied against the vulnerable and those with learning disabilities. We should raise council tax by 2% and lessen the impact of £5 million worth of cuts. This round of cuts will mean there will be fewer staff who are less qualified staff. This will mean people with learning disabilities will be less well

cared for. This puts extra pressure on carers who in turn can become sick, which increases the likelihood of people being taken into care homes. We need to raise council tax or use reserves and convince the people of Merton it is money well spent.

Sue Hubbert, Carers Partnership Group
Their organisation has already received 8 case studies of people who cannot take anymore. Both the carers and the cared for are ageing so they need more support, not less. The council claims it has consulted across the borough however there is no proper impact assessment. Austerity affects people in all sorts of ways.

Lyla Adwan – Kamara, Merton Centre for Independent Living
A number of commitments have been made and it was thought that the full £5 million cuts would be on the table and a 2% increase in council tax would be considered. However the report was issued to the panel on the 8th January with only £1.8 million available to discuss. Labour has refused to increase council tax. People in Merton are clear about impact. We can choose to look away or say enough is enough but please do not say you didn't know.

Carole Mathurin
A carer for more than half my life, current care package includes three hours from crossroads, if this is decommissioned where will support come from. The council provides direct payments but there is no –one available to help people access the support and there is no time to look for it. There needs to be more money for the support service.

John Mayes, South Thames Crossroads
Has been a trustee at South Thames Crossroads for fifteen years and there has been a 90% customer satisfaction rate. It will be a disaster if Crossroads is decommissioned, this will not lead to savings at all as carers will need to find other solutions with additional pressure on care homes and hospitals. Expenditure will be five times more than if the council didn't cut services.

Sarah Henley
Sarah told the panel that she has cerebral palsy and is worried that the cuts will mean that she is not able to make personal choices about her activities as she needs a personal assistant at all times. She already spends two hours per day on her own. She enjoys the freedom to live an independent life like everyone else.
A panel member said there have been too many cuts in this area and they had tried to get the council to look at other areas. They queried if council reserves can be used as a one off payment until savings can be realised through developing a partnership with the NHS. The Director of Corporate Resources said there has been a reduction in the reserves. There are capital reserves we are using to reduce the cost of borrowing so to avoid making savings earlier than planned.

A panel member thanked the Directors of Corporate Services and Community and Housing for their difficult work in this area. They have friends who are carers and understand how difficult it can be. The council is required to set a balanced budget and while some people can afford an increase in council tax others cannot. It is

important that the council does all it can to challenge central government on the cuts in funding.

A panel member sought clarification that there will be a cut in funding in the continence service. The Director of Community and Housing reported that we are continuing to invest in the Age Well programme and investment must be even more targeted. The continence service will not be specifically funded by the council but this does not necessarily mean it will cease. It is hoped the service can continue and alternative sources of funding found as incontinence leads to other issues such as isolation.

A panel member asked what the impact will be of reducing home care hours. The Director of Community and Housing reported that it will be based on individual need but could mean that people are left in bed for longer and receive fewer visits.
A panel member asked about the impact of de-commissioning South Thames Crossroads. The Director of Community and Housing said he understands the need to support carers we are looking at alternatives and will support those who are eligible.

A panel member asked what the impact will be if the caring role breaks down. The Director of Community and Housing said we want to avoid the high costs of nursing and residential care. We need to use our limited resources to prevent situations coming to a crisis point which necessitates the need for high cost care.

A Panel asked about the further 10% cuts in staff who carry out assessments. The Director of Community and Housing said this may mean longer waiting times for assessments fewer reviews will take place and less staff to monitor contracts. However we are planning to mitigate these risks through implementing new information systems which will result in less time recording information and more time with clients. Also flexible working is expected to increase productivity.

A panel member said people do not give enough time to voluntary work and we need to change our attitudes and culture towards voluntary work. We should compile a dossier for national government about the cumulative impact of austerity across the council, voluntary sector and faith groups. In recognition that not everyone can afford a 2% increase in council tax can we run a campaign in My Merton about the challenges we are facing locally and give people the option to contribute to the community fund. The panel member would like to see action taken and investigated swiftly.

A panel member asked how we can make cuts by spending £7 million on wheelie bins and if this money is available to help vulnerable people. The Director of Corporate Resources said there no money in the capital programme for this project so we cannot save any money from ending the wheeled bins borough wide service

A panel member asked if contributions from businesses could support South Thames Crossroads. The Director of Community and Housing said it would be unrealistic to expect any business to completely support the service. Discussions are continuing

about the scope for managing the service with less council funding. Future models are likely to look at building partnerships and working along side volunteers.

The Panel RESOLVED to ask Cabinet to:

1. reconsider the overall reduction in support packages, specifically CH02 and CH29 (page 82 of consultation report on the supplementary agenda):

- CH02–" promoting independence – efficiencies to be found in the hospital discharge process and by enabling customers to regain and maintain independence"

- CH29 – "older people – managing crisis (including hospital admissions to residential care) This would include a number of activities to reduce admissions to residential care placements. WE would be looking to families to continue to support people at home for longer. This would fit in with our overall approach to enable independence."

2. Reconsider de-commissioning the South Thames Crossroads service for carers (CH60 – set out on page 80 of the consultation report on the supplementary agenda). The Panel noted that 72 carers would lose their support services.

3. Reconsider the reduction in the assessment and commissioning staffing budget, specifically savings CH04, CH20, CH58 and CH22 (on pages 78 and 79 of the supplementary agenda) that would impact on service users:

- CH04 – "reduce management costs and reduction in staffing costs – Access and Assessment. Staffing restructure to deliver efficient processes and building on planned shift of some customers to manage their own processes"

- CH20 – "staffing reductions in Assessments and Commissioning teams. Staff savings 12FTE to be deleted in 2016/17 across all service areas. Reduction in the ability to carry out assessments and reviews, social work support, safeguarding activities, DOLs responsibilities and financial assessments"

- CH58 – "Staffing reductions in Assessments and Commissioning teams. Reduction of a further 19-23 FTE posts, in addition to the 12FTE in CH20. Total FTE affected is 30-35 for 16/17"

- CH22 – " Commissioning Employees – staff savings – 4FTE to be deleted. Reduced capacity to monitor quality within provider services, reduced capacity to monitor performance within services and a reduced capacity to proactively work to sustain and develop a local provider market"

The reference was unanimously supported by the Panel.

6 WORK PROGRAMME (Agenda Item 6)

The Panel noted the work programme.

7 IMPACT OF BUDGET SAVINGS PROPOSALS ON SPECIFIC VULNERABLE GROUPS. INCLUDING RESULTS OF THE ADULT SOCIAL CARE CONSULTATION (Agenda Item 7)

8 SAVINGS PROPOSALS CONSULTATION PACK (Agenda Item 8)

Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: **9th February 2015**
Agenda item:

Wards: ALL

Subject: Physical Activity for the 55s and over

Lead officer: Dr Dagmar Zeuner, Director of Public Health.

Lead member: Councillor Caroline Cooper-Marbiah. Cabinet Member for Adult Social Care and Health.

Contact officer: Barry Causer, Public Health Commissioning Manager.

Recommendations:

A. To note the number of activities taking place across Merton to increase physical activity and reduce physical inactivity by the over 55's.

B. To support an application for pilot funding by LBM Public Health to develop and implement a targeted approach to evidence based physical activity provision, through the development and implementation of a local physical activity strategy across all relevant stakeholders.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of this report is to update the Panel on progress in supporting residents who are aged over 55 years of age to become more physically active. The report will provide an overview of the importance of physical activity, the policy context and recent changes, and an overview on the current physical activity levels in Merton. It will also provide information on current approaches to support the over 55s to be more active, and seek to gain support for an application to Sport England for the development of a physical activity strategy, linked to the Health and Wellbeing Strategy 2015-2018.

1.2. It should be noted that the term 'physical activity' will be used as an umbrella term that covers a number of activities including sport, using a leisure centre, walking, cycling, group dance classes or outdoor activities such as gardening. All count as physical activity and are all as important as each other.

2 PHYSICAL ACTIVITY

2.1. 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, such as coronary heart disease, stroke, type two diabetes, cancer, obesity and musculoskeletal conditions.

2.2. 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 people should also undertake physical activity to improve muscle strength on at least two days per week.

2.3. Being physically active is also central to our mental health and people who are inactive have three times the rate of moderate to severe depression of active people. Staying physically active can also reduce the risk of vascular dementia and have a positive impact on non-vascular dementia.

2.4. Importantly, promoting physical activity and reducing physical inactivity is also at the heart of falls and fracture prevention in older people. The Department of Health (DH) guidance "Falls and Fractures: Effective Interventions in Health and Social Care" [1] states four areas for intervention including 'to prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards'. In primary falls prevention, physical activity can prevent the onset of pathology and system impairments that lead to disability and increased risk for falls. In secondary prevention of falls, physical activity slows the progression of disease and system impairments, and in tertiary prevention physical activity contributes to the restoration of function to a level that allows for more autonomy in the performance of essential activities of daily living.

2.5. Being inactive is an issue at every age, but the evidence shows us that people become less active as they age. Generally, the more we do, the greater the benefit. Moving those who are inactive to a significant level of physical activity would have the greatest benefit, but any shift helps. There is a three-year difference in life expectancy between people who are inactive and people who are minimally active. This is an incentive to focus on the most inactive: identifying and supporting them to being physically active.

3 POLICY CONTEXT

3.1. Two significant Government policies have recently been published, each of which aim to raise the profile of physical activity and clearly state the benefits for society of a physically active nation:

3.2. In October 2014, Public Health England (PHE) published their physical activity framework 'Everybody active, everyday'. This provided a high level summary of the evidence for use by Local Authorities and stakeholders to deliver cost effective approaches to increasing physical activity levels. This sets out clear guidance for public sector bodies and others to promote physical activity, under the four themes of: Active society; Moving professionals; Active environments; and Moving at scale.

3.3. More recently, in December 2015, the Government published its Sports Strategy 'Sporting Future: A New Strategy for an Active Nation. This seeks to redefine what success looks like by concentrating on five key outcomes against which funding will be closely tied: physical wellbeing, mental wellbeing, individual development, social and community development and economic development. This strategy comes with a funding opportunity for

[1] Falls and Fractures: Effective Interventions in Health and Social Care, July 2009 http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_109122.pdf

Local Authorities to access pilot funding and resources to support the development and implementation of local physical activity strategies.

4 PHYSICAL ACTIVITY LEVELS IN MERTON

4.1. As described in the 2015 Merton JSNA summary document,[2] the number of Merton residents who are active enough to benefit their health appears to be increasing, with 60.5% of residents active for the 150 minutes per week recommended by the CMO. This is not significantly different than London (57.8%) and England (57%) averages.

4.2. Positively, the number of residents who are classed as inactive (taking part in less than 30 minutes of activity per week) in Merton (23.6%) is significantly better than London (27%) and England (27.7%) but this still shows that 1 in 4 Merton residents are inactive and so moving those who are inactive to a significant level of physical activity should be prioritised.

4.3. Men (50.4%) are more active than women (31.6%) in Merton. This is a trend shown in both London (Men 43.9% vs. Women 32.3%) and England (Men 40.6% vs. Women 30.7%), however it is noticeable that there is a larger gap between the genders than regionally or nationally, which seems to be because men are more active in Merton compared to London and England.

4.4. In Merton, residents with a White British ethnicity are more active (42.9%) than both London (38.3%) and England (25.1%). Merton residents from Black and Minority Ethnic groups (37.8%) are as active as London (38.2%) and more active than England (33.9%). It is noticeable that there is a larger gap between the ethnicities than is seen at regional or national level, which should be explored further.

4.5. London Sport (previously known as Pro-Active South London) reported in 'Activity levels and behaviours of people over 55 within Merton (2014)', that 63.8% of people in Merton aged 55-64 (compared to 60.5% in London and 62.4% in England) and 78.2% of people in Merton aged 65 and over (compared to 75% in London and 74.8% in England) are completely inactive. This report takes a segmentation approach and looks at demand by activity type and ward to suggest activities that should be included in the over 55's programme offer.

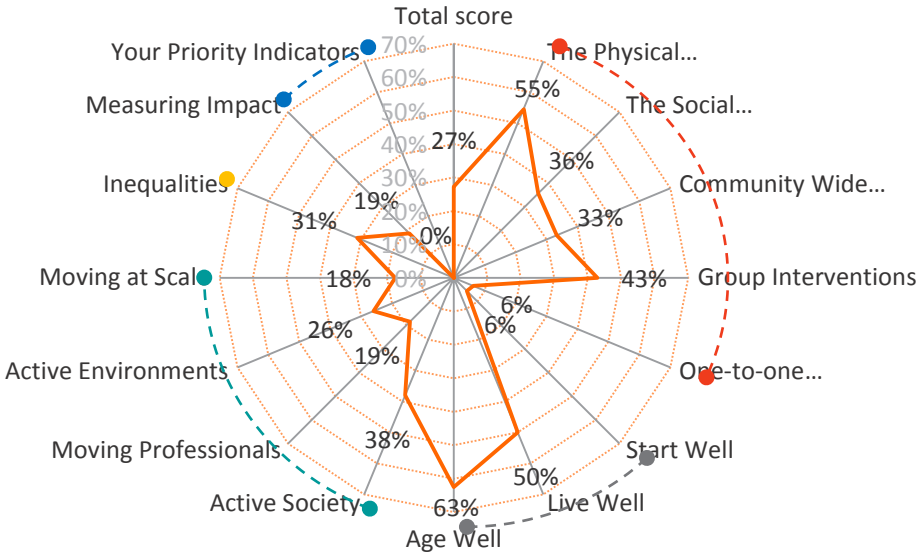
5 MERTON APPROACHES TO INCREASING OVER 55'S PHYSICAL ACTIVITY

5.1. The Merton Health and Wellbeing Strategy (2015/18) and Merton's Culture and Sport Framework (2015) both have a focus on supporting people to improve their wellbeing; which includes a focus on increasing physical activity and reducing physical inactivity. A number of approaches are being taken to increase physical activity in residents over 55, including-

5.1.1 The development by LBM Public Health of a self assessment tool against the evidence contained in PHE's 'Everybody active, everyday' framework, with a potential national roll-out of the self assessment tool in partnership with PHE and Sport England. Although the tool is still being refined, it has

[2] http://www.merton.gov.uk/health-social-care/publichealth/jsna.htm

shown (see diagram below) that Merton is performing relatively well in the design and implementation of physical activity programmes that target older people.



Findings include the need to raise awareness of and therefore the use of the best available evidence, the need to support stakeholders to help measure the impact of physical activity services and interventions, a lack of priority indicators and targets for physical activity and the need to embed physical activity in primary care.

5.1.2 As part of the integrated health improvement, stop smoking and weight management service, LBM Public Health are commissioning a tiered programme of behaviour change to support adult residents to lead a healthy lifestyle. This will include the delivery of extended brief interventions with goal setting and signposting onto physical activity opportunities. As part of the performance management of the contract, LBM Public Health will monitor the referrals and participation by a number of target groups including residents over 55 years of age.

5.1.3 In 2015, LBM Public Health carried out a Falls Prevention Health Needs Assessment (FPHNA) and found that Merton has a significantly higher rate of older people, older women and those aged 80 and above being admitted to hospital for falls related injuries compared to the England average. It also found that

- There is a higher rate of ambulance call out and falls-related A&E attendance in the East of Merton when compared to the West of Merton.
- There is a higher rate of referrals into the NHS Community Specialist Falls Prevention Service in the West of Merton compared to the East.
- There is a higher prevalence of falls in women and emergency hospital admissions for falls when compared to men.
- Although women fall more often than men in Merton, the mortality from falls rate is higher in Men.

Following the completion of the FHNA, a multi stakeholder task and finish group developed the Merton Older People's Falls Prevention Strategy 2015-2018, which aims to achieve a reduction in preventable falls and ensure effective treatment and rehabilitation for those who have fallen. The implementation plan for the strategy includes (1) addressing a lack of "step down" for people who had completed their classes with the NHS specialist falls service, (2) the need to increase the capacity of primary prevention of falls in Merton and (3) the lack of prevention pathways between providers of primary, secondary and tertiary falls prevention.

5.1.4 Linked to the Fall Prevention Strategy (see 6.1.3) LBM Public Health are working with Age UK Merton, Wimbledon Guild, and the NHS Community Falls Prevention service to pilot an 'exercise for life programme'. This aims to meet the needs identified in the FPHNA and increase the capacity of Merton in the primary prevention of falls that is in promoting good bone health, promoting physical activity, preventing frailty and reducing accidents by providing local and various exercise classes (including chair based exercise classes) to people aged 65 and over for a maximum of 8 weeks.

5.1.5 The Merton Befriending Scheme Pilot provides a mixture of face-to-face and telephonic services, operating on a one-to-one basis with Merton residents over the age of 65 years in order to reduce social isolation and loneliness in the people who receive this service. It also promotes physical activity in those who are socially excluded and lonely, as they are encouraged to leave their home with someone to accompany them. The scheme commenced in January 2015 and over two years the scheme will engage with 184 elderly and frail residents. In Year 1 the target number of service users is 80. To date (as of three completed quarters) 51 service users are in receipt of befriending. An overview of the service users is as follows:

- The proportion of socially isolated and lonely older people from a Black, Asian or Minority Ethnic (BAME) group seen by the service is 26% of all the service users.
- The average age of the service users is 84 years.
- The distribution of the service users in terms of gender is 71% Female, 29% Male

5.1.6 The mandated NHS Health Checks programme commissioned by Public health is a prevention programme targeting 40 -74 year olds that aims to assess the risk of developing heart and vascular problems and offers personalised advice on how to reduce it. In the 2015 calendar year 1,306 Merton residents over 55 years of age had a health check conducted by staff at their GP practice. The intervention included a discussion around physical activity status, linked to the validated General Practitioner Physical Activity Questionnaire (GPPAQ). Of these 1,306 residents 8.3% were classed as inactive, 12.4% moderately inactive, 23.7% moderately inactive, 18.7% were classed as active and 36.9% were unspecified. Public health are exploring links to the national GP Clinical Champions programme to support primary care professionals in helping their patients to be more physically active and to signpost onto appropriate services.

5.1.7 LBM Public Health are now routinely invited by planning colleagues to comment on major planning applications which have an implication for population health, including residential developments, highlighting areas where developers need to further consider health and wellbeing of different groups, including older people, to ensure positive impacts are maximised and negative impacts are mitigated. Depending on the development, this has included comments on the proposed proportion of Lifetime Homes and disability spaces, suggestions around improvements to the built environment and streetscape to promote walking and cycling over car use and to ensure accessibility for those with mobility issues, as well as recommending multi-generational uses for proposed community spaces. .

5.1.8 Leisure centre usage by residents who are over 55 has increased 3.5% (up 65,552 in 2014 to 67,883 in 2015) and the opening of the new Morden Leisure Centre will see an increase in members from all age groups. There will also be the ability to offer far more activities for 50+ members in the new facility. Other activities that older adults currently take part include allotments (with 335 out of 1,078 users receiving a reduced rate due to being an older adult), bowls (127 current members are older adults, out of a total membership base of 159) and volunteering opportunities to manage teams at the London Youth Games.

5.1.9 Future Merton provides regular free weekly walks in the boroughs parks and open spaces. The walks are popular and mostly attended by the over 55's with the average age 67 years. There are currently five walks with around 60 attendees each week. There is also a successful monthly walk provided by the Ethnic Minority Centre (EMC) with about 20 older people attending.

Most attending the walks have some type of health concern such as diabetes, high blood pressure, arthritis, COPD etc., but all say how much the regular exercise in the open air have benefitted them. Loneliness can be another problem for the elderly so they also get the chance to talk people and make new friends.

Future Merton also provide free cycle training for beginners, improvers and commuters to encourage a healthier lifestyle and a sustainable modal shift. Since April 2015, 79 residents between 55 and 64 years of age and three residents over 65 years of age have taken part.

6 OPPORTUNITY FOR ACTION

6.1. As described in a 'Sporting Future: A New Strategy for an Active Nation' (see 4.3) Sport England will, following a competitive bidding round, pilot focusing significant resources, including intensive staff input, to support the development and implementation of local physical activity strategies in a number of selected geographic areas.

6.2. In a similar way that Merton's well received (albeit unsuccessful) application to be a Food Flagship borough stimulated debate locally on all things related to food and culminated in the development of a local Merton Food Charter and recognition as a sustainable food city, a commitment to apply for pilot funding for the development and implementation of a physical activity strategy will stimulate debate in all things physical activity.

6.3. Led by LBM Public Health, this strategic debate and subsequent application could include a detailed look at trends in physical activity (including the over 55's), segmentation, demand, how programmes are designed and evaluated, how activities should be targeted and the mechanism for how scarce resources are allocated. It should be a borough wide debate and use the latest available evidence to inform future planning and provision.

7 ALTERNATIVE OPTIONS

7.1. NA

8 CONSULTATION UNDERTAKEN OR PROPOSED

8.1. NA

9 TIMETABLE

9.1. NA

10 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

10.1. This report has no direct financial, resource or property implications however reducing budgets across the Local Authority may have an impact on programmes and services that support increasing physical activity and reducing physical inactivity.

11 LEGAL AND STATUTORY IMPLICATIONS

11.1. NA

12 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

12.1. As part of the on-going monitoring contracts, Service User Analysis is undertaken on a regular basis on commissioned services and is used to help inform priorities and reduce health inequalities.

13 CRIME AND DISORDER IMPLICATIONS

13.1. NA

14 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

14.1. NA

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

15.1. NA

16 BACKGROUND PAPERS

16.1. Merton Health and Wellbeing Strategy. 2015/18.

16.2. Merton Culture and Sport Framework. 2015.

16.3. Government Sports Strategy. Sporting Future: A new Strategy for an Active Nation. 2015

16.4. Public Health England 'Everybody active, everyday'. 2014

16.5. Merton Falls Prevention Health Needs Assessment. 2015.

16.6. Merton Older People's Falls Prevention Strategy. 2015.

16.7. Department of Health. Falls and Fractures: Effective Interventions in Health and Social Care. 2009.

16.8. Pro Active South London. Activity levels and behaviours of people over 55 within Merton. 2014.

Committee: Healthier Communities and Older People Overview and Scrutiny Committee

Date: 9th February 2016

Agenda item:

Wards: ALL

Subject: Urogynaecology Services at St Georges University Hospital NHS Foundation Trust

Lead officer: Miles Scott, Chief Executive, St George's University Hospital NHS Trust

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

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

Recommendations:

A. Panel are asked to comment on the plans for Urogynaecology services at St George's and the concerns raised by staff and service users about the closure plans and consultation process.

B.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The Representatives from St George's University Hospitals NHS Foundation Trust will outline their plans for Urogynaecology services and the impact this will have on the residents of Merton. Representatives of the clinicians and service users will also address the Panel to set out their concerns. Both reports are attached.

2 ALTERNATIVE OPTIONS

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

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

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

3 CONSULTATION UNDERTAKEN OR PROPOSED

3.1. The Panel will be consulted at the meeting

4 TIMETABLE

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

5 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

5.1. None relating to this covering report

6 LEGAL AND STATUTORY IMPLICATIONS

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

7 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

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

8 CRIME AND DISORDER IMPLICATIONS

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

9 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

9.1. None relating to this covering report

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

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11 BACKGROUND PAPERS

11.1.

Briefing Paper - Public Consultation on the Urogynaecology Subspecialty Service

Background

Urogynaecology is a subspecialty gynaecology service for the management of women with pelvic floor dysfunction. St George's University Hospitals NHS Foundation Trust (SGUH) provides an acute tertiary consultant urogynaecologist led service as a subspecialty within the Women's Services directorate. The subspecialty was suspended on 8 June 2015, following concern regarding the provision of sufficient clinical governance arrangements to support the safe delivery of patient care.

The following conditions were being treated at SGUH

Secondary Acute Conditions:

- Primary incontinence and prolapse
- Recurrent incontinence and prolapse
- Postpartum pelvic floor problems Tertiary Acute Conditions:
- Combined Pelvic floor clinic
- Complex Urology
- Neuro-urology
- Paediatric adolescent gynaecology

The subspecialty provided for patients from the boroughs of Wandsworth and Merton in the main. During the period of suspension, 109 patients from the borough of Merton remained on a continuing RTT (referral to treatment) pathway. Patients referred to the subspecialty are seen in an outpatient setting by a consultant led team. Patients undergo clinical investigation, where required, and are treated by way of an outpatient conservative care plan or inpatient surgical management. On both pathways, patients are typically managed over an extended period of time with multiple appointments.

The service was provided and supported by

1 x clinical lead (part time)
2 x consultants (full time)
1 x associate specialist (full time)
2 x clinical fellow (full time)
2 x clinical nurse specialist (full time)
3 x administrators (full time)

Reason for change and decision making process

In early 2014, a senior consultant Urogynaecologist from Croydon University Hospital NHS Trust (CUH) was appointed as a Clinical Director (CD) on a part time basis to provide leadership to the unit and act as a lead expert and accountable decision maker.

The departure of the clinical director in May 2015 has led the service to become unsustainable due to concern of the insufficient clinical governance arrangements to support the safe delivery of patient care.

The 2013 NICE Incontinence Guideline recommends that all invasive treatments for over active bladder and stress urinary incontinence need to be discussed at an MDT (multi-disciplinary team), prior to treatment to help ensure optimal management. However, in the absence of the external CD, and without resolution of the on-going clinical governance, leadership and relationship issues within the department, it is evident that there is no lead clinician internally to take forward appropriate leadership of the unit and effective Chair of the local MDT.

The directorate of Women's Services reviewed the pool of alternative Consultant Urogynaecologist across the region of South West London who were at the sufficient experience and seniority to recruit to the role of clinical lead, however there was no suitable successor identified. Without a senior clinical lead the service has no senior clinical overview and cannot run a functioning multidisciplinary team meeting (MDT) where treatment plans are discussed and agreed. This posed a clinical governance risk and was not compliant with current guidelines.

In response, the trust therefore had to take the highly unusual decision to suspend the service to new referrals and in the interest of patients provide an alternative care provider for those on a continuing pathway from Monday 8 June 2015, until such time as there has been a full review of the options and the service.

The trust maintains that the service users and their safety have always been, and remain at, the centre of this proposal of change. The trust pledged to work hard to ensure all views are heard and responded to as part of a detailed public consultation process.

Service suspension

The trust decided that the best option in the interest of its patients was to temporarily transfer the service to CUH. A service level agreement was put in place with CUH to offer transfer of care for all patients under the care of the urogynaecology team and those that were newly referred and accepted to St George's during the suspension period. CUH is a tertiary level provider of urogynaecology and is the only provider in the SW London region to have received British Society of Urogynaecology (BSUG) accreditation. All patients have been reviewed and contacted to explain their transfer of care to CUH. Those patients who did not wish to transfer their care have been provided with details of the following alternative providers in London to be referred to by their GP.

- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- Kings College Hospital NHS Foundation Trust *(British Society of Urogynaecology (BSUG) Accredited)*
- Guys and St Thomas' NHS Foundation Trust

The General Manager for Women's Services and Care Group Lead for Gynaecology met with Wandsworth Clinical Commissioning Group (CCG) on the 19 August and more recently on 21 October to ensure transparency and collaborative decision making when providing alternative care for users. The CCG supported the trust's agreement with CUH, but requested that on occasions whereby the patient in discussion with their GP elects to be referred to an alternative provider, arrangements be put in place to ensure that the relevant medical case notes were made available to the receiving clinician at the point of referral to avoid any delay. The trust agreed to this request.

The Women's Services management team have continued to engage with patients via telephone and written queries and assist with any concerns as required. No concern has been registered regarding the provision of care at CUH and the trust is reassured that a good alternative quality service has been arranged. There have been no instances of serious incidents registered relating to transfer of care to CUH.

It is important to note that new and follow up patients receiving care from the following areas, have remained at St George's (although their care has been transferred to alternative specialist consultants):

- Maternal Perineal clinic
- Complex Urology
- Neuro-urology
- Paediatric adolescent gynaecology
- Pessary Management

Internal staff consultation

Following a review of the service the following options were considered:

- Do nothing - It was not considered a viable option to reopen the subspecialty urogynaecology service without compromise to the quality and safety of the care we offer to patients.
- Replacement of full time Clinical Director Role - The replacement of the full time CD role, was not considered a viable option due to the unacceptable expectation of governance accountability of the role in contrast to other subspecialty units, the availability of such an individual to appoint to the role and the on-going cost pressure of the role against a recurrent financial deficit.
- Close the Subspecialty Urogynaecology Service – Proposed as the preferred option.

The option to close the subspecialty urogynaecology services was taken forward as an internal staff consultation – in line with the trust's Change Management Policy –from 29 July 2015 to 31 August 2015 inclusive.

The proposal was presented to the ten staff directly affected and their representatives at open meetings. Five staff requested individual meetings to discuss how the proposal will impact on them and the department.

In response to the staff consultation two alternative proposal were submitted by affected staff.

i. Urogynaecology Subspecialty Service to remain, but both consultants to operate as two separate firms working under the governance of the over-arching gynaecology service.
ii. Urogynaecology Subspecialty Service to be reconfigured in to an Integrated Pelvic Floor Disorder and Continence Service. New role of Clinical Director to be established with dual lead across Urogynaecology and female urology care group.

Conclusions from staff consultation

The two alternative proposals were reviewed in detail, but were not supported by the trust as viable options. Proposal (i) was not supported as Urogynaecology is a subspecialty of Gynaecology, rather than a treatment type and therefore the management of the patients under a separate consultant firm model is not achievable. As a subspecialty, Urogynaecology must meet individual governance arrangements and operate as a separate unit. Proposal (ii) was not supported by the Urology Care Group as they do not have the strategic capability or resource required to start a new service at this time.

Public Consultation Process

Following the conclusion of the internal staff consultation the subspecialty of urogynaecology was considered to be unable to become a viable unit providing high quality services in a cost effective way. In response, the trust proposed to public consultation on 12 October that the unit is closed and the provision of the service be moved to CUH. The subspecialty remained in suspension during this process.

The trust feels that an appropriate and proportionate level of engagement has been made with the public and the consultation process has been robust. A spectrum of activity has taken place:

- Notification to Healthwatch Wandsworth who have put the consultation information as a news story on their public website
- Letter emailed with consultation document (including translations in Urdu, Tamil and Polish as appropriate).
- Engagement with the following groups:
    - Age UK Wandsworth
    - Wandsworth Older People's Forum
    - Somali Community Advancement Organisation (SCAO)
    - Women of Wandsworth

    - South London Polish Ladies Circle
    - South London Tamil Welfare Group
    - Wandsworth Asian Women's Association
- Attendance of Senior Management and Clinicians at both internal and external stakeholder meetings
- All Trust governors have been emailed and asked to give their views
- Consultation information has been put on the Trust's public website, which attracts approximately 80,000 visits per month
- Letters have gone out to 900 users of the service asking them to provide their views
- Dedicated consultation email address set up
- Communication via trust website and social media
- Women's Services Management Team attended St George's Patient Reference Group 15 October 2015
- Chief Executive, Medical Director, Clinical Chair and Women's Services Management Team attended Wandsworth Health Overview and Scrutiny Committee on 12 November 2015
- Women's Services Management Team have provided direct and personal communication with service users via telephone and written queries
- Chief Executive and Women's Services Management Team held an open public evening on 1 December 2015

The consultation was originally planned to take place from 12 October to 25 October 2015. In response to feedback received from people who wanted more time to consider the proposal fully, the trust extended the consultation period by two weeks, and then a further three weeks. This brings the total public consultation period to eight weeks, from 12 October to 4 December 2015

Implementation process and Conclusion

The public consultation closed on the 4 December 2015.

Number of formal responses received

Format	**Number**
Email	78
Post	20
Petition signatures	654

A period of review is now underway and options will then be presented and discussed at the Trust's Executive Management Team Board on 25 January 2016 for a decision to be put forward to the Trust Board for agreement on 4 February 2016. The outcome of the decision will be provided to the staff, public and stakeholders on the 5 February 2016.

Michelle Fynes, Consultant Urogynaecologist for St George's University Hospitals NHS Foundation Trust, has provided the following information on behalf of the patients and clinicians:

1. I am a consultant urogynaecologist of 13 years standing and former lead for the urogynaecology service (2003-2012). Urogynaecology looks after women of all ages with urinary and or bowel incontinence and or urogenital (vaginal)prolapse. This includes services for specific at risk groups including post childbirth and the frail elderly. These are common QoL disorders. The issues of urinary incontinence affects 1 in 6 women. This problem was cited in the CMO for England Dame Davie's annual report 12/2015. This identified female urinary incontinence and FGM as problems to be targeted and addressed from 01/2016.

2. I am also the joint lead for the Paediatric and Adolescent Gynaecology (PAG) service including the Rapid Access Forensic PAG Service for suspected Sexual maltreatment of Females <18 years of age (including FGM) (2003-2015). The latter service I set-up (2003) at SGUH FT and I have run this jointly (2009-2015) with my colleague consultant forensic physician and consultant for child safeguarding Dr Peter Green. This colleague is trained in forensic and medical law pertaining to sexual maltreatment (including grooming) of any male or female <18 years.

3. My colleague Dr Green liaises with the local MASH services, other child protection agencies, the police and courts of guardianship. And follows the cases that become criminal or require intervention to safeguard children (and or siblings). We have provided this service across SWT being the only such centre outside UCHL. I also work closely with the school nurses across SWT accepting direct or GP referrals. The urogynaecology and PAG services were suspended without any warning 08/06/2015. They were then bundled together and subject to consultation to close these two separate but key services for women of all ages (urogynaecology) and females<18 years of age (PAG).

The Wandsworth Police disclosed that 85% of sexual assault or maltreatment cases brought to their attention in 2015 had not been formally investigated and no forensic assessment or clinical risk assessment had taken place. Largely this was because the police were not sure what to do or where to send these children. The PAG service at SGUH FT was becoming more and more busy because of these issues. The service has never had a single complaint in 10 years that given how emotive these cases can be says a lot about the service and commitment of the team.

4. These are very serious concerns that other staff, patients, public representatives and advocates resident in the Sutton Borough Council and I have shared relating to the actions of SGUH FT. The Trust suspended two unrelated services from 08/06/2015. From 28/07/2015 they were subject to a joint consultation to close the services. This is unjustified and staff are concerned the real reason relate to addressing a financial deficit that has spiralled out of control and will likely hit 60 million GBP by 04/2015.

5. Clinical services not deemed relevant such as female urinary incontinence and PAG services are being jettisoned across the Trust to save money. In addition, mandatory redundancies are being implemented and staff leaving post not being replaced. Doctors and nurses are being asked to take on roles outside there area of specialty (e.g. General Gynaecologists being asked to see Paediatric Adolescent Gynaecology cases) to save money. This is pushing back quality care and best practice standards to the early 1990's in terms of women's and children's health service provision.

6. The external accountancy group contracted to help financially rescue the Trust from 02/2015 KPMG are supporting this process of jettisoning services over the next 3 years as part of a recovery plan. The Trust was solvent 12/2014 when the announcement was made of our Foundation status. From 02/2015 a whopping deficit was identified. A financial service review instructed across the Trust started with women's services and urogynaecology/PAG services being targeted for closure. The reasons provided are clinical governance and finance but finance is clearly the driving factor (the governance issues not being qualified or addressed) .

7. The concerns stand that the consultation process undertaken by the trust is unlawful. The staff consultation to close these services is flawed and no proper public consultation has been instructed or undertaken. The Trust are trying to steam roll through service closures to the detriment of patients and children including those vulnerable and with serious safeguarding concerns. The residents of Merton borough including patients/public users who require access to these services now/or in the future have not been consulted. As the locally elected council responsible for oversight of how SGUH FT spends public funds (allocated for health service provision) Sutton council have not been informed. As the OSC responsible for oversight of any substantive changes to health care provision affecting the residents of Merton and as councillors responsible for protecting the public interests Merton Council again have not been engaged.

Sent: Monday, 1 February 2016, 14:08
Subject: Regarding: The Merton OSC for Health Panel meeting and agenda item for 09/02/2016-M Fynes

1. Regarding the Merton OSC meeting 09.02.2016 attached are the summary documents as Word and PDF documents. Please feel free to cut the document size for the agenda and supplementary pack. We are second on the agenda for the OSC meeting and I would request to speak after the SGUH FT consultation panel members attending and not before. As stated I will be accompanied by 11 patients and their supporters (21 persons in all). I will provide the names later this week to confirm. There will be a number of patients but only two from the deputation will speak. The rest have provided statements to be reviewed by the Merton OSC councillors. They will also provide the council with copy also of the local women's campaign petition with over 2500 signatures of women objecting to the St Georges service suspension and planned closures.

2. Please note I have 22 letters of concern submitted by patients resident in Merton provided by the campaign group. These patient statements are for review by the

Merton OSC panel of councillors as they relate to Merton residents. These detail the patient's concerns and poor experiences when the urogynaecology services at SGUH FT were suspended without notice 08/06/2015. These patients state they were never told what was happening from June-August 2015. The patients only found out that the services were suspended when they received letters from Croydon to say their appointments at SGUH FT were cancelled and they had been transferred to Croydon Hospital.

3. Please note this transfer occurred without the patients knowledge and moreover without their consent. Their medical records were shared with Croydon also without their consent. When given an appointment to go to Croydon against their wishes and without discussion they were all discharged back to their GP. This was even though they felt they had not been listened too and provided no treatment. In addition, the male doctor they saw had no notes for them or letters even though these records had been transferred. This caused the patients concern and was upsetting because they felt they had wasted their time. It took ages they said to get to Croydon only for them to be dismissed.

4. They all felt they were being seen at Croydon only to be discharged as an exercise to close the care episode. They were advised if they were concerned to go back to their GP and ask for an appointment to another hospital. I might have reservations about the patient's experience of transfer and review at Croydon were it not for the fact that every single one of these patients provides an almost identical account of what happened. This is of concern as most of these women still have unresolved symptoms and nowhere to go. They are not happy and did not feel cared for at Croydon (these are their words not my mine).

5. When some of the patients complained to SGUH FT the GM and chair for the consultation panel sent them a leaflet stating how wonderful Croydon Hospital was. I have been given copy of this and I must agree it is inappropriate. The patient's experience of the Croydon Hospital Service was not reflective of the 'great service' comments on the leaflet they were given when they complained. They say and I can see why they felt patronized. Raising concerns with St Georges Hospital only to be told all the other patients sent there were happy (just not them) is not appropriate. Again I have heard the same story over and over again. I thus believe these accounts are true and not in any way exaggerated.

6. Furthermore the patients also state they were seen at Croydon in the male STD clinic suite at this NHS Trust. This is where they say that extra ad hoc clinics were instructed for the St George's urogynaecology patients. The patients were also all told these were not normal gynaecology clinics and not being held in the l gynaecology clinic area. They were told this arrangement was purely to deal with the St Georges patients. It has been clear from the outset (despite the Trust assurances) that Croydon did not and does not have the capacity to deal with these extra patients.

7. The patients were also unhappy they were seen by a male retired gynaecologist (who was not a urogynaecologist) or a young male Doctor. They were not seen by the female urogynaecologist St Georges had promised them and as was stated in their Croydon letter of appointment. These patients describe being humiliated sitting

in a waiting area for patients attending a male attending STD clinic. The women are all elderly and/or from ethnic minorities or Muslim and this arrangement was not appropriate. These clinics even ad hoc should never have been held in this environment. These actions they believe violated their dignity and right to privacy and respect. The patients did not feel they were listened to or cared for (these are their words and not mine). The patients also state they were not examined and unless they gave the information to the male Doctor they said it was clear the male who saw them had no knowledge of their cases or copy of their notes.

8. Half of these Merton patients state they never received a consultation letter and those who did had no idea what it was. The letter was generic addressed to 'Dear patient' and not by their name. The letters were also all received between 3-5 weeks after the letter dated 19/10/2015. Some but not all patients have kept the envelopes. The letters were in these envelopes that all have a St George's Hospital franking mark indicating the date of postage (second class) were all after the end of the 1st week of November 2015. That is 3-3.5 weeks after the date of the letter. I am very concerned about this same concern related to the letters being backdated and vague. This to I have heard over and over from different patients. Finally the letter has no return address or phone number and merely instructs 'Dear patient' to log onto a website and provide feedback. This assumes they speak English, have a PC, know how to access the internet and submit a response. These actions are highly discriminatory.
9. These women's concerns have only come to light because of engagement by the local women's campaign group from 09/2015. These women have provided statements of concern. They do not want SGUH FT to have copy of the unredacted letters (with their identifying details). I have asked and they have said no and I respect their wishes. They have asked that I give the redacted letters to the Merton OSC panel for their review. They are happy for them to review these concerns. Separately they have asked their details be kept and disclosed cumulatively only with their consent. So to be clear I have consent to disclose the letters to the Merton OSC panel only but not SGUH FT and the letters are not for general release and not to be kept. These women have agreed to allow the women's campaign group leaders to keep their identifying details and statements and the solicitors Leigh Day. I am unclear regarding the reservations disclosing information to St Georges. This the patients state is because they do not want any other care appointments now or in the future at SGUH FT to be compromised this I am unclear about but that is their wishes and we must abide by these requests.

10. I would like the OSC councillors to appreciate how serious these concerns are. The whole consultation process has been flawed and corrupt from the outset it has enough wholes to make a decent colander. I and others including patients and public service users have been flagging these concerns regarding this consultation from 07/2015. I have been intimidated and accused of harassment and patients have been dismissed or ignored. SGUH FT simply refuses to accept these facts and refuses to terminate these processes. They have persistently refused to engage in any constructive dialogue and will not discuss the options and alternatives to service closure. SGUH FT never informed Merton OSC or any other OSC or Health Watch agency until they were reported by me. I deliberately only informed Wandsworth OSC from 09/10. 12/11 the Trust CEO told Wandsworth OSC at their meeting they would engage with staff and the public and patients and all relevant health watch

agencies and the other OSCs for Health in the SGUH FT catchment area. They never did and never honoured any assurance given SGUH FT.
11. I the patients, service users and public have no faith whatsoever that SGUH FT will do anything other than close the urogynaecology and PAG services 03/03/2016 this being the revised outcome date. The public consultation closed 04/12/2015. At this time the Merton OSC knew nothing of the process and the Merton residents were not engaged. This consultation process has been like pulling teeth. It has taken superhuman efforts on my part to get the process this far and it has had an adverse impact on my psychological health and recovery from depression. I have been harassed, bullied and threatened but I will not back down. I will see this through with the patients and women's service users but ask Merton OSC for their support.

12. SGUH FT had no intention at the time and no intention since of complying with the statutory processes for consultation. They wanted to close these services down and quickly to save money and dent the huge financial deficit they face. Incontinence services are core and not accessory services. PAG services are core but must be provided by trained staff. SGUH FT now denies they ever suspended the PAG services this is simply not true and evidenced extensively by correspondence regarding these matters from 03/2015. They SGUH FT managers have set up PAG again without my input or that of the joint PAG lead Dr Green from 2010-2015. There has been no consideration of the specialist skills required to run this service. SGUH FT believes any gynaecologist or paediatrician can provide a PAG service. I have provided the best practice guidance and they have just dismissed this. They also refuse to acknowledge that hoarding PAG referrals addressed to Dr Green and me from 01/2015. These hoarded referrals represent SUIs but have been dismissed by the Trust.
13. I must therefore request supported by the patients who have raised concerns and women's campaign group that these matters are referred to the Secretary of State for Health by Merton OSC enough is enough. SGUH FT's actions are indefensible but they will not listen to reason. I am aware that referral to the SoS may take a long time and the services suspended by SGUH FT are core and much needed women's and children's services. I therefore also ask these services are re-opened immediately and that this is recommended by Merton OSC also.

12. I have no doubt any recommendation you make to SGUH FT at the OSC meeting will be dismissed. SGUH FT has advised me and I realise they are correct that no OSC for Health panel has a regulatory role. I therefore ask for the only option that will see justice being done here and that is formal referral to the SoS. I have referred these matters also to Monitor for separate review of operational concerns and organizational behaviour as well as safeguarding concerns consequent to the consultation and service suspensions. The referral to the SoS now is the only way to stop this unlawful process by SGUH FT anything less will effect no change whatsoever. SGUH FT need to understand they cannot act unlawfully.
13. We face challenging times within the NHS with increasing changes to service provision, different commissioning pathways and need for collaborative working and the formation of strategic alliances. Collaboration like consultation is a verb and an 'action' word. Collaboration must be based on Trust and in turn this is based on honesty and transparency. I have no such faith in SGUH FT and I realise that on so saying I am criticising my employers and will very likely suffer further reprisal. The overriding message from the Francis Enquiry was that NHS staff should be feel safe

to raise concerns in an environment that supports rather than threatens. My experience over the past 12 months suggests to me that this message while acknowledged has not been incorporated into organizational practice by SGUH FT.
14. Everyone including large NHS healthcare organizations can make mistakes. This is not a sign of weakness and the ability to acknowledge these mistakes and provide redress is the mark of a mature organizational approach. While the SGUH FT managers continue to deny that the suspension of core women's urogynaecology and children's PAG services with instruction of formal consultation to close these services was unjustified, corrupt, flawed, discriminatory and unlawful I remain very concerned about these patients. I have also no faith based on experience of this process thus far that the organizational acts will be in the best interests of these patients moving forward. I am very concerned also at the organization's persistent and ever changing stance that contradicts the patients reported experiences and the facts supported by extensive evidence with third party corroboration.
15. The SGUH FT consultation process and organizational actions related to this process were flawed from the outset 08/06. These processes are unlawful and no amount of tweak or changing the consultation documents (also unlawful) will correct these concerns. In addition, no further attempts to badger the staff, patients and public users will change their opinion that the processes were flawed and unlawful. I am entreating the Merton OSC like Sutton and Kingston to challenge SGUH FT. I ask all three OSCs to make the referral to the SoS. Wandsworth OSC simply will not review these matters. I do not know why but I have tried and failed to get them to acknowledge these concerns. I therefore ask the other OSCs to take the right actions.
16. I have agreed to meet again with Health Watch and draft a document for consultation to be approved by the Health Watch agencies and shared for review/approval by the SWT OSCs for Health. This is to provide better information moving forward to ensure this mess does not happen again whereby any other service is put forward for consultation to substantively vary provision. This will hopefully make navigation of the legal framework easier to ensure compliance with statutory processes by the NHS provider seeking to change service provision that will include a check list.
17. SGUH FT have said most recently that they would do things differently with the consultation process if they could start over again. The CEO and divisional lead for women's services for SGUH FT insist they have learnt from this experience. I frankly do not accept this. Both senior officers will not accept the current consultation is so flawed is unacceptable and unlawful. They simply will not listen to the patients, staff, OSC councillors or Health Watch agencies in this regard.
This is simply not good enough. I have been telling the Trust repeatedly from 06/2015 they are acting unlawfully and they have had umpteen chances at the outset to put it right but have not. I have provided them numerous copies of the full statutory documents and DoH guidance and summaries from 09/2015 and they dismissed this information. I see no signs of reflection or acknowledgment of the harm caused. I therefore again for Kingston, Sutton and Merton to consider joint referral to the SoS for Health as a matter of urgency.
I look forward to seeing you next week
Kind Regards
Michelle Fynes

cc:

1. Dr Peter Green PAG service lead and consultant Forensic Physician and Safeguarding Children
2. Ms Katy McKinlay Monitor
3. Ms Rosa Curling Partner Leigh Day Solicitors
4. Mr Gerry Facenna QC Monkton Chambers Greys Inn
5. Mr Steve Broach senior counsel Greys Inn
6. Ms Sue Balding Representative Women's Campaign group for Merton, Tootig, Colliers Wood and Battersea.

Healthier Communities and Older People Work Programme 2015/16

This table sets out the draft Healthier Communities and Older People Panel Work Programme for 2015/16. This Work Programme will be considered at every meeting of the Panel to enable it to respond to issues of concern and incorporate reviews or to comment upon pre-decision items ahead of their consideration by Cabinet/Council.

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

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

Scrutiny Support

For further information on the work programme of the Healthier Communities and Older People please contact: -
Stella Akintan (Scrutiny Officer)
Tel: 020 8545 3390; Email: stella.akintan@merton.gov.uk

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

Meeting Date 02 July 2015

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Consultation	Epsom and St Helier University NHS Trust – update on current priorities	Report to Panel	Daniel Elkeles, Chief Executive, Epsom and St Helier Lisa Thomson, Director of Communications, Epsom and St Helier	Panel to receive an update on the Trust's plans to modernise Epsom and St Helier hospital
Policy Development	Merton Step down accommodation	Report to Panel	Mark Clenaghan, Service Director, South West London and St Georges Mental Health Trust Caroline Farrar, Assistant Director of Commissioning and Planning	Panel to receive an update on proposals to close Norfolk Lodge mental health facility.
	Work Programme			

Meeting date – 03 September 2015

Scrutiny category	Item/Issue	How	Lead Member/ Lead Officer	Intended Outcomes
Pre-decision scrutiny	Healthy Child 0-5 Transfer	Report to the Panel	Julia Groom, Consultant in Public Health	Panel to comment on the report before it goes to Cabinet.
Scrutiny Review	Preventing incontinence task group update report	Report to the Panel	Catrina Charlton, Senior Commissioning Manager. Merton Clinical Commissioning Group	Panel to comment on progress with implementing the recommendations.
	Work Programme –	Report to the Panel	Stella Akintan/ Cllr Peter	

	agree final draft		McCabe	

Meeting date – 22 October 2015

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Performance Monitoring	Adult Social Care Savings	Report to the Panel	Simon Williams, Director of Community and Housing	
Performance Monitoring	Use of Volunteers in day centres	Report to the Panel	Andy Ottoway-Searle, Head of Direct Provision	To review the progress with recruiting volunteers.
Policy Development	Preventing ill health	Report to the Panel	Dr Kay Eilbert, Director of Public Health	To look at the prevention agenda and consider how the Panel can provide ideas and support.

Meeting Date – 10 November 2015

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Policy Development	Update on the Care Act	Report to the Panel	Simon Williams, Director of Community and Housing	To gain an overview and the main implications of the Care Act, and the progress with implementing it in Merton.
Performance monitoring	Budget	Report to the Panel	Caroline Holland, Director of Corporate Services	To review savings proposals

Meeting date – 12 January 2016 BUDGET

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

Meeting date – 09 February 2016

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Performance monitoring	St Georges report on substantial variation to a local Urogynaecology clinic.	Report to the Panel	Miles Scott, Chief Executive, St Georges University Hospitals NHS Foundation Trust	Panel to be consulted on proposed changes to the clinic
Scrutiny Review	Physical activity for the fifty five plus	Report to the Panel	Public Health Team	Panel to review services in place to support physical activity amongst the 55 plus age group

Meeting Date - 17 March 2016

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Consultation	Update from Epsom and St Helier Hospital on Estates Strategy Community Consultation	Senior officers to attend Panel	Daniel Elkeles, Chief Executive Epsom and St Heiler University NHS Trust	To review/ discuss outcomes on recent consultation with community on estates strategy
Scrutiny Review	Diabetes task group Final Report	Report to the panel	Cllr Brian Lewis Lavender	Panel to comment on the final draft report on Diabetes in the South Asian community
Policy Development	Making Merton a Dementia Friendly Borough	Report to the Panel		Panel to consider measures to make the borough more friendly to people with dementia
Policy Development	Healthy High Streets	Report to the Panel	Public Health Team	Panel to consider the measures in place to ensure that Merton's high streets have a variety of shopping outlets to support the health and wellbeing agenda.
Policy Development	Out of hospital Care	Report to the Panel	Merton Clinical Commissioning Group	Review the services available to support people in the community and reduce reliance on in-patient hospital care.
Policy Development	Support for older people with physical and mental disabilities in the community	Report to the Panel		Review the services and support available for the vulnerable group.

Policy Development	Integrated Care	Report to the Panel		Review the progress with integrating health and social care