Public Document Pack

Cabinet

Wednesday 16 August 2017
10.00 am Luttrell Room - County Hall, Taunton

To: The Members of the Cabinet

Cllr D Fothergill (Chairman), Cllr D Hall (Vice-Chairman), Cllr A Groskop, Cllr D Huxtable, Cllr C Lawrence, Cllr F Nicholson and Cllr J Woodman

All Somerset County Council Members are invited to attend meetings of the Cabinet and Scrutiny Committees.

Issued By Julian Gale, Strategic Manager - Governance and Risk - 8 August 2017

For further information about the meeting, please contact Mike Bryant or Scott Wooldridge - 01823 359048 or mbryant@somerset.gov.uk / 01823 359043 or swooldridge@somerset.gov.uk

Guidance about procedures at the meeting follows the printed agenda.

This meeting will be open to the public and press, subject to the passing of any resolution under Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

This agenda and the attached reports and background papers are available on request prior to the meeting in large print, Braille, audio tape & disc and can be translated into different languages. They can also be accessed via the council's website on www.somerset.gov.uk/agendasandpapers

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AGENDA

Item Cabinet - 10.00 am Wednesday 16 August 2017

**** Public Guidance notes contained in agenda annexe ****

1 **Apologies for Absence**

2 **Declarations of Interest**

Details of Cabinet Member interests in District, Town and Parish Councils will be displayed in the meeting room. The Statutory Register of Member's Interests can be inspected via the Community Governance team.

3 **Minutes from the meeting held on 10 July 2017** (Pages 7 - 12)

4 **Public Question Time**

The Chairman will allow members of the public to present a petition on any matter within the Cabinet's remit. Questions or statements about any matter on the agenda for this meeting may be taken at the time when each matter is considered.

5 **Somerset: Our County - Joint Strategic Needs Assessment (JSNA) Summary 2017 - Ageing Well** (Pages 13 - 118)

To consider the report.

6 **Contract award for the provision of highway improvements at Yeovil Western Corridor** (Pages 119 - 130)

To consider the report.

(Confidential Appendix A to follow).

Possible exclusion of the press and public

PLEASE NOTE: Although the main report for this item not confidential, supporting appendices available to Members (to follow) contain exempt information and are therefore marked confidential – not for publication. At any point if Members wish to discuss information within this appendix then the Cabinet will be asked to agree the following resolution to exclude the press and public:

Exclusion of the Press and Public
To consider passing a resolution under Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 to exclude the press and public from the meeting on the basis that if they were present during the business to be transacted there would be a likelihood of disclosure of exempt information, within the meaning of Schedule 12A to the Local Government Act 1972:

Reason: Information relating to the financial or business affairs of any particular person (including the authority holding that information).

Item Cabinet - 10.00 am Wednesday 16 August 2017

7 **Development of a Joint Strategic Commissioning Function** (Pages 131 - 180)

To consider the report.

8 **Any other urgent items of business**

The Chairman may raise any items of urgent business.

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THE MEETING – GUIDANCE NOTES

1 **Inspection of Papers or Statutory Register of Member's Interests**

Any person wishing to inspect reports or the background papers for any item on the agenda or inspect the Register of Member's Interests should contact Scott Wooldridge or Mike Bryant on (01823) 359048 or 357628 or email mbryant@somerset.gov.uk

2 **Notes of the Meeting**

Details of the issues discussed and decisions taken at the meeting will be set out in the Minutes, which the Cabinet will be asked to approve as a correct record at its next meeting. In the meantime, details of the decisions taken can be obtained from Scott Wooldridge or Mike Bryant on (01823) 357628 or 359048 or email mbryant@somerset.gov.uk

3 **Public Question Time**

At the Chairman's invitation you may ask questions and/or make statements or comments about **any matter on the Cabinet's agenda**. You may also present a petition on any matter within the Cabinet's remit. **The length of public question time will be no more than 30 minutes in total**.

A slot for Public Question Time is set aside near the beginning of the meeting, after the minutes of the previous meeting have been signed. However, questions or statements about any matter on the agenda for this meeting may be taken at the time when each matter is considered.

If you wish to speak at the meeting or submit a petition then you will need to submit your statement or question in writing to Mike Bryant by 12.00pm on Friday prior to the meeting. You can send an email to mbryant@somerset.gov.uk or send post for attention of Mike Bryant, Community Governance, County Hall, Taunton, TA1 4DY.

You must direct your questions and comments through the Chairman. You may not take direct part in the debate.

The Chairman will decide when public participation is to finish.

If there are many people present at the meeting for one particular item, the Chairman may adjourn the meeting to allow views to be expressed more freely.

If an item on the agenda is contentious, with a large number of people attending the meeting, a representative should be nominated to present the views of a group.

An issue will not be deferred because you cannot be present at the meeting.

Remember that the amount of time you speak will be restricted normally to two minutes only.

4 **Hearing Aid Loop System**

To assist hearing aid users, the Luttrell Room has an infra-red audio transmission system. This works in conjunction with a hearing aid in the T position, but we also need to provide you with a small personal receiver. Please request one from the Committee Administrator and return at the end of the meeting.

5 **Emergency Evacuation Procedure**

In the event of the fire alarm sounding, members of the public are requested to leave the building via the signposted emergency exit, and proceed to the collection area outside Shire Hall. Officers and Members will be on hand to assist.

6 **Cabinet Forward Plan**

The latest published version of the Forward Plan is available for public inspection at County Hall or on the County Council web site at: http://www.somerset.gov.uk/irj/public/council/futureplans/futureplan?rid=/guid/505e09a3-cd9b-2c10-89a0-b262ef879920.

Alternatively, copies can be obtained by telephoning (01823) 359027 or 357628.

7 **Excluding the Press and Public for part of the meeting**

There may occasionally be items on the agenda that cannot be debated in public for legal reasons (such as those involving confidential and exempt information) and these will be highlighted in the Forward Plan. In those circumstances, the public and press will be asked to leave the room while the Cabinet goes into Private Session.

8 **Recording of meetings**

The Council supports the principles of openness and transparency, it allows filming, recording and taking photographs at its meetings that are open to the public providing it is done in a non-disruptive manner. Members of the public may use Facebook and Twitter or other forms of social media to report on proceedings and a designated area will be provided for anyone who wishing to film part or all of the proceedings. No filming or recording will take place when the press and public are excluded for that part of the meeting. As a matter of courtesy to the public, anyone wishing to film or record proceedings is asked to provide reasonable notice to the Committee Administrator so that the relevant Chairman can inform those present at the start of the meeting.

We would ask that, as far as possible, members of the public aren't filmed unless they are playing an active role such as speaking within a meeting and there may be occasions when speaking members of the public request not to be filmed.

The Council will be undertaking audio recording of some of its meetings in County Hall as part of its investigation into a business case for the recording and potential webcasting of meetings in the future.

A copy of the Council's Recording of Meetings Protocol should be on display at the meeting for inspection, alternatively contact the Committee Administrator for the meeting in advance.

THE CABINET

Minutes of a Meeting of the Cabinet held in the Luttrell Room, County Hall, Taunton, on Monday 10th July 2017 at 10am.

PRESENT

Cllr D Fothergill (in the Chair)

Cllr A Groskop
Cllr D Hall
Cllr D Huxtable
Cllr C Lawrence
Cllr F Nicholson
Cllr J Woodman

Junior Cabinet members:
Cllr C Aparicio Paul
Cllr Fraschini
Cllr G Verdon

Other Members present: Cllr S Coles, Cllr J Hunt, Cllr L Leyshon, Cllr T Lock, Cllr T Munt, Cllr G Noel, Cllr J Thorne, Cllr A Wedderkopp, Cllr R Williams

Apologies for absence: Cllr F Purbrick

12 **DECLARATIONS OF INTEREST** – agenda item 2

There were no declarations of interest.

13 **MINUTES OF MEETINGS OF THE CABINET HELD ON 14 JUNE 2017** - agenda item 3

The Cabinet agreed the minutes and the Chairman signed these as a correct record of the proceedings.

14 **PUBLIC QUESTION TIME (PQT)** – agenda item 4

There were no public questions.

15 **SOMERSET ENERGY INNOVATION CENTRE – APPOINTING A CONSTRUCTION COMPANY** - agenda item 5

The Cabinet Member for Resources and Economic Development, Cllr David Hall, introduced the report highlighting that: phase 1 of the Somerset Energy Innovation Centre opened in February 2016; and that the Council was now in a position to proceed with phase 2 and to develop the design of phase 3, subject to securing funding. Cllr Hall further drew member's attention to the impact assessment appended to the report.

The Commissioning Manager – Economy, Lynda Madge, informed members that Phase 2 consisted of light industrial units and was expected to create 112 jobs, with a GVA of £6m per annum. Members were further informed that Phase 1 had met all expected outputs within its first year of operation.

Further points raised in the debate included: the timescales for completion; the potential use of a Clerk of Works; and the use of wind power.

Cllr David Huxtable requested further details of the Somerset Energy Innovation Centre phases 2 and 3 funding arrangements. Paula Hewitt, Lead Commissioner for Economic and Community Infrastructure services offered to provide a briefing to Cllr Huxtable and Cllr Coles.

The Commercial and Business Services Director informed members that the Council uses external providers to meet its property needs, and that the Somerset Energy and Innovation Centre contract had been awarded through the Scape framework, which included appropriate checks and balances.

The Chairman asked if there was support for the proposal and both junior and cabinet members were in consensus.

Following consideration of the officer report, impact assessment and discussion, the Cabinet RESOLVED to:

- Approve the appointment of the construction works contractor Wilmott Dixon via the SCAPE Major Works Construction Framework for the construction of SEIC2; and
- Authorise the development of the design for SEIC 3 to progress to RIBA Stage 3.

ALTERNATIVE OPTIONS CONSIDERED: As set out in the officer report

REASON FOR DECISION: As set out in the officer report

16 **TREASURY MANAGEMENT END OF YEAR REPORT 2016/17** – agenda item 6

Cllr David Hall introduced the report which covered the treasury management activity for 2016/17, and included details of capital financing, borrowing, and investment activity and reported on the risk implications of treasury decisions and transactions.

The Director of Finance and Performance informed Members that due to the declining number of participants, and the difficulty of straight forward comparison it had been decided that the Council would no longer participate in the Benchmarking Club.

Further points raised in the debate included: the potential to reduce the 4.66% weighted average paid on total borrowings; that no borrowing had been required during the year; the need for the full detail of the 2017/18 MTFP savings proposals; and the cost of out of county placements.

The Chairman asked if there was support for the proposal and both junior and cabinet members were in consensus.

Following consideration of the officer report and appendices the Cabinet RESOLVED to approve the report and submit it to Full Council on 19th July 2017.

ALTERNATIVE OPTIONS CONSIDERED: As set out in the officer report

REASON FOR DECISION: As set out in the officer report

17 **REVENUE BUDGET MONITORING REPORTS END OF MAY 2017/18** – agenda item 7

Cllr David Hall introduced the report which provided the first indication of the potential Revenue Budget outturn position for the 2017/18 financial year. Cllr Hall emphasised that the report was being considered early in the financial year; that the pressures on Local Authority budgets are sector wide; and that the report included a number of positive points.

The Director of Finance and Performance noted that: the potential overspend was less than at the same point last year; and the Children and Families Operations projected overspend included out of county placements, where work to control spend was on-going.

Cllr David Huxtable, Cabinet Member for Adult Social Care highlighted the Adult Social Care service redesign work and invited the Shadow Cabinet Member to meet with him regarding this.

Cllr Frances Nicholson, Cabinet Member for Children and Families informed Members that out of county placements included independent providers within Somerset, and that other Local Authorities also use the provision within the County.

Further points raised in the debate included: the importance of ensuring all children are safe whilst controlling costs; and the need for the full detail of the 2017/18 MTFP savings proposals to be made available to all Members. The Director of Finance and Performance undertook to provide the information regarding the 2017/18 MTFP savings.

The Chairman asked if there was support for the proposal and both junior and cabinet members were in consensus.

Following consideration of the officer report, appendix and discussion, the Cabinet RESOLVED to note the contents of the report and the potential outturn position for the year.

ALTERNATIVE OPTIONS CONSIDERED: As set out in the officer report

REASON FOR DECISION: As set out in the officer report

18 **COUNCIL PERFORMANCE REPORT END OF MAY 2017/18** - agenda item 8

The Strategic Manager for Performance, Emma Plummer, presented the report which offered an overview of the Council's performance across the organisation. The performance summary was depicted in the table at 2.2, there were three red segments which were for consideration and further explanation was shown in appendix A. The Strategic Manager highlighted that this was an extra report, which had been brought forward to be in line

with the end of year Budget Monitoring report.

Members were further informed that work was on-going to increase the number of performance measures which populate C3 Working with our Partners.

Further points raised in the debate included: on-going work to reduce the number of cases of delayed transfer of care; reducing future demand on services through prevention; the Children and Young Peoples Plan, the increased demand for services; and OFSTED inspection timescales.

The Chairman of Scrutiny Committee for Policies and Place, Cllr Tony Lock, highlighted the importance of ensuring Children's and Adults' Services reduce costs sufficiently quickly to prevent the potential end of year overspend.

Cllr David Hall, Cabinet Member for Resources highlighted on-going work regarding business rates and major construction projects within the County. Cllr Hall further thanked Cllr Lock and the Scrutiny for Polices and Place Committee for their work.

The Chairman asked if there was support for the proposal and both junior and cabinet members confirmed they were in consensus.

Following consideration of the officer report, appendix and discussion, the Cabinet:

1. Considered the information contained within the report specifically those areas identified as a potential concern under Section 3.0 of this report and the "issues for consideration" section of Appendix A.

2. Agreed the report and Appendix A as the latest position for Somerset County Council against its County Plan.

ALTERNATIVE OPTIONS CONSIDERED: As set out in the officer report

REASON FOR DECISION: As set out in the officer report

(Cllr David Fothergill left the meeting, and Cllr David Hall took the Chair)

19 **DEVELOPMENT OF THE MEDIUM TERM FINANCAL PLAN 2018/19** – agenda item 9

Cllr David Hall, Cabinet Member for Resources introduced the report, highlighting the reshaping of services and continuation of the themed MTFP approach.

The Director of Finance and Performance informed members that: the themed budget setting methodology allowed a long term approach; that longer term approaches were encouraged by CIPFA; and that Capital grant funding should be used to maximum benefit.

Further points raised in the debate included: attracting investment to Somerset; borrowing to invest; ensuring that any additional responsibilities transferred to Local Authorities carry adequate funding; ensuring the MTFP and the County Plan work is undertaken simultaneously; timescales for refreshing the County Plan; and potential options for placing wind turbines on the Somerset Levels.

The Director of Finance and Performance noted that the Council would need further expertise to advise on an investment strategy if it were to invest outside of its core functions.

Following consideration of the officer report and discussion, the Cabinet RESOLVED to note the forecast MTFP position for the years 2018/19 to 2021/22 as set out in this report and supported the proposed approach to the development of the MTFP.

ALTERNATIVE OPTIONS CONSIDERED: As set out in the officer report

REASON FOR DECISION: As set out in the officer report

20 **ANY OTHER URGENT ITEMS OF BUSINESS** – agenda item 10

Cllr John Woodman, Cabinet Member for Highways and Transport informed members that the Taunton Northern Inner Distributor Road would open on 11 July and that the dispute with Carillion, the contractor, was on-going.

(The meeting ended at 11.16 am)

CHAIRMAN

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Decision Report – Key decision
– 16th August 2017

Somerset: Our County – Joint Strategic Needs Assessment (JSNA) Summary 2017 – Ageing Well

Cabinet Member(s): Cllr Christine Lawrence – Cabinet Member for Public Health and Wellbeing & Chair of the Health and Wellbeing Board
Division and Local Member(s): All
Lead Officer: Trudi Grant - Director of Public Health
Author: Pip Tucker - Public Health Specialist
Contact Details: 01823 359449

	Seen by:	**Name**	**Date**
	County Solicitor	Honor Clarke	31/07/17
	Monitoring Officer	Julian Gale	31/07/17
	Corporate Finance	Kevin Nacey	31/07/17
	Human Resources	Chris Squire	31/07/17
	Senior Manager	Trudi Grant	31/07/17
	Local Member(s)	All	31/07/17
	Cabinet Member	Christine Lawrence	31/07/17
	Opposition Spokesperson	Ross Henley	31/07/17
	Relevant Scrutiny Chairman	Cllr Hazel Prior-Sankey	31/07/17
Forward Plan Reference:	FP/17/06/09		
Summary:	Somerset's draft JSNA 2017 has been produced; this includes updating existing JSNA website information as an on-going process and a focus this year on ageing well with an accompanying qualitative report. Whilst focusing on older people, the implications affect all ages across all communities. The final version was approved by the Health and Wellbeing Board on 13th July. This is a summary of web-based information held on the Somerset Intelligence website. Some key issues in this JSNA include: **Remaining healthy** • **Prevention first and foremost** - Nearly half the burden of disease for older people can be attributed to conditions that can be prevented or delayed by changes in lifestyle. The 'usual suspects' - not smoking, drinking responsibility, maintaining good social contacts, eating well and exercising – contribute strongly to ageing well. **Remaining independent** • **Staying independent**, preferably in one's own home, is important to older people, there is a great deal of emphasis on more self-help and short-term assistance to		

	regain independence. **Remaining active and included in community life** • **Social contact** is an essential part of sustaining health and wellbeing**.**
Recommendations:	**The Cabinet endorses the 2017JSNA summary (Appendix A) and qualitative report (Appendix B) as approved by the Health and Wellbeing Board.**
Reasons for Recommendations:	The JSNA is a statutory requirement of the Health and Wellbeing Board, and informs the Health and Wellbeing Strategy. As this has implications for a wide range of Somerset County Council's activities it is being brought to Cabinet for consideration.
Links to Priorities and Impact on Service Plans:	The JSNA particularly supports the County Plan priority for 'Health' but also informs all SCC activity, including Social Value, by identifying communities of particular need.
Consultations undertaken:	Engagement with stakeholders is maintained through the Health and Wellbeing Board and Executive, commissioners' meetings, JSNA Technical Working Group, CCG Engagement Advisory Group and CCG Equality Delivery System Group. Additionally, a specific piece of qualitative work on ageing well was undertaken, engaging with over 100 Somerset residents in discussion groups, individual interviews and at a health fair for over 65s. Feedback on the JSNA is continually sought through the JSNA webpages, the public summary and meetings with commissioners.
Financial Implications:	The JSNA is statutorily required to be taken into account in the future commissioning plans of Somerset County Council, NHS Somerset, CCG and partners. A public summary has not been produced this year due to cost restraints however a sum may be made available (max. £200) to photocopy the reports as required. Paper copies are made available as requested.
Legal Implications:	The requirement to produce a JSNA is stated in the Health and Social Care Act 2012.
HR Implications:	None.

<table>
<tr><td>Risk Implications:</td><td colspan="6">Failure by commissioners to take into account the results of JSNAs when taking commissioning decisions across agencies is likely to have detrimental impacts on service improvement and delivery and the reduction of inequalities, and could be the basis of legal challenge.</td></tr>
<tr><td></td><td>Likelihood</td><td>2</td><td>Impact</td><td>4</td><td>Risk Score</td><td>8</td></tr>
<tr><td>Other Implications (including due regard implications):</td><td colspan="6"><u>Equalities</u>

An Equality Impact Assessment is not required for this research report. However, the following notes cover its relevance for equalities.
The JSNA pays due regard to protected groups to identify health and social inequalities within the Somerset population. The provision of information about protected groups seeks to:

• Advance equality of opportunity between people who share a protected characteristic and those who do not.
• Foster good relations between people who share a protected characteristic and those who do not.

It may, additionally, provide evidence to identify unlawful discrimination and other conduct prohibited by the Equality Act.

The summary document is available in large print or other formats on request.

In addition, the full, web-based JSNA is part of the Somerset Intelligence website, and includes information on the following protected characteristics, with links to example pages:

• Age - (http://www.somersetintelligence.org.uk/age-group-profiles-for-somerset.pdf)
• Disability - (http://www.somersetintelligence.org.uk/disability-and-health-profiles-for-somerset.pdf)
• Gender reassignment - (http://www.somersetintelligence.org.uk/lgbt/)
• Marriage and civil partnership
• Pregnancy and maternity (http://www.somersetintelligence.org.uk/birth-rates.html)
• Race - (http://www.somersetintelligence.org.uk/ethnicity-profiles-for-somerset.pdf)
• Religion and belief – (http://www.somersetintelligence.org.uk/religion-and-belief-profiles-for-somerset.pdf)
• Sex - (http://www.somersetintelligence.org.uk/equality-and-diversity/)
• Sexual orientation (http://www.somersetintelligence.org.uk/lgbt/)</td></tr>
</table>

	Although not a protected characteristic, the site also includes information on: Armed Forces Community (http://www.somersetintelligence.org.uk/armed-forces.html) **Community Safety Implications** Community Safety is discussed in the summary, and information is available on the website at: • Community Safety http://www.somersetintelligence.org.uk/crime-and-community-safety/ **Sustainability Implications** Information is available on: • Housing http://www.somersetintelligence.org.uk/housing.html • Economy http://www.somersetintelligence.org.uk/economy-and-jobs.html as well as a wide range of social and health indicators. **Health and Safety Implications** Not applicable **Privacy Implications** Not applicable to the report. However, the recommendations include improved information sharing which, if implemented, would require appropriate safeguards such as encryption of data and pseudonymization. **Health and Wellbeing Implications** The Health and Wellbeing Board is statutorily required to take the JSNA into account in the Health and Wellbeing Strategy.
Scrutiny comments / recommendation (if any):	The JSNA summary was considered by • Scrutiny for Policies, Adults and Health Committee 21st June 2017

1. Background

1.1. This JSNA, with its focus on 'ageing well', addresses some of the most pressing issues for individuals and public sector bodies in Somerset. Better healthcare over recent decades has led to an increase in life expectancy. This success story, combined with inward migration during middle age, means that the county's population is getting older on average.

1.2. 'Ageing well' can mean many things, but maintaining good health, social contacts and personal independence are high in almost everyone's priorities. Encouraging people to age well is also of high importance for health and social care services. Healthy, connected and independent people typically delay reaching the stage when they need state-funded support for longer and reduce the pressure on services.

1.3. The points below summarise the findings from both the data and qualitative information that has informed this JSNA. These points have been written to inform how services should be developed and delivered in the future.

Remaining healthy

- Prevention first and foremost - Nearly half the burden of disease for older people can be attributed to conditions that can be prevented or delayed by changes in lifestyle. The 'usual suspects' - not smoking, drinking responsibility, maintaining good social contacts, eating well and exercising – contribute strongly to ageing well.
- Dementia is the condition most associated with getting older. This risk, too, can be reduced by a healthier lifestyle earlier in life.
- There is no 'safe age' before unhealthy activities begin to have an effect, nor an age after which improvements do not help.
- Many older aged people are keen to engage with younger people on matters relating to health and wellbeing, they are keen for young people to learn from what has already past. Many services and communities would benefit from utilising and supporting this natural resource.
- The importance of maintaining social and intergenerational contact is clear and needs a far greater emphasis in the future.
- Inequalities in health are very evident, with a small number of poorer older people having a disproportionate burden of disease and so increased cost to health and care. A far greater focus on reducing inequalities will improve lives and save public money.

Remaining independent

- Staying independent, preferably in one's own home, is important to older people, there is a great deal of emphasis on more self-help and short-term assistance to regain independence.
- Formal health and care exist within a wider context of the immediate and extended family, and the voluntary and community sector. The contribution and needs of family carers in particular needs greater recognition.

- Good transport helps independence and social contact in town and the countryside, affordable and sustainable transport solutions are important to keeping older people healthy and well.
- Design and local planning policy has a significant impact on health and independence, particularly for older people seeking appropriate housing solutions without having to move out of their community and away from their social support. Housing policy should take health and wellbeing impact into account

Remaining active and included in community life

- Social contact is an essential part of sustaining health and wellbeing.
- Volunteering is of benefit to the community and to the volunteer.
- Rewarding and valued work is good for health. Employers should recognise the contribution to be made by older workers, including people past current state pension age.
- Supporting stronger communities through village agents, town and parish councils and voluntary groups such as Men's Sheds provides a cost effective way to health and wellbeing across all ages.
- Maintaining social contact into older age can create a support network that helps people stay independent in their own homes.

2. Options considered and reasons for rejecting them

2.1 The production of a JSNA is a statutory requirement. The decision to hold most data on the web with annual thematic summaries was taken by the Health and Wellbeing Board in 2012 and has proved successful. The 'vulnerable children and young people' theme was endorsed by the HWB in the summer of 2015. The theme for 2016-17 is 'older people and ageing well'.

3. Background Papers

3.1 The 2017 JSNA summary and qualitative report 'Ageing Well'

The JSNA is published in its entirety on the Somerset Intelligence website at: http://www.somersetintelligence.org.uk/jsna/

Joint Strategic Needs Assessment

Summary 2017
Ageing Well

Somerset Health and Wellbeing Board

Contents

INTRODUCTION

Welcome to Somerset's Joint Strategic Needs Assessment (JSNA) summary for 2017.

Since 2008, when the JSNA came into being through the Health and Social Care Act, this needs assessment has been a 'must do' for all county councils in England and is the responsibility of our Health and Wellbeing Board.

Our objective is to examine the health, wellbeing and social care needs of the whole Somerset population. The JSNA's main purpose has always been to inform commissioners and provide them with accessible information to help them develop and improve services. A large needs assessment like this, therefore, brings together a lot of data and statistics and looks at what we can expect in the future and what we can learn from the past.

There are many, many factors that influence how well we are, both mentally and physically, which is why we collect information on housing, transport, employment, education, hospital admissions, environment, employment - and much more. This gives us a rounded picture of need and helps commissioners (not only in the local authority but in the district councils and the NHS) in their decision-making.

There is often a specific focus to a JSNA and ours this year is 'ageing well'. The public health agenda is very much about prevention; how can we prevent or mitigate ill health and how can we help future generations to maintain good health and wellbeing throughout their lives. It might be a 'slow fix' but it is an intention that brings huge benefits.

This summary is complemented by an interesting qualitative enquiry looking at some Somerset people's experience of ageing. His work has mainly taken the form of discussion groups and interviews; these add depth to our facts and figures and we've included quotes and observations in this summary. During these discussions there was often a lot of empathy expressed towards younger people in Somerset and a real desire to encourage and support younger generations to stay healthy and well, learning the lessons from the past.

My personal thanks go to the many people who help put the JSNA together and the Health and Wellbeing Board for its continued direction and support. We hope you will explore the Somerset Intelligence website which hosts the JSNA and all the information that supports it www.somersetintelligence.co.uk

Christine Lawrence

Chair of Somerset Health and Wellbeing Board

Trudi Grant

Director of Public Health

EXECUTIVE SUMMARY AND IMPLICATIONS FOR COMMISSIONERS

Most of us aspire to health and wellbeing throughout life but in reality many of us do not achieve this. As we explore in this JSNA, many people in Somerset live a long life but not necessarily a healthy one throughout, often people experience health problems as they get older which hinder the way we are able to live our lives and how independent we remain.

Being aware of how we remain healthy and well throughout life and knowing about aging and how to prepare for it is a responsibility of all of us. Moving into older age should be a positive and celebrated part of life. It should be the time when a lifetime of experience, learning and hard work come to fruition. It's often the time of our lives when we know ourselves best of all.

The points below summarise the findings from both the data and qualitative information that has informed this JSNA. These points have been written to inform how services should be developed and delivered in the future.

Remaining healthy

- **Prevention first and foremost** - Nearly half the burden of disease for older people can be attributed to conditions that can be prevented or delayed by changes in lifestyle. The 'usual suspects' - not smoking, drinking responsibility, maintaining good social contacts, eating well and exercising – contribute strongly to ageing well.
- **Dementia** is the condition most associated with getting older. This risk, too, can be reduced by a healthier lifestyle earlier in life.
- There is **no 'safe age'** before unhealthy activities begin to have an effect, nor an age after which improvements do not help.
- Many older aged people are keen to engage with younger people on matters relating to health and wellbeing, they are keen for young people to **learn from what has already past**. Many services and communities would benefit from utilising and supporting this natural resource.
- The importance of maintaining **social and intergenerational contact** is clear and needs a far greater emphasis in the future.
- **Inequalities in health are very evident**, with a small number of poorer older people having a disproportionate burden of disease and so increased cost to health and care. A far greater focus on reducing inequalities will improve lives and save public money.

Remaining independent

- **Staying independent**, preferably in one's own home, is important to older people, there is a great deal of emphasis on more self-help and short-term assistance to regain independence.

- Formal health and care exist within a wider context of the immediate and extended family, and the voluntary and community sector. **The contribution and needs of family carers** in particular needs greater recognition.
- **Good transport** helps independence and social contact in town and the countryside, affordable and sustainable transport solutions are important to keeping older people healthy and well.
- Design and local planning policy has a significant impact on health and independence, particularly for older people seeking appropriate housing solutions without having to move out of their community and away from their social support. **Housing policy** should take health and wellbeing impact into account.

Remaining active and included in community life

- **Social contact** is an essential part of sustaining health and wellbeing.
- Volunteering is of benefit to the community and to the volunteer.
- Rewarding and valued **work** is good for health. Employers should recognise the contribution to be made by older workers, including people past current state pension age.
- Supporting **stronger communities** through village agents, town and parish councils and voluntary groups such as Men's Sheds provides a cost effective way to health and wellbeing across all ages.
- Maintaining social contact into older age can create a **support network** that helps people stay independent in their own homes.

MAIN SUMMARY - BACKGROUND AND CONTEXT

This JSNA, with its focus on 'ageing well', addresses some of the most pressing issues for individuals and public sector bodies in Somerset. Better healthcare over recent decades has led to an increase in life expectancy. This success story, combined with inward migration during middle age, means that the county's population is getting older on average.

'Ageing well' can mean many things, but maintaining good health, social contacts and personal independence are high in almost everyone's priorities. Encouraging people to age well is also of high importance for health and social care services. Healthy, connected and independent people typically delay reaching the stage when they need state-funded support for longer and reduce the pressure on services.

The JSNA concentrates in particular on matters that can be directly influenced through local policy. Issues such as state pension, national retirement age and genetic influence are largely outside of the scope of local action and therefore have not been considered in detail here.

Aging well is an issue that impacts on all of us. It is not a question of simply balancing wellbeing against cost to the public sector; we should expect that a county where more people age well should give benefits to all, whether it's a vibrant third sector, a more thriving economy or greater opportunity to maintain traditional skills and knowledge. This report looks at what it means to age well, what can be done by individuals in middle age and beyond to achieve it, and how Somerset can pull together to improve the life experiences of older people.

The United Nations describes population ageing as 'one of the most significant social transformations of the twenty-first century'[i] and its consequences are unsurprisingly wide ranging. A wealth of information on the social circumstances in Somerset is available on the Somerset Intelligence website (www.somersetintelligence.org.uk/jsna , links to relevant individual pages are also shown throughout this summary. All the webpages relating to ageing well are collected in a single document at (www.somersetintelligence.org.uk/older-people). The web site *is the JSNA*. This document is a summary of its implications.

Definitions and Scope

We have taken 65 as the start of old age – matching state pension age for many. There are 125,000 people aged over 65 in Somerset (http://www.somersetintelligence.org.uk/population-estimates-and-projections/). We have not set an upper age limit, but accept that beyond 85 many people may find activities limited by ill health. Ageing well is also inevitably linked to good quality end of life; this important issue has not been explored it in detail here but is the subject selected for the 2017 Annual Public Health Report in order to complement this JSNA[ii].

Demography – general overview

Somerset covers 3,452 square kilometres (1,333 square miles). The county comprises:-

- Five Districts (Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset)
- 54 County Electoral Divisions
- 138 District electoral wards
- 330 Parishes (excluding Taunton, which is 'unparished') and 276 parish or town councils

An estimated 545,390 people live in Somerset (June 2015[iii]) and currently the population is rising by more than 3,000 per year. It is estimated that 48% of the population live in a rural area.

Somerset attracts people of working age, who get older, and people who move on retirement. One in five of the resident population is now aged over 65 with West Somerset having the highest percentage of people over 65 at 33% of the population.

Figure 1- Map of Somerset and Districts (Ordnance survey)

SECTION I: REMAINING HEALTHY

Just as life expectancy is the most comprehensive summary measure of population health, so healthy and disability-free life expectancy, calculated on the basis of surveys, summarises how much of life is spent in good health. Figure 2 shows that, excepting a slight fall in the last years' data[iv], life expectancy has shown a steady rise, this has not been matched by an increase in healthy life, meaning that a longer length of time, and a longer proportion of life, is being spent, in poor health. This is not only bad news for the population, but for providers of health and care services. Ageing, *per se*, is not putting pressure on services, but an increasing number of people living with long term conditions *is*.

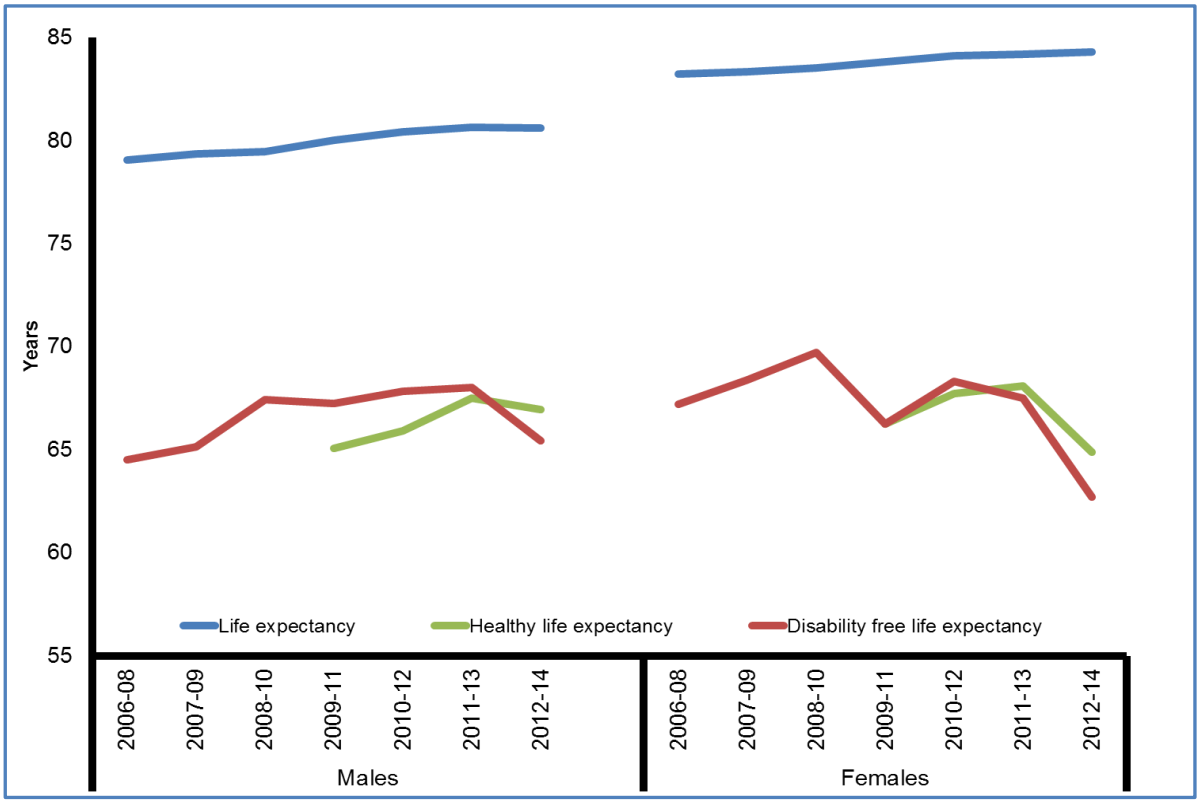


Figure 2 - Life Expectancy and Healthy Life Expectancy, Somerset

Figure 3 following shows how the proportion of people who describe their health as 'good' or 'very good' declines with age. This is not unexpected. What is more interesting however is looking at the best and worst areas nationally. Hart in Hampshire does best on this measure in England, they show little variation before people are in their late 30s and 40s. Tower Hamlets in East London which does worst nationally on this measure shows half of all people aged 60 and above say that their health is not good – a level that is only reached in people aged over 80 for Hart. Somerset shows a healthier pattern than the England average, but is still some way behind the best.

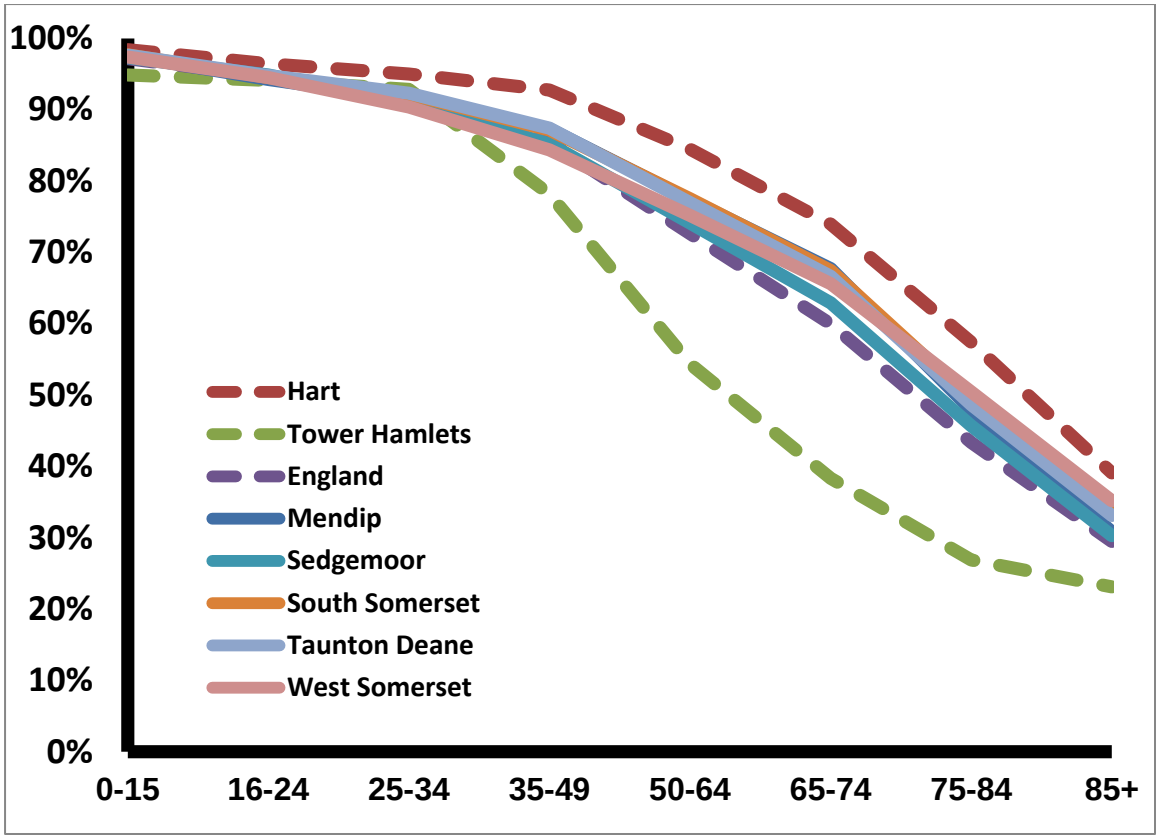


Figure 3 - Self Reported Health (2011 census)

Looking within Somerset, we are able to use census data to compare how ill people are with how well that they feel. Figure 4 following shows the proportion of people with long term conditions, plotted against the proportion of people saying their health is good or very good, for LSOAs in Somerset. Unsurprisingly, there is a strong relationship. But, it is not a perfect relationship and clearly some communities have more people with long term conditions, but *feeling* well, and some have the reverse.

Areas labelled in black are those where more people are able to age well; they seem generally more prosperous than those in red, where self-reported health is worse than the 'actual' health might suggest. The higher social capital of prosperous neighbourhoods is reflected in a better feeling of health as well.

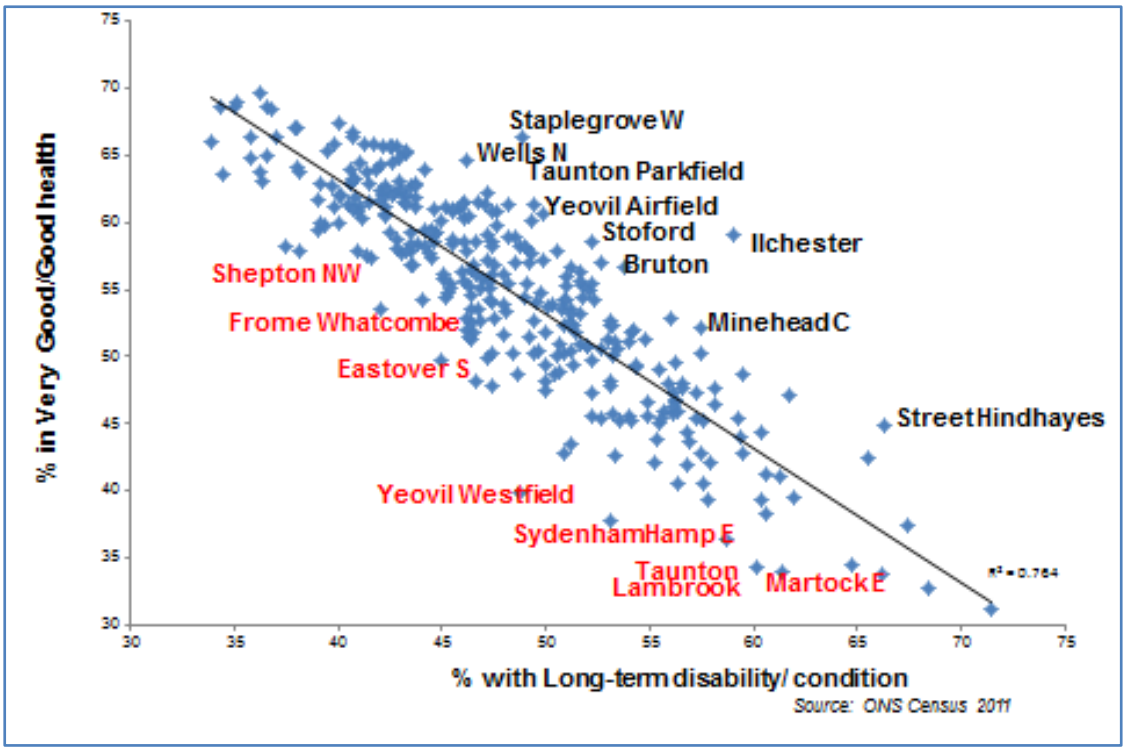


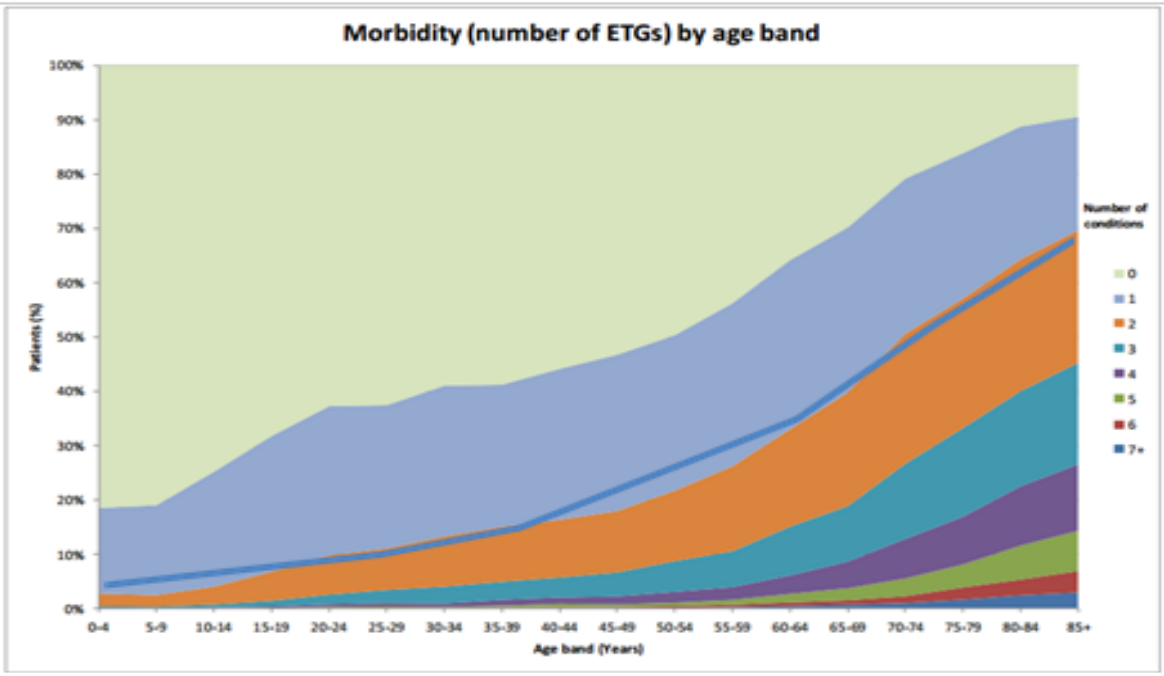
Figure 4 - Age 65+ Good health vs Long-term Condition

There needs to be a far greater focus on improving the health and wellbeing of those people who are the worst off in our society. Tackling the inequalities associated with ageing well can improve people's lives and makes financial sense for health and social care services.

Figure 5 following shows how more than 80% of under 5s have no long term conditions; by 90 this falls to less than 10%. Figure 5 also shows a close association between the line showing people's perception of whether their health is good/very good and two long term conditions in the Symphony dataset[v]. The Symphony Dataset identifies the following eight priority long term conditions for their prevalence and seriousness:

- Depression
- Cancer
- Diabetes
- Coronary Heart Disease (CHD)
- Stroke
- Chronic Obstructive Pulmonary Disease (COPD)
- Dementia
- Chronic Kidney Disease (CKD)

This could suggest that one to two of these long term conditions can be sufficiently managed and during younger age. It could however reflect the type of long term conditions that are predominant at different ages.



Somerset percentage reporting health as neither good nor very good

Figure 5 – Long-term Conditions and Ageing Well (Somerset)

Long-term conditions and multi-morbidity

To explore this a little further, some of the long term conditions, such as mild asthma, which represents a high proportion of long term conditions in young people, are generally easily-treated and have little broader impact on quality of life or susceptibility to other illness.

Other long term conditions can be more restricting and more limiting on health, especially for people who have more than one. Two or more conditions which occur together are called co-morbidities; having more than two conditions is often termed 'multimorbidity'. This can be more debilitating than just having two problems at the same time: for instance, someone with diabetes may find it harder to manage their medication if they also have dementia, and such patients may be described as having 'complex' needs.

Discussion group snapshot

We asked: What motivates you to keep well?

Somerset people said:

- *Having grandchildren and wanting to watch them grow up*
- *Observing other people who are **not** ageing well*
- *Making a physical effort to do things – walking, swimming, but more free activities would help*

Using the dataset it is possible to see whether the distribution of the various conditions is random or whether there are factors connecting them causing a clustering of conditions. Table 1 (Symphony) below compares the 'observed' and 'expected' values (if it were just random) of conditions. Most people – more than we would expect if it were random - have no long term conditions (LTCs). We have fewer than we would expect with just one, but we have *many* more people than we would expect with three or more. If it were simply random, we would expect that about 700 people in the county would have three or more LTCs, whereas the true number is over 5,600. This finding demonstrates that multimorbidity is closely linked to inequality. The clustering of conditions is likely to be the result of common risk factors such as smoking, poor diet and exercise, excessive alcohol consumption, social isolation – all associated with deprivation – causing disproportionate ill health in a small group of people.

Table 1 - Observed and Expected Numbers with Long Term Conditions

Number of conditions out of 8	Observed (number of people)	Expected (number of people) given overall prevalences	Obs/Exp
0	447,727	429,243	1.0
1	79,909	110,708	0.7
2	19,187	11,799	1.6
3	4,519	671	6.7
4	953	22	43.5
5 or more	149	0.4	356.8

Depression is the most commonly occurring sole condition (and also that the observed number of people with a lone diagnosis of depression is close to what would be expected by chance). Chronic Kidney Disease is the least common and it occurs with other conditions much more often than would be expected by chance.

All conditions occur alone less often than would be predicted by chance.

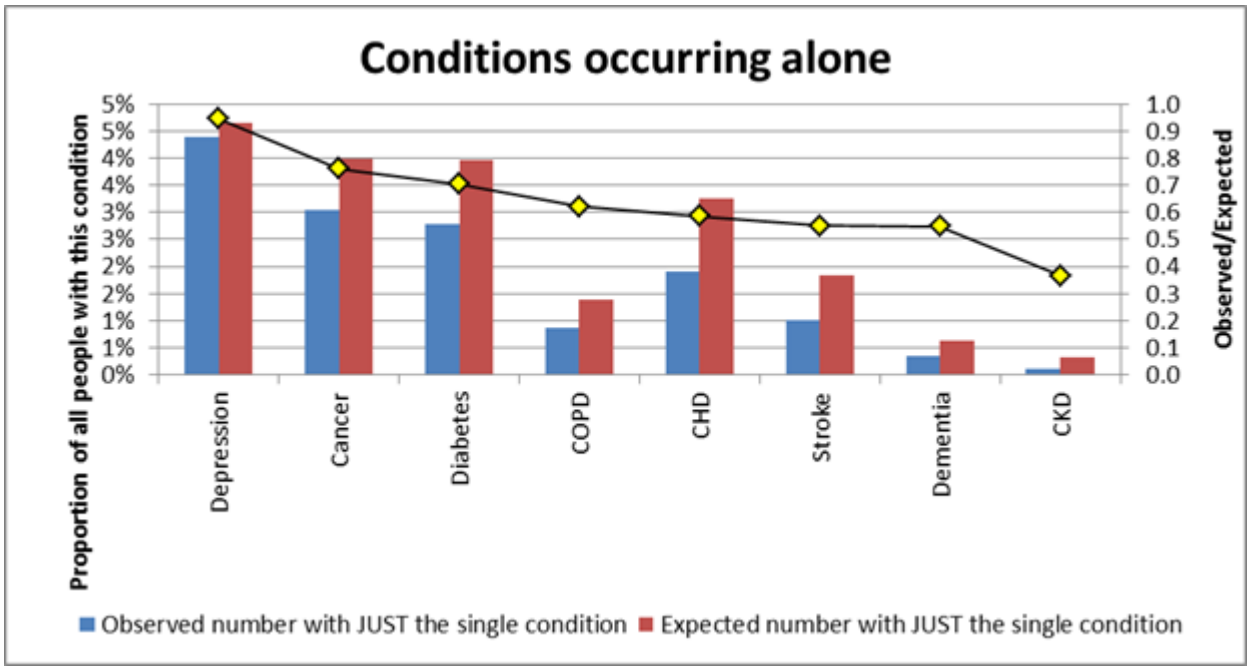


Figure 6 - Long Term Conditions Occurring Alone

It is also possible to look at combinations of the conditions to see which are observed more often than expected by chance. The graph below (Figure 7) looks at people in whom the two conditions listed on the horizontal axis occur together (some of those people will have other conditions as well).

All combinations occur more often than would be expected by chance. Depression occurs in the combinations on the left of the chart and where the observed value is getting more similar to the expected value, which fits with the observation above, that depression appears almost to occur independently of other conditions. There are almost nine times more people with both dementia and stroke diagnosed than expected. Indeed groups of vascular conditions tend to show the greater excesses of observed numbers compared to expected numbers.

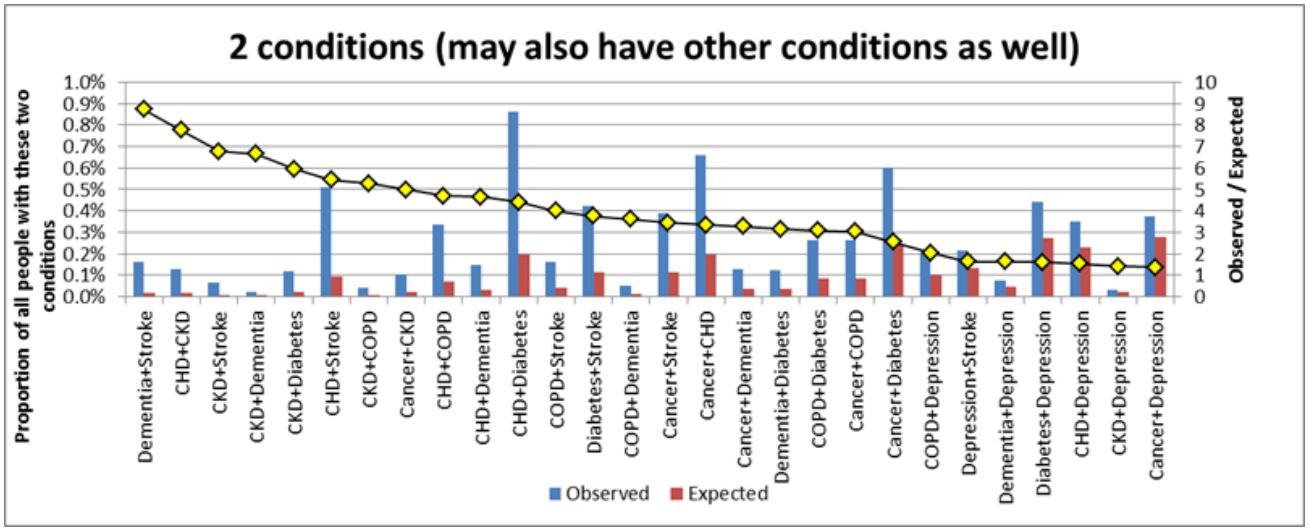


Figure 7 - Prevalence of Two Long Term Conditions Occurring Together

In summary, the Symphony dataset shows that there is evidence that some LTCs cluster together. It is likely that predominant diseases that cluster together do so as a result of common lifestyle risk factors which are strongly linked with people who live in areas of higher deprivation.

In relation to demand on services, people with many conditions – 'multimorbidity' – tend to require *much* more expensive health and social care than those with fewer because the conditions and their treatment affect each other and make the individuals health status more complex. The dataset shows that the healthiest 78% of the population require only 35% of expenditure – about £300 each. The 4% with three or more conditions require approximately 50% of expenditure –about £10,000 each per year.

Ageing is inevitable, but 45% of the associated ill-health burden is preventable[vi].

The evidence is clear, prevention of LTCs (particularly multimorbidities) is key to improving lives in older age **and** reducing costs to the taxpayer. Keeping 100 people in the '78%' rather than the '4%' for one year would save Somerset health and care system £1m.

Inequality in Multimorbidity

Patterns of multimorbidity show the strong relationship between social and economic disadvantage and ill health. Long term conditions are disproportionately found together, and found more in the most deprived communities. As an *additional* effect, people with multiple long term conditions (rather than simply older people) are disproportionately expensive for health and care.

Projections of Multimorbidity

If current trends continue we will see multimorbidity rise steadily. Using the rates for all Somerset registered patients and the ONS 2014-based population projections for Somerset residents gives the following projections over the next 20 years. The

number with three or more of the eight conditions is projected to increase by over 60% from 5,900 to 9,600 and the number with five or more to increase by nearly 70% from 160 to 270.

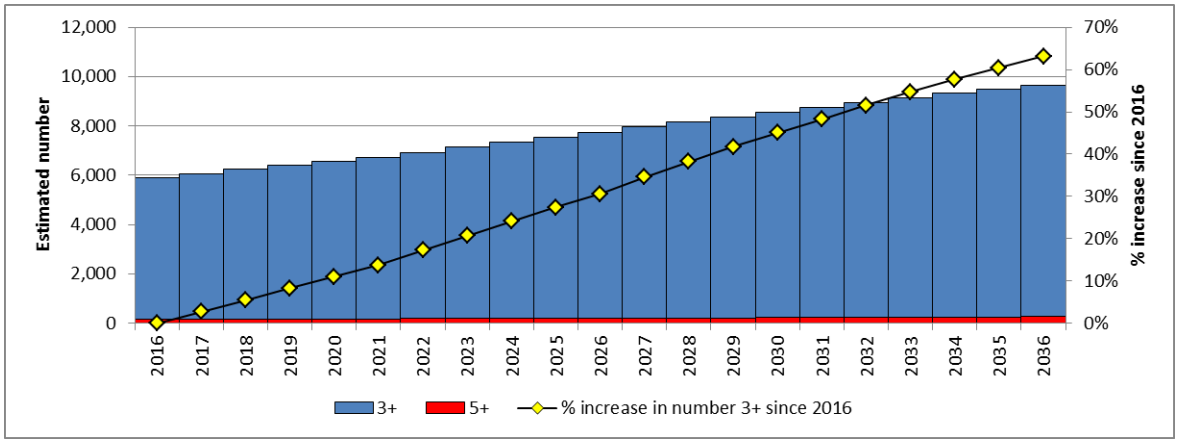


Figure 8 - Projections of Numbers with 3+ and 5+ Long Term Conditions

The estimated increases can only be a rough guide as the population projections are themselves modelled. However, the impact of multimorbidity on wellbeing, and health and social care resources, is such that the increases demonstrated here need to be taken into consideration in planning services.

Cause of death

Understanding the burden of disease also requires studying the causes of death. (Analysis here is of *underlying* cause of death; the immediate cause of death may often be flu or pneumonia that only proves fatal because of the underlying condition.) Figure 9 below shows cause of death for those dying before and after 80.There is a larger number of male deaths than female under 80, and the pattern is reversed for those over 80, reflecting lower male life expectancy.

Secondly, the proportion of deaths from flu and pneumonia is much lower for the over 80s, probably because many by that age have acquired an underlying condition[vii]. Thirdly, and most interesting, the largest increase in cause of deaths is dementia and Alzheimer's, especially for women. To an extent this reflects medicines and lifestyle improvements in reducing the incidence of the major killers – cancer and heart disease. In 2013-15 nearly a fifth of emergency admissions (5,000 out of 26,000) for people over 85 were for someone with dementia.

The rise in dementia, for which there is currently no cure, poses considerable challenges for the health and care system, and the families of those affected.

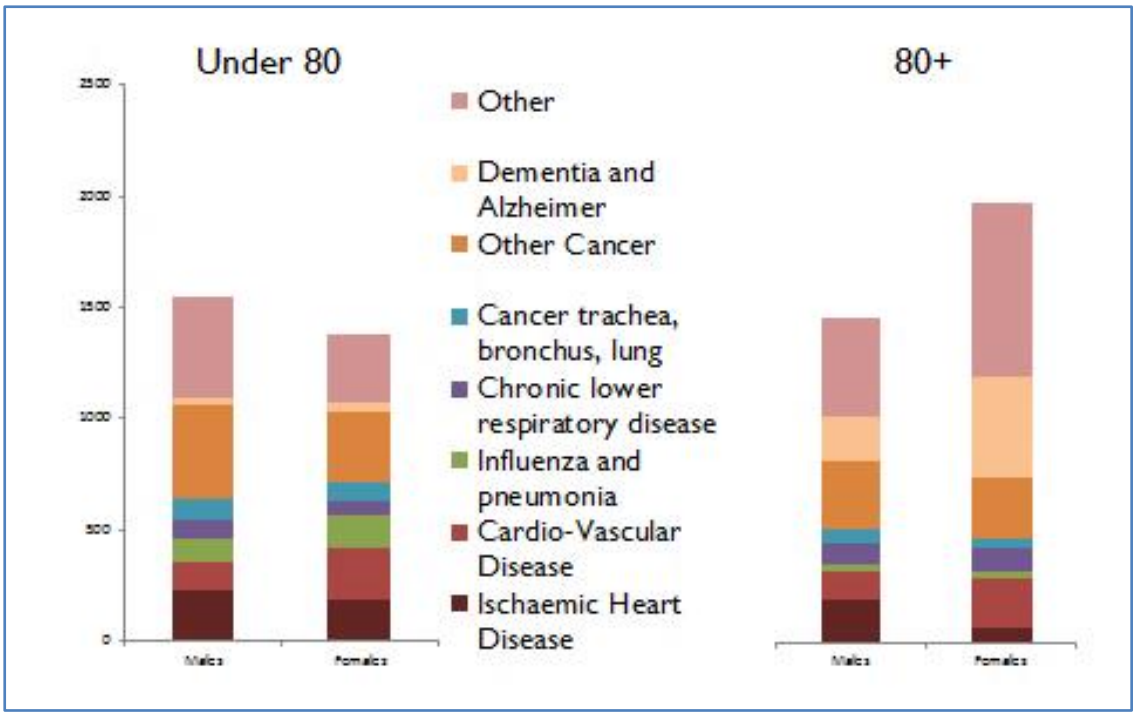


Figure 9 - Cause of Death, Somerset 2015

There were over 2,000 deaths from dementia and Alzheimer's disease in Somerset care and nursing homes in 2015, with a notably small proportion at home. The recent rise in dementia shown in Figure 10 demonstrates the scale of the challenge.

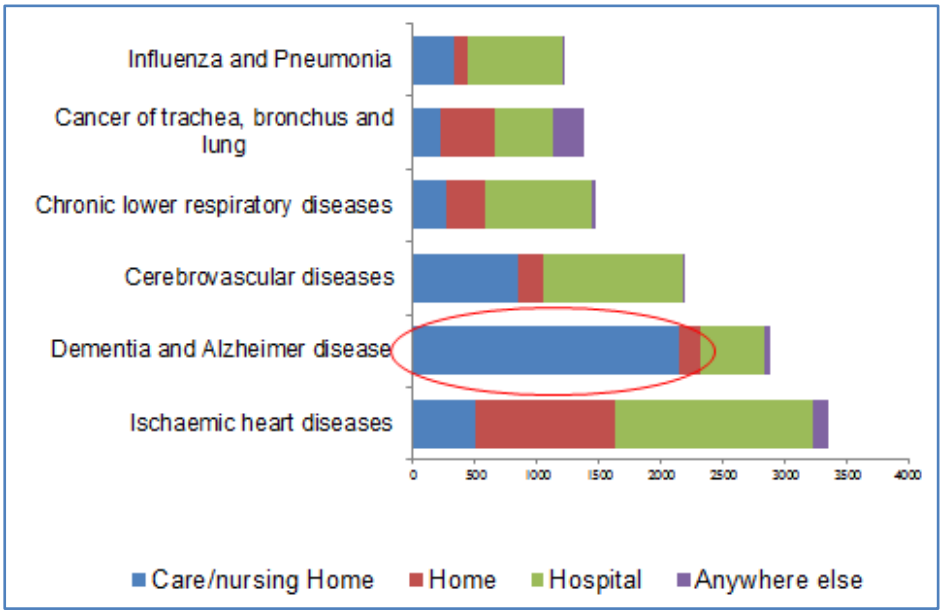


Figure 10 - Place of Death, Somerset

The slight fall in the *proportion* with the condition in 2016 may reflect a genuine reduction, perhaps related to healthier lifestyles at younger ages; this has to be offset by the rise in the absolute *number* from population growth and ageing, and the

possibility that the condition is under-recorded in the county. The number of people with dementia is projected to double by 2035 to approximately 18,000 people.

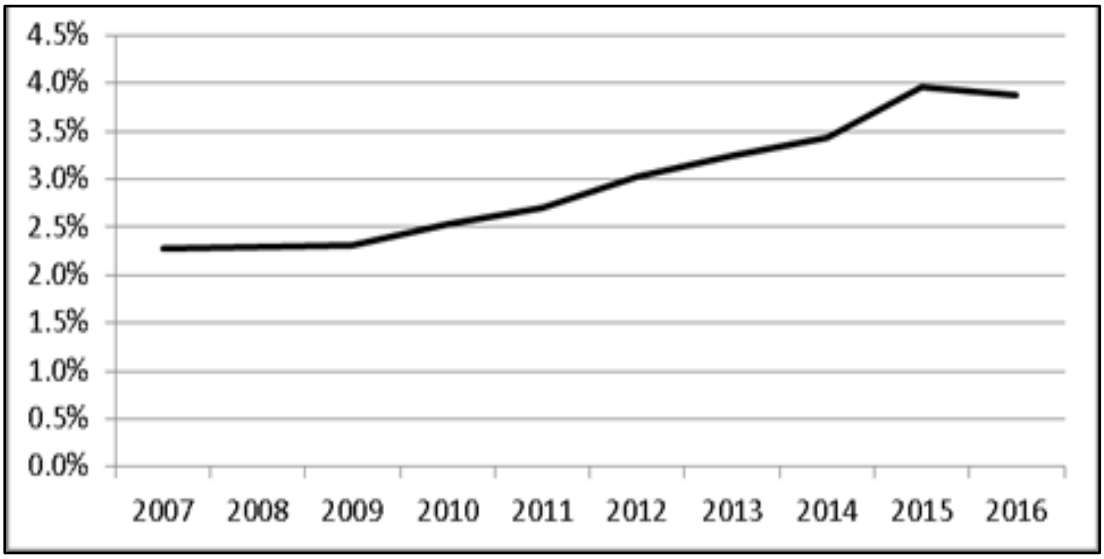


Figure 11 - Dementia Recorded Prevalence 65+, Somerset Registered Population

Lifestyles and prevention

In broad terms, the lifestyle factors that have the greatest contribution to make in preventing or delaying the greatest burden of disease are clearly understood, with good diet, exercise, not smoking, drinking responsibly and having good social contact being beneficial for heart disease, stroke, cancer, lung disease, Type II diabetes and dementia, amongst others. Of these, diet was by far the most frequently raised in the discussion groups. Some focus group members referred back to the good habits that begun in their childhood rationing.

Discussion group snapshot

Diet

- *No junk food, cook your own*
- *During the war we had a limited diet, but wholesome. Food was from the land, you knew what was in it*
- *Eating smaller, healthier meals, 'but I am terrible sometimes, I binge on chocolate!'*

It is perhaps interesting that smoking and alcohol were not raised specifically during the qualitative work although the discussion of lifestyle would suggest that members of the discussion groups were not unaware of their effects.

Screening, too, has a role in prevention, with health checks a way of identifying conditions early. Nationally, the uptake of bowel screening amongst 50-70 year olds

is less than 70%, and less than 50% in men aged 60-64, even though this is the second most common form of cancer in the whole population [xii].

Physical activity

The importance of physical activity was raised in a case study from the Quantocks.

CASE STUDY FROM THE COMMUNITY COUNCIL FOR SOMERSET

At a Village Agent Knowledge Café the village agents were introduced to 'Zing'; a bag of sports games that is loaned to Village Halls with the aim of getting a group together to try different fun social games whilst helping people to become fitter and more active.

Once the group is hopefully established after about eight weeks, if the group wishes to continue then Zing help them to apply for funding for their own bag. A Village Agent introduced the village of Timberscombe to Zing and they trialed the group for eight weeks. It proved to be a big success and now the group meets weekly having received funding to purchase their own bag and members of the group report that they feel healthier and look forward to meeting up with the friends and having fun.

Summary

Ageing does not *have* to be associated with diminished health, and lifestyle improvements throughout life can delay the onset of illness. Healthy people also tend to show 'compressed morbidity', with a much higher proportion of life spent in good health. This is good for us all, and good for health and care service provision.

Social inequality means that a small number of people, experience a disproportionate burden of disease and an even more disproportionate impact on cost. Enabling more people to age well will be a 'win-win' for people and the economy.

SECTION II: REMAINING INDEPENDENT

Living an independent life or having a sense of independence emerged strongly in the discussion groups and conversations. For the majority, being independent meant being able to get out and about, meet others and participate in their local community without having to feel over-reliant on other people.

Social contact emerged as the most important aspects of ageing well. Others included being able to live in your own home, having access to public transport, receiving the appropriate type and quality of social care. Because of its prevalence and impact, dementia care is a significant element of maintaining independence in older life.

Care

Figure 12 shows that the bulk of unpaid care in Somerset is provided by those over the age of 50. Importantly, nearly half of carers over the age of 65 provide care for more than 20 hours per week. It is likely that people over 65 years are predominantly providing care for spouses; many 50-64 year olds provide care for their ageing parents. Whilst providing some care for others can be beneficial to health and wellbeing, giving a sense of purpose, high intensity caring has been shown to have a detrimental effect on wellbeing[viii].

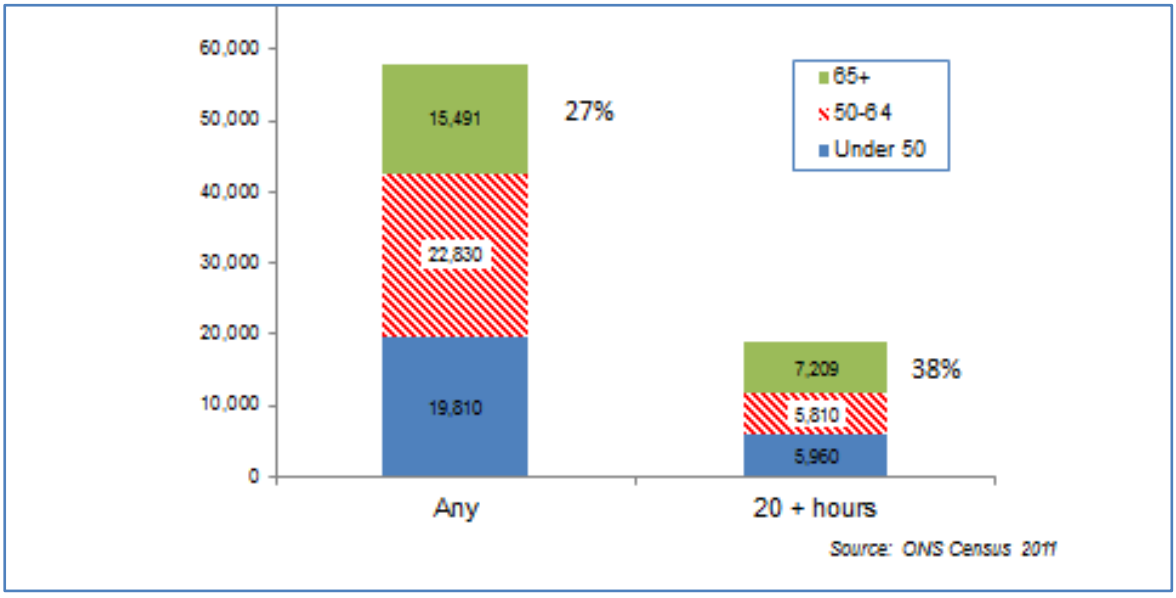


Figure 12 - Providing Unpaid Care in Somerset

Unsurprisingly, carers' needs were strongly stated during the qualitative work for this JSNA. People commented that families were often more dispersed than in the past and children were unable to give the support that they might have done formerly.

Discussion group snapshot

Carers

- *My husband has to stay well to look after me. But [his caring responsibility] puts his health at risk.*
- *Look after the carer or you will have to look after two people.*
- *Increased stress with caring for someone with dementia – makes you defensive all the time – there's no let-up….you become run down, getting ill…..*

We were interested to ask about the attitudes older people experience and whether attitudes towards older people promoted independence or not. Some people in the discussion groups had experienced being 'talked down to' and were extremely resentful of it. There was a feeling that in some circumstances receiving direct support had left them feeling less capable of looking after themselves and more dependent.

Discussion group snapshot

Attitudes to older people

- *Too much being done 'for you' – a bit of help, yes, but more encouragement is needed*
- *Negative expectations of being old from family and well-meaning friends*
- *Being treated like you don't matter – it's degrading*

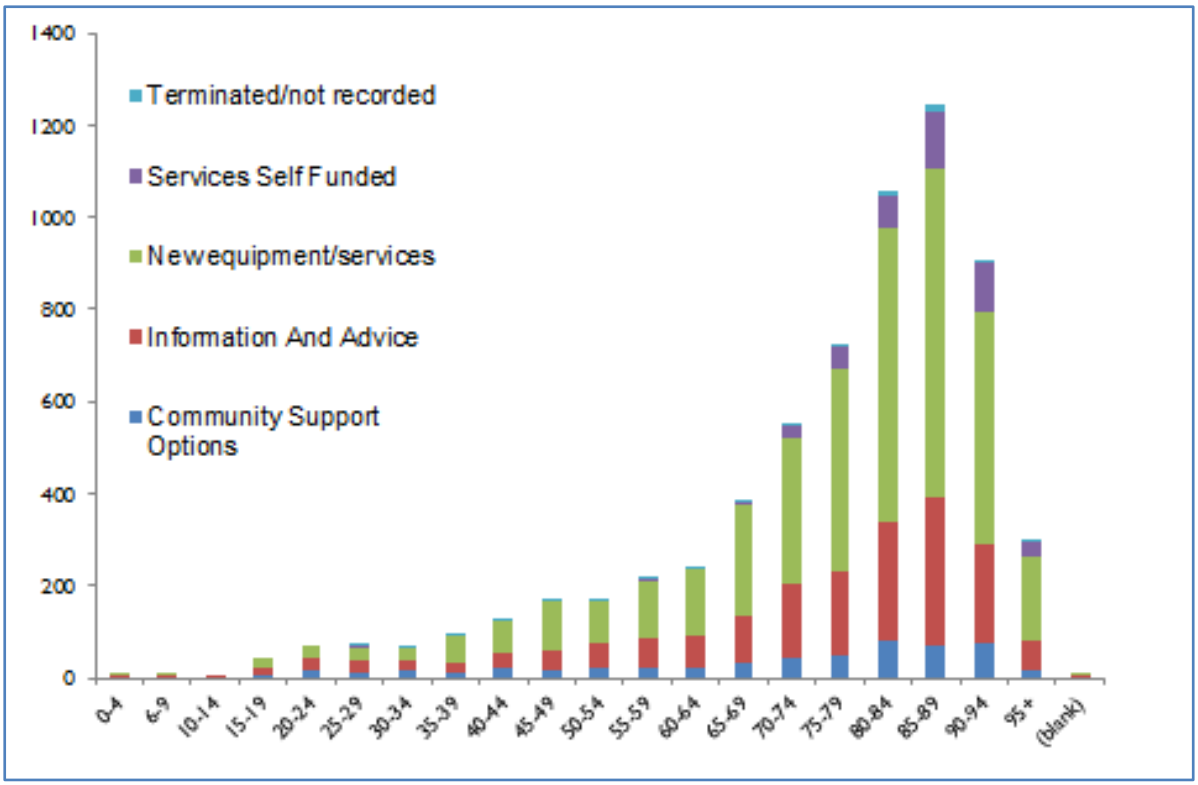


Figure 13 - Social Care Assessment Outcome

Outcomes of adult social care assessments provide a useful insight into how older people are supported. Figure 13 shows the outcomes of assessments done in response to a change in need. The most frequent support is the provision of new equipment or services. For all age groups, only a small proportion of assessments result in support provided by the community. This possibly reflects the complex needs explained above as a result of multimorbidity but it could also suggest a paternalistic approach by services. Interestingly, this is counter to what people want for themselves and their overriding preference to live independently and without undue reliance on others.

An example of how support from the community can work (prompted by the local GP) is can be drawn from Martock, in South Somerset.

Case study from 'Our Place', Martock:

Grace, 80 – Martock

Grace who is 80 had a fall and spent time in hospital. Before, the fall she was highly independent. Afterwards, she was fearful of going out and had become isolated and lonely. The GP asked the seniors' support coordinator to arrange a volunteer befriender, to visit Grace once or twice a week. They started with a walk in the garden, slowly progressing to the local shops. She is now confidently back walking to the shops, and has resumed her social life.

This example of community support is encouraging and shows how GP services, working closely with their communities, can provide the right solutions which may not be medical at all. This simple form of support provided social contact for the befriender as much as it did for Grace. Above all, it helped Grace regain her independence and back to being able to look after herself[ix].

Discussion group snapshot

Promoting independence

- *"I'm here to help you get dressed; but what can **you** do?" (An attitude of a paid carer, commended by a participant.)*

Social care has a strong emphasis on promoting independence to its service users, particularly through 'reablement' – the provision of intensive advice and support for a relatively short time and equipment if necessary – to bring people back to a state of independence.

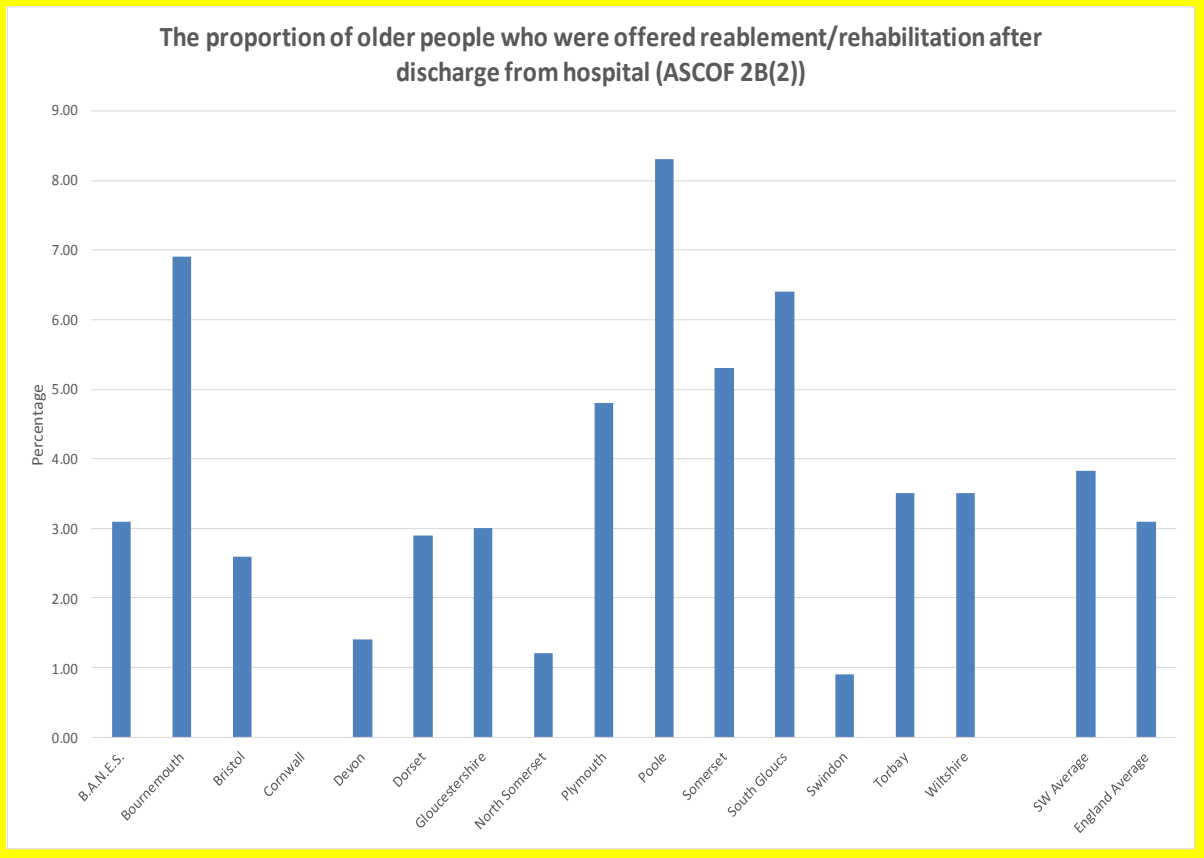


Figure 14 above shows that Somerset is one of the highest in the South West for reablement following discharge from hospital. In principle, this would appear positive, however Figure 15 following compares the outcomes of reablement in Somerset with the rest of the South West. The numbers entering into reablement is extremely high compared to other areas, but interestingly, there is a disproportionate number of people who require ongoing support following the reablement period,

This suggests that reablement wasn't appropriate for some of these individuals in the first place. Similarly, there is a very high proportion of people who needed no support following reablement.

This could also reflect that some of these individuals did not need reablement, they may have regained independence without it. Ensuring and adhering to a suitable referral criteria for reablement is important in maintaining its effectiveness to improve outcomes and the cost effectiveness of the service.

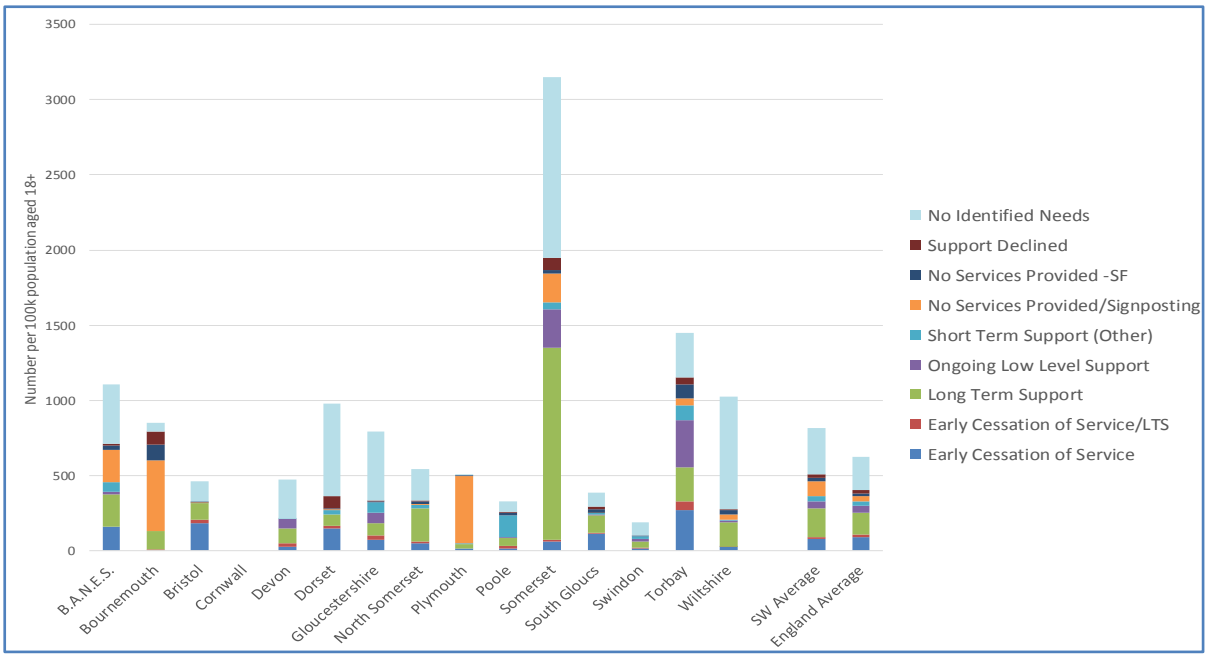


Figure 15 - New and Existing Customers Receiving Reablement 2014/15, Showing Sequels

Figure 16 following shows that the number of people in Somerset over 65 receiving long term support is somewhat higher than the regional average. What is notable, though, is that more than half are receiving 'traditional' commissioned support with managed personal budgets and direct payments (both of which give the service user far more control over what services are provided and how) being lower than any other local authority.

It may be argued that this pattern does not encourage independence amongst service users, or people taking responsibility for their health and wellbeing. In thinking about 'ageing well', it is likely that people who are more in control of their support would be more likely to rate their health and wellbeing as 'Good'.

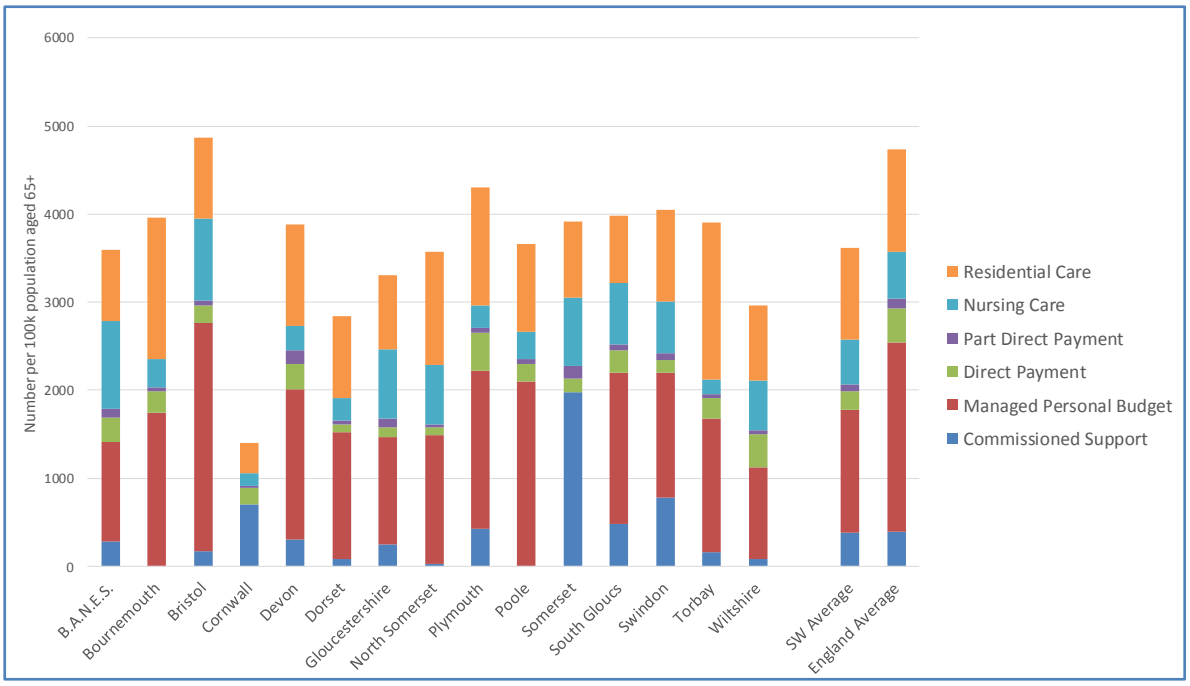


Figure 16 - Number of People Aged 65+ Receiving Long-term Support at Year End 2014/15 by Service Type

Within the discussion groups there was a strong desire to take responsibility and 'be treated like adults'. Some people expressed criticism of the attitudes of some care workers either not engaging with them or being patronising. They also expressed concern regarding the short length of time they were able to spend with service users being a barrier to providing 'useful' support to help develop independence.

Housing

A major part of independence is the desire to stay in one's own home and this was expressed strongly in the discussion groups. With a rising population of elderly people, it is important to consider whether the current and planned stock of housing is adequate for the population needs.

A quarter of Somerset's households include no one younger than 65. Figure 17 following shows the change in 'heads of household' projected for Somerset to 2039. This shows that almost all increase in demand for housing will come from households in which the oldest person is 65 or above.

On the basis of current provision, the draft Somerset Housing Market Assessment suggests that 300-400 more supported care home places, and 200 residential care places are needed over that period. That, of course, assumes that there is no change in how services are provided. The approach put forward through this JSNA and expressed within the discussion groups, suggests that a different way ahead, in which people are helped to stay at home, with integrated support from statutory, family and community supporters, may be much better received and more effective.

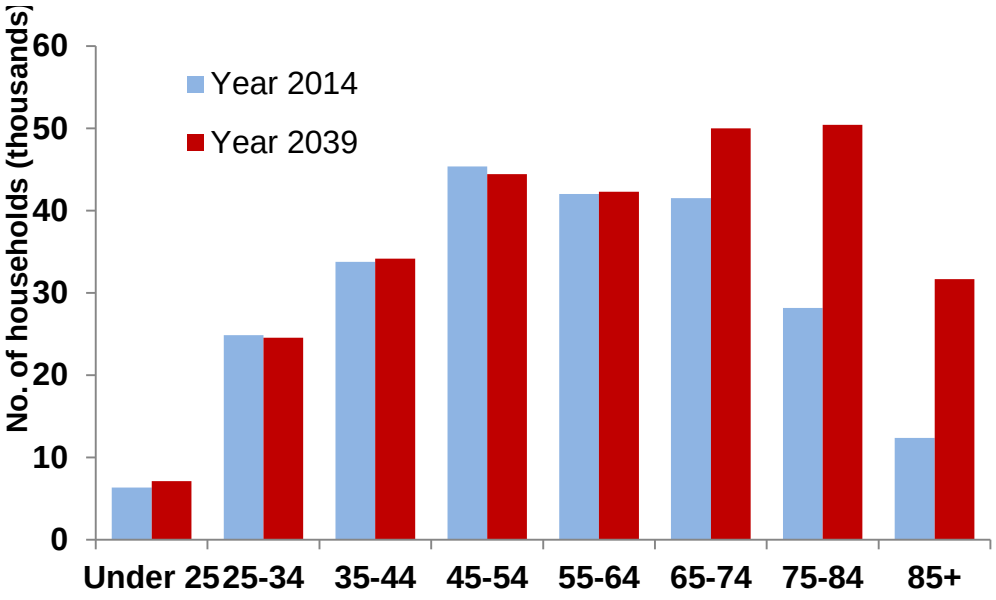


Figure 17 - 'Heads of Household' by Age

Figure 18 below shows the reasons given by people over 65 for looking for new social housing. Although this source only covers those in housing need, these are many of the people for whom 'ageing well' is particularly difficult and the findings accord closely with national surveys of all house moves. The answers given reinforce the importance of maintaining good health in order to stay at home as we age. It also emphasises families as a cornerstone of support for each other.

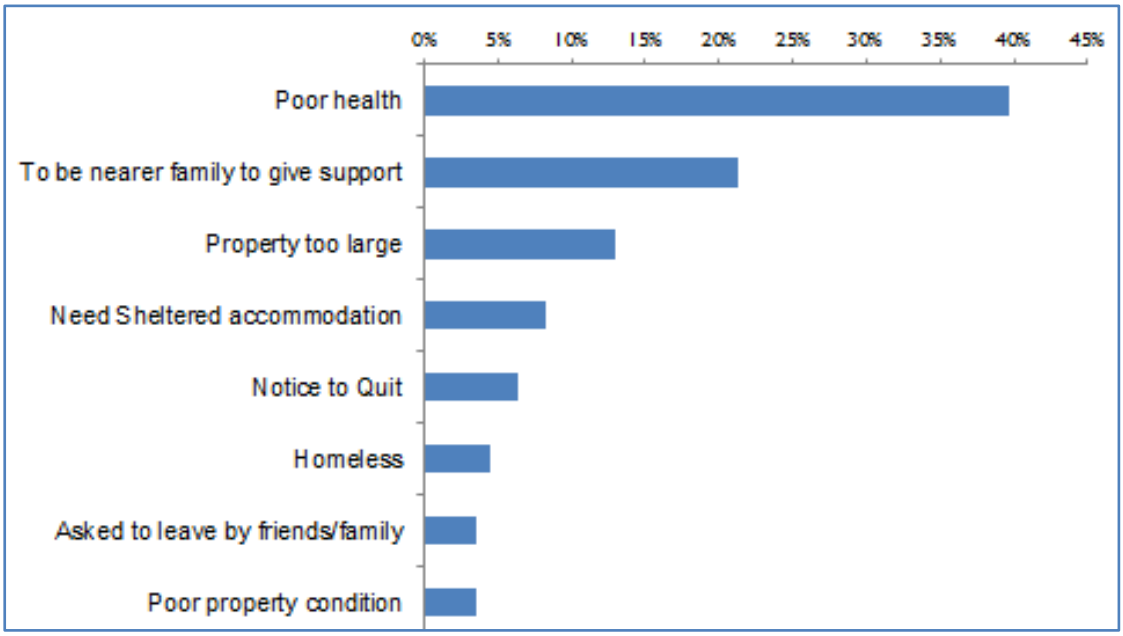


Figure 18 – Homefinder – Reasons for Moving

Discussion group snapshot

Housing

- *More could be done to keep people in their homes…like the new hospital at home*
- *More community and health support to keep people at home*

The 10% or so (in Figure 18) who wanted to move because their dwelling was too large, raise the question of whether older people 'under-occupy' houses while younger families are overcrowded. Unfortunately we do not have the data sources to answer that question adequately, but we did find resentment amongst older people who felt 'blamed' for the housing crisis (and the crisis in health and social care) and under pressure to 'downsize'.

Transport

http://www.somersetintelligence.org.uk/transport-older-people/

According to information on our Somerset Intelligence website, older women are particularly affected by a lack of transport, especially if they outlive their partner as they are less likely to drive a car. In Somerset, the female to male ratio of non-car ownership for the 65+ age group is around 3:1 across all three rural-urban classifications, with rural towns marginally the higher ratio and urban the lowest (see table 2 following)

While older people (and those of other ages, too) are less likely to have access to private transport if they live in towns, there are nevertheless around 2,700 women and 900 men aged 65 or over living in rural villages with no access to car or van, which can often contribute to increased social isolation and poorer wellbeing.

	Female 65+ No car	Male 65+ No car	% Female 65+ No car	% Male 65+ No car
Rural village and dispersed	2,679	903	15.2%	5.6%
Rural town and fringe	3,547	1,070	28.0%	10.4%
Urban city and town	9,886	3,389	35.0%	15.3%

Table 2 - Older people (aged 65+) With No Car, by Rural-Urban Classification % Based on Those Living in a Residential Household, Not Communal Establishments

Source: ONS Census 2011

This is not a study of transport, but perhaps inevitably in a rural county, this issue was raised by many involved in the engagement work to support the JSNA. More surprising was the importance given to it by people living in urban areas. Across the board, a lack of accessible transport was an issue that came up repeatedly.

Discussion group snapshot

Transport

- *No transportation in Priorswood in the evenings*
- *Very difficult to get to Musgrove on the bus, for example from Street and Bridgwater*

Section III: REMAINING ACTIVE AND INCLUDED IN COMMUNITY LIFE

Figure 19: Service Users' Engagement Group (Social Care)

There is a wealth of evidence that social contact supports and sustains wellbeing.

The qualitative work highlighted just how important socialisation is to ageing well and the opportunities it brings to share in activities and conversations, to share knowledge and experience and often to 'lighten the load'. Many activities are low cost – such as coffee mornings, book groups, walking groups and require goodwill and commitment to keep them going. Without this, and the input from statutory and voluntary organisations to support facilities and activities, many people would face increased mental and physical ill health.

Inevitably our strength and abilities decline with age. Accepting the physical restrictions that come as we get older means we need to accept support from other people. This acceptance can contribute to safety and security and highlights the importance of company and social contact.

Social contact and loneliness

http://www.somersetintelligence.org.uk/social-isolation.html

Being lonely is as harmful as smoking 15 cigarettes a day. Being older is itself a risk factor for loneliness, and having no car, being single (through bereavement), having poor health, low internet and Facebook use, as well as low income, can all be associated with ageing. Figure 20 following maps loneliness risk factors at the LSOA level. This shows that the greatest risk of loneliness is in poorer urban areas.

Rural areas have particular problems of transport, although, as noted before, discussion groups in urban areas also demonstrated its importance.

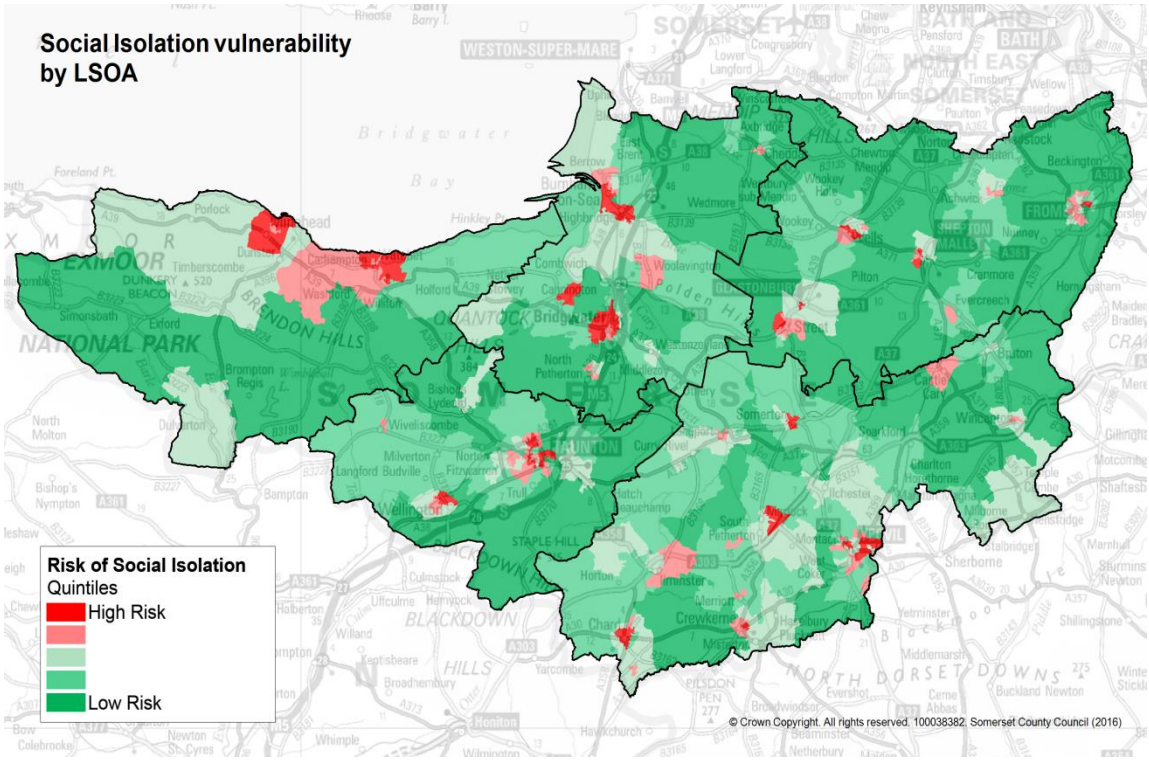


Figure 20 - Risk of Social Isolation (All Ages)

We know isolation and loneliness are bad for health; and social contact and having a purpose are good for it. The term 'social capital' is often used to describe the value associated with a supportive community.

Older people to whom we spoke gave many examples of the importance of social contact and community support to their wellbeing, including a sense of purpose and the pleasure of still learning.

Discussion group snapshot

What helps people to age well?

- *Church work – active in community; drama groups and social singing*
- *Just having somewhere to meet and chat with people*
- *Having the courage to think 'If I don't do it now…'*
- *Coming to the Men's Shed*

In a previous JSNA, talking to younger people who lived rurally, social contact was just as important and social isolation a reality for many of them, particularly digitally.

Discussion group snapshot

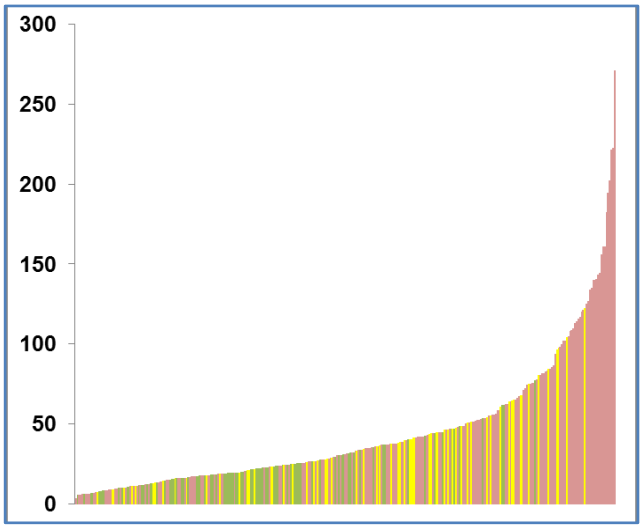
What helps people to age well?

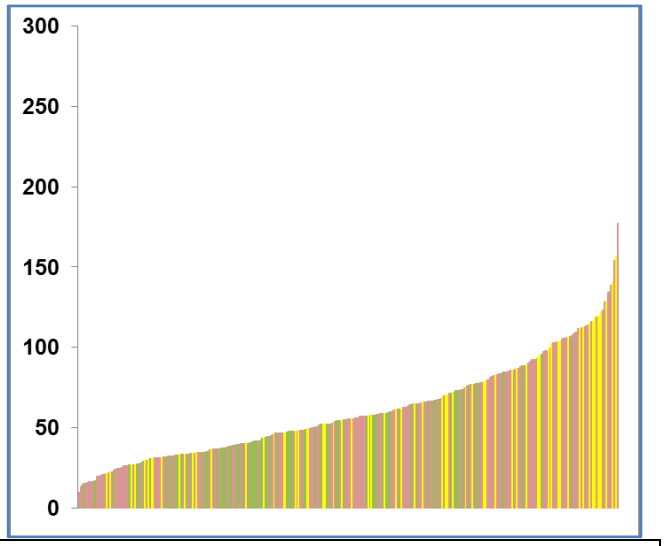
- *Community support or asking for help through support networks – feeling you can **do** that*
- *Laughter, sharing common interests, walking with other people*
- *Having the basics in place: heat, light, food, transport, companionship….and hugs*

Work and Income

We have already seen how being wealthy – having financial capital – usually makes it easier to age well[x]. Figure 21 following shows a graph of the numbers of people over 65s and under 18s in low-income households (as calculated in the Index of Multiple Deprivation) in each Lower Super Output Area[xi] in Somerset. This helps understand how interventions might be focused to encourage healthy ageing.

The distribution of poorer children shows a distinct concentration in a small number of urban areas, and a great dispersal of very small numbers across the rest of the county. The distribution of poorer older people however is very different, with large numbers in rural towns and urban areas particularly, but showing a much more even pattern than for children. It is also important to note the significant numbers with approximately 20,000 people over the age of 65 living in income-deprived households.





Poorer Young People (14,500 total)	Poorer Older People (20,000 total)

Rural Village
Rural Town
Urban

Figure 21 - Numbers of Poorer Children and Older People by LSOA

In a 2016 report on the health people aged between 50 and 70, the Chief Medical Officer for England said that 'staying in work, volunteering or joining a community group can make sure people stay physically and mentally active for longer. The health benefits of this cannot be overestimated'[xii].

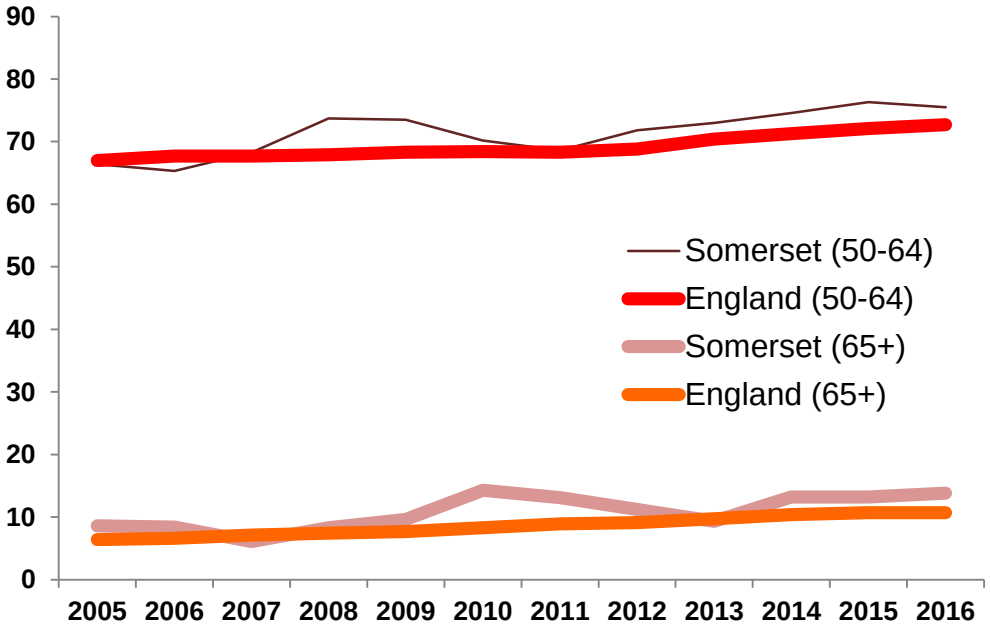


Figure 22 – Economic Activity Rates – Somerset and England

Figure 22 shows that economic activity rates have risen slowly for people in later working age and past male retirement age, and that Somerset has higher rates of both than the England average. However, there is a dramatic fall in economic activity at retirement age.

Whilst an obvious point, this 'cliff edge' represents a major change in lifestyle that can see some people losing social contact and 'purpose' in life. As we have seen, both of these can lead to a decline in wellbeing. Whilst much of this is dependent on national rather than local policies, there is a message for Somerset employers to treat older workers positively in recruitment and retention and, as for all ages, to promote 'good' work that has a health benefit.

Discussion group snapshot

The value of work

- *Being independent and keeping working*
- *Not being stuck at home on your own and isolated*
- *I'm still working, that gets me up in the morning.*
- *Losing your job* [on retirement] *can take away your identity*

Volunteering

There's good evidence that volunteering brings benefits to both the person volunteering and the people and organisations they support [xiii]

Benefits can include:

- Quality of life.
- Ability to cope with ill health
- A healthier lifestyle
- Improved family relationships.
- Meeting new people. ...
- Improved self-esteem and sense of purpose. ...
- Increased self-esteem and confidence. ...
- Better social interaction, integration and support.

Somerset Community Foundation – 'Active and In Touch' was set up in 2011 in response to the number of people in and around Frome who were known to be suffering from social isolation and loneliness. The group has a network of volunteers who reach out to people and befriend them.

Case study

An older lady who resides in a village just outside Frome was referred to the 'Active and In Touch' group after a spell in hospital. She has lived alone since her husband passed away, and her remaining family live on the other side of the world. She was no longer able to drive, lacking in confidence and felt trapped in her home, with the only social interaction coming from infrequent visits from a neighbour.

Having spent Christmas 2015 alone and feeling very low, this person was first visited by 'Active and In Touch' in January 2016. Just three months later she is visited each week by her one-to-one befriender who takes her shopping, visits at the weekend, invites this person for lunch and has taken her to an antiques fair. The same volunteer has also introduced this person to Skype to help her stay in better contact with her children, grandchildren and great-grandchildren.

Another volunteer has been taking this person to hospital visits in Bath, which previously had been a source of great anxiety for her and a frightening experience on her own. She has been introduced to a support group for those who have lost their partners and is being connected with a hobby group in Frome, as she is interested in crafts.

The level of volunteer support this lady has received from 'Active and In Touch' has transformed her life completely, and she has made many new friends as well. She is now looking to move into Frome so that she can enjoy even more opportunities to interact with others, and she says "I feel as though they have opened up my life again…I am thrilled".

CONCLUSION

Growing older in Somerset is a privilege that many people in in early 1900s never experienced. It is potentially the time of life when we know ourselves and our communities the best we ever have. It can be a time of life when we are able to indulge interests to a greater extent as well as enjoy the fruits of our labours. All this relies on aging well though, preferably in good health with those we love around us.

The longer we live as a population, arguably the harder we have to work at achieving ageing well. Through this work we have heard from some older people about their experiences during the Second World War and rationing and how this influenced their health and wellbeing. We have also heard about the lifestyles some have led and how these have, in many cases, better equipped them for life now - such as growing vegetables, cooking and sustaining a certain level of personal resilience.

One of the main benefits of being able to maintain good health is the continuation of personal independence. This is also dependent on factors such as transport and community support. Although unquestionably people felt the need for health and social care when they were ill, many also wanted to be supported to 'get back to normality', rather than have a long term reliance on carers.

Social contact was a strong theme that ran through much of what we found. This was both a benefit to be gained from health, independence and mobility, and something that helped in maintaining good physical and mental health. For many people, retirement could mean a loss of both social connections and income, and managing this transition is an important part of ageing well.

Some people, of course, fall ill regardless of their income or lifestyle. Whilst this report has shown ways in which ageing can be positive, it should not be forgotten that there is more ill-health associated with age, and one requirement of ageing well is the provision of efficient and effective health and care services. People in deprived communities tend to have greater needs than the better off.

The Somerset population is ageing; adopting a holistic approach to health and wellbeing can lead to a healthier, more content and socially active county.

In summary, the older population of Somerset is a great asset and should be supported in a way that promotes healthy living and provides opportunities for people to continue contributing to society.

Endnotes

[i] http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf
[ii] End of life care is the subject of the 2017 Somerset Annual Public Health report, see http://www.somerset.gov.uk/organisation/departments/public-health/
[iii] Office of National Statistics (ONS)
[iv] This has been observed in other nations; see http://www.bbc.co.uk/news/world-us-canada-38247385
[v] The Symphony project in South Somerset aims to improve health and wellbeing of the population in response to the findings from integrating data about health and social care, giving a more holistic understanding of the cost of different ways in which an individual is treated (http://www.symphonyhealthcare.co.uk.gridhosted.co.uk/about-symphony/)
[vi] https://www.gov.uk/government/news/health-of-the-baby-boomer-generation
[vii] Flu jabs for the elderly may also contribute.
[viii] Age UK's Index of Wellbeing in Later Life http://www.ageuk.org.uk/professional-resources-home/research/reports/health-wellbeing/wellbeing-research/ 2017.
[ix] Whilst there is anecdotal evidence for the value of community support, it is worth noting that analysis of hospital admission rates by the Nuffield Trust did not show evidence of reduction in numbers http://www.nuffieldtrust.org.uk/publications/harnessing-social-action-support-older-people
[x] See also https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/571471/changing_risk_cognitive_health_report.pdf
[xi] LSOAs are census-based areas with about 1500 inhabitants.
[xii] https://www.gov.uk/government/publications/cmo-annual-report-2015-health-of-the-baby-boomer-generation ; for the value of volunteering see also https://16881-presscdn-0-15-pagely.netdna-ssl.com/wp-content/uploads/2016/12/Evidence-Review-Community-Contributions.pdf
[xiii] NHS Choices website

Appendix B

AGEING WELL

"...inside every old person is a young person wondering what happened."

Terry Pratchett

Qualitative report 'Ageing Well'

Somerset: Our County

Joint Strategic Needs Assessment 2017

Contents

Introduction and background

Welcome to the 'Somerset: Our County Joint Strategic Needs Assessment' (JSNA) qualitative report on ageing well. The JSNA is a government 'must do' and is undertaken each year by our Health and Wellbeing Board.

We collect and analyse a lot of data for our JSNA about health and wellbeing. Equally important is the experience, observations and perceptions of 'ordinary people' – the human face of the JSNA - which gives context to the facts and figures.

We've talked to over 100 people, from different areas and walks of life to see what ageing well in Somerset means to them. As you might imagine, there is some good and some bad, with useful insight in-between reflecting real life about getting older.

We've been able to record a rich and interesting mix of views that ensures our JSNA is deepened by personal experience.

While this report was being written, AgeUK released a summary of its Index of Wellbeing in Later Life. It says, *"The most striking finding is the importance of maintaining meaningful engagement with the world around you in later life."* which mirrors the findings in our results.

Report structure

The report is a summary of all our qualitative work and includes individual comments that illustrate different perspectives; all the comments from each discussion group, interviews and engagement events can be seen in detail by clicking on the link in the 'List of Participants' on pages 2 and 3. Some views and opinions may seem obvious, but all are taken from individual experience and perception. This sort of insight is what makes a qualitative report so invaluable to our JSNA.

Feedback following circulation of the draft report to all participants indicated one group felt there should have been more emphasis of the effects of violence toward older people. Although this subject was not raised in discussion, it is a real concern to be acknowledged,

Methodology - What did we do and how did we do it?

We took an informal approach and looked at groups and individuals who might be interested in talking about ageing well. The majority of people were over 65; some were in their nineties, a scattering were younger and their views were equally valuable as they looked ahead to their own older age and also reflected on older people they knew.

We spoke to people whose experiences show marked differences in their own personal circumstances. We found people to hear from through a broad range of representative groups. We acknowledge a potential gap in talking directly to known ethnic minority groups and also members of the LGBT community.

All responses are anonymised.

We wrote a facilitator guide for the interviews and discussion groups and for the informal engagement work, we took display boards with three key questions:

- What helps people to age well
- What doesn't help people to age well
- What motivates you

List of participants

Below is a list with links to the detail of all the discussions. This is where to find the all the views and observations recorded as they were given.

- Four individual interviews

- Discussion groups with:

  - District and County Councillors
  - Priorswood Community Centre drop in
  - Priorswood Community Centre Scrabble Group
  - Members of Sedgemoor Older Persons' Forum
  - Members of the Somerset Engagement and Advisory Group (SEAG)
  - Members of the Service User Engagement Group (SUEG) – Social Care
  - Members of the Taunton Deane Borough Council Sheltered Housing Development Group
  - Members of the Burrowbridge Men's Shed

Engagement events with:

- Members of the University of the Third Age (U3A) and drop in at Burnham on Sea Active Living Centre
- Health Fair for the Over 60s at Junction 24

In addition, we are also grateful for a case study given to us by the Somerset clinical Commissioning Group with Age UK and case studies from the Community Council for Somerset (CCS).

Acknowledgements

Carrying out this work isn't possible without people prepared to take part and to give of their time and experience. A very grateful and sincere thank you is due to all the participants.

Thank you also to these key contacts for their support:

Ken Hindle (Burnham on Sea Community Centre), Pat Foster (The Care Forum), Angela Farmer (Sedgemoor District Council), Ivor Dixon (Men's Shed Burrowbridge) Neil Anderson, and Martin Price (Taunton Deane Borough Council), Lesley Thomas and Rebecca Vile (Priorswood Community Centre) Jill Downey and Sue Lilley (Somerset Clinical Commissioning Group) Kerrie Jones, Tim Baverstock, Nitin Sharma, Carolyn Arscott, Tom Rutland, Pip Tucker, Cllr. Ann Bown (Somerset County Council), Mandy Seaman (Compass Disability) Bethany Fear (Taunton Road Medical Centre), Nicola Thorne (Somerset CCG), Raj Singh (Community Council for Somerset).

Feedback is always welcome.

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1. Ageing Well Summary

1.1 **Social contact** (specifically in terms of face to face social contact through a wide and hugely varied range of activities) was the key link in all discussions and the overwhelmingly positive factor in people's mental wellbeing and for ageing well.

1.2 Conversely**, isolation and loneliness** are factors that significantly reduce a person's quality of life and reflect the importance of social contact and adequate transport.

1.3 **Transport** was a big, repeated, negative issue. Its availability, affordability and accessibility were just some of the barriers it created to ageing well.

1.4 Effective and timely **support**, health and social care when it's needed, community support and information about 'what's out there' help people age well.

1.5 The importance of opportunities for and the benefits of **intergenerational contact**. Many older people empathised with the younger generation and wanted to use their own experiences of life to help young people improve and sustain their own health and wellbeing.

1.6 **Media negativity** toward older people and in general is playing a part in making people anxious and fearful and to some extent frustrated.

1.7 **Independence**, personal resilience, being in control, good relationships (including with young people and pets) contribute to ageing well.

2. What does 'ageing well' mean to you?

This 'Wordle' below (a creative text programme) is created from comments from the Priorswood Scrabble Group – what does **ageing well** mean to you?

Other comments:

"A sense of independence and safety"

"A sense of community, being valued."

"Still using the skills, knowledge and experience you've gained working – into your retirement."

"Knowing that people need you."

"Not being lonely."

"Active Living Centres are excellent. I volunteer once a week. It's fantastic. You go home feeling you have actually done something."

Diet

2.1 Diet - not overeating, not eating late, keeping weight stable, home cooking or adding vegetables to ready meals, more fruit and vegetable, less junk food, eating less red meat (for some), the social aspect of eating with others, all

were seen as positives for older life.

2.2 Diet in **childhood** was considered by most to be healthier: more fruit and vegetables, often home grown and always home cooked, seasonal, smaller portioned and without the intervention of 'snacks'. Of course, for those who had been children during World War II and in its immediate aftermath, a lot of food was rationed, often scarce or unavailable.

"We couldn't eat too much of anything!"

"[We had] home cooking, home economics, we ate to survive, no processed food, had to make the best use of food yourself, no freezer no waste and we grew more [food],"

"….food was valued more, people knew about their food and how it was produced."

"Food was from the land, no processed food, you knew what was in it."

2.3 Also raised were the many **influences to changes in diet**; the invention of the microwave, ready prepared food, more choice of food (not always perceived to be a good thing) and food no longer being seasonal. Additional factors were linked to isolation or bereavement

"If you're isolated or lonely, you don't cook so much."

"Eating alone – there's not so much enjoyment so you don't eat so well and don't cook so much."

2.4 There were concerns about **changes to eating habits** generally *"There used to be time for preparation….[ ]….meals are now often refuelling rather than social occasions…",* the growth in portions and again, generally how much food is now available in supermarkets, and also how much is wasted when it is still safe to eat. However, one participant threw caution to the wind:

"Get past sixty; don't give a damn about what you eat!"

Exercise

2.5 Exercise featured similarly to diet, in terms of helping people age well; keep fit classes for older people, Tai Chi, swimming and walking; there is a strong link

with social contact and encouragement in many activities. The ability to exercise, naturally differed depending on participants' physical and mental health but was also influenced by the accessibility and cost of leisure facilities, transport and for some older cyclists, an increase in traffic.

"Walking to the community centre, walking in to town and around town…."

"Making a physical effort to do things [helps you age well] – walking, swimming, but more free activities would help."

"I would do a lot more if I had someone to do it with. It helps to have a kindred spirit to motivate me."

"[ ]....now there is a proliferation of cars and computers."

2.6 Some exercise and physical activity in **childhood** (and indeed for many adults at that time) seemed to just be a 'part of life': walking to get to school and back and in one case, to the GP - a four mile round trip. Sport was described as 'seasonal' with summer and winter sports on the curriculum, as much of it took place outside. Cycling, games, swimming, *"running after boys"*, music and movement, climbing trees, hockey, tennis and cricket were some of the activities mentioned and, as children playing outside, without a perceived sense of danger.

"There was no fear about going out to play…."

"[We were] always encouraged to go outside and I carried this on with my own family."

Leisure activities

2.7 Leisure activities such as cooking, gardening, growing vegetables, dancing and groups with specific interests like drama, books, scrabble, history, social singing, walking, swimming, postcards, community groups within Sheltered Housing, Tai Chi, art, music, U3A, Active Living Centres, the church and learning new things were felt to have a very positive influence on health and wellbeing. Additionally, intergenerational interaction, campaigning, volunteering, and the Men's Shed (which involves men across all age groups) were all spoken about as beneficial.

"….having the freedom, as a volunteer, using your own experience, saying things that others want to say but can't…."

"Having a purpose, especially in retirement when you have lost your connections at work. Volunteering [is important] but some people just don't get it. Volunteering gets rid of stress."

"Being with other people helps you go out at night – and things being organised for you, in groups."

"I have not got time to be ill if I come to the [Men's] shed."

2.8 The biggest influence to giving up hobbies and pastimes from earlier life appeared to be marriage and having a family, where time pressures meant they were difficult to pursue.

2.9 At the Men's Shed it was felt there was a gap in activities for men in the 40 – 60 year old age group and that the needs of this group were not being recognised. Additionally, it was perceived that a lot of activities are based around or associated with alcohol (such as skittles and darts) and that there should be more places for men to meet to chat and have tea or coffee.

Transport

2.10 Transport plays an important role in enabling people to take part in activities and to socialise. Without someone to provide a lift in their car, many would be (or are) excluded, particularly if an activity happens to be in a rural area. This was an issue raised over many discussions across many different aspects of older life and was very much associated with the risk of loneliness and isolation.

"Transport [is]…not afforded the level of importance it should be."

"The lack of transport isolates people – you might be able to get one way but then you can't get back! It goes against the drive to alleviate loneliness."

"There is a lack of accessible infrastructure for people who don't drive."

"If these [transport] issues were addressed, we would age well!"

"There are many disabled people who are stuck out in villages – community transport looks good on paper but you have to book a Slinky bus two weeks in advance."

"….it's a problem that community transport runs along district council lines – if you need to cross over into another district on your journey."

Technology

2.11 Access to and use of 'technology' (such as computers, laptops, Smart phones etc) was a mixed bag overall and not dominant in conversations but in terms of ageing well included computers being used to Skype friends and family, send emails, play computer 'brain games', make GP appointments online, shop, look for information and book travel. One participant said, *"Life would be very difficult without it."* but in one group (of 12 people), less than half used technology – a lack of access and training being key barriers.

2.12 The increasing expectation of and reliance on **being online** was a concern; some feeling pressured to access services digitally and then "pushing the wrong button", particularly with banking. It highlighted the continuing importance for personal contact with different services – including banks and post offices and also supermarkets, where automated checkouts are perceived to be on the increase.

"There is an increasing need for people to use computers – [1]Digital by Default, banking online, whether they want to or not."

"Everyone is an individual – confidence helps people – digitalisation does not include people."

"People will see the perils of technology and things will level out – and they will come to enjoy being outside again….."

"Computers are a means to an end."

Employment and retirement

2.13 Employment and retirement was explored in more detailed in the individual interviews however, it was a thread in most discussions affecting perspectives, activities and circumstances in both positive and negative ways around ageing well. One participant referred to discrimination:

"Ageism in the workplace; if you lose your job and you are over 50, it is very difficult to get work",

[1]The **Digital by Default** Service Standard is a set of criteria for **digital** teams building government services to meet.

Another participant referred to extended working: *"Late retirement has an impact on jobs for young people."*

Other comments included:

"Thinking positively, keep talking to people who are working, after you retire."

"Losing your job can take away your identity."

"A lack of funds [in retirement] – you don't have the funds that you thought you would."

[Being a councillor] "You need passion, a caring attitude and to want to make a difference each day."

"Being a parent was a full time job and I was happy to do it."

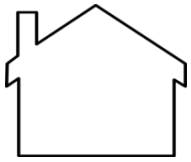
2.14 Although the majority of participants (but certainly not all) were retired, it was obvious that although work connections were often lost and in many cases money was tight, most were involved with other activities such as the University of the Third Age ([2]U3A), volunteering, Active Living Centres, community groups, older persons' forums and Men's Sheds.

2.15 It was interesting to hear about how some participants from outside the county had holidayed or been billeted in Somerset as children. This experience had influenced (for some and their families) a move to Somerset in retirement. A familiarity with the area helped them settle more easily in to local communities.

Housing

2.16 Housing in childhood was often described as 'cold' in the winter but this was considered to be healthier than the perceived trend for overheated houses today. One participant's home (interview) was bombed during the Second World War, a relative's home they moved into was also bombed and at the third relative's house they moved to, bombs fell on the garden.

2.17 Participants living in **sheltered housing** (overall, positive about sheltered housing schemes), voiced several concerns including withdrawal of an internal phone system (leading to isolation), the installation of a communal computer without training for



[2] University of the Third Age 'Retired and semi-retired people come together and learn together, not for qualifications but for its own reward'

residents, a lack of support to staff, loss of general maintenance and the potential consequences of reduced public sector funding.

"Maintenance not done in the short term, just costs money in the future."

2.18 Some people felt there was pressure growing for older people who owned their own homes, to down-size.

"'Downsizing is becoming a phrase that says this is something you <u>should</u> do."

"[It] depends on the length of time in a house. Your house is an expression of who you are."

"It ages you when you move…it puts two and a half years on your age if you move once in your 70s."

2.19 One participant had changed a garden area to be low maintenance which enabled her and her husband to go out more and also reduced the need to move.

2.20 Many felt there wasn't adequate housing for older people to move into anyway and more could be done to keep older people in their own homes. Some housing schemes do not allow older people to take their pets and this was considered to be detrimental to ageing well.

"[There is a] lack of choice of housing for older people – people who sell may be prepared to pay more for a bungalow but the focus is always on the bottom line."

"More could be done to help older people stay in their homes – free solar panels, examples like the new hospital at home and equipping homes properly."

"…when you take a dog for a walk….you aren't just taking the dog out. Having a pet keeps you alive. A pet is a friend."

"[Older people] need to weigh up the cost of paying for help at home versus the cost of a residential home."

Caring

2.21 Becoming a carer can be a common feature of ageing just as needing to be cared for can be. Caring responsibilities are demanding at any age but for people who are older there are more often existing concerns about their health and how they can be sustained to keep providing care at home.

"Look after the carer or you will have to look after two people."

"My husband has to stay well to look after me. But [his caring responsibility] puts his health at risk."

"Older carers have a much tougher time [as it is so physically tiring]."

2.22 For one participant who had been a carer to her husband some years ago, the support she received from her GP and social services made such a positive difference she volunteered at the facility where her husband received respite care, after he had passed away. *"Planned respite before crisis is so important."*

2.23 Other participants with caring responsibilities spoke of feeling isolated, tired and unsupported.

"There's not enough time and not enough carers – this feeds back on family carers."

"Carers and people with mental health problems need more community support and different sorts of community support."

"People with dementia should be looked after as a unit with their carer."

"Care homes should take people for night – to help carers get some rest – or take them together."

"[There is] increased stress with caring for someone who has dementia – makes you defensive all the time, there's no let up….you become run down, getting ill…."

2.24 Some, including those in extra-care housing, shared concerns about additional costs and the lack of time **paid carers** had to do their jobs.

"[Time] is not just an issue in the community, [it's] also the case in extra care housing."

"*An elderly person in the scheme wanted a newspaper and was told they would be charged £5.00 by the care company for this."*

"The time paid carers have with patients [is an issue] and not enough care assistants in the community. Community care is fine in theory but not practically."

2.25 Some mothers and carers in the Service User Engagement Group felt they were able to get valued time off when the children or cared-for adults took part in sporting events.

2.26 Additionally, there was the challenge of resuming a 'normal' life if the caring role came to an end.

"Rebuilding confidence after being a carer. Caring is like being in a bubble – going back to your own life – it's a big change over."

Attitude and personal resilience

2.27 Attitude and personal resilience was a factor in many conversations and strongly influenced the way individuals reacted to different circumstances. Personal resilience was sometimes influenced by childhood, upbringing, faith or relationships. Interestingly, one participant observed,

"Peers can judge you for taking up help. It can be perceived as going against the self-reliance ethic".

Others commented:

"Mental wellbeing – looking forward to the future – there is a lot of adverse publicity – you have to be optimistic."

"Children were <u>known</u>. Being <u>known</u> in your community gives you a stronger identity. Behaviour was monitored [by neighbours and other people in the community] in a protective way which leads to a positive mindset, which leads to resilience."

"When my parents were in their 70s they were old. We under estimate how young we feel. Now in our 70s we do not feel old."

"The war taught you no matter how bad things were, there were always positives. The attitude then was defiant but also fatalistic."

"I am a positive person."

"[Councillors] need passion, a caring attitude and to want to make a difference each day."

Family

2.28 The support of family and friends, the presence of grandchildren and wanting to watch them grow up provided strong positives for some to ageing. Being able to pass on knowledge and experience to the younger generation generally was also considered important.

"[It's a] good idea for older people to go into schools – having a two way conversation about 'life'."

"[There is a] loss of family units and a lack of connection to grandparents. So much begins at home, teaching practical skills to the very young."

2.29 A lack of family (for whatever reasons) was, of course, also reflected in discussions, some finding life harder and feeling anxious as they got older when did not have any relatives. Changes in family structure played a part, illustrated by a younger participant with children.

"Pressures on young families are different – and have changed – we can't look after parents anymore."

Communities

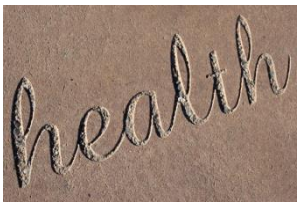
2.30 Voluntary community support is a valuable and <u>valued</u> asset in the course of ageing well and a lack of it was perceived to increase isolation. Many participants volunteered in their communities or were active in community groups (eg. in sheltered housing or through pastoral care, outreach and community centres), providing comfort and conversation, once again, emphasising

the importance of social contact.

2.31 Community services were felt to be under-resourced (see also paid carers - 2.24) and financially under threat. With more reliance on volunteers, ensuring they can be most effective needed planning. *"Infrastructure for community services needs to be taken into account – libraries etc – volunteers need IT training etc."*

2.32 Across both community services, support and networks 'knowing what's out there' was considered very important and some people had found support just by chance. *"I found out about [the Men's Shed] through Points West."*

Health services

2.33 

The NHS**,** but most specifically GPs, were mentioned in some conversations but in terms of ageing well, perhaps not as much as would have been expected. Getting information from GPs about support networks, a perceived over-reverence toward GPs by some older people, feeling rushed during a consultation, problems with access to GPs, having a named GP *"…the person you know"*, a surgery closure in a village, a GP with a dismissive attitude (from a participant in the Service User Engagement Group) but also the benefits of having a helpful GP, were all mentioned.

"….some GPs understand the wide range of your needs; others do not. There's an 'I'm all right, Jack' attitude amongst some. They don't want to interact with you at all. There's a lack of conversation in the world."

"…..the NHS is a complex bureaucracy, a system that functions too rigidly. People need to know how the system works in order for it to work for you."

2.34 Transport featured (again), such as difficulties with access to buses for some people who were disabled or had a sensory impairment, having to make two separate trips to get to the district hospital by bus from Street and Bridgwater and no bus service direct to a GP surgery available from Monkton Heathfield (near Taunton).

Independence

2.35 The importance of being independent combined with the need to accept limitations as we age was a thread in many discussions. The need to

balance a freer personal life with having have the 'right' help and support when it's needed ; to *"not be overwhelmed by illness"* but looking at what can be achieved, however small, played a positive part – particularly for mental wellbeing. Again, one of the key factors in striking this balance links to social contact.

"Having a sense of control over something."

"[there are] negative expectations of 'being old' – from family and well-meaning friends."

"Too much being done for you, a bit of help yes, but more encouragement is needed."

"The need to come to terms with the fact you can't do things for yourself."

[The care worker said]…"I'm here to help you get dressed, but what can you do?"

Isolation and loneliness

2.36 The threat and effect of isolation and loneliness as a barrier to ageing well came up in many conversations but was acknowledged as not just a potential problem for older people.

"It is very easy here not to see anyone all day."

"There can be heavy social penalties for people who move nearer their children – it can be difficult."

[Isolation] *"Not having people to encourage you."*

"Some people can resist contact with others, you feel you have nothing to say."

"[An] increasing lack of community – affects isolation."

"Loneliness for your own age group, which can be across the board."

"Isolation [is] made worse by lack of transport."

"Being unwell makes you isolated."

Bereavement

2.37 Throughout all the conversations, those who were in relationships had a reliance on and appreciation of their husband, wife or partner. Bereavement therefore had a powerful negative impact and could contribute to becoming isolated and lonely, one person referring to her *"shyness and isolation"* after her husband died.

"The hardest part of making contact with others after bereavement is 'going through the front door'. A lot of people can't do that."

"It's completely on you [to make contact after bereavement]. *Health and care services don't help. You need friends and family to persuade you to go out."*

"I've not been on holiday since my husband died."

Media

2.38 Media negativity**,** interestingly, was a recurring theme in discussions. There were references to the influence the media has on negatives attitudes to older people and also to a perceived increased fear and anxiety in the young.

"I'm fed up with older people being blamed for the woes of the health service. Older people know about self-care!"

"[the] media makes people live in a state of fear now – when we were young we were wary, yes, but not fearful."

[the importance of] *"mental wellbeing – looking forward to the future – there is a lot of adverse publicity."*

"There was no fear about going out to play – there is an atmosphere created by the media when most people have children's interests at heart [and] also negativity from the media about young people…..[ ]."

"The media divides us." [generations]

2.39 A collaboration between Bridgwater Senior Citizens Forum and Somerset Film called "In It Together", based at the Engine Room, Bridgwater aims to counter the myths about conflict between generations, through discussion, songs, music and poetry.

Motivation

2.40 In discussions about what motivated participants there were many different responses:

"Observing other people who are <u>not</u> ageing well."

"Having grandchildren, wanting to watch them grow up."

"You have to cope and not give up!"

"Wake up with a smile, something to look forward to."

"Having the courage to think 'If I don't do it now….."

"The thought of coming to the [Men's] Shed, to do something that is valued and has a purpose."

Young people

2.41 Some discussions included a question about what young people could be doing now, to help them age well further down the line. There was concern about a lack of physical activity and being overweight in some young people, over-reliance on technology, damage to mental wellbeing and growing levels of personal debt, young people needing to learn 'to live within their means'.

2.42 Many participants talked protectively and empathetically about young people *"Don't apologise for where you come from or who you are."* and demonstrated a great willingness to be involved in sharing knowledge and experiences with them to help better (both) generations' lives. There was often concern that these opportunities were being eroded or lost.

"There are a lot of good kids and we need to expand on the positives about them."

"[there is] significant pressure on young people, like league tables in schools, social media, the 24/7 economy."

"Sowing educational seeds of practical skills when children are young [is important]."

"Young people's lives are not entirely in their control – there are too many assessment regimes within education and too many adults on their backs."

"Young people should be given the opportunity to look after an animal – to have that responsibility and fun."

"The world is changing – it's important to be in touch. We're the last generation affected by war. People now have no model of what war-time life was like."
"There is a 'expect everything now and not save for it' attitude that leads to debt."

"Curb the need for better and bigger things – [and by curbing this] to have quality of life."

"[there are] not enough places on apprenticeships and many can't afford to finish the courses."

"Higher expectations and pressures are making some young people unhappy – leading to mental health problems."

"There is a more transient lifestyle now [for young people] – more travel, they don't settle like their parents did – and don't have that 'platform' to come back."

"Protect the individuality of young people – [there is] too much pressure on them to be the same."

'Anything else?' Additional comments:

2.43 *"I am a person and I have a place in society – you can't box people."*

"Don't assume people want to do things or aren't doing things they enjoy – respect their point of view."

"Parents [are] more compliant in providing what's expected by their children [in terms of branding], *afraid to say "No" – healthy neglect wouldn't be a bad thing."*
"The earlier you stop bad habits, the better it is for you in older age – and don't pass poor lifestyles on to your children!"

"People do tend to look back on the good, but wouldn't want to necessarily relive childhood and adolescence."

"Older people mix with older people – they have the same sort of memories."

"[People] mustn't just see the outer shell – but see all the experience an older person has in them."

3. Conclusion

3.1 These have been wide ranging and interesting conversations illuminating the lively positives of ageing well and reflecting on the difficulties and problems that can come in older age or indeed, throughout life.

3.2 A participant finished one discussion with the words "*Old age is a bugger*" but the insight from this engagement highlights the reason why there needs to be an emphasis on prevention (in public health terms) to help us have better health and wellbeing later in life.

3.3 Attitudes toward younger people were, in the main, positive and supportive. A film collaboration like "In It Together" (which brought together members of the pensioner and youth communities in Bridgwater, to explore perceived generational differences) is a good example of how well younger and older people can work together. Intergenerational activities should be encouraged and celebrated as a way to improve wellbeing and harness valuable experience.

3.4 In the design of services for older people and the work in preventing ill health and sustaining wellbeing as we get older, the importance of social contact is paramount.

3.5 These conversations illustrate this importance and the infrastructure that's needed to maintain such a key element to ageing well – transport, community support and activities, training to be able to use a computer, paid carers saying more than just "Hello" – differences that often aren't expensive and make a real and positive difference.

3.6 The importance of social contact also has implications for social prescribing (where some patients are referred for community support to help their wellbeing) and is an area Somerset Clinical Commissioning Group (CCG) has referred to building on in its Sustainability and Transformation Plan (STP).

Ends

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AGEING WELL

Somerset: Our County Joint Strategic Needs Assessment (JSNA) 2017

Pip Tucker – Public Health Specialist

Jo McDonagh – JSNA Project Manager

SOMERSET'S JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2017

Q. ***What is it?***

A. A statutory obligation so it's a 'must do'

Q. ***What does it do?***

A. It looks at the health, wellbeing and social care needs of the *whole* population = data/qualitative

Q. ***Who is it for?***

A. Ultimately, all of us….it's primary function is to inform commissioners

AGEING WELL

"...inside every old person is a young person wondering what happened."

Terry Pratchett

AGEING WELL

Informal engagement (3)

Individual interviews (4)

Discussion groups (6)

Over 100 people involved

AGEING WELL

Burnham on Sea Active Living Centre

Priorswood Community Centre

Taunton Deane Sheltered Housing Forum

Service Users' Engagement Group (social care)

District and County Councillors

Over 60s Health Fair at Junction 24

Somerset Engagement and Advisory Group members (CCG)

Sedgemoor Older Persons' Forum

The Men's Shed – Burrowbridge

+ four individual interviews

AGEING WELL

What does ageing well mean to you?

- *"I want to **feel** well. I'm not worried about looks."*
- *"Still using the skills, knowledge and experience you've gained working – into your retirement."*
- *"A **feeling** of good health but also accepting your restrictions……."*
- *"A sense of independence and safety."*

Having a purpose, having a sense of community, feeling valued

AGEING WELL

What helps people to age well?

- *"Community support or asking for help through support networks – feeling you can **do** that."*
- Laughter, sharing common interests, walking with other people
- Having the basics in place: heat, light, food, transport, companionship…."*and hugs…"*
- *"Just having somewhere to meet and chat with people."*

Socialising, community, personal resilience

AGEING WELL

What motivates you?

- *"An attitude of mind, **wanting** to do it."*
- Observing other people who are **not** ageing well
- Having grandchildren and wanting to watch them grow up
- The presence of husband/wife/partner
- Having something to look forward to…..

Keeping busy, taking an interest, family and friends – stimulation

AGEING WELL

What doesn't help people to age well?

- Bereavement/loneliness
- Caring responsibilities
- Transport (a key issue)
- Negativity of media – across all generations

*("When we were young we were wary, yes, but not **fearful**.")*

Social and physical isolation, lack of confidence, negative media

AGEING WELL

Some additional points:

- Ageing referenced in terms of disability – *"Someone with Down's Syndrome may be 'ageing well' at 37."*
- Housing for older people not allowing pets – *"….having a pet keeps you alive. A pet is like a friend…."*
- A sense of 'blame' (again media driven)…..e.g. pressures on the NHS, not downsizing/moving, generational conflict

Implications for Commissioners

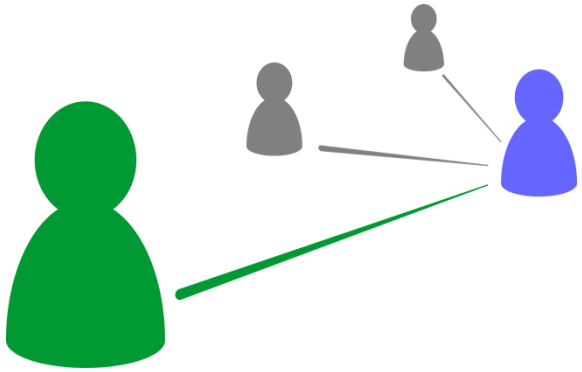
Promoting good health

- 45% of disease – including dementia - can be prevented or delayed by lifestyle
  - not smoking
  - drinking responsibly
  - good social contacts
  - eating well
  - exercise
- There is no age after which improvements do not help.
- Inequalities were very evident. Addressing them will reduce suffering and save money.

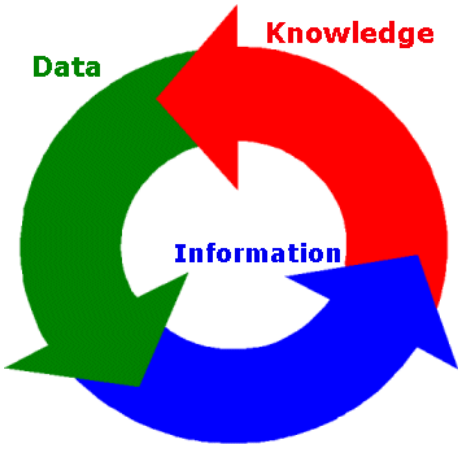
Connected and independent

- Self-help and short-term assistance to regain independence were commended.
- Recognizing the contribution and needs of family carers and the community could bring benefits to all.
- Good transport helps independence and social contact in town and country.
- New housing should take account of ageing and existing stock be adapted accordingly.
- Good work, including voluntary, is good. Employers should recognize older workers' contribution.

AGEING WELL



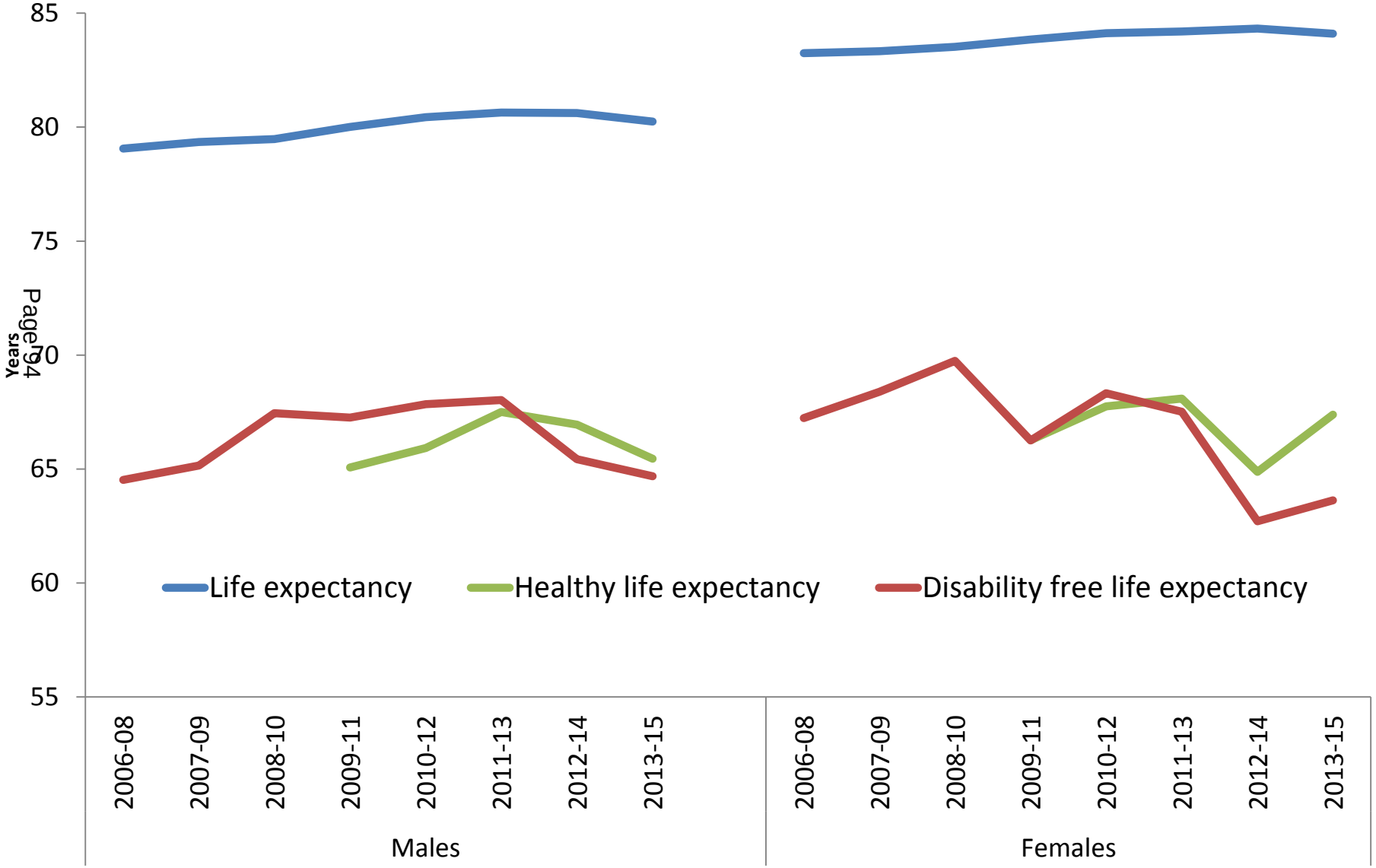
What the data tell us……



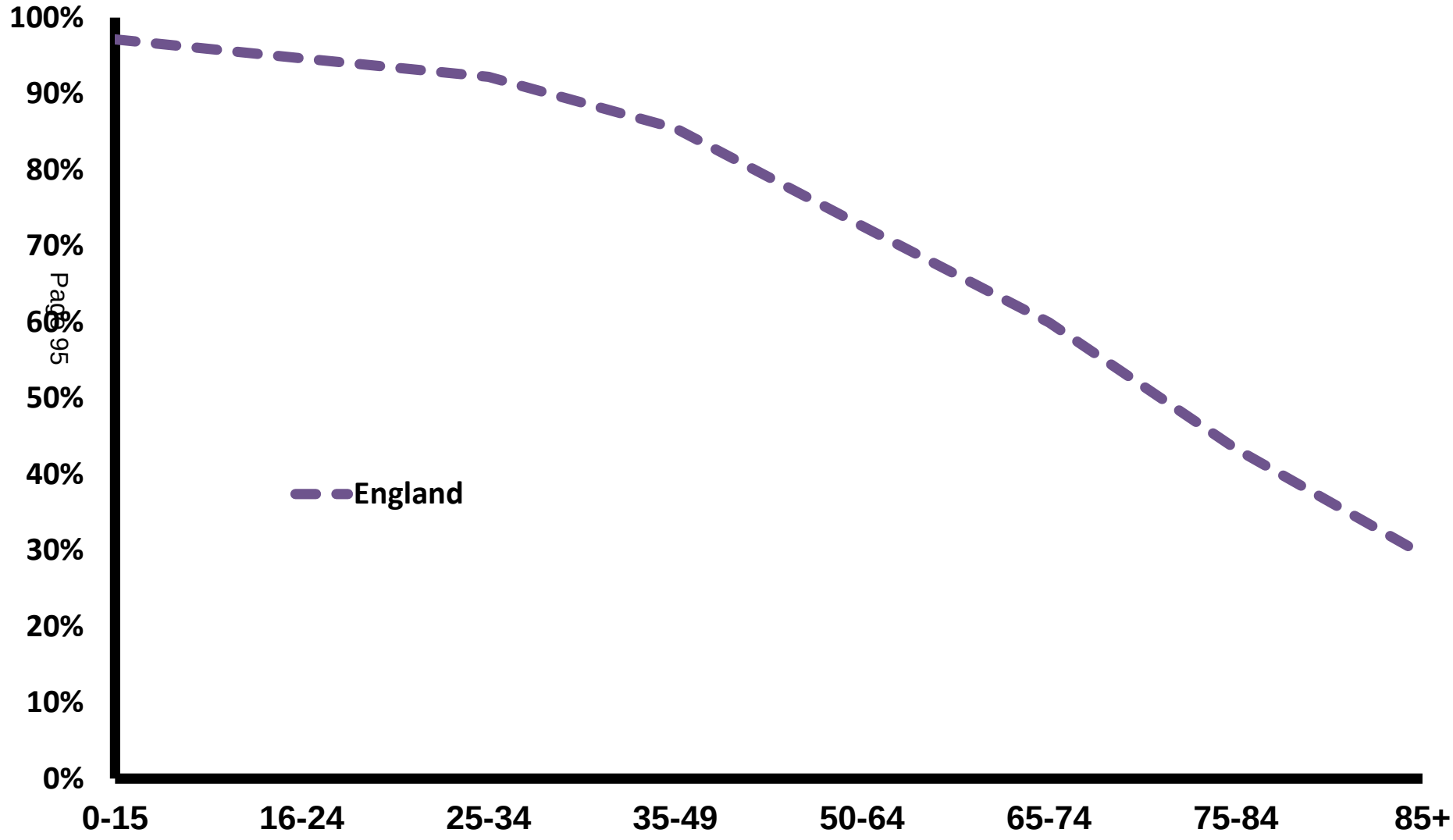
Healthy

Connected and independent

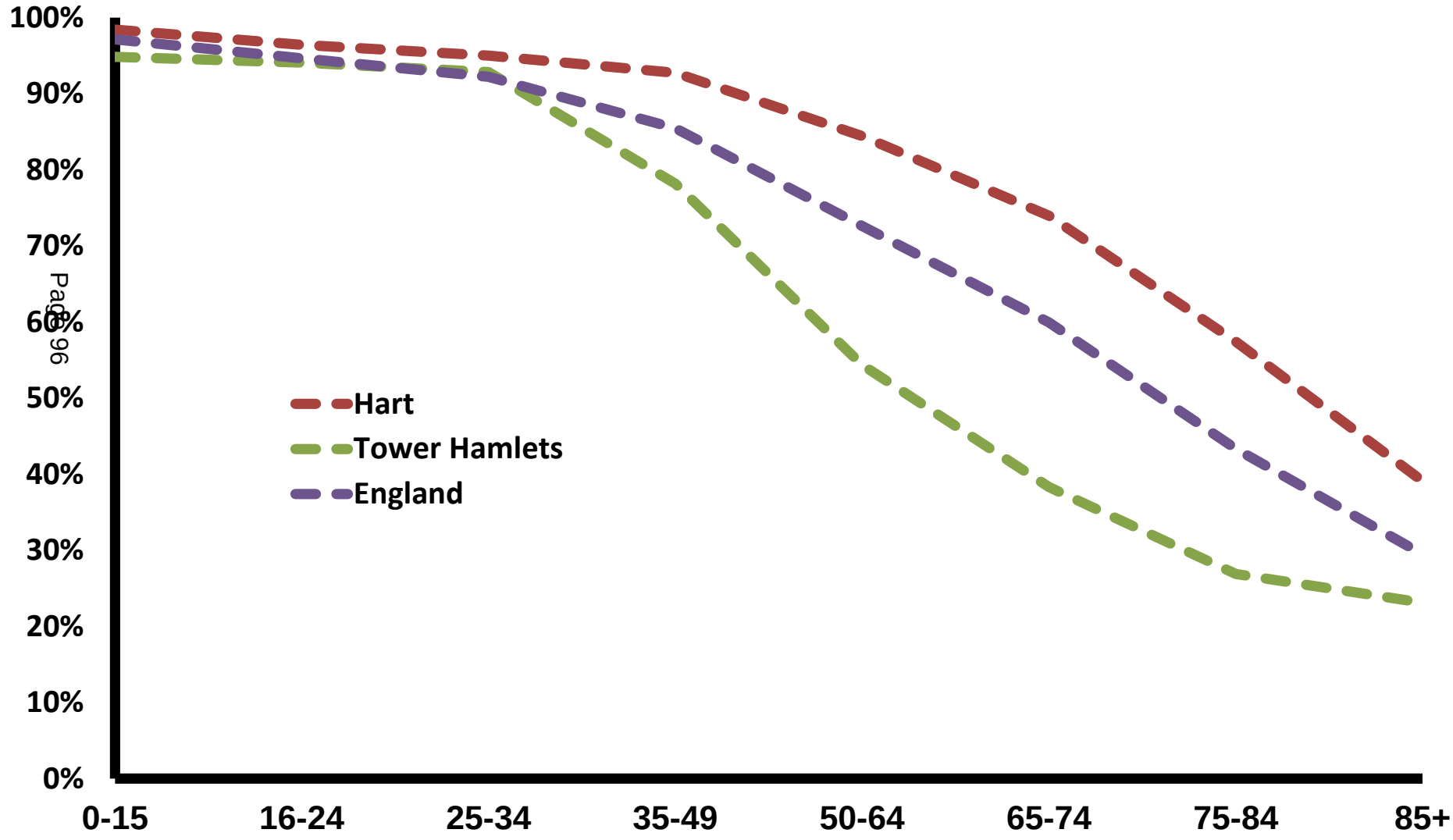
Healthy Life Expectancy - Somerset



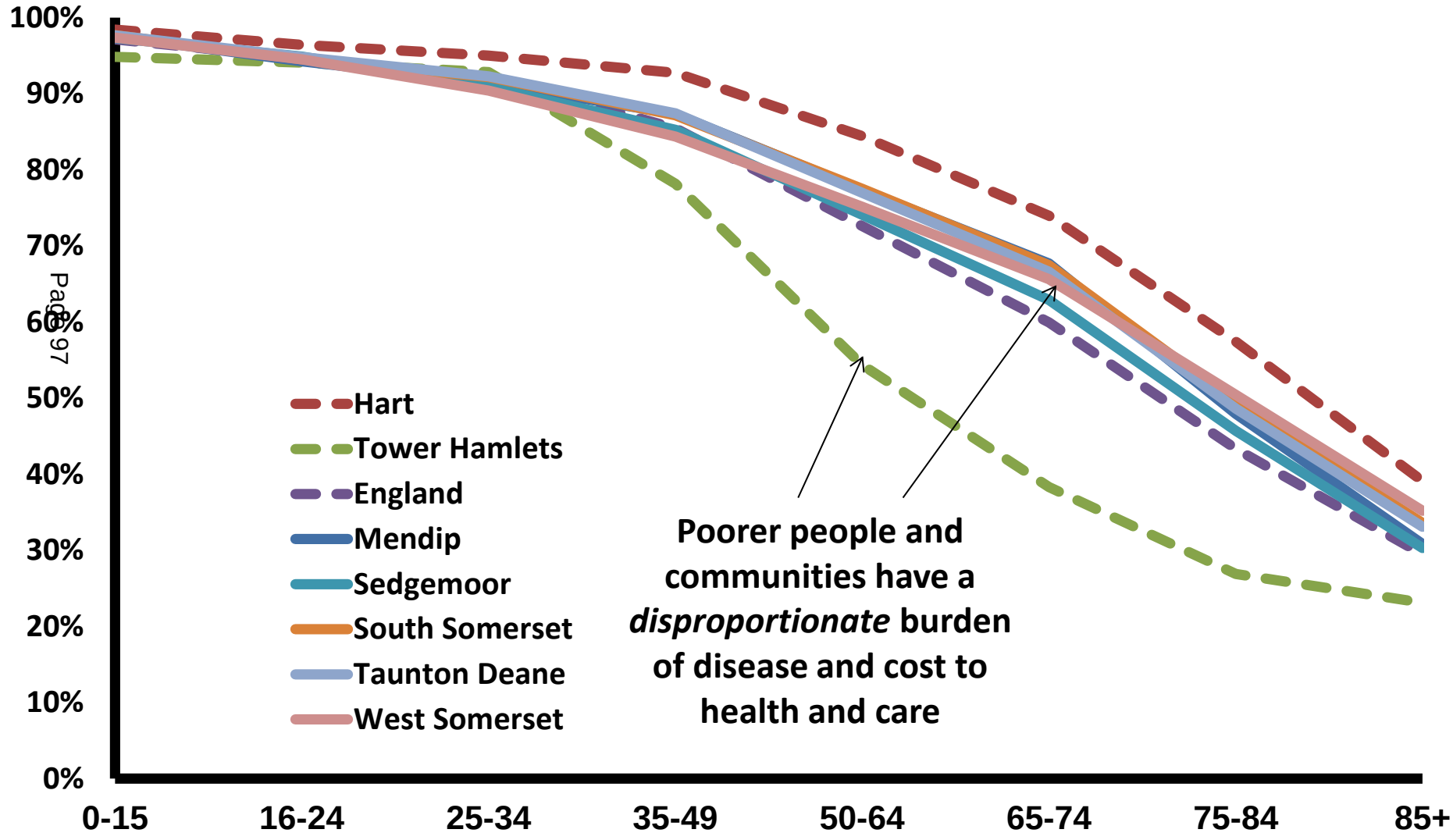
Self-reported ‘Good health’



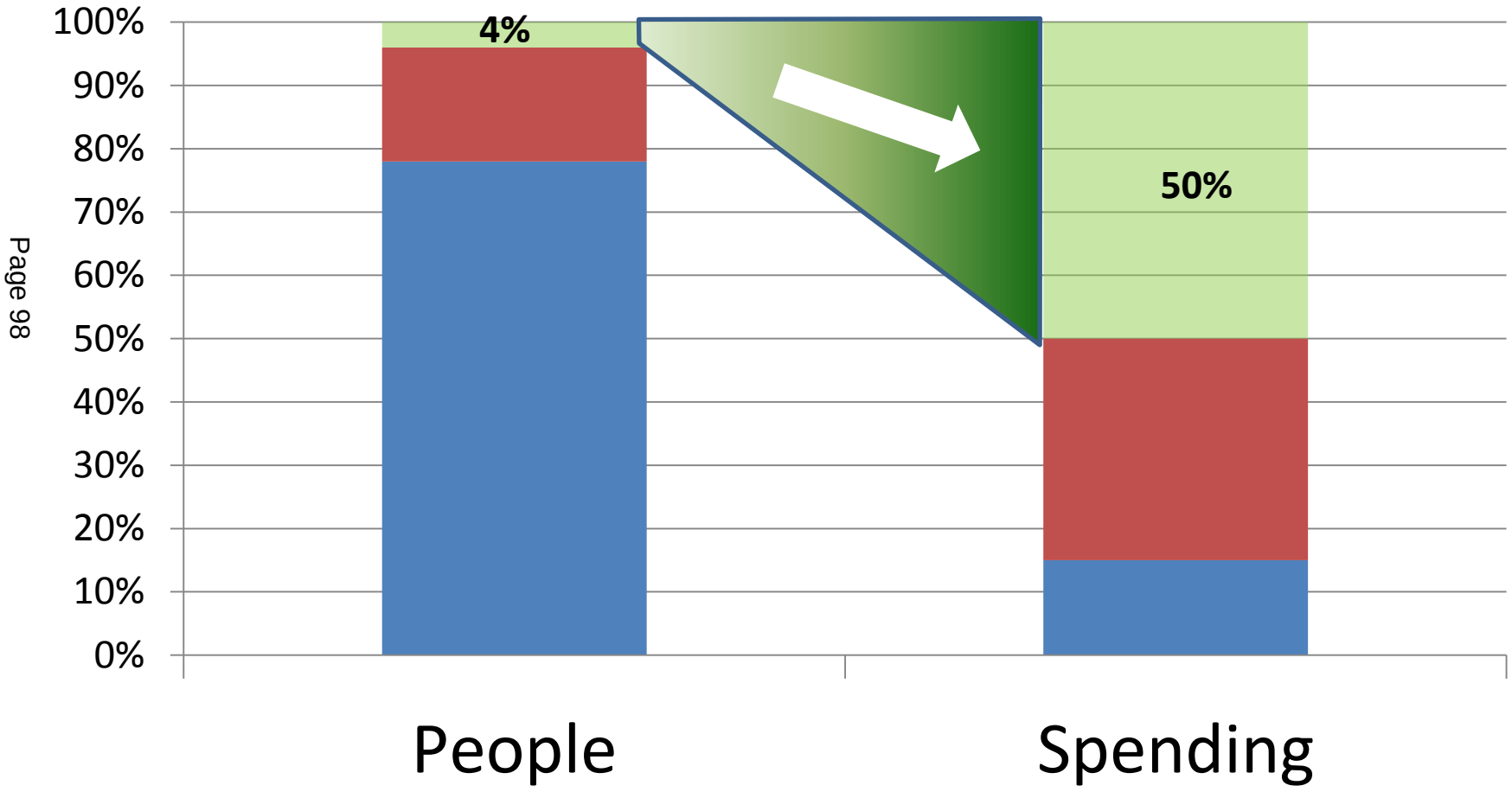
Self-reported ‘Good health’



Self-reported ‘Good health’

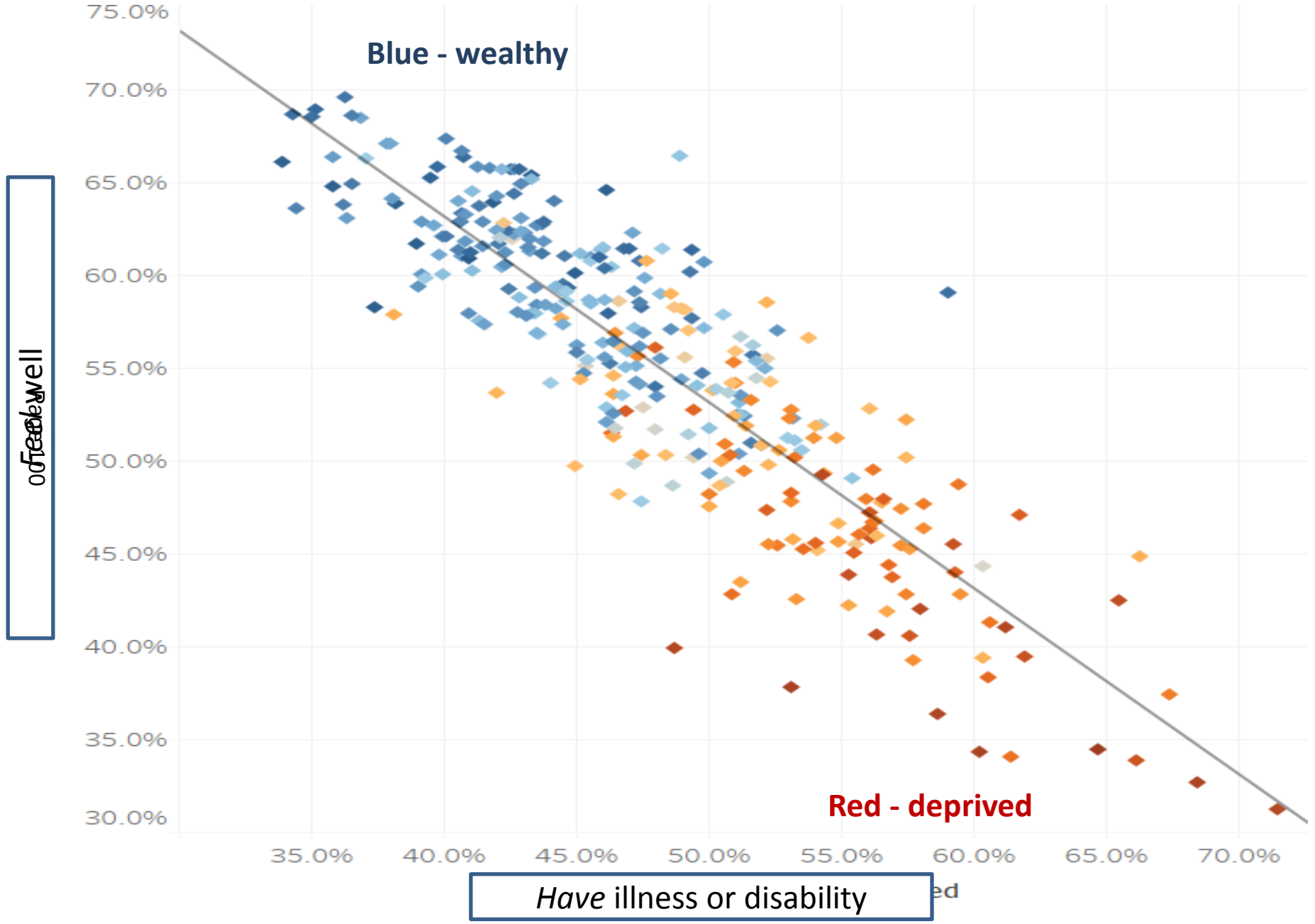


Health and Care Spending (Symphony data)



Healthy (communities)

Connected and independent


Blue - wealthy
Red - deprived
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
35.0%
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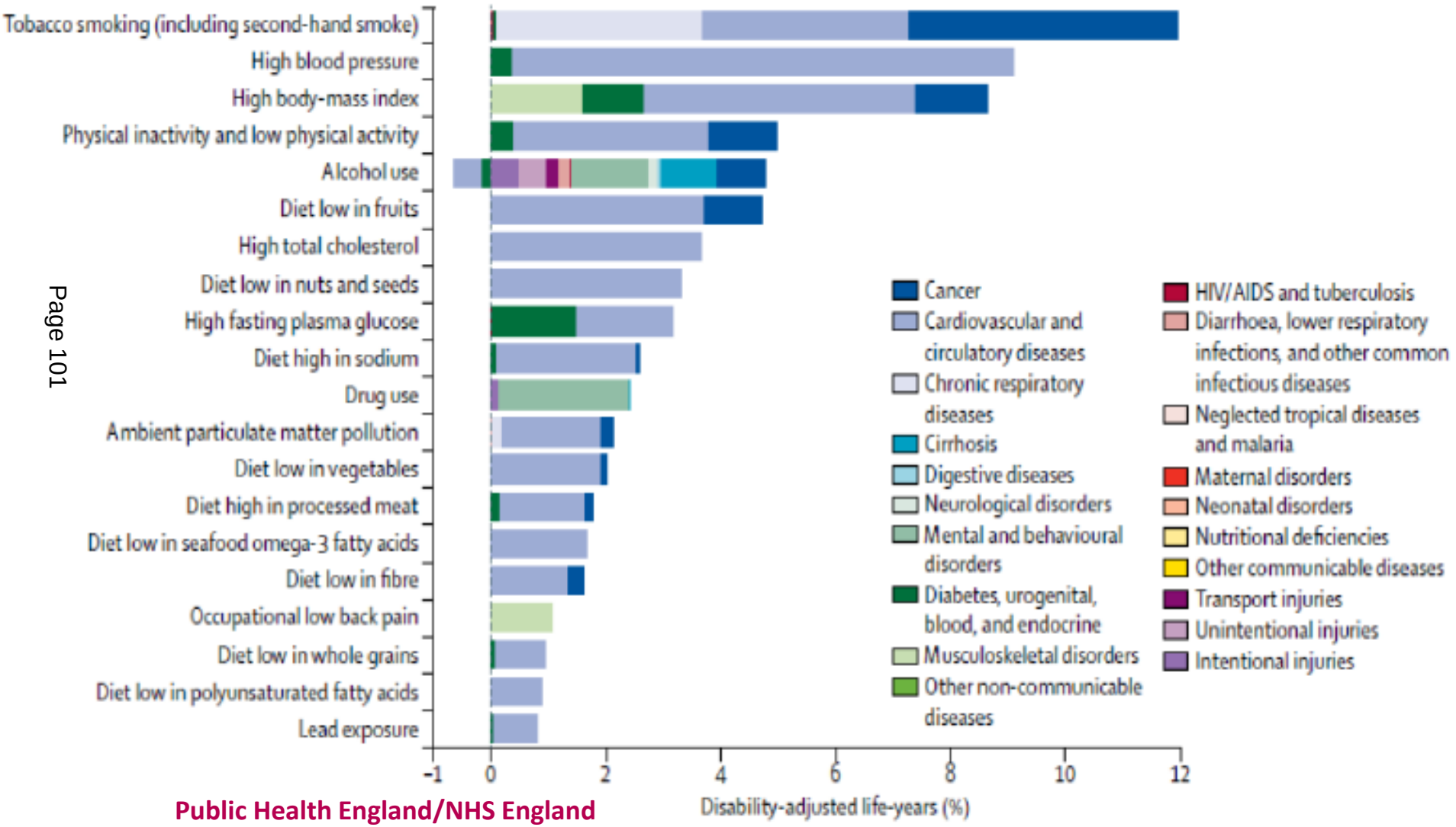
60.0%
65.0%
70.0%
Feel well
Have illness or disability

What to prevent?



Public Health England/NHS England

***A call to action: commissioning for prevention* 2013**

PREVENTION

Diet

- *No junk food, cook your own*
- *During the war we had a limited diet, but wholesome. Food was from the land, you knew what was in it*
- *Eating smaller, healthier meals, 'but I am terrible sometimes, I binge on chocolate!'*

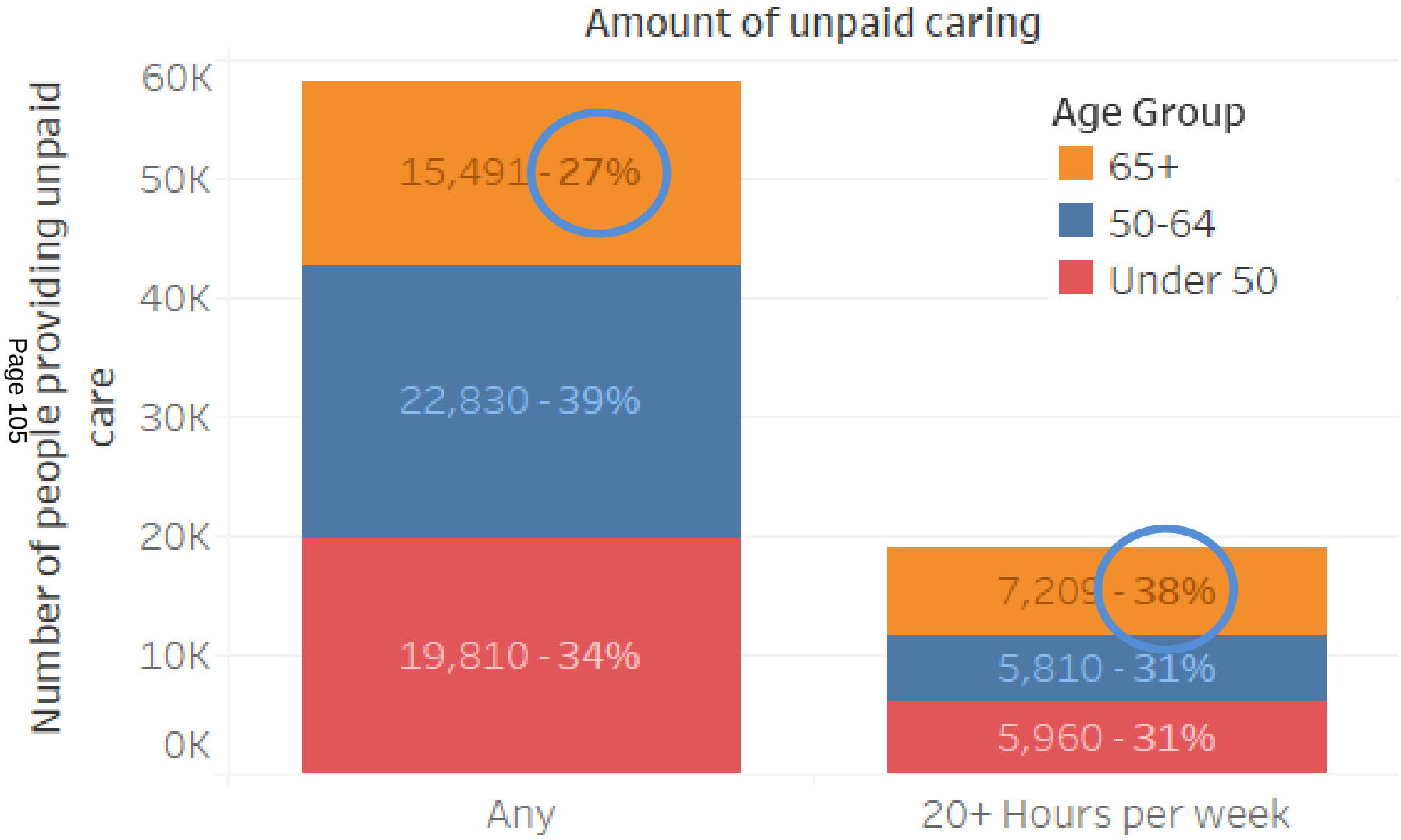
Healthy

Connected and independent

Healthy

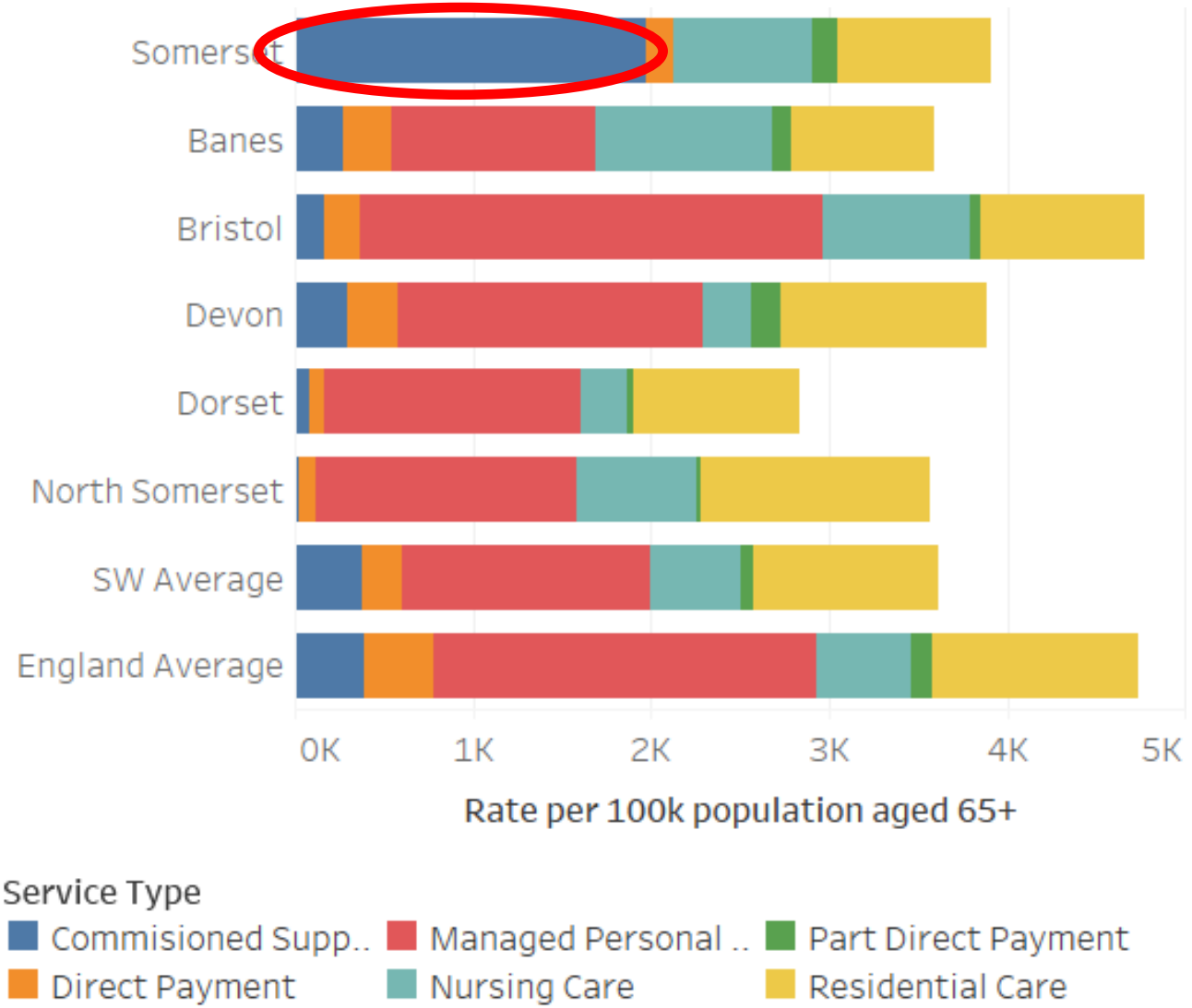
Connected and independent

Caring responsibilities



Source: ONS Census 2011

People 65+ receiving long term support at end 2014/15



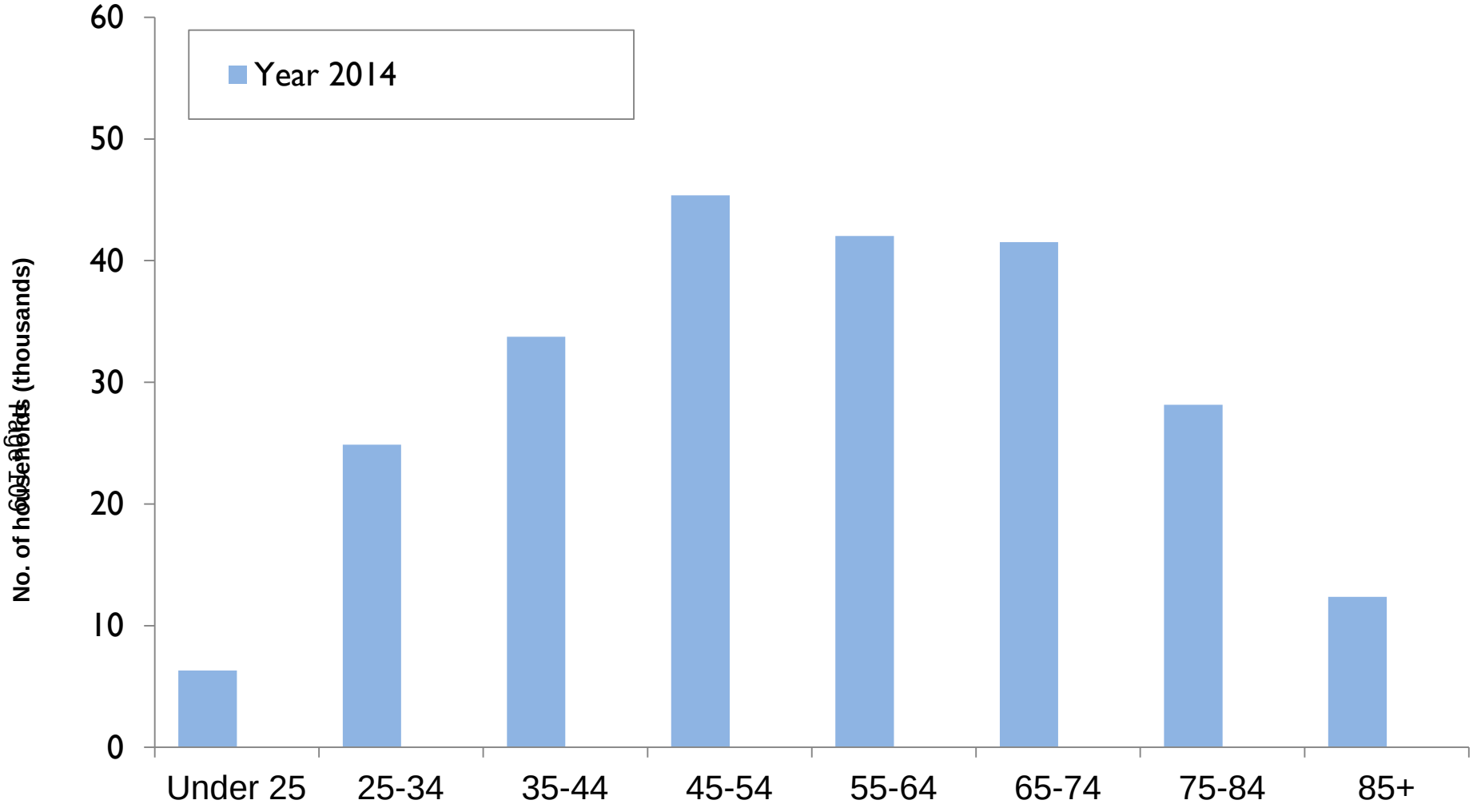
COMMUNITY SUPPORT

Grace, 80 – Martock

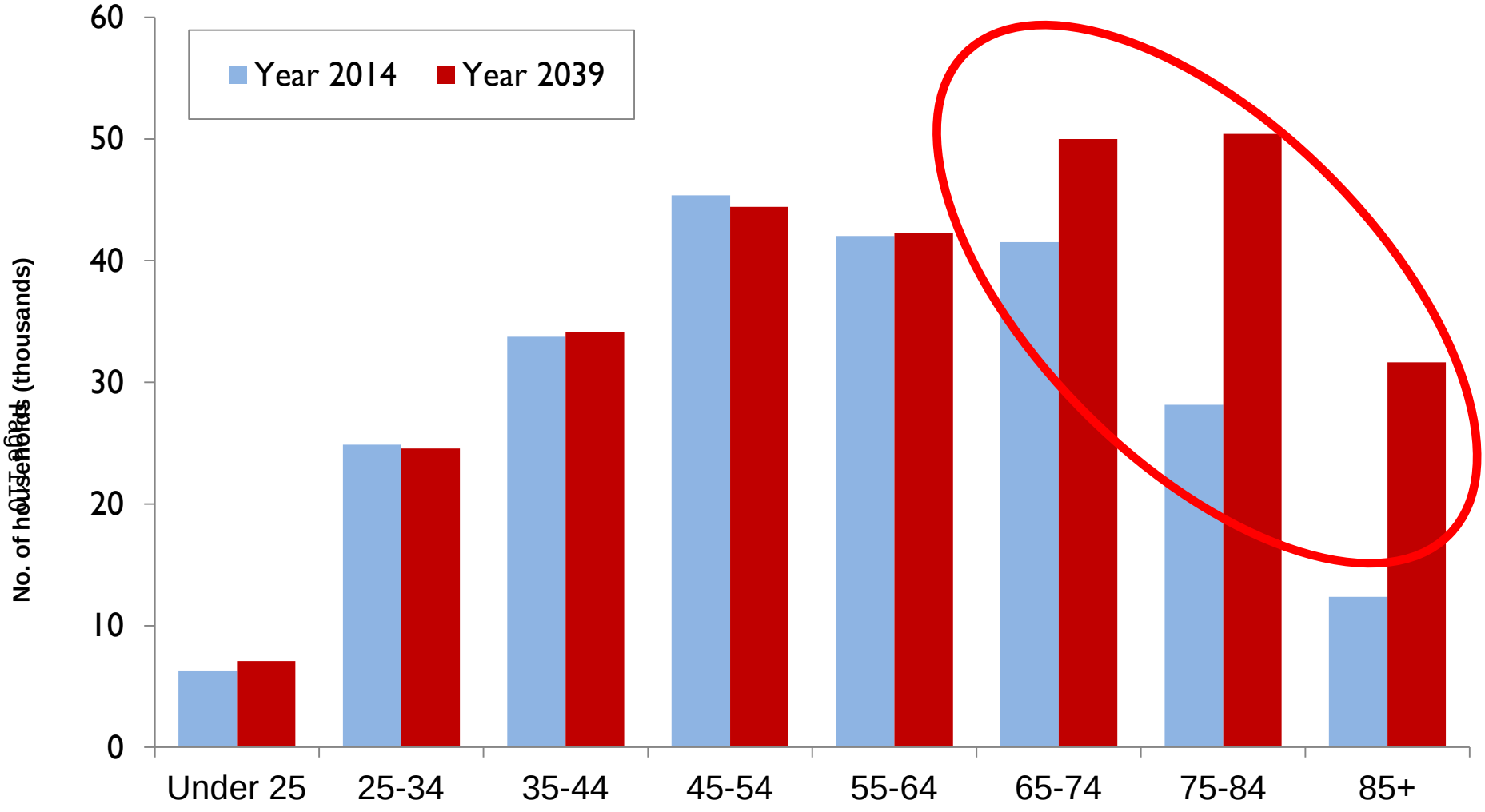
- She fell and spent time in hospital. Before, she was highly independent. After, she was fearful of going out and had become isolated and lonely.
- The GP asked the seniors' support coordinator to arrange a volunteer befriender, for visits once or twice a week.
- They started with a walk in the garden, slowly progressing to the local shops. She is now confidently back walking to the shops, and has resumed her social life.

Healthy

Connected and independent (housing)



‘Heads of household’ by age



‘Heads of household’ by age

Healthy

Connected and independent (transport)

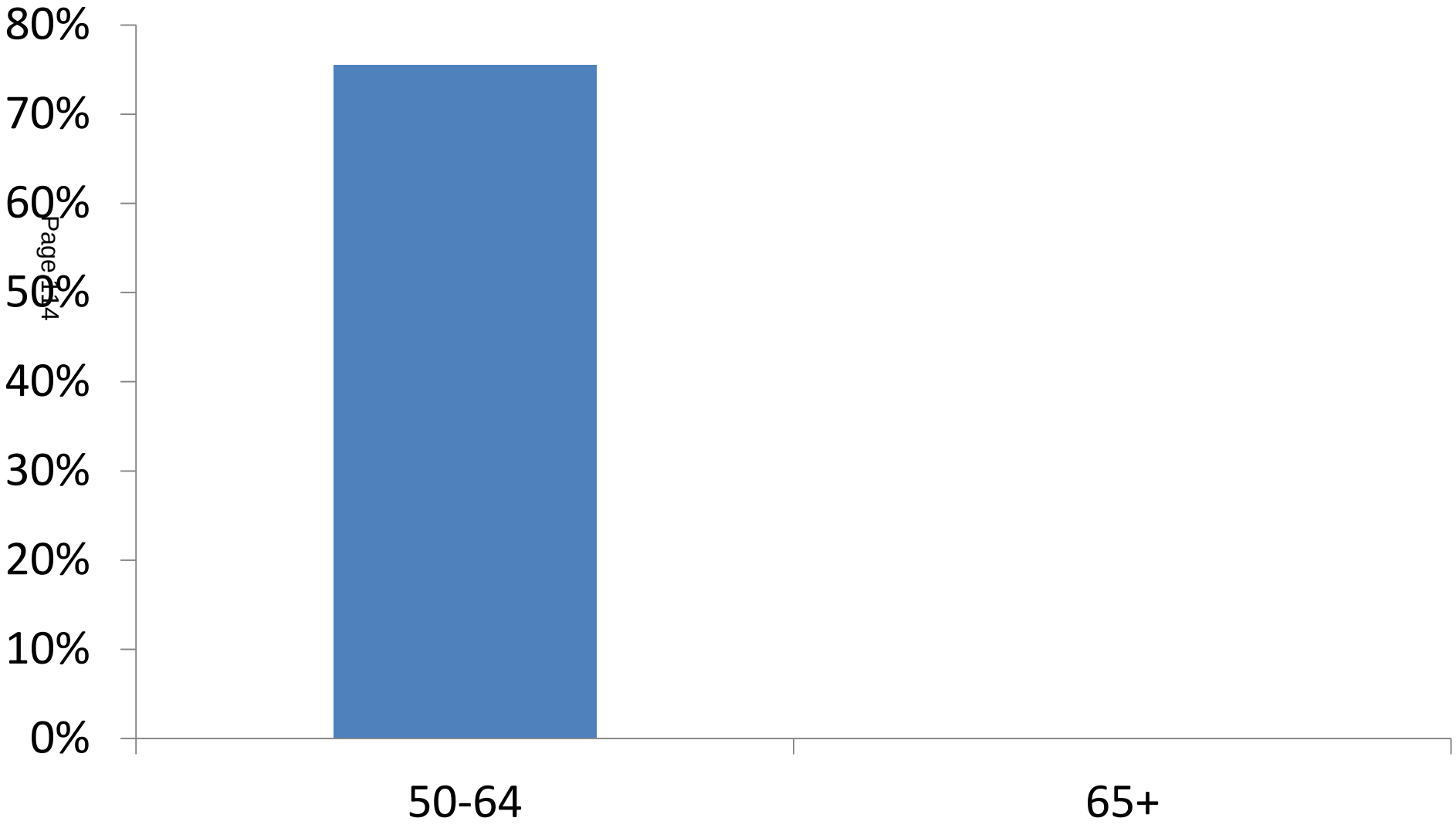
TRANSPORT

- *No transportation in Priorswood in the evenings*
- *Very difficult to get to Musgrove on the bus, for example from Street and Bridgwater*

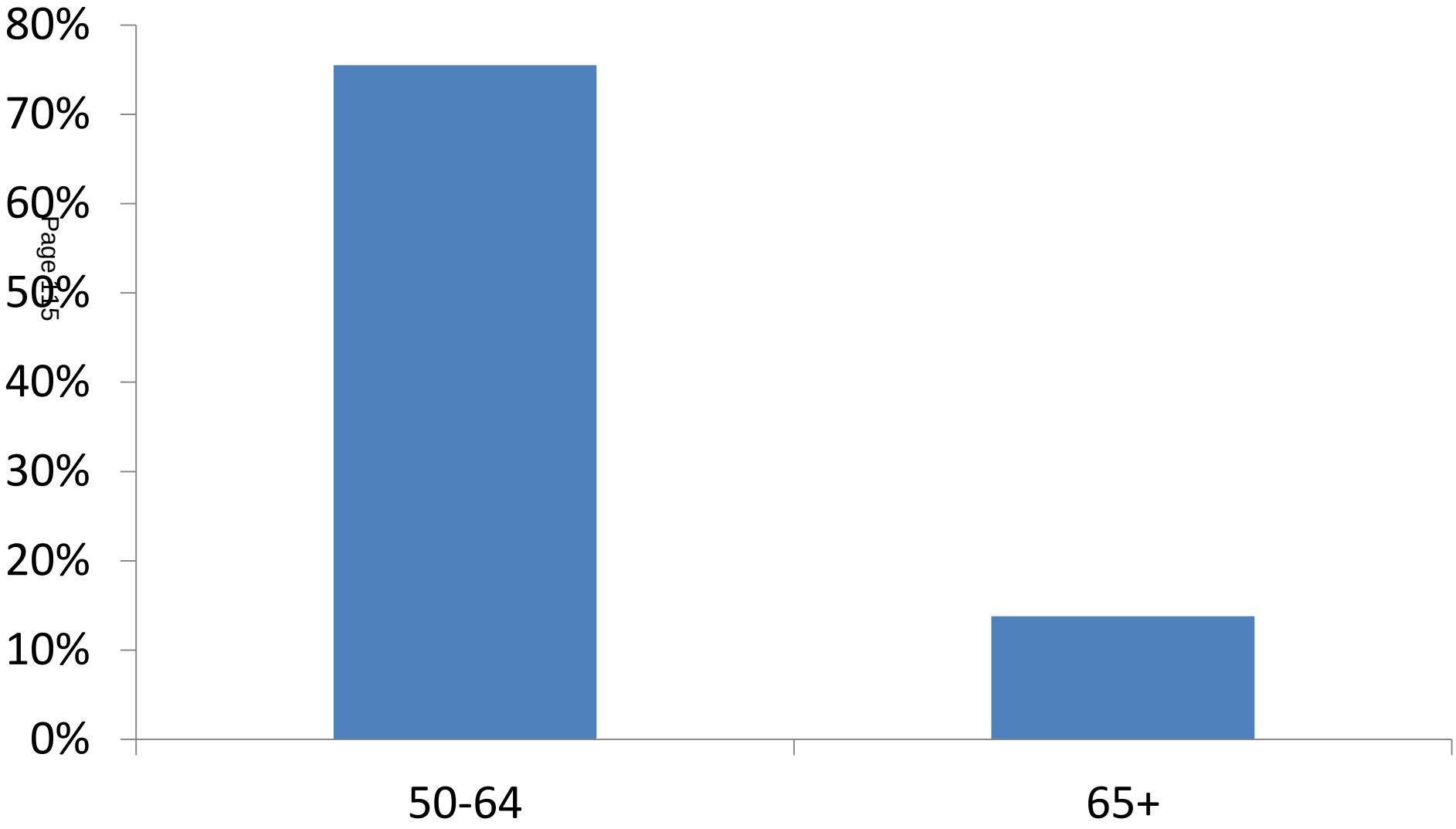
Healthy

Connected and independent (work)

Somerset Economic Activity Rates 2016



Somerset Economic Activity Rates 2016



IMPLICATIONS FOR COMMISSIONING

Connected and independent

- Self-help and short-term help to regain independence were commended.
- Family carers & the community bring benefits to all.
- Independence and social contact need good transport.
- New housing should take account of ageing and existing stock be adapted accordingly.
- Good work, including voluntary, is good. Older workers' contribution should be recognized.

Healthy

- 45% of disease – including dementia - can be prevented or delayed by lifestyle
  - not smoking
  - drinking responsibility
  - good social contacts
  - eating well
  - exercise
- There is no age after which improvements do not help.
- Inequalities were very evident. Addressing them will reduce suffering and save money.

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Decision Report – Key decision
– 16 August 2017

Contract award for the provision of highway improvements at Yeovil Western Corridor following re-procurement

Cabinet Member(s): Cllr John Woodman – Cabinet Member for Highways and Transport
Division and Local Member(s): Cllr Andy Kendall (Yeovil Central); Cllr Tony Lock (Yeovil East); Cllr Faye Purbrick (Yeovil South); Cllr Jane Lock (Yeovil West); Cllr Josh Williams (Brympton); Cllr Mark Keating (Coker).
Lead Officer: Mike O'Dowd-Jones - Strategic Commissioning Manager, Highways and Transport.
Author: Mike O'Dowd-Jones - Strategic Commissioning Manager, Highways and Transport.
Contact Details: 01823 356238

	Seen by:	**Name**	**Date**
	County Solicitor	Honor Clarke	17/7/2017
	Monitoring Officer	Julian Gale	20/7/2017
	Corporate Finance	Kevin Nacey	20/7/2017
	Human Resources	Chris Squire	20/7/2017
	Property / Procurement / ICT	Richard Williams	20/7/2017
	Senior Manager	Paula Hewitt Michele Cusack	20/7/2017 20/7/2017
	Local Member(s)	Cllr Andy Kendall Cllr Tony Lock Cllr Faye Purbrick Cllr Jane Lock Cllr Josh Williams Cllr Mark Keating	26/7/2017 26/7/2017 26/7/2017 26/7/2017 26/7/2017 26/7/2017
	Cabinet Member	Cllr John Woodman Cabinet Member for Highways and Transport	20/7/2017
	Opposition Spokesperson	Cllr Mike Rigby Highways and Transport	26/7/2017
	Relevant Scrutiny Chairman	Cllr Tony Lock for Scrutiny Place	26/7/2017
Forward Plan Reference:	FP/17/06/08		
Summary:	The Yeovil Western Corridor transport scheme has been developed over a number of years to accommodate planned growth in the surrounding area of Yeovil. It was selected to be funded as part of the Heart of the South West Local Transport Board Scheme Prioritisation Process subject to the submission of a successful business case.		

	In June 2017 a decision was taken by the Leader of the Council to abandon a previous procurement process and commence a new procurement process for provision of the scheme. This has now been completed and this Key Decision needs to be taken to award the contract. The Tender Evaluation Report is attached as Confidential Appendix A.
Recommendations:	**That the Cabinet** **1. Agrees to award a contract for highway junction improvements and associated works at Yeovil Western Corridor to the supplier identified in Appendix A, following a competitive process.** **2. Agrees the case for exempt information for Appendix A to be treated in confidence, as public disclosure of the commercially sensitive data contained within would prejudice the Council's position in ensuring competitiveness of future tender processes.** **3. Agree to exclude the press and public from the meeting where there is any discussion at the meeting regarding exempt or confidential information (Appendix A).** **Exclusion of the Press and Public** **To consider passing a resolution under Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 to exclude the press and public from the meeting on the basis that if they were present during the business to be transacted there would be a likelihood of disclosure of exempt information, within the meaning of Schedule 12A to the Local Government Act 1972:** **Reason: Information relating to the financial or business affairs of any particular person (including the authority holding that information).** **The County Council reserves the right to not proceed with the award of a contract should new information come to light during the standstill period and/or before entering into a contract. In this instance, it is recommended that the relevant Service Director and Commercial and Business Services Director be given joint delegated**

	authority to take any necessary action to protect the Council interests - this could include a decision not to enter into a contract and go back out to market.
Reasons for Recommendations:	Appendix A contains commercially sensitive information relating to the tender submissions. Detailed commercial reasons for these recommendations are set out in that Appendix. This transport scheme has been developed to reduce congestion and to improve the pedestrian and cycling environment whilst also taking into account the planned development proposals in Yeovil as defined in the South Somerset Local Plan. A funding package to cover the cost of the contract is in place via funding contributions from The LEP Local Transport Board (LTB) Local Growth Fund, developer contributions and the SCC capital programme This decision will allow the Council to award a contract, following the competitive tender process which has identified the most economically advantageous tender for the works. This decision now needs to be taken to award the contract so that works can commence to ensure delivery on the ground in line with the timetable required to accommodate housing and economic growth in the area and to meet the requirements of the Local Enterprise Partnership as a key funding body. A significant amount of expenditure has already been incurred in the development and advance works associated with the scheme such as utility diversions and vegetation clearance.
Links to Priorities and Impact on Service Plans:	The proposed major transport scheme is a major investment in transport infrastructure in Yeovil. This investment in infrastructure would support development and the local economy in Yeovil and further the following objectives of the County Plan: • a thriving local economy, which attracts jobs and investment; and • invest in Somerset; improve broadband connections and road links like the A303, to help businesses and residents. The procurement process has followed the principles contained in the Social Value Policy Statement to deliver social value benefits. The scheme is included in the Future Transport Plan 2011-2026, being identified within the Transport & Development Policy

	document as required in order to support housing and economic growth.
Consultations and co-production undertaken:	Consultations have taken place with the Cabinet Member for Highways and Transport and the Local County Council Members at a meeting to present the schemes in January, March & May 2014 and July 2015. No issues were raised regarding the implementation of a scheme at this location. South Somerset District Council councillors were presented the schemes in January 2014 and July 2015, again no issues were raised regarding the implementation of a scheme at this location. Somerset County Council undertook a public consultation event in Yeovil in May 2014, this was in addition to the further public consultation that was undertaken by the LTB once the scheme has been submitted. The general public have been consulted on the inclusion of the Yeovil Western Corridor within the LTB major scheme programme. This was undertaken by the LTB. The scheme has been discussed with a number of local stakeholders a various points in its development including individual local County and District Council members, the Town Council and Chamber of Commerce.
Financial Implications:	The Yeovil Western Corridor is a transport scheme that helps to deliver approximately 1500 dwellings and 19.5 hectares of employment land. This will help to deliver housing and economic targets as well as helping to release New Homes Bonus revenue and business rates that will support the Council's financial situation. A recent review of the funding package and developer contributions (taking latest indexation into account) concludes that up to £16.148m is currently available for the scheme comprising: **Funding source** / **Value** LEP Local Growth Fund — Up to £6.49m S106 contributions already received — £0.842m S106 contributions now due — £2.776m S106 contributions yet to reach trigger points and which will require SCC to cashflow until triggers met. — £1.190m SCC capital programme contingency — £4.850m **TOTAL** — **£16.148m** By the end of June 2017 approximately £1.3m had been spent on scheme development and advance preparatory works following earlier decisions to proceed with advance works.

	The estimated scheme cost is currently being finalised following completion of the tender process with final sums such as risk allocations and land values currently being calculated. The tender price confirms that the scheme is deliverable within the funding package available.
Legal Implications:	The procurement process undertaken complied with the requirements of the Public Contracts Regulations 2015. The NEC 3 Contract provides a mechanism for dealing with risks and the associated costs of those risks as they arise.
HR Implications:	HR implications have been considered and no issues have been identified.
Risk Implications:	A suitable supplier has been identified as part of the procurement process. If the decision is not implemented there is a business and reputational risk related to the Council not delivering major transport schemes and would affect the ability of the Council to deliver future investment in transport infrastructure. Not selecting a contractor would delay the scheme being delivered and the wider economic benefits may not be realised. Delay in delivery of the scheme would increase the risk of the Local Enterprise Partnership reviewing its financial contribution to the scheme.
	Likelihood **1** **Impact** **4** **Risk Score** **4**
Other Implications (including due regard implications):	There will be road closures and diversions in place when the works are being completed which will mean restricted access to the community for the duration of the works. Implications for equality & diversity, human rights, community safety, sustainability, FOI and data protection have been considered and no issues have been identified. All tenderers have given due regard to the awareness and application of the equalities, social and economic requirements of the Council. The contract documents will include requirements regarding monitoring of the successful Contractors' compliance An Equalities Impact Assessment has been completed.
Scrutiny comments / recommendation (if any):	Not applicable.

1. Background

1.1. The Yeovil Western Corridor transport scheme has been developed over a number of years to accommodate planned growth in the surrounding area of Yeovil. A total of 1,547 dwellings are proposed by residential developments at Brimsmore (830) and Lufton (717) and a 16 hectare site at Bunford Park has planning permission for B1 employment. The Western corridor will also serve a 4.5 hectare site of predominately B1 employment at Lufton which also has planning permission. The scheme will help to deliver housing and economic targets as well as helping to release New Homes Bonus revenue and business rates that will support the Council's financial situation.

1.2. The outline business case for the Yeovil Western Corridor was submitted to the Local Transport Board. This was approved April 2014 and the next step was for Officers to work up the Full Approval Business Case. As part of this work an appropriate decision was taken undertake the procurement process and land acquisition activities.

1.3. The project will deliver a number of transport infrastructure improvements including junction improvements, new footway/cycleway and new and improved pedestrian/cycle crossing facilities. The proposed junction improvements are based on the latest forecast traffic flows derived from the Yeovil Traffic Model which has recently been updated in accordance with the most appropriate relevant guidance. The current proposals are considered to be best suited to accommodate future travel patterns on the local transport network and without this intervention, the issues identified will hold up current planned growth.

1.4. The local highway network is forecast to suffer from significant congestion problems in the future, and currently experiences capacity problems during the morning and evening peak periods. If the junctions are not improved there will be an increase in peak hour delays and journey times caused by increases in traffic flows and the associated worsening of severance issues affecting pedestrian and cycle movements. The existing junctions have insufficient capacity to accommodate planned development and traffic growth to 2028, and the improvements will allow the junctions to operate effectively with that additional growth. The scheme has been forecast to reduce journey times in 2028 by up to 36% in the morning peak and 27% in the evening peak.

1.5. Pedestrian and cycle facilities on the Western Corridor are limited and do not provide good access to homes, shops and workplaces. The existing crossing facilities provided at junctions can be difficult to use when traffic flows are high creating severance issues and dropped crossing provision is currently inconsistent.

1.6. The scheme provides very good value for money with the economic benefit of reduced traffic delay estimated at £123m, and provides an estimated £1.384m saving in the cost of collisions.

1.7. Extensive consultation has taken place since 2014 with Elected Members from Somerset County Council and South Somerset District Council. Presentations have also taken place to the Chamber of Commerce. A communications plan has been drafted which details stakeholders and proposed actions.

1.8. The successful contractor has provided a stakeholder management plan incorporating customer care and relations with the public, landholders and local residents. The successful contractor will provide a public liaison officer and develop a Communications and Customer care plan which will provide a structured framework for communications activities.

1.9. The plan will include writing to stakeholders with details of the proposed works and provide contact details. An information centre will be established to act as a central point for discussions to take place and access to project information. A web page will be set up along with social media feeds. Works will be carefully managed to minimise disruption, particularly during events such as football matches.

1.10. There will be weekly meetings on site which will allow integration with SCC's communications team and press office.

1.11. The procurement objective for the project was to ensure that the most suitable supplier was selected to deliver a programme of works including the provision of all associated Labour, Materials and Design to deliver the Improvement works.

1.12. A procurement process was developed for the project to ensure:

- Better cost certainty over the life of the scheme;
- The scheme at tender stage remains within the budgetary constraints;
- Appropriate conditions of contract were put in place;
- Development of an approach for commercial and technical delivery through a strong professional client team. The existing SCC team will be supplemented by an external 'NEC3' Technical Project Manager.

1.13. Cabinet took a decision in April 2017 to award a contract for construction of the scheme following a procurement process which included an evaluation of tender submissions.

1.14. Cabinet's decision allowed the contract to be awarded following the satisfactory completion of the remaining procurement procedures which include a mandatory standstill period enabling the market and participants to respond to the proposed award, and to allow finalisation of the contractual arrangements between the parties.

1.15. Issues arose following Cabinet's decision such that it was recommended that it was not in the best interests of the Council or our communities to complete the award of the contract, and a decision was taken by the Leader of the Council in June 2017 to abandon that procurement process and commence a new procurement process for provision of the scheme. The reasons for this decision are set out in a confidential (legally priveliged) appendix to that decision.

1.16. Amendments were made to procurement process to avoid similar issues arising again, and tenders submitted under the new process have now been received and evaluated as summarised in the confidential appendix to this report.

1.17. It is proposed that immediately following the cabinet decision and after sufficient time has elapsed for scrutiny call-in, letters will be issued to the successful and unsuccessful tenderers allowing the mandatory standstill period to commence. Should no market challenge arise, the contract may commence immediately

following the expiry of the standstill period, whereupon a Contract Award Notice shall be published in the Official Journal of the European Union.

2. Options considered and reasons for rejecting them

2.1. Options considered included:

- Utilise the existing highway term maintenance contract.
- Join an existing framework contract procured by another Authority.
- Utilise a National framework.
- Procure a dedicated new contract for the scheme.

2.2. Due to the value of the scheme, and the desire to specify particular terms and conditions of contract it was decided to undertake a dedicated procurement under the European Procurement rules, utilising Option A of the NEC Contract. The procedure followed the open procurement procedure.

3. Background Papers

3.1. Cabinet decision to award a contract for Yeovil Western Corridor. April 2017. Accessed from www.somerset.gov.uk.

3.2. Leader decision to abandon procurement of a contract for Yeovil Western Corridor and launch a new procurement process. June 2017. Accessed from www.somerset.gov.uk.

Equality Impact Assessment Form and Action Table 2015 (Expand the boxes as appropriate, please see guidance (www.somerset.gov.uk/impactassessment) to assist with completion)			
"I shall try to explain what "due regard" means and how the courts interpret it. The courts have made it clear that having due regard is **more than having a cursory glance** at a document before arriving at a preconceived conclusion. Due regard requires public authorities, in formulating a policy, to give equality considerations the weight which is **proportionate in the circumstances**, given the potential impact of the policy on equality. It is not a question of box-ticking; it requires the equality impact to be **considered rigorously and with an open mind**." **Baroness Thornton, March 2010**			
What are you completing the Impact Assessment on (which policy, service, MTFP reference, cluster etc)?	Decision Paper for FP/15/04/04. Authorising the award of a contract to undertake a capacity improvement scheme at Yeovil Western Corridor		
Version	2	**Date**	20/03/2017
Section 1 – **Description** of what is being impact assessed			
The decision is to award a contract for the construction and delivery of the Yeovil Western Corridor highway junction improvements and associated works.			
Section 2A – People or communities that are **targeted or could be affected** (taking particular note of the Protected Characteristic listed in action table)			
It has been identified that the existing transport network would not be able to accommodate the growth planned for the Yeovil area without significant increases in journey times and delays. This means that the community as a whole, will benefit from this scheme as the aim is to reduce congestion, improve facilities for pedestrians and cyclists and support the economy of Yeovil. There will be road closures and diversions in place when the works are being completed which will mean restricted access to the community for the duration of the works.			
Section 2B – People who are **delivering** the policy or service			
Commissioning has undertaken the initial scoping work with procurement and operations to ensure viability. The chosen contractor will undertake the works and will be obliged to adhere to agreed policy and working practices including personal conduct on a daily basis on site.			
Section 3 – **Evidence and data** used for the assessment (Attach documents where appropriate)			
An Options Assessment Report was completed as part of the Business Case process which identified several options and reasons why they were discarded. Environmental and ecological stakeholders were consulted and an information session was held for the community.			
Section 4 – **Conclusions** drawn about the equalities impact (positive or negative) of the proposed change or new service/policy (Please use **prompt sheet** in the guidance for help with what to consider):			
Works may involve disruption to existing pedestrian crossings which may impact on people with protected characteristics, particularly older people, children and people with			

limited mobility such as wheelchair users.
The scheme and associated traffic management during construction will be designed to appropriate standards of accessibility to meet the needs of all users including provision of appropriate lighting and other facilities (such as footways and crossings) which meet the needs of people with disabilities.
Traffic management and footway diversion plans should be designed to ensure their needs are taken into account.
Once the scheme has been completed, it is likely to have a positive impact overall.

If you have identified any negative impacts you will need to consider how these can be mitigated to either reduce or remove them. In the table below let us know what mitigation you will take. (Please add rows where needed)

Identified issue drawn from your conclusions	**Actions needed – can you mitigate the impacts? If you can how will you mitigate the impacts?**	**Who is responsible for the actions? When will the action be completed?**	**How will it be monitored? What is the expected outcome from the action?**
Age			
Elderly pedestrians impacted whilst works are being carried out.	Traffic management and footway diversion plans will need to be designed to accommodate appropriate levels of accessibility	SCC/Contractor	Design review. No impact
School age children impacted whilst works are being carried out	Traffic management and footway diversion plans will need to be designed to accommodate appropriate levels of accessibility and volume of movements.	SCC/Contractor	Design review. No Impact.
Disability			
Disabled pedestrians impacted whilst works are being carried out	Traffic management and footway diversion plans will need to be designed to accommodate appropriate levels of accessibility	SCC/Contractor	Design review. No impact
Gender Reassignment			
N/A			
Marriage and Civil Partnership			
N/A			
Pregnancy and Maternity			
N/A			
Race (including ethnicity or national origin, colour, nationality and Gypsies and Travellers)			
N/A			
Religion and Belief			

N/A			
Sex			
N/A			
Sexual Orientation			
N/A			
Other (including caring responsibilities, rurality, low income, Military Status etc)			
N/A			

Section 6 - How will the assessment, consultation and outcomes be published and communicated? E.g. reflected in final strategy, published. What steps are in place to review the Impact Assessment	
Non sensitive items are being published for the public to see. There is a monitoring and evaluation plan in place to assess the scheme over a period of 5 years.	
Completed by:	Nisha Devani
Date	20/03/17
Signed off by:	Mike O'Dowd - Jones
Date	20/03/17
Compliance sign off Date	23/03/17
To be reviewed by: (officer name)	Sunita Mills
Review date:	01/04/18

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Decision Report – Key decision
– 16th August 2017

Development of a Joint Strategic Commissioning Function

Cabinet Member(s): Cllr David Fothergill – Leader of the Council and Cllr Christine Lawrence - Cabinet Member for Public Health and Wellbeing
Division and Local Member(s): All
Lead Officer: Pat Flaherty - Chief Executive
Author: Trudi Grant - Director of Public Health
Contact Details: 01823 359015

	Seen by:	Name	Date
	County Solicitor	Honor Clarke	27/7/17
	Monitoring Officer	Julian Gale	31/7/17
	Corporate Finance	Kevin Nacey	31/7/17
	Human Resources	Chris Squire	31/7/17
	Property / Procurement / ICT	Richard Williams	31/7/17
	Senior Manager	Trudi Grant	26/7/17
	Local Member(s)		
	Cabinet Member	Cllr David Fothergill Cllr Christine Lawrence	27/7/17 27/7/17
	Opposition Spokesperson	Cllr Jane Lock Cllr Amanda Broom	27/7/17 26/7/17
	Relevant Scrutiny Chairman	Cllr Hazel Prior-Sankey	27/7/17
Forward Plan Reference:	FP/17/05/10		
Summary:	In line with national policy, Somerset has agreed the development of an Accountable Care System by April 2019. The paper provides background to this transformation and sets out initial thinking on the Joint Commissioning Function of the system, bringing together the health and social care commissioning responsibilities of Somerset Clinical Commissioning Group, Somerset County Council and NHS England. Six options for the development of a Joint Commissioning Function have been identified and an option appraisal undertaken recommending a preferred option. This option involves the development of a new vehicle to lead the Joint Commissioning of health, public health and social care across the county, whilst retaining organisational statutory responsibilities. This approach requires much greater use of pooled budget arrangements through Section 75.		

	This option also enables the organisations to make shared use of their combined commissioning skills and experience through a joint management and officer arrangement.
Recommendations:	**This report recommends that:** • **the Cabinet considers the initial proposal and options appraisal.** • **the Cabinet provides support in principle to progress to a full business case for the recommended option to be considered by Cabinet again in November 2017.**
Reasons for Recommendations:	The strength of a single vision achieved by a single robust commissioning function could bring far greater focus to commissioning for the needs of the population both now and in the future. The proposed model offers the widest possible coordination of services across the whole Health and Wellbeing System, giving greater scope for a more preventative approach. This option has the added benefit of increasing local democratic accountability within the NHS as well as maintaining strong clinical engagement and leadership within health and social care. It would also make best use of the skills and resources of the county as a whole, building on the community development and communication and engagement skills across the system. This option has the ability to achieve savings in overheads and staffing by reducing duplication, estate and travel and enhancing shared back office functions.
Links to Priorities and Impact on Service Plans:	The recommendations within this report are in line with and contribute to an increased integration between health and social care as highlighted in the County Plan, Health and Wellbeing Strategy and the Somerset Sustainability and Transformation Plan.
Consultations and co-production undertaken:	These proposals have been developed jointly with Somerset Clinical Commissioning Group (CCG) and also through discussion with NHS England. The proposals have been discussed with the Sustainability and Transformation Plan Programme Executive Group, the CCG Clinical Operations Group and the Health and Wellbeing Board. The report has already been discussed at the CCG Governing Body in July and was supported to proceed to the next phase.

	The report has been discussed with the Opposition Spokesperson and the Chair of the Adults and Health Scrutiny Committee
Financial Implications:	It will be necessary to identify the project management resource to support this change. The long term financial implication is that there will be a stronger system alignment and set of incentives to improve efficiency and effectiveness across services. VAT consequences need to be considered in detail to ensure no additional costs or liabilities are incurred.
Legal Implications:	The approach will lead to revised Governance arrangements and proposals will need to be checked with legal advisers. Early work has identified limitations in the range of services that can be included in a s75 agreement. Both parties will need to consider appropriate due diligence arrangements
HR Implications:	It is not proposed at this stage that there will be any change in employment of staff; the proposal is for staff across the system to work together as a single team. There will be a requirement to consider the cultural differences and organisational development required to achieve this outcome. Greater partnership working between commissioners across the system has been started through the development of the Somerset Commissioning Academy. There may be changes to staff base in order to achieve the benefits of colocation of commissioning staff. A full HR framework will be developed during the next phase of the work.
Risk Implications:	There is a risk that maintaining fragmented commissioning for health, public health and social care compromises the ability of SCC to deliver the vision of improved population health and wellbeing, a reduction in inequalities and control demand for services.

Likelihood	**4**	**Impact**	**3**	**Risk Score**	**12**

Other Implications (including due regard implications):	**<u>Equalities Implications</u>** Both organisations are subject to the Public Sector Equality Duty and share a common objective to ensure the whole population receives good quality health and care services and that inequalities are reduced.

	Tackling inequalities is one of the identified outcomes for the development of a Joint Commissioning Function and has been considered as part of the options appraisal. The issues of - Access - Equality and Diversity - Human Rights Are not directly applicable to this report at this stage however these will be fully considered if the decision to move to a full business case is taken. **Community Safety Implications** None identified **Sustainability Implications** None identified to date, further consideration would need to be given if there is a change of staff base **Health and Safety Implications** None identified **Privacy Implications** None identified **Health and Wellbeing Implications** This proposal could have significant positive health and wellbeing benefits for the local population. One of the main purposes of this proposal is to bring together commissioning so the system as a whole is working towards one vision for improving health and wellbeing and reducing inequalities. This proposal contributes significantly to the delivery of the priorities within the Health and Wellbeing Strategy as seen below: 1. People, families and communities take responsibility for their own health and wellbeing. 2. Families and communities are thriving and resilient. 3. Somerset people are able to live independently for as long as possible. The proposal will benefit the whole population but will have particular benefit to people who are already receiving support from health and social care services and those with multiple or

	complex health and wellbeing issues that require co-ordinated care across many service areas.
Scrutiny comments / recommendation (if any):	The Chairman of the Scrutiny for Adults and Health Committee supports the development of the business case.

1. Background

1.1. Through its Sustainability and Transformation Plan, health and social care leaders in Somerset have agreed to develop one Accountable Care System for the county by 2019. It has also been agreed that this will require joint commissioning arrangements to be developed. This paper sets out proposals for the development of these joint arrangements.

1.2. Currently the commissioning of health and social care services spans across three organisations: the Somerset Clinical Commissioning Group (CCG), Somerset County Council (SCC) and NHS England (NHSE). This paper puts forward and reviews the options available, under current legislation, to bring together a joint commissioning function for Somerset.

2. Options considered and reasons for rejecting them

2.1. Six options have been considered and detailed in the paper (see appendix 1). One option has been identified as providing the greatest benefit to Somerset when assessed against ability of the model to:

- Commission for improved population health & wellbeing outcomes
- Reduce health & social inequalities
- Develop well co-ordinated & seamless care
- Support individuals & communities to take responsibility for their own health & wellbeing

2.2. Option 6 has been identified as the preferred option, proposing the joint commissioning of health, social care and public health services, undertaken through a new Joint Health and Care Board. Under this option, the statutory commissioning organisations would retain their respective responsibilities but the organisations would take decisions at the same time through a joint meeting of the CCG Governing Body and Cabinet. This Joint Board would control a significant pooled budget under a Section 75 Agreement. The CCG and local authorities would retain their respective statutory responsibilities and would therefore not require delegated authority. It is proposed this new governance is supported by a single combined officer base from the organisations, making good use of the skills and providing options for greater efficiency.

3. Background Papers

3.1. The full report and options appraisal can be seen in appendix 1

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Appendix 1

SOMERSET SUSTAINABILITY AND TRANSFORMATION PLAN

PROPOSAL FOR THE DEVELOPMENT OF A JOINT COMMISSIONING FUNCTION

Version 2 – July 2017

CONTENTS

APPENDICES

EXECUTIVE SUMMARY

Through its Sustainability and Transformation Plan, health and social care leaders in Somerset have agreed to develop one Accountable Care System for the county by 2019. It has also been agreed that this will require joint commissioning arrangements to be developed. This paper sets out proposals for the development of these joint arrangements.

Currently the commissioning of health and social care services spans across three organisations: the Somerset Clinical Commissioning Group (CCG), Somerset County Council (SCC) and NHS England (NHSE). This paper puts forward and reviews the options available, under current legislation, to bring together a joint commissioning function for Somerset.

The paper reviews six options and, following an options appraisal, proposes an option to develop a new delivery vehicle, combined with an integrated staffing structure and greater use of pooled budget arrangements through a Section 75 agreement.

This paper also sets out a suggested timescale for further work and decision making. It is proposed that subject to this proposal being agreed by the CCG Governing Body, NHS England and the Somerset County Council Cabinet in July 2017, a more detailed Business Case will be developed in consultation with staff and leaders within the Somerset health, public health and social care system. This would be considered by relevant organisations for a decision to proceed in November 2017.

1 INTRODUCTION

1.1 The Sustainability and Transformation Plan (STP) for Somerset has agreed the following vision for health and social care in Somerset:

> **People in Somerset will be encouraged to stay healthy and well through a focus on:**
>
> - Building support for people in our local communities and neighbourhoods
> - Supporting healthy lifestyle choices to be easier choices
> - Supporting people to self-care and be actively engaged in managing their conditions
>
> When people need to access care or support this will be through joined up health, social care and wellbeing services. The result will be a healthier population with access to high quality care that is affordable and sustainable.

1.2 Through the Sustainability and Transformation Plan, health and social care leaders in Somerset have agreed to develop one Accountable Care System (ACS) for the county by 2019. It has been agreed that this will require joint commissioning arrangements to be in place which will have responsibility for setting the outcomes for the system.

1.3 The success of an ACS relies on many things, but strong clear and integrated commissioning is one of the firm building blocks. Current legislation and organisational form means that local organisations with a will to jointly commission for a whole health and social care system, need creative solutions in order to achieve this.

1.4 This paper specifically considers the options available for the development of a joint commissioning function across Somerset Clinical Commissioning Group (CCG), NHS England and Somerset County Council (SCC).

1.5 It recommends a preferred option, as well as proposing a plan that describes the transition to this outcome with the appropriate development of the commissioner workforce.

2 BACKGROUND

Context

2.1 The Spending Review in November 2015 announced the government's plan to integrate health and social care services by 2020. Each part of the country will develop plans for this by 2017, to be implemented by 2020. There is a need, now more than ever, to make best use of public money. Joint commissioning can contribute to this, ensuring shared leadership, working towards shared priorities and outcomes.

2.2 There is a need for the NHS in Somerset to make approximately £600m in efficiency savings by 2021. Added to this, there is also an expectation that social care budgets will become increasingly more pressured, given the increasing needs of the population. Stronger and more efficient ways of commissioning and delivering care must be identified.

The Benefits and Risks of Joint Commissioning

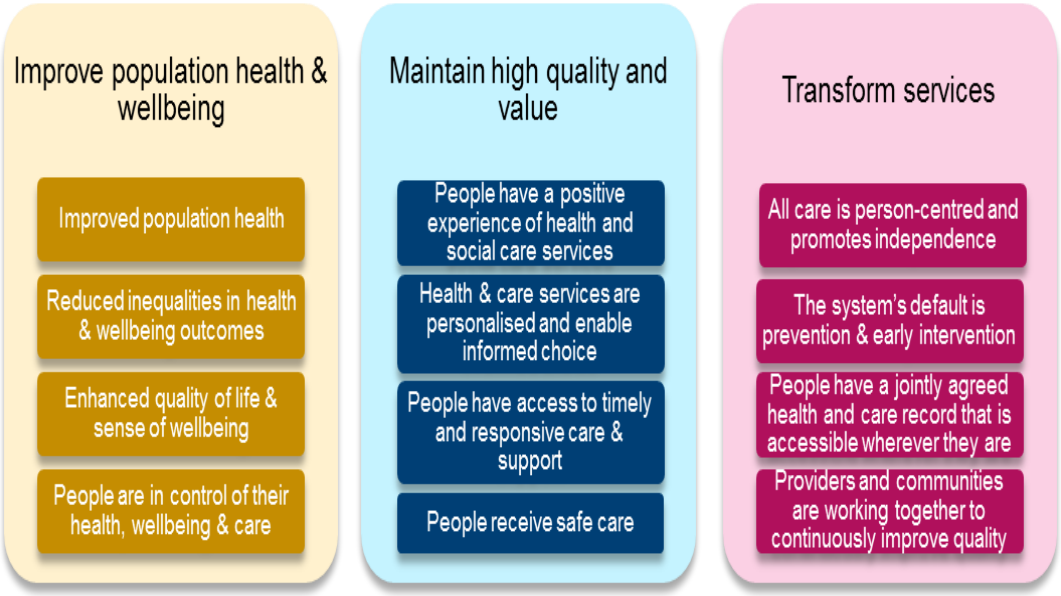
2.3 Table 1 outlines the overall benefits and risks of developing a joint commissioning function; the specific benefits and risks of each option have been identified in the options appraisal.

Table 1: Showing the benefits and risks associated with developing a joint commissioning function

Benefits of integrating	Risks of integrating
A unified commissioner function with a single decision making process	Complex decision-making processes
Maximise the opportunities in the financial regimen for system gain	Differences in the financial regimen drive confusion and add complexity
Reduced duplication of organisational running costs	Additional short term costs could be incurred e.g. Excess Mileage
Clarity and certainty to commissioning staff	Uncertainty to staff who don't have a commissioning role
'Pooling' and maximising available commissioning skills	May be additional short term overheads to manage tactical and operational commissioning
New perspectives, skills and experience bring significant opportunities for strong commissioning	The joint commissioning function is weakened due to significant loss of organisational knowledge

2.4 There is an increasing emphasis on the delivery of improved outcomes via health and care organisations working together within locally determined organisational forms, and there is an opportunity to reform the commissioning incentives to achieve these objectives. Three core themes have been developed by health, social care and public health commissioners and, subject to further review and engagement, will be used as framework to develop the expected outcomes for the whole population of Somerset (Figure 1).

Figure 1: Somerset Draft Outcomes Framework: Core Themes and Measures



Current Position – Joint Commissioning

2.5 The CCG and SCC already have a firm foundation to build upon, with a local history of joining up commissioning in targeted areas through Section 75 arrangements, joint posts, and since 2014 through the Somerset Better Care Fund (BCF) initiative. Appendix 1 sets out areas of current joint commissioning.

2.6 There are already some joint governance arrangements in place which encourage joint working and which can be developed further to support joint commissioning, such as:

- the Somerset Health and Wellbeing Board
- a Joint Commissioning Board
- STP governance arrangements including a Programme Executive/Oversight Group and system Steering Groups and work streams.

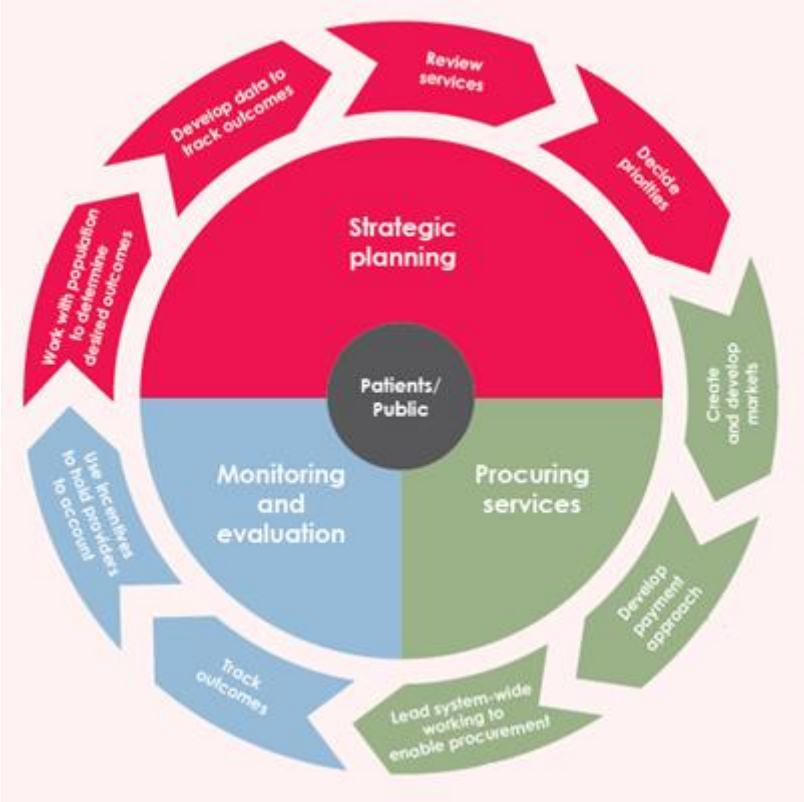
3 A SHARED VIEW OF COMMISSIONING

The Commissioning Cycle

3.1 The commissioning cycle illustrated in Figure 2 shows the range of commissioning functions that could be joined up. Each step of the cycle can be applied to a joint commissioning approach. Whilst this commissioning cycle is recognised by both local authorities and the NHS, the development of joint

commissioning arrangements will not be without challenge, given the differences in the approach to commissioning procurement and contracting between the NHS and local authorities.

Figure 2: Outcomes Based Commissioning Cycle



Defining Joint Commissioning

3.2 Joint commissioning can be broadly described as the coming together of organisations in the form of a 'partnership, alliance or other collaboration' to take joint responsibility for commissioning of a set of services.

3.3 This is likely to involve organisations working in partnership at all stages of the commissioning process, from the assessment of needs, to the planning and procuring of services, the decision making processes and the monitoring of outcomes. A study undertaken by *Glasby et al* in 2013 highlighted that although arrangements may vary significantly there are a set of features common to all joint commissioning which include:

- *Formalised structures:* often through the development of formally integrated organisations or management teams
- *Pooled budgets*: a shared budget which is associated with a particular population or disease group with needs that span the responsibilities of both organisations
- *Lead commissioning arrangements*: one partner often takes the lead on commissioning a particular service to avoid duplication

- *Co-location*: often involves the co-location of relevant staff from each organisation

- *Hybrid roles*: joint commissioning can involve the appointment of staff who span more than one organisation, often at a senior level

3.4 Specific operational and legal enabling mechanisms are required to support joint commissioning, including:

- Use of Section 75 of the NHS Act 2006 which gave PCTs (and subsequently Clinical Commissioning Groups) and local authorities legal powers to enter into integrated and lead commissioning roles

- Aligned budgets in agreed service areas

- Pooled budgets – use of Section 75 enabling NHS bodies and local authorities to create pooled budgets using contributions from their individual organisations. However, Section 75 does not allow for all health and social care services to be included within a joint fund. Further details are set out in Section 5.9 – 5.10.

Understanding the Difference between Strategic Commissioning, Tactical Commissioning and Operational Commissioning

Strategic commissioning

3.5 Strategic commissioning is the term used for all the activities involved in:

- assessing and forecasting needs

- identifying the desired health and wellbeing outcomes for the population

- being responsible for assurance and oversight of statutory responsibilities

- linking investment to agreed outcomes

- engaging and consulting with the public and services users

- monitoring and performance managing the contract/s with the Accountable Provider Organisation in line with the outcome requirements

3.6 A Joint Commissioning function in Somerset would require the CCG, NHS England and SCC to work together using a pooled budget through a Section 75 agreement.

3.7 Leaders within Somerset recognise that there are strategic, tactical and operational commissioning functions within the emerging ACS.

Functions of strategic commissioning

3.8 The proposed functions which would be the responsibility of the joint commissioners are set out in Table 2.

Table 2: Showing the different levels of commissioning within the emerging Accountable Care System (ACS)

	Strategic Commissioning
	Longer term strategic planning for the health and wellbeing of the population, in line with the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy The strategic commissioning function has responsibility to advocate on behalf of the population and influence across the wider determinants of health: for example, education, housing, employment etc, as well as influencing and commissioning across and beyond Somerset's boundaries, including national lobbying. The strategic commissioning function is responsible for defining the outcomes required for the population from the system, informed by the JSNA. As the ACS matures, it would be responsible for developing and managing the outcomes and contractual framework for a capitated outcomes-based contract. Through shared leadership, the system would need to ensure achievement of financial balance and future sustainability and the strategic commissioning function would be required to assure this is in place. The strategic commissioning function within the system would manage strategic risks, assure compliance with policy and regulatory frameworks and foster a culture of continuous improvement across the system. Assurance on a range of areas would be required such as: • Quality and patient safety • Emergency planning and business continuity • Safeguarding
	Tactical Commissioning
	Tactical commissioning relates to the commissioning of services which enhance and support core health, public health and social care services. They are often provided by a wide range of providers, including social enterprises and the voluntary and community sector, and usually cover a specific population or geographical area. As the Accountable Care System matures and moves toward a capitated, outcome-based approach, it is envisaged that many tactical commissioning responsibilities will become the responsibility of the Accountable Provider Organisation.

	Operational Commissioning
	Operational commissioning refers largely to decisions taken on a single individual level: they include individual packages of care and decisions on individual referral and treatment pathways that are within scope of current policy.

3.9 The Joint Commissioning function would need to undertake strategic, tactical and some operational commissioning in the early stages of the ACS, while an Accountable Provider Organisation (APO) is developing. It is acknowledged that some of the tactical and operational commissioning could then become the responsibility of the APO in the longer term.

4 OPTIONS FOR THE DEVELOPMENT OF A JOINT COMMISSIONING FUNCTION

4.1 The King's Fund paper 'Options for Integrated Commissioning – Beyond Barker' provides three broad options on how a single commissioning function, with a single integrated budget, could be developed:

- Option 1: Build on existing organisational and policy arrangements
- Option 2: Option 2a: CCG to take responsibility

  Option 2b: LA to take lead responsibility
- Option 3: A new vehicle for strategic commissioning

4.2 These broad options have been considered and developed into six more detailed options, to be taken forward into an options appraisal for the development of joint strategic commissioning arrangements in Somerset. Each of the six options is detailed in Table 3.

Table 3: Six options considered in the options appraisal

Option 1	Do nothing option – commissioning arrangements remain separate, split between the two organisations with separate decision-making
Option 2	Greater use of existing funding alignment arrangements, such as Section 75/Better Care Fund
Option 3	The CCG acts as lead commissioner for all health, social care and public health commissioning
Option 4	The Local Authority as lead commissioner for all health, social care and public health commissioning
Option 5	The Local Authority acts as lead commissioner for Children and Young Peoples services. The CCG acts as lead commissioner for Adult Services
Option 6	Commissioning of health, social care and public health services is undertaken through a new vehicle such as a Joint Health and Care Board

Options Appraisal

4.3 A detailed appraisal of these options has been undertaken using The Chartered Institute of Public Finance and Accountancy principles. An options matrix has been developed that has assessed each option against the following aims:

- achievement of the outcomes set out by the system through the Sustainability and Transformation Plan
- achievement of straightforward and acceptable governance under current legislation
- achievement of financial advantages for the public purse
- making the most effective use of the workforce skills and experience in Somerset.

4.4 The detailed options appraisal is set out in Appendix 2 but Table 4 below summarises the main findings.

Table 4: Summary of the Results of the Detailed Options Appraisal

Option	Score	Options appraisal summary
Option 1 Do nothing option – commissioning arrangements remain separate, split between the two organisations with separate decision-making	31	This option is least disruptive for organisations but less likely to achieve significant improvements in population health outcomes or efficiency for the public purse. This option does not make best use of the different commissioning skills and expertise across the workforce. It is unlikely that the relationship between commissioners will improve as this perpetuates the organisational silos.
Option 2 Greater use of existing funding alignment arrangements, such as Section 75/Better Care Fund	48	This option requires no significant changes to current structures. It would be entirely possible for commissioners to enter into new or expanded Section 75 agreements to pool budgets covering a wider range of services and more joint commissioning posts could be established to support this. Without more collaborative decision making in place also, this option is clumsy, requiring the same decisions to be taken to separate boards.
Option 3 The CCG acts as lead commissioner for all health, social care and public health commissioning	50	Lead responsibility for strategic commissioning is delegated to the CCG. The clear advantage of this is that there would be a single and unambiguous local body with clear responsibility and accountability for the entire integrated budget. Lead commissioner arrangements are already used between the CCGs and local authority (e.g. Integrated Community Equipment Service). This option is arguably more suited to commissioning of specific services rather than complete delegated authority for statutory duties.
Option 4 The Local Authority as lead commissioner for all health, social care and public health commissioning	54	Lead responsibility for strategic commissioning is delegated to the County Council. The clear advantage of this is that there would be a single and unambiguous local body with clear responsibility and accountability for the entire integrated budget. Lead commissioner arrangements are already used between the CCGs and local authority (e.g. Integrated Community Equipment Service). This option is arguably more suited to commissioning of specific services rather than complete delegated authority for statutory duties.
Option 5 The Local Authority acts as lead commissioner for Children & Young Peoples services, the CCG acts as lead commissioner for Adult Services	37	This option makes good use of the skills and knowledge of the existing workforce and would require little organisation disruption; however, it poses a significant risk of detaching children and adults services, thereby not achieving the advantages that come about through a whole population approach or capitated outcomes-based contract. This option could significantly hinder the smooth transition between children and adults services.
Option 6 Joint commissioning of health, social care and public health services is undertaken through a new vehicle such as an Joint Health and Care Board	57	This option is to establish a new joint vehicle to be the single commissioner. The statutory commissioning organisations would retain their respective responsibilities but the organisations would take decisions at the same time through a joint meeting of the CCG Governing Body and Cabinet. This joint Board would control a significant pooled budget under a Section 75 Agreement. The CCG and local authorities would retain their respective statutory responsibilities and would therefore not require delegated authority. This new governance could be supported by a single combined officer base from the two organisations, making good use of the skills and providing options for greater efficiency. This option could involve an extensive organisational change however, there could be an evolutionally process that would not involve a complete upheaval of existing organisations in one go.

Proposed Preferred Option

4.5 Taking into account the outcome of the options appraisal, the proposed preferred option is Option 6: the development of a new vehicle bringing together the commissioning of health, public health and social care, whilst retaining organisational statutory responsibilities. The rationale for this recommendation is set out below.

Achievement of outcomes set out by the system

4.6 The strength of a single vision and a single robust commissioning function could bring far greater focus to commissioning for the needs of the population both now and in the future.

4.7 This option establishes a Somerset Together Health and Care Board, bringing together the CCG Governing Body, NHS England and the SCC Cabinet to be at the heart of the joint commissioning function. This option could strengthen commissioning against population needs, in line with the JSNA and Health and Wellbeing Strategy. The degree to which this option could influence outcomes will be determined by the effectiveness of the shared leadership across the system, including confirmation and clarity of NHS England's role within the arrangement.

4.8 This model offers the widest possible coordination of services across the whole Health and Wellbeing system.

Achievement of acceptable governance under current legislation

4.9 The bringing together of the SCC Cabinet and the CCG Governing Body into a Somerset Together Health and Care Board would require robust governance structures to be established. It is important that the structures can operate within the complex legal framework of both organisations, preferably without having to have delegated authority for statutory responsibilities.

4.10 This option has the added benefit of increasing local democratic accountability within the NHS as well as maintaining strong clinical engagement and leadership within health and social care.

Achievement of financial advantages

4.11 This option has the ability to achieve savings in overheads and staffing by reducing duplication, estate and travel and enhancing shared back office functions.

4.12 Commissioning across the population could incentivise increased investment in preventative work thereby bringing about greater efficiencies in the longer term. This option enables efficiencies to be made through integration of the management support and by having the potential to pool wider budgets to gain the greatest health and wellbeing benefit.

Making the best use of workforce skills and experience

4.13 This option would require an integrated commissioning construct that should draw on the skills and expertise right across the health and wellbeing system in Somerset. This could provide an exciting employment and development opportunity for commissioners, providing a breadth of experience.

4.14 This option would make best use of the skills and resources of the county as a whole, building on the community development and communication and engagement skills across the system.

5 THE PROPOSED MODEL

Governance

5.1 Appendix 3 sets out the proposed Commissioning Governance structure for the health, public health and social care system. This would sit within the wider Somerset partnership structures within the ACS as seen in Appendix 4.

5.2 This option uses joint decision making through a joint meeting of the CCG Governing Body, NHS England and SCC Cabinet. The meetings would be held in public and would need to satisfy the decision-making arrangements and governance of each of the organisations. The organisations would retain their statutory responsibilities in line with the current legislative requirements. It is envisaged that the boards would also need to continue to meet separately for governance reasons and to manage business that may be outside of the joint commissioning. However, it is likely that the need for separate meetings would be reduced.

5.3 Any proposals for joint commissioning arrangements which result in a change to the role of the CCG Governing Body or SCC would require amendments to the appropriate constitutions. For SCC, these changes would need to be approved by Full Council. For the CCG any changes would need to be agreed with NHS England.

5.4 NHS England would need to be satisfied that the constitution complies with the particular requirements of the NHS Act 2006. The submission would need to be discussed with relevant NHS England regional leads and should include:

- reasons why the variation is being sought
- assurance that member practices have agreed to the proposed changes
- assurance that stakeholders have been consulted if required
- assurance that the CCG has considered the need for legal advice on the implications of the proposed changes
- a complete impact assessment of the changes

5.5 It is proposed that the Health and Wellbeing Board continues to undertake its statutory duties to produce a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. This Board will, as now, have an influencing role across the system to ensure all organisations are aligning their strategic plans with the needs of the population and the priorities in the Health and Wellbeing Strategy.

Scope of joint commissioning

5.6 Bringing the commissioning function together would enable a joint approach to a wide range of issues impacting Somerset residents and could significantly benefit the Somerset population, but particularly vulnerable people who experience multiple issues and inequalities. The aspiration should be for the scope of joint commissioning to be as broad as possible in order to gain maximum gain for the population.

5.7 To maximise the opportunities for joint planning, cost effective commissioning and the development of integrated pathways of care, it would be the intention to use pooled budgets across the following areas. It should be noted that there will need to be a phased approach to the pooling of budgets as the ACS matures:

- all health budgets currently held by Somerset CCG, with the exceptions of any legal exclusions
- NHSE Specialised and Primary Care Commissioning budgets
- all adult and children social care budgets, with the exceptions of any legal exclusions
- public health commissioning budgets

Financial considerations

5.8 Whilst the joint board provides the opportunity for the organisations to take the same decisions simultaneously, there is still a need to pool potentially significant budgets through a Section 75 agreement in order to commission jointly. This would build on the existing pooled budget arrangements currently in place in the county but have the added benefit of having much clearer transparency through the work of one single officer base.

Requirements for Section 75 under the current regulations are detailed below:

- to improve the provision of services
- to have a written agreement with agreed aims and objectives
- to identify the functions to be supported and the people who will benefit
- agreement on contributions to the Fund
- an agreed length of the agreement

- agreed hosting arrangements and a pooled fund manager
- plans for managing over and underspends
- exit arrangements

5.9 An agreement on scope of budgets to be pooled over time needs to be more fully explored in the full business case.

Exclusions from S75 Agreements

5.10 The use of Section 75 enables NHS bodies and local authorities to create pooled budgets using contributions from their individual organisations. However, Section 75 does *not* allow for all health and social care services to be included within a joint fund. For example, NHS organisations are prevented from delegating the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services

5.11 Whilst local authorities can delegate a broad range of their services, the legislation sets out some detailed exclusions. Given that both NHS organisations and local authorities can utilise these arrangements, it is not considered that restrictions around Section 75 should hinder any approach we wish to take towards creating joint commissioning.

5.12 Given that all functions cannot yet be included within a pooled budget, other arrangements will need to be established to compliment the Section 75 agreements. Possible solutions to be discussed may include:

- aligned budgets - ensuring transparency of remaining budgets and ensuring alignment to overall objectives
- grants to transfer money between organisations
- lead/joint commissioning arrangements for some services

Audit and Right of Access

5.13 Where a pooled budget is in place, one partner is required to act as the host (Host Partner) and becomes responsible for the budgets, accounts and audits, as well as for paying suppliers. This would reduce transactional costs and bureaucracy but would need agreement by both parties. Each organisation would need to ensure that the relevant regulatory requirements relating to their funding stream are met when funding decisions are made.

5.14 The parties will each have responsibilities for audit and so the arrangement needs to provide for the responsibilities of the Host Partner relating to audit and the right of internal and external auditors to be given access to anything they need to carry out their duties.

Risks

5.15 The treatment of risks from services commissioned from the pool will need to be agreed on with the establishment of the fund. Risks arising from services outside of the pooled fund will also need formal agreement on any risk share/gain share. Current risk share arrangements with providers (2017/18 to 2018/19) may need to be incorporated in the short term.

VAT

5.16 Local authorities and the NHS have different VAT treatments. Professional advice on the general VAT implications of developing a joint commissioning function has been sought. This advice suggests there may be VAT benefits to particular options for joint commissioning and these have been fed into the options appraisal. Further work would need to be undertaken to identify the extent to the potential VAT benefit (or indeed any VAT implications to any of the organisations) of the specific option to be worked up into a full business case.

Finance workforce

5.17 To deliver the joint strategy through a pooled budget, the finance teams from the organisations will need to work together, either through joint posts or an integrated back office function. There is a need for a greater understanding between the NHS and local authority staff regarding the respective financial regulations and processes of the organisations.

Information Governance

5.18 Since the establishment of Somerset CCG, a lot of work has been undertaken to ensure that, where possible, information sharing is integrated across the county. A countywide Information Sharing Protocol is in place which all health partners and SCC are signatories to and which has ensured there is a high-level, consistent approach for information governance for all participating agencies to refer to, when establishing second level information sharing agreements for specific initiatives and activities.

5.19 In accordance with the requirements of information law and 'best practice' guidance, this protocol provides a formal agreement between agencies to share information for a range of specific purposes, such as direct care or to safeguard and promote the wellbeing of the Somerset patient population, wherever they reside. Any information sharing is carried out in the context of recognising duties of confidentiality and the right to privacy in respect of patient's personal information.

5.20 Within a joint commissioning function, the aim will be to continue to promote a consistent approach to the sharing of information that will benefit individuals and services whist protecting the people that information is about.

5.21 Sharing patient information must always be within the legitimate activities undertaken by an organisation in providing a service to the public and with a legal basis for sharing. Each of the statutory bodies, as data controllers, will need to ensure they understand and retain their responsibilities as legal entities, taking into account relevant legislation such as the Data Protection and Freedom of Information Acts.

5.22 Work has begun to understand how we can best streamline our processes so that, wherever possible, all organisations adopt a common and consistent approach to information sharing and management and we enable far greater integrated decision making in the future.

5.23 There has also been considerable work to determine how to appropriately link health and social care data to support integrated commissioning decision making. This will need to be further developed in our work with NHS Digital nationally. NHS Digital controls the flow of national NHS statistical data sets. Both the CCG and SCC complete the Information Governance Toolkit which underpins the development of systems and processes to manage information governance.

Workforce

5.24 In order to support the commissioning, a joint management framework would need to be established. Appendix 5 shows a proposed integrated framework which brings the commissioners together in order to commission against population needs, in line with the JSNA and Health and Wellbeing Strategy. Whilst Somerset has a few examples of joint commissioning posts, the lack of an integrated officer base has arguably been one of the reasons for tension within the current joint commissioning and pooled budget arrangements.

5.25 In the longer term, there will need to be consideration given to which commissioning functions need to stay with the joint commissioning function and which need to be the responsibility of the APO. Initial thoughts on this are set out in Appendix 6 but will need to be continued thought throughout the development of the ACS. In part, this function list will help determine the movement of workforce required. In time, the officer base could harmonise employment but this is not considered a priority initially.

5.26 In addition to a joint commissioning function, there is scope to develop a system-wide business unit, offering the potential to integrate core functions such as business intelligence and communications across the system. This approach could not only drive greater efficiencies in the system but makes best use of the skills of the current workforce and ensures that strategic, tactical and operational commissioning use the best intelligence available.

5.27 Table 5 shows the potential functions that could be included in the business unit highlighting those that may be needed for the different levels of commissioning.

Table 5: Possible functions that could be included in the joint business unit

Strategic, Tactical and Operational Commissioning	Strategic Commissioning Function
Business Intelligence	Finance
One Public Estate	HR & OD
Communications & engagement	IT
	Corporate Governance
	Legal services
	Quality & patient safety
	Procurement

HR Process

5.28 Each organisation will be required to carry out a piece of work to identify employees who would form part of the joint commissioning function.

5.29 Following this, employees will be written to, describing how their functions align. As this paper has described, there will be no new organisation as a result of the changes, so those employees that are aligned to the joint commissioning function will continue to work for either the CCG, NHS England or SCC. This means that there will be no TUPE implications. However, there may be a new organisational agreement developed in order to support joint working arrangements across both organisations. This is likely to result in:

- different job roles and job descriptions
- a different culture and way of working
- a potential change of base to support joint working and alignment of roles
- different system level relationships with stakeholders

5.30 It is recognised that bringing together employees from the NHS and local authority will mean that employees will have different terms and conditions of employment. However, as employees are not TUPE transferring into a new organisation, respective terms and conditions would remain the same.

5.31 Throughout this change process, both the CCG, NHS England and SCC will ensure that the HR principles laid out below will be followed:

- consult and engage at the earliest opportunity with employees and their representatives and make sure all parties are kept fully informed and supported during the change process
- promote transparency, equitability and fairness in all transfer, selection and appointment processes

- ensure professional and respectful behaviour towards all employees moving between organisations
- ensure the consistent treatment of all employees
- actively promote quality and diversity standards through all transfer, selection and appointment processes
- ensure full compliance with employment legislation
- undertake early engagement with employees and their representatives to enable effective and sustainable change
- ensure equality impact assessments take place when required
- ensure that all reasonable steps are taken to avoid redundancies and work to ensure that valuable skills and experience is retained

Co-Location

5.32 In order to achieve the joint commissioning function, the officer construct would need to change significantly, with the coming together of teams and individuals from different backgrounds and cultures. Evidence suggests that co-location of teams is an important element in achieving this.

5.33 Giving consideration to the estate available across Somerset there would be significant benefits in centralising the commissioning function. The obvious options to be considered are the current headquarters of the two organisations – for example, County Hall, Taunton and Wynford House, Yeovil. The solution would need to provide sufficient capacity for commissioning staff. An options appraisal and business case would need to be conducted in Phase 2 of the project, subject to there being a decision to proceed.

Principles, Standards and Conflict Resolution

5.34 The STP has already identified and agreed 14 principles for the new ACS as set out in Appendix 7. These are equally as relevant for the joint commissioning function as they are for the rest of the system and therefore it is proposed that they should also be adopted for this workstream of the STP.

5.35 In 1994, the Standards Committee of Public Life set out seven standards of behaviour which remain widely used today. The standards, as seen below, are entirely relevant in this context and form the basis for the behaviours that would be required of the organisations and staff whilst forming and working within a new strategic commissioning function.

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

- **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership** – Holders of public office should promote and support these principles by leadership and example.

5.36 Each of the organisations has its own culture and ways of working; at times of integration, it is important that trust is built between the organisations and staff. It should be recognised that there will be challenging times and it is important to agree that is it acceptable to appropriately challenge each other where the Standards of Public Life are not being adhered to.

6 PROPOSED MOBILISATION PLAN

6.1 An indicative timeline for implementation of a Joint Commissioning function is attached as Appendix 8. This indicates a decision point in July 2017 followed by a four phased approach.

Phase 1: Decision Phase

6.2 This phase runs from May to July 2017. During this phase the emphasis would be on continuing to develop the thinking regarding what is needed for the joint commissioning function, continuing to consult and discuss initial proposals with elected members, Governing Body Members, staff and the wider health and social care system. During this phase, legal advice would also need to be obtained, particularly around the pooling of budgets, VAT implications and any legal requirements/considerations of the joint board.

6.3 There will need to be early discussions with all organisations within the health and social care system to get clarity across the system on the roles of a strategic, tactical and operational commissioner. The system will also need to

consider the willingness and options for the development of a shared business unit as proposed in Table 5.

6.4 This phase would conclude with formal proposals being put to the CCG Governing Body and SCC Cabinet in July, for a decision on the preferred option and to proceed to a full business case. During this phase, discussion would also be required with NHS England to more fully understand their involvement going forward.

Phase 2: Development of full business case and shadow working

6.5 This phase is proposed to run from July to November 2017. During this time a full business case will be developed for the preferred option and agreed by the relevant organisations. This business case will be developed in consultation with staff and leaders within the health, public health and social care system. It is proposed that the final business case is considered by the relevant organisations in November 2017 and a decision taken to proceed to Phase 3.

6.6 This phase will consider the arrangements required for the formal establishment and running of the Somerset Together Health and Care Board and will run one meeting in shadow form to help develop the relationships between the boards and test out any new operating procedures. Any organisational constitutional changes will be identified during this phase.

6.7 Shadow working arrangements would provide an opportunity for both organisations to focus jointly on development of the Outcomes Framework and progression towards an ACS.

6.8 A detailed workforce assessment will need to be undertaken by July 2017, building on the work already done, to establish those staff across the organisations that will form the joint commissioning function. It should be noted that some staff with responsibility for tactical and operational commissioning may need to remain with this commissioning function until such a time whereby their function is passed over to the new APO.

6.9 Workforce and team development will be essential during this phase and beyond to create new integrated teams and start to address differences in culture and ways of doing business. A local Commissioning Leadership Academy programme is already underway, which could be a significant step in supporting commissioners from across the system to work together on specific issues.

6.10 An informal approach to the integration of executive teams and officer groups will be started during this phase, enabling joint senior team meetings, shadowing of staff across organisations.

Phase 3: Co-location, joining up of IT and development of the business unit

6.11 This phase is proposed to run from November to April 2018. This is the mobilisation phase; as early as possible, commissioning teams will be moved

to one location with relevant teams physically sitting together and an integrated IT solution achieved.

6.12 Similarly, the business unit will be formed, for the interim, while the system is transforming. This may include staff who will ultimately will be placed within the APO.

6.13 During this phase, any changes to relevant constitutions will need to be formally agreed, following engagement with relevant stakeholders including GP member practices. In addition, the new Somerset Together Health and Care Board will hold its inaugural meeting formally in public.

6.14 The aim, by the end of this phase, is for:

- the governance structures to have been tested and, where needed, organisational constitutions changed
- the first formal meeting of the new Somerset Together Health and Care Board to have taken place
- all joint commissioners to be in one office-base
- new, integrated senior leadership arrangement in place
- workforce to be integrated together in appropriate teams
- the new function and business unit to be using one IT strategy
- an information governance framework in place

Phase 4: Full implementation

6.15 The phase will take place from April 2018 and beyond. It will be a phase of consolidating the new model and reviewing opportunities for the future as the national legislative framework allows and the ACS develops.

7 SUMMARY AND RECOMMENDATIONS

7.1 This paper has set out options for the development of a new joint commissioning function for Somerset as an integral part of developing an ACS by 2019.

7.2 The paper proposes the development of a new vehicle to lead the joint commissioning of health, public health and social care, whilst retaining organisational statutory responsibilities. This approach makes much greater use of the power to develop pooled budget arrangements through Section 75 agreements and enables us to make use of the commissioning skills and experience across the two organisations through a joint management arrangement.

7.3 The Somerset CCG and SCC Cabinet are asked to approve the recommended option and approach in principle, and request that a more detailed business case is developed for further consideration in November 2017. NHS England is asked to consider this proposal as part of a phased approach towards an ACS for Somerset by April 2019.

References:

- *Integrated Commissioning to support Joined up care, better health and better value – draft discussion paper (C Parry)*
- *The Kings Fund – Place-based systems of care. Particularly pages 35 to 38*
- *The Kings Fund – Options for Integrated Commissioning – Beyond Barker. Particularly pages 39 to 55*
- *Exploring Strategic Commissioning Models – A discussion paper*
- *Faulty by Design. The state of public-service commissioning – Reform*
- *Need to Nurture – Outcomes-based Commissioning in the NHS*
- *CIPFA Options Appraisal Guidance*

Appendix 1

Somerset CCG and Somerset County Council

Joint Commissioned Services/budgets/other

Description	Relationship	Budget	Comments
Integrated Community Equipment Store	County Council is the lead commissioner of a joint contract	Pooled budget 50/50 split £1,039,609 each Section 75 agreement?	Overseen by JCB
Carers Service	County Council is the lead commissioner of a joint contract	Pooled Budget 50/50 split £203,500 each Section 75 agreement?	Overseen by JCB
Learning Disabilities	County Council is the lead Joint LD manager appointment hosted by County Council	Pooled budget 75/25 split CCG contribution - £16,904,490 Section 75 agreement	Overseen by JCB
Mental Health	Joint MH manager appointment hosted by CCG	Pooled budget for some services e.g. CAMHS Section 75 agreement	Overseen by JCB (On CCG Schedule – Mental illness specific grant contribution £106,225 and Personal Care £311,525)
Reablement	Under Better Care Fund – Section 75 agreement	£14,305,000 – Section 75 agreement	HWB agree strategic direction of fund Overseen by JCB
Housing adaptations	Under Better Care Fund	£3,466,000 – Section 75 agreement	HWB agree strategic direction of fund Overseen by JCB
Improved DTOC arrangements	Under Better Care Fund	Up to £3m – Section 75 agreement	HWB agree strategic direction of fund
Person Centric Care	Under Better Care Fund	£20,908,000 – Section 75 agreement	HWB agree strategic direction of fund

Appendix 2

Decision Matrix Tool

Development of a Joint Commissioning Function

Options	Proposal
Option 1 – Retain existing Strategic commissioning arrangements **Aggregated Score = 31**	• Sovereignty of organisations remains the same • Commissioning and officer arrangements remain as current, embedded in separate organisations • Existing lead organisation and pooled budget arrangements remain in place • Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy
Option 2 – Increased use of existing legal arrangements e.g. BCF/Section 75 agreement **Aggregated Score = 48**	• Sovereignty of organisations remains the same • Far greater use of a legal framework to pool resources under section 75 agreement • Officer workforce remains as current embedded in separate organisations with no co-location • Decision-making undertaken by separate sovereign organisations • Health and Wellbeing Board would need to be enhanced to continue to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy but also to have increased responsibility to oversee significant pooled budgets
Option 3 – CCG as the lead commissioner **Aggregated Score = 50**	• Sovereignty of organisations remains the same • CCG leads the commissioning of health, social care and public health services requiring formal delegation of statutory duties from SCC to the CCG and use of a legal framework to pool resources to a far greater extent • Integration and co-location of social care and public health officer workforce with CCG • Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy
Option 4 – SCC as the lead commissioner **Aggregated Score = 54**	• Sovereignty of organisations remains the same • SCC leads the commissioning of health, social care and public health services requiring formal delegation of statutory duties from CCG to SCC and use of a legal framework to pool resources to a far greater extent • Integration and co-location of CCG officer workforce with SCC • Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy
Option 5 – CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people **Aggregated Score = 37**	• Sovereignty of organisations remains the same • Integration and co-location of officer workforce in line with population based commissioning responsibility • Formal delegation of statutory duties relating to population group from CCG and SCC or use of a legal framework to pool resources to a far greater extent • Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy

Options	Proposal
Option 6 – Commissioning of health and social care through a new commissioning vehicle **Aggregated Score = 57**	• Sovereignty of organisations remains the same • No formal delegation of statutory duties from CCG to the SCC **but** use of a legal framework to pool resources to a far greater extent • Integration and co-location of CCG and SCC officer workforce • Joint decision making through a formal joint structure with democratic and clinical involvement • Health and Wellbeing Board continues to fulfil statutory duties in relation to JSNA and setting the strategic direction through the Health and Wellbeing Strategy

Scoring:

1	The model will bring significant negative impacts on this objective
2	The model will slightly negative impacts on this objective
3	The model will not impact on this objective positively or negatively
4	The model will achieve moderate improvements in this objective
5	The model will significantly benefit this objective

Achievement of Outcomes

Ability of the model to:	Commission for improved population health & wellbeing outcomes	Reduce health & social inequalities	Develop well co-ordinated & seamless care	Support individuals & communities to take responsibility for their own health & wellbeing	
Option 1 – Do nothing option	2. Unless we commission differently outcomes are likely to deteriorate due to funding pressures.	2. Inequalities are currently widening, this is likely to increase	2. Current organisational silos will not be broken down, further cost shunting likely as funding pressures increase	3. This is unlikely to change if there is not a cultural shift across the whole system	9
Option 2- Build on existing funding alignment arrangements	4. The Better Care Fund is currently narrow and over regulated nationally. It is unlikely that this option would achieve the scale and pace of change required for significant gain in population health and wellbeing. Use of the Section 75 agreement to pool funding across the two organisations could however provide a legal vehicle if it was used to maximum effect.	4. Joint commissioning under this model is currently very service driven and less person-centred with little consideration given to social influences on health. This option could however bring about significant advancements in the joining up of commissioning across organisations and could provide a clear and strong commissioning function with a single line of accountability. To narrow health inequalities this option would need to be used at scale for a whole population budget rather than specific services and would need to be commissioned through one officer construct.	3. This option has not broken down organisational silos to date and is unlikely to further benefit the development of well coordinated and seamless care	3. This requires a radical shift in the commissioning and providing culture. This will only be achieved at scale through a strong strategic vision driven forward by strong commissioning. Using a Section 75 agreement to pool resources and integrate commissioning can provide a legal vehicle however it would only work with significant transformation of officer arrangements and culture to ensure the vision of increased community and individual responsibility is driven through.	14

Ability of the model to:	Commission for improved population health & wellbeing outcomes	Reduce health & social inequalities	Develop well co-ordinated & seamless care	Support individuals & communities to take responsibility for their own health & wellbeing	
Option 3 – CCG as lead Commissioner Model	4. The lead commissioner model could drive more of a whole system, whole population approach to health and wellbeing improvement. The CCG as lead commissioner could restrict the benefits to the traditional People based services and have less influence over place based commissioning.	4. This model could lead to greater accountability for tackling health and social inequalities as lines of responsibility are clearer. Services could be commissioned with a greater emphasis on the needs of vulnerable people as a more complete picture of need could be achieved.	4. This model could achieve better co-ordination of Health and Social Care Services due to stronger and simplified commissioning.	4. This option could foster local empowerment depending on the approach adopted by commissioners. A traditional medical model of health would be less likely to achieve this effect	16
Option 4 - LA as the lead commissioner model	4. The lead commissioner option could drive more of a whole system, whole population approach to health and wellbeing improvement. The LA as lead commissioner could bring added benefits by linking the traditional people-based services with place-based commissioning.	4. This model could lead to greater accountability for tackling health and social inequalities as lines of responsibility are clearer. Services could be commissioned with a greater emphasis on the needs of vulnerable people as a more complete picture of need could be achieved. The LA as lead could present more opportunities to align work on the medical and social influences on health to a greater extent.	4. This model could achieve better co-ordination of a wide range of services including, traditional health and social care services. A wider range of services could be aligned and commissioned with a common vision.	4. This option could foster local empowerment depending on the approach adopted by commissioners. This is more likely to be achieved with the LA as lead commissioner due to adoption of a more asset-based approach and greater experience in community development	16

Ability of the model to:	Commission for improved population health & wellbeing outcomes	Reduce health & social inequalities	Develop well co-ordinated & seamless care	Support individuals & communities to take responsibility for their own health & wellbeing	
Option 5 - CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people	2. The lead commissioner option could drive more of a whole system, whole population approach to health and wellbeing improvement. However this option maintains some of the current division in the county and even extends it further around the transition of young people into adult services.	2. This option could lead to increased age inequalities as well as inequalities in relation to deprivation. It does not recognise the importance of a Think Family approach. To tackling inequalities and the importance of the family in lifting people out of deprivation.	3. Whilst this may help co-ordinate care for adult and children, this option is considered detrimental to the transition of young people into adult services.	3. It is not envisaged that this option would have a significant positive or negative effect on supporting individuals to take responsibility for their own health and wellbeing. It could be argued that the separation of children and families lacks recognition of the importance of families	10
Option 6 – A new Vehicle	4. This option places a new joint decision making body at the heart of the new Accountable Care System. This option could provide a strengthened commissioning function, bringing together democratic and clinical decision making. This option provides significant opportunity to influence outcomes, bringing vision across all factors that influence health.	4. This option has the ability to join up commissioning across the whole Health and Wellbeing System, including the wider determinants of health. The degree to which the option could influence outcomes will be determined by the scope of services included in the joint commissioning function.	5. This model could offer significant co-ordination of services across the system. The degree of clarity on commissioning arrangements could hinder the strength of commissioning achieved.	4. This option would make best use of the skills and resources of the county as a whole, building on the community development and communication and engagements skills across the system. The degree to which these can be galvanised using a shared leadership model could restrict the benefits achieved by this option.	17

Governance Considerations

Ability of the model to:	Provide clear and strong leadership to the new Accountable Care System	Enable local democratic and clinical engagement and accountability	Commission for a whole population using a capitated outcome-based contract	Be feasible under current legislation (Not scored	
Option 1 – Do nothing option	3. Unlikely that any less or more clarity will be achieved.	3. Unlikely to change	1. It is unlikely that a whole system vision would be achieved using this model due to the continuation of organisational silos	This option is already in place	7
Option 2- Build on existing funding alignment arrangements	3. It is not considered that this option would significant improve clear and stronger leadership of the system, it is an extension of existing arrangements	4. BCF is currently overseen by the Health & Wellbeing Board. A much more considerable section 75 agreement could also be overseen by an enhanced Health and Wellbeing Board. Unless the Board was given considerable delegated powers, the agreement would also need to be overseen by SCC Cabinet and the CCG, possibly through a regular joint public meeting.	4. If used at scale, this option could be used to commission a whole population capitated, outcomes-based contract, but would require significantly stronger partnership working arrangements and agreed governance	This is already feasible under current legislation but underused.	11
Option 3 – CCG as lead Commissioner Model	4. This option would provide a single local body with clear commissioning responsibility. The option would not bring the whole strength of commissioning skills as some would need to remain in SCC. This option could be confrontational and not improve the relationship of the two organisations at a time when collaboration is needed more than ever	4. If the CCG was the lead there would be a need to increase the democratic accountability of commissioning in order to enable the delegation of statutory duties. Clinical engagement and accountability would be maintained	5. This outcome is fully achievable under this option if the CCG had delegated authority to undertake the social care and public health responsibilities	This option is considered feasible but would require significant delegation of statutory duties	13

Ability of the model to:	Provide clear and strong leadership to the new Accountable Care System	Enable local democratic and clinical engagement and accountability	Commission for a whole population using a capitated outcome-based contract	Be feasible under current legislation (Not scored	
Option 4 - LA as the lead commissioner model	4. This option would provide a single local body with clear commissioning responsibility. This option could be confrontational and not improve the relationship of the two organisations at a time when collaboration is needed more than ever	4. If the LA was the lead, local democratic accountability would be central to the commissioning of health and social care services. The process of decision-making would be aligned to the current council democratic processes. Clinical engagement and accountability would need to be carefully considered in order to maintain it	5. This option enables system join up for all SCC and CCG commissioned services not restricted to the health, social care and public health services. This approach could commission a whole population, capitated, outcomes based contract	This option is already in place	13
Option 5 - CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people	4. This option would provide clear and potentially specialised leadership to the system however this would not be shared leadership, it would need to be aligned between adults and children's services	3. This would provide greater democratic accountability in children's commissioning and less in adults.	2. This option would hinder the commissioning of a whole population, capitated, outcomes based contract. It would require collaboration across the two organisations and therefore does not take the system any closer to commissioning for the whole of Somerset.	This is already feasible under current legislation but underused.	9
Option 6 – A new Vehicle	3. This option requires shared leadership across a range of partners. It would require significant restructuring and development of the Board as well as significant delegation of authority.	5. This option could provide significant democratic and clinical accountability in decision making with the right construction of governance arrangements	5. This option enables whole system alignment throughout the health and wellbeing system, not restricted to the health and social care services. This approach is capable of commissioning a whole population, capitated outcomes based contract but will require significant integration of the officer structures to be able to achieve it.	May need work around for some services that cannot come under a Section 75 agreement. Will require formal delegation of statutory duties	13

Officer Considerations

Ability of the model to:	Provide one strong and robust strategic commissioning and contract management function	Create an environment of collaboration between commissioners & providers	Develop excellent commissioning skills & expertise across the system	Requires organisational reform (Not Scored)	
Option 1 – Do nothing option	2. No change therefore the relationships are unlikely to improve, could deteriorate as organisational knowledge is lost	3. Unlikely to change, this model maintains silos	2. Little sharing of resource and expertise, as capacity in the system decreases this is likely to worsen	None needed.	7
Option 2- Build on existing funding alignment arrangements	4. Significant use of the Section 75 arrangement is unlikely to achieve a stronger commissioning arrangement as this option just extends the current financial pooling further	4. This model could be detrimental to fostering collaboration if national imperatives are imposed (e.g. BCF) that are counter to the local direction of travel. If not done under the BCF however great collaboration could be achieved through an alignment of commissioning priorities	3. This option is unlikely to achieve significant benefits to developing skills across the system, it is an extension of the financial pooling only	This option does not require changes to the sovereignty of the different organisation but does require significant organisational change both in terms of the staffing structures and culture.	11
Option 3 – CCG as lead Commissioner Model	4. This option is likely to provide a stronger single voice for commissioning however it would be more limited to health and social care and less likely to maximise the opportunities to influence the wider determinants of health	4. Greater clarity of roles in the system could help develop better collaboration between commissioners and providers. The CCG would have to develop a greater collaboration with social care providers than it currently has	3. The different skills within health and social care commissioning would be brought together in the CCG under this option however there would be less of a critical mass of commissioners and therefore less opportunity to learn from a wider breadth of skills.	This option does not require changes to the sovereignty of the different organisation but does require organisational change both in terms of the staffing structures and culture.	11

Ability of the model to:	Provide one strong and robust strategic commissioning and contract management function	Create an environment of collaboration between commissioners & providers	Develop excellent commissioning skills & expertise across the system	Requires organisational reform (Not Scored)	
Option 4 - LA as the lead commissioner model	5. This option could provide a strong clear commissioning function. Both people and place based commissioning could be aligned offering considerable benefits to social influences on health. This option has the additional benefit of integrating different skills, experience and knowledge of commissioning.	4. Greater clarity of roles in the system could help develop better collaboration between commissioners and providers. The LA would have to develop a closer working relationship with health providers than it currently has.	4. The skills within health and social care commissioning would be used to better effect. This option also offers input from skills and experience of different forms place of commissioning	This option does not require changes to the sovereignty of the different organisation but does require organisational change both in terms of the staffing structures and culture.	13
Option 5 - CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people	3. This option maintains a split in the commissioning and contract management functions, just split in a different way than it currently is.	3. This option goes no further in creating an environment of collaboration between commissioners and providers it is just split in a different way than it currently is.	3. This option does not make best use of the complete set of commissioning skills across the system, it maintains silos, just different silos that we currently have	This option does not require changes to the sovereignty of the different organisation but does require organisational change both in terms of the staffing structures and culture. It also relies heavily on significant delegation of responsibilities	9
Option 6 – A new Vehicle	4. Lines of responsibility are shared providing less clarity than some of the other options. This option will require significant restricting of the commissioning function in order to achieve benefit.	4. As this option requires the integration of commissioning officers, it does provide an opportunity to join up some strategic and operational commissioning support as well as some back office functions which could lead to greater collaboration	5. This option could help develop commissioning skills depending on the integration of the officer base that would also be required.	This option does not require changes to the sovereignty of the different organisation but does require organisational change both in terms of the staffing structures and culture.	13

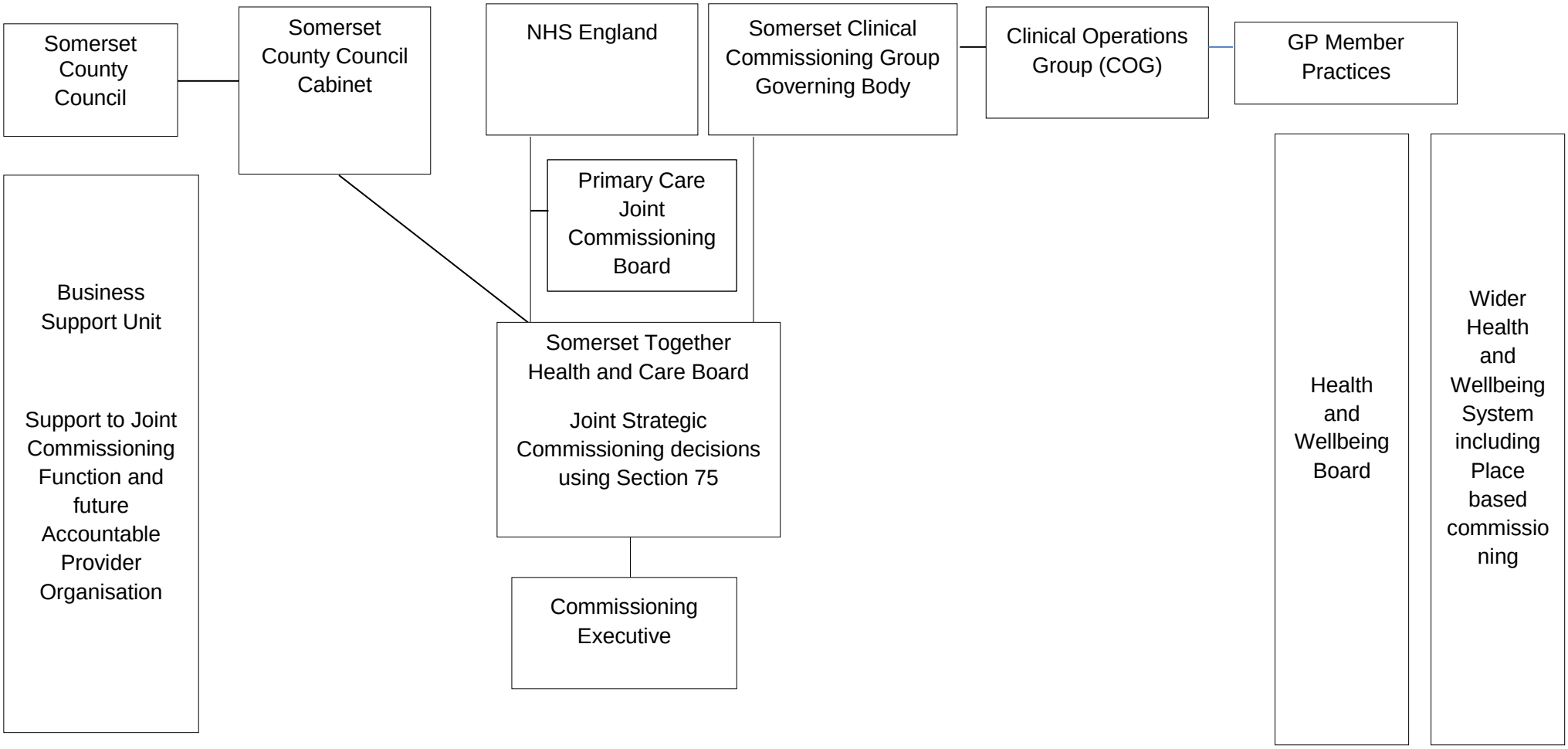
Financial Considerations

Ability of the model to:	Make best use of the Somerset £	Achieve management efficiencies	Make best use of VAT regulations	
Option 1 – Do nothing option	2. Likely to deteriorate as less likely to invest jointly in prevention therefore the system will become increasingly less sustainable	3. Unlikely to achieve management efficiencies	3. No different than current arrangements	8
Option 2- Build on existing funding alignment arrangements	5. There would be significant benefits in bringing together these significant streams of public funding and commissioning as one entity, thereby avoiding duplication and cost shunting. The strength of a single vision could bring far greater focus to commissioning for the needs of the population now and in the future. Commissioning across the population and with a capitated budget will incentivise increased investment in preventative work, thereby bringing about greater efficiency in the longer term.	3. This option simply enables greater pooling of the funding and aligned commissioning priorities, it does not include a joint officer structure and therefore is unlikely to achieve significant management efficiencies	4. There could be VAT benefits if the pooled arrangements were le4d by SCC	12
Option 3 – CCG as lead Commissioner Model	4. This option could provide some marginal benefits in the use of the Somerset pound but it depends on the degree to which delegated authority is passed.	4. Could be some efficiencies through shared roles however this is likely to be restricted if the co-location is at Wynford House	2. This option is likely to be disadvantageous due to the different VAT treatment in the NHS and LA	10

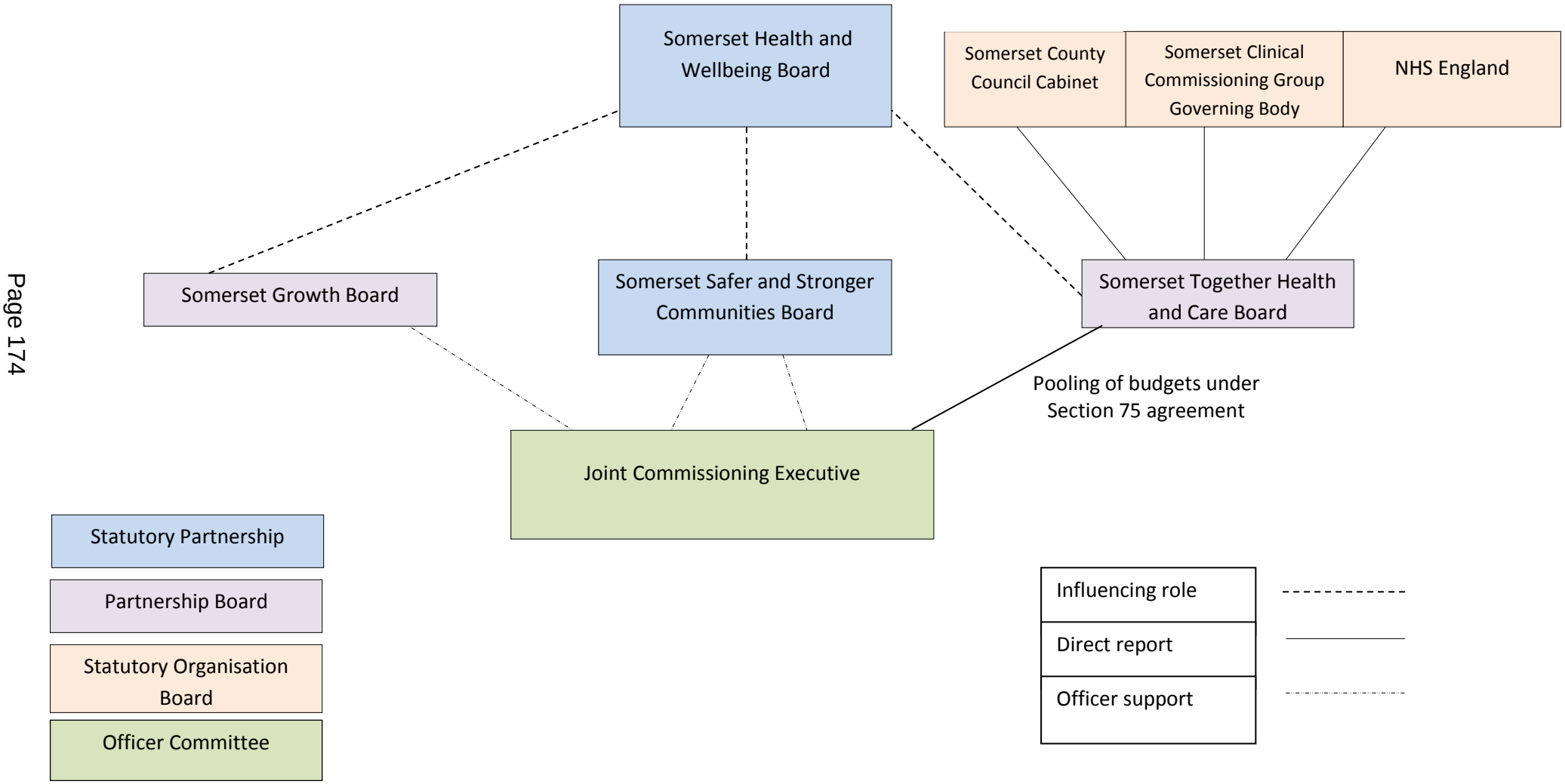
Ability of the model to:	Make best use of the Somerset £	Achieve management efficiencies	Make best use of VAT regulations	
Option 4 - LA as the lead commissioner model	4. This outcome could be improved if the LA were the lead commissioner due to less duplication and greater efficiencies. This could be further enhanced if the LA was the lead commissioner as there would be a greater potential for joint investment in some of the wider social and environmental influences on health	4. Could be some efficiencies through shared staffing, estates etc.. This could be more substantial than option 3 if the co-location was County Hall as there could be greater use of a wider range of support staff	4. This option is likely to be advantageous due to the different VAT treatment in the NHS and LA	12
Option 5 - CCG as Lead Commissioner for Adults and SCC lead commissioner for Children and young people	3. This option simply cuts the commissioning in a different way than it currently does, it is not envisaged that it would make significant difference to maximising the use of the Somerset £	3. As this option maintains a split between organisations it is unlikely that this option would make significant efficiencies in management costs	3. It is unlikely there is significant difference than current arrangements	9
Option 6 – A new vehicle	5. This option enables efficiencies to be made through integration of the commissioning function and by having the potential to align other budgets and commissioning to gain the greatest health and wellbeing benefit	5. This option has the ability to achieve savings in overheads and staffing by reducing duplication, estate and travel and enhancing shared back office functions	4. This option is likely to be advantageous due to the different VAT treatment in the NHS and LA if the LA becomes the accountable body for the entity	14

Appendix 3

Proposed Joint Commissioning Governance for the Somerset Accountable Care System



Potential Countywide Strategic Partnership Structures



OFFICE SUPPORT (DRAFT)

Appendix 5

HEALTH & WELLBEING BOARD
(Setting strategic direction for Health and Wellbeing)

SOMERSET COUNTY COUNCIL
(Retaining statutory social care and public health responsibilities – set budget and monitor performance and outcomes)

SOMERSET TOGETHER HEALTH & CARE BOARD
(Jointly commissioning health and social care and public health)

SOMERSET CLINICAL COMMISSIONING GROUP
(Retaining statutory health responsibilities – set budget and monitor performance and outcomes)

JOINT COMMISSIONING FUNCTIONS

- Longer term strategic planning and oversight
- Commission in line with the JSNA and HWB Strategy
- Strategic influence across wider health and wellbeing system and across boundaries
- Defining the outcomes and development of Outcomes Framework
- Leadership of the STP
- Contracts and commercialisation
- Assurance and contract management
- Management of strategic risks
- Achievement of financial balance and sustainability
- Ensuring focus on continuous improvement
- Ensuring compliance with policy & regulatory frameworks
- Some continued tactical commissioning

SOMERSET TOGETHER EXECUTIVE LEADERSHIP TEAM

Specific structure of this team to be developed in Phase 2

PUBLIC, PATIENT AND SERVICE USER INVOLVEMENT, ENGAGEMENT AND PARTICIPATION

JOINT COMMISSIONER BUSINESS SUPPORT FUNCTIONS -

- Finance
- Corporate governance
- Shared HR / OD function
- Shared legal advice of commissioning functions
- Shared procurement
- Quality and safety function
- IM&T

WHOLE SYSTEM BUSINESS SUPPORT FUNCTIONS -

- Shared business intelligence
- Estates
- Communications

Appendix 6

Joint Commissioning Functions – Initial Thoughts

* A significant part of this activity will be undertaken jointly. Contracting responsibility could sit with an APO in the future under a system where budgets have been delegated. The strategic commissioner will have a contractor role to contract with the APO

DRAFT COMMISSIONING REFORM AND GOVERNANCE (subject to agreement with STP)		
	Strategic Commissioning	Accountable Provider Organisation
Primary Care	X	
Enhanced Services		X
Human Resources and OD	X*	X*
IM&T Primary Care		X
Mental Health and LD	X	X
Community Contracts		X
Service Improvement/ Development		X
Somerset clinical networks		X
GP Service Leads		X
Strategy	X	
Service Development		X
OBC contract & outcomes	X	
Governance including FOI & Information Governance	X	X
Emergency Planning	X	X
Contracting	X	X
IT programmes – Sider		X
Discharge to assess		X
Continuing Healthcare	X	X
Residential and Nursing homes provision	X	X
Homecare including reablement homecare	X	X
Community Development & Wider Determinants of Health	X	X
Personalisation support services		X
Joint Equipment Service	X	X
Information and Demand Management approaches (e.g. Somerset Direct)	X	X
Public Health commissioned Services	X	X

DRAFT QUALITY & PATIENT SAFETY (subject to agreement with STP)		
	Strategic Commissioning	Accountable Provider Organisation
Medicines management		X
Individual Funding Reviews		X
Safeguarding	X*	X*
Quality	X*	X*
PALS	X*	X*
Continuing Health Care		X
Engagement & consultation	X	
Patient Safety	X*	X*
Equality Delivery System	X	
Infection control		X
Risk management	X*	X*
Communications/ engagement	X*	X*

DRAFT FINANCE & PERFORMANCE (subject to agreement with STP)		
	Strategic Commissioning	Accountable Provider Organisation
Financial accounting	X	
Management accounting	X*	X*
Urgent Care Programme Management		X
Urgent Care Commissioning		X
Performance	X*	X*
Acute Service Transformation		X

Appendix 7

14 STP Principles

These *MUST DO* principles should be formally adopted through Boards and communicated throughout the system.

1. We will apply all of our collective resources to deliver outcomes that show we are improving the health and wellbeing for patients, carers and families in Somerset and ensure that we live within the funds available across the system. This is the core principle which underpins each of these subsequent principles.

2. All organisations and individuals **must** commit to system working and act as one: with common purpose, standards and outcomes

3. Leaders **must** test and shadow how an ACS collaboration across Somerset would work.

4. Boards **must** align their organisations' day to day operations, executive responsibilities and management support to deliver system wide immediate recovery and radical transformations.

5. For the first phase of delivery of the STP, there **must** be immediate and persistent focus on the three keys to system recovery: cost reduction, demand reduction and return on investment (ROI)

6. There **must** be a System Financial Framework that is Outcome Based, supports an affordable STP and is underpinned by business processes that will deliver the change. Including Minimum Income Guarantees, incentive payments and risk share.

7. There **must** be a single system savings plan with organisational components. Ongoing and committed individual organisation CIPs/Recovery Plans they must transparent across the system.

8. Long Term Financial Models **must** be updated regularly to reflect the long term vision of the STP and progress towards it.

9. There **must** be a common set of measurable quality, outcome and financial targets, commonly agreed, understood and articulated by all.

10. All proposals **must** have a system impact assessment and actions evidence the impact being made

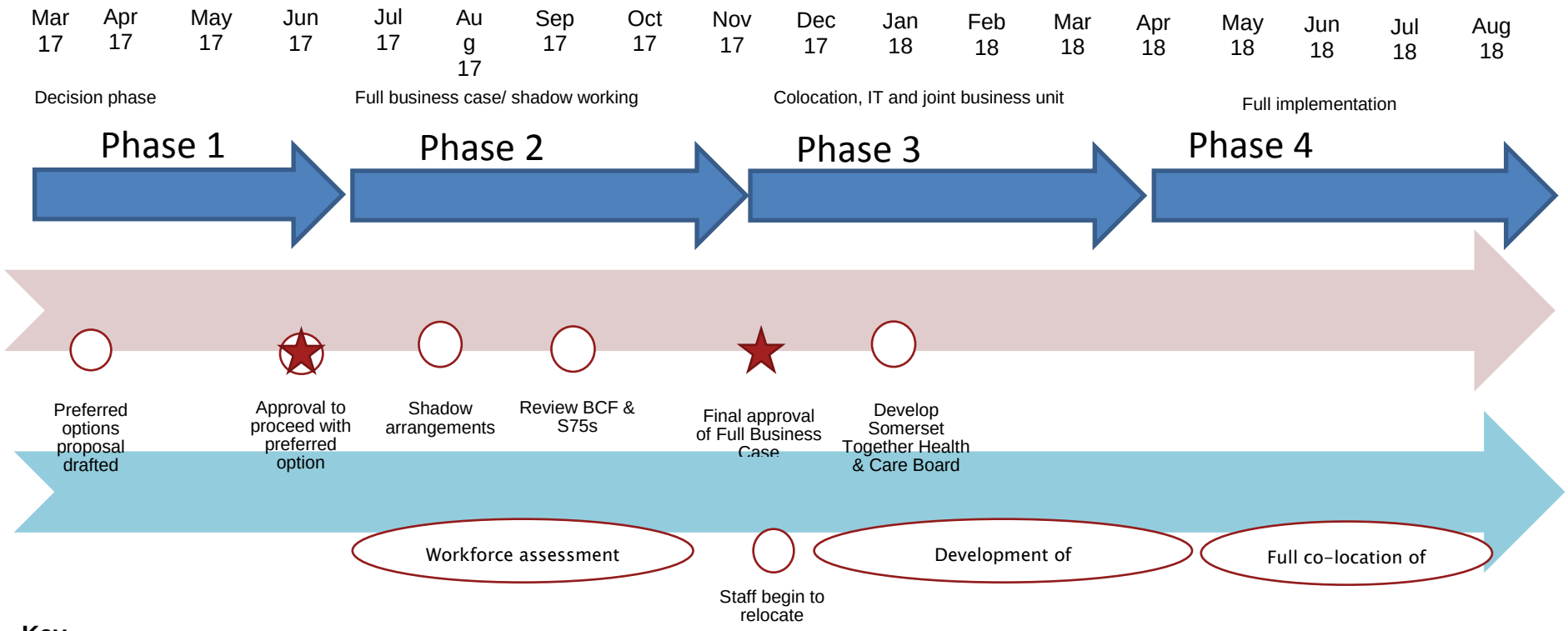
11. All agreed plans **must** have identified system leader responsibility and dedicated operational support (PM and PMO

12. All OD, personal development and recruitment and retention **must** be developed and delivered within an ACS framework.

13. There **must** be agreed common messages and shared responsibility across all organisations to communicating, involving and engaging patients, carers, staff, public and other stakeholders.

14. All system leaders **must** be held and hold each other and their teams to account for delivery, based on system level evidence.

Indicative Timeline for Joint Strategic Commissioning Function



Key

★ Approval required by Governing Body and Cabinet

○ Key actions

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