Making the Shift to Affordable and Sustainable Social Care and Support in Merton

Our Joint, Local Adult Services Commissioning Strategy 2010 -2013

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Executive Summary

E1. There are a number of national drivers for changing the way in which adult social care services are commissioned. These include:
- Forecast demand for services running ahead of the money to pay for them
- A new emphasis on prevention and avoiding unnecessary dependency
- The need to provide advice and support to those who fund their own care
- The need to commission in a way sensitive to choice and self directed support

E2. Merton has a diverse population in terms of affluence and ethnicity. It is becoming more ethnically diverse. At present its population has a higher weighting towards middle age than average, but there is a rapid growth in older people over 80 and in children and young people. This presents a challenge to the whole council and its partners.

E3. Merton's financial context is very challenging, as a “floor” authority which overall spends the lowest amount per head of population of all London boroughs. Its Medium Term Financial Strategy forecasts the need to reduce spend by up to 30% between 2010 and 2013.

E4. Merton’s adult social care service is a low spender per head of population. Its most recent performance rating is “Good” for all outcomes. Sutton and Merton PCT has a rating of Fair for financial management and Good for quality of commissioning

E4. The aim of this strategy is to facilitate this reform by providing:
- A framework to deliver better outcomes
- A framework to shift to preventative and early intervention
- A framework for allocation of adult social care resources
- A guide to inform the expectations of those in need of care and support and their families

E5. The strategy’s objectives have been mapped against the “inverse triangle of care”, in line with the aim to maximize effective prevention. Essentially investment in preventive services is being protected for 2010/11 and re-focused while investment elsewhere is being reduced.

E6. The main opportunities for improvement are:
- Reducing numbers of people of adult working age in care homes, and reducing unit costs
- Reducing dependence on current block contracts for older people
- Improving the transitions process between children’s and adult services
- Increasing the number and range of accommodation options
- Working with the voluntary sector under Compact principles to re-focus the current investment in their services, including an increase in volunteering
- Streamlining information and advice services to make them easier to find
- Increasing the use of Telecare
- Working with the local NHS to bring re-ablement and intermediate care closer together, and having shared teams based on clusters of practices
Chapter 1 The Purpose of the Commissioning Strategy

What is Adult Social Care?

1.1 Adult social care includes preventative services, assessment and care management, nursing and residential homes, community Services (home care, day care, meals), re-ablement to prevent hospital admission or enable continued independence, intermediate care (after a spell in hospital), supported and other accommodation, individual budgets and direct payments to service users, safeguarding and the provision of equipment and other related areas such as telecare, prescriptions and equipment store. Service users include older people, adults with learning disabilities, or mental health issues, and with physical or sensory impairments.

Why focus on commissioning?

1.2 Commissioning involves:
- Consulting, identifying the needs to be met and the desired outcomes
- Planning how best to meet those needs and achieve better outcomes
- Procuring high quality and cost effective services
- Monitoring service delivery to ensure outcomes are being achieved

1.3 Through improved commissioning we will:
- Achieve better outcomes for service users, carers and families
- Make sure services are designed and shaped to meet the needs of service users and carers

What is the Purpose of the Commissioning Strategy?

1.4 Local authorities spend around £18 billion each year on adult Social care, including £11.6 billion on external providers. It is now well documented that local authorities are facing rapidly rising costs in adult social care. There is increased demand as a result of demographic changes, particularly an ageing population and increasing life expectancy for people with a range of different needs. The impact of the recession and inequalities in health also cause financial pressures. Local authorities are under pressure to reduce expenditure on and the cost of adult social care. At the same time service users and carers expect high quality services. Millions could be saved each year through more effective and collaborative commissioning, including better procurement of services.

1.5 The aim of this strategy is to provide:
- A framework for local services to deliver quality improvements and outcomes for service users and carers
- A framework to shift to preventative and early intervention, cost-effective local services
- A framework for allocation of adult social care resources
- A guide to inform the expectations of those in need of care and support and their families

Sources of Information: IDeA Guide to Improving Outcomes through Better Commissioning in Adult Social care
Chapter 2 National Policy Context and the Case for Change

Chapter Summary

The national policy context has these key drivers:

- Forecast funding will not keep up with forecast demand
- Rigid distinctions between health and social care get in the way
- People need to be supported to live normal lives in the community and to use universal services, rather than be pushed into segregated services, and this should be a right not a “gift”
- Unit costs of services have been rising beyond inflation
- For some years many councils focussed adult social care resources on fewer and fewer people. Councils now need to invest in preventive services which work and to support those who fund their own care
- The shift towards choice and self directed support continues, with an aim that by 2011 30% of social care customers will be using a personal budget to control their own support
- It is a good use of resources to use services which are universal for all or which offer support at the right time, rather than forcing people into higher dependency settings of care

Background

2.1 In recent years there has been growing awareness that aspects of the adult social care system are under considerable strain and there is now clear consensus on the need for radical and ambitious social care reform. There is also a growing realisation that the distinction between health and social care is preventing people getting the service they need. The boundaries between health and social care have long been regarded as problematic for older people who require community based support.

2.2 Cost avoidance and reduction were themes throughout the first decade of the 21st century. But with increasing resources, the incentives to take transformational approaches to tackle the financial implications of an ageing population were weak. The second decade will see greater financial pressures.

2.3 The Disability Discrimination Act 1995 placed a duty on all Health and social care organizations not to discriminate against disabled people or provide them with poorer quality service. It obliges organizations to make ‘reasonable adjustments’ to reflect needs of disabled people. The wider recognition of the social model of disability sees it as “people disabled by society” rather than as something intrinsic in the person.
2.4 Government policy from 2000 emphasised the role of public services in helping people to live independent lives giving them better choice and control culminating in Putting People First (2007). The main themes are:

- Facilitating access to universal services
- Building on social capital within local communities
- Making a strategic shift to prevention early intervention
- Ensuring people have greater choice and control over meeting their needs

2.5 In 2009, the government produced two policy statements on issues related to the financial implications of an aging population. ‘Building a Society for All Ages’, focused on the wellbeing theme and the positive contributions that older people can make to their communities. ‘Shaping the Future of Care Together’, described options for reforming social care to meet future needs within expected resources. The Audit Commission’s response to ‘Shaping the Future Together’:

- Supported the move to reform services
- Welcomed the emphasis on prevention and service integration
- Recognised that principles of fairness, transparency and value for money should underpin future funding arrangements
- Supported councils’ continuing role in making local decisions about using resources to improve the lives of older people

2.6 The government commissioned review by the University of Birmingham (February 2010), ‘The case for social care reform’, identifies that social care reform is necessary in order to:

- Maintain social and public expectations that the state will provide a degree of collective support to its most vulnerable citizens
- Support people to be safe, be well and to have greater choice and control. Under this approach, decent social care is not a ‘professional gift’ from the state, but a citizen right for all
- Enable people to remain independent and in control for as long as possible so that emerging and initial needs do not deteriorate into a future and costly crisis
- Provide support to those in need so that they can contribute fully as active citizens
- Reduce some of the negative impact on families and individuals who care for others - so that they can have a good life in their own right, but also so that they can continue caring and contributing to society and the economy in other ways
2.7 The Audit Commission’s report, ‘Under Pressure’, states that Councils must balance the need to provide social care and to support active aging. If care service provision is simply increased alongside population growth, public spending on care services could nearly double between 2010 and 2026. Private spending on social care would increase from £5.3 billion to £23 billion over the same period, if trends in means testing and self-funding continue (See adjacent graph).

2.8 Eighty-five percent of older people don’t use council care Services. They may use other services such as housing, leisure and adult education, that play an important role in keeping them active and independent; and they use a full range of general council services.

2.9 Tighter finances create an opportunity to rethink and redesign services to improve lives, while spending less public money. The challenge of an aging population is a challenge for the whole council, not just adult social care services. It is a challenge to all Partners in housing, health and community safety who also contribute to the wellbeing of an aging population.
2.10 The Audit Commission, in its review, ‘Financial implications for local authorities of an ageing population’ (October 2009), looked at the costs of older people’s social care. It identified that there is no significant correlation between the Care Quality Commission (CQC) inspection ratings and the level of spend. Councils that spent more didn’t necessarily get better ratings. Spending more in home care did not mean that authorities spent less in residential. The table below looks at the different elements which make up the cost of older people’s social care. Some add to councils’ costs (+), but others reduce costs to councils (-).

Source: Audit Commission, 2009
The effective use of resources is a balancing act between user expectations and the priorities of adult social care services and the wider local authority services. The Department of Health’s Use of Resources guide states that only when all of these are met can a local authority deliver efficient, effective and economic adult social care in an affordable and accountable manner. Within this context an excellent local authority will:

- Be able to demonstrate how it has given priority for adult social care within its other priorities
- Be clear about how it has proportioned its resources between the different groups of people
- Understand its patterns of spend and its costs for services – it should be managing its resources to deliver good quality outcomes and be able to meet predicted demands
- Be commissioning services to ensure a good supply at an affordable cost – it will have set as its starting point the need for a range of services to support people to live in their own homes (or suitable community alternatives) and a supply of residential care
- Have a balance of services available with less than 40% of its overall budget being spent on residential care
- Be working in partnership with the PCT to share investments that improve outcomes for their customers and will have agreed how to share the benefits and risks in such a way that encourages joint working
- Achieve efficiencies through a system focused on early intervention, prevention and re-ablement - i.e. where good information and advice, practical support, appropriate housing options, re-ablement and joint working between health and social care assist people living fulfilled and independent lives, thereby reducing the number of people entering or requiring ongoing support from social care

- Have efficiency statement within its medium-term financial strategy, which makes it clear how it will deliver 3% cashable savings for the Comprehensive Spend Review (CSR) period; the efficiencies will focus on re-shaping the services that involve a strategic shift towards prevention, rather than making cuts in services
- Be moving towards personalisation of services in a measured way, with a Resource Allocation System (RAS) or a similar mechanism for showing the resources available to the individual that is transparent and sustainable
- Procure services in an effective way – it will be mindful of both the needs of service users and the ability of providers to deliver good quality care
- Have robust systems in place to monitor and review the effectiveness of their procurement and contracting arrangements so that underperformance of commissioned services can be identified early and remedied
- Be working with other local authority departments and agencies to harness their activities and resources in order to achieve the greatest efficiencies in addressing shared outcomes for people who have care and support needs
The Department of Health’s guide, ‘Making a strategic shift to prevention and early intervention states that excellent local authorities will be demonstrating improvements in performance on a number of relevant indicators in the National Indicator set (see below).

Population ‘needs’

- General population
- Low to moderate needs
- Substantial needs
- Complex needs

National Indicator Set

- 140 fair treatment by local services
- 6 participation in volunteering
- 9/10/11 engagement/use of arts, libraries and museums
- Employment rate of 50-69 years old

- 139 satisfaction of over 65’s with home and neighbourhood
- 175 access to services and facilities by public transport

- 187 tackling fuel poverty
- Pensioner incomes/benefit take up

- 119 overall health and wellbeing
- 137 healthy life expectancy
- 8 participation in sport

- 136 supported to live independently
- 139 views on extent of support to live independently
- 142 ‘Supporting People’ support to live independently

- 125 achieving independence through rehabilitation/intermediate care

- 124 LTC supported to be independent with choice and control
- 127 self reported experience of social care users
- 132/133 Timeliness of assessment/care packages

- 129 end of life care – enabling people to die at home
- 134 emergency bed days

- 131 delayed transfers of care

Choice and Control: 130 social care clients receiving self directed support
Dignity: 128 users treated with dignity and respect
Carers: 135 carers receiving assessment of needs and specific carers service, advice or information

LTC = Long term conditions
2.13 In summary, the biggest financial implications of an aging population concern social care costs, yet these costs relate currently to services which reach a minority of the older population. The mitigating actions are service transformation, value for money initiatives, prevention and early intervention activities in partnership with other council departments, NHS and the provider market. Providing care and support through traditional models of service provision is no longer sustainable.

2.14 Councils have to take a strategic long-term approach, but also deliver quick wins.
- Stronger corporate approaches to financial planning, led by quality of life objectives, should avoid silo-based thinking
- Joint strategic needs assessments provide opportunities to overcome obstacles to collaborate and preventative working
- Councils and partners can control service costs by reducing spending, avoiding spending, preventing waste and achieving better outcomes for the same, or fewer inputs

2.15 A strategic approach needs:
- Clear objectives for older people’s quality of life
- Better information about costs and savings
- Co-operation with other local services
- Recognition that spending from other budgets will lead to savings in social care and health
- Difficult choices

2.16 Many of the potential savings will be long-term and will need an invest to save approach. Focusing on prevention, early intervention and minimum use of institutional solutions can deliver more for less.

Sources of Information:
- Under Pressure – Audit Commission February 2010
- Use of Resources a Guide for Local Authorities - Department of Health, October 2009
- Making a Strategic Shift to Prevention and Early Intervention, a Guide – Department of Health, October 2008
- After the Downturn – CIPFA, December 2009
- Financial implications for local authorities of an aging population – Audit Commission (October 2009)
Chapter 3  The Merton Vision and partnership structure

Our aim over the next three years is to demonstrate that we are an excellent authority against the criteria in Use of Resources (Chapter 2). We will work jointly with our partners, re-focusing and pooling our resources, where appropriate, to achieve value for money, shift to prevention and early intervention, empowering our customers to have greater choice in and control of their lives with significantly improved outcomes and improved National Indicator set performance.

The Council’s Vision for Merton

3.1 A great place to live and call home, where citizens are also Neighbours and take responsibility for improving their own lives and Neighbourhoods, supported by good value local services.

3.2 The vision is supported by the strategic themes that are set out in the Council’s Business Plan 2009-2012:

• Sustainable communities – improving community safety and promoting diversity and community cohesion
• Safer and stronger communities – improving community safety and promoting diversity and community cohesion
• Healthier citizens – improving health, promoting wellbeing, reducing health inequalities and engaging constructively with older people so they are able to play an active part in the life of the borough
• Children and young people – improving the lives of children, young people and their families
• Corporate capacity – providing effective, value for money services

3.3 The Council’s vision for Merton is inter-locked with the vision of its local NHS partner.

NHS Sutton & Merton Vision for Merton

3.4 NHS Sutton and Merton, 2010-2015: Faster, Safer, Fairer, Nearer. The local health vision is to develop an excellent local NHS that serves the needs of our population driving up quality of life and providing healthcare faster, safer, fairer and nearer.

3.5 In the next five years, the aim is to commission services that will ensure health services are available when and where they are needed, providing high quality, cost-effective health care and promoting health and wellbeing for the whole population.

3.6 This is underpinned by 3 Goals:

• GOAL ONE: NHS Sutton and Merton will reduce the inequalities in life expectancy of our population from a difference of 6.8 to 5.9 years in males and 4.8 to 4.2 years in females over the next five years with targeted prevention and early intervention services (particularly: smoking cessation, falls prevention, cancer screening, improved acute care for stroke) and better management of long-term conditions (particularly: CHD, diabetes)
• GOAL TWO: NHS Sutton and Merton will improve patient experience of healthcare services provided particularly with respect to improving mental health services and end of life care and improved self-management of long-term conditions, which will require the development of patient experience frameworks and measures during 2010/11

• GOAL THREE: NHS Sutton and Merton will commission high quality care in more local settings where it is clinically and cost effective to do so, with an initial focus on long term conditions, as measured by the successful implementation of our two strategic programmes, Better Healthcare Closer to Home and Integrated Care Organisations

3.7 The Better Healthcare Closer to Home and Integrated Care Organisation programmes are the main delivery vehicles for moving care from hospital-based settings to local care settings with integrated teams providing patient-centred care in appropriate surroundings.

Merton Partnership Structure

3.8 The Merton Partnership was established as the overarching strategic partnership for the Borough. Its aim is to work together with all partners on issues that are key to the people of the Borough, including residents, workers and visitors, as reflected in the Community Plan.

3.9 The Partnership’s primary objectives are to deliver the Community Plan, Neighbourhood Renewal Strategy and, more recently, the Local Area Agreement. This is achieved through:

• promoting a network of public and other agencies committed to the delivery of effective, efficient and high quality services, that will provide optimum outcomes;

• the establishment of set strategic objectives and operational plans, including commitment of core resources and agreement to continuous review of Partnership arrangements;

• in particular, coordinating the development and implementation of the Community Plan for Merton, ensuring that the needs of all parts of Merton’s community, including black ethnic minority groups, people with disabilities and other minority interests are taken into account;

• coordinating the development and monitoring the implementation of the Merton LAA

• developing and overseeing the implementation of a Neighbourhood Renewal Strategy for Merton. This will address areas of deprivation and identify actions to improve the life chances and experiences of those living in the most deprived neighbourhoods in the borough;

• promoting collaboration between Partnership Members, particularly relating to skill sharing, training, resource management, external funding and bid development; and good practice; and

• development and implementation of a Communications Strategy that ensures effective communication between the work of the Merton Partnership, Partnership Members and the
3.10 Membership of the Merton Partnership consists of senior representatives from the public, private, voluntary and community sectors. Members are recruited on the basis of their capacity to represent their organisations and not their individual interests. The partnership consists of a number of key groups:
- Merton Partnership;
- Executive Board;
- Thematic Partnerships
- A number of delivery groups; and
- Ad hoc working groups

**Thematic Partnerships**

3.11 These bodies are tasked with coordinating delivery of the priorities of the Merton Partnership, as identified in the Community Plan. They determine the need for, and the work programme of, any delivery groups that report to them and will actively monitor and manage the work programmes that take place. They take responsibility for embedding key targets and for pursuing specific pieces of work on behalf of the Merton Partnership.

3.12 The 4 Thematic Partnerships are:
- Sustainable Communities
- Safer and Stronger Communities
- Healthier Citizens
- Children and Young People

3.13 Adult Social care falls under the umbrella of Healthier Citizens Thematic Partnership.

3.14 The Healthier Citizens Partnership has 4 Deliver Groups reporting to it:
- VAST (Vulnerable Adults Safeguarding Team)
- Healthy Living
- Service Delivery
- Citizenship and Inclusion

3.15 The implementation of the adult social care commissioning strategy will be monitored by the Healthier Citizens Thematic partnership via the Service Delivery Group.

3.16 To realise our vision, within our local partnership, we will need to adopt a whole system approach to prevention, intervention and cost effective services. This includes support available that will enable any citizen requiring help to stay independent for as long as possible. The key to this is ensuring council-wide and partnership approach to making universal services widely accessible e.g. information, leisure, adult education, transport, employment, healthy living and health improvement, along with housing and supported living options.

**Source of Information:**
- Merton Partnership Governance Handbook 2009-10
- NHS Sutton & Merton Strategic Plan 2010-2015
- London Borough of Merton Business Plan 2009-2012
Structure of the Merton Partnership

Partner agencies’ BUSINESS PLANS → COMMUNITY PLAN → Partner agencies’ BUSINESS PLANS

Community Engagement representatives

LOCAL AREA AGREEMENT

Merton Partnership
Providing governance and high-level strategic leadership for the work of the Partnership

Executive Board
Delegated powers from the Partnership to determine delivery arrangements

COMPACT BOARD
Reports twice a year to the Executive Board

THEMATIC GROUPS
Sustainable Communities ← Safer and Stronger Communities ← Healthier Citizens ← Children and Young People

DELIVERY GROUPS

Improved Quality of Life for the community
Chapter 4: Merton’s financial context

4.1 Merton Council is a “floor” authority, meaning that alongside other “floor” councils it receives the lowest possible share of central government funding support.

4.2 This means that every year, in order just to maintain its financial position, the council has to close a gap between its resources (mainly council tax and central government funding) and its commitments. Annual cost pressures on commitments are particularly around inflation.

4.3 In the budget round for 2010/2011, the initial budget gap was over £14m. This was closed in the budget around and indeed there was a council tax reduction of 1.4%. As part of the required savings across the council, adult social care found some £3m mainly from procurement and staff reductions; it also received some £1.5m in growth for forecast increases in demand for care and support due to demographic pressures.

4.4 Looking ahead, the council’s assumption is that there will be another £14m gap for 2011/12, and a slightly smaller gap for 2012/13, on the assumption that there is no increase in council tax, that central government support remains unchanged, and that there will be inflationary pressures to meet. Again adult social care will need to make a significant contribution to any required savings.

4.5 The council overall has embarked on a transformation programme in order to make the required reductions in spend while maintaining or improving the customer experience of services. This means taking a radical look at what the council will look like in the future (called its “Target Operating Model”) on the assumption that it may be up to 30% smaller in terms of cost base and staffing. It also means looking at processes to ensure that the council only spends money on things which add value to the customer: this is technically known as “Lean” thinking. Adult social care has already sought to embrace these concepts, alongside the Putting People First national policy agenda, and access and assessment has been one of the first wave council services to do a full “lean” review.

4.6 Later in 2010 adult social care along with other parts of the council expects to clarify where it expects to be within the above model. Given that most of the spend in adult social care is in commissioning, we expect to make further revisions for this strategy as we approach 2011/12 and beyond.
Chapter 5  Needs of our Merton Population

Introduction
5.1 This chapter draws on a number of needs assessments that have been undertaken, which measure the current scale of health and social care needs for older people, people with physical disabilities, people with learning disabilities, and mental health needs in Merton. It looks at current population and future trends in expected need, which will inform commissioning decisions set out in this strategy. It also signposts to sources of further information.

Overview
5.2 This section summarises key commissioning messages from the needs assessments:

• The population of Merton is expected to increase and people are living longer. The number of people with health and social care needs is expected to rise and there will be greater demand for health and social care from people with complex needs.

• There is a need to focus on primary and secondary prevention and access to preventative services that support health and well-being and maintain health, with a focus on smoking and maintaining a healthy weight. At the same time there is a need to focus on early interventions that prevent and delay the need for social and health care, supporting people to maintain independence.

• Estimates suggest that Merton’s ethnic diversity is similar to London as a whole. 12% of the Merton population estimated to be from Asian or British Asian groups. Evidence suggests that there has been a significant increase in ethnic minority groups since the last census. This implies a continuing and increasing need for sensitivity to cultural diversity, specific culturally tailored services may become necessary to cater for the increase in older people from black and minority ethnic groups.

• Life expectancy in Merton is increasing, and this is reflected in improvements in All Age All Cause Mortality, current rates place Merton among the healthier areas in England. However wide inequalities persist between the east and the west of the borough. This is also reflected in the Index of Multiple Deprivation, which implies a need for a geographically targeted approach.

• The expected increase in people ages 85 and over, and rise in people with limiting long term illness, is likely to create greater demand for health and social care services. There will be a need to provide increased services for very elderly people with complex health needs.

• A higher proportion than expected of Merton expenditure goes towards residential care for adults of working age with physical disabilities and there is a need to focus on supporting more people to live in community settings.

• People with learning disabilities are living longer than previously and need to have general access to medical and social services that can be tailored to meet their specific needs. In particular they should ensure that services have the right level of communication skills.

• More work undertaken to identify the skills that people with learning disabilities may be needed to be developed to achieve their full potential, maximise independence and gain sustained employment.

• There is a need to engage with the population with unknown and unmet mental health needs in particular, identifying people with depression and schizophrenia and older people with dementia who may not be know to local service providers.

• Increasing awareness of the nature of mental illness should result in more willingness to seek help at the onset of problems, and demand for primary care and community-based services is likely to grow over the next 5 years. Prevention and early intervention are important to increase independence.

• There is a need to provide support for carers. The projected rise in the number of people aged 65-74 living alone in Merton by 2020 has significant implications for how to support carers who do not live with the person they care for, and indicates a need to build support and social capital, for example through volunteering.

Sources of information:
• Joint Strategic Needs Assessment Core Data Set 2009
The population of Merton - Demography

5.3 Population projections (based on Office for National Statistics (ONS) projections) suggest in 2009:

There are around 203,800 living in Merton which is projected to rise to 223,700 in 2019.

The population aged under 5 years accounts for around 7.1% of the total population in Merton, compared to 7.3% in London. This is projected to remain fairly consistent in 2019.

Merton has a relatively young population. The population of working age (20-64 years) accounted for 66.1% of the population in Merton, compared to 64.7% in London. This age group is proportionally likely to decrease slightly (although absolute numbers will increase).

The population aged 85 and over accounted for 1.9% of the population in Merton compared to 1.6% in London. Proportionally the number of people aged 85 years and over are projected to increase.

5.4 At the end of June 2009 the registered population for GPs in Merton was 190,242 people.

5.5 Our older people are predominantly living in the Village, Wimbledon and Cricket Green in Merton. However our more deprived older people are living in St Helier and Colliers Wood.

5.6 Our young population predominately live in St Helier, (Wandle Valley) and Cricket Green areas which also have the highest numbers of births.

5.7 Population figures indicate that our population of people with learning disabilities in Merton are tending to live longer than expected.
The population of Merton: Ethnicity/Inequalities

Ethnicity

5.8 Office of National Statistics (ONS) estimates suggest that in mid-2007 the ethnic group of around 73% of people living in Merton was white, whereas nationally is was 88% and in London it was 69%.

5.9 12% of the population in Merton were estimated to be from Asian or Asian British ethnic groups, compared to 13% in London.

5.10 Evidence suggests there has been a significant increase in ethnic minority groups since the last Census in 2001, for example there were over 4 times as many applications for National Insurance from foreign nationals between 2003 and 2008.

Health and Social Inequalities

5.11 Over the last 15 years there has been a steady increase in life expectancy and estimates suggest it will continue to increase. This is also reflected in progressive improvements in All Age All Cause Mortality, current rates place Merton among the healthier areas in England, with mortality rates significantly below national and regional levels.

5.12 However there is variation in life expectancy between men and women, at 78.8 years and 82.2 years respectively (2002/06). There is also wide geographical variation between east and west Merton, for example there is a gap of 8 years in life expectancy between Figge’s March (73.8 years) and Village wards (82.7 years).

5.13 This trend is reflected in the Index of Multiple Deprivation (IMD). The IMD 2007 ranks Merton 222 out of 354 boroughs in England, where 1 is the most deprived, but this masks marked variations across the borough. The most deprived areas are in the east of the borough and Figge’s March and Colliers Wood are the areas of highest income deprivation among older people.
Drawing 1: Lower Super Output Area (SOAs) by National Rank Quintiles

Source: http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07

Drawing 2: Lower Super Output Area (SOAs) by National Rank Quintiles

Source: http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07
What we know about Older People

**Key findings**

5.14 The older population in Merton is projected to increase, (a 24% rise in people aged 50-59, and an 18% rise in people aged 85 and over by 2019).

In general older people are living longer and are healthier than ever before, but significant inequalities persist between east and west Merton, which indicates the need for a targeted approach.

5.15 It is projected that more older people will live alone (e.g. 24% increase in people aged 65-74 by 2020) and there will be a rise in older owner-occupiers, this has implications for both how to support carers and work with the private-purchase supported housing sector.

5.16 Death rates among older people have progressively declined, consistent with a rise in life expectancy. There has been a significant decline in the death rate among men aged 65-74 years.

5.17 Circulatory disease (including coronary heart disease and stroke) is the single biggest cause of death among older people (37%), this is followed by deaths from cancers (29%).

5.18 Smoking and obesity are the biggest lifestyle risk factors for older people and there is a need to focus on supporting older people to make healthy lifestyle choices. Secondary prevention and supporting self care for people with long term conditions is important to ensure older people can take control of their health and have support from professionals.

5.19 There has been a 21% increase in fractures of the neck of femur since 2004/05, which is a proxy indicator for falls and related to osteoporosis, this is disproportionately high compared to Sutton, which has a much higher proportion of older people.

5.20 There is a projected rise in older people with a limiting long term illness. Estimates suggest that there are currently 10,800 people over 65 with a limiting long term illness, and that if nothing changes there will be a need to provide care for 1,340 more people by 2020. This has implications for the development of both preventative services and services for more older people with complex health needs.

It is estimated that 1,600 to 1,800 people aged 65 and over have dementia in Merton, just under 6.5% of the population, this is projected to rise by 10% by 2021.

**Sources of information:**

- Older People in Merton: Update of Health and Social Care Needs (January 2010)
- Dementia Joint commissioning Strategy for Merton 2010-2015

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5.21 There has been a reduction in residential and nursing care, and a reduction in community services, with a focus on supporting older people and their carers to maintain independence.

5.22 58% of LB Merton expenditure on Adult Social Care is on older people. Merton has lower comparative expenditure on nursing and residential care, and higher comparative expenditure on day and domiciliary care.

5.23 There are significant variations in the rate of emergency admissions among people aged 50 and over. Geographical analysis can be used to target prevention and early intervention support.

**Commissioning Implications**

5.25 There is a need to focus both on prevention services to maintain people’s health, and provide increased services for the very elderly with complex health needs. In particular, the expected increase in people ages 85 and over, and rise in people with limiting long term illness, is likely to create greater demand for health and social care services.

5.26 The increase in the population ages 50-59 underlies the need to re-orientate services towards prevention, promoting health and wellbeing of those in middle age as well as older people, to reduce the impact of an ageing population.

5.27 There is a continuing and increasing need for sensitivity to cultural diversity, specific culturally tailored services may become necessary to cater for the increase in older people from black and minority ethnic groups.

5.28 The higher numbers of more deprived older people living in east Merton and health gap between east and west Merton indicates the need for a geographically targeted approach.

Partnerships should focus on approaches to support older people making healthy lifestyle choices to reduce smoking and maintain a healthy weight.

5.29 The decline in the numbers of older people supported by social care indicates a need to engage more with older people who self fund their care, offering advice and support. There is also a need to consider the information and advice needs of older people with ‘low to moderate needs’.

5.30 There is a strong case for a shift in resources to prevention and early intervention for older people. It is important both in terms of access to preventative services that support health and well-being, and preventing and delaying the need for social and health care in the short term. There is a need to ensure that older people and their carers are at the centre of new developments in social and health care and have a strong voice.
What we know about People with Physical Disabilities

Key Findings
5.31 There are currently 12,500 adults of working age (18-64 years) estimated to be living with a physical disability in Merton. Over three quarters are estimated to have a moderate physical disability (78%, 9,782 people). Less than a quarter are estimated to have a severe disability (22%, 2,690 people).

5.32 The prevalence of physical disability increases with age, it is estimated that 16% of 18-24 year olds have a physical disability compared to 28% of those aged 55-64 years.

5.33 By 2013 the number of people with a physical disability is projected to increase by 5% (560 people). The number of people with a moderate disability will increase by approximately 440 and the number of people with a severe disability will increase by 124.

5.34 The greatest increase in absolute numbers of people affected by physical disability are projected to be people aged 45-54 years, estimated to increase by 11.5% (282 people) by 2013.

5.35 In 2010, 5,691 people aged 18-64 are predicted to have a personal care disability, of those 81.5% will have a moderate disability. Personal care includes getting in and out of bed; getting in and out of a chair; dressing, washing, feeding, use of the toilet. A moderate disability means a task can be performed with some difficulty, and a severe disability means the task requires someone else to help. By 2013 the number of people with personal care disability is projected to increase by 5% (273 people moderate; 50 people severe).

5.36 It is estimated that in 2010, 5050 people of working age will have a physical disability and be permanently unable to work, 60% of these are estimated to be male. By 2013 the number of people with a physical disability who are permanently unable to work will increase by 5.4% (266 people), of which men account for 67% (178 people).

5.37 Disabled people experience significantly poorer health outcomes than their non-disabled peers. They are also at greater risk of experiencing social exclusion and discrimination due to their disability. This can have a direct health effect e.g. reduced access to appropriate health care; and indirect health effects through restricted social mobility and psychological impact of discrimination. Poorer health outcomes are also experienced by the carers of disabled children and adults (Centre for Disability Research 2009).

5.38 Locally there is limited data on health status and health outcomes of people with physical disabilities of working age. Therefore it is unclear precisely what conditions have caused the physical disability of adults of working age. The main causes of death (coronary heart, stroke, cancers, COPD, dementia) reflect the main causes of limiting long term disability. But there are also a number of conditions that are not generally the cause of death, including mental health and arthritis.

5.39 In terms of self reported disability 13.8% of people in Merton reported having a limiting long term illness. There is geographical variation, ranging from 10.5% in Dundonald ward to 18.7% in St Helier ward.

5.40 Prevalence of Stroke (i.e. the proportion of people living with a stroke) has been modelled at 2.09% of the population of Merton, and is projected to rise to 2.16% by 2015, and 2.75% by 2020. Current data sources suggest that while prevalence is rising, the outcomes are improving both in terms of mortality from stroke and against a measure of death within 30 days of emergency admissions. This may indicate that more people are surviving and therefore may require additional social care and services.

5.41 The absolute numbers of people living with serious visual impairment are not predicted to vary from 2009 (90 persons) to 2013 (94 persons).

Sources of information:
• Health Needs Assessment: Working Age adults with Physical Disabilities in Merton (January 2010) (Draft)
• Stroke Rehabilitation Needs Assessment (July 2009)
5.42 The vast majority of people of working age with a hearing impairment are projected to have a moderate or severe impairment (4,270 in 2010, this is projected to rise by 160 by 2013.).

5.43 8% of LB Merton expenditure on Adult Social Care is on adults of working age with physical disabilities, of that, 55% is spent on day and domiciliary care. 32% on nursing and residential care which is high proportion compared to other London boroughs. 13% is on Assessment and care management, which is low compared to London (see Chapter 5).

**Commissioning Implications**

5.44 Consideration needs to be given to how better to ascertain information on health status and outcomes of people with physical disability. For example, through better sharing of data between service providers and commissioners.

5.45 Increasingly people are living longer and are therefore more likely to develop long term conditions. As medical and assistive technologies improve people will live longer with more complex conditions.

5.46 Trends in Stroke indicate that more people are surviving stroke and therefore more people may potentially require additional social care services.

5.47 More preventative services need to be in place (primary and secondary) to support people stay independent.

5.48 A high proportion of Merton expenditure goes towards residential care for adults of working age with physical disabilities and there is a need to focus on supporting more people to live in community settings.
What we know about People with Learning Disabilities

Key Findings

5.50 The proportion of people with Learning Disabilities in Merton does not appear to be increasing, but there will be an increase in absolute numbers as the overall population increases. There is will also be a shift in age with more people with learning disabilities surviving into older ages, so that by 2021 the average age of people with learning disabilities will have increased by about 10 years.

5.51 The ‘true prevalence’ of people with learning disabilities in Merton is an estimate of those known to services, and those who generally have milder learning disabilities and are not always known to services. This is estimated at 2.2% of the population and figures 5 and 6 show trends in the true population up to 2021.

5.52 The ‘Administrative prevalence’, or the number of people with learning disabilities known to services, is estimated at just under 0.5% of the population. The Register for people with learning disabilities reflects those known to services who wish to be registered, and in the younger age groups (20-44 years) this is lower than expected, which may reflect a choice not to register.

5.53 Research has suggested that 57% of people on learning disability registers have significant levels of health and social care needs, and 56% receive some form of out-on-home residential support, which rises to 76% in the 50+ age group (Emerson and Hatton 2004).

5.54 The level of learning disability recorded by the Merton Learning Disability Register 2009 is 9% mild, 41% moderate and 42% severe, with Downs syndrome being the primary cause of disability of 15% of the overall Register.

5.55 The life expectancy of people with learning disabilities is increasing over time (67 years for men, 69 years for women, 55 years for people with Downs), but it is still significantly less than the general population. The main cause of death is respiratory disease, between 46 – 52% of people with learning disabilities die from respiratory disease, compared to 15-17% of the general population.

5.56 Significant health issues identified in the Register 2009 include epilepsy (27%); ongoing mental health problem (22%), Visual impairment (46%), hearing impairment (18%), mobility problems (23.3 %) and obesity (25.5%), oral health.

Sources of information:

•Merton Register for People with Learning Disabilities (December 2009)
<table>
<thead>
<tr>
<th>Section</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.57</td>
<td>There is clear evidence that attention to preventative services and annual health checks can reduce morbidity in people with learning disabilities (Alborz et al 2005). The 2009 Register estimates that only 12 Merton GP practice have accessed the requirements to undertake health checks.</td>
</tr>
<tr>
<td>5.58</td>
<td>There are currently 253 (42%) registered adults living in their family home, 300 (49%) living in residential accommodation and 55 (9%) living independently in their own home. However comparison with estimates of people with learning disabilities living in their family home (PANSI) show that significantly fewer in the 25-44 age group live in the family home than would be expected, which suggest more should be done to support people living in the community.</td>
</tr>
<tr>
<td>5.59</td>
<td>79% of registered people with learning disabilities say they have a day activity including attending a specialist day service (221 people), in education (83 people) and in employment (71 people, 12%).</td>
</tr>
<tr>
<td>5.60</td>
<td>Of interests and pastimes watching television, spending time with family or friends, outings and clubs were the 4 most commonly cited activities. European research (POMONA 2008) identified that over half respondents with learning disabilities reported leisure time as ‘reading, watching TV or other sedentary activities’, and 69% reported experiencing one or more barriers to engaging in physical activity, most commonly lack of motivation.</td>
</tr>
</tbody>
</table>

**Commissioning implications**

5.61 With increasing age there are increasingly complex health and social care needs. Therefore more support may be needed to help people with learning disabilities remain in their own home. People with learning disabilities will need to have:

- General access to medical and social services that can be tailored to meet the specific needs of people with learning disabilities. In particular they should ensure that services have the right level of communication skills and that people with learning disabilities can be followed up appropriately.
- Availability to housing and supported housing that can support an ageing learning disabilities population with increasingly complex social and health needs.
- Availability of services within a framework of personalisation that can support an ageing learning disabilities population with increasingly complex social and health needs.

5.62 A life course approach to supporting people with learning disabilities is recommended ensure that emphasis is placed on functionality and need for services and not age, with a more flexible approach to managing service provision.

5.63 More work undertaken to Identify the skills that people with learning disabilities may need to develop to achieve their full potential, maximise independence and gain sustained employment. This should be used to inform Community support teams and employment providers.

5.64 More emphasis on supporting people with learning disabilities to promote their health is needed. All GP practices in Merton should be encouraged to undertake health checks for people with learning disabilities.

5.65 Building on existing services, there is a need to consider how people with learning disabilities can themselves be more involved in developing services, including new and extended services under the transformation programme.

5.66 The needs and outcomes of carers should be considered in the context of transforming social care, and the prioritisation of caring funds reviewed in the light of the evidence of the impact of caring.
What we know about People with Mental Health Problems

<table>
<thead>
<tr>
<th>Key Findings</th>
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</thead>
<tbody>
<tr>
<td>5.67 Prevalence rates of mental health disorders have been applied to the forecasted population of Merton (ONS projections) to show the expected number of disorders between 2010 and 2015.</td>
</tr>
<tr>
<td>5.68 This estimates that in 2010 for adults of working age nearly 13,500 people have depression or anxiety disorders; 830 people have Schizophrenia; nearly 1,400 people have bipolar (I) disorder; and between 700 and 1050 people have Antisocial Personality disorder.</td>
</tr>
<tr>
<td>5.69 For older people it is estimated that in 2010 between 690 and 1,000 people have depression, nearly 1,300 have anxiety, 95 have schizophrenia and nearly 240 have Bipolar (I) disorder. It is estimated that between 1,600 and 1,800 older people have dementia, this is projected to increase by 3% by 2015, and by 10% by 2021.</td>
</tr>
<tr>
<td>5.70 It is projected that by 2015 the number of people adults with mental health disorders will broadly follow overall population increases, with increases ranging from 4-6%, with the exception of dementia (at projected 3% increase), which reflects the relatively young age profile of Merton.</td>
</tr>
<tr>
<td>5.71 It is important to note that not all of the individuals in these projections will present themselves for treatment. Many cases will remain unknown to services and the figures represent both met and unmet needs. The challenge remains how to engage with the population with unknown and unmet needs.</td>
</tr>
<tr>
<td>5.72 Social and environmental factors have an influence on mental health needs including ethnicity, deprivation, income, employment, long term limiting illness, education, homelessness, alcohol and crime. An analysis of these compared to England as a whole indicates that levels of mental health should be broadly comparable or possibly slightly below all England estimates.</td>
</tr>
<tr>
<td>5.73 Mental health need indicators that estimate the likelihood of admission for psychiatric services based on social factors (MINI 2K) have estimated that Merton has lower than standard need. A Local Index of Need (LIN) that estimates general mental health need suggests that Merton has the 10th lowest mental health need in London, but is still slightly higher than the England average.</td>
</tr>
</tbody>
</table>

5.74 Comparison of prevalence estimates with local data about health service use has suggested that many cases of depression are not being identified within primary care; and that many people with schizophrenia/bipolar disorders, and older people with dementia may also not be known to local primary care services. Local studies show that stigma and lack of understanding of the nature of mental health problems may account for some of this apparent unmet need.

5.75 Views of service users and carers have expressed concerns about the effects of weaknesses in community mental health services, notably about the lack of co-ordination between various health and social services agencies and the lack of provision for continuing care and support. All of these weaknesses can reduce the potential of a successful recovery.

5.76 Of all expenditure on adult social care by LB Merton, 7% is on mental health services for adults (18-64 years), which is the same as the England average. Of this expenditure a comparatively low proportion is spent on day and domiciliary care (14.6%, ranking 28/33 London boroughs, where 1 is the highest proportion of spend), and Nursing and residential care (32.3% of gross current expenditure), whereas a high proportion is spent on assessment and Care management (53.1%, ranking 1/33 London boroughs) (see chapter 5).

Sources of information:
Mental Health Core Needs Assessment (2009)
Commissioning Implications

5.77 There is a need to engage with the population with unknown and unmet mental health needs in particular, identifying people with depression and schizophrenia and older people with dementia who may not be known to local service providers.

5.78 There is a need for more emphasis on education for staff on mental health and well-being awareness and a need to reduce stigma associated with mental health problems.

5.79 Increasing awareness of the nature of mental illness should result in more willingness to seek help at the onset of problems, and demand for primary care and community-based services is likely to grow over the next 5 years.

5.80 Improving quality, co-ordination, effectiveness and safety of community services should be a priority. A growing body of evidence shows that a care-model centred on the needs and choices of the individual which encourages recovery are more effective than a medicalised approach.

5.81 Community services should in principle be distributed in a way which allows for the pattern of deprivation i.e. with better staff/population ratios in more deprived areas.
What we know about the needs of Carers

Commissioning Implications

5.90 Merton Carers Strategy (LB Merton 2008) is led by Merton Carers Partnership and has identified 7 priorities for improvement in Merton:

- Information, guidance and advice
- Breaks from caring
- Health and wellbeing
- Economic wellbeing
- Employment and training
- Access to services and carers assessment
- Recognition and involvement

5.91 There is projected to be a 24% rise in the number of people aged 65-74 living alone in Merton by 2020. This has significant implications for how to support carers who do not live with the person they care for, and indicates a need to build support and social capital, for example through volunteering.

5.92 The national indicator for carers receiving support shows that Merton has improved steadily between 2004-2008, but from a lower base than comparable areas.

Key Findings

5.82 Carers have a vital role to play in providing care and support to people with care needs. The value of care provided by unpaid carers in Merton has been estimated at £204 million per year (Source: Calculating the Value of Unpaid Care 2006/07, Carers UK 2007).

5.83 Carers give many different kinds of practical, physical and emotional support to the people they care for. Caring responsibilities will vary over time and becoming a carer maybe a gradual process or the result of a sudden event, such as an accident or stroke.

5.84 Merton recently took part in a national pilot carers survey (2010). 382 surveys were sent to Carers known to the borough and 140 were returned (36% response rate). Findings from the survey indicate that:

- 79% of respondents were female and 73% of carers were aged 55 years and over.

Of those people cared for the main reasons for care were:

- 23.5% had physical disabilities
- 11.8% had sensory disability
- 12.9% had long term medical issue
- 11% had learning disability
- 10% had mental health problem

5.85 74% of people being cared for were aged 55 years or over and just over 82% of people being cared for lived with their carer. Over 50% of carers spend 100 hours of more looking after or helping the person they cared for.

4.86 87% of respondents had had a separate carers assessment or review in the last 12 months and over 98% of carers had received services or information following assessment or review.

5.87 Of support services available to carers, 41% of respondents had used information and advice services and over 26% support from carers groups or someone to talk to in confidence.

5.88 57% of respondents rated their quality of life as ‘alright’, compared to 19% who rated it good or very good, and 21% who rated it bad or very bad. 76% wanted more control over daily life, and 26% had a long standing illness themselves.

5.89 The survey identified a range of services that carers want, including: respite care; information and advice; home care; physical and emotional support; financial help.

FIGURE 7

Carers Receiving Needs Assessment or Review and a Specific Carer's Service or Advice and Information comparison of ONS Statistical Neighbours

Source: http://www.flcommunity.gov.uk/Home/adownbad.aspx

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<tr>
<th></th>
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<tbody>
<tr>
<td>Bromley</td>
<td>20</td>
<td>22</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Kingston</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
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<tr>
<td>Merton</td>
<td>24</td>
<td>25</td>
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<td>27</td>
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<tr>
<td>Richmond</td>
<td>21</td>
<td>22</td>
<td>23</td>
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<tr>
<td>Sutton</td>
<td>19</td>
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<td>England</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
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28
Chapter 6. Our performance and use of resources profile

Chapter summary:

- Merton Council is rated as a 4 star excellent authority which is improving strongly
- Sutton and Merton PCT is rated as Good in the quality of its commissioning and Fair in its financial management
- Merton’s adult social care services are rated Good in all 7 outcomes
- Merton spends a slightly above average percentage of its overall budget on adult social care, but due to its low funding base this still leads to Merton’s spend on adult social care per head of population being the lowest of its comparator group
- Within the overall national indicator set for performance, Merton is in the bottom quartile for end of life care, participation in volunteering, and carers’ assessments. This suggests some opportunities for improvement
- In its use of resources, Merton uses care homes comparatively seldom for older people when compared to other councils, but for adults of working age (learning disabilities, physical disability and sensory impairment, mental health) Merton is more in line with other councils.

- Merton makes more use of community based alternatives for older people than other councils, but for adults of working age is more in line with other councils
- Merton invests more than comparator councils in grants to the voluntary sector for older people, and less for people a learning disability
- Within the healthcare system Merton makes average use of emergency hospital beds. Merton council performs well in preventing delayed transfers of care out of hospital
- Detailed information about our use of resources and performance can be found in Appendices 2 and 3
Overview of the Council’s Performance

6.1 In 2008/2009, we were rated as a 4 star authority and improving strongly in the 2008 Comprehensive Performance Assessment (CPA), published on 5 March 2009. The CPA measured our performance across all our services. The CPA was conducted annually by the Audit Commission for every council in England and Wales.

6.2 The CPA reported on how well a council was performing overall compared to other councils in England. It drew together information on auditors’ views, other inspectorate views, and the Commission’s inspections of environment, housing and cultural services. It provided, for the first time, a judgment on a council’s corporate ability to improve services for local people and its leadership of its local community.

6.3 From 2009, the CPA was replaced by the Comprehensive Area Assessment (CAA). CAA will provide an independent assessment of how well people are being served by their local public services including councils, health bodies, police forces and fire and rescue services, working in partnership to tackle the challenges facing their communities.

6.4 Merton Council was judged to be improving strongly. In the priority areas of education and community safety improvement had been significant. Good knowledge of the local community informs priority setting and partnership working. Merton remains within the top four safest London boroughs and has sustained its excellent performance on crime and public safety. Attainment at GCSE level has improved substantially, most notably at the higher grades. Merton provides good value for money. Robust medium-term financial planning underpins allocation of resources to priorities, with effective use of external resources and partnerships to deliver improvements. Among the community improvements delivered is the first brand new suburban railway station in London for 70 years, developed in a deprived area to stimulate regeneration. The Council has made significant improvements in corporate capacity and leadership, providing more efficient and effective services. Governance of the children’s trust is strong. Plans are linked well to support the overarching objective of reducing inequalities across the borough and there is developing engagement with strategic partners. However, issues remain around planning and delivery of services for older people and waste management.

6.5 Direction of travel
The progress made by Merton Council

<table>
<thead>
<tr>
<th>Direction of travel</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
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<tbody>
<tr>
<td>This assessment indicates the progress being made, or otherwise, to achieve improvement.</td>
<td>improving well</td>
<td>improving well</td>
<td>improving well</td>
<td>improving strongly</td>
</tr>
</tbody>
</table>
6.6 Service assessments, use of resources and corporate assessments are scored on the Local Services Inspectorate Forum scale:

1 = Inadequate performance – below minimum requirements  
2 = Adequate performance – only at minimum requirements  
3 = Performing well – consistently above minimum requirements  
4 = Performing strongly – well above minimum requirements

6.7 Use of resources
How Merton Council manages its finances and provides value for money

<table>
<thead>
<tr>
<th>Use of resources</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
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<td>2</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>

We have assessed how well the Council manages its finances and provides value for money.

6.8 Service performance
How Merton Council's main services perform

<table>
<thead>
<tr>
<th>Service area</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits - The Council's performance in providing housing and council tax benefit services as assessed by the Department for Work and Pensions (external link) and is based primarily on achievement against the 2005 housing benefits/council tax benefits performance standards.</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Children and young people - The Council's performance in providing children's services, such as children's education and social care. The joint assessment is made by the Commission for Social Care Inspection (external link) and Ofsted (external link) following a review of the Council's overall performance and key indicators.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Culture - The Council's performance in services, such as libraries and leisure, as assessed by the Audit Commission.</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Environment - The Council's performance in services, such as transport, planning and waste, as assessed by the Audit Commission.</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Housing - The Council's performance in community housing and, where applicable, housing management services, as assessed by the Audit Commission.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Social care (adults) - The Council's performance in adult social care services. The assessment is made by the Commission for Social Care Inspection (external link) following a review of the Council's overall performance and key indicators.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
6.9 Corporate assessment
How Merton Council is run

In assessing how the Council is run, the Commission considers what the Council, together with its partners, is trying to achieve; what the capacity of the Council, including its work with partners, is to deliver what it is trying to achieve; and what has been achieved.

Under CPA - The Harder Test, corporate assessments were undertaken once for each single tier and county council between 2005 and 2008.

6.10 In 2008/2009, the Care Quality Commission (CQC) assessed the performance of NHS Sutton & Merton.

6.11 The overall performance rating for PCTs is made up of two parts: 'quality of financial management', which looks at how effectively a trust manages its financial resources; and 'quality of commissioning', which is an aggregated score of performance against national standards, existing commitments and national priorities. The quality of financial management ratings for the four years of the annual health check are shown; as is the quality of commissioning rating for 2008/09.

6.12 Based on the CQC assessment for 2008/09, the quality of commissioning of services by NHS Sutton & Merton for its local population was 'good'. The financial management rating for this organisation is 'fair', as this organisation has been assessed as performing adequately with regard to its financial arrangements and performance.
### Overview of the Council’s Performance in Adult Social Care

6.13 This following is a summary of the performance of how the Council promotes adult social care outcomes for people in the council area assessed by the CQC as part of the Annual Performance Assessment Report 2008/2009. The grades are:

- Poorly performing – not delivering the minimum requirements for people
- Performing adequately – only delivering the minimum requirements for people
- Performing well – consistently delivering above the minimum requirements for people
- Performing excellently - overall delivering well above the minimum requirements for people

6.14 Overall Merton Council performance:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1</td>
<td>Improved health and well-being</td>
<td>Well</td>
</tr>
<tr>
<td>Outcome 2</td>
<td>Improved quality of life</td>
<td>Well</td>
</tr>
<tr>
<td>Outcome 3</td>
<td>Making a positive contribution</td>
<td>Well</td>
</tr>
<tr>
<td>Outcome 4</td>
<td>Increased choice and control</td>
<td>Well</td>
</tr>
<tr>
<td>Outcome 5</td>
<td>Freedom from discrimination and harassment</td>
<td>Well</td>
</tr>
<tr>
<td>Outcome 6</td>
<td>Economic well-being</td>
<td>Well</td>
</tr>
<tr>
<td>Outcome 7</td>
<td>Maintaining personal dignity and respect</td>
<td>Well</td>
</tr>
</tbody>
</table>

### Assessment of Leadership and Commissioning and use of resources in Adult Social Care

6.15 Leadership. What the council does well:
- There have been improvements in the levels of sickness absence and vacancy rates amongst social care staff.
- There is good partnership working with health to deliver the social care and health agendas.
- The Council has achieved a number of key deliverables on its transformation programme.

6.16 What the council needs to improve:
- Continue to progress with their Putting People First Agenda.
- Develop a workforce strategy linked to the transformation programme.
- Continue to develop mechanisms for engagement with service users and carers to evaluate the impact on services.

6.17 Commissioning and use of resources. What the council does well:
- The Council is working jointly with health on service design and improvement.

6.18 What the council needs to improve:
- Ensure that self funders are receiving support through timely and accessible information and advice.
- The Council should continue to develop partnership working with health to develop joint commissioning for all service user groups with user engagement to improve service delivery.
Use of resources and spend profile in Adult Social Care

6.19 Appendices 1 and 2 provide comparative information on our spend, use of resources and our National Indicator set performance. They give a snapshot of our performance in comparison to other Councils to enable us to assess how far we are from achieving our vision. Although Merton spend on Adult Social Care is relatively high compared to other councils, our spend per head is low. Within this we spend more on older people than we do on adults of working age. For older people our spend on residential care and admission into residential care is low. We spend more on homecare and perform excellently on delayed transfer of care. In other care groups our spend is average in comparison to other councils, in line with our performance. We invest in our voluntary sector relatively more than others.
Gross spend per head by client group compared to the selected comparator group median, 2008/09

This chart compares total spend on each client group with the median of the comparator group. The amount spent on older people, by far the largest client group, is likely to be much higher than for other groups. The Association of Directors of Adult Social Services (ADASS) also report that the rising numbers of high cost, complex care packages for people with learning disabilities is an increasing concern.
<table>
<thead>
<tr>
<th>Client group</th>
<th>Period</th>
<th>Spend per head</th>
<th>Spend per head - comparator group median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total spend on adults aged 65+ including older mentally ill</td>
<td>2008/09</td>
<td>£1,314.7</td>
<td>£1,446.22</td>
</tr>
<tr>
<td>Total spend on adults aged 18-64 with mental health needs</td>
<td>2008/09</td>
<td>£27.04</td>
<td>£44.42</td>
</tr>
<tr>
<td>Total spend on adults aged 18-64 with learning disabilities</td>
<td>2008/09</td>
<td>£101.1</td>
<td>£120.48</td>
</tr>
<tr>
<td>Total spend on adults aged 18-64 with a physical disability or sensory impairment</td>
<td>2008/09</td>
<td>£32.86</td>
<td>£50.51</td>
</tr>
</tbody>
</table>
The above charts show that Merton used 22% of its total spend on Adult Social Care in 2008/2009.
The National Indicator Set

Population ‘needs’

- Citizenship
- Home and community
- Information
- Lifestyle
- Practical support
- Early intervention
- Enablement
- Community support for LTC
- Institutional avoidance
- Timely discharge

National Indicator Set

- 140 fair treatment by local services
- 6 participation in volunteering
- 9/10/11 engagement/use of arts, libraries and museums
- Employment rate of 50-69 years old

- 139 satisfaction of over 65’s with home and neighbourhood
- 175 access to services and facilities by public transport

- 187 tackling fuel poverty
- Pensioner incomes/benefit take up

- 119 overall health and wellbeing
- 137 healthy life expectancy
- 8 participation in sport

- 136 supported to live independently
- 139 views on extent of support to live independently
- 142 ‘Supporting People’ support to live independently

- 125 achieving independence through rehabilitation/intermediate care

- 124 LTC supported to be independent with choice and control
- 127 self reported experience of social care users
- 132/133 Timeliness of assessment/care packages

- 129 end of life care – enabling people to die at home
- 134 emergency bed days

- 131 delayed transfers of care

Choice and Control: 130 social care clients receiving self directed support
Dignity: 128 users treated with dignity and respect
Carers: 135 carers receiving assessment of needs and specific carers service, advice or information
The table below provides Merton’s performance against the 33 London boroughs

<table>
<thead>
<tr>
<th>NI</th>
<th>Outcomes via National indicators detailed</th>
<th>London Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>Participation in volunteering</td>
<td>26</td>
</tr>
<tr>
<td>NI</td>
<td>Participation in sport</td>
<td>11</td>
</tr>
<tr>
<td>NI</td>
<td>Engagement - use of libraries</td>
<td>12</td>
</tr>
<tr>
<td>NI</td>
<td>Engagement - use of museums</td>
<td>13</td>
</tr>
<tr>
<td>NI</td>
<td>Engagement - use of arts</td>
<td>15</td>
</tr>
<tr>
<td>NI</td>
<td>Alcohol related hospital admissions</td>
<td>6</td>
</tr>
<tr>
<td>NI</td>
<td>Overall health and well-being</td>
<td>5</td>
</tr>
<tr>
<td>NI</td>
<td>People with Long Term Conditions supported to be independent</td>
<td>3</td>
</tr>
<tr>
<td>NI</td>
<td>Achieving independence through rehabilitation or intermediate care</td>
<td>14</td>
</tr>
<tr>
<td>NI</td>
<td>End of Life care</td>
<td>30</td>
</tr>
<tr>
<td>NI</td>
<td>Self Directed Support</td>
<td>27</td>
</tr>
<tr>
<td>NI</td>
<td>Delayed transfers of care</td>
<td>2</td>
</tr>
<tr>
<td>NI</td>
<td>Timeliness of Assessments</td>
<td>21</td>
</tr>
<tr>
<td>NI</td>
<td>Timeliness of Services</td>
<td>7</td>
</tr>
<tr>
<td>NI</td>
<td>Emergency bed days 07/08</td>
<td>9</td>
</tr>
<tr>
<td>NI</td>
<td>Carers receiving carer's service, advice and information</td>
<td>31</td>
</tr>
<tr>
<td>NI</td>
<td>Supported to live independently</td>
<td>12</td>
</tr>
<tr>
<td>NI</td>
<td>Healthy life expectancy</td>
<td>9</td>
</tr>
<tr>
<td>NI</td>
<td>Satisfaction of over 65 with home and neighbourhood</td>
<td>16</td>
</tr>
<tr>
<td>NI</td>
<td>Views on extent of support to live independently</td>
<td>18</td>
</tr>
<tr>
<td>NI</td>
<td>Fair Treatment by local social services</td>
<td>9</td>
</tr>
<tr>
<td>NI</td>
<td>Support People support to live independently</td>
<td>10</td>
</tr>
<tr>
<td>NI</td>
<td>Tackling fuel poverty</td>
<td>7</td>
</tr>
<tr>
<td>n/a</td>
<td>Pensioner incomes benefit take up</td>
<td>4</td>
</tr>
<tr>
<td>n/a</td>
<td>Employment rate of 50-69 years old</td>
<td>7</td>
</tr>
</tbody>
</table>
Grants to Voluntary Organisations

Grants to Voluntary Organisations for OP services in 2008/09
£ per head of population (65+)

Merton: £38.3  Average: £23.5

Source: CIPFA Benchmarking 2009
Grants to Voluntary Organisations

Grants to Voluntary Organisations for LD services in 2008/09
£ per head of population (18-64)
# Chapter 7. Merton’s strengths, weaknesses and opportunities

## Strengths
- Good performance from a low resource base
- Completed Joint Strategic Needs assessment
- Willingness to invest in Adult Social Care
- Below average spend in residential and nursing care for older people
- Below average spend in residential and nursing care for people with mental health needs
- Low discharge rates into residential care
- Transfers of care from hospital excellent
- Good investment in voluntary sector for older people support
- Strong voluntary sector, innovative
- The Compact
- Partnership working. Good joint working with local NHS
- Focus on delivering efficiencies beginning to pay
- Mascot
- Good performance in 11 out of 25 National Indicator set
- Waiting times for service delivery

## High Opportunity Areas
- Drive down cost of residential care for working age adults
- Reduce use of residential care for adults of working age
- Procurement efficiencies
- Rationalise plethora of information and advice channels
- Assessment and care management efficiencies
- Enable young people in transition to return from out of borough residential school
- Focus on housing solutions
- Focus on Telecare
- Focus on reablement, rehab and intermediate care
- Focus voluntary sector grant investment on effective prevention, early intervention
- Shift to universal services
- Effective assessment and support for informal carers
- Workforce development
- Implement learning from Government pilots – POPPs, CSED

## Weaknesses
- Above average spend on residential and nursing home care for people with physical disabilities
- High spend in assessment and care management in mental health
- Low carer assessments
- Availability of suitable housing options
- Duplication of information and advice services
- Waiting times for assessment

## Limited Opportunity Areas
- Further significant reduction in use of care homes for older people
- Reduction in Delayed Transfers of Care
- More money on prevention
- Inward investment
Vision for a personalised approach to the delivery of adult social care

8.1 The ‘Putting People First’ (PPF) concordat was published by the Department of Health (DH) in December 2007. It describes the vision for development of a personalised approach to the delivery of adult social care. PPF concordat is an agreement between central and local government and other key organisations about the direction for adult social care for the next 10 years and beyond.

8.2 Putting People First is underpinned by four key themes:
• access to universal services such as transport, leisure and education as well as information, advice and advocacy – planning for these to consider the implications for disabled and older people
• prevention and early intervention – helping people early enough or in the right way, so that they stay healthy and recover quickly from illness
• choice and control – people who need support can design it themselves, understanding quickly how much money is available for this, and having a choice about how they receive support and who manages it
• social capital – making sure that everyone has the opportunity to be part of a community and experience the friendships and care that can come from families and friends.

Source: Department of Health, Putting People First – Transforming Adult Social Care
The reform of adult social care is radical and ambitious and although many aspects of it are still being worked out, the strategic framework and end result is clear. The diagram below provides the local framework to enable us to make the strategic shift to affordable and sustainable social care and support in Merton. We will use this to work with our clients, carers and partners to produce our local three year delivery plan. We will use the National Indicator set to measure our performance in achieving this shift.

Source: Audit Commission 2009, Association of Directors of Adult Social Services/Local Government Association 2003
8.4 The Wanless review (2005) identified the four main causes of adults’ social care needs:

• Health, mobility and rehabilitation problems
• A lack or breakdown of informal care – or stress on carers
• Poor or inappropriate housing and environment
• Social reasons – loneliness, fear of crime, abuse and so on

8.5 The above prioritises our strategic commissioning focus to:

• Information and service access
• Lifestyle
• Practical Support
• Enablement and early intervention
• Long-term care in the community
• Institutional avoidance and timely discharge
• Timely discharge
• Value for money/efficiencies

8.6 This is underpinned by value for money improvements. Research from the University of Bristol identified four types of value for money (vfm) improvements and the means to achieve them in adult social care (see adjacent diagram).

8.7 The Commissioning strategy is aligned to the local NHS Better Health Closer to Home (BHCH) programme. This proposes a reconfiguration of health services to ensure they are provided as far as possible in primary and community care settings. This includes the development of local health centres at the Wilson Hospital, the Nelson Hospital, St Helier and Wallington Hospitals.

<table>
<thead>
<tr>
<th>Type of vfm improvement</th>
<th>Means to achieve this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending is no longer needed or is reduced</td>
<td>Prevention services, eligibility criteria, commissioning, removing waste, charging</td>
</tr>
<tr>
<td>Spending that would otherwise have been incurred is prevented</td>
<td>Prevention services</td>
</tr>
<tr>
<td>Waste (money spent with no useful outcome) is prevented</td>
<td>Commissioning, removing waste</td>
</tr>
<tr>
<td>Better outcomes are achieved for the same expenditure</td>
<td>Prevention services, commissioning, charging</td>
</tr>
</tbody>
</table>

Source: Department of Work and Pensions and University of Bristol, 2007
8.8 In the next 3 years we will be shifting our resources to focus on prevention. The term prevention has 3 categories:

- **Primary prevention/promoting wellbeing**: this is aimed at people who have no particular social care needs or symptoms of illness
  - The focus is therefore on maintaining, independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc

- **Secondary prevention/early intervention**: aims to identify people at risk and to halt or slow down any deterioration, and actively seek to improve their situation.
  - Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those who have existing low level social care needs

- **Tertiary prevention**: this is aimed at minimising disability or deterioration from established health conditions or complex social care needs
  - The focus here is on maximising people’s functioning and independence through interventions such as rehabilitation/enablement services and joint case management of people with complex needs.

Source: Making a Strategic Shift to Prevention and Early Intervention, a Guide – Department of Health, October 2008

8.9 We have already started to re-structure our resource base through our Transformation Programme. We will continue this and will use 2010/2011 to establish the baseline resource requirements to commission and deliver affordable and sustainable social care and support.

8.10 The diagram below provides an overview of how we have started to re-structure our resource base in terms of reductions, investments and no change:

- Light blue = resource reduction
- Red = resource increase
- Yellow = no change in resource
Shift in Adult Social Care Resource Base

- Residential Care Working Age via CFC Tool
- Procurement spend via efficiencies
- Vol Sector Grants for 2010/11
- Income – no increase in fees/charges
- STAFF
- DAY CENTRES
- TELECARE
## Chapter 8  Programme of action

<table>
<thead>
<tr>
<th>Strategic focus</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizenship</td>
<td>For public transport, improve forecourt access to Wimbledon station,</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>make access to Mitcham Junction DDA compliant,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue work on reducing vulnerability of older people to doorstep</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>crime</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work with London Fire Service and local domiciliary care providers to</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Increase awareness of fire risks and how to manage them</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue to invest in MOVIT to ensure that older people and other</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Merton citizens have access to excellent benefits advice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invest in Celebrating Age, Merton’s annual festival for older people</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>encouraging full lives as active citizens, and evaluate programme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue to support Merton Seniors Forum in its advice to local older</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>People regarding fuel poverty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase the number of people supported in employment</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
Programme of action

<table>
<thead>
<tr>
<th>Strategic focus</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbourhood and community</td>
<td>Initiate council wide programme to increase level of volunteering</td>
<td>2010-2012</td>
</tr>
<tr>
<td></td>
<td>Formally open Inter-generational Acacia Centre and launch borough wide programme of associated work</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Introduce minimum standards for dealing with Anti Social Behaviour Complaints</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Increase crime prevention messages to all residents</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Introduce volunteering programme for library service</td>
<td>2010</td>
</tr>
</tbody>
</table>
## Programme of action

<table>
<thead>
<tr>
<th>Strategic focus</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and access</td>
<td>Consolidate council run channel for information and advice, building on Care Connect, to provide single focal point</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Support Merton’s Centre for Independent Living to form as an organisation capable of providing user led support</td>
<td>December 2010</td>
</tr>
<tr>
<td></td>
<td>Improve the design of the adult social care website within the overall council website</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Introduce an inter-active portal for information, early and full self assessment, and looking for providers of support</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Consolidate the Merton Adult Access Team including provision of simple equipment</td>
<td>2010</td>
</tr>
</tbody>
</table>
## Programme of action

<table>
<thead>
<tr>
<th>Strategic focus</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifestyle</td>
<td>Introduce year 1 delivery plan for Healthy Living, in line with pathway and including establishment of Hub (detailed plan available on request)</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Work with Merton Priory Homes on reprovision of 3 traditional sheltered housing schemes for older people</td>
<td>2010-2013</td>
</tr>
<tr>
<td></td>
<td>Continue to maximise opportunities from private rented sector, including Golden Lane scheme for learning disability</td>
<td>2010-2012</td>
</tr>
<tr>
<td></td>
<td>Ensure that there is appropriate accommodation and support for offenders within Supporting People programme</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Ensure that there is a pipeline of affordable accommodation for people with physical disabilities</td>
<td>2010-2014</td>
</tr>
<tr>
<td></td>
<td>Host wellbeing workshops in libraries</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Promote LifeCheck on line self assessment</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Continue targeted smoking cessation programmes for people with mental health issues, Tamil community</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Deliver and evaluate brief intervention programme for alcohol in primary care</td>
<td>2010-11</td>
</tr>
</tbody>
</table>
# Programme of action

<table>
<thead>
<tr>
<th>Strategic focus</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical support</td>
<td>Consolidate floating support within in-house service for people with learning disabilities</td>
<td>2010-2012</td>
</tr>
<tr>
<td></td>
<td>Monitor investment in Integrated Community Equipment Service to ensure appropriate controls and share of investment</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Join Wave 2 of Transforming Community Equipment Services to look at application of retail model for Merton</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Increase take up of Telecare through MASCOT marketing campaign, with investment from mainstream care management budget</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Evaluate and re-focus investment in practical support delivered by voluntary sector, in partnership with PCT and voluntary sector</td>
<td>2010-2012</td>
</tr>
</tbody>
</table>
# Programme of action

<table>
<thead>
<tr>
<th>Strategic focus</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-ablement and early</td>
<td>Consolidate council’s re-ablement service with lower staff numbers, working to new pathway and in line with findings from LEAN review of access and assessment</td>
<td>2010</td>
</tr>
<tr>
<td>intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work with PCT to establish desired end point for any integration or closer working between re-ablement and community nursing service</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Support PCT in establishing new model of community nursing service with generic teams based on clusters of practices</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Invest stroke grant in re-ablement and PCT community service</td>
<td>2010</td>
</tr>
</tbody>
</table>
## Programme of action

<table>
<thead>
<tr>
<th>Strategic focus</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term care in community</td>
<td>Market test and re-tender contracts for domiciliary care ensuring that this is in line with self directed support requirements</td>
<td>2011</td>
</tr>
<tr>
<td></td>
<td>Reduce unit costs of procuring care in care homes for older people through using opportunities for renegotiating block contracts</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>For day services, refocus learning disability services with one less centre, move All Saints and Taylor Road towards community resource centre model</td>
<td>2010-2012</td>
</tr>
<tr>
<td></td>
<td>Re-model residential respite care for learning disabilities</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Establish community team to support and improve quality of nursing care in nursing homes in Merton</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Expand Shared Lives (adult placement) service</td>
<td>2010-2013</td>
</tr>
<tr>
<td></td>
<td>Change Meadowsweet and other residential carehomes to supported living model</td>
<td>2010-2011</td>
</tr>
<tr>
<td></td>
<td>Increase number of carers assessments, including working in partnership with voluntary sector</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Use Care Funding Calculator tool to achieve fair pricing for residential care for adults of working age</td>
<td>2010-2012</td>
</tr>
</tbody>
</table>

54
<table>
<thead>
<tr>
<th>Strategic focus</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional avoidance and timely discharge</td>
<td>Finalise Orchard Hill and campus homes reprovision through initiating work on site at Birches Close</td>
<td>2010-11</td>
</tr>
<tr>
<td></td>
<td>Establish fully staffed falls prevention team (PCT)</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Implement new end of life care pathway, including H2H model and reduction in hospital admissions for out of hours cancer symptom control</td>
<td>2010-2012</td>
</tr>
<tr>
<td></td>
<td>Maximise benefits of transitions team by more effective use of information and resource allocation at c. age 14</td>
<td>2010-2012</td>
</tr>
<tr>
<td></td>
<td>Use refocused community health service based on practice clusters to reduce hospital admissions</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Support mental health Trust in improving timely discharge through access to range of accommodation and support</td>
<td>2010-2011</td>
</tr>
</tbody>
</table>
8.1 Our aim is to have a final adult social care commissioning strategy by the end of September 2010.

8.2 The consultation period will last from May 2010 until end of July 2010.

8.3 In considering this consultation draft, we would like you to answer the questions below in your response:

a. Do you agree with the commissioning strategy case for reform of adult social care and the focus on prevention? Please explain your answer.

b. What do you think are our strengths and weaknesses?

c. What services areas should we be investing/prioritising/focusing on and why in the next 3 years?

d. It is widely acknowledged that public sector resources will be limited, what do you think we should stop providing and why?

e. Do agree or disagree with our programme of actions we have identified? Are there additional actions you would like us to take?

f. Where do you think we can make efficiencies and savings?

g. If you have used services, what services have you found to be most helpful and why?

h. Have we missed anything in the strategy?

i. If you are responding on behalf of a group or organisation please tell us who.

j. If you are responding as an individual please tell us if you are a client or carer?

Please send back your response no later than 30 July 2010 by email to:

commissioningconsultation@merton.gov.uk

or by post to:

Commissioning Consultation Response

c/o Rahat Ahmed-Man

Interim Head of Commissioning

London Borough of Merton

3rd Floor

Civic Centre

London Road

Morden

SM4 5DX
Appendices

1. Audit Commission: differential financial impact on councils of various service areas
2. Merton Use of Resources Performance Data Set
3. Merton National Indicator Performance Data Set
Appendix 1

Audit Commission:
Differential financial impact on councils from service areas
Councils and their partners need an understanding of all the financial impacts of an ageing population on local public services, the roles of prevention and wellbeing activities, and the difficult choices about charging and demand management. Once understood, the strategic approach reflecting the needs of the local population can be developed using the resources they have to meet those needs. The table below from the Audit Commission illustrates the financial impact on the different service departments/activities within councils.

<table>
<thead>
<tr>
<th>Service or activity</th>
<th>Financial implications for service budget and council budget</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult social care</td>
<td>High</td>
<td>Spending driven by population change and changing needs. Managed by eligibility criteria, and means-testing. Mitigated by service transformation and value-for-money initiatives and mitigated by prevention and early intervention activities – many of which involve other council services.</td>
</tr>
<tr>
<td>Benefits administration</td>
<td>High</td>
<td>Administrative costs driven by population change, and number of claims (including failed claims), Mitigated by clearer benefits and financial advice. Management and impact of benefit uptake campaigns.</td>
</tr>
<tr>
<td>Financial advice</td>
<td>High</td>
<td>Driven by recession-linked falls in post-retirement income and asset values with consequent decrease in self-funding older people. Strong third sector role. Possible efficiencies through partnership with benefits administration and the Department for Work and Pensions.</td>
</tr>
<tr>
<td>Service or activity</td>
<td>Financial implications for service budget and council budget</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Housing</td>
<td>High</td>
<td>Strong strategic housing vision. Impact related to local tenure and household profiles. Driven by housing needs and expectations of different age groups. Linked to adult social care (Supporting People) and benefits administration (disabled facilities grant, home insulation grants). Depends on ownership of housing stock Partnerships with home improvement agencies to improve housing for older people. Decent homes mitigate social care costs.</td>
</tr>
<tr>
<td>Sport and leisure services</td>
<td>Medium</td>
<td>Age-proofing, and marketing services. Develop role of third sector and private sector.</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Maintain health and independence, for example, through exercise prescription. Possible partnership co-funding.</td>
</tr>
<tr>
<td>Bereavement services (registration, cemeteries and crematoria)</td>
<td>High</td>
<td>Services that recognise increasing diversity. Minimising stress to bereaved partners, relatives, and friends.</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Link to financial advice and care services. Link to private sector service providers.</td>
</tr>
<tr>
<td>Highway maintenance</td>
<td>Medium</td>
<td>Maintenance of footpaths and pedestrian areas to reduce falls and to encourage walking.</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Age-proofing pedestrian areas.</td>
</tr>
<tr>
<td>Refuse collection</td>
<td>Medium</td>
<td>Age-proofing collection and recycling services. Increased clinical waste provision.</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>High</td>
<td>Under-funding of concessionary fares. Administration costs.</td>
</tr>
<tr>
<td></td>
<td>Medium to low</td>
<td></td>
</tr>
<tr>
<td>Economic development</td>
<td>Low</td>
<td>Enabling responses to changing local consumption patterns.</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Assess and recognise increased role of older people in the labour market.</td>
</tr>
</tbody>
</table>

- Service budget
- Council budget
<table>
<thead>
<tr>
<th>Service or activity</th>
<th>Financial implications for service budget and council budget</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>Low</td>
<td>Age-proofing services.</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Low</td>
<td>Role of older volunteers in schools and in intergenerational projects (</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Adult education provision.</td>
</tr>
<tr>
<td>Cultural services</td>
<td>Low</td>
<td>Age-proofing.</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Volunteering.</td>
</tr>
<tr>
<td>Children's services</td>
<td>Low</td>
<td>Role of volunteers in supporting families</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Waste disposal</td>
<td>Low</td>
<td>Clinical waste disposal.</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Street cleaning and</td>
<td>None</td>
<td>Contribution to local wellbeing and sense of safety.</td>
</tr>
<tr>
<td>street lighting</td>
<td></td>
<td>No specific age-related cost influences.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Service budget
- Council budget
Appendix 2

Merton Use of Resources Performance Data Set
Total spend on Adult Social Care over service areas for the different client groups

<table>
<thead>
<tr>
<th>Area of spend</th>
<th>2008/09 £m</th>
<th>OP £m</th>
<th>PS £m</th>
<th>LD £m</th>
<th>MH £m</th>
<th>Other £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Strategy</td>
<td>£0.311</td>
<td>£0.000</td>
<td>£0.000</td>
<td>£0.000</td>
<td>£0.000</td>
<td>£0.311</td>
</tr>
<tr>
<td>Assessment and care management</td>
<td>£8.822</td>
<td>£5.147</td>
<td>£0.574</td>
<td>£1.142</td>
<td>£1.959</td>
<td>£0.000</td>
</tr>
<tr>
<td>Nursing care placements</td>
<td>£3.495</td>
<td>£2.836</td>
<td>£0.451</td>
<td>£0.106</td>
<td>£0.102</td>
<td>£0.000</td>
</tr>
<tr>
<td>Residential care placements</td>
<td>£11.296</td>
<td>£4.042</td>
<td>£0.774</td>
<td>£5.764</td>
<td>£0.716</td>
<td>£0.000</td>
</tr>
<tr>
<td>Supported and other accommodation</td>
<td>£2.075</td>
<td>£0.712</td>
<td>£0.015</td>
<td>£1.080</td>
<td>£0.268</td>
<td>£0.000</td>
</tr>
<tr>
<td>Home care</td>
<td>£7.998</td>
<td>£5.963</td>
<td>£1.010</td>
<td>£0.806</td>
<td>£0.219</td>
<td>£0.000</td>
</tr>
<tr>
<td>Day Care / Day Services</td>
<td>£5.420</td>
<td>£2.016</td>
<td>£0.518</td>
<td>£2.789</td>
<td>£0.097</td>
<td>£0.000</td>
</tr>
<tr>
<td>Direct Payments</td>
<td>£1.044</td>
<td>£0.511</td>
<td>£0.388</td>
<td>£0.074</td>
<td>£0.071</td>
<td>£0.000</td>
</tr>
<tr>
<td>Asylum Seekers</td>
<td>£0.474</td>
<td>£0.000</td>
<td>£0.000</td>
<td>£0.000</td>
<td>£0.000</td>
<td>£0.474</td>
</tr>
<tr>
<td>Equipment and adaptations</td>
<td>£1.265</td>
<td>£1.058</td>
<td>£0.204</td>
<td>£0.003</td>
<td>£0.000</td>
<td>£0.000</td>
</tr>
<tr>
<td>Meals</td>
<td>£0.366</td>
<td>£0.366</td>
<td>£0.000</td>
<td>£0.000</td>
<td>£0.000</td>
<td>£0.000</td>
</tr>
<tr>
<td>Other services</td>
<td>£4.713</td>
<td>£2.213</td>
<td>£0.278</td>
<td>£1.412</td>
<td>£0.120</td>
<td>£0.690</td>
</tr>
<tr>
<td><strong>Total Spend</strong></td>
<td><strong>£47.279</strong></td>
<td><strong>£24.864</strong></td>
<td><strong>£4.212</strong></td>
<td><strong>£13.176</strong></td>
<td><strong>£3.552</strong></td>
<td><strong>£1.475</strong></td>
</tr>
</tbody>
</table>

The above table shows Merton’s spend on the different services split over the main client groups.

OP = Older people          PS = Physical disabilities    LD = Learning disabilities    MH = Mental health
A2.1 The Department of Health guide, ‘Use of Resources’ (October 2009) Highlighted that councils are spending their money on:
- Residential care
- Day and domiciliary care
- Care management and assessment
- Strategic functions including senior management

A2.2 A council might have a high proportion of its money going into residential care because of:
- High costs being paid for a number of people
- Large numbers being admitted
- Tight eligibility criteria only supporting people with high care needs
- Supply available that needs filling (e.g. an in-house contract that guarantees full occupancy)

A2.3 The above will in turn be impacted by:
- Emergency admissions to hospital
- Options for post hospital care and recovery
- Availability of intermediate care and enablement based services
- Availability of district nursing services in the community
- Availability of domiciliary care support in the community
- Availability of therapists in the community
- Availability of emergency and rapid response services

- Availability of suitable housing options
  - Major adaptations (Disabled Facilities Grants)
  - Supply of adapted housing (e.g. for a wheel chair user)
  - Supply of supported housing or sheltered housing
  - Supply of Telecare
- Availability of informal support (carers)

A2.4 The factors affecting admission to residential care for younger adults are:
- Availability of housing supply
  - Services to help people prepare for housing
  - Access to housing
  - Specialist housing
  - Adapted housing
- Availability of supported housing
  - Supported tenancies and contract agreements
  - Floating support
  - On site support
- Use of Telecare
- Inability of assessment and care management staff to work on timely solution

The chart below shows the distribution of spend in Merton Adult Social Care
Spend on services per client group

The Graph below shows the spend on the different services for Older People.

The Graph below shows the spend on the different services for clients with Physical Disabilities or Sensory Impairment.
Spend on services per client group

The Graph below shows the spend on the different services for Clients with Learning Disabilities.

The Graph below shows the spend on the different services for clients with Mental Health needs.
Merton Percentage distribution of Total Gross Current Expenditure on adult social services, 2008-09
NASCIS006: Use of Resources
Merton (730)

1. Chart 01 Proportion of Total LA Spend on Adult Social Care (excluding School Funds) (2007-08)

Comparator Average 31.4% Comparator Max 40.4% Comparator Min 24.8% Comparator Ranking: 6 of 32

Note: CLG RO Data for 2008-09 currently unavailable but will be incorporated into this report in February 2010

Source: CLG RO Data 2007-08
Merton (730) 2a. Nursing and Residential Care: Proportion of Gross Current Expenditure across client types
2008-09 Chart 03 OLDER PEOPLE (AGED 65 OR OVER)
Merton (730) 2a. Nursing and Residential Care: Proportion of Gross Current Expenditure across client types 2008-09 Chart
04 ADULTS WITH A PHYSICAL DISABILITY (AGED 18-64)
Merton (730) 2a. Nursing and Residential Care: Proportion of Gross Current Expenditure across client types 2008-09 Chart 05 ADULTS WITH LEARNING DISABILITIES (AGED 18-64)
Merton (730) 2a. Nursing and Residential Care: Proportion of Gross Current Expenditure across client types 2008-09 Chart 06
ADULTS WITH MENTAL HEALTH NEEDS (AGED 18-64)
Merton (730) 2b. Day and Domiciliary Care: Proportion of Gross Current Expenditure across client types 2008-09 Chart 07 OLDER PEOPLE (AGED 65 OR OVER)
Merton (730) 2b. Day and Domiciliary Care: Proportion of Gross Current Expenditure across client types 2008-09 Chart 08

ADULTS WITH A PHYSICAL DISABILITY (AGED 18-64)
Merton (730) 2b. Day and Domiciliary Care: Proportion of Gross Current Expenditure across client types 2008-09 Chart 09
ADULTS WITH LEARNING DISABILITIES (AGED 18-64)
Merton (730) 2b. Day and Domiciliary Care: Proportion of Gross Current Expenditure across client types 2008-09 Chart 10 ADULTS WITH MENTAL HEALTH NEEDS (AGED 18-64)
Merton (730) 2c. Assessment and Care Management: Proportion of Gross Current Expenditure across client types 2008-09
Chart 11 OLDER PEOPLE (AGED 65 OR OVER)
Merton (730) 2c. Assessment and Care Management: Proportion of Gross Current Expenditure across client types 2008-09 Chart 12
ADULTS WITH A PHYSICAL DISABILITY (AGED 18-64)
Merton (730) 2c. Assessment and Care Management: Proportion of Gross Current Expenditure across client types 2008-09 Chart 13
ADULTS WITH LEARNING DISABILITIES (AGED 18-64)
Merton (730) 2c. Assessment and Care Management: Proportion of Gross Current Expenditure across client types 2008-09 Chart 14
ADULTS WITH MENTAL HEALTH NEEDS (AGED 18-64)
Merton (730) 2d.1 Proportion of Total Gross Current Expenditure arising from Client Contributions to Nursing and Residential Care 2008-09 Chart 15 ALL CLIENT TYPES
Merton (730) 2d.2 Proportion of Total Gross Current Expenditure arising from Client Contributions to Day and Domiciliary Care 2008-09 Chart 16 ALL CLIENT TYPES
Merton (730) 2e. Proportion of Total Gross Current Expenditure on Direct Payments 2008-09 Chart 17 ALL CLIENT TYPES
NASCIS006: Use of Resources

Merton (730)

3. Chart 18 CASSR Efficiency Gains (2007-08)

Note: This information is no longer captured in the Self Assessment Survey (SAS), future charts on Efficiency will be subject to ongoing development  
Source: CQC - SAS

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NASCIS006: Use of Resources

Merton (730)

3. Chart 19 CASSR Efficiency Gains (2008-09)

Note: Efficiency Gains for 2008-09 are forecast figures, uplifted by the estimated PP and PI of 4.2%. This information is no longer captured in the Self Assessment Survey (SAS), future charts on Efficiency will be subject to ongoing development.

Source: CQC - SAS

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NASCIS006: Use of Resources

Merton (730)

4. Chart 20 Percentage of patients age 65 or over discharged to residential homes (2006-07)

Comparator Average 3.7%  Comparator Max 11.2%  Comparator Min 0.4%  Comparator Ranking: 30 of 33

Note: Please note the latest available data for this measure is for 2006-07. Ongoing development work at DH is looking to provide more recent figures for similar measures to the above.

Source: Hospital Episode Statistics

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Merton (730)
4. Chart 21 Occupied bed Days of those age 75 or over associated with 2+ emergency admissions per 1,000 population (2006-07)
Merton (730)

4. Chart 22 Number of individuals age 75 or over with 2+ Emergency admissions per 1,000 population (2006-07)

Comparator Average: 71 Comparator Max: 90 Comparator Min: 48 Comparator Ranking: 19 of 33
Appendix 3

Merton National Indicator Performance Data Set
2008/2009
National Indicator Set

Population ‘needs’

- General population
- Low to moderate needs
- Substantial needs
- Complex needs

Citizenship
- 140 fair treatment by local services
- 6 participation in volunteering
- 9/10/11 engagement/usa of arts, libraries and museums
- Employment rate of 50-69 years old

Home and community
- 139 satisfaction of over 65’s with home and neighbourhood
- 175 access to services and facilities by public transport

Information

Lifestyle
- 187 tackling fuel poverty
- Pensioner incomes/benefit take up

Practical support
- 119 overall health and wellbeing
- 137 healthy life expectancy
- 8 participation in sport

Early intervention
- 136 supported to live independently
- 139 views on extent of support to live independently
- 142 ‘Supporting People’ support to live independently

Enablement
- 125 achieving independence through rehabilitation/intermediate care

Community support for LTC
- 124 LTC supported to be independent with choice and control
- 127 self reported experience of social care users
- 132/138 timeliness of assessment/care packages

Institutional avoidance
- 129 end of life care – enabling people to die at home
- 134 emergency bed days

Timely discharge
- 131 delayed transfers of care

Choice and Control: 130 social care clients receiving self directed support
Dignity: 128 users treated with dignity and respect
Carers: 135 carers receiving assessment of needs and specific carers service, advice or information
Merton National Indicator Set performance

**NI 6 Participation in Regular Volunteering**

- 2008
- Merton
- London
- England
- no data

**NI 9 Usage of Libraries**

- Oct 2009
- Merton
- London
- England
- no data

**NI 10 Usage of Museums**

- Oct 2009
- Merton
- London
- England
- no data

**NI 11 Usage of Arts**

- Oct 2009
- Merton
- London
- England
- no data
NI 139 Support needed by OP to live independently at home

NI 142 Vulnerable people supported to maintain independent living

NI 125 Achieving Independence for older people through rehabilitation/intermediate care

NI 124 People with long term conditions supported to be independent