Health Scrutiny Action Learning Project

Community Leadership To Improve Health

OCTOBER 2006

Putting You First
www.merton.gov.uk

merton

Project Membership

This project (funded by the Centre for Public Scrutiny) has been overseen by the Health & Community Care Services Scrutiny Panel, with the following members taking the lead:-
Councillor Gilli Lewis-Lavender
Councillor Sheila Knight

External Researchers

GR Associates
9 Dalebury Road
London
SW17 7HQ
email@rayner.uk.com

Health Scrutiny Contact

Barbara Jarvis, Scrutiny Officer
London Borough of Merton
Chief Executive's Department
Policy, Partnerships and Performance Division
9th Floor, Civic Centre
London Road
Morden
Surrey SM4 5DX
020 8545 3390
barbara.jarvis@merton.gov.uk

Acknowledgements

Health Scrutiny Members wish to express their thanks to all those who have contributed to the Action Learning Project, including everyone who has –

- attended a meeting or event,
- been interviewed,
- taken part in a focus group,
- promoted the Project,
- commented on the findings.

Thanks to the Sutton & Merton Primary Care Trust (PCT) for its involvement in the Project Steering Group.

Particular thanks to Geof and Nigel of GR Associates, who have conducted their research with energy and enthusiasm.

For further information on overview and scrutiny, visit
www.merton.gov.uk/council/scrutiny or email scrutiny@merton.gov.uk

Contents

Appendices:-

Note: The reports from GR Associates have been produced as a separate reference volume available from Barbara Jarvis, Merton Scrutiny Team (see contact details on inside cover of this report)

Executive Summary/Foreword

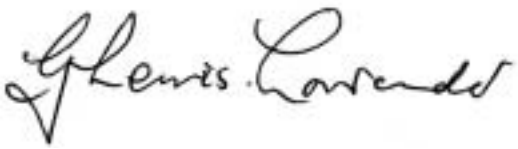
As part of Merton's Health Scrutiny Work Programme for 2005/6, we were successful in securing funding from the Centre for Public Scrutiny to enable us to undertake a Health Scrutiny Action Learning Project on how community engagement can contribute to improving health. For this Project we have been very fortunate to secure the services of GR Associates, who have undertaken research around the health of older people in the Borough. It has been a pleasure to work with Geof Rayner and Nigel Goldie and we will be able to use their work to link into our main health review for 2006/7 as indicated below.

Building on the outcomes from the Action Learning Project and the research of GR Associates, the Health and Community Care Overview and Scrutiny Panel has recently commenced an extensive review to consider the issues around prevention of ill health and early intervention, for the benefit of the residents of the London Borough of Merton, with particular focus on initiatives to address health inequalities. This continues to be an enormous piece of work and I would like to sincerely thank all members of the Panel for their enthusiasm and commitment to this project and also our Scrutiny Officer, Barbara Jarvis, for her tireless dedication to supporting the Panel. In addition, the invaluable contributions that Merton's officers, our Health partners and local voluntary organisations have made must not go unnoticed and I would like to thank them too.

The Action Learning Project has clearly highlighted the importance of working closely with local groups and service providers in order to promote health improvement and well-being. It also highlights areas where there are gaps in services provided and it will be the task of the Scrutiny Panel to persuade health service providers of the benefits in taking the recommendations on board, particularly for older people.

I know you are all going to find this report thought provoking and, as responsible members of the community, it is important that collectively we should take the findings and recommendations contained in the report forward.

Yours Sincerely



Chair, Health & Community Care Overview & Scrutiny Panel
Chair, Action Learning Project Steering Group

Recommendations

Recommendation 1:

That elected members continue to develop and strengthen their liaison role in the local community/ward, to allow concerns and issues around health and well-being to be brought to the fore and addressed appropriately.

Recommendation 2:

That the need to tap into skills such as those held by older people to aid preventative strategies is acknowledged and addressed, in particular through expansion of volunteering activity.

Recommendation 3:

Given the recent attention to government policy on ageing, it is anticipated that the limited focus on ageing may be subject to change. The issue of older people's health and well-being must be considered in all strategic planning, including the Older People's Strategy being developed by the Community and Housing Department, as recommended by the Health and Community Care Overview and Scrutiny Panel on 6th September 2006.

Recommendation 4:

Health Inequalities needs to remain at the top of the agenda for health overview and scrutiny and for health and local authority partners and voluntary sector organisations, so that real efforts are made to reduce the inequalities gap.

Recommendation 5:

Local government, NHS and voluntary bodies, need to work harder, and in partnership with local people, to promote local communities with good facilities, opportunities for social participation, increase independence, affordable and accessible transport and services, and environments which are perceived to be safe.

Recommendation 6:

With reference to how community services could do more to initiate and conduct testing (e.g. cholesterol, blood pressure, diabetes etc), there should be consideration given to someone specialising on the needs of older people located within community settings, such as clinics, surgeries, pharmacies, or even non-health related settings.

Recommendation 7:

That there should be much wider and more intensive advertising and promotion of local initiatives to improve health, to maximise participation.

Recommendation 8:

That initiatives to help older people take advantage of local opportunities (such as specific arrangements for use of leisure facilities and the Allotments Strategy currently being worked on), continue to be developed.

1. Project Rationale in the Context of the 'Choosing Health' White Paper

1.1 This Health Scrutiny Action Learning Project, which has been funded by the Centre for Public Scrutiny, is based on a theme from the *Choosing Health* White Paper. *Choosing Health* outlines a new approach to the health of the public, with a stronger focus on action and decision-taking resting with the population at large in relation to public health matters, rather than a prescribed approach from the Department of Health. The White Paper outlines three core principles underpinning this new approach to reflect what the public wishes to see by way of change:

- Informed choice

People want to be able to make their own decisions about issues that impact on their health and to have access to the necessary information to help them do this. There also needs to be arrangements to protect the health of children and to deal with situations where one person's choices may be to the detriment of other people's health and well-being.

- Personalisation

Support needs to be tailored to meet the realities of individual lives, particularly for deprived groups and communities, who can find that health services do not meet their needs or circumstances. Services and support need to be provided flexibly and conveniently.

- Working together

Real progress on health improvement depends on effective partnerships across communities, including local government, the NHS, business, advertisers, retailers, voluntary sector, communities, the media, and faith groups.

1.2 A major issue for local authorities is to establish how they can play a key role in the community drive for improving health.[1] In Merton, there are areas of affluence contrasting with areas of deprivation with a broad east/west geographical divide. Particular wards have profiles indicating greater levels of health needs and higher numbers of vulnerable people. This Project aims to focus on where the greatest need lies to maximise the impact in terms of health improvement and raise the profile of local community leadership and the voluntary sector in meeting this need. A specific sector of the local population will be focused on through a case study on older people.

1.3 Previous scrutiny work in Merton has highlighted the contribution made by the voluntary sector/local community in providing frontline services through enhancing vital health and care services, with the need for these to be seen as having parity with services provided by the local authority/health sector. Also, local people may have valuable skills and knowledge which could be harnessed through voluntary work in the community, but which remains an untapped resource.

1.4 This Project is therefore based on the need to tap into and utilise local knowledge and expertise which can contribute to improving the health of the local community. The Choosing Health White Paper focuses strongly on the public setting the agenda for their health and particular needs. This Project aims to promote the role of the wider community in health improvement and ill health prevention to lead to improvements in health which are sustainable in the longer term.

1.5 Local consultation has been undertaken throughout the Project with a wide range of practitioners and stakeholders. Over 100 older people have been engaged with by the researchers through focus groups or interviews, but individuals have not been named here. However, a list of local organisations consulted is included at the end of this report. (Appendix 2)

[1] Department of Health, Choosing Health White Paper, Chapter 4

2. A Research Case Study of Older People (aged 50+ years)

2.1 Funding from the Centre for Public Scrutiny has been used to commission the services of a local research consultancy, GR Associates, who were selected on the basis of their local knowledge and experience of Merton and the surrounding locality and for their work for the Department of Health on health inequalities and the Choosing Health agenda.

2.2 Due to the wide remit of the Project topic, it was agreed that GR Associates would focus their research on a specific sector of the local population when looking at the issues of health and well-being and how local action can contribute to improving these. The 50+ years age group was selected as being one which often appears to be neglected in key strategies, which may experience cuts in services from time to time and which also may feel marginalised/ excluded from mainstream activities.

2.3 GR Associates have interviewed a range of local authority managers and health service professionals as part of their work and have provided their research findings in a set of briefing papers. Over 100 older people locally have also been engaged with, through a series of focus groups held across the Borough and through other interviews. The research findings are contained separately as a complete set for reference purposes.[2] However, the key issues and recommendations arising from the research have been incorporated into this Project report at the appropriate point.

2.4 Although the research focus has been on the 50+ age group, health scrutiny members have had the opportunity to consult other groups, such as young people as part of Local Democracy Week in 2005 and also as part of the new Annual Healthcheck process, which has replaced star ratings for NHS trusts. Young people can also feel marginalised and ignored and interviewing them has proved to be very informative. They highlighted personal experiences in:

- Delays for dental treatment
- Difficulty getting GP/health appointments
- Being talked down to by health staff
- Lack of feedback on treatment
- Difficulty in registering with a GP when first arriving in the UK

2.5 Members also interviewed the Merton and Morden Guild of Social Services and Wimbledon Guild of Social Welfare to hear about their work and the services they offer (which is detailed as part of GR Associates' findings).

2.6 Local bodies have also been consulted, including Merton Voluntary Service Council (MVSC), which assisted with promoting the Project in the early stages, and organisations such as Age Concern Merton.

[2] GR Associates Briefing Papers 1-4 plus summary

3. Elected Members as Community Leaders for Health

3.1 The modernisation agenda for local government has resulted in a stronger community role for elected members and particularly those members involved in scrutiny. Scrutiny members provide a vital mechanism for issues of local concern to be raised and referred for scrutiny if appropriate and for members of the local community to actively participate in the democratic process.

3.2 With the specific power of health scrutiny being introduced through the Health and Social Care Act 2001, local authorities are now able to scrutinise local health issues, seek to achieve health improvement and tackle health inequalities, which underpin the local government responsibilities for promoting the environmental, economic and social well-being of the local community. Health scrutiny requires strong links to be forged with local NHS trusts and for effective communication channels to be developed with local primary care trusts (PCTs).

3.3 The Choosing Health agenda provides a vital opportunity for scrutiny to contribute to improving the health of the local community. People can make their own choices about their health but want advice and support to help them exercise their choice. Scrutiny can ask the right questions:

- Are local services which can impact on health, e.g. leisure opportunities, really accessible to all?
- Are details about advisory groups, such as those which can help people to stop smoking, readily available?
- Are local partnerships, which are working in relation to health, effective and wide enough e.g. including NHS trusts, voluntary sector, community groups, community care?
- Are local businesses/retail outlets involved in health campaigns?
- Has the issue of health been given a high profile in the local media?
- Are hard to reach groups engaged with on health issues which affect them?
- How has the Council and its partners responded to the Director of Public Health's annual report?
- What is the Executive doing to address health inequalities?
- What is the Council doing as an employer to improve the health of the workforce?
- What account is taken of health issues when decisions are taken to invest funding in local initiatives?

3.4 Scrutiny has huge potential to drive the implementation of health policy at a local level and establish the value of scrutiny within local governance.

The power of health scrutiny can be used to effectively demonstrate the importance of the wider determinants of health, rather than just having a narrow focus on local NHS services. Information on local health needs (from the Director of Public Health, the PCT, ward surveys, local community groups etc) will drive scrutiny's focus.

3.5 The role of the local authority councillor is developing and strengthening all the time, so that issues of concern at ward level can be brought into the public domain and organisations and agencies can work together to resolve them for the benefit of the local community. This new role for elected members is crucial in the drive for change at local level.

3.6 At the time of preparing this report, the Government's White Paper on local government has just been published. This includes initiatives to strengthen the role of councillors through the concept of community calls for action, whereby residents can take a wide range of issues of local concern to their ward councillors and seek action to address problems through the local authority and partner organisations. It is also proposed that the scrutiny function will develop through enhanced powers to ensure that overview and scrutiny is more effective.

Recommendation 1:

That elected members continue to develop and strengthen their liaison role in the local community/ward, to allow concerns and issues around health and well-being to be brought to the fore and addressed appropriately.

4. The Role of the Voluntary Sector in Meeting Local Health Needs

4.1 Health and social care services must fulfil their statutory obligations when providing and delivering services. When considering what level of non-statutory services can also be provided to benefit the local community, then the issue of resource pressures inevitably comes into play. It is the discretionary services that bear the brunt of financial planning and budget savings year on year. This is where the voluntary and community sector has a key role to play.

4.2 The focus of the Project research has been on those issues impacting on how the health and well-being of older people can be improved.

GR Associates have determined that -

'The contribution of the voluntary and community sector towards ageing and older people within Merton is currently largely one of prevention, support, information and advice.' Such contribution is…

'vital to enable people to live independent lives and thereby reduce the pressure and costs on health and social care services… many of these activities are funded by statutory agencies and provided by paid staff. In addition there is the additional unpaid contribution of volunteers. A recent review of the contribution of volunteers within Merton has estimated the time they give to be the equivalent of 8 million hours at a saving of £90million. This excludes the savings made by the thousands of largely unpaid carers in the borough.' [3]

The Merton Compact and Partnership working

4.3 GR Associates note that many voluntary and community groups and agencies emerge and often continue without public funds. As such they are genuinely independent. By contrast there are voluntary organisations that increasingly act as partners of the statutory sector and in some cases are totally dependent on it financially. The voluntary sector in Merton, as in most local areas, is composed of organisations of varying degrees of independence, as well as national organisations, with some well-established local bodies working alongside an array of small organisations serving very specialist needs and interests.

4.4 Through its 'Change Up' programme, the government has done much to raise the expectations of the voluntary sector, in that there is to be a new dawn of greater collaboration, equal partnership status, a level 'playing field' when bidding for projects, and the opportunity to bid for a range of activities previously the preserve of the statutory sector. Merton like other boroughs has developed a Compact with its voluntary sector. This sets out a number of aims and principles by which to assess the changed relationship. These principles cover such matters as: consultation and policy appraisal; funding procurement and commissioning; black and minority ethnic organisations; community organisations; volunteering; and, governance.

[3] GR Associates, Briefing Paper No.3 *'The Contribution Of The Public Sector To The Voluntary And Community Sector Means Of Delivering Health and Social Care'*

4.5 The stakeholders who spoke to GR Associates had mixed views as to the impact and value of the Compact. While welcoming it as a statement of principles and intent, some observers believe that 'it will only benefit a few large organisations around Merton Voluntary Service Council (MVSC)'; and that the key issue is still one of securing long term funding to properly meet overheads and office costs. However, Merton is gradually moving to three-year funding on a service level agreement or contractual basis. Some organisations are now funded in this manner, although there remain a large number still funded through an annual programme.

4.6 The Compact has benefited the voluntary sector through giving it a clearer right to have a place at the table of the various boards that make up the Partnership arrangements within Merton. It has established a number of working groups, the most active of which is one dealing with procurement and funding.

4.7 Within the health and social care field, the voluntary sector has its own forum called INVOLVE. This meets periodically, and is a means of bringing together health and social care providers in the voluntary sector. It has had attendances of 40+ and occasionally invites senior statutory sector representatives to attend. INVOLVE is one of the activities that the MVSC supports. This body plays an important role in representing the voluntary and community sector within Merton and currently provides the means through which voluntary sector representation in the Compact and on Partnership Boards is arranged. A recent report commissioned by the Merton Partnership, *Review and Proposals for Community and Business Engagement in the Merton Partnership*, has suggested its role in this regard be enhanced through hosting a new Community Engagement Network.

4.8 GR Associates also conclude that partnership working has been somewhat slow to develop in Merton in comparison with other boroughs (especially those in receipt of Neighbourhood Renewal Funding). However, steps are now in place to develop more effective structures and a report was recently commissioned to examine ways of improving community and business engagement in the Merton Partnership. The report *Review and Proposals for Community and Business Engagement in the Merton Partnership* places the need to address this issue within the context of the new Comprehensive Performance Assessment (CPA) and the introduction of Local Area Agreements (LAAs).

4.9 The Council's forthcoming Corporate Assessment by the Audit Commission in 2006-07 will focus on sustainable communities and transport; safer and stronger communities; healthier communities; older people; and children and young people. Within the current partnership structure there is an Older People's Partnership Board and agendas are largely driven by National Service Framework (NSF) and current service provision concerns. As such, it is not a forum within which to address the more strategic issues of improving the health and well being of the 37% of Merton's population aged over fifty. However, through the development of an LAA and thematic partnership, the issue of promoting healthier communities including for

older people will be taken forward, so that there will be a stronger focus on prevention of ill health.

Funding for the voluntary and community sectors

4.10 The remit of this Project was not to specifically consider voluntary sector funding issues. A scrutiny review at Merton conducted in 2005 on the Voluntary Sector Funding Process highlighted some of the issues facing the voluntary sector in Merton. The context of that review was the Government's 'Change Up' agenda and the challenge this poses for the development of a more sustainable voluntary sector. The main findings of the Scrutiny Review are within its report (which can be found on the Council's website – www.merton.gov.uk/scrutiny (under Scrutiny Publications), but there are some points of particular relevance to this report. The recommendations include:

- *There should be a development of a corporate funding and support strategy for voluntary and community organisations and the voluntary sector should be consulted on this; and*
- *There is a need for mapping of various types of services across the borough*

4.11 The review also highlighted the problem of funding for 'health and well being activities' falling between different funding streams, both within the Council and between the Council and the PCT. A unified funding process working to an overarching set of priorities would simplify the means of funding such activities. The gradual move to three-year funding was welcomed as a means of ensuring greater continuity and stability of service provision. The review report also sets out the role of the Sutton and Merton PCT in health promotion and its use of Health Improvement Fund (HImp) to fund voluntary and community based activities. This funding is limited to three years and this raises the issue of sustainability.

4.12 The Head of Community Care within Merton is also referred to within this report as having emphasised:

'the link between health and social care, together with the need for increasing focus on the voluntary sector to deliver services as part of a shift away from care at the high need end of the spectrum to the intermediate care level'.[4]

Recommendation 2 :

That the need to tap into skills such as those held by older people to aid preventative strategies is acknowledged and addressed, in particular through expansion of volunteering activity.

[4] Scrutiny Review Report June 2005 ' Review of Voluntary Sector Funding Process'

Voluntary and Community Organisations Supporting Older People and Health Activities in Merton

4.13 GR Associates provide a simple analysis of the range of organisations that in one way or another contribute to the health and well being of people over the age of fifty in Merton. The table in Briefing Paper 3 sets out basic information derived from the Merton Voluntary Service Council's directory of organisations on its website.

Observations include:

- At first sight there are indications of a range of activities addressing health and other needs of older people. There are also groups addressing the needs of BME communities. Mental health is an area that appears well catered for, with a range of projects mainly for adults generally, but also for older people. There are several projects addressing other specialist needs such as hearing and visual impairment; disabling conditions such as MS, diabetes and sickle cell; and the needs of carers. Not surprisingly most projects work across the age range, yet there is an absence of projects addressing health promotion in a focused and engaged manner. The ones that most clearly engage with health and fitness of older people are Age Concern and the Guilds, with some reference by other organisations to 'coffee, lunch and tea with activities' (often bingo).
- Among the organisations that deal with 'health' across the age range the ones that appear to be addressing health promotion (as opposed to advocacy and information about access to services) are those within BME communities. For the most part, reference to 'health' is one activity among many and it is difficult to know how much attention this receives.

4.14 As noted above, the issue receiving the most attention is mental health through a range of specialist projects. Nevertheless, health scrutiny members at Merton remain concerned about mental health services for Merton residents and in particular the continual savings made to mental health budgets. A Mental Health Review Group of four health scrutiny members has been set up to monitor progress with implementing the mental health action plan drawn up following a mental health inspection by the Commission for Social Care Inspection in 2005. Mental well-being is crucial to general good health.

Voluntary sector organisations addressing health and well being among older people

4.15 Age Concern is the major voluntary organisation within Merton providing a range of services for older people. It has an 'Ageing Well' programme, provided for people aged over fifty aimed a keeping people healthy and independent. This programme (which is HImp funded) includes a number of courses/activities, such as:

- Links to a dietician from the PCT
- Eating well on a budget – how to avoid high fat foods

- Eating healthily
- Illnesses associated with diet – e.g. diabetes etc
- Men's health issues
- BME health issues
- 'Astute' shopping - talk about the tricks supermarkets get up to.

The aim is to get people to commit and 'buy into' these activities through choice and so the activities are made as enjoyable and sociable as possible.

4.16 Comments about these activities include:

- 'There are some older people around who have always been active and maintain fitness readily, but others lost the habit of exercise – if they ever had it – so there is a lot to learn and get over in terms of their inhibitions'.
- 'You need to have trainers who are their age and can be good role models. – e.g. a yoga teacher in her 60s and a walks tutor who is 70+'.
- 'Dance is often the best form of exercise, it can be done in so many different ways and it's good exercise, enjoyable and social company'.

And a comment in relation to health services:

- 'We find in these activities we are spending time undoing much of the harm done by well meaning doctors and the health service, too often people are encouraged to 'take it easy'. So people with arthritis are 'told' not to exercise etc – we need to challenge some of their notions about health and illness. We also tackle such issues as depression in older age and bereavement'.

4.17 The issue of programmes to address mental health issues, in particular that of depression among older people, was also raised by MIND. It was observed that there is resistance among commissioners to fund projects to work with widows and widowers, as if 'older people cannot engage in group work'.

4.18 Age Concern advise that the 'Ageing Well' programme also involves training volunteers. There are ten volunteers being trained at present and 20-30 are already engaged. They work wherever groups want them, usually in day centres, where they give information and talk about 'ageing well'. They undertake a 6 week course and use other organisations' premises, but the problem in Merton is finding suitable premises. Both of the Merton Guilds provide exercise opportunities as well. Age Concern tries to ensure that it does not duplicate what the Guilds are doing.

4.19 Older people also want aromatherapy, complementary therapies and mind/body courses. They are aware of stress in their lives and they are curious and interested in taster classes, such as martial arts, belly dancing etc.

4.20 Views such as these indicate the need for a plan reflecting what older people want, to set out a strategic framework that points to the inter- connections between different agencies and activities. It is all too fragmented at present. However, stronger planning and greater cohesion will be achieved through the development of the Older People's Strategy for Merton, which will be widely consulted on in 2007 and on which Merton's Health and Community Care Scrutiny Panel will continue to be consulted.

4.21 As well as visiting and gaining views from Age Concern, GR Associates also visited the Merton and Morden Guild, Friends in St Helier, the Wimbledon Guild and the Asian Elderly Group. Comments from some of the users of these services are incorporated in GR Associates' Briefing Paper 4. The key issues that arose from these other groups can be summarised as:

- Concern over the lack of suitable premises in which to conduct activities with older people.
- One key issue to consider regarding the suitability of venues is availability of good transport links.
- Awareness that current services are only reaching a very small proportion of the potential user base.
- Lack of overall co-ordination and strategic vision as to how the different groups can work together and with the statutory sector
- Need for more secure funding that is more appropriate to the levels of need with the communities served by voluntary and community sector organisations.
- Infrequency of contacts with those commissioning services (other than for grant monitoring purposes).

The Role of Volunteering in Merton

4.22 GR Associates focused on the issue of volunteering as part of their research. Attention is drawn to the importance of harnessing untapped resources within communities and of extending the role of volunteering, particularly in relation to expanding the involvement of older people in volunteering activities. It is fortunate that a recent report has been produced that addresses the broader picture of volunteering within Merton. *Mapping and assessing the impact of volunteering within the London Borough of Merton* was produced by Brian Thomas of Roehampton University in November 2005.

4.23 This report had the aims of identifying the ways and contexts in which voluntary action takes place in Merton; providing estimates of the numbers of volunteers and the time they contribute; and assessing the impact of volunteering on the volunteers themselves and the wider community. This work was also to enable Compact members to develop a more strategic approach to volunteering. The report sets out some useful distinctions between types of volunteering based on the definitions used in the 2003 Citizenship Survey, published by the Home Office in 2004.

These are:

Formal Volunteering – giving unpaid help through a constituted club, group, organisation, project or faith group to benefit other people or the environment i.e. any organisation that depends on people giving their time freely for a good cause.

Informal Volunteering – giving direct and unpaid help as an individual to people who are not relatives

Civic activity – when a person helps campaign for improvements in local conditions, attending public meetings or rallies, inter-acting with local campaigners, councillors, Members of Parliament etc.

4.24 Using these classifications of different forms of volunteering the report provides a revealing estimate of the extent and value of various types of volunteering activity in Merton:

Regular formal volunteering (taking place at least monthly)

About 26% of over 16s in Merton (40,000 people) give 4.1 million hours per year, equivalent to 106 hours per person. If the national average pay rate of £10.41 per hour (ONS, 2004) is used, this would be worth some £43m per year. Adding overheads of 20% (giving £12.50 per hour) generates a value for volunteering in Merton in the region of £51m per year.

Regular informal volunteering

About 36% of over 16s in Merton (54000 people) give 3.9 million hours per year equivalent to 72 hours per person. If this had to be funded, the value would be £48m per year, again assuming an hourly rate of £12.50.

Civic activities

The statistical sources indicate that about 3% of over 16s (4000+ people) were regularly engaged in voluntary civic activities. However sources do not reveal the amount of time involved and in any event, it is probable that these figures overlap the formal volunteering figures. Hence no economic value was placed on this activity.

4.25 A short public survey was undertaken in Wimbledon and Mitcham. Of around 1,000 people approached, 100 provided data which serves to confirm the above figures. In addition, a survey was undertaken within voluntary and community organisations in Merton. In various ways some 400 forms were returned from forty different organisations. This revealed that older volunteers (aged 55 and upwards) were very much the majority in the sample, which contrasts with national data that suggests that volunteering peaks in middle age.

4.26 The report includes analysis of the impact of volunteering on the volunteers as perceived by themselves. This is done across a range of dimensions and overall points to the beneficial impact. Age makes a difference, with younger people seeing greater benefits, especially with regard to employment skills, social skills and making new friends, whereas for older

people it was more a case of keeping active, forming new friendships and social activities.

4.27 The Volunteer Centre Merton's (VCM) Strategic Plan 2005–2009 sets out how it:

'could make a more significant contribution to developing volunteering opportunities and the skills of Merton's volunteers, and to the building of greater social cohesion and social renewal within Merton'.

4.28 VCM currently provides six programmes in the areas of recruiting and placement; volunteering development; youth action; help service; Merton MIND; and, Disability Alliance Merton. The main activities of VCM are:

- Recruiting and placing volunteers – a brokerage function that includes: developing good practice – with organisations that use volunteers; developing volunteering opportunities (there are three programmes); and, marketing – team based activity
- Supportive volunteering for people with mental ill health, physical, learning, and sensory disabilities – this takes pressure off the statutory services. For this VCM provides continuing support and seeks opportunities for volunteers with providers and also provide support for the volunteers.
- Help services – support for isolated and vulnerable older people (again takes pressure off statutory services) through befriending and such activities as gardening/shopping activities.
- In addition, attention is placed on the importance of strategic development of volunteering and the wider campaigning activity to promote volunteering within Merton.
- VCM sees enormous potential for more volunteering, but advises that more resources are needed to fund these activities – there are costs to finding and supporting (training) volunteers – if it is to be done responsibly and they are to be effective.

4.29 GR Associates were informed that VCM recruits 500+ new volunteers a year, with 1,000 – 1,500 enquiries received per year. 15 volunteers support the Centre itself (worth £45-50k in value to the organisation, including specialist assistance with IT, marketing, accounts, website etc)

4.30 VCM also acknowledged that:

'there are many older people who have been volunteering for years with a wide range of organisations within Merton, they have done for many years and we know nothing about them. We would love to be pro-active with the 50+ age group, but we have no resources to devote to this group – it would need a co-ordinator of recruits. We are working on a proposal to go through the Older People Partnership Board (H and S care) – we did a 'POPP' bid for this. There is a need for a focus on senior citizen volunteering – to parallel that for young people'.

4.31 GR Associates have sought to set out a range of issues within the relationship of the public sector to the voluntary sector, in relation to the latter's engagement with improving the health and well-being of older people. Attention has been given to those wider developments of partnership that are aimed at changing the nature of this relationship. Although the voluntary sector is diverse, the main financial dynamic is the fundamentally unequal relationship between statutory and voluntary sectors, with all major sources of funding coming through the local and health authorities.

4.32 The Merton Partnership Older People Thematic Group has been charged with the task of ensuring that the goals of the older people section of the Community Plan are delivered. A comprehensive strategy is in the course of being prepared to ensure that the Council and its partner organisations look holistically at issues affecting those in the 50 + age range.
This will contribute to achieving:

- unified commissioning and funding arrangements;
- greater coherence over the range of activities to be provided;
- clearer service specifications that tie health promoting activities to funding;
- more effective utilisation of resources such as premises;
- further expansion of the contribution of older people as volunteers across a range of activities.

5. Addressing Health Inequalities

5.1 Sutton and Merton Primary Care Trust (PCT) produced its Annual Public Health Report 2005, entitled 'Health inequalities in Sutton and Merton – Developing a Platform for Local Action'. This report describes local inequalities and suggests ways of tackling them.

5.2 In the borough of Merton, there is a clear east/west divide with the more deprived wards in the east around Mitcham, for example in the Phipps Bridge area, Lavender and Pollards Hill wards, contrasting with the more affluent area of Wimbledon and Raynes Park.

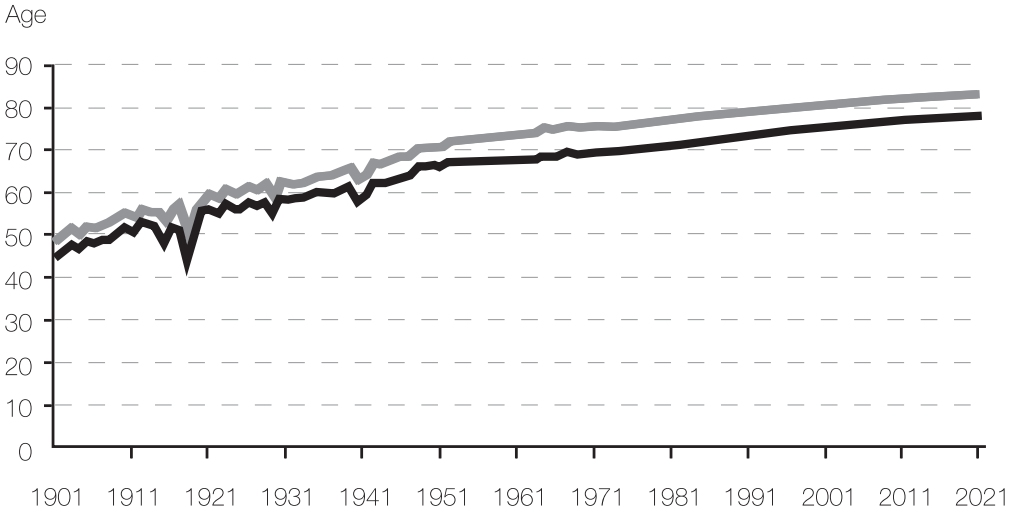
5.3 GR Associates state that

'Merton people are living longer and healthier lives than ever before. However, good health and active, enjoyable lives, achieved by many, are not enjoyed by all. While many enjoy good health for the majority of their lives, health problems and disabilities accumulate over time; some are avoidable; some can be mitigated or compensated for; others cannot. Some disabilities occur through the natural 'wearing out' of the body; some health problems occur in some groups and less in others; some problems may result from factors accumulated over the life course, others in the context of current living circumstances; others may occur on a genetic basis. While health differences and inequalities, by their nature, affect different groups in complex ways, one of the endemic features of society which affects the health of many older people is rooted in society rather than the body: 'ageism'. Ageism operates as cultural bias against older people in both subtle and less subtle ways, and it even appears with the best of intent; it is found among older people towards each other and even towards themselves. Seen in this light improving the health of older people through social, environmental, economic and cultural means, and addressing inequalities, becomes as important as attending to the health consequences of ageing process through medicine.'

5.4 Over the last century in Merton, and elsewhere in Britain, society has witnessed a massive and unprecedented improvement in mortality (death) trends. GR Associates state that, in 1901, the average life expectancy in the UK was 49 years for females and 45 years for males. By 2002 life expectancy at birth for females born in the UK was 81 years and 76 years for males.[5] In the space of a hundred years life expectancy at birth has almost doubled.

[5] Government Actuary's Department for expectation of life data. Office for National Statistics for mortality data, 7 May 2004

Life Expectancy at Birth



Figures estimated from 1996

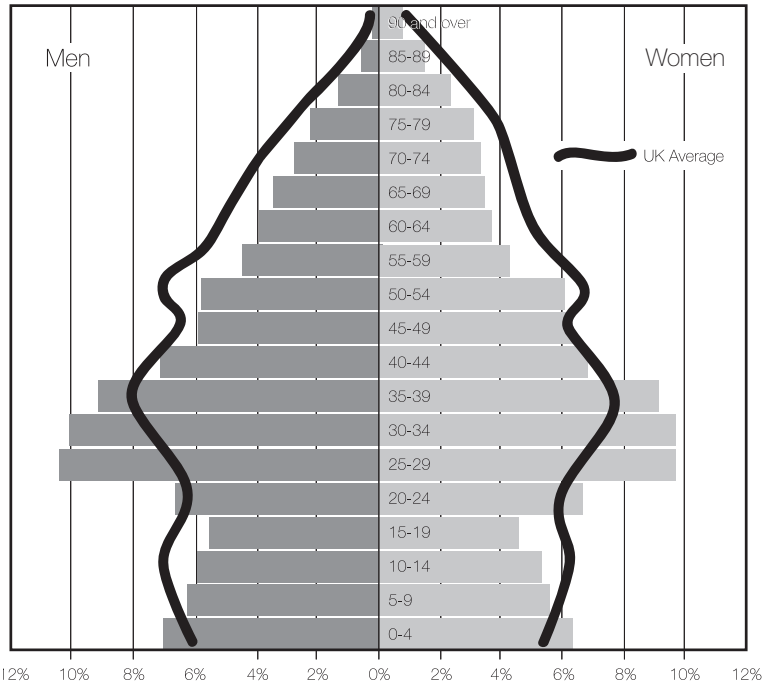
Key: Men

Women

5.5 Office of National Statistics (ONS) data shows that over 21 per cent of the population is now aged over 60 years, which for the first time ever constitutes a larger share of the population than children under 16. By 2008, it is predicted that the number of people aged 45-64 will for the first time exceed those aged 20-39 years. Life expectancy at birth is continuing to rise while the birth rate is falling. This means that the overall population balance is growing older. Another major indicator is the very recent increase in the number of people aged 85 and over: now over 1.1 million – equivalent to 1.9 per cent of the population.

5.6 The 'age map' of Merton based on the 2001 Census is contained in the diagram overleaf and shows that, between the 1991 census and 2001 census, Merton's population rose by 20,300 (12.1 per cent). By mid-2003 Merton had an estimated 191,400 residents, comparing with the 2001 Census figure of 187,908 residents. This would indicate a steady gain of 5.4 per cent in 2 years (compared with the rate of growth for England of 5.0 per cent.) There is a scattering of population age ranges throughout the borough with the highest density of people aged 65 or more in central Mitcham.

Merton Age Map (2001 Census, source ONS)



Merton Age Map: underlying data (2001 Census, source ONS)

Age (years)	Total	Males	Females
0 - 4	12708	6516	6192
5 - 9	11158	5774	5384
10 - 14	10723	5520	5203
15 - 19	9585	5121	4464
20 - 24	12617	6126	6491
25 - 29	19058	9603	9455
30 - 34	18725	9325	9400
35 - 39	17412	8483	8929
40 - 44	13208	6580	6628
45 - 49	11608	5452	6156
50 - 54	11303	5363	5940
55 - 59	8293	4128	4165
60 - 64	7222	3556	3666
65 - 69	6511	3143	3368
70 - 74	5919	2630	3289
75 - 79	5084	2061	3023
80 - 84	3546	1250	2296
85 - 89	2149	620	1529
90 and over	1079	263	816
Totals	**187908**	**91514**	**96394**

5.7 The age map shows that Merton has a 'population bulge' in the 20-39 age group, whilst the population between 39 and 54 is around the UK average, with the population between 54 and 75 significantly below the UK average. The proportion of the very elderly group is almost in line with the UK average. Looking at the 50 plus age group (the greyed area of the underlying data chart), this shows that there were a total of 23,014 men and 28,082 women in the 50 plus age group. Until retirement age men and women are roughly balanced. After retirement age the survival rate of men falls much more quickly than women. By the age of 80 there are roughly two women for every man.

5.8 There are over 1000 Merton residents who are 90 years and older. The proportion who are 50 plus is 37%. In one or two decades' time, the early middle age population 'bulge' will move into middle age. Given that younger age groups are under-represented in Merton's overall demographic shape, the ageing of the population will then become more pronounced. The 2001 census also shows that only 14.5% of minority ethnic groups were aged 50+, compared to 35.1% of the white population; while only 0.3% of minority ethnic groups were aged 85+, compared to 2.1% of the white population. Over time, since there is a higher proportion of ethnic minority membership among younger age groups, the proportion of 50 plus who are composed of minority ethnic groups will expand.

Health inequalities

5.9 Many of the determinants of health and illness are linked to patterns of social life and behaviour, with many of these factors unequally distributed across the population. GR Associates have highlighted the following key issues:

- The health and well-being of people as they enter late middle and old age has its roots in other factors outside the ageing process, such as social and economic equalities and quality of the living environment, including housing, education or other factors.
- The experience of material disadvantage across the life-course has an effect on quality of life in later life and a person's work history will have an effect on the value of their pension. By contrast, owner occupation carries an advantage over being in rented accommodation in terms of mortality, self-reported limiting long-term illness, and later moves into institutional care.

- Around one-third of people aged 60-64 have some disability but this increases to almost three in four of people 85 and over. Many of the differences between people who are disabled are linked to socio-economic factors and official surveys show a stepped increase in the (age-standardised) prevalence of disability from 8% for men and women in Social Class I to 22% for men and 24% for women in Social Class IV, with similar rates for Social Class V. Among those with a disability, the proportion categorised as seriously disabled was also lower in Social Classes I and II (about one in four) than in Social Classes IIIM, IV and V (one in three).[6]
- Since Merton has a very mixed population structure with affluent populations in some wards and much poorer populations in others, it would be expected that these socio-economic differences would also be translated into health inequalities, with economic differentiation between social groups as a significant factor.

5.10 GR Associates outline in their report some of the academic research undertaken in relation to mortality rates and the persistence of a health inequalities gap. Smoking, diet, and other behavioural factors with biological effects contribute to, but do not fully explain, the persistence of striking health inequalities.[7] Government is now formally committed to reducing health inequalities and to significantly reducing poverty across the life course on which many of the explanations for such health inequalities is based. The London Health Strategy, in its most recent update, focuses on children and young people, with the implication being that less attention is given to tackling health inequalities among older people. Consequently there are fewer indicators and targets pertaining to older groups, despite a population increasing in age.

5.11 Nevertheless there are several targets of particular impact for older people, which are also contained in the Sutton and Merton PCT public health report.[8] Additionally there are a range of preventive services, for example, influenza immunisation, breast screening, smoking cessation, diabetes testing, which have either a direct or general applicability to older people. What has been missing from central government policy, and also therefore for the PCT, is more focused consideration on the broader determinants of health for the wider older population, as opposed to, as appears in such reports, a focus on vulnerable older people only.

[6] Madhavi Bajekal, Paola Primatesta and Gillian Prior ,HSE 2001 - Summary of Key Findings, Joint Health Surveys Unit National Centre for Social Research Department of Epidemiology and Public Health at the Royal Free and University College Medical School.

[7] Townsend P, Davidson N, Whitehead M. Inequalities in health: The Black report; the health divide. London: Penguin, 1990.

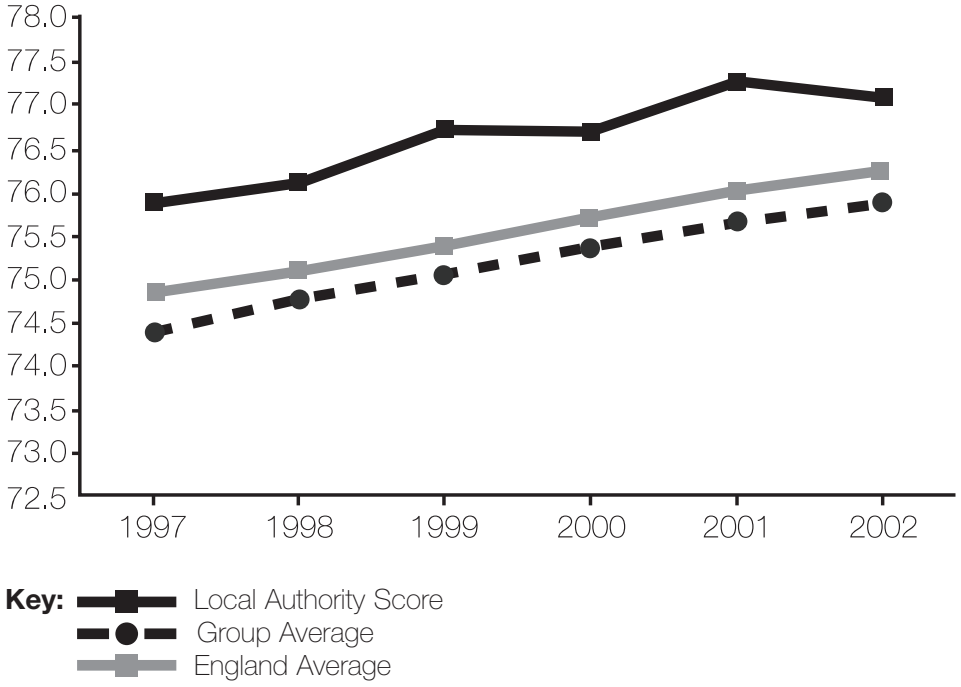
[8] Health Inequalities in Sutton and Merton – Developing A Platform For Local Action; Sutton and Merton PCT, 2005

Recommendation 3 :

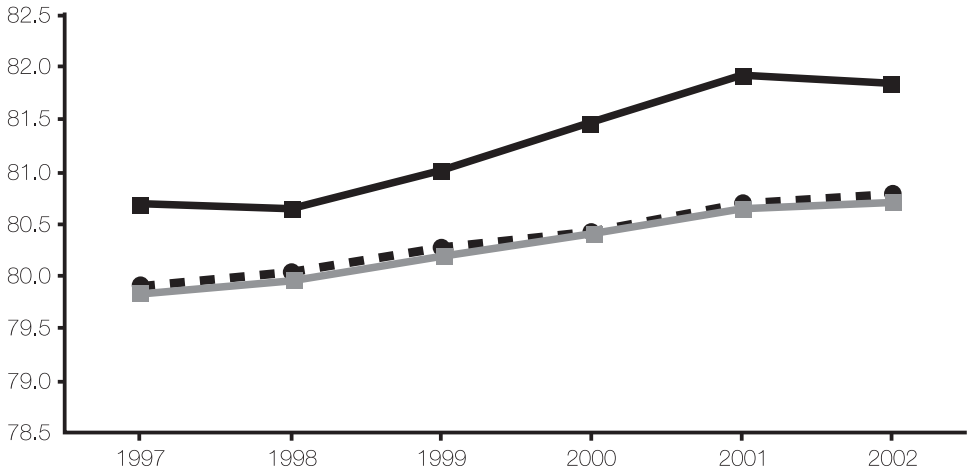
Given the recent attention to government policy on ageing, it is anticipated that the limited focus on ageing may be subject to change. The issue of older people's health and well-being must be considered in all strategic planning, including the Older People's Strategy being developed by the Community and Housing Department, as recommended by the Health and Community Care Overview and Scrutiny Panel on 6th September 2006.

5.12 GR Associates report that Merton is currently ranked at 220 out of 354 local authorities in England in terms of average deprivation. Put another way, Merton is in a borderline position on the lowest third of rankings. However, Merton is relatively less disadvantaged even at the ward level than inner London boroughs and comparable to other outer London boroughs. Merton is one of six local authorities in London which, according to the London Health Observatory, has no wards in the worst 20% of wards by Coronary Heart Disease (CHD) Standardised Mortality Ratio (SMR). Merton has almost two years better life expectancy for women compared to London as a whole and around one year for men.

Merton LB, Female Life Expectancy, Comparison With London (source ONS)



Merton LB, Male Life Expectancy, Comparison With London (source ONS)



Key: Local Authority Score
Group Average
England Average

5.13 GR Associates report life expectancy for men and women on a ward by ward basis. Evidence of these health inequalities explains the location and development of the Merton Horizons Healthy Living Centre, which provides a range of activities focused on communities in the Mitcham and Colliers Wood area, and employs a variety of health promotion initiatives, i.e. in the part of the borough where evidence reveals a shorter life expectancy.

Recommendation 4 :

Health Inequalities needs to remain at the top of the agenda for health overview and scrutiny and for health and local authority partners and voluntary sector organisations, so that real efforts are made to reduce the inequalities gap.

The ageing process

5.14 One factor to explain both decline of the health of older people and some variation in health is ageism. Ageism encompasses fatalistic and negative sets of beliefs and attitudes towards older people. It can be understood as both a cause and a consequence of failing to appreciate that the ageing process contains numerous modifiable factors which define personal health and well-being among older people. Customarily ageism is assumed to be sets of attitudes held by younger people, however it also encompasses attitudes and beliefs by older people towards each other, even towards themselves.

5.15 In tackling ageism, health inequalities remains a critical focus. Even so, a fuller picture from self reports, both from census data in Merton as well as other studies, suggests that despite the ageism that many report experiencing, many older people report very good health, little difficulty with the activities of daily living and high rates of social participation and engagement. The more optimistic view of future trends might be that, while some level of disability is inevitable as people age, more effective prevention and more effective treatment and rehabilitative care could lead to ill health being compressed into shorter episodes and eventually into an ever shorter period before one's inevitable death.

5.16 Health becomes increasingly important to us as we grow older and in many cases becomes the defining element of our lives: currently around 38% of NHS expenditure is spent on the 16% of the population currently over 65. Older people are thus high users of the health services, although the most frequent complaints commonly fall on the simple, body maintenance aspects, such as podiatry services. As the population ages it will have significant implications for the NHS, the local authority, voluntary services and the local economy. The question is whether the opportunities for lessening the demand on health care and social care provision by reducing the burden of chronic disease, disability and diseases of well-being, will be taken. In some cases it may involve the care providers doing more (attempting to meet the needs for podiatry, for example) with the benefits being that more intensive services are used less (fewer foot infections, better mobility and reduced dependency).

5.17 The obstacles to doing so are numerous. Many are financial. Arguably the chief obstacle to redefining the treatment of older people (and not just by NHS and social services) is cultural. Across society, growing older is almost always presented in negative health terms. It is usually associated with declining mental and physical capacities, worsening health (physical and/or mental), and the seemingly inevitable slide into economic and social dependency. As noted, this overwhelmingly bleak picture is not accurate for the majority of older people. If ageing inevitably leads to weakening health and disability, the period of poor health can be compressed into a shorter space of time.

5.18 One of the reasons for this pervasive negative view of ageing is the commonly poor understanding of the ageing process. The most widely understood view of ageing is that it operates as some kind of built-in bodily self-destruct mechanism. A further view, becoming more common, is that ageing is driven solely by genetic factors.

5.19 Environmentally caused organic damage is poorly understood and therefore difficult to prevent. Nevertheless much is understood about harm to the body by other means and a substantial part is preventable. For example, damage to cells and molecules within the body can be accelerated by exposure to specific toxic agents, such as tobacco smoke, drugs and excess alcohol. On the other hand, cell damage can be slowed by good diet and physical activity. Ageing is not just about physical decline but it is also associated, as noted, with mental decline. This process can also be substantially mitigated.

Diet and physical activity

5.20 Diet and physical activity can have a profound impact on limiting the onset of chronic diseases. It is now fully accepted by all scientific authorities that a diet which is composed of sugary, fatty, salty and processed foods and lacking in vegetables and fruit is associated with weight gain, diabetes, some forms of cancer and other ailments. There is much discussion (albeit without much scientific evidence) that a vegetable and fruit rich diet conversely has antioxidant properties which reduce cellular decay.[9]

5.21 Physical activity, on the other hand, has been shown to have a positive impact on mental health and cognitive function.[10] Physical activity appears to have a protective effect on functional limitation among older adults.[11] The impact of natural muscle loss in ageing is worsened by older people taking less exercise. Physical activity and physical fitness are strongly correlated, and both are inversely correlated to risk of cardiovascular disease. The implication is that physical activity should be maintained, albeit in different forms to that for younger ages. One important implication might be that the age-related decline in physical fitness appears to be more related to expectation than to biology. As we age, we expect to be less fit, so we exercise less, worry less about weight gain, and attempt less demanding activity.[12] Across the 50 plus pre-retirement age period, body mass and shape appear to be major determinants of disability, with increases in waist circumference being a marker for abdominal obesity and the best predicting risk for most disability outcomes.

5.22 Conversely, high levels of physical activity can help older people stay independent and live longer and exercise programs can maintain or improve performance of regular daily activities. Research has shown that some older people lead more physically active lives than some teenagers.[13] The evidence is also clear that frail older people can benefit from well-designed exercise programs.

[9] Lindsay DG. Diet and ageing: the possible relation to reactive oxygen species.J Nutr Health Aging. 1999;3(2):84-91.

[10] Colcombe SJ, Erickson KI, Raz N, Webb AG, Cohen NJ, McAuley E, Kramer AF. Aerobic fitness reduces brain tissue loss in aging humans. J Gerontol A Biol Sci Med Sci 2003 Feb;58(2):176-80

[11] Huang Y, Macera CA, Blair SN, Brill PA, Kohl HW 3rd, Kronenfeld JJ., Physical fitness, physical activity, and functional limitation in adults aged 40 and older. Med Sci Sports Exerc 1998 Sep;30(9):1430-5

[12] Angleman SB, Harris TB, Melzer D. The role of waist circumference in predicting disability in periretirement age adults. Int J Obes, 2006 Feb;30(2):364-73.

[13] Kimberly Fisher Chewing the Fat - The Story Time Diaries Tell about Physical Activity in the United Kingdom, ISER Working Paper 2002-13

For example, dancing may stimulate balance responses and may help balance in a variety of ways; swimming increases muscle strength.[14] The challenge is to provide activities and support to maintain higher levels of physical activity among all older people.

5.23 Of course, limbs wear out; disabilities are (although in varying forms) inevitable. However the rapidly-improving science of ageing (gerontology) shows that the process can be slowed down by targeting non-genetic factors such as nutrition, lifestyle and environment as early as possible. Furthermore, to view such inevitable disabilities as the determining factor in the appreciation of life is false. One 93 year old Merton resident contacted during this study failed to accept the description of being 'old'. Having received four replacement hips he remained an active member of the local Ramblers Association and eschewed any notions of dependency on health or social care services. He maintained his own allotment (unfortunately damaged by vandals) and was seen as an icon by people who, in our discussions, considered themselves 'old' but were actually 20 years younger than he was.

Culture and physical activity

5.24 The cultural aspects of ageism, some of which are embedded in beliefs, others in institutional or commercial practices, mean that some older people appear to be more affected than others. Culture also says that it is permissible for older people to 'do less' or 'slow down'. Hence the expectation that people will become less fit as they age means they take less exercise which produces the actual effect. Some of the obstacles are non-cultural, however e.g. difficulties of transport, or disinterest in addressing the additional qualities in services which older people value.

5.25 The explanation for decreasing health/increasing disability is therefore not fully explained by a 'natural' process of decline but by decreased access to settings or circumstances which promote physical activity. Some of the difficulties in access have cultural roots. The negative effects of a more youth oriented culture works in a variety of ways. Culture gives more emphasis to younger age groups and filters into the general workings of society. In terms of physical activity, gyms play pop music rather than music appealing to older age groups and swimming pools primarily cater for young people (and are heated accordingly). Behaviour which is quite normal to younger people may be discouraging to some older age groups. There is not a single answer to these issues, however the answers can never emerge unless the problems are considered.

[14] Jette AM, Lachman M, Giorgetti MM, et al. Exercise-It's never too late: The strong-for-life program. Am J Public Health 1999;89:66-72;Taunton JE, Rhodes EC, Wolski LA, et al. Effect of land-based and water-based fitness programs on the cardiovascular fitness, strength and flexibility of women aged 65-75 years. Gerontology 1996;42:204-210

Social engagement, living environments and personal identity

5.26 One of the most powerful factors explaining the maintenance of good mental health as people age is the strength of social networks in supporting a person's sense of identity, even enlarging that identity. Social and psychological studies have shown that a number of factors profoundly affect our physical and mental health – these being in many cases indivisible. On the contrary, much of the focus on the elderly and ageing has, until recently, focused on the factors associated with decline, such as dementia rather than on causes of good health, good mental health and good cognitive functioning. Also, until perhaps quite recently, ageing was not considered in an environmental or cultural perspective, nor has ageing been looked at from the perspective of different social identities, for example the influence of ethnic minority status, sexual orientation or social class.

5.27 Maintenance of control over one's surroundings or over decisions affecting one's life is an important ingredient of people's health as they age. This was shown in a classic study of an American nursing home, where death rates of residents, who were encouraged and perceived to exercise control over their surroundings, were compared to those who were not.[15] A sense of being in control, even of minor events, requires a high level of sensitivity on the part of busy, often overworked caregivers. It is so often easier to "do for" the frail elderly instead of allowing them to accomplish minor tasks such as buttoning, drinking or pill-taking. "Little courtesies" and "small acts" that increase a sense of control and convey a sense of taking responsibility make a great difference.

5.28 Similarly, strong social relationships have been shown to strengthen the immune system, extend life (to an equal degree to quitting smoking), speed recovery from surgery and reduce risk of depressions and anxiety disorders. A variety of studies undertaken by the Economic and Social Research Council (ESRC) using interviews with older people on the main building blocks of quality of life - and therefore pattern of health and sense of well-being as one ages - reveals the factors to be:

- a sense of optimism;
- good health and physical functioning;
- engaging in a large number of social activities, plus other activities/hobbies performed alone;
- feeling supported;
- living in a neighbourhood with good community facilities and services, including transport;
- feeling safe in one's neighbourhood;
- feeling able to use one's home as a comfortable base – rather than a prison;

[15] Langer E, Rodin J. The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. J Pers Soc Psychol 1976;34(2):191-198.

- maintaining independence and control over one's life;
- having good social relationships with family, friends and neighbours; and
- having an adequate income.[16]

5.29 These findings exactly coincide with the interviews conducted in Merton. Membership of social networks, a sense of feeling in a safe neighbourhood, and other social aspects of daily life have overlapping and interdependent qualities which support people. Conversely the absence of these qualities, or the gradual loss of them, compromises the others. For example, retaining one's independence and social activities are described as being dependent on retaining good health and an adequate financial situation, as well as access to transport. Having good local facilities (shops, markets, post-office), health services, policing, good local council services (i.e. street lighting, refuse collection, repairs, libraries, including a good local mobile library), and having a pleasant landscape/surroundings is seen to be important to quality of life. Creation of local opportunities to meet other people and to maintain a role in society (e.g. work or voluntary work), access to transport and having enough money is thought to be important for retaining independence. In the ESRC studies the most commonly mentioned fear about growing older was ill health and deteriorating physical ability, followed by physical dependency. Other fears include loneliness and isolation. Sense of safety is important for access to parks or walking to school for children. Adults living in neighbourhoods that have low social cohesion (lack of strong relationships among neighbours, limited availability of social resources, low levels of trust among residents, etc.) tend to walk less for leisure (65 minutes per week) compared to adults in neighbourhoods with high social cohesion (76 minutes per week).

5.30 Strong social networks help people's coping skills in the face of the challenges of older age. Part of this picture is not just involvement as a 'recipient' but as a 'doer'. ESRC research has revealed that people who live in areas that record high levels of informal voluntary activity in their neighbourhood, also enjoy better health.[17]

5.31 The maintenance of personal identity is affected by a wide variety of factors, one of which is ethnic origin. The number of people from ethnic minority communities in the borough who are aged 65 and over has more than doubled since 1991. Studies suggest that ethnicity has a significant bearing on quality of life; however the picture is a mixed one. White older people tend to report better levels of health and higher incomes than participants from other ethnic groups while other ethnic groups tend to view the process of growing older more positively. For all older people practical and emotional support was most often provided by families and friends, but for minority ethnic older people

[16] A P Bowling, ESRC Research Report L480254003, Adding Quality to Quantity: Older People's Views on their Quality of Life and its Enhancement - 28/02/2003

[17] Charles Pattie, Patrick Seyd, Paul Whiteley, Civic Attitudes and Engagement in Modern Britain (ESRC Democracy and Participation Programme) 2004

voluntary organisations played a vital role in providing support in terms of information and advice.[18] In interviews with Asian elders in Merton these considerations also apply. Asian older people share many of the same issues as other older people, but maintenance of identity becomes important for people for whom reflecting on earlier life becomes a source of pleasure and self-maintenance.

5.32 Similar considerations about identity apply to men. Some research has shown that both statutory and voluntary organisations are presently geared towards the needs of lone older widows, since most husbands die before their wives, and there is little infrastructure in place for men who live without partners in later life. Their suggestion was that efforts need to be made to make the clubs specifically aimed at older people more congenial for older men so that they do not feel they are 'yielding up' their individuality, or admitting some sort of 'defeat' by attending. Many older men are therefore less likely to contact, or admit contact, with health professionals in later life, not wanting to be seen to give in to sickness and postponing appointments until they were very sick with adverse health consequences. Working-class older men were less likely to belong to civic or religious organisations and sports clubs than middle class men. Middle-class men had higher levels of health-promoting physical activity after retirement than working-class men, which could not be explained by differences in health status, material resources or car ownership.[19]

5.33 Perhaps more difficult than other forms of identity previously mentioned is that of being lesbian or gay. Openly ageing as a non-heterosexual is a new social phenomenon.[20] The research indicates that older gay men, lesbians and bisexuals can feel largely shut out of mainstream society. Apart from feeling discriminated against in society generally, lesbian and gay community groups are often excessively youth-orientated. Many choose to be less involved in lesbian and gay community activities, clubs and businesses, with a considerable number of men feeling excluded by their age. Most accept that they will have to rely on health professionals for care in old age. Few have made plans for care of that sort and do not expect family members to take on the role.

[18] J Butt, Quality of Life and Social Support Among Older People from Different Ethnic Groups

[19] S L Arber, L480254033 - Older Men: their Social Worlds and Healthy Lifestyles - 31/08/2002

[20] Heaphy, B., Yip, A. K. T. and Thompson, D. (2003). Lesbian, Gay and Bisexual Lives over 50. Nottingham: York House Publications

6. Achieving Health Improvement and Well-Being

6.1 Health Scrutiny members at Merton are committed to working on promoting health improvement and reducing the health inequalities gap in the borough. A new health scrutiny review on prevention of ill health and early intervention will involve cross-cutting work to identify ways in which local people can be encouraged to lead healthier lives and how resourcing initiatives at the preventive end will deliver savings to acute health and social care services.

6.2 GR Associates state that:

'The main case for developing strategies to promote action around the wider determinants of health is a moral one. However, there is also a strong economic case as well, expressed in the formulae, that keeping people healthy, independent and living in the community reduces the costs of institutional provision. Nationally, personal social care services cost local authorities some £8 billion in 2004-5 and another £3.7 billion went out in non-means tested benefits for older people with disabilities. For families and individuals too, the extra expenses of long term care are considerable, already reaching an estimated £3.5 billion.'

6.3 The importance of good health underlines the need for healthy lifestyles and preventive health strategies throughout life in order to help retain independence.

Recommendation 5 :

Local government, NHS and voluntary bodies, need to work harder, and in partnership with local people, to promote local communities with good facilities, opportunities for social participation, increase independence, affordable and accessible transport and services, and environments which are perceived to be safe.

6.4 There have been some local initiatives aimed at improving health in a part of the borough where there are higher levels of deprivation and poorer health generally. The Merton Horizons Healthy Living Initiative aims to reduce health inequalities, and to deliver increased mental, physical and emotional well-being to the three target areas within Merton. Merton Horizons deliver this programme of health improvement through the following Community Centres:

- South Mitcham Community Centre, Haslemere Road, Mitcham.
- St Marks Family Centre, St Marks Road, Mitcham.
- North East Mitcham Community Centre, Woodland Way, Mitcham.

6.5 These community centres work closely with local providers to offer a range of services to the people of Mitcham in community venues. The Merton Horizons Healthy Living Initiative encourages local residents to take part and make use of the following services and activities on offer as part of Merton Horizons:

- Physical Activity Sessions, such as Ladies Aikido, 50+ Exercise Classes, Circuit Training, Walking Events, Capoeiro, Football, and Keep fit classes.

- Self-help groups for people experiencing stress, depression and anxiety. Plus a support group for carers of people with dementia (Merton MIND).
- Pharmacy and Healthy Living Advice in community locations, such as health screening, weight and medicine management (local pharmacists)
- Income maximisation advice, benefits advice, and access into other statutory and voluntary sector services (Merton CAB). Arts and New Media sessions, such as Water Colour Painting, Drama Sessions, Street Dance and Chit-Chat Computer Group.

6.6 As part of their research on older people's health, GR Associates engaged with a broad spectrum of older people through focussed discussion groups, and more general discussion sessions. This included people recruited through Merton Association of Pensioners, with whom there were three focussed discussion groups with a total of 35 participants. There were also discussion groups through the Merton Healthy Living Centre (St Mark's Centre, Mitcham) and with people attending activities at Friends in St Helier (FISH) and the Merton and Morden Guild. There are many people who would otherwise be housebound if it were not for the organisations, volunteers and use of community transport to bring them to their centres. The groups were mostly ethnically diverse, except for an Asian elders discussion event. GR Associates estimate that they spoke to and had contact with approximately 100 older people during the course of the project.

6.7 The views of a range of older people straddling the 50+ to 90+ age range were heard, from the very fit and active to those with very limited mobility and those clearly no longer participating in much physical activity. Many of the participants had lived in Merton for most of their lives and all had lived 20+ years in the borough. At many points during the discussions the issue of the differences between Morden, Mitcham and Wimbledon were raised, with few people identifying with 'Merton' and most identifying one of these neighbourhoods as 'where they lived'. There was a strong sense of the social class profile of the borough, with Mitcham being seen as the poorer end and Wimbledon at the upper end. Not all thoughts were negative however.

6.8 GR Associates reported on their findings according to the themes introduced within the focussed discussion groups and other matters raised by participants:

Merton as a healthy place to live

6.9 Generally positive views were received – there were many references to the open and green spaces, the fresher air than more central areas. Several talked of having moved to Merton many years before, for reasons of housing and the better quality of life, contrasting with other areas of London at that time. Mitcham residents, one who had lived there for over 80 years, lamented the way in which a village community on the border of London had become just another suburb, filled with fast food restaurants, street rubbish and graffiti.

Access to and use of green space

6.10 Across the groups, a range of views were expressed concerning the use of parks and open spaces by older people. There were detailed discussions of the way the maintenance and facilities within open spaces had deteriorated. Examples of burnt out and neglected buildings associated with bowling greens, tennis courts, and tea rooms were mentioned, as indeed the way failure to cut the grass was reported as 'the creation of meadow'. Overall, people highly valued Merton's parks and open space but felt more could be done to improve maintenance, especially of the trees and other supposed planted areas on streets, roundabouts and such public spaces. People wanted places to be able to sit, to meet and be refreshed within parks as an incentive to use them more often. This was a particular concern of the less mobile older people for example those attending Friends in St Helier (FISH) who made the point that they were discouraged from going to visit, for example, the rose beds and other attractions as there were few places to sit and rest and enjoy the gardens. Related to this point was the way the lack of public conveniences was also experienced as a deterrent to venturing forth into public spaces.

6.11 Many of the points made above provide support to the observations of the Audit Commission in its recent report on Cultural Services. For example, under a section entitled Quality of Life (Para 59 p 21) details are given about the lower level of use of parks and open spaces by people over 75 years of age (which drops from 84% for the overall population to 51%). In addition it is noted how reductions in funding to parks has led to lowered standards, and there is a consistent view that standards have been falling for some years.

6.12 Walking emerges as the activity to be ideally pursued in green spaces and parks and this was referred to as something people enjoyed doing. Possibly the oldest participant in the groups, a man in his ninety third year, regularly joined Croydon Ramblers' Association walks, often doing seven mile walks on a weekly basis. He reported how walks regularly attracted upwards of fifty people and how the numbers had increased in recent years. This Mitcham man was seen very much as a role model for personal independence, forward thinking and community involvement.

Wider mobility and transport issues

6.13 Although Merton was seen as a 'green' borough, there were many influences moving against this. Older people are in many ways more affected by aspects of their immediate physical environment than younger age groups. Uneven pavements, high pavement edges, tree roots and other obstacles such as badly located street 'furniture', ridged pavements and cycles lanes can all make walking (and in particular the manoeuvring of a wheel chair) difficult. One group complained about the number of dogs and dog mess:

"The council has pooper scooper bins, but they are not emptied". Also, parked cars on the pavement blocking the path of people with disabilities, serve as a disincentive to walk along pavements, as indeed do the presence of cyclists on paths.

6.14 The environmental impact of abandoned mattresses in backyards and alleyways, and of old vehicles in front of houses, was experienced by many older people as creating a 'hostile environment'. Merton, they said, used to organise regular skips for such refuse. Among some of the younger older people attending the Merton Association of Pensioners based groups, there was a willingness to participate in 'green guerrilla ' activities to help clear neglected public spaces.

6.15 Questions of accessibility arose throughout the groups, with some being more focused than others on this matter. This inevitably raised many issues over the provision of transport services. The changed means of administering Dial-a-Ride caused some concern, with several accounts of activities being missed through system failures. There were concerns over the general availability of both LB Merton's own transport and Community Transport. Some, though not all, were very aware of the way raised charges and general costs had limited the availability of such provisions. There was also general concern at the wider provision of bus services within the borough, with many expressions of concern at the lack of small buses and the perceived unwillingness of drivers to operate access ramps on larger buses. Such matters were seen as critical when talking about accessing physical and other activities. Issues of transport featured as being among the 'three most important things' within the groups.

'People' environment

6.16 The Mitcham group complained about the habitual 'alcoholics' on the Fair Green. They were viewed as 'degrading', although it was also seen that they needed help. One couple had suffered harassment on their estate from young people and others complained about the young men spitting, which they saw as an emergent fashion. People thought that the community support officers were 'powerless' and unavailable in the period when it really mattered, for example, in the evening.

Sports and leisure facilities for older people

6.17 As noted above, there was a view that there used to be a wider range of physical activities for older people such as bowling greens and clubs, badminton courts, croquet lawns and places to walk to. Some detailed discussions developed over what used to exist and how it had been neglected and fallen into disrepair. A certain fatalism pervaded such exchanges that reflected a general view of the needs of older people not being considered, as compared to younger people, with wider budget cuts and 'bureaucracy' being held to be part of the problem. The groups provided for an exchange of information about sessions for activities for the over 50s in leisure centres and elsewhere. These exchanges point to the need for more effective publicity and active promotion of such events.

Access to and use of bathing/water sports

6.18 Within the groups there were several participants who were keen to participate in swimming, water aerobics and related activities. Discussion of access and availability provoked a lively debate within the

groups. Clearly not everyone wanted to participate in these activities, but those that did had strongly held views.

6.19 This was one of the areas of activity that people felt should be provided in special sessions for older people. Even with roped off lanes to keep faster swimmers separate, people felt vulnerable and wanted to have sessions exclusively for older people. This raised the matter of timing and access by public transport, with one person feeling excluded from participating in appropriate sessions because they occurred before she could use her travel pass. Others were concerned at the difficulties of getting in and out of the water and expressed a preference for pools with sloping means of access to shallow water. It would appear more could be done to review all the 'obstacles' that need to be negotiated with a swimming pool, such as 'foot baths', as these unintentionally impede access. There was the view that costs of entry were too high, standards of cleanliness were not adequate, and one person who had been a regular swimmer had been put off going as a consequence of finding the pool frequently closed due to staff absence. The view was also expressed that older people were vulnerable to the cold changing areas of pools and the scheduling of their pool use with schools and children, which created difficulties in the changing rooms.

6.20 Some of the less mobile older people expressed concern at no longer feeling able to go to a swimming pool for reasons of cost, access and lack of special sessions at times that suited them.

Gyms and fitness centres

6.21 The issue of separate sessions for older people also came up within discussions of gyms and fitness centres. Many people had ventured inside these facilities but few, if any, had returned. Comments about finding them 'intimidating', 'too noisy', 'too full of young people', 'self conscious' and so forth were made, such that it seemed no one saw these as a place they would wish to go to. One person, a former ballet dancer, was a regular gym attendee but, though enthusiastic, the cost aspect was a key issue for her.

6.22 There were people within the groups who had taken part in and benefited from the gentler forms of chair-based exercises practised in some places. These were seen as having their place within the spectrum of opportunities for exercise that needs to be provided. But many felt there was a major gap in provision of active exercise for older people between that provided for younger people in gyms, and that for the chair-bound. The lack of such provision led to consideration of the shortage of halls and other facilities for the provision of exercise classes.

6.23 A few participants took part in activities, such as line dancing and one woman was even a keen belly dancer. The value of dancing as an enjoyable physical activity promoting social contact was noted, yet it was felt more could be done to promote this.

6.24 Merton has recently produced a Sport, Health and Physical Activity Strategy as part of a wider cultural strategy and this aims to promote wider access and participation in all aspects of physical activity.

Community centres

6.25 Given the spread of participants from across the borough it is not surprising people had differing views on access to local facilities such as community centres. There was a Wimbledon view that what had been a thriving and 'vibrant' centre had fallen into a sorry state of neglect and inactivity in large part 'due to withdrawal of Council funding'.

6.26 A lunch club group at a community centre very much appreciated the setting and the company. Some had travelled a distance by themselves on buses, others by voluntary providers, some had walked. None had journeyed to the club by their own private transport.

6.27 There was also awareness among participants of the general shortage of accommodation within Merton for social, recreational and physical activities. Competition with other age groups (especially young children in playgroups) for daytime access was noted, as well as the limitations imposed on others because of poor transport links.

Access to Internet and computers

6.28 There were variable views - with evidence of some regular and skilled users - but some were put off by the costs of 'narrow band' access. Many had no IT skills. Some disdained the use of computers. However, a group of 'silver surfers' was also interviewed. They very much appreciated the class and took pride in what they were learning. There emerged a mixed picture, with some people puzzled by the Internet or email and some, probably a minority, embracing it.

Adult Education

6.29 During the focus groups, some interesting discussion occurred during which participants exchanged information about courses and activities they had undertaken in various adult education venues. There was a view that some neighbouring boroughs had a better range of courses and that these were not as costly as within Merton. Cost and accessibility was seen to be an issue. There was emphasis on the need for concessions to be affordable. The issue of using adult education as a means to mix with a cross section of ages was mentioned and the need to attend the evening classes to achieve this. Daytime classes were seen as being for 'those like themselves' and thus segregating.

Use of libraries

6.30 Access to and use of libraries was also variable within the groups. One matter of particular concern was the withdrawal of the mobile library. One of its major benefits had been accessibility and also it obviated the need to carry heavy books long distances. Some attended book clubs (Mitcham library), which were valued.

Mental well being/ Carer and befriending issues

6.31 During the discussions, most participants drew a distinction between themselves as active and generally in good state of health and those other older people they saw as 'isolated', 'apathetic', 'lonely', 'depressed' and often 'wanting to keep themselves to themselves'.

A generalised respect for the right of people to live as they choose appeared to influence thinking in this regard, for although reference was made to attempts with neighbours to get them involved, or to advocate on their behalf, there was a view that 'there was nothing you can do' with some older people. However, this was not just seen as a matter of old age, but as phenomena affecting people across all ages. One couple discussed their befriending of a man who was isolated and lonely. They noted that he had rejected them but they persisted, even to the extent of attending his eventual funeral. Almost by definition the people interviewed were part of broader social networks, though they recognised that many people were not.

Health service issues

6.32 The aim of the focus groups was to address non-health service issues, yet inevitably the discussions brought up many concerns over the provision of health services, and as far as possible this was steered towards preventative issues.

6.33 The question of access and transport was raised many times. For people using hospital provided transport there were observations concerning long waits and journey times and the lack of provision of 'comfort stops'.

6.34 There was strong support for the idea of a service more attentive to the preventative health needs of older people. Some felt their GPs/primary care were monitoring their health, whereas others either stayed away unless 'required' to attend or they had low expectations of what they would receive.

Recommendation 6:

With reference to how community services could do more to initiate and conduct testing (e.g. cholesterol, blood pressure, diabetes etc), there should be consideration given to someone specialising on the needs of older people located within community settings, such as clinics, surgeries, pharmacies, or even non-health related settings.

6.35 Within one group there was discussion of the loss of the 'well women' clinic and the value of such targeted services and the need to have similar provision for men especially given their neglect of health as they age.

6.36 People interviewed in Mitcham were very critical of the difficulties of securing appointments, which they presented as a form of game, being impossible to get through to the surgery at the time to ring (9am) and then, when there was an answer the receptionist told them that the appointments had gone and to ring back the following day.

6.37 When asked about the 'healthy living centres' (HLCs) no one in the groups had heard of them. Admittedly these are currently in one part of the borough (Mitcham) but this raises the issue repeatedly made within the groups concerning the lack of publicity and information about services.

6.38 Further inquiries were made within the Mitcham discussion group about HLCs and with the staff of one of the centres. The staff said that people using the HLC facilities generally thought of them as being linked to the particular centre and that the overall Merton Horizons brand needed stronger emphasis. Members of the discussion group at the HLC were very aware of the broader 'determinants of health'.

Recommendation 7 :

That there should be much wider and more intensive advertising and promotion of local initiatives to improve health, to maximise participation.

Eyes, ears, teeth and feet

6.39 All the groups came around at some point to expressing concerns over the costs and difficulties of accessing services especially for foot care (e.g. toenail cutting) and NHS dentistry. It was recognised that some groups were more in need than others, but one lady complained that she was over 80 years old and her untended feet had developed an infection requiring antibiotics. There was discussion over the cost of private foot treatment (£25-£27) and lack of treatment from primary care. These issues were seen in terms of social justice, the neglect of early prevention and in scheduling/care management (i.e. once outside of the appointments system it was difficult to get in again). The service provided through FISH, by which a chiropodist attends for sessions with clients during other activities, was clearly much appreciated by the users.

6.40 Concerns were also expressed over the difficulties of finding NHS dentists, some issues over opticians and the provision of hearing aids. These were not explored in the groups as being outside the remit of this project. However, these and other issues around accessibility to health services will be picked up in the Scrutiny Review on Prevention of Ill Health already mentioned.

Diet, food and allotments

6.41 Participants in the groups generally considered they had good diets and they rarely ate processed and junk foods. Frequent references were made to the benefits of having lived through the war and of growing up eating 'real' food. Most felt it was easy to access good food in Merton, although some lamented the loss of the small, specialist and locally available food shops.

6.42 Discussion of food also led onto references to the benefits of having an allotment for the pleasures of growing one's own food, the physical activity this provided and the social contact that came from mixing with others. This was an activity where older people with accumulated knowledge of gardening could be of direct assistance to the many younger people now having allotments. The view was also expressed that many allotments were too big for older people to manage and that there should be a more flexible approach taken to dividing them up.

Concern was also expressed at the neglect of many allotments, for example at Phipps Bridge. An engaged discussion of gardening arose among those people who might be regarded as being at the less active end (e.g. those attending FISH). Within this group there was interest in the idea of allotments designed to make gardening feasible – such as raised beds and smaller areas to care for. It should be noted that the Audit Commission has made positive reference to the allocation of allotments, so that young people and older people are placed alongside one another.

Recommendation 8 :

That initiatives to help older people take advantage of local opportunities (such as specific arrangements for use of leisure facilities and the Allotments Strategy currently being worked on), continue to be developed.

Ageing and Ageism

6.43 All the groups had lively discussions concerning the nature of old age, how to define it and how they felt about ageing. The general view was that 'you are only as old as you feel' and many affirmed how within themselves they did not feel to have aged. However, changing appearance and socio-legal definitions (such as retirement ages, pension entitlements etc) imposed 'old age' upon them. Examples, such as those given above, pointed to ways people felt 'excluded' from participation in such activities as swimming, and in particular how issues of access and affordability impacted on their quality of life.
However, while a case for separate provision was made for physical activities, most people did not wish to be segregated into age specific provision (the example being adult education). Many comments were made about being patronised, of being talk down to in a demeaning manner, of assumptions being made of diminished faculties and so forth, such as being offered 'bingo' and other activities with no intellectual stimulation. In this context there were many appreciative comments about being asked to take part in the discussion groups, as they felt they had participated in a serious process.

6.44 The brief of this research element of the Action Learning Project has been to look at how to improve the health of the over 50s. This is the age that is currently targeted by most health promotion activities as the point where 'older people' begin. Most of the people who presented their views were actually older than the state pension age.

6.45 GR Associates concluded their work with a workshop session held on 2 October 2006, which provided an opportunity to present their findings and conclusions to some of the people they had engaged with. The workshop included an opportunity to network and to thank those who had participated in the Project. Extracts from the research have been included in this report. A full set of the research briefing papers are available as a separate body of work – see inside cover of this report for contact details.

7. Future Actions

7.1 It is clear that preventative health measures are the key to improving the health and well-being of the local community and reducing the health inequalities gap. Initiatives to improve general health and reduce levels of sickness must be actively promoted therefore. Both physical and mental health will benefit through a range of activities, including sport, leisure, arts, education, volunteer work, libraries etc.

7.2 The Choosing Health White Paper emphasises the relationship between care agencies and those doing preventative work. Merton Council is embracing such initiatives through developing strategies for sport, leisure and physical activity and for older people. Merton Sport, Health and Physical Activity Strategy 2006-2009 is one of a number of initiatives, such as the Merton Open Space Strategy and the Allotment Strategy, which contribute to the overarching Cultural Strategy being developed. Merton's Arts Strategy is also being updated. The ongoing development of an Older People's Strategy will specifically address ways to meet the needs of the 50+ age group.

7.3 A key priority for Health Scrutiny members will be to focus on prevention of ill health and to promote health and well-being at local level, through advertising the merits of healthy lifestyle choices. Partner organisations such as the local authority, the PCT and voluntary sector organisations will need to play a part in this. Health scrutiny members will continue to work closely with partner organisations to the mutual benefit of local residents.

7.4 Merton's Health Scrutiny members will continue with the current review on prevention of ill health and early intervention and make appropriate recommendations in due course.

7.5 The recommendations in this report are not intended to have any major resource implications, given the continuing financial pressures faced locally in terms of health service provision and social care budgets. It is more about change to the way health is perceived – a taking up of the opportunities presented to keep fit and well and to promote healthy living, so that there is less need for people to call on health services to treat illness and poor health.

7.6 Healthier communities and older people are strategic themes in Merton's community planning and business planning processes and work will continue to provide benefits to local residents in these areas through new initiatives. This includes a Local Area Agreement currently being developed, which makes a clear link between Health and Older People. The thematic partnership looking at healthier communities is ideally placed to work together on both the 'preventative' agenda as well as the 'cure' agenda.

8. Action Learning for Scrutiny

8.1 The Centre for Public Scrutiny has funded this Action Learning Project with the aim of identifying learning points to aid future health scrutiny and also general scrutiny nationally.

8.2 A number of action learning points have emerged through the duration of the Project and these are detailed in the Project Timetable attached as an appendix to this report. Some of the key action points to note are:

- regular liaison meetings between local authority and health (PCT) allows for good exchanges of information and briefings on key developments and new health initiatives;
- meeting directly with frontline voluntary sector groups results in key health issues which they directly respond to, being highlighted, including problems they face in meeting local pace of change in the NHS is having considerable impact on health scrutiny agenda priorities;
- the range of health issues young people were able to raise was surprisingly extensive and informative: but it is important to actively approach them- they won't come to you;
- the pace of change in the NHS is having considerable impact on health scrutiny agenda priorities; in particular, local NHS financial pressures are a major concern;
- it is important to hold meetings in the local community rather than in the formal civic centre setting, to take the project out into the community so that people feel more comfortable speaking frankly about their work and the key issues;
- some engagement methods have worked better than others; face-to-face events seem to be more successful – possibly because people can encourage debate more easily in a group setting and the discussion can generate progression of ideas;
- there has been positive responses from focus groups – which were well attended; however the issue of engaging housebound/excluded people has not been resolved and remains a challenge; and lastly
- having funding for external research makes a real difference to health scrutiny!

Appendix 1

Project Timetable

	September 05	October 05	November 05
Meetings/ events	13/9/05 – Manchester University Workshop; 28/9/05 – Health Scrutiny Panel – arrange working group of Members to take project forward and reconsider project priorities.	Identify initial dates for Review meetings – and to arrange first meeting of partners; (KPO1) Chair/Vice-Chair/PCT rep – informal meeting 13/10/05 (This group to act as a Project Steering Group and will meet approx. a monthly basis)	Approach key Vol Sector groups (KPO2; KPO4) Meeting with young people 7/11/05 on relevant health issues * (KPO3) Steering Group meeting 15/11/05 Meeting with potential researchers 15/11/05 (??Tender for research) Meeting with social services guilds/Age Concern – 28/11/05 (KPO1; KPO2; KPO4)
Issues/topics covered	Identification of key Project Members;	Project Plan submission to Panel Members; Flag up key issues from existing data – Neighbourhood Renewal Strategy, Census, Health Inequalities Report, Kings Fund. (KPO3) Identify key VS provider groups to attend meetings Nov/Dec 05 (Chair)	Discuss research brief - older people. Focus on Identified priority wards/areas in Merton (KPO3) Health Inequalities Report to be circulated. Undertake consultation on PCT services (KPO3)
Action Learning: **a) Health:** **b) Scrutiny:**	b) need for lead members to be identified to steer the project.	Framework Reporting Deadline 14.10.05 a) regular liaison meetings between local authority and health (PCT) allows for good exchanges of information and briefings on key developments and in the project and new health initiatives. b) Project requires intensive input in terms of time resources and against other scrutiny priorities.	a) range of health issues young people able to raise was surprisingly extensive and informative: But it is important to actively approach them- they won't come to you b) in arranging meetings with voluntary sector groups, sufficient notice needed; also choice of dates to maximise opportunity for groups (many of which are small with only one/two full-time staff) to attend and contribute to project.

	December 05	January 06	February 06
Meetings/ events	Member Steering Group 5/12/05 Agree external research remit/consultants Hold meetings with key VS service provider groups: 5/14 Dec (KPO1; KPO2) Continue consultation: PCT services	Member Task Group/Steering Group 17/1/06 Contact relevant ward councillors (6 most deprived wards) (KPO3) Evaluate PCT consultation findings Evaluate a young people's survey of peers on health issues (KPO3)	Steering Group meeting 14/2/06 Finalise evaluation of PCT consultation findings (KPO3) Members engaging on health services through February Area Forums (KPO2; KPO3)
Issues/topics covered	Voluntary sector roles and responsibilities + key local health issues; perception by others of vs role and contribution. Research element: 3 stages: Stage 1 – to end December 05 Stage 2 – to beginning April 06 Stage 3 – to mid July 06 (All KPOs)	Conclusion of Stage 1 Research	External Researchers – Interviews with health partners and stakeholders (KPO2)
Action Learning: **a) Health:** **b) Scrutiny:**	a) meeting directly with frontline voluntary sector groups results in key health issues which they directly respond to being highlighted, including problems they face in meeting local community health needs. b) it is important to hold meetings in the local community rather than in the formal civic centre setting, to take the project out into the community so that people feel more comfortable speaking frankly about their work and the key issues. b) it helps to give sufficient notice, choice of dates and venues to maximise the opportunity for groups (many of which are small with only one or two full-time staff) to attend and contribute to the project	a) local consultation – it is inevitable that good and bad experiences of health services will be received. It is important to evaluate personal experiences and consider them as part of wider trends where appropriate, if meaningful recommendations are to be taken forward. b) some engagement methods have worked better than others. Face-to-face events seem to be more successful – possibly because people can encourage debate more easily in a group setting and the discussion can generate progression of ideas.	a) evidence has emerged to suggest that better communication through wider dissemination of health service information would allow users to have more informed choice e.g. various locations for blood testing services, but not everyone knows. b) scrutiny member engagement in a round of local area forums has proved beneficial, with reasonable public attendance and a range of useful views on health services.

	March 06	April 06	May 06
Meetings/ events	Liaison with Health (PCT) re consultation findings (to inform PCT's final Annual Health check declaration and future health scrutiny work programme) (KPO3). Health and Community Care Panel meeting 22/3/06 – update on Project progress and outcome of PCT consultation exercise.	Steering Group meeting 4/4/06 – presentation by external researchers, GR Associates on their findings to date (Steering Group to meet again after the elections when new health scrutiny members identified – date to be agreed in due course). Embargo on public meetings due to 2006 Local Elections.	New Health Scrutiny members to be identified – 24/5/06 Annual Council
Issues/topics covered	External Researchers Focus Groups x3 (KPO3) Conclusion of current Member involvement in review (prior to possible election changes to Council)	Conclusion of Stage 2 Research: Receipt of first draft papers from GR Associates Researchers' arrangements for further Focus Groups (Mitcham) (KPO2)	Project Report drafting begins (Scrutiny Officer)
Action Learning: **a) Health:** **b) Scrutiny:**	a) useful views and practical suggestions to contribute to access and opportunity to improve health and well-being of older people. b) positive responses from Focus Groups – well attended; however the issue of engaging housebound people remains a challenge.	Framework Reporting Deadline (7/4/06)	a) need for health scrutiny training and induction on health services and trusts' organisational structures required – PCT to be invited to play a part in this. b) problems of change of elected members with impact on continuity part-way through the Project.

	June 06	July 06	August/Sept 06
Meetings/ events	Officer meetings with Health (PCT) in liaison with Health Panel Chair/Vice-Chair to develop report.	Officer meetings with Health (PCT); other key stakeholders to draw together findings.	
Issues/topics covered	Initial drafting of review outcomes commences New members familiarising themselves with health scrutiny, with each other and with Action Learning Project to date. Progress report on Project to first meeting of 2006/7 Health and Community Care Scrutiny Panel (20/6/06)	Continue drafting outcomes Conclusion of Stage 3 Research Focus Groups	Drafting final report/ recommendations Receipt of 5 updated draft briefing papers from GR Associates: -Summary -Promoting Health Reducing Health Inequalities -Wider national context of national policies and policy framework in Merton -Contribution of the public sector to the voluntary and community sector means for delivering health and social care -Views/experiences of older people Stakeholder workshop arranged to conclude Project – 2nd October 2006 Final Project report to be presented to Health and Community Care Panel on 31/10/06. (as agreed by CfPS)
Action Learning: **a) Health:** **b) Scrutiny:**	a) Pace of change in NHS is having considerable impact on health scrutiny agenda priorities. In particular, local NHS financial pressures are a major concern. b) Political complexity of new Council means it takes time for dust to settle and meaningful work to commence.	a) Health partners have let scrutiny panel take the initiative on the Project. b) New health scrutiny members need urgent training and induction to enable them to undertake scrutiny effectively – are currently learning as they go. Induction takes time to arrange and members are overwhelmed by mass of information.	Final Framework Reporting Deadline – 31st August 2006

Key Project Objectives (KPOs):

1. To provide a baseline that maximises the positive impact of the local community setting, with measures to include following 3 elements:

   (i) local authorities providing local leadership to bring concerted and integrated local action on health

   (ii) investment and new initiatives in disadvantaged and deprived communities

   (iii) promoting partnership between the public and voluntary sectors to develop national and local champions for health and extend opportunities for people to take up healthy lifestyles in local communities.

2. To determine ways to strengthen existing links between the voluntary sector, local authority and health trusts in providing health and social care services.

3. To provide a focus on local health needs and contribute to tackling health inequalities.

4. To recommend ways to promote the involvement of local community groups and individuals in contributing to health improvement.

Appendix 2

Thanks are expressed to all those local organisations consulted during the Action Learning Project, including the following:

London Borough of Merton:

- Sue Tanton, Regeneration Partnerships Team Manager
- Robert Bowler, Principal Voluntary Sector Officer
- John Haffenden, Interim Head of Community Care
- Yvonne Tomlin, Head of Community Education
- Ingrid Lackajis, Head of Libraries
- Peter Mulloy, Head of Strategy and Partnerships, Community and Housing
- Sally McEnhill, Principal, Merton College

Sutton and Merton Primary Care Trust:

- Angela Gibson, Executive Director, Merton Locality
- Janie Conlin, Assistant Director, Merton Locality
- Maggie Harding, Director of Public Health
- Fiona Wright, Public Health Consultant
- Janet Coninx, Clinical Effectiveness Manager
- Jatinder Bhuhi, Health Partnership Officer
- Ann-Marie Liew, Merton Horizons
- Clare Lowrie-Kanaka, Merton Horizons
- Abdul Chaudhary, Chair, Merton Horizons

Voluntary Sector:

- Chris Frost, Director, Merton Voluntary Service Council
- Stephen Blann, Merton Voluntary Service Council
- Andy Norrell, Volunteer Centre Merton
- Frank Anti, Merton Race Equality Partnership
- Reuben Hyacinth, Ethnic Minority Centre
- Lynne Bainbridge, Age Concern Merton
- Merton and Morden Guild of Social Services
- Wimbledon Guild of Social Welfare
- Merton MIND
- Merton Association of Pensioners

- Citizens Advice Bureau
- Care Connect
- Carers Support Merton

Greenwich Leisure Limited:

- Peter Hickey (Wimbledon Leisure Centre)
- Jenny Burr (Morden Park Pool)
- Mark Basker (Canons Leisure Centre)

If you would like more information in your own language, please contact us at the address shown in the box below. You can also get this information in large print, in Braille and on audiotape.

Albanian — Nese deshironi me shume informacion ne gjuhen tuaj, ju lutemi te na kontaktoni ne adresen e dhene ne kutine me poshte.

Arabic — إذا أردت معلومات إضافية بلغتك الأصلية الرجاء الاتصال بنا في العنوان المدون ضمن الإطار أدناه.

Bengali — যদি আপনার নিজের ভাষায় লেখা আরও তথ্য চান তাহলে দয়া করে আমাদের সঙ্গে যোগাযোগ করুন, তলার বক্স সে আমাদের ঠিকানা রয়েছে।

Chinese — 如果你需要用中文印成的资料，请按低端方格内提供的地址与我們聯系。

Farsi — اگر مایل به اطلاعات بیشتر به زبان خود هستید، لطفاً با ما از طریق ادرس زیر تماس بگیرید.

French — Pour tout renseignement complémentaire dans votre propre langue, veuillez nous contacter à l'adresse figurant dans l'encadré du bas.

Polish — **Jeśli życzy sobie Pan/i więcej informacji w swoim języku, proszę się z nami skontaktować pod adresem podanym w dolnej ramce.**

Punjabi — ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਵਿਚ ਹੋਰ ਜਾਣਕਾਰੀ ਲੈਣੀ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਹੇਠ ਲਿਖੇ ਖਾਨੇ ਵਿਚ ਦਿੱਤੇ ਪਤੇ 'ਤੇ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰੋ।

Somali — Hadii aad u baahan tahay faahfaahin intaa kabadan oo ku soobsan afkaaka hooyo ama Af Somali fadlan lana soo xiira cinwaanka hoos ku qoran.

Spanish — Si usted desea más información en su propia lengua, por favor contáctenos en la dirección al pie del formato.

Tamil — உங்களுக்கு மொழியில் மேலதிக தகவல்கள் வேறு ஏதேனும் வேண்டுமானால், அவற்றை தயவுசெய்து கீழ்க்காணும் முகவரியில் எங்களுடன் தொடர்பு கொள்ளுங்கள்.

Urdu — اگر آپ اپنی زبان میں مزید معلومات حاصل کرنا چاہتے ہیں تو براہ کرم ہم سے رابطہ کریں۔ ہمارا پتہ نیچے دیے گئے خانے میں لکھا ہوا ہے۔

Scrutiny Team
Merton Civic Centre, London Road
Morden, Surrey SM4 5DX
Tel: 020 8545 3390

Designed and printed by Merton Print 020 8545 3410