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Scrutiny for Policies, Adults and Health Committee

Wednesday 21 June 2017

11.00 am Luttrell Room - County Hall, Taunton

To: The Members of the Scrutiny for Policies, Adults and Health Committee

Cllr H Prior-Sankey (Chairman), Cllr M Caswell, Cllr M Chilcott, Cllr M Keating, Cllr A Govier, Cllr G Noel, Cllr B Revans and Cllr R Williams (Vice-Chairman)

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 - 13 June 2017

For further information about the meeting, please contact Lindsey Tawse on 01823 355059 or LTawse@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 Section 100A (4) of the Local Government Act 1972.

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AGENDA

Item Scrutiny for Policies, Adults and Health Committee - 11.00 am Wednesday 21 June 2017

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

1 **Apologies for Absence**

- to receive Member's apologies.

2 **Declarations of Interest**

Details of all Members' 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 previous meeting held on 29 March 2017** (Pages 7 - 18)

The minutes of the previous meeting held on 29 March 2017 are provided for the Committee's information.

4 **Public Question Time**

The Chairman will allow members of the public to ask a question or make a statement about any matter on the agenda for this meeting. **These questions may be taken during the meeting, when the relevant agenda item is considered, at the Chairman's discretion**.

5 **Update on the Development of the Somerset Sustainability & Transformation Plan (STP)** (Pages 19 - 22)

To receive the report.

6 **CQC Inspection of Somerset Partnership NHS Foundation Trust** (Pages 23 - 62)

To receive this report.

7 **Joint Strategic Needs Assessment (JSNA)** (Pages 63 - 126)

To receive this report.

8 **Update on the Implementation of the Somerset-Wide Integrated Sexual Health Service (SWISH)** (Pages 127 - 134)

To receive this report.

9 **Scrutiny for Policies, Adults and Health Committee Work Programme** (Pages 135 - 148)

To receive an update from the Governance Manager, Scrutiny and discuss any items for the work programme. To assist the discussion, attached are:

- The Committee's work programme

- The Cabinet's forward plan

10 **Any other urgent items of business**

The Chairman may raise any items of urgent business.

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Guidance notes for the meeting

1. **Inspection of Papers**

Any person wishing to inspect Minutes, reports, or the background papers for any item on the Agenda should contact the Committee Administrator for the meeting – Lindsey Tawse on 01823 358355 or 357628 ; Fax 01823 355529 or
Email: ltawse@somerset.gov.uk They can also be accessed via the council's website on **www.somerset.gov.uk/agendasandpapers**

2. **Members' Code of Conduct requirements**

When considering the declaration of interests and their actions as a councillor, Members are reminded of the requirements of the Members' Code of Conduct and the underpinning Principles of Public Life: Honesty; Integrity; Selflessness; Objectivity; Accountability; Openness; Leadership. The Code of Conduct can be viewed at: **http://www.somerset.gov.uk/organisation/key-documents/the-councils-constitution/**

3. **Minutes of the Meeting**

Details of the issues discussed and recommendations made at the meeting will be set out in the Minutes, which the Committee will be asked to approve as a correct record at its next meeting.

4. **Public Question Time**

If you wish to speak, please tell Lindsey Tawse, the Committee's Administrator, by 12 noon the (working) day before the meeting.

At the Chairman's invitation you may ask questions and/or make statements or comments about any matter on the Committee's agenda – providing you have given the required notice. You may also present a petition on any matter within the Committee'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.

You must direct your questions and comments through the Chairman. You may not take a 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 just because you cannot be present for the meeting. Remember that the amount of time you speak will be restricted, normally to two minutes only.

5. **Exclusion of Press & Public**

If when considering an item on the Agenda, the Committee may consider it appropriate to pass a resolution under Section 100A (4) Schedule 12A of the Local Government Act 1972 that the press and public be excluded 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, as defined under the terms of the Act.

6. **Committee Rooms & Council Chamber and hearing aid users**

To assist hearing aid users the following Committee meeting rooms have infra-red audio transmission systems (Luttrell room, Wyndham room, Hobhouse room). To use this facility we need to provide a small personal receiver that will work with a hearing aid set to the T position. Please request a personal receiver from the Committee's Administrator and return it at the end of the meeting.

7. **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 this 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 wishing to film part or all of the proceedings. No filming or recording may 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.

SCRUTINY FOR POLICIES, ADULTS AND HEALTH COMMITTEE

Minutes of a Meeting of the Scrutiny for Policies, Adults and Health Committee held in the Luttrell Room - County Hall, Taunton, on Wednesday 29 March 2017 at 10.00 am

Present: Cllr H Prior-Sankey (Chairman), Cllr J Parham (Vice-Chairman), Cllr P Burridge-Clayton, Cllr A Govier, Cllr R Henley, Cllr N Pearson, Cllr N Woollcombe-Adams, Cllr M Healey and Cllr D Yeomans

Other Members present: Cllr S Coles, Cllr A Dimmick, Cllr A Groskop, Cllr D Hall, Cllr C Le Hardy, Cllr J Lock and Cllr W Wallace

Apologies for absence: Cllr M Adkins and Cllr D Huxtable

12 **Declarations of Interest** - Agenda Item 2

There were no declarations of interest.

13 **Minutes from the previous meeting** - Agenda Item 3

The minutes of the meeting held on 01 March 2017 were accepted as being accurate and were signed by the Chairman.

14 **Public Question Time** - Agenda Item 4

There were two public questions.

Debbie Russell, a registered nurse and member of Unison, asked the following question in relation to Item 5:

The changes proposed by the Somerset Sustainability and Transformation Plan will affect the health and social care services locally. This is the biggest threat to the future of the NHS that I have seen in my career. I fully welcome the vision proposed but have grave doubts about how it will be funded. How is the Committee going to exercise its powers to ensure that these changes undergo appropriate scrutiny and are preceded by full and transparent consultation?

Campbell Main asked the following question during Item 7:

Campbell Main spoke on behalf of adults with autism but without a Learning Disability. This includes adults with a diagnosis of Asperger's Syndrome or high functioning autism. Mr Main stated that there had previously been a specialist service to help this specific group. The small, specialist service was set up in December 2004 by Somerset Partnership, prior to the Autism Act 2009. The service was supported by a part time social worker. Recently, the part time social worker has been transferred to SCC Mental Health teams and was now on sick leave.

Mr Main expressed concern that the Somerset Autism Strategy covers a huge field and has lost its focus on the specific group of adults with Asperger's Syndrome. He asked for this to be reconsidered, along with suggestions made

to the Health and Wellbeing Board with regard to the restoration of leadership and resources for both diagnosis and post diagnostic support.

15 **Somerset Sustainability and Transformation Plan Update** - Agenda Item 5

The Committee received a report and presentation from the Sustainability and Transformation Plan (STP) Programme Director and the Strategic Lead – Communication and Engagement.

The presentation set out the shared vision for reforming health and social care to address the challenges of the rising needs of our population, changing demographics and increasingly stretched resources. The presentation highlighted the strategic priorities identified by the Programme Executive Group and the proposals for engagement with stakeholders and the public. This included: the STP vision and case for change; the priorities for closing the Health & Wellbeing, Quality and Financial gaps; the 'One Plan' approach for integrating care and pathways; identifying 'quick win' projects; establishing Design Groups to develop and implement solutions; addressing issues of sustainability and improving efficiency; and the three phases of the engagement and communication process.

The following points were raised during the discussion:

- One of our biggest problems is that the NHs is enormous and parts of it are not accountable to the public. How will you get each department to work together?
- We can't underestimate the challenge but there are incentives for this to work. Individual organisations don't have the resources and adequate funding so this encourages collaboration and co-operation. There are national issues to address in Somerset.
- Have you thought about working with the emergency services? We are all talking the same language and experiencing the same issues. I would invite you to attend the South West Emergency Services Forum and explore avenues there.
- We haven't properly engaged with the emergency services and there is opportunity there. Thank you for the insight.
- I applaud the vision of this ambitious project but have concerns as we have been talking about this for years. There is an emphasis on early intervention but there is a huge cohort already in the system that has missed early intervention so savings are a long way off.
- With prevention, longevity is the key in this area. Some people who already have a problem can be helped e.g. those with hyper-tension.
- Can community care be stepped up to the level that we require to make this work? Staffing in this area is already a challenge. The STP will be seen to be driven by financial cuts and people will focus on this instead of the need to make clinical change. I think the timescale to achieve this will be difficult to meet.
- I agree with a lot of what you say. The key is to have something in place which has been tested to show the public and to reassure them of change.
- I am concerned that the perception will be that the STP is a delivery model to achieve cuts. The closure of community hospitals and beds is

concerning. The NHS needs more public money. I don't believe that we can achieve savings through efficiency alone.

- There has been no discussion of closing community facilities as part of the STP yet but we do recognise that we have a finite pot of money no matter what plan we develop.

- How did you achieve the £8m saving in overspend?
- This was achieved through savings and cost improvement plans, for example, reduced agency spend and reduced costs of delayed transfers of care. There were lots of small things that added up to that saving.

- How will early intervention work?
- These are being developed at the moment with clinicians. At this stage we have identified this as an area to improve and the plan is yet to come.

- The language used in the report is not simple enough for the public to access it.
- We agree with the need to use plain English and to explain things better.

- With regards to housing, there is a huge challenge to get groups together. How to get people back into their homes for care instead? Volunteers are difficult to find especially in large built-up areas.

- This is seen as a cost-saving exercise and the five year timeframe is not achievable. The NHS is a bottom-less pit. You could poor money into it forever. There are huge staff shortages and they can't be trained at the drop of a hat and there are not enough volunteers. We are going to lose expertise and knowledge.
- The workforce challenge is very real; only 4% of the workforce is under 24. We are very supportive of a university for Somerset. It's important to remember that we are not coming from a standing-start. We already have some good examples in Somerset and we are considering hwo we can widen this.

- Village agents – we don't have the in urban areas and Councillors don't always know who they are. I think that village agents are working well but they are not in every community.
- This is being developed and grown. We will have them in all areas in the future. We could bring this to Scrutiny at a later stage once it has been developed.

- I am hearing that there is consensus amongst NHS staff that the NHS needs reform but that there is huge disagreement about how it should be changed. There is a conflict between strategic views and local views. It requires a change of culture and the NHS needs to engage more.
- We will get local differences and may need to take account of these in our plans.

- What percentage does the £600m overspend represent of the total budget?
- It's around 6-7% over that period.

- That is very low compared with the savings that other public sectors have had to make.

- Are you going to engage with the One Public Estate (OPE) process for sharing facilities?
- We are engaged with OPE and have a representative on the Board. We are having conversations about sharing facilities.

- With regards to the need to consult if significant service change is needed; what is the definition of 'significant'?
- There are very clear guidelines around this and we would be happy to circulate this. We would expect to consult over significant changes to clinical services but it may not be required for some areas, for example, changes to back office systems.
- I am concerned about recruitment and training of staff and I am not sure that this has been addressed in a meaningful way. This is not a joined up approach in my view.
- Recruitment and retention is key and there is a benefit to collaboration. Historically, we have been competing with each other to recruit from the same pool of people. There is work to do also around re-defining roles but it is a big challenge. There is a dedicated workstream looking at this.
- I have heard that Musgrove Park Hospital is very consultant heavy and there is not enough theatre time to support them but that this is not being addressed. There doesn't seem to be a balance of responsibility. Where do community hospitals fit into this? What's the plan for them? You need to be upfront early on with the public over this.
- Community hospitals are only one piece of the strategy and shouldn't be looked at in isolation. There is the voluntary sector, complex care at home and bed-based care in the community. We don't yet have a plan for this so we are not at a stage to share it. Somerset does have more community beds than other areas.
- It is critical to engage at a local level. In South Petherton the village agent, volunteers and parish councillors are collaborating together and this is working very well.
- What does a local community care plan look like? Who decides if someone is fit enough to go home? Some people need an in-between service and historically this has been delivered by community hospitals.
- We need to consider the issue of transport. It makes more sense for staff to travel around the county rather than patients.
- A&E needs a stronger message that it is only for emergencies. If someone presents several times, we are not addressing their problem. GP's used to filter patients and now patients just go direct to A&E because they can't see their GP.
- People do present at A&E for reasons that are not emergencies.
- I would like to give a Public Health perspective. The STP is about what is right for the health of the population. Need and demand is undoubtedly increasing and the NHS is becoming unsustainable. I have been inspired by the Fire Service which used to be very reactive but has had a huge shift to prevention. The NHS needs to achieve this flip to being more proactive in keeping people healthy to stop them needing to use services.
- It all came back to education for the Fire Service. One severe road incident costs the emergency services and NHS £1.6m so prevention is very worthwhile.
- I agree but it is hard to back this up with evidence when you see the Government making so many cuts to preventative services.

The Committee agreed with the priorities identified and was content with the direction of travel for consultation and engagement. It noted the report and requested an update at the next Committee meeting.

16 **Winter Pressures Update** - Agenda Item 6

The Committee received a report from the Head of Urgent Care Programme Manager and the Adult and Health Operations Director.

There has been increased demand across the urgent care system within health and social care services during the winter period for 2016/17 and this remains a persistent challenge for all organisations concerned within the urgent care system. During the winter period the Somerset system has been predominantly in Operational Pressures Escalation Level (OPEL) 2 and 3. The system has not declared the highest level of alert which is OPEL 4. Health and Social Care services have worked more collaboratively together than in previous years and are comprehensively planning for winter together.

A debrief event was held last month to consider the learning from this winter. Successes identified included: effective use of planning; working well together as a system and becoming more efficient at treating people as they present. It also highlighted the need to communicate more effectively and to increase performance with regard to discharge to access. Discharge to access refers to how a patient is moved back to a bed whether that is at home or at a community hospital or nursing home. Several different methods have been explored and these will continue to be trialled. Some short-term beds have also been purchased for people who aren't ready to go home but don't need to be in an acute hospital.

Services are still not performing well when compared nationally so there is much more work to do but performance is improving on previous years. Planning for next winter is beginning now and will also incorporate planning for the Easter period which is another time of challenge.

It was clarified that the Government has announced extra funding for Adult Social Care. For Somerset this will be £11m, £7m and £3m respectively over the next three years. This funding will be ring-fenced, primarily to help with delayed transfers of care but more detail is yet to follow.

The following points were raised during discussion:

- Is the increased performance due to the fact that this winter was not so bad, with no real flu epidemic?
  - I agree that there has been less pressure on the system but even so some of our near neighbours have been on OPEL 4.
- What about patients who cross the Somerset border?
  - Numbers have been low this year from Royal United Hospital and we have had good conversations with them. Collaboration with Weston Hospital has been more difficult but we have recently begun to work together to address this. There has been a 6% increase in Adult Social Care patients over the winter period.

- I have heard that Yeovil District Hospital is experiencing a frailty in its system on Saturday afternoons. Has this affected mortality rates?
- We haven't seen any increase of mortality rates.
- The extra funding only represents investment for one small part of the system when it really needs to be looked at as an entire system. I hope that it can be used flexibly and not ring-fenced too narrowly.
- Public Health data shows that healthy life years are not increasing so we need to be cautious and not too optimistic about expecting improvements year on year.
- It seems there has been a culture of passing problems from one part of the system to another, for example, primary to acute.
- The system is not yet well set up enough to care for those patients who do not need treating in hospital but are not able to look after themselves at home. We do need better pathways.
- It's difficult to get a sense of the scale of the problem. What is the percentage of people in hospital that don't need to be there?
- We completed an audit recently at Musgrove Park Hospital (MPH) and we will share this with the Committee. This is a snap shot of one day at MPH.
- It was clarified that extra beds had been purchased at Cookson Court, Yeovil. These were mainly for reablement. It was emphasised that the culture of the providers of reablement services was very important. Providers need to encourage patients to become independent.
- We previously had a convalescent hospital system and this is now called reablement. A one size fits all system will not work.
- We need to look at when a social worker is required and when we can use a different member of staff. We need to use the workforce differently.
- Can we get a better deal with block purchases rather than spot purchases? Somerset Care have 200 empty beds across Somerset.
- We can get a supply of beds at our fee rate at short notice and there is no problem with supply. We use a mixture of block and spot booking. We are currently testing different models of care and we know that different places may need different models.
- We need to change the culture of treatment within hospitals.

The Committee noted the report.

17 **Update on the Somerset Autism Strategy** - Agenda Item 7

The Committee received a report from the Acting Head of Joint Commissioning (Mental Health & Learning Disabilities) which provided a progress update on the implementation of the Somerset Autism Strategy, launched in November 2015.

The Strategy is aligned to the national strategy and the Autism Strategy Group brings together, Somerset CCG and SCC commissioners from adults, children's and public health teams, along with a range of agencies. The group meets on a quarterly basis to oversee the implementation of the Strategy and the action plan and has four priority areas of work: Living with Autism; Workforce Development; Identification and Diagnosis; and Children and Young

people. The report highlighted the areas of progress and next steps for each priority area.

The report concluded that while services have developed there is always more to do in assuring that outcomes are being met for individuals with autism and their families. Work will continue within each of the priority areas.

The following points were raised during discussion:

- It was clarified that there is a small Asperger's Syndrome Service with one social worker but they have now transferred to adult Social Care. The rationale behind this was to increase the number of staff that could help and specialise with Asperger's rather than relying on one member of staff.
- There is some evidence that autism is more difficult to diagnose in females. How is this being addressed?
  - There is some thought that it might be underdiagnosed in females.
- Is there a clear pathway for diagnosis?
  - There is a clear pathway but there are significant delays. This is not out of line with the region but clearly there is work to be done in this area.
- There is some good work going on in the service, for example, in raising awareness but there is a lack of resource and support, particularly for adults. Many adults feel abandoned by the system. There are huge delays, even just to begin the process and it can take over two years to get a diagnosis and this is not right.
  - The service provider is taking steps to make improvements but I agree that there is more work to do.

The committee noted the report but expressed concern over the delay in diagnosis. They would welcome actions to improve the delays.

18 **Improved Access to GP Services** - Agenda Item 8

The Committee received a report from the Director of Clinical and Collaborative Commissioning which outlined the commissioning process of the improved access service for the population of Somerset.

In October 2016 it was announced that Somerset CCG was identified as a transformation area for improved access to GP services. In January 2017 Somerset CCG Governing Body approved a proposed commissioning, financial and service framework for the delivery of Improved Access to the Somerset population.

The foundation of the Somerset CCG improved access service is based on four primary objectives that are coherent with the Somerset Primary Care Plan and supported by key enablers;

- Commission a sustainable and effective model of care that enhances the availability of primary medical services across the county whilst maintaining high quality services, increasing patient satisfaction, managing demand and reducing duplication

- To deliver joined up, collaborative and responsive out of hospital care for patients across 7 days, meeting population needs and reducing unnecessary demand through the use of patient education and awareness
- Increase the capacity of primary medical services through the delivery of at scale services, sharing of resources and utilisation of IT innovations
- Deliver an integrated and responsive primary medical service that is clinically led and supported by a multi-disciplinary team, providing care to population groups in collaboration with multiple provider organisations

It is the ambition of the CCG to deliver the national requirements from April 2017, with the model for delivery being developed over the course of the contractual period. The intention is to learn from potentially different delivery models across Somerset and allow for the collaboration and integration between providers to take place.

A phased model has been developed to allow movement towards an integrated same day service across seven days, joining up service provision to deliver better care for patients and enhance the sustainability of services. Some federations were already considering or moving towards different ways of managing demand for primary care services. Having a phased approach prevents the CCG from unintentionally restricting any local innovations.

The following points were raised during discussion:

- I am cynical about this being achieved. In wellington, I can't see a GOP for any reason because they use a phone triage system and the surgery doesn't have any evening or weekend opening. I don't think this service is deliverable.
  - I understand the frustration and anxiety if patients can't access their GP. There is quite a wide variation in the spectrum of practices and what they can deliver. Workforce challenges are also an issue and we need a skill-mix model.
- There seems to be a wide range of accessibility. Best practise will need to be recognised and rolled out across the county.
  - We would definitely want to learn and roll out best practise but we also want to be better integrated and this is part of what the STP is developing.
- There are issues around communication too. Patients need to know what services are available.
- There has been a move to nurse practitioner practices in other areas of the county. This seems to be a logical model.
  - There is a practice in Exeter that runs this way. There is a challenge with the nursing workforce too - they have the same age profiles. We need to increase the number of nurses and the level of training. I think that nursing is an important part of the system and this will increase in future.
- Is the extended hours voluntary for GP practices?
  - It is a government manifesto commitment but it is not negotiated in the national GP contract. Instead CCG's have been given this mandate. Surgeries could opt-out but it would be difficult as they cannot access the extra funding without committing to extended hours.

- I think we should introduce ratings for GP surgeries, in a similar way to restaurants.
  - The Care Quality Commission inspects all health care providers and rates them. Patients can see this on the NHS choices website.
- Did the CCG apply to be a transformation area?
  - It was an opportunity that was given to us rather than applied for.
- It seems to have brought a number of surgeries to the brink of collapse.
  - Some are significantly challenged but it is also an opportunity for practices to work together and share resources. So collaboration may help with some of the issues that surgeries are facing.
- Are there opportunities to encourage career changes and returners to health services?
  - Yes we are pursuing all of these avenues with some rigour.

The Committee noted the report and requested an update early in the new quadrennium.

19 **Maternity Services Update** - Agenda Item 9

The Committee received a report from the Deputy Director of Quality and Safety which provided an update on Somerset Maternity Services and the local Maternity Transformation programme.

The report focused on how maternity services are responding to the Betters Births report published in Feb 2016 and the quality measures put in place to ensure monitoring of the key priorities. Somerset has been chosen as one of eight national early adopter sites for Better Births, to support this transformational change in maternity services. The core Somerset bid is for the implementation of IT and Post-natal support for Somerset.

It is expected that the Local Maternity Services (LMS) will align with Sustainability and Transformation Plans (STP) footprints in Somerset. The challenge we have in Somerset is that the RUH, Weston and Dorset are outside our STP footprint and Local Maternity Systems will be expected to develop and implement a local vision for improved services.

- commissioners and providers are asked to work together across areas as local maternity systems (LMS)1, with the aim of ensuring women, their babies and their families have equitable access to the services they choose and need, as close to home as possible. In particular, the role of the LMS is to:
- bring together all providers involved in the delivery of maternity and neonatal care, including, for example, the ambulance service and midwifery practices providing NHS care locally
- develop a local vision for improved maternity services based on the principles of Better Births
- co-design services with service users and local communities
- put in place the infrastructure needed to support services working together

In addition, the Committee received an update with regard to potential changes to maternity services at Dorchester Hospital which may impact on Yeovil District Hospital.

In September 2015, as part of its overall Clinical Service Review, Dorset CCG asked the Royal College of Paediatrics and Child Health (RCPCH) to conduct an Invited Review of the current service provision for maternity, neonatal and paediatric services. This review focussed on the services provided at Poole, Bournemouth, Dorchester and Yeovil Hospitals. The resulting report raised questions about the long-term sustainability of the current model of provision and proposed some high level future service options. The RCPCH report is publically available via the Dorset CCG website.

Following the publication of this report, the Boards of Yeovil District Hospital and Dorset County Hospital have agreed to work together to explore in more detail the options for the future model of maternity and paediatric services across the two sites. It was acknowledged that key to this work will be ensuring that the broader access implications for the populations of West Dorset and East Somerset are fully considered, recognising the responsibility of Yeovil District Hospital to work as part of the Somerset NHS. A data modelling exercise is underway to inform this.

The work is on-going and an options appraisal will be developed for consideration in the summer 2017. Any future service change will be subject to the NHS England requirements which would involve a full public consultation.

The following points were raised during discussion:

- Why is there such a high level of induced births in Somerset?
  - It's because of becoming risk adverse to decrease the number of still births.
- It was clarified that the review of service at Dorchester Hospital and Yeovil District Hospital (YDH) was concerned with safety and not with cutting services. Weston Hospital and YDH are two of the smallest maternity units in the country.
- If YDH maternity service is taken away, it is a long way to Dorchester.
  - I don't think it is about YDH closing but more about how YDH would cope if Dorchester closes.

The Committee noted the report and asked for an update when more information was known regarding Dorchester Hospital.

20 **Scrutiny for Policies, Adults and Health Committee Work Programme** - Agenda Item 10

The Committee considered and noted the Council's Forward Plan of proposed key decisions.

The Committee requested the following changes to the work programme:

- An update regarding the Sustainability & Transformation Plan (21 June)
- An update regarding Improved Access to GP Services

- An update regarding proposed changes to maternity services at Dorchester Hospital
- An update regarding performance at Weston Hospital.

In addition, the Committee requested a briefing note to explain the issues experienced in gynaecology at Musgrove Hospital and the recovery plan in place to address these concerns.

21 **Any other urgent items of business** - Agenda Item 11

The Chairman thanked the Vice-Chairman and Community Governance Officers for their support.

The Committee discussed the lessons learnt from the Committee meeting on 29 June 2016 and concluded that:

- When Officers present they must use the microphone to ensure that they are recorded
- The Committee must request written reports and have access to confidential papers before the meeting
- The Committee did not have a full understanding of TUPE regulations.
- The Committee was too easily reassured by Officers

The Committee discussed the importance of training for Members of Scrutiny Committees.

(The meeting ended at 1.00 pm)

CHAIRMAN

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Somerset County Council
Scrutiny for Policies, Adults and Health Committee
– 21 June 2017

Somerset Sustainability and Transformation Plan

Lead Officer: Pat Flaherty, Chief Executive
Author: Phil Brice, Director of Strategy and Corporate Affairs, Somerset Partnership
Contact Details: phil.brice@sompar.nhs.uk
Cabinet Member:
Division and Local Member:

1. Summary

1.1. The Somerset STP has been developed jointly by Somerset Clinical Commissioning Group, Somerset County Council, Somerset Partnership NHS FT, Yeovil District Hospital NHS FT and Taunton and Somerset NHS FT and was launched in November 2016. It sets out a shared vision for reforming health and social care to address the challenges of the rising needs of our population, changing demographics and increasingly stretched resources.

1.2. Since the launch, the STP Programme Executive Group has undertaken a prioritisation process to identify those projects set out in the original submission which, if tackled first, would have the greatest immediate impact, recognising the need to ensure that everything we do now will help us deliver the wider vision for transformed and sustainable health and care services across Somerset.

1.3. The next phase of the STP is to take forward these priority schemes, working with health and social care professionals, patients, service users and the public to develop new models of care that are effective and sustainable.

2. Issues for consideration / Recommendations

2.1. Scrutiny is asked to consider and comment on the development of the STP.

3. Background

3.1. NHS England challenged the health and care system to develop a Sustainability and Transformation Plan (STP). This five-year forward view is intended to describe the key priorities for an area, describe the challenges that fit within the system, define the priorities for transformation going forward and address any financial gap within the NHS system within that time period.

3.2. The demands on the NHS and social care are increasing, partly because there are more people who are living longer with more complex health problems such as dementia, diabetes and high blood pressure, but also because of the increasing cost of new medicines and treatments. Public demand for health and social care services is constantly growing and the only way to manage this is by thinking as one single health and social care system – rather than as individual organisations – working with people, carers and communities.

3.3. The STP has identified as its focus the following key aims to close the current health and wellbeing, quality and financial gaps:

- **Focusing on prevention to develop a sustainable system** - encouraging and supporting everyone in Somerset to lead healthier lives and avoid getting preventable illnesses
- **Redesigning out of hospital services** – to enable us to move care, where appropriate, out of hospital beds and into people's homes wherever possible, providing care designed specifically for each patient's needs, supporting faster recovery and, in many instances, avoiding the need to go into hospital in the first place
- **Addressing the problems of sustaining acute hospital care** – reviewing acute care services and increasing the joint working between the hospitals to ensure that urgent and planned care services that rely on specialist skills can be sustained
- **Driving financial improvement across the system over the next two years** – sharing financial risk across the health system to drive collaboration and improvement and making sure all the back office functions are as efficient as possible
- **Creating an accountable care system** – with a strategic commissioning function where the NHS and social care commissioners work together under a single commissioning arrangement to secure outcomes and pool budgets; and an Accountable Provider Organisation where services are delivered by a provider, or group of providers (through a single governance structure), who have agreed to take accountability for all care and care outcomes for the population of Somerset

3.4 The prioritisation process undertaken by the STP Programme Executive Group identified a number of areas that provide immediate opportunities for change within the existing ways of working within health services. These include:

- Tackling delayed transfers of care for patients out of acute or community hospitals, either to their own homes or other residential care
- Improving the efficiency and effectiveness of the current flow of patients through Musgrove Park Hospital and Yeovil District Hospital
- Developing a Psychiatric Liaison Service, supporting patients with mental health needs when they are being treated within acute hospitals
- Reviewing Procedures deemed to be of Limited Clinical Value (e.g. cosmetic procedures)

3.5 In terms of delivery of those priorities:

- Delayed transfers have seen a significant reduction on a county wide basis, the continued sustainability of the solution is being established.

- A&E performance across the county has improved with all providers achieving the 95% target within the last month.

- Proposals for psychiatric liaison services into both Musgrove Park Hospital and Yeovil District Hospital have been agreed and funding identified to support their implementation. An update will be provided to a future Scrutiny meeting on the roll out of the service which will be county wide once the complete workforce is in place.

- The South Somerset Vanguard (enhanced primary care) is now rolled out to all the GP practices that are undertaking it, and preliminary evidence is showing increased GP availability, reduction in non-elective admissions, and there is positive feedback from those involved. This will be formally evaluated by Autumn this year.

- Prevention future models of care and business cases for falls, smoking, and Making Every Contact Count have progressed including how these will be implemented and when.

3.6 The STP has established 'design' groups, working on new models of patient care. The design groups are looking at:

- Improving the management of urgent / same day demand for primary care services
- Developing Enhanced Primary Care, improved community services and building stronger communities to support care outside of hospital
- Implementing the 'Right Care' programme, benchmarking our services against national standards for care such as Musculo-skeletal physiotherapy; hypertension; COPD and neurology – particularly chronic pain
- Improving the management of elective care – how and when patients are referred into hospital to ensure patients are referred in to the right place first time

4. Consultations undertaken

4.1. A range of engagement and information events were held prior to and following the launch of the STP.

4.2. Following the end of the election 'purdah' period, the next phase of engagement will be to involve patients, service users and carers in the design groups so they can actively contribute to the development of the models of care and how people experience the services.

4.3. A programme of engagement work is now being planned and undertaken with representative groups, including experts by experience and voluntary sector groups, relevant to the priority areas identified to ensure that a wide range of views are taken into account in developing the new models.

4.4. If the outcome of these reviews leads to significant service change then we will undertake a formal consultation with people, families and communities across Somerset.

5. Implications

5.1. The STP identifies a potential cumulative deficit within the region of £600million in 2020/21 if we do nothing differently.

5.2. Any future financial implications will be brought back for consideration.
It is however anticipated that the implementation of the STP will result in considerable financial efficiencies to the Somerset health and care budgets

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Somerset County Council
Scrutiny for Policies, Adults and Health Committee
– 21 June 2017

Somerset Partnership NHS Foundation Trust – CQC Inspection Report

Lead Officer: Dr Nick Broughton, Chief Executive, Somerset Partnership
Author: Phil Brice, Director of Strategy and Corporate Affairs, Somerset Partnership
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Cabinet Member:
Division and Local Member:

1. Summary

1.1. On 27 February – 2 March and 8 – 9 March 2017, the Care Quality Commission (CQC) carried out a re-inspection of nine core services of Somerset Partnership NHS Foundation Trust to find out whether Somerset Partnership NHS Foundation Trust had made improvements to the following services since their last comprehensive inspection of the trust. That inspection was undertaken in September 2015 where the CQC rated the trust as requires improvement overall.

1.2. Following the inspection in March 2017, CQC has changed the overall rating for the trust from requires improvement to **GOOD.**

1.3. This was because:

- The trust had made significant progress in addressing the concerns the CQC had raised following its inspection in September 2015. CQC has changed the overall trust ratings in the key questions of effective, responsive and well-led from requires improvement to good.

- In particular, improvements to the trust's community learning disability services for adults, which had been rated as inadequate in September 2015, have meant that this service is now rated as good and because of the dramatic improvement to these services and the way they had been implemented by managers and the trust, CQC rated the key question of well-led in these services as outstanding.

- In the services which were re-inspected, the trust had acted to meet the requirement notices issued after the inspection in September 2015. Out of 17 core services provided by the trust, 15 are now rated **good** overall. One of the other services was not visited as part of this re-inspection.

- CQC identified that the trust's new chief executive had provided positive and proactive leadership which had enabled its senior leadership team to address the issues identified in the 2015 inspection visit. This had led to an improvement in the trust governance processes.

1.4 CQC has still identified areas for improvement for the trust, particularly in relation to community hospital and mental health inpatient services and the trust will be developing an action plan to address the areas identified as requiring improvement.

2. Issues for consideration / Recommendations

2.1. Scrutiny is asked to consider and comment on the report of the CQC inspection.

3. Background

3.1. The Care Quality Commission (CQC) is

3.2. To fully understand the experience of people who use services, CQC always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

3.3. Before visiting, CQC reviewed a range of information about Somerset Partnership NHS Foundation Trust and asked other organisations for information. CQC inspectors carried out a short notice, announced inspection visits between 27 February and 2 March 2017, together with a 'well led' inspection of trust management between 8 and 9 March 2017.

3.4 The inspection was carried out to see if the trust had responded to the requirement notices issued by the CQC following its inspection in September 2015, the report of which was published in December 2015. The re-inspection report was published on 31 March 2017.

3.5 In 2015, CQC rated eight of the Trust's 17 core services as requiring improvement and one (community learning disability services for adults) as inadequate. All of these services were re-inspected (except community dental services) together with one service rated as good in 2015 (forensic/secure inpatient services).

3.6 Following the 2017 inspection, five of the services previously rated as requiring improvement are now rated as good. The service rated as inadequate is now also rated as good. This means that 15 of the Trust's 17 core services as now rated as good.

4. Consultations undertaken

4.1. During the inspection visit, the inspection team:

- Visited 38 locations from which the trust delivered services including the trust HQ.
- Spoke with 201 patients and carers
- Received 239 comment cards with feedback from people who used services
- Reviewed 357 patient records, including medication charts.
- Spoke with 323 staff and 45 managers

5. Implications

5.1. The trust accepts the findings of the report and welcomes the very positive comments made by CQC about the improvements made since the 2015 inspection across all of the services.

5.2. The trust has developed an action plan to address those areas where the CQC has indicated the Trust **must** improve and has instigated improvement plans for those areas where the trust **should** take action to enhance its services. In particular, the Trust has established a Service Improvement programme for community hospital services. These actions will be monitored regularly through the Trust's Quality and Performance Committee and the Trust Board.

6. Background papers

6.1. Appendix A – CQC Quality Report – Somerset Partnership NHS Foundation Trust.

The full report of the inspection carried out in September 2015 can be found at http://www.cqc.org.uk/provider/RH5

Note: For sight of individual background papers please contact the report author

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Somerset Partnership NHS Foundation Trust

Quality Report

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Tel: 01278 432000
Website: www.sompar.nhs.uk

Date of inspection visit: 27 February – 2 March 2017
8 – 9 March 2017
Date of publication: This is auto-populated when the report is published

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units.	Rydon Wards One and Two	RH576
Acute wards for adults of working age and psychiatric intensive care units.	Rowan Ward	RH572
Acute wards for adults of working age and psychiatric intensive care units.	Holford Ward	RH576
Acute wards for adults of working age and psychiatric intensive care units.	St Andrews Ward	RH502
Community mental health services for people with learning disabilities	Trust Headquarters	RH5
Wards for older people with mental health problems	Magnolia ward	RH572
Wards for older people with mental health problems	Pyrland 1	RH576
Wards for older people with mental health problems	Pyrland 2	RH576
Forensic inpatient/secure wards	Ash Ward	RH5Y5
Community-based mental health services for adults of working age.	Trust HQ (Mallard Court)	RH5AA

Summary of findings

Community-based mental health services for adults of working age.	Minehead Community Hospital	RH5F5
Community-based mental health services for adults of working age.	Priory Health Park	RH5Y7
Community health services for adults	Dene Barton Community Hospital	RH5X5
Community health services for adults	Minehead Community Hospital	RH5F5
Community health services for adults	Priory Health Park	RH5Y7
Community health services for adults	Shepton Mallet Community Hospital	RH5F7
Community health services for adults	South Petherton Community Hospital	RH5Y8
Community health services for adults	West Mendip Community Hospital	RH5F8
Community health services for adults	Williton Community Hospital	RH5F1
Community health services for adults	Wellington Community Hospital	RH5X9
Urgent care services	Shepton Mallet Community Hospital	RH5F7
Urgent care services	Frome Community Hospital	RH5G5
Urgent care services	Chard Community Hospital	RH5X3
Urgent care services	Burnham-on-Sea War Memorial Hospital	RH5X2
Urgent care services	Bridgwater Community Hospital	RH5X1
Sexual Health Services	Contraceptive and Sexual Health Service	RH5H6
Community health inpatient services	Bridgwater Community Hospital	RH5X1
Community health inpatient services	West Mendip Community Hospital	RH5F8
Community health inpatient services	Dene Barton Community Hospital	RH5X5

Summary of findings

Community health inpatient services	Burnham-on-Sea War Memorial Hospital	RH5X2
Community health inpatient services	Chard Community Hospital	RH5X3
Community health inpatient services	Crewkerne Community Hospital	RH5X4
Community health inpatient services	Williton Community Hospital	RH5F1

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

Following the inspection in March 2017, we have changed the overall rating for the trust from requires improvement to **good** because:

- The trust had made significant progress in addressing the concerns we raised following our inspection in September 2015. We have changed the overall trust ratings in the key questions of effective, responsive and well-led from requires improvement to good.
- In the services we inspected, the trust had acted to meet the requirement notices we issued after our inspection in September 2015. Out of 17 core services provided by the trust, 15 are now rated **good** overall.
- In response to our March 2017 findings, we have changed the rating for community mental health services for people with learning disabilities or autism from inadequate to good. Because of the dramatic improvement to these services and the way they had been implemented by managers and the trust, we rated the key question of well-led in these services as outstanding.
- Following the inspection in March 2017 we have changed the ratings for six core services from requires improvement to good: community based mental health services for adults of working age; wards for older people with mental health problems; acute wards for adults of working age and psychiatric intensive care units; community health services for adults; MIU/urgent care; and sexual health.
- In September 2015, we rated eight of the 17 core services as good. Since that inspection we have received no information that would cause us to question those ratings. In March 2017, we sampled one of those eight services, forensic inpatient/secure wards to check if it had maintained the rating of good, which it had.
- We completed a 'well-led' review and found the trust's new chief executive had provided positive and proactive leadership which had enabled its senior leadership team to address the issues we identified in our last inspection visit in September 2015. This had led to an improvement in the trust governance processes.

However:

- Despite improvements across all the services that we inspected, the key question of safe for the trust remains requires improvement.
- Despite seeing improvements in five core services in the key question of safe, there continued to be concerns in community health inpatient units and acute wards for adults of working age and psychiatric intensive care units and community health services for adults. This meant that we have again rated the trust overall as requires improvement for safe.
- We still had concerns about the core service of community health inpatient units. We have again rated this core service as requires improvement overall.
- In the key question of effective we found concerns surrounding the recording of capacity and consent in a number of areas.

The full report of the inspection carried out in September 2015 can be found here at http://www.cqc.org.uk/provider/RH5

At the inspection in March 2017, we did not reinspect the community dental services that we had rated requires improvement in September 2015. CQC will reinspect this core service as part of its ongoing dental inspection programme.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- In September 2015, we rated nine of the 17 core services as requires improvement for safe. We rated two services, community mental health services for people with learning disabilities and community health services for adults, as inadequate. This led us to rate the trust as requires improvement overall for this key question. Following this most recent inspection in March 2017, we have again rated community health inpatient units and acute wards for adults of working age and psychiatric intensive care units as requires improvement. Also, whilst we did see improvements in community health services for adults, there was still work to be done to address the risks in those services, so we changed the rating from inadequate to requires improvement.
- In acute mental health wards and psychiatric intensive care units there were problems with medicines management, concerns on recording of seclusion and restraint, and a number of blanket restrictions.
- Although we found a number of improvements in community health services for adults which meant they were no longer inadequate in the key question of safe, there remained problems with staffing and inconsistent management of wounds which meant that we re-rated them requires improvement.

However:

- We have changed the rating for safe of five of the core services from requires improvement to good. This included community mental health services for people with learning disabilities, which had previously been rated as inadequate. The trust had addressed the issues that had caused us to rate safe as requires improvement following the September 2015 inspection in the following services:
- In wards for older people with mental health problems, the trust had addressed the environmental concerns and training issues identified at our last inspection.
- Community-based mental health services for adults of working age had addressed caseload management issues and were conducting good risk assessments.

Summary of findings

- Urgent care services (minor injuries units) had taken action to understand and mitigate risks to the service. The time from arrival to assessment had improved, as had the quality of some areas of record keeping.
- Community based mental health services for people with a learning disabilities had improved its risk assessments which were now comprehensive and identified areas of concern.

Are services effective?

Good

We re-rated effective as **good** because:

- In March 2017 we found significant improvements in most areas. The trust had addressed the issues that had caused us to rate effective as requires improvement in September 2015 in the following services. We re-rated these five services as good for effective.
- In forensic/secure inpatient wards the service had ensured that patients' were aware of their section 132 rights when detained under the Mental Health Act, that staff documented patients consent to medicines and ensured that they received feedback from second opinion appointed doctors.
- In wards for older people with mental health problems the trust was meeting its legal obligations under the Mental Capacity Act and do not attempt cardio pulmonary resuscitation decisions were being made and recorded appropriately.
- In urgent care services (minor injuries units) we found improved systems for clinical supervision, and improved delivery of care in accordance with national standards and guidance.
- Community health services for adults had strengthened their arrangements for appraisals and supervision. Multidisciplinary working had improved, as had the use of outcome measures to benchmark and improve services.
- During our inspection of acute mental health wards and psychiatric intensive care units in September 2015, we found that staff had not been gaining consent for treatment or clearly recording it in patients' notes. During our inspection in March 2017, we found staff had not recorded consent in the expected place in 11 out of 29 records. However, the trust produced additional evidence to confirm that staff had recorded consent elsewhere in the patients' notes.

Summary of findings

- The trust had also addressed the issues that had caused us to rate effective as inadequate following the September 2015 inspection in the community based mental health services for people with learning disabilities. Service users now had holistic and detailed care plans with an effective clinical team.
- However, although we found that community health inpatients services had met the requirement notices from 2015, we also found additional areas for improvement at this inspection. As a result we have re-rated this service from good to requires improvement. We found pain scoring was not being consistently recorded, and in some cases was inaccurate. Staff felt the organisation had not responded to ongoing concerns and issues raised about medical cover on Exmoor Ward. Fluid balance charts were not being completed effectively and patient information did not always contain up-to-date best practice guidelines. Consent and capacity was not always clearly recorded.
- Two further services remain requires improvement in the key question of effective that were not visited during the March 2017 inspection.
- This is a change of rating since the last inspection.

Are services caring?

Good

We rated caring as **good** because:

- At the last inspection in September 2015, we rated caring as **good** overall**.**
- In September 2015, we rated community mental health services for people with learning disabilities as requires improvement for caring. Following this most recent inspection in March 2017, we have revised the rating for this core service to good following improvements in how they engaged with service users.
- This means the trust now has 16 out of 17 core services rated as good and one as outstanding.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- In September 2015, we rated eight out of the 17 core services as requires improvement for responsive. This led us to rate the trust as requires improvement overall for this key question.

Summary of findings

Following this most recent inspection in March 2017, we have changed the rating of six of these core services to good. We did not visit the remaining two services that require improvement in this key question at this inspection.

- Due to the improvements we found in March 2017, 15 out of 17 core services are now rated as good.
- The trust had addressed the issues that had caused us to rate responsive as requires improvement following the September 2015 inspection in the following services:
- In community based mental health services for adults of working age, staff were meeting referral to assessment times and waiting lists were being managed well.
- In the community sexual health services we found improved access to clinics, including for patients with limited mobility. Additionally, waiting times for patients had been improved. We therefore re-rated this service from requires improvement to good.
- Community health services for adults had considered the needs of patients when planning and delivering services, and staff were flexible to meet those needs. Although some waiting lists were long, initiatives were in place to reduce the waiting times.
- Community health inpatients services had improved their investigation, learning and response to complaints. Care planning took account of the needs of the patient and activity coordinators had been employed to improve the stimulation available to patients.
- In community based mental health services for people with learning disabilities there were clear criteria for which service users would be offered a service that did not exclude service users who needed treatment and would benefit. Information was accessible and available and waiting times were met.
- This resulted in these services being re-rated to good. This meant that all the services we inspected at this inspection were rated as good for responsive.

Are services well-led?

Good

We rated well-led as **good** because:

- In September 2015, we rated nine out of 17 core services as requires improvement for well-led, and one, community mental health services for people with learning disabilities, as

inadequate. This, with a review of the trust's governance and senior leadership, had led us to rate the trust as requires improvement overall for this key question. Following this most recent inspection in March 2017, we have changed six of these ratings to good. We changed the rating for community mental health services for people with learning disabilities to outstanding.

- When we visited in September 2015 the trust had failed to identify the number and severity of issues relating to community mental health services for people with learning disabilities. The trust had improved its systems to identify areas of concern and encouraged staff to engage with them.
- We rated well-led in community mental health services for people with learning disabilities as outstanding because of the dramatic improvements in the service since our September 2015 inspection. This was due to the leadership of the divisional manager, who had just been appointed at the time of our last inspection, and the service manager who had been appointed by the trust to complete the transformation. The team leaders had also embraced the need for change and worked to support their teams in the process. Staff morale was high and staff were keen to show us the improvements to the service. Staff were fully involved in the improvements and changes to the service, with groups of staff from each team reviewing how the service worked for patients and asking is the service safe, effective, caring, responsive and well led. The trust had supported this change with a no blame approach to the staff team following the previous rating of inadequate. The trust had requested support from another NHS organisation with a good learning disability service to help with the improvement plan and there was visible senior management support for the service development, including the chief executive attending meetings in the service and shadowing visits.
- At this inspection, we completed a 'well-led' review and found the trust's new chief executive had enabled its senior leadership team to address the issues we identified in our last visit. This had led to an improvement in the trust governance processes.
- At our last inspection, the culture of the organisation we described as "top down". There had been a marked change in this with managers feeling more empowered and enabled to make decisions. Although this change in culture was still bedding in, staff and managers were positive about the direction the trust was moving in and the leadership style set by the chief executive.

Summary of findings

- At our last inspection, we were concerned that the trust's vision and values were not clear to staff. The trust had new values that had been worked on with staff consultation. At this inspection, the majority of staff were able to identify the new values and some staff described their role in their creation.
- The trust continued to be in a period of considerable change with changes to the relationship with the local authority, new care pathways and the development of the local sustainability and transformation plan. Staff affected by these changes felt more informed than at our last inspection and appropriate consultation with staff appeared to be happening.
- The trust had also addressed the issues that had caused us to rate well led as requires improvement following the September 2015 inspection in the following services which led to a change of rating to good:
- At this inspection, we found community sexual health services had improved their risk identification and management processes. The service had also focussed on longer-term strategies to develop the service. As a result, we have re-rated this service from requires improvement to good.
- Urgent care services (minor injuries units) had improved their risk identification and management processes. We also found learning points and action plans following complaints and incidents had been strengthened.
- In the community health services for adults, we found improved systems for keeping lone workers safe. Risk management had been improved to ensure risks had a nominated owner to follow through monitoring and mitigating actions.
- In acute mental health wards and psychiatric intensive care units staff reported having good morale, great mutual support from their team and that they felt supported by their managers. Three wards had been involved in a quality improvement process involving an outside organisation and teams of other professionals visiting to assess them.
- Although staff in older peoples mental health wards did not feel particularly engaged and were anxious about potential further changes, the trust were taking steps to address the improvements needed. Local governance of the wards was effective, there was high staff morale and ward managers were visible on the ward and respected by the staff team.
- Community-based mental health services for adults of working age had positive leadership within the service which ensured that managers had addressed issues with the waiting list identified at the last inspection.

Summary of findings

However:

- In community health inpatient services we found the service had addressed the requirement notices following our September 2015 inspection. However, further areas for improvement were identified, which is why the rating for well led and the overall service has not changed since 2015.
- We did not visit two other services rated as requires improvement for well-led at our September 2015 inspection.
- Although the trust senior leadership considered risk more carefully than at our last inspection and were proactive in their approach, the trust had adopted an 'exception' rather than a 'positive assurance' model of reporting.

Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: Gary Risdale, Inspection Manager (Mental Health) Care Quality Commission

The team included a CQC head of hospital inspection, four CQC inspection managers, 18 CQC inspectors, a CQC assistant inspector, two Mental Health Act reviewers and 18 specialist advisors including allied health professionals, doctors and nurses.

Why we carried out this inspection

We undertook this inspection to find out whether Somerset Partnership NHS Foundation Trust had made improvements to the following services since our last comprehensive inspection of the trust:

- Community based mental health services for adults of working age
- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Community mental health services for people with learning disabilities or autism
- Forensic inpatient/secure wards
- Community health services for adults
- MIU/urgent care
- Sexual health
- Community health inpatient services.

That inspection was undertaken in September 2015 where we rated the trust as **requires improvement** overall.

At the last inspection in September 2015, we rated the community mental health services for people with learning disabilities as **inadequate** because we were concerned that staff did not always respond appropriately to meet peoples' individual needs to ensure the welfare and safety of service users. These concerns included the lack of risk assessments, person-centred care planning, and mitigation of risks, incident reporting and working with others where responsibility for care is shared or transferred.

Following the September 2015 inspection we issued a warning notice. The warning notice was served under Section 29A of the Health and Social Care Act 2008 on the 25 September 2015 because of concerns about the safety of community mental health services for people with learning disabilities or autism provided by Somerset Partnership NHS Foundation Trust.

The warning notice required the trust to conduct an immediate review of the service's case load focusing on risk assessments with safety plans being put in place where necessary within six weeks of receipt of the warning notice. It also required the trust to undertake a comprehensive review of the assessment and care planning in the service which it needed to complete within the six months following us serving the warning notice.

We completed an unannounced, focussed inspection on 10 May 2016 to see if the requirements of the warning notice had been met. We found the requirements of the warning notice had been met and that risk assessments were comprehensive and identified all areas of concern for service users. All service users had holistic and detailed care plans that addressed known risks and areas of treatment that service users required. Multidisciplinary team meetings considered risk in a collaborative way.

Following the September 2015 inspection, we also told the trust to make the following improvements to community mental health services for people with learning disabilities:

- The trust must assess, monitor and improve the quality and safety of services provided and improve governance processes.
- The trust must assess monitor and mitigate risks for patients and staff
- The trust must seek feedback from patients, relatives and carers and engage them in evaluating and improving services.
- The trust should ensure that care plans had a version that was available in a format that service users who used the service could understand.

Following the September 2015 inspection, we also told the trust to take the following actions to improve wards for older people with mental health problems:

Summary of findings

- The provider must assess and address in full the risks associated with the physical ward environments as safe as possible, appropriate measures must be implemented to mitigate effectively the risks to people using the service.
- The provider must ensure that the training staff receive is adequate to be able to safely manage aggressive, physically fit and strong older adults.
- The provider must take the appropriate steps to demonstrate that care and treatment are provided with the consent of each patient or other relevant person, and be able to demonstrate that they act in accordance with the Mental Capacity Act 2005 (MCA) in all instances where a patient lacks mental capacity to make specific decisions and to consent to their care and treatment. Specifically, the provider must ensure they act in accordance with the MCA in all instances where a formal instruction to not attempt cardiopulmonary resuscitation (DNA/CPR) is in place.

Following the September 2015 inspection, we told the trust it must take the following action to improve community based mental health services for adults of working age.

- The trust must take action to further mitigate the risks of the 120 patients waiting the allocation of a care coordinator.

Following the September 2015 inspection, we told the trust it must take the following actions to improve forensic inpatient/secure services:

- The trust must ensure patients' capacity to consent to medication is assessed, reviewed and recorded regularly.
- The trust must ensure patients are being given their Section 132 rights on admission and at regular intervals.
- The trust must share the outcome of a second opinion appointed doctor (SOAD) visits with patients.

Following the September 2015 inspection, we told the trust it must take the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that staff have sufficient knowledge of safeguarding procedures and that all safeguarding incidents are correctly identified and raised. Safeguarding alerts and concerns were not always being made when they should and some staff were not aware of their responsibilities with regard to alerting safeguarding authorities.
- The trust must ensure that consent for treatment is gained and that this is clearly documented.
- The trust must ensure that all sites where rapid tranquilisation is used hold the appropriate medicines to reverse the effects of benzodiazepine medication.
- The trust must ensure resuscitation equipment and refrigerators are checked and maintained.

Following the September 2015 inspection, we told the trust to make the following actions to improve community health inpatient services:

- The provider must ensure that there is suitable access to fire escapes and training for emergency equipment to all at Chard Community Hospital.
- The provider must ensure that risk is properly assessed at the community hospitals and that this is recorded and escalated Patient records should be consistently completed in full.

Following the September 2015 inspection, we told the trust to make the following actions to improve sexual health services:

- Equipment used in the delivery of care and treatment should be maintained and checked in accordance with the manufactures guidelines and trust policy.
- Patient records should be consistently completed in full.
- The trust database which identified mandatory training completed by staff was not kept up to date and did not provide an accurate record.
- Emergency medication and equipment should be clearly labelled for use in an emergency.
- The staffing levels and skill mix of the service should be reviewed to ensure a consistent and timely service can be provided to patients. The main booking line should be accessible to patients when they telephone.
- The provider should ensure that patients with mobility requirements are provided with the means to access the service.

Following the September 2015 inspection, we told the trust to make the following actions to improve community health services for adults:

Summary of findings

- The provider must ensure that patients receive a thorough and timely assessment that includes essential observations and risk assessments that are necessary to detect deterioration in patients' health and wellbeing.
- The provider must deploy sufficient staff to meet the demand in the district nursing service
- Check e-rostering in all district nurse federations
- Check caseload zoning across all Federations and set guidelines for best practice groups
- The provider must ensure that a safe protocol for lone working at night time is actioned and embedded and audited regularly
- The provider must ensure that record keeping is of a consistently safe standard

Following the September 2015 inspection, we told the trust to make the following actions to improve urgent care services:

- Strengthen governance arrangements to ensure that maintenance logs for equipment used on and with patients are up to date and show where equipment is not maintained.
- Strengthen governance arrangements to ensure that all risks to service delivery are outlined in the service's local risk register, and where appropriate are included on the corporate risk register. Also ensure that there are clear management plans to address risks and that these management plans are regularly reviewed.
- Strengthen supervision or one to one arrangements to ensure that all staff receive one-to-one management and clinical supervision in line with trust policy.
- Ensure that the minor injury unit service is compliant with statutory and mandatory training.

These actions related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 9 Person centred care

Regulation 11 Need for consent

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding patients from abuse and improper treatment

Regulation 15 Safety and suitability of premises.

Regulation 17 Good governance

Regulation 18 Staffing

At our September 2015 inspection we also rated community dental services as **requires improvement**. We did not reinspect this service during this inspection. Community dental services will be visited again for an inspection as part of our ongoing programme of dental inspections.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Somerset Partnership NHS Foundation Trust and asked other organisations for information. We carried out short notice, announced inspection visits between 27th February and 2nd March 2017.

We looked at information provided to us on site and requested additional information from the trust both immediately before and following the inspection visit relating to the services inspected.

We also carried out a 'well-led review' on the 8th and 9th March 2017 to look at any changes that had taken place in the leadership and governance of the trust since the previous inspection and to assure ourselves the trust was still well-led. This also involved receiving feedback from external stakeholders.

During the inspection visit, the inspection team:

- Visited 38 locations from which the trust delivered services including the trust HQ.
- Spoke with 201 patients and carers.

Summary of findings

- Received 239 comment cards with feedback from people who used services.
- Reviewed 357 patient records, including medication charts.
- Spoke with 323 staff and 45 managers.
- Interviewed members of the senior executive team including the chief executive, chief operating officer, medical director and director of nursing.
- Looked at a range of policies, procedures and other documents relating to the running of the services in the trust.

Information about the provider

Somerset Partnership NHS Foundation Trust provides a wide range of integrated community health, mental health and learning disability services to people of all ages.

The trust employs 3,838 staff, and has a turnover of £158 million.

The trust provides services from 13 community hospitals across the county of Somerset, and mental health inpatient services on nine mental health wards.

The trust runs seven minor unit units and four dental access centres, including on the Isle of Wight, in Dorset.

The trust has more than one million patient contacts each year.

The trust was inspected in September 2015 as part of our comprehensive inspection programme. We rated the trust as **requires improvement.**

We issued a warning notice following that inspection. The warning notice was served under Section 29A of the Health and Social Care Act 2008 on the 25 September 2015. This was due to concerns about the safety of community mental health services for people with learning disabilities or autism provided by Somerset Partnership NHS Foundation Trust.

We completed an unannounced, focussed inspection on 10 May 2016 to see if the requirements of the warning notice had been met. We found the requirements of the warning notice were met at that time and lifted the warning notice.

The current inspection focussed on areas where we served requirement notices following the inspection in September 2015 to see if improvements had been made. The current inspection took place fourteen months after the publication of the comprehensive inspection report (in December 2015).

What people who use the provider's services say

We spoke with 201 patients and their carers. Patients were overwhelmingly very positive about the staff that looked after them. Patients told us that services were accessible.

Good practice

Community health inpatient services

- The care provided to end of life patients in the community inpatient service was exceptionally good. In one example we were given at West Mendip community hospital, a patient had requested to die outdoors. Nurses at the hospital were able to accommodate this patient's dying wish despite the challenging weather conditions. Nursing staff put canopies up to keep the patient dry and ensured they remained warm and comfortable. A harp was also playing to help the patient remain relaxed.
- Burnham-on-Sea hospital had adopted 'compassionate interviewing,' a recommendation from the Francis report. Compassionate interviewing was based on the 6C's, (values from the nursing and midwifery council, which all nursing staff should aspire to). The interview incorporated various tasks which

identified elements of the 6C's demonstrated by the interviewee. Only candidates who demonstrated awareness of the 6C's in their application were invited to interview. This approach ensured staff being recruited were caring and compassionate.

Community health services for adults

- The 'after stroke clinic' at South Petherton Community Hospital had volunteers involved in assisting patients under the direction of the qualified staff. Some of these volunteers had suffered a stroke and they were able to share their experiences with patients. One patient told us this was beneficial to them after their stroke to see how they could improve.
- The trust ran balance and safety courses over eight weeks with follow up at the end of the sessions to encourage people to continue their exercises at home. They were very well attended. Patients we spoke with were very positive about the service.
- Orthopaedic assessment service sessions (OASIS) ran from several locations across the trust. They were delivered by specialist physiotherapists and podiatrists in collaboration with local GPs and orthopaedic surgeons from the local NHS trusts. We observed two clinics. Staff made a thorough examination of each patient, discussed their presenting condition and their treatment options in depth and were very clear about what was to happen next, for example a scan or referral for surgery.

Community-based mental health services for adults of working age

- Staff at the Taunton site had started up a wellbeing clinic for the monitoring of patients physical health and to provide a drop in service for patients' depots medication. Staff monitored patients who had started antipsychotic medication and completed tests in line with NICE guidance on psychosis and schizophrenia in adults and young people. To monitor the side effects of the antipsychotics staff used the Glasgow Antipsychotic Side Effect Scale (GASS). Staff said that they would welcome any new referrals into the wellbeing clinic if they felt they needed a physical check. Staff used a room on the Taunton site that had the appropriate physical monitoring equipment and health lifestyle information. Staff told us that they had helped people stop smoking and used health promotion to encourage healthier lifestyles. There had been an incident with a patient at the wellbeing clinic that had meant staff needing to transfer him to local hospital for chest pains, staff at the clinic had uncovered a serious health condition in that particular patient. Since the start of the clinic, they had offered 756 appointments with 552 appointments attended. The wellbeing clinic had won two trust recognition awards and the managers were looking at options on how they could expand the clinic across the trust.
- Staff at the clozapine clinic at the Taunton site were able to test blood on site to ensure that there was a quick result in order to confirm that patients could be dispensed further medication. The pharmacy technician working at the site was able to dispense medication promptly when the blood test result had been confirmed.

Community mental health services for people with learning disabilities

- Senior managers from the trust were very visible. They went out on community visits with the staff team and had supported the changes to the service which had been rated inadequate with a no blame culture. This had supported dramatic improvements to the service.

Areas for improvement

Action the provider MUST take to improve

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that managers monitor the administration of medication and act on any errors found. The monitoring should include ensuring documents regarding consent to taking medicines under the Mental Health Act are easily accessible to staff and completed correctly.

Urgent care services

Summary of findings

- Ensure training and processes for implementing the Mental Capacity Act 2005 and establishing and recording consent are adequate.

Community Health Inpatient Services

- Ensure the duty of candour regulation is fully complied with in the inpatient service.
- Ensure compliance with the Mental Capacity Act (2005), and in particular capacity assessments and consent recording.
- Ensure medicines are stored and managed correctly across the community inpatients service, and that refrigerator temperature checks are completed.

Action the provider SHOULD take to improve

Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that staff understand what a restraint or seclusion incident is and document the incident thoroughly and contemporaneously as per trust policy.
- The trust should ensure there is clear signage to indicate where emergency equipment and medicines are stored and that CCTV is being used to monitor the environment.
- The trust should review current blanket restrictions in place on all wards to ensure they are working within least restrictive principles.
- The trust should ensure that staff record consent consistently in the appropriate section within patients' notes to ensure that this information is easily accessible to all staff.
- The trust should ensure that staff supervision is completed and recorded consistently.

Wards for older people with mental health problems

- The provider should ensure all care plans and records demonstrate involvement with the patient throughout treatment.
- The provider should ensure the staff on the wards have the necessary skills and confidence to effectively manage older people with mental health problems and receive appropriate training to do so within current best practice.
- The provider should ensure that all bedrooms and ward areas protect patient privacy and dignity.
- The provider should ensure managers provide regular supervision as per trust policy.
- The provider should ensure they engage and involve all staff in all potential changes in the wards and support staff to have a voice in these changes.

Forensic inpatient/secure wards

- The provider should continue to roll out Mental Health Act Training.

Community-based mental health services for adults of working age

- The provider should ensure that informal complaints within the service are recorded.
- The provider should ensure that supervision is recorded in order to evidence that staff receive regular supervision.

Urgent care services

- Ensure adequate systems are in place to ensure Patient Group Directives used in minor injury units (MIU) are in date.
- Ensure adequate systems are in place for checking medicines in MIUs are in date and stored appropriately.
- Ensure all staff in MIU comply with handwashing best practice and strengthen the processes to monitor handwashing technique.
- Ensure all patients in MIUs are assessed for pain and that the assessment and treatment of pain is recorded in all cases.
- Ensure appropriate safeguarding assessments for adults and children are recorded in patient records in MIUs.
- Ensure all staff are up-to-date with mandatory training, including safeguarding.
- Consider having a consistent process for identifying and sharing risk alerts on patients' notes across all MIUs.

Summary of findings

- Consider carrying out a training needs analysis for 'sieve and treat' training and other MIU specific tasks for reception staff.
- Consider how patient confidentiality in MIUs can be improved.
- Review the visibility of patients in all MIU waiting areas.

Community health services for adults

- Ensure cupboards used for storing dressings and medicines are within the expected temperature ranges.
- Ensure sharps bins are always labelled with hospital details and the specific area in which they are being used.
- Ensure all the emergency trolleys have in date equipment stored on them. Also that a systematic check of the trolleys is carried out and documented on a daily basis.
- Ensure all staff in clinic settings wash their hands and clean the examination couch between patients.
- Ensure an acuity (dependency) tool is in place across the trust to enable senior staff to see each team's dependency ratings.
- Ensure staffing levels and waiting lists continue to be monitored to ensure safe working practices.
- Ensure community nurses are able to photograph wounds to assess progress or deterioration of wound healing.
- Ensure there is a corporate chaperone policy available to staff.
- Ensure the wound assessment toolkit that is currently being developed is continued and rolled out at the earliest opportunity.

Sexual health services

- Consider how the privacy and dignity of service users in sexual health services' clinic waiting areas can be maintained.
- Continue to improve the booking system for sexual health services.
- Consider the further provision of appropriate bariatric examination couches in key locations around the county.

Community Health Inpatient Services

- Ensure all staff required to complete level three adult safeguarding training have done so.
- Make sure the resuscitation policy stored on the resuscitation trolleys is in date.
- Ensure all equipment is serviced and in date.
- Make sure all clinical waste is put in designated clinical waste bins and not left on the floor.
- Make sure cupboards containing cleaning fluids and detergents remain closed and locked at all times.
- Ensure safe staffing levels are met at all times in the community inpatient services.
- Make sure staff complete patient fluid balance charts to enable accurate monitoring of patients.
- Ensure all staff are up-to-date with their appraisals.
- Establish one consistent method of monitoring pain between the community hospitals.
- Ensure the admission transfer and discharge policy is in date and reviewed according to set timeframes.
- Make sure leaflets available for patients contain the most up to date information from best practice guidelines.
- Ensure patients are receiving regular physiotherapy input to ensure the service provided is responsive to the needs of the patient.
- Make sure there is consistent use of the "This is Me" documentation throughout the community hospitals.
- Continue to strengthen the governance framework across the community inpatient service to ensure it fully supports the delivery of good quality care.
- Ensure there is good oversight and leadership of audits across the community inpatient service to ensure actions are put into practice.
- Ensure matrons have the capacity to lead effectively.

Somerset Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We include our assessment of the provider's compliance with the Mental Health Act in our overall inspection of the trust.

We do not give a rating for the Mental Health Act; however, we do use our findings to determine the overall rating for the trust.

Further information about findings in relation to the Mental Health Act can be found later in this report.

Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act in our overall inspection of the trust.

We do not give a rating for the Mental Capacity Act; however, we do use our findings to determine the overall rating for the trust.

Further information about findings in relation to the Mental Capacity Act can be found later in this report.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe and clean environment

- Staff did not always comply with infection prevention and control best practice or policy within the community health services. This was noted particularly within the minor injuries units and community adults service where staff did not always wash their hands between patient contacts.
- Infection control was managed well in mental health services.

Safe staffing

- There were staffing pressures across the community health services, although the trust was well aware of these and taking actions to ensure patients were safe. This had included the temporary relocation of a ward at Minehead hospital to Williton hospital. Recruitment was ongoing to fill vacancies and regular staffing reviews were taking place.
- The trust was a pilot site for the nursing associate roles, 28 posts have been created working closely with a university
- The trust considered acuity of wards when considering staffing numbers and was developing tools to consider acuity in community caseloads. Caseload zoning was used to manage work pressures.
- 95% of staff were up-to-date with mandatory training across the trust.

Track record on safety and reporting incidents and learning from when things go wrong

- We found a positive incident reporting culture in the community health services. Staff were encouraged to report incidents and felt confident doing so. Investigations were completed and learning was shared widely to ensure improvements were made.

Safeguarding

- Across all services, we found safeguarding systems and processes were understood by staff and implemented to keep people safe. Safeguarding concerns were recognised and reported promptly to ensure patients were protected.
- Safeguarding training at enhanced level three training appeared low in community health inpatients. However, this was due to the trust reviewing which staff required this proactively in line with draft national guidelines from NHS England. This meant more staff were required to do the training than previously which had affected the training figures. There was a detailed training plan to meet the new standards. Prior to the new standards being adopted by the trust the compliance rate for level three was 97%.

Seclusion

- We carried out a review of the management of seclusion and segregation across the trust led by two Mental Health Act reviewers. We visited three wards that either had a seclusion suite or a de-escalation room to establish how the policy was applied. We carried out a review of the policy and environment, reviewed seclusion paperwork and interviewed staff across these three areas.
- We reviewed the environment across all three areas. The seclusion suite on Holford ward met the strict national standard in place for seclusion suites.
- The seclusion/ de-escalation suite on Ash ward consisted of a de-escalation room with foam seating. The seclusion suite, which was located further along the corridor, consisted of one room with a foam bed. There was a light porthole in the ceiling which was covered in a green coating, limiting the only natural light. Observation was via the observation panel in the door

or by CCTV, which was located in the nurses' office on the main ward away from the seclusion suite. The toilet, washing and shower facilities were located opposite the seclusion room across the hall. Staff gave cardboard urinals to patients who were too agitated to use the facilities across the hall. The trust had sought quotes on making changes to the facilities which were a considerable cost. The use of seclusion was rare (six times in the year before the inspection) and so the trust had opted to continue the use of cardboard urinals, but only allowing them into the room when a patient requested them.

- The de-escalation room in Rowan ward was a small room on the ward with no natural light, it included a series of three foam chairs. Staff told us they did not use this room for segregation and tried to use other areas of the ward for de-escalation due to the lack of therapeutic nature of the room.
- SOMPAR had a proactive care policy embedded across the trust since August 2015, that had been updated in August 2016. The trust told us they had updated the policy to reflect the 2015 changes to the Mental Health Act Code of Practice. Staff we spoke to were aware of the policy. However, when we reviewed the policy document it was open to interpretation and terms such as segregation and isolation were used interchangeably.
- We found evidence on Holford ward that the proactive care policy had not always been followed regarding the four-hourly medical reviews of secluded patients. We found evidence that four-hourly medical reviews did not always take place as per trust policy. We found evidence that doctors were not always accessible to complete these reviews. Documentation to end periods of seclusion was inconsistent. We found that seclusion records were not fully completed and the standard of information recording was not consistent.
- On Ash ward, we found that staff had not used the seclusion area for some time and so there were limited number of recent seclusion records to review. Therefore, we reviewed two patients' records from the last six months. We found no completed seclusion review forms for one patient who was secluded. We also found that times and dates on seclusion reviews were not always updated therefore, they were not a true reflection of periods spent in seclusion. For one of the two patients whose records we reviewed on Ash ward had no evidence of two hourly nursing reviews as per trust policy. We scrutinised documentation for another patient who had been secluded. We were unable to find documented evidence of four-hourly medical reviews taking place over a 12-hour overnight period. The patient eventually stayed in segregation for a period of seven days whilst awaiting transfer to another hospital. During this time in segregation there was inconsistent recording of daily medical reviews, it was hard to find evidence of when seclusion stopped, and segregation started.

Assessing and monitoring safety and risk

- Risk assessments were better in all services and risk was considered both clinically and wider in a more structured way.
- Trust dashboards monitored risk assessment completion on the electronic recording system. It showed that only one percent of records did not have a risk assessment completed and that only seven percent had not been updated in the last 12 months. Managers and clinicians would receive reminders about this.
- Lone-working arrangements had been strengthened across the community health services, but particularly with the community adults service where staff told us they felt new processes kept them safe.
- Medicines management across the community health services was generally well managed, although there were some examples where processes needed to be strengthened. For example, we found some refrigerators were not being checked regularly to ensure they were within acceptable temperature ranges. In two minor injuries units we found some medicines which were out of date and had not been disposed of. Within the community health inpatients service controlled drugs were not always being appropriately countersigned.
- However, we found errors in 13 out of 53 patient medication charts on the acute mental health wards. These included staff not signing to confirm that they had administered medicines. This meant that we were unsure if staff had administered medicines as prescribed. We also found occasions where staff had given patients more "as required" medication than the doctor had indicated staff should administer.

Duty of Candour

Requires improvement

Are services safe?

- The trust understood and applied the duty of candour appropriately. This was evident in the majority of services and local teams where staff received training at corporate induction and received an aide memoire to enable them to follow the trust's policy and expectations. We reviewed 15 letters of response to complaints and all were appropriate and gave explanations and apologies where necessary. The trust had commissioned an external audit of its application of the duty of candour requirements which had highlighted concerns within their policy and procedures that the trust had responded to and changed accordingly.
- However, in community inpatient services we found cases where the policy had not been fully followed by staff.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Our findings

Assessment and delivery of care and treatment

- Care plans and care records were generally of a good standard.

Best practice in treatment and care

- Care and treatment was being delivered in accordance with national guidance and standards, and various audits took place to check performance against these.
- We found that policies and guidance were not always up to date within the community health services. For example, we found the admissions, transfer and discharge policy for the inpatients service was out-of-date by seven months, as were a number of patient group directives (PGDs).

Skilled staff to deliver care

- Staff were encouraged to develop their skills and knowledge. Staff were able to attend training courses if these had been identified as a development opportunity, and often these were funded by the trust.

Multidisciplinary and inter-agency team work

- All services demonstrated strong multidisciplinary working, both internally and externally. In particular, close working relationships with local emergency departments, GPs and the ambulance service had been developed.
- The trust had become more outward facing since our last inspection. This was shown by its engagement with local partners but also in how it requested support from another NHS trust to help it address the concerns we raised in the learning disability service at our inspection in September 2015.

Consent to care and treatment and good practice in applying the MCA

- There were difficulties in the recording of consent and capacity, particularly in community health services. We found generally poor documentation of capacity assessments and recording of consent. The trust was aware of the issues as the trust's county-wide performance report showed that consent was not recorded in 22% of all patient records. This was an improvement from two years ago where consent was not recorded in 50% of cases. However, the 22% not recorded equated to 5,980 patient records. Staff in the governance team would contact individual teams where they noted there was an exception, but there was no coherent strategy to address this.
- The trust provided us with an audit of all 103 patients in mental health inpatient wards at the time of inspection that showed that consent and capacity was recorded for all patients. 20 of these were not in the consent location on the electronic record system but recorded in the running record of the notes which made them difficult to locate in those cases.
- However, there were services that were recording capacity and consent well, for example sexual health services, wards for older people with mental health problems and community mental health services for people with learning disabilities. In these services there was appropriate reporting of consent and capacity which was decision specific.
- Training in consent and the Mental Capacity Act was predominantly through e-learning. The e-learning programme was a package bought from an external provider which covered the principles of the Mental Capacity Act in detail and would take over seven hours to complete. However, it did not have an element of practical application to inform a member of staff how to record consent and capacity on the trust's electronic record system.

Adherence to the MHA and the MHA Code of Practice

- The trust had implemented a process to ensure they had oversight and scrutiny of its application of the Mental Health Act (MHA). This was co-ordinated by a non-executive director (NED) and a Mental Health Act co-ordination lead. The trust, in 2016, formed a mental

health legislation committee to increase their oversight across the trust. Chaired by the NED and attended by the medical director and the head of mental health services four times a year.

- Examples of the steps undertaken by the trust to ensure it had scrutiny of the application of MHA included reviewing incidents that affected patient safety and experience, meetings with the independent managers three times a year to offer formal training, chairing MHA managers hearings which allowed them to check the quality of the reports submitted. They have good links with the advocacy service and MHA monitoring visit reports were reviewed at the mental health legislation committee.
- We found there were some areas of the Mental Health Act and Code of Practice, which the Mental Health Act Co-ordination Lead did not appear to have oversight of. This included things such as patient involvement in care plans, recording and authorising of section 17 leave, recording of seclusion or use of extra care areas as we were informed these were the responsibility of the Head of Operations.
- The trust were running a programme of MHA training, currently limited numbers of staff had received the new updated training package. All new staff received the training on induction. However, the trust's action plan highlights that this is the only outstanding action from the previous inspection in 2015. We found that staff delivering care on the wards had an awareness of the MHA and the code of practice and were implementing it correctly.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Our findings

- At our last inspection in September 2015 all services were rated as good except for community dental services which were rated as outstanding and community based mental health services for people with learning disabilities that were rated as requires improvement.
- At this inspection, the community based mental health services for people with learning disabilities had addressed the issues that had caused us to rate caring as requires improvement following the September 2015 inspection. Service users were more involved in their care. The service was re-rated as good.

Kindness, dignity, respect and support

- We received very positive feedback from patients about the care provided within the trust.
- We observed that staff treated patients with compassion, dignity and respect, and provided genuinely person-centred care.
- Staff took the time to interact with patients and involved them in their care. They ensured patients understood their care and treatment options and supported them to make decisions about their own care.

The involvement of people in the care they receive

- Although some of the environments in community health services did not promote privacy or confidentiality, staff were aware of these challenges and did their best to overcome them. For example, a number of reception areas in the minor injuries units and the sexual health service were open and allowed conversations with receptionists to be overheard. Reception staff in one minor injury unit used a radio to disguise conversations, and generally conversations were conducted quietly so others could not overhear.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Our findings

Access and discharge

- The needs of patients and the local population were taken into account in the design and delivery of services.
- Across services we saw good support given to patients with complex needs. In particular, within the inpatients service we saw excellent end of life care provision.
- Most services ensured patients were able to access their services quickly, although there were some long waiting lists in the community adults service. However, these were recognised and initiatives had been introduced to reduce the length of time patients were waiting. In the sexual health service, the countywide telephone booking system struggled to meet demand and patients often reported the line being engaged, unanswered or calls being dropped. However, following our inspection the trust provided us with a plan to address the issues, which included increasing the operating hours of the booking line and speeding up the introduction of internet-based booking solutions.

Meeting the needs of all people who use the service

- The trust had a sufficient budget for translators and information to meet the needs of the local population. The main languages being accessed were Portuguese, Polish and British Sign Language.

Listening to and learning from concerns and complaints

- We found information about how to raise a concern or make a complaint was readily available to patients across all the services.
- Learning from complaints was considered and discussed in team meetings. A new policy and procedure had been created since the concerns raised at the last CQC inspection. There was a robust investigation process in place. A formal action plan was completed for every complaint.
- The director of nursing reviewed letters to complainants that have a clinical component, ensuring that they were patient focussed and had an appropriate amount of detail. This had resulted in an improvement in the quality of the letters. The chief executive saw all final letters before they went out with the case file.
- There were multiple examples of the trust learning from complaints at both a local and trust wide level. For example, the trust had a complaint from a patient who was blind receiving non-accessible letters. This resulted in a change where the trust was rolling out a new system to check at first contact the format that patients wanted information sent in.
- The trust monitored for trends and completed quarterly thematic reviews of complaints and compliments.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Our findings

Vision, values and strategy

- At our September 2015 inspection we were concerned that the trust vision and values were not clear to staff. The trust had worked on developing new values with staff consultation. These were simpler and more understandable. They were incorporated in three phrases of: working together; everyone counts; and making a difference. At this inspection, the majority of staff were able to identify the new values and some staff described their role in their creation. For example, the IT manager described how the ethos of working together focussed her team on supporting clinical staff. Staff in the learning disability services described how collaborative the IT team had been in solving the problems of getting pictorial life stories and easy read care plans onto the electronic record system.
- The trust's vision of 'care in the heart of the community' was created in 2014. Staff understood this, although there was acknowledgement it needed review, even though much of it was still applicable and in line with the direction of the sustainability and transformation plans.
- The trust was taking a positive view of the Somerset sustainability and transformation plan and how this would change care pathways for patients in future. The chief executive and senior managers were working closely with other local partners on the plans and implementation. However, there was some concern expressed by various staff about the amount of time that was being devoted to this with no additional resources: staff said this affected some of the day to day roles.
- The trust's future strategy was linked closely to the sustainability and transformation plan. However, senior managers were mindful that the development of mental health services was not as clear as it could be in the plans and that they had to ensure that they kept it on the agenda. This also meant aligning to national strategy and developments. For example, in child and adolescent mental health services.

Good Governance

- The trust board was more proactive in ensuring governance structures and processes were effective since our inspection in September 2015. In particular, all the board members that we spoke with described how they had become more searching and questioning, how they had sought greater assurance about the reliability of data and the sources of assurance which the board members themselves relied upon. They agreed they had some way yet to go to achieve governance maturity. However, it was evident from the board and the quality and performance committee minutes that board members, including non-executive directors, were appropriately challenging and probing. This search for assurance and wariness of complacency and willingness to invest time and effort in formal governance is a necessary key foundation of governance improvement and was a positive change from our previous inspection findings.
- The non-executive directors described how they had sought greater assurance following our last inspection. This had taken the form of more visits to the front-line wards and service areas, deep dives on topics and more questioning in committees and at the board.
- The trust had a clear and fit-for-purpose governance structure. In the last 12 months, the trust had moved board governance oversight of performance from the finance committee to examine performance alongside quality in a new governance committee. The quality and performance committee was attended by the executive directors including the director of nursing as lead for quality and the director for finance as lead for performance. Senior leaders were positive about the change of bringing quality and performance together.

This was in line with the management structure changes at division level where the trust had created management triumvirates which include clinical and management leads.

- We judged that this revised committee structure would help ensure that quality performance and risks would be examined together in a simplified structure ensuring the flow of risk, assurance and performance data would be reviewed and escalated appropriately. This could be seen in the trust board and committee agendas and papers.
- The trust recognised and had acted on the lessons learnt from our previous inspection findings in September 2015. Previously the trust's risk identification and escalation processes had failed to alert the board and senior management team to the risks and issues in the trust's learning disability services which we rated as inadequate. The trust had developed a revised risk management strategy. This had led to a revision of the risk management system. This work was reflected in the design and content of the board assurance framework (BAF), corporate risk register (CRR) and divisional risk registers. These registers were well designed; each risk was labelled with a named owner, dated, contained current and target risk scores, and a recognition of the difference between controls and mitigations. Each recorded risk had an up-to-date commentary about how the risk was being treated and recent action on controls and mitigations. The BAF and CRR demonstrated an appropriate distinction between 'strategic' and 'operational' risk (recognising too that these can overlap and interlink). The risks in the BAF and CRR generally were clearly defined and described; and each contained a manageable number of risks.
- In practice, staff told us that risk was more prominent at service and divisional governance meetings. Managers said there was more time for detailed discussion of the risks and their management. For example, at divisional governance meetings over the course of a year each team committed to present their top risks for other to learn from. This also aided service managers' development in understanding how the risks were understood at divisional level and escalated to the board. Managers told us that at every meeting the question "what are you worried about?" was asked, and every meeting ended identifying any new risks that had been raised in the meeting.
- The trust had clearly invested effort into generating better performance and quality data since our inspection findings in September 2015. Several examples of detailed dashboards were examined. The non-executive directors had identified the need to be assured of the integrity of data and had challenged this in specific areas, e.g. pharmacy. The trust was considering using internal audit to provide wider and systematic assurance about data used for decision-making and assurance.
- Managers at all levels from divisional manager to ward and team leaders described a more shared approach to risk, which was open and encouraged concerns to be raised. The trust had a programme called "see something, say something" which encouraged staff of all grades to raise any concerns they had.
- Senior managers and leaders in the trust recognised that at our last inspection the governance systems were designed primarily to hold people to account for performance. The systems were designed to help managers meet targets. However, they now felt they were designed to give staff and managers the information they needed for their jobs in a format that was more useful and focussed on quality of care. This was a significant change in the culture of how information in the trust was used.
- The trust had adopted an 'exception' rather than a 'positive assurance' model of reporting up to board level and whilst the trust has adopted a revised risk management strategy, this did not describe an assurance model , e.g. 'three lines of defence' or similar, nor was this described elsewhere. Therefore, although significant positive changes had been made to the governance behaviours, the processes to support these were not yet fully matured.
- The trust had improved its systems for learning from incidents and complaints since our last inspection. It was part of the NHS England "making families count" programme in how to involve families in investigations when things went wrong.

Good

Are services well-led?

- The trust had good resource and budget management which ran through all levels of the organisation. At the time of the inspection the trust had no deficit and was meeting the challenging financial targets set be commissioners. When asked how this had been achieved compared to other NHS organisations, the finance director did not take the credit but praised good managers in the trust who understood financial governance.
- Safeguarding was managed well through the trust. There had been an emphasis on training in the six months prior to this inspection. The trust had also expanded the number of staff required to undertake level three safeguarding training.
- Commissioners in the local clinical commissioning group (CCG) felt that the trust was responsive and had taken the previous September 2015 CQC inspection seriously. The CCG had confidence in the action plan. The CCG felt there had been progress in the relationship with other providers and NHS trusts and that the trust worked more as part of a system. NHS England which commissioned the forensic service agreed that the trust was responsive and provided detailed evidence in its reports to demonstrate its service delivery.

Leadership and culture

- The appointment of a new chief executive in February 2016 had resulted in a change in culture for the organisation. In our September 2015 inspection, we described a culture that was “top down”. Since the arrival of the new chief executive, there had been more empowerment of senior leadership to fulfil their roles. This had filtered down to divisional mangers and to some local managers. Leaders in the trust recognised that this change needed to be embedded further to all parts of the organisation but we saw that managers were more enabled to make decisions and were enthusiastic and positive about the changes the new chief executive had brought.
- The trust encouraged staff to be open about concerns. Senior leadership always asked managers to share their concerns at meetings, this had fed down to team level. The trust had a scheme called ‘see something, say something’ that staff were able to describe. The senior leadership team were more visible than at our previous inspection in visiting local teams. The divisional managers described getting frequent emails from the chief executive asking them to clarify things following a visit to a service or an enquiry from a member of staff.
- The chair and non-executive directors of the trust felt that the trust and senior leaders were more open to constructive challenge and less defensive when concerns were raised since our last visit.
- However, not all executive and non-executive directors regularly attended all divisional meetings for the divisions they were responsible for.
- Senior managers felt the new chief executive was setting the culture of the organisation to be open and approachable which was an approach for them to model. The chief executive had a regular blog in which he invited comments. This had generated feedback which was acted on. There was also more visibility of executives visiting services. The chief executive regularly visited services.
- The introduction of the new divisional clinical director roles and nursing/allied health professional leads had played a part in ensuring that there was clear clinical leadership within the trust, reporting to the medical director and to the director of nursing. Divisional managers were positive about the change and the support that gave them in managing their portfolios and engaging with clinical staff. Although these posts were relatively new, having been appointed in January 2017, there were multiple examples of the positive impact of this new way of working.
- Since our last inspection the trust had introduced an emerging leaders programme to develop leadership qualities in the workforce.
- The trust understood and applied the duty of candour appropriately. This was evident in the majority of services and local teams where staff received training at corporate induction and received an aide memoire to enable them to follow the trust’s policy and expectations. We reviewed 15 letters of response to complaints and all were appropriate and gave explanations and apologies where necessary. The trust had commissioned an external audit of its application of the duty of candour requirements which had

highlighted concerns that the trust had responded to within their policy and procedures were changed accordingly. However, the policy was not always applied fully in community inpatients.

Fit and Proper Person Requirement

- The trust had systems in place to ensure board members were fit and proper. However, these systems did not fully meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Regulation 5: Fit and proper persons: directors. This regulation ensures directors of NHS providers are fit and proper to carry out this important role.
- The trust's recruitment and selection policy and procedure (May 2015) confirmed the requirement for director level appointments to meet the standards of this regulation, and for this to be evidenced. The policy stated checks would be made in accordance with the regulation, and made reference to a separate Disclosure and Barring Service (DBS) policy. The recruitment and selection policy did not provide detail about how the recruitment process and checks would be managed to meet the requirements of the regulation.
- The trust's list of posts requiring a DBS check stated that the chief executive and board appointments required a basic DBS disclosure check. However, an advanced DBS is required for those working with vulnerable adults and children and, because board members visit clinical areas, CQC required the trust to take action immediately to meet the requirements of the Health and Social Care Act regulations.
- When we raised this with the trust they took action to request enhanced DBS checks for all directors who had only had a basic check.
- The trust had introduced a self-declaration form for directors, which required them to sign to say they remained compliant with the fit and proper persons' requirements. A recruitment checklist and an ongoing compliance checklist had also been introduced. These were stored in the personnel files as evidence of relevant checks being completed.
- We reviewed the personnel files of seven directors on the board, including the chair, chief executive, executive and non-executive directors. The files provided evidence that relevant checks had been completed in accordance with the trust's policy.

Engagement with the public and with people who use services

- The trust had an 18-month public and patient involvement strategy. Participation of patients in services was more advanced in areas which traditionally had stronger participation, such as child and adolescent mental health services and community learning disabilities services. The trust was looking at those models to see how other services could learn from that.
- The trust had an event called 'feedback February' which had involved the patient advice and liaison service (PALS) visiting services and wards. This had generated over 500 pieces of feedback which were being collated at the time of the inspection.
- The trust was trialling new ways to engage people who use their services. For example, access audits had been completed at four sites. The trust had requested local organisations that supported people with sight loss and wheelchair users to visit the sites and produce a report on accessibility. This produces reports with photographs to improve the experience of people with disabilities. For example, a photograph of a water cooler in place that prevented a disabled toilet door from fully opening. This photo was then used for training to help staff understanding of how things can impact patients. The result was moving of a play area, the water cooler, and storage of wheelchairs and changing the door fittings, all of which were impeding the use of wheelchair users at the site.

Quality improvement, innovation and sustainability

- There was a positive relationship between the trust and staff side (unions), with regular meetings and appropriate consultation on the majority of changes. Staff side felt that the trust was responsive to issues raised and addressed issues.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Acute wards for adults of working age and psychiatric intensive care units** The completion of medicine administration records was inconsistent and managers did not act promptly on errors made by staff. Staff had given patients more as required medication than the doctor had prescribed. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Community Health Inpatient Services** 11(1) Care and treatment of the service users must only be provided with the consent of the relevant person. 11(3) If the service user is 16 or over and is unable to give consent because they lack the capacity to do so, the registered person must act in accordance with the 2005 Act. 11(1) There were inconsistencies and a lack of understanding and clarity about how and where consent should be recorded across the community hospitals we visited. Some patients had paper documentation completed and some did not. Some patients had their consent

This section is primarily information for the provider

Requirement notices

electronically recorded, however there were inconsistencies with how this was recorded. Some staff told us that if they felt the patient lacked capacity, they would get the patient's family to sign the consent form on their behalf. Confusion had arisen following advice that the paper consent forms were not fit for purpose and should not be in use, but no alternative solution had been provided.

11(3)

Staff we spoke with did not understand or feel confident with the relevant consent and decision making requirements and guidance, including the Mental Capacity Act 2005. Staff told us they received minimal training around the Mental Capacity Act and were provided with no training on how to complete a mental capacity assessment. Staff told us they could recognise whether or not a patient had capacity but did not know how, or feel confident, to undertake appropriate actions to formalise and document a capacity assessment if required.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Community Health Inpatient Services** 12 (2) (g) the proper and safe management of medicines 12 (2) (g) Staff on Exmoor ward were neither following the trust's policy or working in line with best practice with regards to the management of controlled drugs. Controlled drugs were being countersigned by a healthcare assistant, rather than a registered nurse. We saw no risk assessment completed, despite the deviation from the trust's policy.

This section is primarily information for the provider

Requirement notices

Medicines were not always being stored safely. Liquid medicines did not always have the date they were opened recorded. This issues had been identified at our previous inspection in 2015 but remained unresolved.

Medicines refrigerators did not always have temperature checks completed and were not always locked.

Twelve of the 55 prescription charts we checked contained omissions and reasons for these were not documented.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **Community Health Inpatient Services** 20(4) the notification given under paragraph (2) (a) must be followed by a written notification given or sent to the relevant person containing – 20 (4) (a) the information provided under paragraph (3) (b) 20 (4) (b) details of any enquiries to be taken in accordance with paragraph (3) (c) 20 (2) (c) the results of any further enquiries into the incident, and 20 (4) (d) an apology The community inpatients service did not provide written notifications, including an apology and details of the investigation findings and actions taken, in order to meet this regulation.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Urgent care services** 11(1) Care and treatment of service users must only be provided with the consent of the relevant person. Arrangements for recording consent were not clear. The 'capacity to give consent checklist' in MIUs included the term: 'Fraser competent'. Fraser guidelines are only for contraceptive advice. The correct standard should be Gillick competence, which refers to a child's capacity to make specific decisions. The consent checklist was not clear and could also be interpreted that consent could be gained from a carer of an adult who had decision making capacity. This was not in line with the Mental Capacity Act (2005) and best interests decision making.

Somerset County Council
Scrutiny for Policies, Adults and Health Committee
21st June 2017

Somerset: Our County Joint Strategic Needs Assessment 2017

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Cabinet Member: Christine Lawrence
Division and Local Member: All

1. Summary

1.1. Summary and Purpose of Paper

Production of a Joint Strategic Needs Assessment is a statutory duty for Health and Wellbeing Boards (HWB). The assessment presents evidence on the scale and nature of the population's health and care needs, and likely future need, to inform decision making by the Board and its members. The bulk of the information is published as a website at www.somersetintelligence.org.uk/jsna. An annual summary is also produced, usually concentrating on a cross-cutting issue or population group in the county. The draft annual report for 2017, appended here, has a focus on ageing well. It looks at the health, social care and wellbeing needs of the population aged over 65 and is complemented by a qualitative report detailing personal experience and attitudes to ageing well.

1.2. The report is produced collaboratively by the partners on the Health and Wellbeing Board, and consulted upon widely to assess whether it is presenting a useful and realistic picture of need. The Health and Wellbeing Board is formally a committee of the County Council, but also includes members from each district council in Somerset, the Somerset Clinical Commissioning Group and Healthwatch, representing patients' views. The HWB is required to take the findings of the JSNA into account in developing the Health and Wellbeing Strategy. Somerset County Council and CCG are required to take it into account in commissioning decisions.

1.3. Scrutiny is asked to discuss and comment on the report and its findings, and their implications for commissioning services. Scrutiny's comments will be taken into account in the final draft and passed through to the Health and Well-being Board for consideration before the JSNA is approved.

1.4. This JSNA supports the County Plan's objectives, specifically:

- 'Health inequalities, where people from deprived backgrounds have poorer health, are more likely to live with long term conditions, and have a shorter lifespan than people living in more affluent areas'
  and
- 'Joining up our own social services with those services provided by the NHS. The aim is to improve results for individuals and families, but importantly to do this efficiently to make all our public funding go further.'

1.5 The JSNA summary for 2017 has been discussed by the Health and Wellbeing Board in a development session and by the Clinical Operations Group of the Clinical Commissioning Group. It will be taken to the Health and Wellbeing Board for approval on 13th July 2017.

2. Issues for consideration / Recommendations

2.1. The Scrutiny Committee is asked to discuss and comment on the draft JSNA summary 2017 and accompanying qualitative report and the JSNA website (http://www.somersetintelligence.org.uk/jsna/) as a source of evidence in its work to inform the health, social care and wellbeing needs of the whole population.

2.2. The following themes abstracted from the JSNA summary have particularly important implications for the commissioning of health and care services, and wider policy.

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.
- There is **no 'safe age'** before unhealthy activities begin to have an effect, nor an age after which improvements do not help.
- **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

- **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.
- 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.

Remaining active and included in community life

- **Social contact** is an essential part of sustaining health and wellbeing**.**
- 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.

3. Background

3.1. Production of the JSNA is a statutory requirement of the Health and Wellbeing Board, as stated in the Health and Social Care Act (2012).

4. Consultations undertaken

4.1. A specific piece of qualitative work was undertaken to support this JSNA and provide insight and experience regarding ageing well. The results have been shared with participants for comment and are summarised in a separate report to compliment the JSNA summary. Detail of all the discussions will be linked from the qualitative report on the Somerset Intelligence website once the JSNA has been approved by the Health and Wellbeing Board for publication.

4.2. Engagement with stakeholders is maintained through the Health and Wellbeing Board and Executive, commissioners' meetings, JSNA Technical Working Group, Healthwatch Somerset Executive Group, CCG Engagement Advisory Group and CCG Equality Delivery System Group.

4.3. Feedback on the JSNA is continually sought through the JSNA webpages and meetings with commissioners, stakeholders and broader audiences such as those in the voluntary sector.

5. Implications

5.1. The Department of Health (DH) guidance suggests that commissioning plans of CCGs, NHS England and local authorities will be expected to be informed by relevant JSNAs and the health and wellbeing strategy. Where plans are not in line, the organisations could potentially be asked to explain why. The policy intention as cited by the DH is that *"local services which impact upon health and wellbeing will be based on evidence of local health and wellbeing needs and assets, including the views of the community; meaning that services and the way in which they are provided meet local needs"*.

5.2. The JSNA pays due regard to protected groups to identify health and social inequalities within the Somerset population.

6. Background papers

6.1. Appendix A - Somerset: Our County JSNA Summary 2017 Ageing Well
Appendix B - Ageing Well – qualitative report

Somerset's Health and Wellbeing Strategy and Somerset's County Plan

Somerset: Our County

Joint Strategic Needs Assessment

Summary 2017
Ageing Well

DRAFT

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/jsna/ageingwell2017.pdf). 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*.

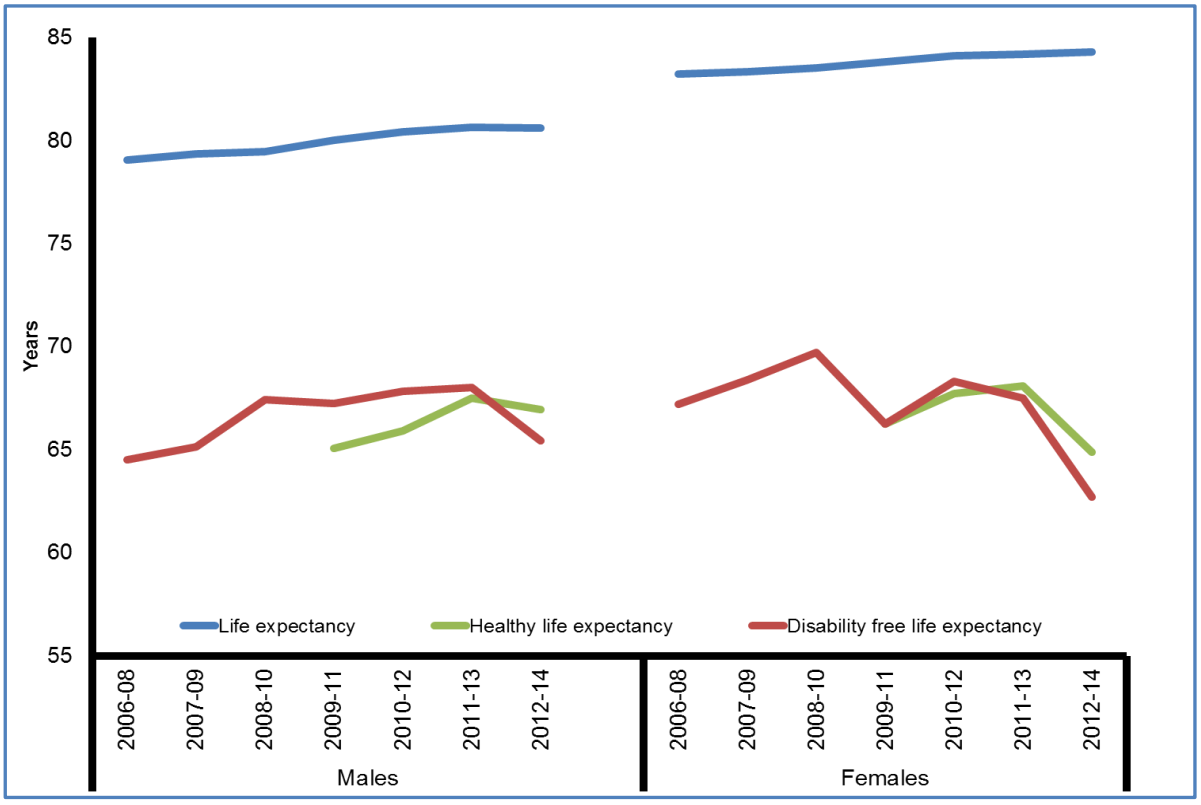


Figure 1 - Life expectancy and healthy life expectancy, Somerset

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.

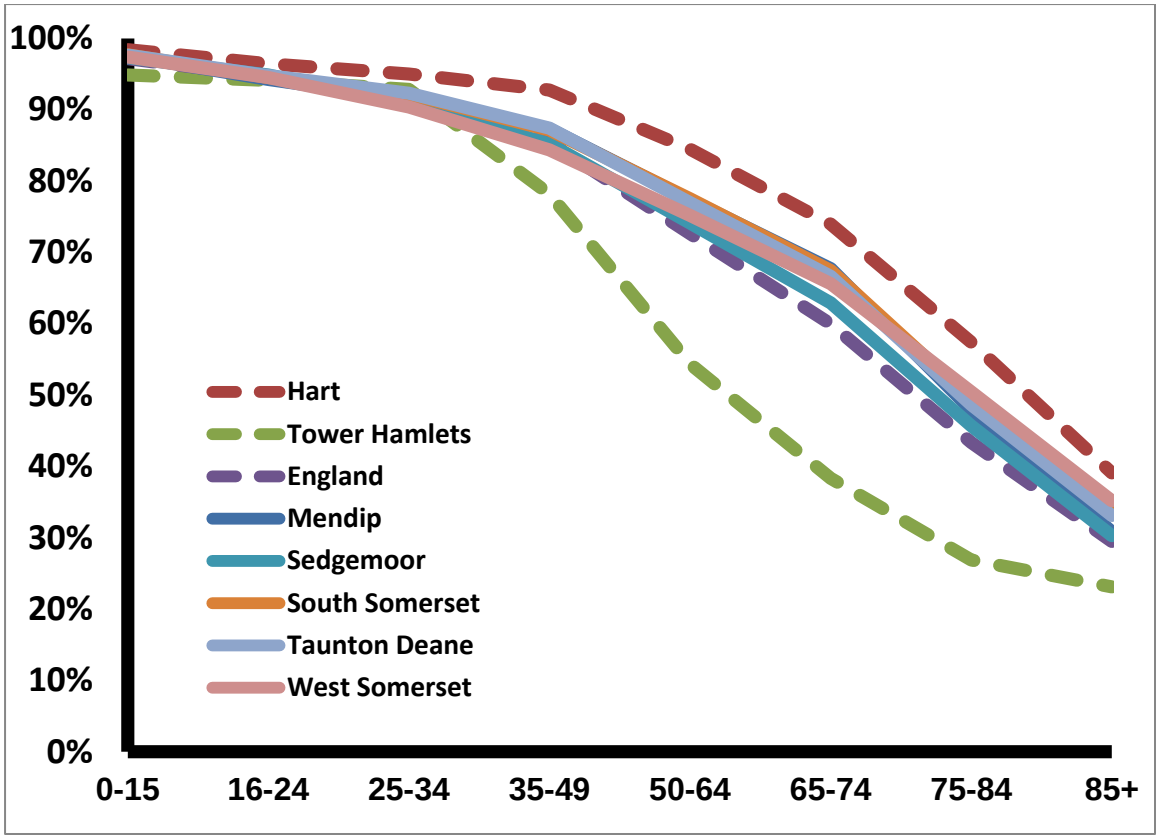


Figure 2 - Self reported health (2011 census)

Looking within Somerset, we are able to use census data to compare how ill people are with how well that they feel. Figure 4 below 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.

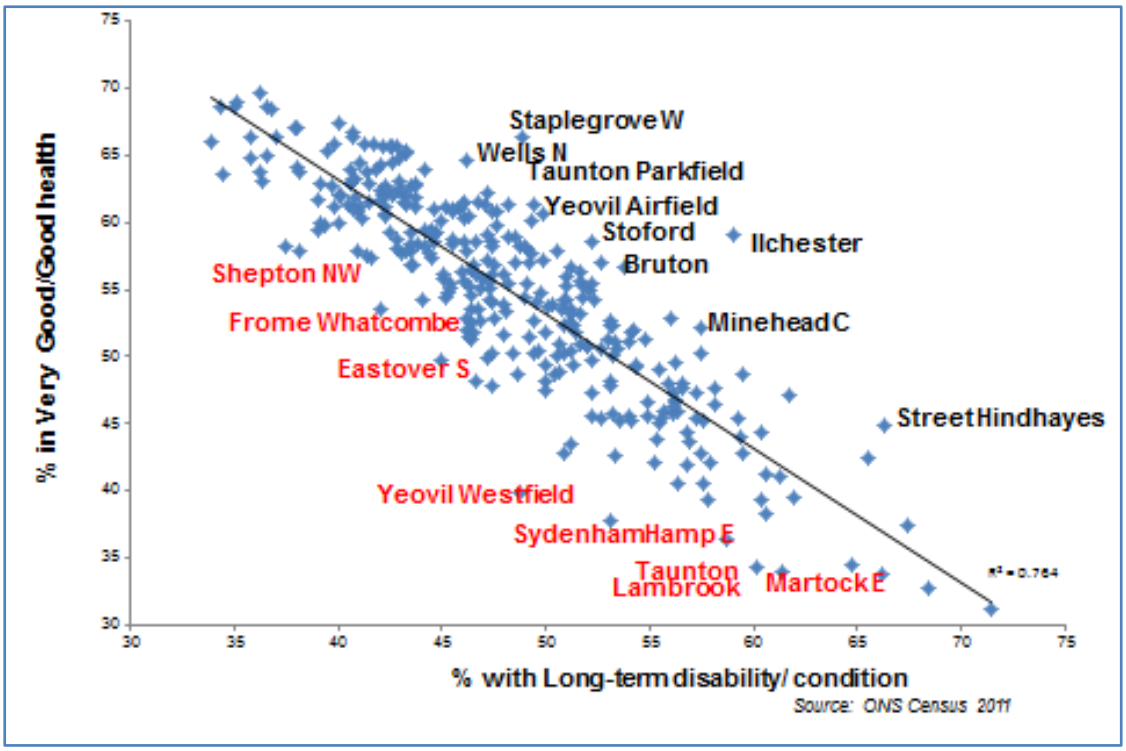


Figure 4 - Age 65+ Good health vs long-term condition

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.

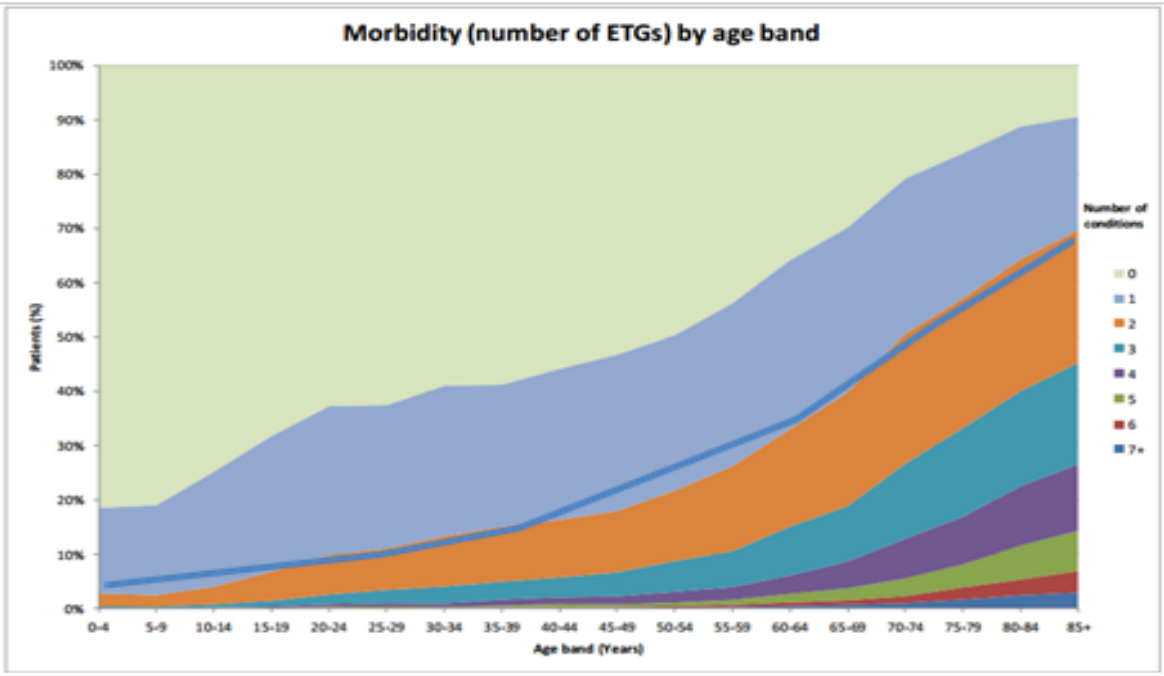


Figure 5 - Long term conditions and ageing well (Somerset)

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, 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.

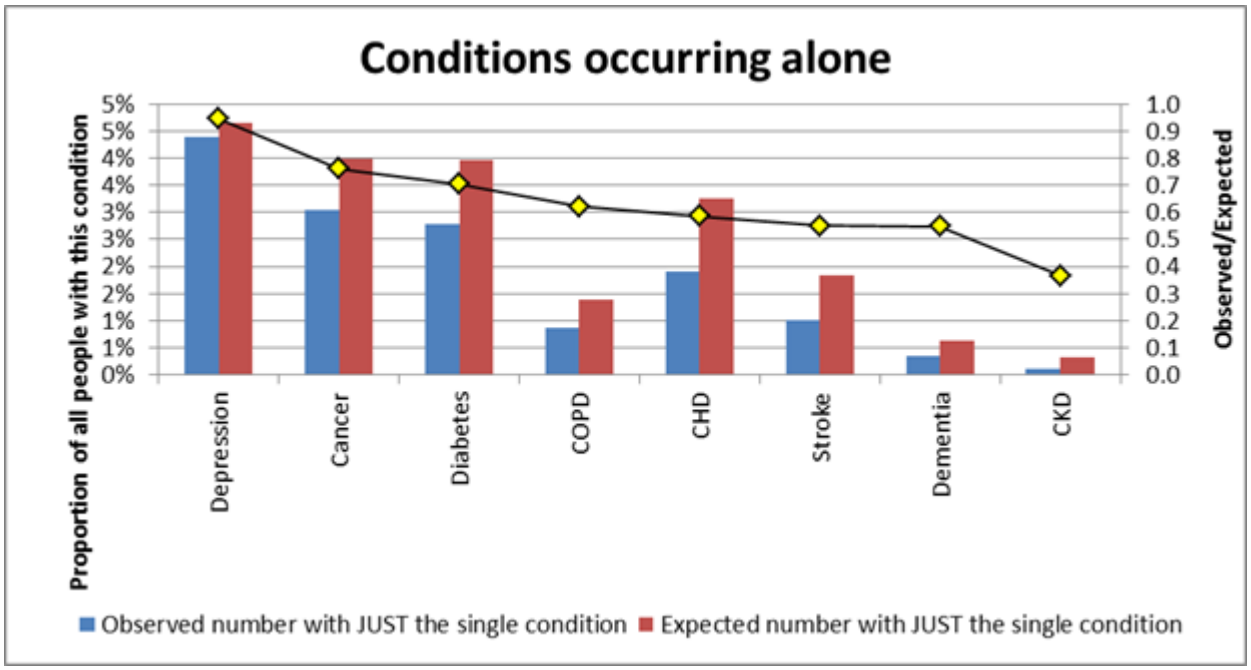


Figure 6 - Long Term Conditions Occurring Alone

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.

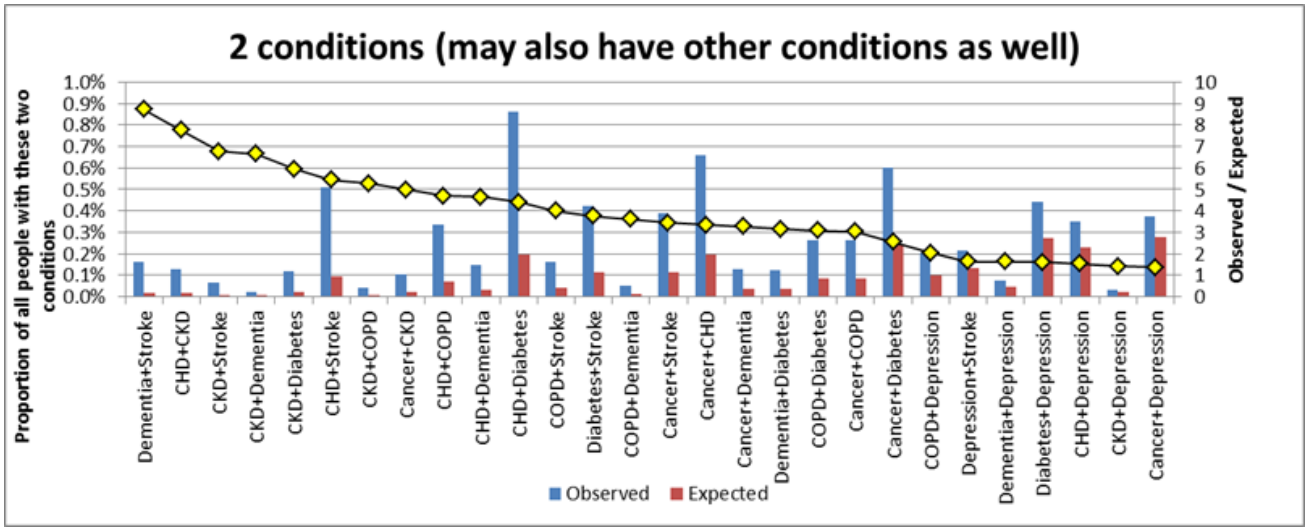


Figure 7 - Prevalence of Two Long Term Conditions Occurring Together

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.

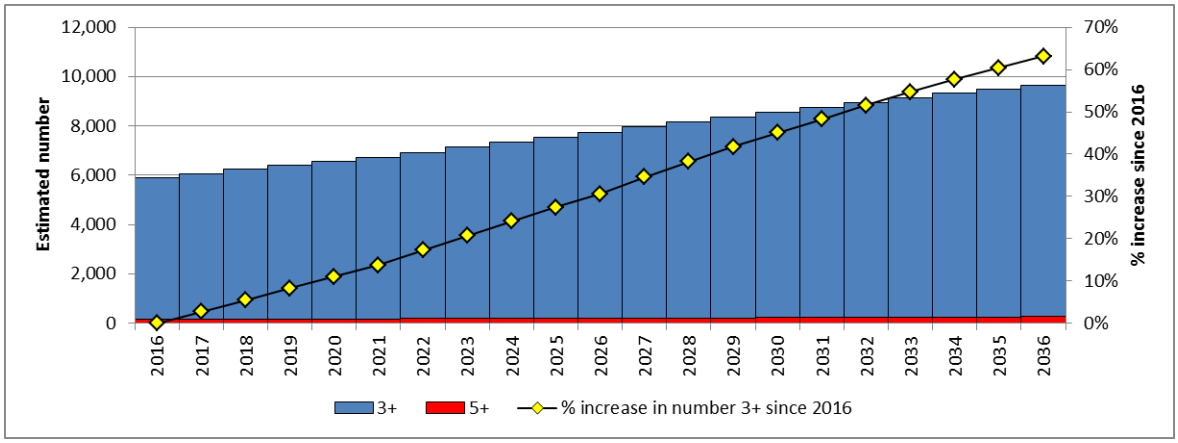


Figure 3 - Projections of Numbers with 3+ and 5+ Long Term Conditions

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.

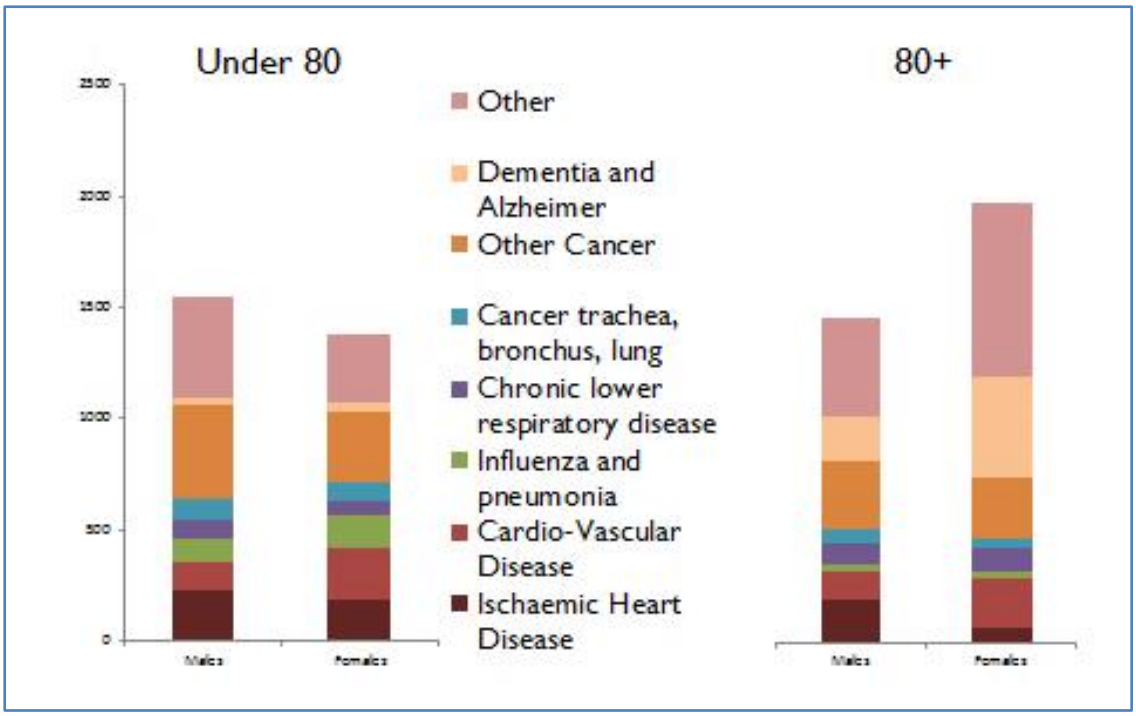


Figure 9 - Cause of death, Somerset 2015

There were over 2000 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.

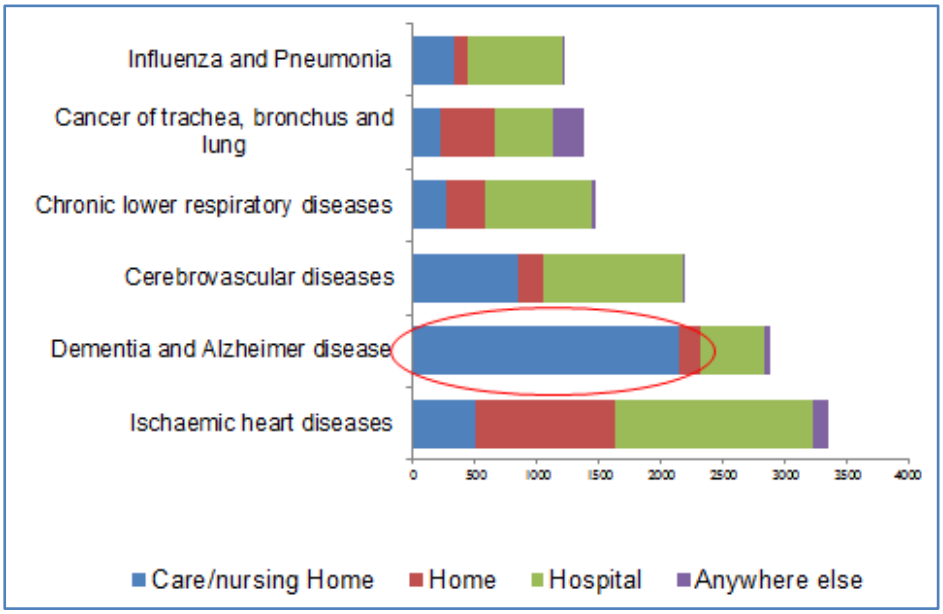


Figure 10 - Place of Death, Somerset

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.

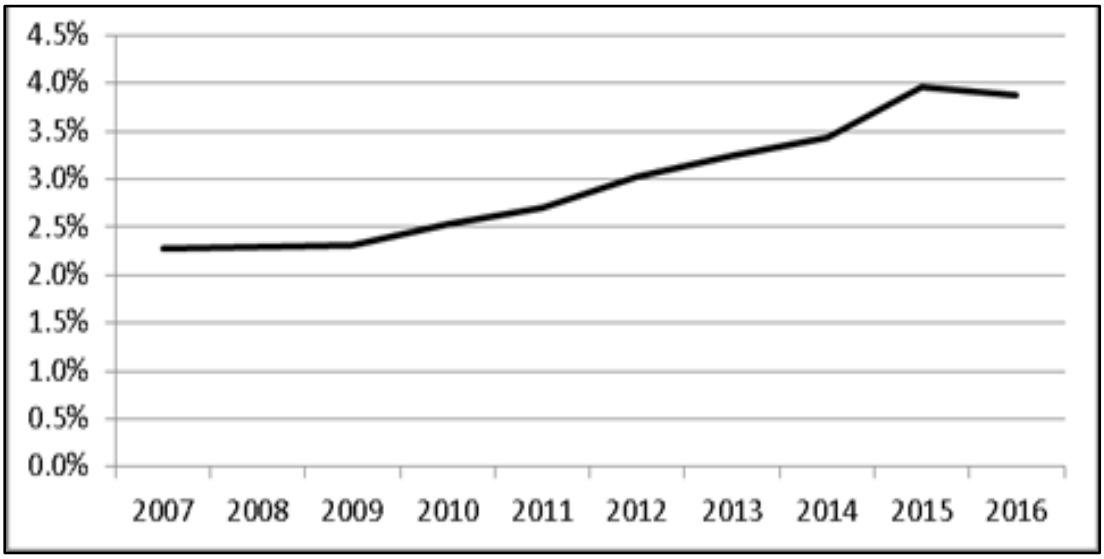


Figure 11 - Dementia recorded prevalence 65+, Somerset registered population

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*

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].

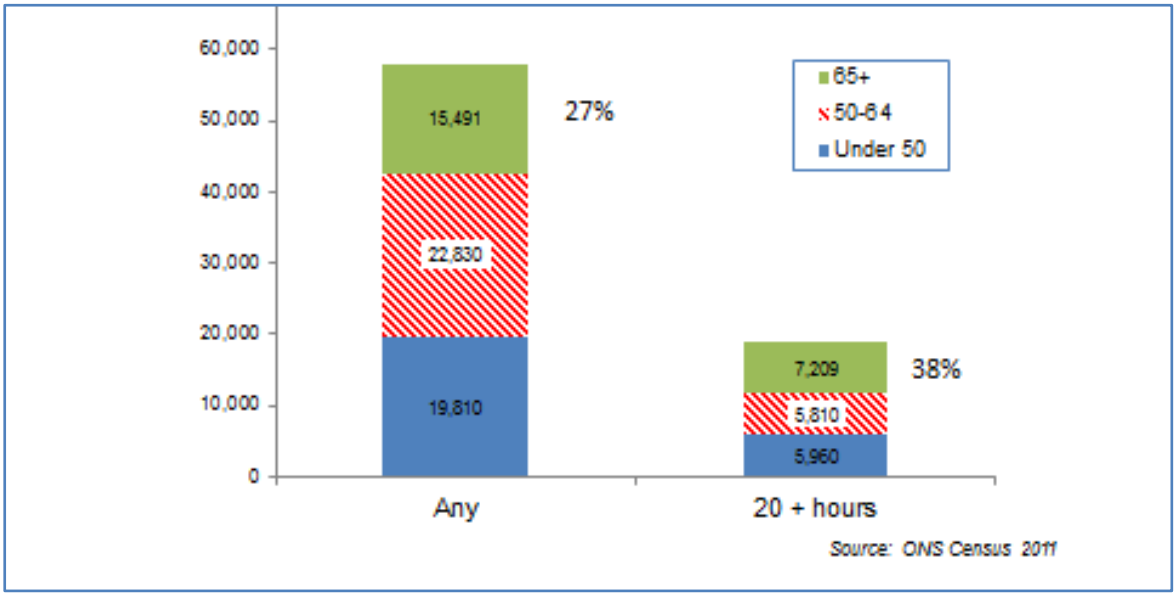


Figure 12 - Providing unpaid care in Somerset

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. Others pointed out how, in some groups such as the Chinese community, caring for elderly people was given particular respect.

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*

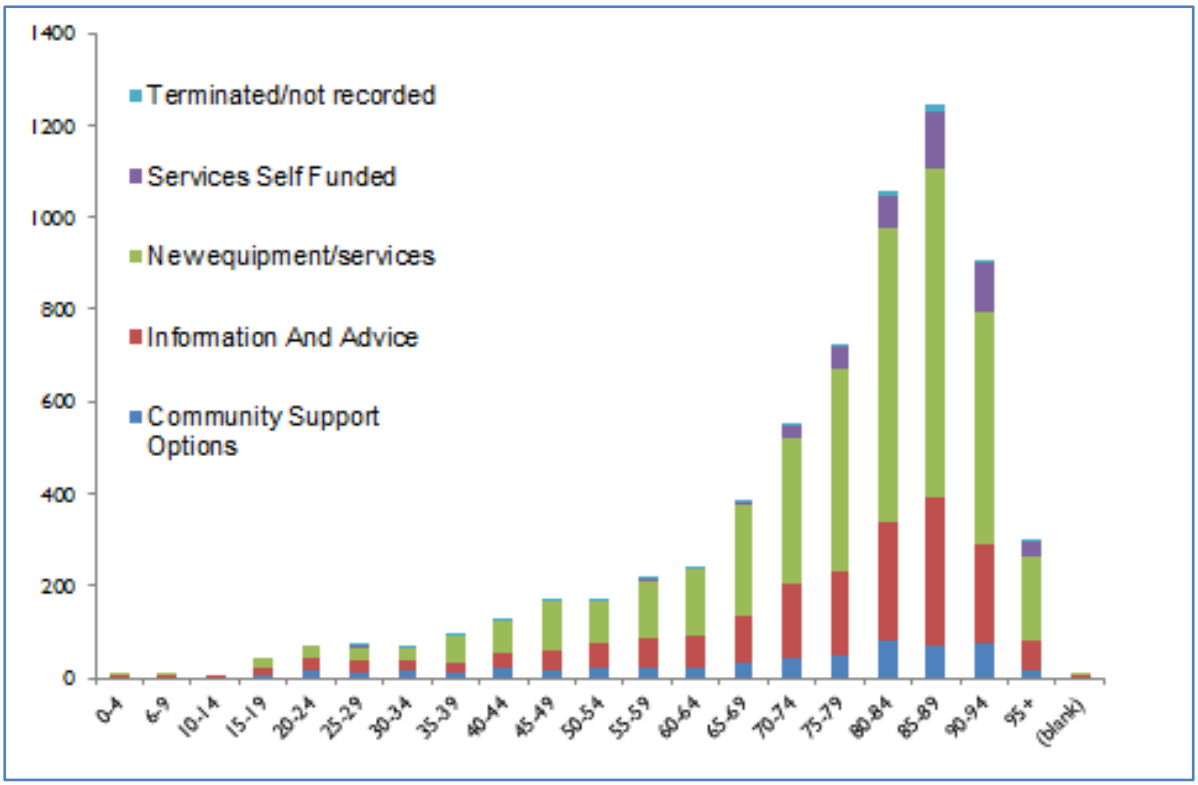


Figure 13 - Social Care Assessment Outcome

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 participants.)*

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.

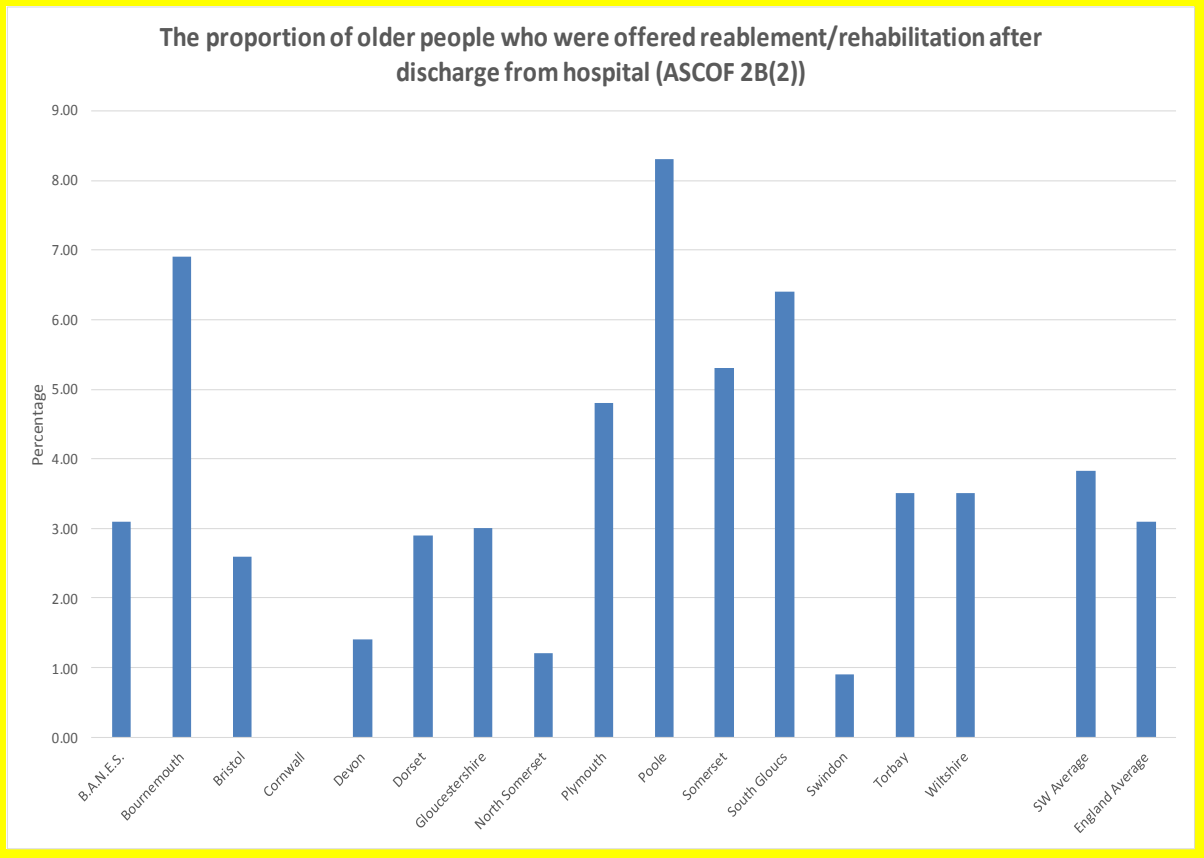


Figure 14 above shows that Somerset is one of the highest in the South West for reablement following discharge from hospital. In principle, this would appear positive, however Figure 15 following compares the outcomes of reablement in Somerset with the rest of the South West. The numbers entering into 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.

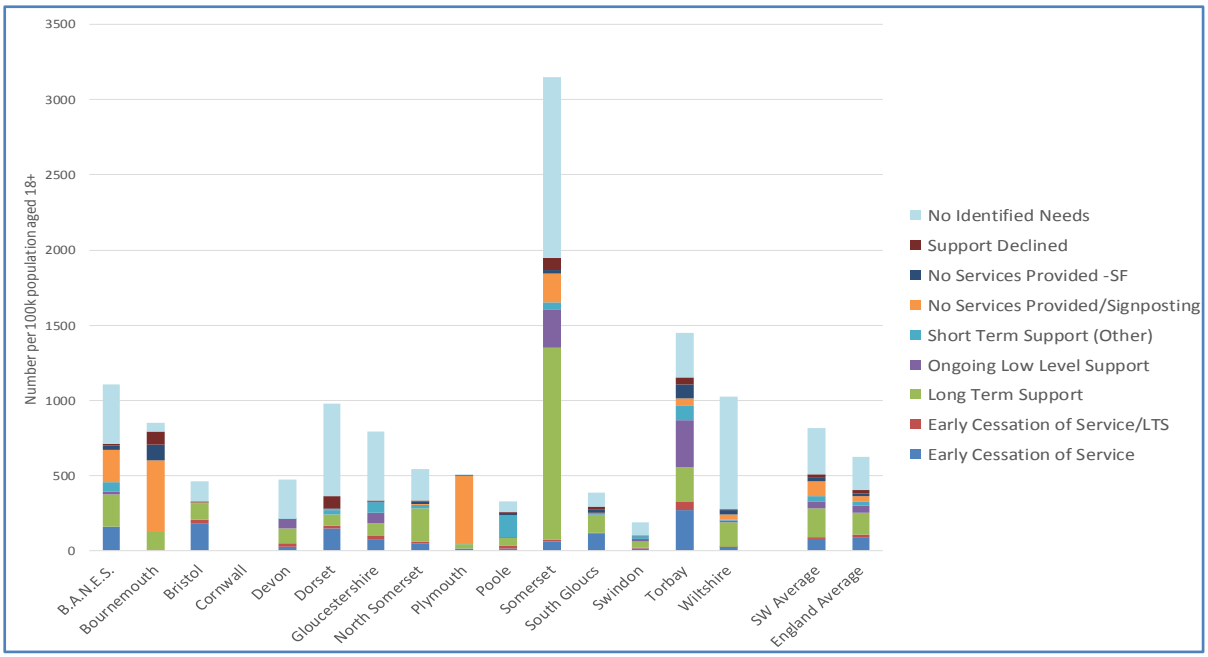


Figure 15 - New and existing customers receiving reablement 2014/15, showing sequels

Figure 16 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'.

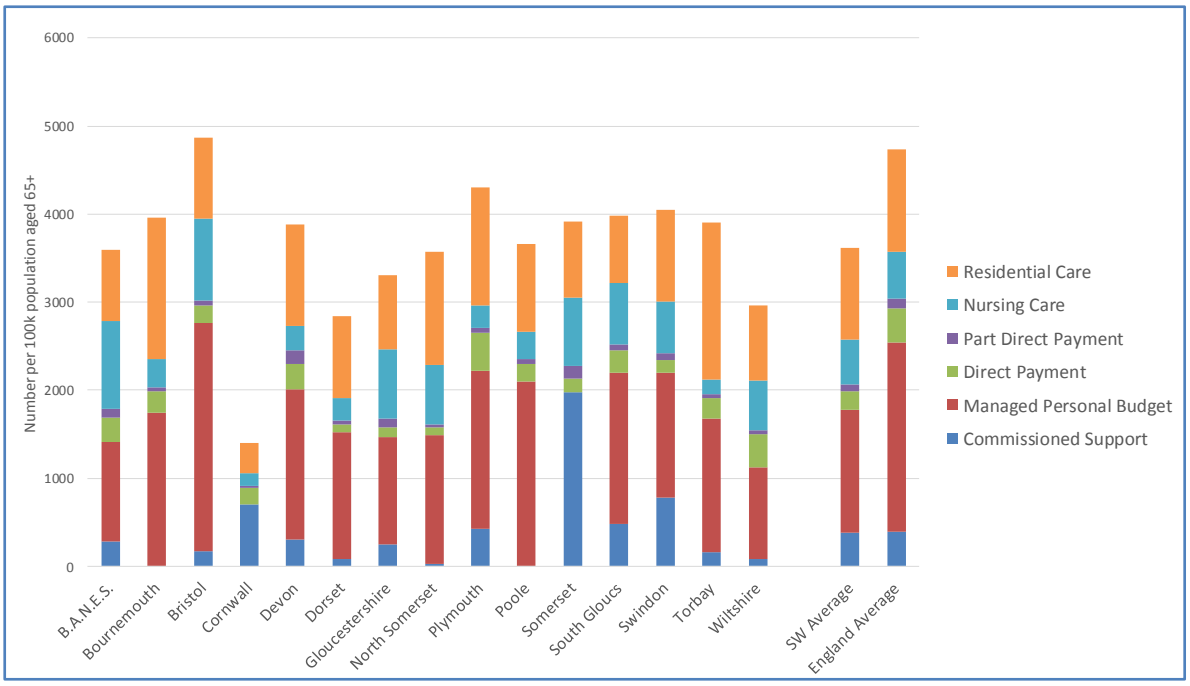


Figure 16 - Number of people aged 65+ receiving long-term support at year end 2014/15 by service type

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 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 below 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.

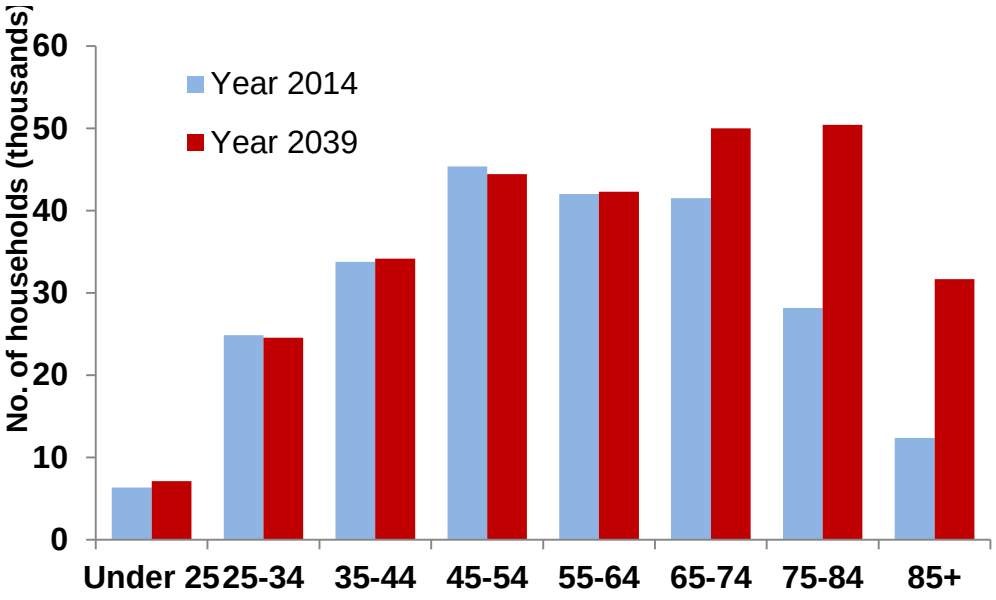


Figure 17 - 'Heads of household' by age

Figure 18 following 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.

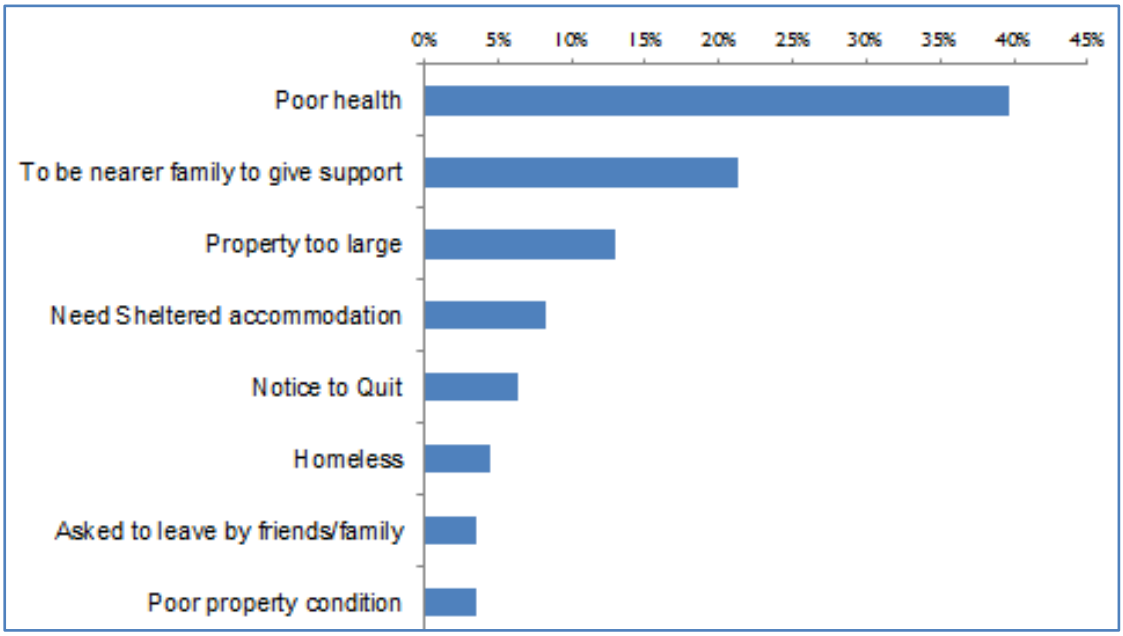


Figure 18 – Homefinder – reasons for moving

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 below 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.

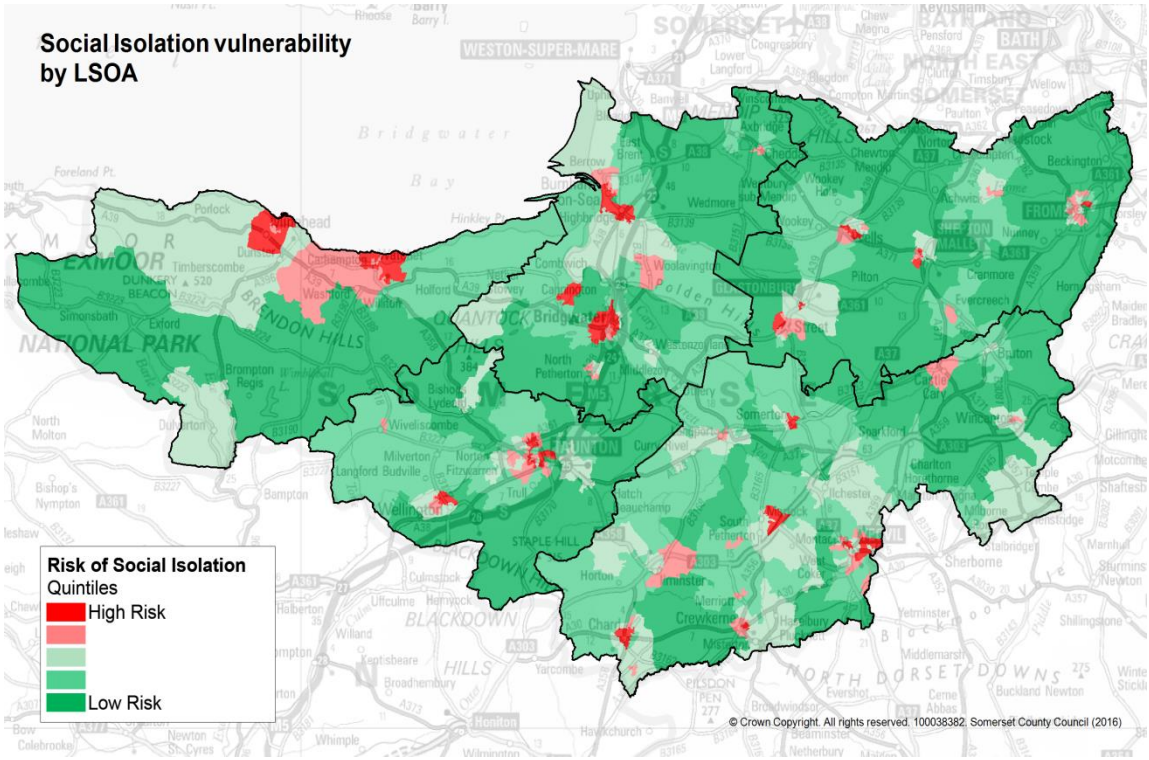


Figure 20 - Risk of social isolation (all ages)

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

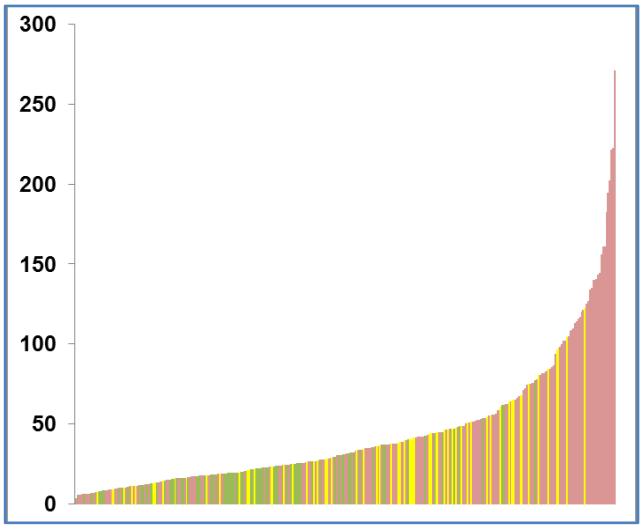
What helps people to age well?

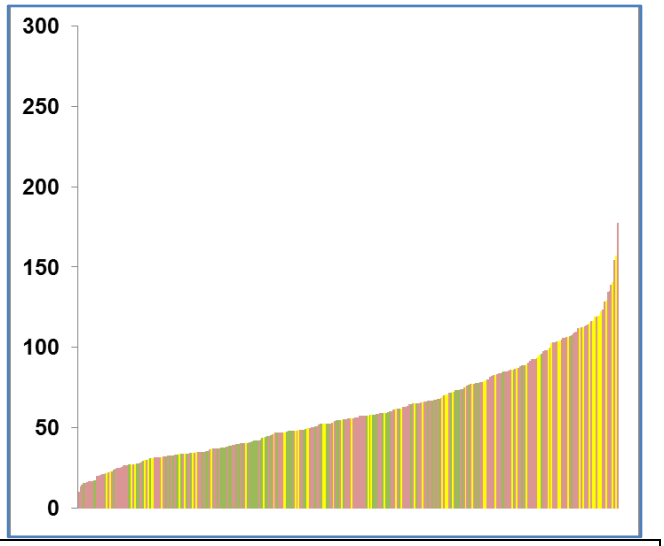
- *Community support or asking for help through support networks – feeling you can **do** that*
- *Laughter, sharing common interests, walking with other people*
- *Having the basics in place: heat, light, food, transport, companionship….and hugs*

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].

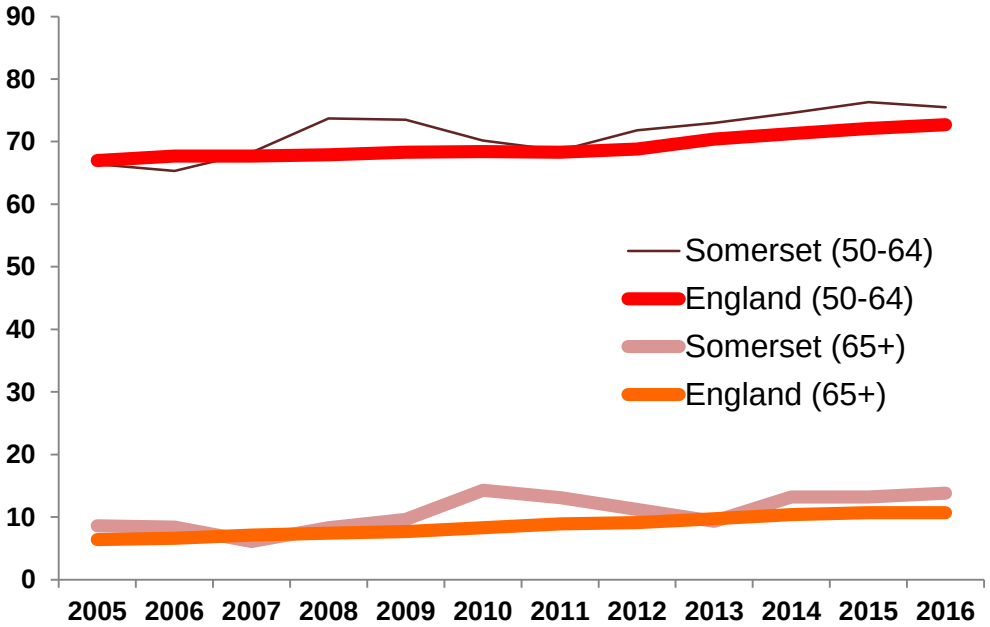


Figure 22 – Economic Activity rates – Somerset and England

Figure 22 above hows 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,*

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 1900's 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

AGEING WELL

B

"...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 (please note these links aren't 'live' yet)
- Discussion groups with: (links below are 'live')
  - 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) (please note these links aren't 'live' yet)

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."

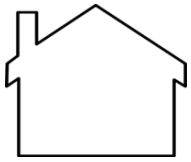
2.14 Although the majority of participants (but certainly not all) were retired, it was obvious that although work connections were often lost and in many cases money was tight, most were involved with other activities such as the University of the Third Age ([2]U3A), volunteering, Active Living Centres,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

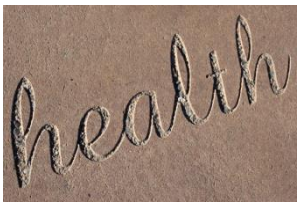
2.30 Voluntary community support is a valuable and valued asset in the course of ageing well and a lack of it was perceived to increase isolation. Many participants volunteered in their communities or were active in community groups (eg. in sheltered housing or through pastoral care, outreach and community 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).

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Somerset County Council
Scrutiny for Policies, Adults and Health Committee
- 21 June 2017

Progress Report Update - Implementation of New Integrated Sexual Health Service

Lead Officer: Trudi Grant, Director of Public Health
Author: Michelle Hawkes, Public Health Specialist
Contact Details: 01823 357236
Cabinet Member: Cllr Christine Lawrence
Division and Local Member: N/A

1. Summary

1.1. From April 2013 local authorities were mandated by the Health and Social Care Act 2012 to provide open access sexual health and contraceptive services for their population. This includes the testing and treatment of sexually transmitted infections (STIs), HIV testing and the provision of contraceptive services. SCC are also responsible for sexual health promotion and the provision of support to people living with HIV. Commissioning responsibilities became fragmented following the Health and Social Care Act in 2012 and whilst local authorities were mandated to provide the majority of sexual health services there are a number of services that are commissioned by other bodies. Appendix 1 details the current sexual health commissioning responsibilities for sexual health. Regardless of commissioning arrangements the provision of local sexual health services need to be delivered as part of a whole system approach to ensure pathways of care are in place for the local population and service demand can be appropriately managed.

1.2 This report provides an update on the progress report of the new Somerset-Wide Integrated Sexual Health service (SWISH) from the Scrutiny for Policies, Adults and Health Committee in November 2016.

1.3 Improving sexual health outcomes and healthy relationships contribute to a number of priorities in the County Plan and the Health and Wellbeing Strategy. There are also three specific sexual health indicators in the Public Health Outcomes Framework which form part of the key performance indicators for the new service:

- Under 18 conceptions
- Chlamydia diagnoses (15-24 year olds)
- People presenting with HIV at a late stage of infection

2. Issues for consideration / Recommendations

2.1. The report to the Scrutiny for Policies, Adults and Health Committee on the 9th November 2016 acknowledged the good progress made by the SWISH service in implementing a substantial service change and the committee are advised that the service continues to perform well. There were a number of challenges for the new service that were highlighted and section 5 details developments against these concerns for the committee to consider and comment on.

3. Background

3.1. Overall the sexual health of the Somerset population is good and sexual health and contraceptive services in the county have provided good quality clinical services. However, sexual ill health impacts on certain populations more significantly and there are considerable inequalities in sexual health making it a public health priority. The key outcomes for sexual health include reducing the transmission of sexually transmitted infections (STIs) and HIV, preventing unwanted pregnancies and reducing teenage conceptions, and reducing the late diagnosis of HIV.

Good progress has been made in reducing teenage conceptions in Somerset, with a 55.9% reduction from the baseline year of 1998. However there remain some wards in Somerset with significantly high teenage conception rates. Whilst the prevalence of many STIs are low in Somerset there are some areas that demonstrate that access to services remain poor for some of the population. Nationally young people aged 16-25 have the highest rate of STIs, with the most common being chlamydia; the second highest peak for STIs is in middle aged people. Somerset are struggling to ensure enough young people are being tested, and therefore treated, for chlamydia. The prevalence of HIV is low in Somerset, but the proportion of those being diagnosed at a late stage of the disease is significantly higher than the national average, leading to increased morbidity and mortality. More detail on how chlamydia and HIV late diagnosis are being tackled is provided in section 5. The table below shows how Somerset compares with England and the South West:

	Somerset	England	South West
Teenage conceptions rate per 1000 15-17 year old young women in 2015	17.1	20.8	16.8
Chlamydia detection rate per 100,000 young people aged 15-24 years in 2015 (target is 2,300)	1523	1887	1716
Proportion of 15-24 year olds screened for chlamydia in 2015	20%	22.5%	22.5%
Percentage of 15-24 year olds tested for chlamydia that tested positive in 2015	7.6%	8.4%	7.6%
HIV late diagnoses 2013-2015 as a percentage of new diagnoses	55.6 %	40.3%	41.1%

3.2 In 2015 SCC developed a new model for sexual health services in the county integrating community based contraceptive services with hospital based sexual health services to provide a one stop model in community settings. Following a procurement process Somerset Partnership NHS Foundation Trust were awarded the contract to provide the new Somerset-Wide Integrated Sexual Health service (SWISH) from April 2016.

SCC also redesigned the provision of targeted sexual health promotion, point of care HIV testing and the provision of support services for people living with HIV and the contract for this service was awarded to The Eddystone Trust, commencing April 2016. Both services are required to work collaboratively to ensure prevention is embedded throughout and that services are targeted at those most at risk of poor sexual health. Key performance indicators have been

established for both services and are reviewed quarterly; shared indicators have also been developed to review the effectiveness of joint working.

4. Consultations undertaken

4.1. Consultations were undertaken to inform the service design and procurement of the integrated sexual health service. This involved stakeholder engagement with the public, service users and practitioners and focus groups targeting those at higher risk of poor sexual health.

5. Progress to Date Update

5.1. The Somerset-wide Integrated Sexual Health Service is making strong progress and is performing well against the key performance indicators and outcomes for the service. The main objectives for the first year of the service were to manage the merging and transformation of a range of sexual health services previously provided across a number of organisations in order to deliver a community based integrated sexual health service. SWISH are to be commended on establishing the new service providing clinics across the county and improving accessibility. During the first year of operation SWISH dealt with 16,000 attendances providing comprehensive sexual health and contraceptive services whilst managing this transformation, which also involved managing the transfer of the workforce, dual-training of clinicians and nurses and recruiting into new roles.

5.2. The service continues to manage public demand through the telephone booking system and there have been no complaints in regards to this. However, following service user feedback they have extended the booking line opening hours from 9am-3pm to 9am to 5pm. The online triage and booking system is still not operational after it was found the provider were unable to deliver the required service despite initial assurances. New software is being developed by the company and it is expected that the new system will be viable at the end of 2017/18. In response SWISH have enhanced their email booking system which has proved very popular but it is recognised that long-term the online system will be more efficient.

5.3. Access to the service in the Yeovil area has been improved with the opening of a weekly clinic based at Hendford Lodge medical practice. The majority of patients from the Yeovil area attend services at South Petherton Hospital or would go to Millstream House in Taunton. Somerset Partnership did not pursue the Yeovil NHS Walk-In service as this was not considered viable. The service have been to visit Yeovil Library as part of the development of the Yeovil Hub and options are being considered for the viability of a clinical space. East Somerset based services now account for nearly 15% of total attendances compared to 11% previously. Attendances at the satellite clinics in the area are similar to those in other areas outside of Taunton, except for Frome which has a lower attendance rate likely to be due to those east Mendip residents who attend sexual health services in Bath. There is still a need to monitor service access by east Somerset residents and SWISH are currently reviewing DNAs and waiting times for services.

5.4. There have been developments with the HIV pathway to improve the transition for patients diagnosed with HIV through SWISH and The Eddystone Trust to the HIV treatment service at Taunton and Somerset NHS Foundation Trust.

Relationships between the HIV treatment service and The Eddystone Trust remain strong ensuring packages of support to newly diagnosed patients and existing patients with a need. Recent joint meetings with HIV patients have been more positive and patients are now routinely using the SWISH service. The pathway is being further developed to improve relationships between the services in relation to the sexual health screening of HIV positive patients including clinical information sharing protocols. The joint Consultant for SWISH and HIV treatment resigned from the SWISH post in April 2017 to focus on HIV services and Somerset Partnership are in the process of interviewing for a new Consultant in Genito-urinary Medicine.

5.5. The HIV treatment service have completed a look back review on patients with a late diagnosis and identified missed opportunities within primary care and hospital A&E for patients attending with a variety of conditions. The Consultant for HIV is sharing information across clinical networks to raise awareness and will be working with the Somerset Sexual Health Network to disseminate knowledge and good practice. The Eddystone Trust have delivered some point of care HIV testing in the community targeting high risk groups and this service will be expanded during 2017/18 including at public sex environments across the county. This will enable earlier access to HIV testing particularly amongst those who are less likely to attend sexual health services including men who have sex with men (MSM) but who do not identify as being gay or bisexual men. The service will also target high risk heterosexual men and women as this group form part of those being diagnosed late.

5.6. Post exposure prophylaxis (PEP) can be given to someone who has been exposed to HIV through sexual activity or a needle stick injury and is very effective in preventing HIV from developing if administered within 72 hours. A pathway for PEP for sexual exposure (PEPSE) has been developed and SWISH are now being reimbursed by NHS England for the associated antiretroviral therapy drugs as per national guidance. The Consultant for HIV has developed pathways with Taunton and Somerset NHS Trust, Yeovil District Hospital NHS Foundation Trust and Optima (occupational health) to support needle stick injuries for healthcare workers and to ensure these are not sent inappropriately to sexual health services. The pathway is being further developed to ensure support is in place for non-health care workers who experience needle stick injuries (such as the police); PEP would rarely be clinically necessary for this group and it is essential A&E staff have the appropriate training to determine risk.

5.7. SWISH are responsible for managing the chlamydia screening programme for 15-24 year olds, including sub-contracting services from general practices and pharmacies. The service has developed a multi-faceted plan to increase coverage of the programme and this includes visiting general practices to provide training and to identify chlamydia champions to increase the confidence and skills of practitioners in offering opportunistic screening. SWISH and The Eddystone Trust have a shared key performance indicator to ensure that vulnerable young people and those most likely to be sexually active are targeted for screening and this element of the service will be closely scrutinised during 2017/18. There is good evidence within Somerset of young people accessing screening online and through minor injury units and pharmacies all of which show high positivity rates demonstrating that these areas are targeting the right young people.

5.8. A significant challenge for the new SWISH service is managing demand within a fixed budget. This is a national issue, with the numbers of attendances to sexual health services increasing across the country whilst services are having to deal with cost efficiencies. SWISH is funded through both fixed costs (e.g. staffing and estates) and non-fixed activity costs (e.g. pathology for sexual health tests, STI treatment, contraception and medical supplies). During 2016/17 there were nearly 16,000 attendances at SWISH services demonstrating huge demand. To mitigate against financial risk an improvement plan has been developed with Somerset Partnership with identified areas of focus. SWISH have a leadership role for the whole sexual health system and are responsible for ensuring that pathways exist with other services including those provided by General Practices, pharmacies, HIV treatment services, sexual assault centres and abortion services as well as training and updating practitioners.

To ensure financial viability it is essential that service demand is managed across the health system and that prevention targets those at greatest risk. An example of this would be access to Long Acting Reversible Contraception (LARC) which SCC also commission from General Practices. SWISH is not commissioned to provide contraceptive services for the whole of the population and most women would and should access this through their GPs. A training programme is being put in place for GPs and Practice Nurses to ensure more women can access them for LARC and to reduce the numbers of women being sent by GPs to the SWISH service for e.g. routine coil fits and removals. The Somerset Sexual Health Network is engaged with the Local Medical Committee to review access to LARC and to increase uptake in training and provision in General Practice. In addition the SWISH website has been amended to reflect that contraceptive services and some sexual health services are available from General Practice to raise public awareness.

5.9. Local authorities are responsible for the sexual health of their population including when individuals may access services in other areas. SCC has contracts with the Royal United Bath NHS Foundation Trust (RUH) and Western Area Health Trust as these services can be more accessible for many of those living on the borders of the county. In addition, SCC is charged by sexual health service providers across England if a Somerset resident uses them under national cross-charging arrangements (and SWISH will charge other local authorities for any out of area patients attending their service for sexual health purposes). The expansion of community services by SWISH has seen an increase in patients from Mendip using Somerset based services, with numbers using RUH decreasing during 2016/17. This has led to a reduction in the activity based charges from RUH to SCC.

5.10. The Eddystone Trust are commissioned to work with SWISH to provide targeted interventions to repeat attenders and high risk groups. Referral pathways between the services are now established but it is not clear at this stage whether this is having an impact. A system has been developed to monitor repeat attenders and collaborative working between the services will be closely scrutinised. The Eddystone Trust are required to provide evidence of targeted interventions and their outcomes over the next three months to understand impact.

6. Background papers

6.1. Appendix 1 – Sexual Health commissioning Responsibilities from April 2013.

6.2. Cabinet Key Decision Report October 2015 – 'Somerset Sexual Health and Contraceptive Services – management and co-ordination of the integrated sexual health service request to award contract'.

6.3. Progress on the Implementation of Somerset-wide Integrated Sexual Health Services Report for the Scrutiny for Policies, Adults and Health Committee meeting on the 9th November 2016.

6.4. More information on Somerset sexual health services can be found at www.swishservices.co.uk

Appendix 1 - Sexual Health Commissioning Responsibilities from April 2013

Local Authorities will commission:-	**Clinical Commissioning Groups will commission:-**	**NHS Commissioning Board will commission:-**
comprehensive sexual health services, including: • Contraception,including LESs (implants) and NESs (intrauterine contraception) – but excluding contraception provided as an additional service under the GP contract) • STI testing and treatment, including post-exposure prophylaxis after sexual exposure, chlamydia screening as part of the National Chlamydia Screening Programme and HIV testing) • sexual health aspects of psychosexual counselling • Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies	fully integrated and comprehensive termination of pregnancy services – [but there will be a further consultation about the best commissioning arrangements in the longer term] sterilisation vasectomy	contraception provided as an additional service under the GP contract HIV treatment and care [although work is continuing to determine whether CCGs should commission some elements of the pathway], promotion of opportunistic testing and treatment for STIs and patient requested testing by GPs

Note: Local Authorities will be mandated to provide confidential, open access STI testing and treatment services and contraception services, including free supply of any STI treatment and reasonable access to all methods of contraception.

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Scrutiny for Adults and Health Work Programme – as at 13 June 2017

Agenda item	Meeting Date	Details and Lead Officer
	21 June 2017	
Update on Sexual Health Contract		Michelle Hawkes
Update on Somerset Sustainability & Transformation Plan		tbc
CQC Inspection of Somerset Partnership Trust		Dr Nick Broughton
Joint Strategic Needs assessment (JSNA)		Jo Mcdonagh/Pip Tucker
	12 July 2017	
Progress update on Minehead & Williton Hospitals		Andy Heron (SomPar)
NHS 111 and OOH Service Performance Report		Alison Henly (CCG)
Adult Social Care Performance Report		Stephen Chandler
Weston Hospital Performance Update		Dr Mary Backhouse/Colin Bradbury (NS CCG) and James Rimmer (Weston Hosp)
Council Performance Monitoring Report – Q4 2016/17		Emma Plummer
	20 September 2017	
Mental Health Promotion		Christina Gray
Somerset Safeguarding Adults Board (SSAB) Annual Report 2016/17		Richard Crompton/Niki Shaw
Improved access to GP Services - tbc		Michael Bainbridge - tbc
	11 October 2017	
Pharmaceutical Needs Assessment		Pip Tucker
Corporate Performance Monitoring Report – Q1 +1 2017/18		Emma Plummer
	08 November 2017	
Adult Social Care Performance Report		Stephen Chandler
	06 December 2017	

Scrutiny for Adults and Health Work Programme – as at 13 June 2017

Corporate Performance Monitoring Report – Q2 2017/18		Emma Plummer

Note: Members of the Scrutiny Committee and all other Members of Somerset County Council are invited to contribute items for inclusion in the work programme. Please contact Jamie Jackson, Service Manager Scrutiny, who will assist you in submitting your item. jajackson@somerset.gov.uk 01823 359040

To be added:

- Serious Case Reviews (as applicable)
- CQC Inspection findings (as applicable)
- Community Safety Conference
- Shared Maternity & Paediatric Services (as applicable)
- Dimensions Update (as applicable)
- Sustainability Transformation Plan – Implementation
- Update on the Milverton & Wiveliscombe GP surgery (Jun/Jul)

Somerset County Council Forward Plan of proposed Key Decisions

The County Council is required to set out details of planned key decisions at least 28 calendar days before they are due to be taken. This forward plan sets out key decisions to be taken at Cabinet meetings as well as individual key decisions to be taken by either the Leader, a Cabinet Member or an Officer. The very latest details can always be found on our website at:
http://democracy.somerset.gov.uk/mgListPlans.aspx?RPId=134&RD=0&FD=1&bcr=1
Regulation 8 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 defines a key decision as an executive decision which is likely:

(a) to result in the relevant local authority incurring expenditure which is, or the making of savings which are, significant having regard to the relevant local authority's budget for the service or function to which the decision relates; or

(b) to be significant in terms of its effects on communities living or working in an area comprising two or more wards or electoral divisions in the area of the relevant local authority.

The Council has decided that the relevant threshold at or above which the decision is significant will be £500,000 for capital / revenue expenditure or savings. Money delegated to schools as part of the Scheme of Financial Management of Schools exercise is exempt from these thresholds once it is delegated to the school.

Cabinet meetings are held in public at County Hall unless Cabinet resolve for all or part of the meeting to be held in private in order to consider exempt information/confidential business. The Forward Plan will show where this is intended. Agendas and reports for Cabinet meetings are also published on the Council's website at least five clear working days before the meeting date.

Individual key decisions that are shown in the plan as being proposed to be taken "not before" a date will be taken within a month of that date, with the requirement that a report setting out the proposed decision will be published on the Council's website at least five working days before the date of decision. Any representations received will be considered by the decision maker at the decision meeting.

In addition to key decisions, the forward plan shown below lists other business that is scheduled to be considered at a Cabinet meeting during the period of the Plan, which will also include reports for information. The monthly printed plan is updated on an ad hoc basis during each month. *Where possible the County Council will attempt to keep to the dates shown in the Plan. It is quite likely, however, that some items will need to be rescheduled and new items added as new circumstances come to light*. Please ensure therefore that you refer to the most up to date plan.

For general enquiries about the Forward Plan:

- You can view it on the County Council web site at http://democracy.somerset.gov.uk/mgListPlans.aspx?RPId=134&RD=0&FD=1&bcr=1
- You can arrange to inspect it at County Hall (in Taunton).
- Alternatively, copies can be obtained from Scott Wooldridge or Julia Jones in the Community Governance Team by telephoning (01823) 359027 or 357628.

To view the Forward Plan on the website you will need a copy of Adobe Acrobat Reader available free from www.adobe.com
Please note that it could take up to 2 minutes to download this PDF document depending on your Internet connection speed.

To make representations about proposed decisions:

Please contact the officer identified against the relevant decision in the Forward Plan to find out more information or about how your representations can be made and considered by the decision maker.

The Agenda and Papers for Cabinet meetings can be found on the County Council's website at:
http://democracy.somerset.gov.uk/ieListMeetings.aspx?CId=134&Year=0

FP Refs	Decision Date/Maker	Details of the proposed decision	Documents and background papers to be available to decision maker	Does the decision contain any exempt information requiring it to be considered in private?	Contact Officer for any representations to be made ahead of the proposed decision
FP/17/04/04 First published: 19 April 2017	14 Jun 2017 Cabinet	Issue: Council Performance Monitoring Report Q4 2016-17 Decision: To consider the report			Emma Plummer, Strategic Manager Performance Tel: 01823 359251
FP/16/11/10 First published: 27 September 2016	14 Jun 2017 Cabinet	Issue: Children's Services Improvement - Somerset's Children and Young People's Plan 2016-19 progress Decision: To consider the report and agree necessary actions.	Report to Cabinet 29 April	Open	Philippa Granthier, Assistant Director Childrens Services Tel: 01823 359054
FP/17/03/12 First published: 29 March 2017	14 Jun 2017 Cabinet	Issue: Somerset Prevention Charter Decision: To consider the report and agree necessary actions. Somerset Prevention Charter			Trudi Grant, Public Health Director Tel: 01823 359015

FP Refs	Decision Date/Maker	Details of the proposed decision	Documents and background papers to be available to decision maker	Does the decision contain any exempt information requiring it to be considered in private?	Contact Officer for any representations to be made ahead of the proposed decision
FP/17/03/09 First published: 13 March 2017	14 Jun 2017 Cabinet	Issue: Framework Agreement for Travel Demand Management Decision: To appoint Suppliers to a Framework Contract in particular for delivery of an integrated Travel Behaviour Change and Road Safety Training and Awareness Programme in connection with the Hinkley Point C development	Key Decision on 25 March 2013 regarding the contributions to Somerset County Council within the Hinkley Point C Site Preparation Works and Development Consent Order Section 106 Agreements Non-Key Decision Report by Strategic Manager – Major Programmes on 3 August 2016 - Authority to commence procurement for services in connection with a Travel Behaviour Change and Road Safety Training and Awareness Programme associated with the Hinkley Point C development Non-Key Decision on 2 December 2016 by the Director of Commissioning and Lead Commissioner for Economic and Community Infrastructure Hinkley Point C – Authority to appoint a supplier for assurance services in connection with a Travel Behaviour Change and Road Safety Training and Awareness Programme Non-Key Decision on 6 March 2017 by the Director of Commissioning and Lead Commissioner for Economic and Community Infrastructure Hinkley Point	Part exempt	Andy Coupe, Acting Strategic Manager - Major Programmes Tel: 01823 355145

FP Refs	Decision Date/Maker	Details of the proposed decision	Documents and background papers to be available to decision maker	Does the decision contain any exempt information requiring it to be considered in private?	Contact Officer for any representations to be made ahead of the proposed decision
FP/17/04/05 First published: 19 April 2017	14 Jun 2017 Cabinet	Issue: Capital Budget Monitoring Report Q4 2016-17 Decision: To consider the report			Elizabeth Watkin, Service Manager - Chief Accountant Tel: 01823359573
FP/17/04/06 First published: 19 April 2017	14 Jun 2017 Cabinet	Issue: Revenue Budget Monitoring Report Q4 2016-17 Decision: To consider the report			Elizabeth Watkin, Service Manager - Chief Accountant Tel: 01823359573
FP/17/04/09 First published: 24 April 2017	Not before 19th Jun 2017 Commercial & Business Services Director	Issue: Heathfield School, Taunton - Proposed Art and Science Blocks Decision: Awarding of Contract for Construction of Proposed Art and Science Blocks		Part exempt	Carol Bond, Project Manager, Property Programme Team Tel: 01823 355962
FP/17/04/10 First published: 28 April 2017	Not before 19th Jun 2017 Commercial & Business Services Director, Cabinet Member for Children and Families	Issue: Creation of two New Academies in Somerset Decision: The Secretary of State for Education has directed via an Academy Order, the conversion to Academy Status for the following two schools.	Academies Act 2010		Elizabeth Smith, Service Manager – Schools Commissioning Tel: 01823 356260
FP/17/05/03 First published: 15 May 2017	Not before 19th Jun 2017 Cabinet Member for Business Investment & Policy	Issue: Contract to supply books to Library Service Decision: To award the contract to the preferred supplier(s) as an outcome of the ESPO led procurement for the supply of books.	ESPO Framework 376F_14	Part exempt	Tabitha Witherick, Service Manager: Development Tel: 01823357480

FP Refs	Decision Date/Maker	Details of the proposed decision	Documents and background papers to be available to decision maker	Does the decision contain any exempt information requiring it to be considered in private?	Contact Officer for any representations to be made ahead of the proposed decision
FP/17/05/05 First published: 15 May 2017	Not before 19th Jun 2017 Cabinet Member for Adult Social Care	Issue: Commissioning of Mental Health Services in Somerset: Community outcomes based preventative and enablement support services Decision: Agreement to approve the Award of contracts for the provision of Mental Health Services in Somerset (as above) following a comprehensive EU compliant tender process	Tender Evaluation Report Impact Assessment Non-key decision to commence a procurement process for contracts for the provision of Mental Health Services in Somerset (as above)	Part exempt	Stephen Barker, Adults and Health - Senior Commissioning Officer
FP/17/03/01 First published: 6 March 2017	Not before 19th Jun 2017 Cabinet Member for Adult Social Care	Issue: Provision of Healthwatch Somerset Decision: Agree to the award of a contract for the provision of Healthwatch Somerset following a competitive procurement exercise	Tender evaluation report	Part exempt	Catherine Logan, Procurement Officer Tel: 01823 359293

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FP/17/05/07 First published: 18 May 2017	Not before 19th Jun 2017 Cabinet Member for Children and Families	Issue: School Place Planning Infrastructure Growth Plan for Somerset 2017 Decision: Approve the publication of The School Place Planning Infrastructure Growth Plan for Somerset by the 30th June 2017	Cabinet 18 March 2015: The Policies and Principles of Early Years and School Place Planning Scrutiny for Policies, Children and Families Committee 13 May 2016: Early Years and School Place Planning Infrastructure Growth Plan Cabinet 8 June 2016: Early Years and School Place Planning Infrastructure Growth Plan School Population Forecasts 2016 School Organisation Plan 2017		Helen Waring, Commissioning Officer - Schools
FP/17/03/07 First published: 13 March 2017	Not before 26th Jun 2017 Director of Commissioning for Economic and Community Infrastructure	Issue: Somerset Energy Innovation Centre - Approving Growth Deal Funding and Appointing a Construction Company Decision: Approves the acceptance of the offer of Growth Deal Funding , delegate the the authority to certify SCC's Growth Deal payment claims and authorise the appointment of the construction company for phase 2 & 3 and advance design work for Phase 3	Impact Study Cabinet Member Decision 09.02.17 Officer Non-Key Decision 27.04.15	Part exempt	Lynda Madge, Commissioning Manager – Economy & Planning Tel: 01823 356766

FP Refs	Decision Date/Maker	Details of the proposed decision	Documents and background papers to be available to decision maker	Does the decision contain any exempt information requiring it to be considered in private?	Contact Officer for any representations to be made ahead of the proposed decision
FP/17/04/03 First published: 12 April 2017	Not before 3rd Jul 2017 Public Health Director	Issue: Extension of Somerset Integrated Domestic Abuse Service contract Decision: To approve a 12 month extension to the current contract	Safer Somerset Partnership Domestic Abuse Annual Report 2015-16		Lucy Macready, Public Health Specialist- Community Safety Tel: 01823 359146
Fp/17/05/08 First published: 1 June 2017	10 Jul 2017 Cabinet	Issue: Capital and Revenue Budget Monitoring Reports End of May 2017/18 Decision: To consider the financial position for the 2017/18 Capital and Revenue Budgets as at the end of May 2017/18			Elizabeth Watkin, Service Manager - Chief Accountant Tel: 01823359573
Fp/17/05/09 First published: 1 June 2017	10 Jul 2017 Cabinet	Issue: Development of the Medium Term Financial Plan 2018/19 Decision: To consider the proposed approach and the timescale for the MTFP 2018/19			Elizabeth Watkin, Service Manager - Chief Accountant Tel: 01823359573
FP/17/06/01 First published: 7 June 2017	10 Jul 2017 Cabinet Member for Resources and Economic Development	Issue: Disposal of Property at Northgate, Bridgwater Decision: Authority to conclude negotiotions for the disposal of surplus land, completion of the Joint Venture Agreement with Sedgemoor District Council with associated land transfers and lease and the grant of an Academy Lease to the Clevedon Learning Trust	Disposal of property at Northgate, Key decision 4 march 2011 Disposal of Property at Northgate, Key decision 14 January 2015		Charlie Field, Estates Manager, Corporate Property Tel: 01823355325

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FP/17/05/10 First published: 1 June 2017	10 Jul 2017 Cabinet	Issue: Proposal for the development of joint commissioning for Health and Social Care Decision: To consider the proposals			Trudi Grant, Public Health Director Tel: 01823 359015
FP/17/06/02 First published: 12 June 2017	10 Jul 2017 Cabinet	Issue: Libraries Strategy Decision: To endorse a medium term strategy for libraries (including financial and non-financial objectives); consider delivery model options and approve a profile of financial savings between 2018 and 2020.	Previous Cabinet Decisions Key Decision report Alternative Delivery Models – Options appraisal Impact Assessment		Oliver Woodhams, Strategic Manager, Community and Traded Services, Sue Crowley, Strategic Manager Library Services, Community and Traded Services Tel: 07977400667, Tel: 01823355429
Fp/17/03/11 First published: 29 March 2017	10 Jul 2017 Cabinet	Issue: Review of the Asset Management Plan and the 2017/18 potential disposals programme Decision: Review of the Asset Management Plan and approval to the 2017/18 potential disposals programme			Claire Lovett, Head of Property Tel: 07977412583
FP/17/04/07 First published: 24 April 2017	10 Jul 2017 Cabinet	Issue: Treasury Management End of Year Report 2016-17 Decision: That the Cabinet endorses the Treasury Management End of Year Report for 2016-17 and recommends its approval by Full Council on 19th July 2017.	TMSS 2016-17 TMSS App A 2016-17 TMSS App B 2016-17 TMSS App C 2016-17 TMPs V5 May 2016		Alan Sanford, Principal Investment Officer Tel: 01823 359585

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FP/17/04/01 First published: 3 April 2017	10 Jul 2017 Cabinet	Issue: Council Performance Report end of May 17/18 Decision: To consider the report			Emma Plummer, Strategic Manager Performance Tel: 01823 359251
FP/16/05/02 First published: 9 January 2017	10 Jul 2017 Cabinet	Issue: Road Safety Strategy Update Decision: To agree to adopt the updated Road Safety Strategy			Sunita Mills, Service Commissioning Manager Tel: 01823 359763
FP/17/02/01 First published: 14 February 2017	Not before 17th Jul 2017 Commercial & Business Services Director	Issue: Award of Contract for the provision of a 3 Classroom Block at Court Fields School, Wellington Decision: To approve the awarding of the contract to the successful contractor	Confidential Financial Report Capital Programme Paper	Part exempt	Carol Bond, Project Manager, Property Programme Team Tel: 01823 355962
FP/17/05/02 First published: 12 May 2017	17 Jul 2017 Cabinet Member for Business Investment & Policy, Cabinet Member for Children and Families	Issue: Revision of Section 106 contributions formula for Early Years Provision Decision: To increase the Section 106 contributions formula for Early Years Provision from 3.5 places per 100 houses to 5 funded places from 1st September 2017	Early education and childcare; Statutory guidance for local authorities (2017) Early Years and School Place Planning Infrastructure Growth Plan (2016) - www.somerset.gov.uk/EducationIGP		Charlotte Wilson, Service Manager Early Years Commissioning Tel: 01823 357386

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FP/17/04/08 First published: 24 April 2017	Not before 20th Jul 2017 Director of Commissioning for Economic and Community Infrastructure, Finance & Performance Director	Issue: Approval to accept Highways England Growth & Housing Fund award toward the M5 J25 improvement scheme. Decision: To accept the funding awarded by Highways England & sign the funding agreement	Copy of the funding agreement to be signed.		Sunita Mills, Service Commissioning Manager Tel: 01823 359763
FP/17/05/06 First published: 18 May 2017	Not before 7th Aug 2017 Director of Commissioning for Economic and Community Infrastructure	Issue: Somerset Energy Innovation Centre Building 2 acceptance of funding Decision: The acceptance of the offer of ERDF funding (£869,090), subject to legal acceptability of the final funding agreement, for the Somerset Energy Innovation Centre, Phase 2			Lynda Madge, Commissioning Manager – Economy & Planning Tel: 01823 356766

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