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Scrutiny for Policies, Adults and Health Committee

Wednesday 6 December 2017

10.00 am Luttrell Room - County Hall, Taunton

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

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

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 - 28 November 2017

For further information about the meeting, please contact Julia Jones on 01823 359027 or JJones@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 - 10.00 am Wednesday 6 December 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 8 November 2017** (Pages 7 - 12)

The Committee is asked to confirm the minutes are accurate**.**

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 **NHS 111 and GP Out of Hours** (Pages 13 - 34)

a) To consider a verbal update by Vocare
b) To consider the report by the CCG

6 **NHS waiting times for Somerset patients** (Pages 35 - 42)

To consider the report

7 **Somerset Suicide Prevention Scrutiny report** (Pages 43 - 114)

To consider the report

8 **Adult Social Care Performance Update** (Pages 115 - 128)

To consider the report

9 **Council Performance Report - End of September (Q2) 2017/18** (Pages 129 - 134)

To consider the report

10 **Terms of Reference for the Learning Disability Services Task and Finish Group** (Pages 135 - 136)

To consider the report

Item Scrutiny for Policies, Adults and Health Committee - 10.00 am Wednesday 6 December 2017

11 **Discovery contract - performance update**

To consider the confidential report

Possible exclusion of the press and public

PLEASE NOTE: The report for this item is confidential. If Members wish to discuss information within this report then the Committee will be asked to agree the following resolution to exclude the press and public:

Exclusion of the Press and Public
To consider passing a resolution having been duly proposed and seconded under Schedule 12A of the Local Government Act 1972 to exclude the press and public from the meeting, on the basis that if they were present during the business to be transacted there would be a likelihood of disclosure of exempt information, within the meaning of Schedule 12A to the Local Government Act 1972:

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

12 **Scrutiny for Policies, Adults and Health Committee Work Programme** (Pages 137 - 150)

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

13 **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 – Julia Jones on 01823 359027 or 357628 ; Fax 01823 355529 or
Email: jjones@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 Julia Jones, 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 8 November 2017 at 10.00 am

Present: Cllr H Prior-Sankey (Chair), Cllr A Govier, Cllr P Burridge-Clayton, Cllr M Chilcott, Cllr James Hunt (substitute), Cllr J Williams, Cllr B Revans, and Cllr R Williams (Vice-Chair)

Other Members: Cllr C Aparicio Paul, Cllr J Clarke, Cllr S Coles, Cllr H Davies, Cllr D Hall, Cllr D Huxtable, Cllr T Munt, Cllr G Noel, Cllr C Lawrence, Cllr J Lock

Apologies for absence: Cllr M Caswell, Cllr M Keating

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

There were no declarations of interest.

46 **Minutes from the previous meeting held on 11 October 2017** - Agenda Item 3

The minutes of the meeting were accepted as accurate and were signed by the Chair.

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

There were 22 requests from members of the public to speak about agenda item 5 which was an Update on the Learning Disability Service Contract.

Members listened to the views and questions from the following people:

a) Angela Hayward, who asked about personal budgets and the cost of new offices.
b) Gwyneth Philip, who raised concerns about unhappy customers, the loss of experienced staff, the possible closure of Six Acres, staff wages, and an invoice error.
c) Mrs Dowling was concerned on behalf of a customer she supported because the service was being run predominantly with agency staff; there was significant staff turnover and lack of continuity which had directly affected her client.
d) Mike Bruce, who worked as carer, said there were significant staff shortages which had resulted in lack of cover for shifts and activities having to be cancelled. He questioned the new service provider Discovery's claims that flaws in the service were pre-existing. He highlighted that the Council had promised outsourcing the service would bring continuity of care and a sustainable high quality service.
e) Sarah Mainwaring, a staff member, said the service was understaffed, worked long hours; there was a high number of agency staff, and a lack of quality care. She further stressed uncertainty about jobs, staff feeling devalued and unsettled about their future, staff turnover, and changes to staff's terms and conditions.

f) Ama Bolton was concerned about plans to downgrade experienced staff, a reliance on agency staff, and a lack of respect for staff. She also asked about future plans for the service.
g) Suzanne Matthews was also concerned about staff turnover, agency staff and the impact this had on providing a quality service and providing a safe environment for both customer and staff.
h) Sonia Hastie highlighted staff concerns of feeling not valued and that they had rejected Discovery's proposals for changes to their terms and conditions.
i) Sean Cox said there had been a general lack of effort throughout the process to engage with customers, family members or staff with any honesty or transparency. He asked if a meaningful and sensible dialogue with customers, families and staff could have provided an easier and more effective route to a high quality and financially sustainable service. He was also concerned about the projected costs for the first year.
j) Jon Robinson spoke about the increase in 'never events' and said this was due to the shortage of staff particularly at weekends. He was concerned that a lot of staff hired had little if any experience of people with learning disabilities.
k) David Rankine informed the meeting about changes in the service to customers due to lack of staff and changes in personnel. There was hardly any one-to-one time and many customers hardly left the unit where they were looked after all week for trips or excursions. Staff were working without breaks, staff sickness had increased, and morale was low.
l) Steven Maws, a customer, had concerns that he had not be listened to in the changeover to the new provider, had no interaction with the new care providers since they had taken over, and worried about the quality of service and consistency of staff.
m) Jo White highlighted the lack of reporting on key performance indicators by Discovery and evidence to show the transformation programme had succeeded. She was concerned about the temporary suspension of any new business.
n) Cheryl Freeman spoke about the effects of changes in staff and a lack of staff on her stepson who was a customer. She had grave concerns for her stepson's wellbeing and the future of the learning disability service.
o) Ewa Marcinkowska said there was a massive challenge to deliver care hours to the customers. Experienced staff had time taken up with mentoring new agency workers, who had to learn and read a lot of material. This had resulted in a lot of hours not being used to support customers. Customers were uncomfortable with new people and would not go out with them.
p) Paul Kitto felt that the service was far away from providing a high quality than ever before and asked for Discovery to provide evidenced based information to the scrutiny committee. He asked for a survey of customers and staff to be carried out to enable an holistic view of the current situation.
q) Eleanor Amos, also raised concerns about the changes to working conditions for staff, salaries the effect on morale, and staff turnover. Customers like consistent routines and familiar faces and she feared the proposals would result in a reduction of quality of care.

r) Nigel Behan, UNITE representative, asked questions about evidence of performance of Discovery, the Council's satisfaction, Somerset Clinical Commissioning Group assessment of Discovery's performance, delivery projections, risk registers, and number of questions around key performance indicators.

s) John Clarke, County Councillor, was concerned about the health and welfare of customers with continued staffing changes and also the issue of quality monitoring.

t) Nick Batho, volunteer for the Learning Disability Service in Minehead, said that outcomes needed to be measured but the current information provided was focused on input data. Staff conditions were not resolved and there appeared to be a lack of commitment to the contract from the Council. He also asked for a survey to be taken, an advisory panel to be set up, and independent review of the service to be taken at the end of the first year of the contract.

Members were also provided with a letter from a Discovery staff employee who listed a range of issues around staffing hours, staff turnover, agency staff with no experience or knowledge, checks not being done properly, customers unable to enjoy usual activities in the community due to lack of staff or those with experience. Admin and finance tasks were not being completed correctly and staff felt unsupported and unable to raise any concerns.

48 **Update on the Learning Disability Service Contract** - Agenda Item 5

Director of Adult Social Care Stephen Chandler assured all those who raised questions that they would receive written responses. He reminded the meeting of the background to this. He highlighted the requirements were transformation and sustainability and that changes in the first year were part of the plan. If no changes were made to staff terms and conditions the service would cease to exist as it would not be affordable. The situation was not unique in Somerset and was happening all over the country. He encouraged everybody to work through this difficult period.

Cabinet Member for Adult Social Care Cllr David Huxtable said that he was part of the Cabinet that took the decision about the learning disability contract. The Council were determined to do their best for people in care.

A presentation was given by Discovery's Managing Director Luke Joy-Smith. He said that the company recognised that the staff had the customers' best interests at heart and that it was a listening organisation. He was happy to fast-track a survey with customers, family and friends. There was need to resolve the limbo and uncertainty.

Further discussion on this included:

- The aim was to get to an outstanding service
- Important to get the right foundations and settle colleagues anxieties
- Current mismatch between core hours, amount of staff and temporary staff
- Management of the contract had to be good in order to deliver a good service
- Confusion around the governance structure

- Customers and family voices needed to be heard
- The junior Cabinet member for Adult Social care had a seat on one of Discovery's boards and had committed to attend these
- It would be useful to have a forward plan available to look at for the next 6 months to give the committee some assurance. A transformation plan was available and it was agreed this could be circulated to the committee.
- Staff needed support and training but flexibility was important and the aim was to get full compliance for mandatory training by December
- It was unhelpful to blame the Council for the current poor service
- Good quality of care came from good staff morale and continuity
- This was about vulnerable people and staff that supported them and they could not wait another 5 years for a quality service.
- Concerns about the significant loss of staff and experience.
- The next 6 months were incredibly important and members did not want to see a deterioration in the service
- The data provided did not give any indication of what was working well or safely
- Discovery were reminded of the importance of experienced staff
- Assurance was sought on the safety of customers

The Chair summed up the discussion and noted that committee members were not content with the information they had received.

It was agreed that a monthly report showing Key Performance Indicators for the contract should be brought to the next four scrutiny meetings.

The Committee also agreed:

- it was not satisfied with the report and information provided.
- to request that a survey with customers, families and staff of the service be conducted as soon as possible
- to establish a Task and Finish group to look at the contract performance in more detail
- to refer the contract matter to the Audit Committee for its consideration.

There was a short break in the meeting here at 11.35am.

49 **Update on the Somerset Sustainability and Transformation Plan**- Agenda Item 6

The meeting resumed at 11.45am.

Councillor James Hunt declared an interest as an employee and governor of Taunton and Somerset NHS Foundation Trust and Rod Williams also declared an interest as a governor of the Trust.

Chief Executive Pat Flaherty introduced the report regarding the Somerset Sustainability and Transformation Plan. This has been developed jointly by the Somerset Clinical Commissioning Group, Somerset County Council, Somerset Partnership NHS Foundation Trust, Yeovil District Hospital NHS FT and Taunton and Somerset NHS FT. This set 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.

The 5 year forward view was intended to describe the key priorities and challenges. These included workforce challenges, demographic changes including an ageing population. The current system was challenged and stressed and there was an uncertainty around what had served in the past that could fall over in the future.

Further discussion on this included:

- There had been a change of leadership at the NHS trusts.
- The focus was on prevention to develop a sustainable system, driving financial improvement, and creating an accountable care system
- A full review of acute services in Somerset was about to be commissioned to find out whether it was fit for purpose
- There was currently a £30m debilitating gap for NHS in Somerset and there was no extra money coming from government.
- Transformation was difficult without the funding for it and currently there was an impasse
- Concerns that there had been little progress with this and fears that the plan would disappear
- Whether the district councils were involved in discussions about this.
- It was hoped that the Council would keep sighted on what was happening
- Consultation about the new plan was due in the spring and this would be brought back to the committee in the future.

The Committee noted the report and asked for an update when there was further information to report.

50 **Adult Social Care Performance Report** - Agenda Item 7

The Committee agreed to defer this report as there was insufficient time to examine this matter.

51 **Scrutiny for Policies, Adults and Health Committee Work Programme**- Agenda Item 8

The Committee agreed to update the work programme for the next meeting.

52 **Any other urgent items of business** - Agenda Item 9

There were no other items of business.

(The meeting ended at 1.25 pm)

CHAIR

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Somerset County Council
Scrutiny for Policies, Adults and Health Committee
6 December 2017

NHS 111 & GP Out of Hours

Lead Officer: Deborah Rigby, Acting Director for Quality and Safety
Authors: Karen Taylor, Acting Deputy Director for Quality and Safety
Alex Burn, Urgent Care Commissioning Manager, Somerset CCG
Contact Details: 01935 384182
Cabinet Member: N/A
Division and Local Member: N/A

1 Overview

1.1 Within Somerset there have been ongoing challenges within the NHS 111 Service and the GP Out Of Hours (OOH) Service both provided by Vocare Limited (known locally as Somerset Doctors Urgent Care). These challenges have been closely monitored by Somerset CCG from both a Performance and Quality Perspective.

1.2 In April 2017 the Care Quality Commission (CQC) conducted an announced comprehensive visit to both services based at Wellington House in Taunton to inspect these services for safe, effective, caring, responsive and well-led care. Immediately following the inspection, the CQC issued one warning notice to the NHS 111 service and two warning notices to the GP OOH service, which highlighted areas requiring urgent attention. The conclusion of the CQC's inspection, published in reports on 4 August 2017, was that overall the NHS 111 service was awarded 'Requires Improvement' and the GP OOH service 'Inadequate'. The GP OOH service following the award of this rating has been placed into 'Special Measures' by the CQC.

1.3 The CQC conducted a follow-up visit to review the services against the three warning notices on 24 August 2017. The CQC issued a further four warning notices, which replace the original three warning notices, with an additional requirement relating to confidentiality arrangements at the call centre (open widows and window blinds permitting potential disclosure of patient information). The report relating to the inspection and issue of the warning notices was published by CQC on 17 November 2017. The report finds although action has been taken, progress has be insufficient for the requirements in warning notices to have been met. The review stated that the service was still in 'special measures' and still requires improvement.

Areas of non-compliance are listed in section 3.2 below. Accordingly the warning notices include requirements to further improve:

- Leadership and good governance (Regulation 17)
- Staffing (Regulation 17)
- Safe Care and Treatment (Regulation 12),
- Dignity and Respect (Regulation 10) *T*

Further detail and full report is available at Appendix A and via the link http://www.cqc.org.uk/sites/default/files/new_reports/AAAG7849.pdf

1.4 The CQC carried out their planned follow-up announced comprehensive inspection of both the NHS 111 and GP OOH services on 16 and 17 November 2017. The findings of which are not yet available.

1.5 This report summarises the findings of quality and safety monitoring conducted by Somerset CCG as commissioners of both the 111 and out of hours primary care doctors service.

1.6 Overall although the CCG finds Vocare, the service provider has made some progress in implementing improvements, there remains significant concern about the quality of the service. The key area of concern arises from delays in providing care and treatment due to shortages in achieving full complement of staffing requirement. Although Safety risk to patients is mitigated through the application of systems for triage and scheduling to prioritise patients according to clinical need, quality of service is compromised through delay and risk to safety is increased.

1.7 Achieving sufficient staffing is not an issue isolated to the 111 and out of hours service, they arise across all healthcare sectors and particularly in primary care GP recruitment and retention, both locally in Somerset and nationwide.

1.8 In August 2017 updated guidance was published for the national Integrated Urgent Care Specification. This requires change to the service model for 111 and out of hour's services https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf

This revised service model will deploy a different approach to initial receipt and management of calls. Calls which can be addressed by a more diverse range of professionals and services will be streamed away from being managed by GPs. For example 20% of current calls are for prescriptions where the caller has run out of their current supply. These calls will in future be directly dealt with by pharmacists and pharmacy services. This model is known as a Clinical Assessment Service (CAS) and will result in people getting access to the right type of service more quickly and make better use of available staffing resource. This work has been started in Somerset, but has not yet gone live and therefore delays are still an enduring problem. The CAS service is due to commence in December 2017 and to be fully operational by 1 April 2018. In the meantime arrangements are being put in place for the winter months to escalate support when needed to 111 and Out of Hours services from the other urgent and emergency care services within the county.

1.9 Action has been taken to remedy a wide range of organisational systems to maintain standards which are key to controlling quality and mitigating safety risk; there remains further work by Vocare to ensure these improvements are fully implemented, embedded and sustained. When considered alongside the ongoing concerns about delays to completing care delivery, the CCG remain concerned about the overall quality of the service and a consequent increased risk to patient safety.

1.10 Somerset CCG believes the response of the provider was initially insufficient given the scale of the shortfalls identified. Critically there was a failure by the service to have sufficient quality monitoring arrangements of its own in place to have identified these issues themselves earlier. In recent weeks the CCG has been advised considerable additional resource has been allocated by the

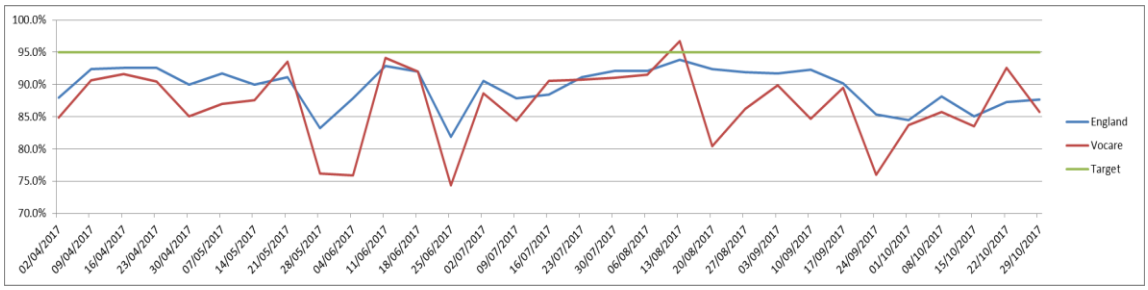
Vocare central corporate team to support their local Operational management team in Somerset.

2 Service Performance Delivery and Improvement Actions, including Transition to the Revised Service Model Specification

2.1 Vocare Limited has provided a revised staffing improvement trajectory for the NHS 111 Service expected to deliver performance against 95% 60seconds Call answering. Somerset CCG is monitoring comprehensively this improvement trajectory. Staffing with the GP OOH service remains a challenge and as a consequence Somerset CCG are applying high levels of scrutiny to GP shift fill and patient waiting times within the service setting very clear expectations for improvement.

NQR 8 (60 Second Call answering)

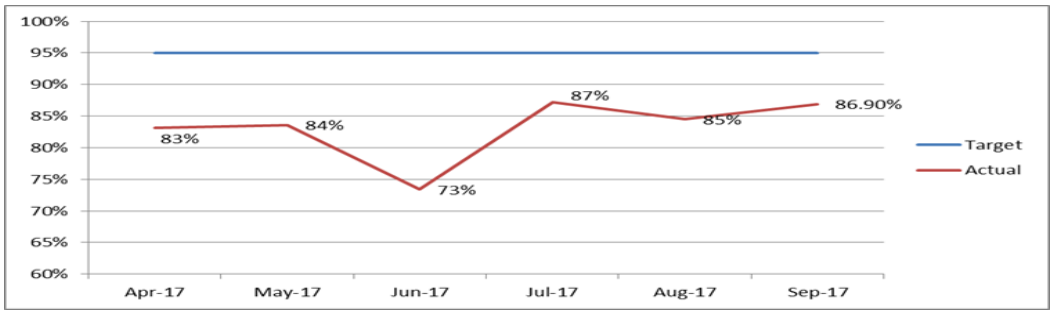
2.2



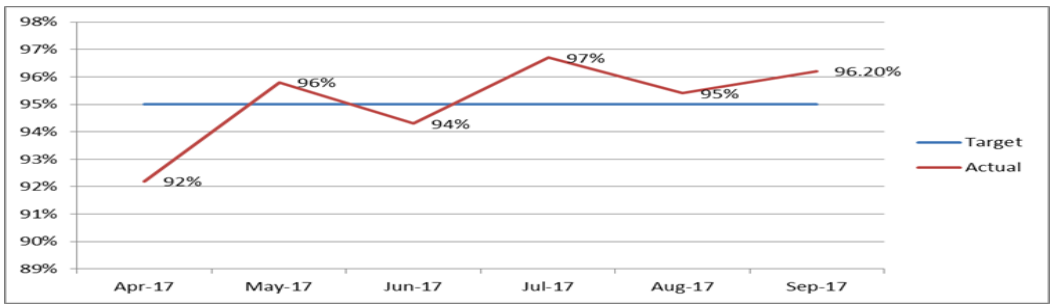
2.3 Somerset CCG smilalrly closely monitor perfromance against the national quality requirements (NQRs) for people accessing the 111 and OOH service have their episode of care completed in accordance with the urgency allocated within the 1 hour (Emergency), 2 hour (Urgent) and 6 hour (Routine) targets for face-to-face care at delivered by either a centre visit or a home visit. All 1 hour targets have been met with 100% compliance.

NQR 12 b (2 hour Centre Visit).

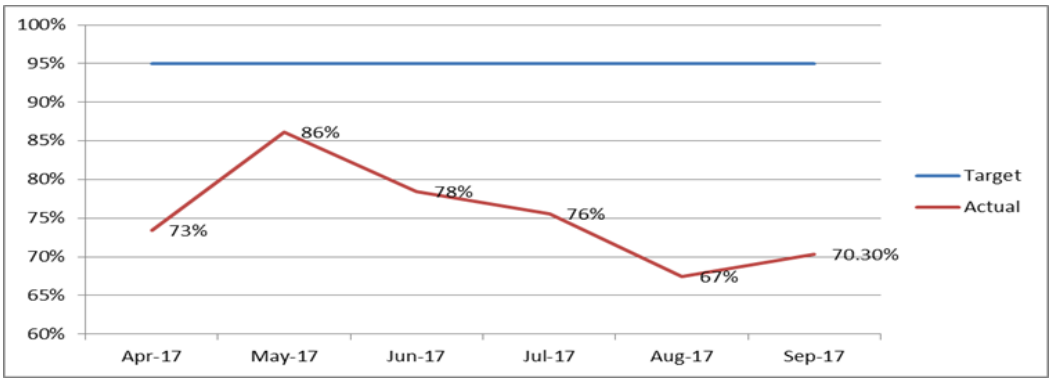
2.4



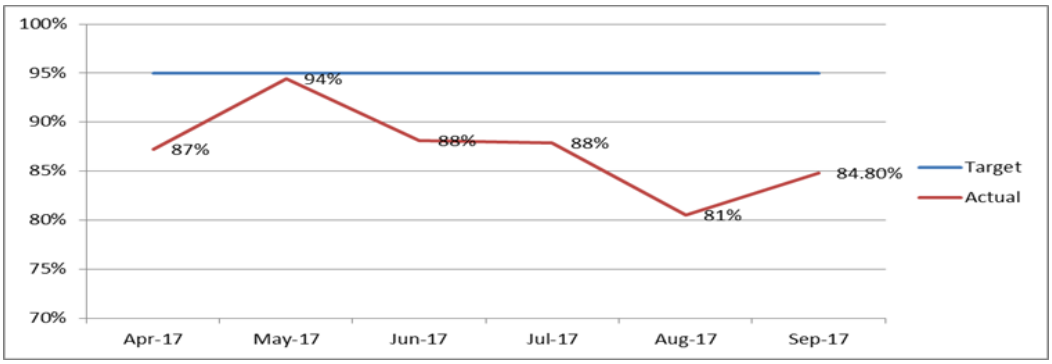
NQR 12 c (6 hour Centre Visits)



NQR 12 e (2 hour Home Visits)



NQR 12 f (6 Hour Home Visits)



2.5 Quality and Safety Standards Requiring Improvement

2.5.1 CQC priorities:

- Ensure adequate staffing
- Improve the system for internal quality and safety monitoring
- Staff supervision and appraisals, including keeping up to date with audit of staff performance in call handling and case management
- Effective management of complaints and serious incidents to ensure improvement is implemented as a result of learning
- Ensure notifications are submitted to CQC as required by statutory requirements

2.5.2 CQC standards where compliance levels required improvement:

- Safeguarding training
- Infection control arrangements, including decontamination of equipment and cleaning up of body fluid spillages
- Medicines management, security of medicines and controlled stationery I.e blank prescription forms, ease of access to emergency medicines, checking of medicine stocks
- Recruitment checks
- Health and safety checks, including safe arrangements for lone working
- Routine maintenance checks and access to medical devices and equipment

2.5.3 Somerset CCG will be required to implement the recently published NHS England national service specification for integrated urgent care and will be working with the existing urgent care system to deliver a more sustainable model. NHS England has, on 24 August 2017, published a paper 'Integrated Urgent Care Specification' which encompasses the traditional NHS 111 service and the GP OOH service into one fully integrated service. This combined service, in addition to this integration, adds a Clinical Assessment Service (CAS). The CAS would add an extra layer of staff who would provide specialised clinical assessments. These assessments offer patients, by phone, the opportunity to either have their care concluded during the call or are referred into the most appropriate service for their care needs to be concluded. Plans are being put in place for this to become operational in December 2017

3 Remedial Action plan (RAP)

3.1 The process regarding performance challenges is that the CCG issue a formal contract performance notice to a provider regarding their performance. This notice sets a clear timescale and an expectation for the provider to outline their expected performance improvements. This information is contained within a Remedial Action plan (RAP) which is prepared by the provider and signed off by the commissioner if they are in agreement. It is expected that the plan offers assurance to the commissioner that it is robust and able to deliver the required service improvements.

3.2 Following two previously failed trajectories in March 2017 and August 2017 Somerset CCG has continued to raise concerns regarding staffing levels. To address these staffing shortfalls, in order to build a more robust workforce, Vocare Limited has commissioned some external support to achieve a sustainable position. Somerset CCG are monitoring the improvements in the shift fill and monitoring performance improvements against the expect levels of service delivery but have not signed off a revised RAP at this stage.

3.3 Within the GP OOH service Somerset CCG raised concerns regarding staffing levels and the impact that this is having on the timeliness that patients are seen. Initial concerns were focused on periods of higher pressure such as bank holidays and weekends. Somerset CCG has requested a higher level of scrutiny regarding the level of GP shift fill to gain assurance that there are adequate staffing levels in place, which is shared with Somerset CCG weekly, and system partners.

3.4 Following the CPN, issued in March 2017, Somerset CCG and Vocare Limited are having ongoing conversations regarding the recovery of staffing levels and actions required to address the delivery of timely performance. Somerset CCG has clearly set expectations of the provider to make rapid and sustainable improvements in the staffing position. At this point in time Somerset CCG is not in a position to sign-off a RAP.

4. Summary

4.1 Escalating quality concerns were identified by Somerset CCG through commissioner contract and quality monitoring activities and concerns raised by GPS working in the service in the later part of 2016 and early 2017. Since that time there has been an enhanced level of clinical quality review and oversight of the service.

In addition to routine monthly and quarterly oversight arrangements, since the early CQC inspection findings being known to the CCG, initial weekly and now fortnightly oversight meetings to review progress against action plans have been in place.

The CCG also conducts its own range of routine and enhanced surveillance visits to the call centre and headquarters in Taunton and the treatment centres across the county. During these visits it has been identified the triage of cases is not always well organised, resulting in risk minimisation strategies to allocate the caller for a treatment centre or home visit. It then may later transpire that the caller can be managed remotely, either before or after a treatment centre visit. This leads to callers being given mixed messages. Perversely it also leads to inefficient use of the GP treatment centre capacity.

4.2 In November 2017 the CCG has worked with Vocare, to develop a Standing Operating Procedure for the Escalation of concerns when the triage que reaches a critical point (this is based on staffing and complexity of patients). The SOP is in agreement with Somerset System Partners to work with Vocare and is currently being finalised through a series of contingency planning meetings held with NHS providers.

Following the acquisition by Totally plc, Vocare Ltd continue to be the legal entity with a change of control of Vocare Ltd from its previous shareholders to Totally. The CCG have met with Directors from Totally Healthcare on 8 November 2017 to raise concerns regarding current performance.

Somerset CCG continue to hold Vocare to account through:

- Review of daily staffing levels in the OOH service and rota planning
- Implementation of Remedial Action Plan (RAP)
- Weekly review of performance against the national quality requirements
- Implementation of an escalation procedure
- The CCG risk register reports a risk of 16, as the CCG has provided both challenge and support to the Somerset Vocare team to make improvements in accordance with CQC inspection findings and separate CCG concerns arising from our contract performance and quality review monitoring activity.
- Bi-Weekly monitoring of Vocare's Quality Improvement Action plan

Wellington House

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused follow up inspection at Wellington House (known locally as Somerset Doctors Urgent Care) on 24 August 2017.

Following our comprehensive inspection at Wellington House NHS on 24 and 25 April 2017 the location was rated as inadequate for the Out of Hours service with an inadequate rating for the safe, effective and well led domains, good for caring and requires improvement for responsive. We rated the NHS 111 service as requires improvement with requires improvement rating for safe and effective, good for caring and responsive and inadequate for well-led. Our levels of concern following this inspection were significant and we placed the provider into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Summary of findings

The serious concerns were such that we took further steps to ensure the provider made changes to the governance of the service to reduce or eliminate the risks to patients. The provider was required to make improvements in respect of these specific deficits, as outlined in the warning notices of 17 May 2017 to be completed by 18 August 2017.

We issued warning notices in regard to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance and Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.

This focused follow up inspection was undertaken on the 24 August 2017 to assess if the regulatory breaches had been met in regard to the warning notices. Other areas of non-compliance were planned to be reviewed at a later date by a comprehensive inspection when the provider has had time to implement all the changes required.

The provider had taken steps to ensure the significant concerns that had been found in relation to the warning notices for Regulations 12 and 17 had or were in the process of being addressed. For example we found evidence that the concerns around emergency medicines, calibration of clinical equipment, health and safety relating to risk assessments and COSHH (control of substances harmful to health) and complaints had been rectified. Infection prevention and control measures had been improved.

The provider had implemented changes to the management and administration system for safer recruitment and for mandatory learning and development. However there were still gaps in the safer recruitment process such as pre-employment references and the completion of mandatory training such as safeguarding, basic life support, fire safety and evacuation and infection, prevention and control had not been completed by all staff. With regard to medicine management, the systems to securely store and monitor medicines including controlled medicines remained inadequate. The service had not met all the National Quality Requirements used to monitor safe, clinically effective and responsive care which meant patients' care needs continued to not always be assessed and delivered in a timely way. Further concerns remained unmet, the implementation of an overarching governance framework for systems and processes, including the action plan following our previous inspection concerns, required attention to improve the quality and safety of the services and to mitigate risks relating to the health, safety and welfare of staff and service users.

In addition we found new concerns with infection prevention and control measures such as such as spillage and contamination relating to used sharps. There was limited evidence of learning being embedded in policy and processes; for example, there were ongoing incidents of missing blank prescriptions and blank prescriptions not being held securely. Additional concerns around patient confidentiality were raised with the service.

There were also areas of service where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that all patients are treated with dignity and respect.
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure that serious incidents, deaths or safeguarding referrals are subject to statutory notifications to the Care Quality Commission.

The provider should:

- Complete resulting actions from the health and safety risk assessment relating to lone working as a priority.
- Enable staff at Out Of Hours sites staff to easily identify which equipment has been calibrated and which equipment they need to re-calibrate regularly such as blood glucose monitors and which is safe to use.

In this situation with the issuing of warning notices, we returned to check the progress the provider was making in regard to the key concerns. The service remains under special measures until we have returned to carry out a

Summary of findings

comprehensive inspection at the end of this six month period after the initial report was published. If the service has failed to make sufficient improvements the CQC will consider taking steps to cancel the provider's registration.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

At our last inspection on 24 and 25 April 2017 we rated the safe domain as inadequate for providing safe services and improvements must be made.

We saw some improvements however; the provider was not always providing care and treatment in a safe way. There was limited evidence of sustained learning from significant events that prevented reoccurrence of events. For example, security and safe storage of blank prescriptions and medicines. Significant events that required statutory notification to the CQC were not always completed.

The provider had implemented a new recruitment policy and had implemented a new management and administration system for recruitment. However we saw gaps where some recruitment checks had not been completed.

Checks relating to infection prevention and control measures and clinical equipment required improvement in some areas and action plan timescales for implementation of improvements had not always been met.

Are services well-led?

Inadequate

At our last inspection on 24 and 25 April 2017 we rated the well-led domain as inadequate.

The delivery of high-quality care was not assured by the leadership, governance or culture in place at the service. Significant issues that threaten the delivery of safe and effective care were not adequately managed. For example, substantial or frequent clinical staffing shortages within the Out Of Hours service led to breaches of National Quality Requirement 12 for face to face clinical assessments and increased risks to patients who used services and patients were not always treated according to urgency of need. Comfort calls in relation to delays were not always timely. Adequate clinical audits to ensure improvements in clinical care and other processes were required.

Patients could get information about how to complain. We found the complaint system to be detailed and appropriate although we saw themes and trends around complaints such as delays and cancellations in care and access to treatment.

Summary of findings

The provider had implemented a new management and administration system for statutory and mandatory training however gaps within training such as infection, prevention and control, fire safety and evacuation, basic life support and safeguarding led to risks.

Patient information and confidentiality was not always maintained at all times.

Summary of findings

Areas for improvement

Action the service MUST take to improve
Importantly, the provider must:

- Ensure that all patients are treated with dignity and respect.
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure that serious incidents, deaths or safeguarding referrals are subject to statutory notifications to the Care Quality Commission.

Action the service SHOULD take to improve
The provider should:

- Complete resulting actions from the health and safety risk assessment relating to lone working as a priority.
- Enable staff at Out Of Hours sites staff to easily identify which equipment has been calibrated and which equipment they need to re-calibrate regularly such as blood glucose monitors and which is safe to use.

Wellington House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a specialist GP advisor, a second CQC inspector and an inspection manager.

Background to Wellington House

Wellington House is known locally as Somerset Doctors Urgent Care (part of the Vocare Group). This service provides the 24 hour NHS 111 service and GP led Out Of Hours (OOH) care for a population of approximately 540,000 patients in the Somerset region. They also provide the 24 hour NHS 111 service across the whole of Somerset. Somerset Doctors Urgent Care Ltd. (SDUC) is a private limited company. Vocare deliver GP Out Of Hours and urgent care services to more than 4.5 million patients nationally.

The population of Somerset is dispersed across a large rural area. The County of Somerset covers a large geographical area and incorporates five District Councils; Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset. One in four people live in one of Somerset's largest towns: Taunton, Yeovil and Bridgwater (Somerset JSNA, 2011).

Areas of multiple deprivations in Somerset are found within the towns as well as more remote rural areas. Patterns of deprivation in rural areas are strongly influenced by distance to services. Around 95% of Somerset's population are White British. Outside of the UK and Ireland the most common countries of birth across all districts are Poland, Germany, South Africa, India and the Philippines. There are a growing proportion of residents across Somerset who have settled from abroad.

There are around 3,400 households (1.5% of all households) in Somerset in which the household members do not speak English as their first language. Members of these household may require language support when accessing services. There is a high proportion of single pensioner households in West Somerset (remote parts of the County) and a higher prevalence of single parent households in Mendip, Sedgemoor and Taunton Deane than the Somerset average. A significant proportion of the Somerset population do not have access to their own transport, particularly in Sedgemoor, West Somerset and Taunton Deane. Almost a fifth (19%) of Somerset residents rate themselves as being limited in activities of daily living (Census 2011). Residents in Sedgemoor and West Somerset are likely to have higher health care needs than the Somerset average.

Young families and older people tend to access OOH services more commonly than other age groups. Younger families tend to live in north east parts of the County and closer to towns.

The GP led Out Of Hours service is accessed through NHS 111, providing telephone triage and face-to-face consultations 24 hours a day to patients across Somerset. This service is based at the organisation's headquarters at Wellington House, in Taunton.

Wellington House provides Out Of Hours care between 6.30pm and 8am Monday to Friday. At weekends and bank holidays the service provides 24 hour access. As part of the Out Of Hours service there are five OOH sites which open at varying times and days:

Detailed findings

- Bridgwater Community Hospital Bower Lane, Bridgwater, TA6 4GU
- Minehead Community Hospital Luttrell Way, Minehead, TA24 6DF
- Musgrove Park Hospital Parkfield Drive, Taunton, TA1 5DA
- Shepton Mallet Community Hospital Old Wells Road, Shepton Mallet, BA4 4PG
- Yeovil District Hospital Higher Kingston, Yeovil, BA21 4AT

During our inspection we visited the headquarters in Taunton along with four of the five Out Of Hours sites (Bridgwater, Taunton, Shepton Mallet and Yeovil).

On average the service receives 900 referrals per week via NHS 111. Of these an average of 70 patients received contact with the service each weekday and 550 patients receive contact at weekends.

The regional clinical director is a GP who works in this role two days per week. There is 171 clinical staff of which 165 are GPs. The remaining six are nurse practitioners or emergency care practitioners. All are either employed by the service or provide sessional work. There is 51 operations staff including receptionists, a clinical manager and a regional clinical and non-clinical director. In addition 27 drivers are employed.

Why we carried out this inspection

We undertook this focused inspection on 25 August 2016 and visited the service to follow up the warning notices for breaches of Regulation 12 of The Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment and Regulation 17 of The Health and Social Care Act (Regulated Activity) Regulations 2014, good governance, to ensure patients who used the service were safe.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We also held regular meetings with Somerset Clinical Commissioning Group, NHS England and the provider. We carried out an announced visit on 24 August 2017.

During our visit we:

- Spoke with a range of staff including the regional clinical and non-clinical director, assistant regional director and clinical support manager, the clinical manager, administrative and operations staff such as a driver, rota administrator and base lead manager. We also spoke to the provider's project coordinator and head of recruitment.
- Visited the local headquarters for the service which housed the NHS 111 service and two of the five Out Of Hours bases.

Please note that when referring to information throughout this report, this relates to the most recent information available to the Care Quality Commission at that time.

Are services safe?

Our findings

At our previous inspection on 24 & 25 April 2017 we rated the Out Of hours (OOH) service as inadequate and the NHS 111 service as requires improvement for providing safe services as systems, processes and practices did not always keep patients safe. Our substantial concerns with some aspects in the safe domain led us to take further steps to ensure that the provider made changes to the governance of the service to reduce or eliminate the risks to patients. The provider was required to make improvements in respect of these specific deficits, as outlined in the warning notices of 17 May 2017 with a compliant date of 18 August 2017.

We issued warning notices in regard to:

• Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

• Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.

During our follow up inspection of 24 August 2017 we saw some improvements however, the provider was not always providing care and treatment in a safe way.

Safe track record and learning

There was a system in place for reporting and recording significant events. However the provider had not always notified the Care Quality Commission of significant events that require statutory notifications. Following this focused inspection we continued to request information but did not always receive a prompt reply and were not provided with all of the information we requested. In addition, during this inspection we looked at the administrative system for incident reporting within the service and incidents regarding allegations of physical abuse by a health care professional in another organisation; missing controlled medicines and evidence of requests from the Police for confidential patient data in the form of call recordings. To date statutory notifications relating to these issues have not been received by CQC.

- We saw evidence some learning had been disseminated to staff although there was little evidence of learning being embedded in policy and processes.

Overview of safety systems and processes

The service had clearly defined provider-level policies and processes in place to keep patients safe and safeguarded from abuse however these were not always followed:

- During our previous inspection not all staff we spoke to had received training on safeguarding children and vulnerable adults relevant to their role. We saw the provider had implemented a new, improved e-learning training system with easier staff access and comprehensive training packages. We reviewed the data of completion of training within the new e-learning training system and saw that not all staff had completed the mandatory safeguarding training. For example, none of the advanced nurse practitioners and only 42% of clinical advisors had received relevant safeguarding training for their role. Most GPs had level three children's safeguarding training.
- At our previous inspection we were told by the local leadership team that staff at the Out Of Hours (OOH) sites were not expected to provide a chaperone service to patients and non-clinical staff such as drivers and receptionists were not provided with chaperone training. Members of staff had told us that they had acted as a chaperone when this had been requested of them. 33% of receptionists and 19% of drivers had since undertaken online chaperone training. Staff told us they did not feel confident with their role and ability to act in the interest of the patient. There was no evidence training was then consolidated with them.
- At our previous inspection we raised concerns around infection prevention and control (IPC) measures. We had observed the premises to be clean and tidy except for one site where dirty linen was found at the start of the shift. We had spoken to non-clinical staff at the sites who told us they had not received any infection prevention and control training including handwashing. At this inspection we looked at the e-learning training system data and saw not all staff had received IPC training such as; 25% receptionists, 50% of advanced nurse practitioners and GPs and 54% of drivers. This meant staff may not have an overview on the key elements of IPC. At the two Out Of Hours (OOH) sites we visited we found procedures for containers which enable the safe storage and disposal of all categories of sharps waste had not been followed, we found a box which had not been put together correctly, had been overfilled and was still in use. This presented a risk of spillage and contamination.

Are services safe?

- Previously staff told us they were unaware of procedures to clean and decontaminate clinical equipment when dirty, used by an infectious patient or at the end of each shift. A new procedure had been implemented since our last visit however we found a glucometer used to test a person's blood glucose level was blood stained. We spoke to staff who advised us there was a process to check and decontaminate equipment at the start of each shift. The checking tool for the day we visited was not available at the OOH sites. We asked how staff would clean the equipment and were advised they would use equipment that did not disinfect the devices. The impact of this was the system for cleaning and disinfecting equipment put patients at risk as the equipment was not cleaned immediately after use. And some staff with the responsibility to decontaminate and clean equipment had not received the relevant infection prevention and control training.
- At our previous inspection OOH staff told us patient urine samples were tested in clinical rooms and the urine disposed of in clinical waste bags. We saw evidence that a system and procedures had been put in place to allow the safe disposal of clinical waste. However there was no evidence that a system was in place to check staff followed the correct procedures.
- We asked to look at the organisations overall infection prevention and control (IPC) measures. We looked at the IPC audit completed on 21 June 2017, the CQC improvement action plan and the organisations health and safety action plan. We saw the three plans had differences in relation to actions and outcomes. For example, staff told us they checked equipment at the start of the shift whereas the action plan stated staff completed this at the start and end of a shift. In addition data within the plans for levels of IPC staff training completed were different from the data available from the training system.
- Previously we reviewed personnel files of which related to OOH and NHS 111staff. We found evidence a significant number of recruitment checks had not been completed.
- During this visit we saw the provider had implemented a new recruitment policy and had implemented a new management and administration system for recruitment. The provider had employed additional staff to undertake a full audit of staff files and this was still work in progress. We reviewed 13 files for staff at Wellington House and found gaps where some recruitment checks had not been completed. For example, interview summaries, details of appraisals, application forms and references. One senior member of the leadership team did not have an application form or interview notes and had commenced employment without references. In the absence of the provision of evidence of safe recruitment the provider could not demonstrate that an effective system was in place to assess monitor and mitigate risks relating to recruitment. We also noted that where the provider had staff who had been transferred from a predecessor organisation there were gaps in documentation but part of the new system these had been requested.

Medicines Management

- At our previous inspection we found the blank prescription forms and pads were securely stored, but the monitoring systems in place were not adequate to be able to track their use. At this inspection we reviewed changes the service had made to the security arrangements for blank prescriptions which had been introduced. At one OOH site we found the audit record for individual blank prescriptions was not completed fully and one prescription was missing. We spoke to the Registered Manager who told us that there continued to be gaps in logging prescriptions. This was evidenced in the administrative system for incident reporting within the service which detailed incidents of missing blank prescriptions and blank prescriptions not being securely stored at various OOH sites when the service was closed. For example, the incident log for 22 May 2017 detailed prescriptions being found left out and the computer left on allowing unauthorised access to information; on 6 June 2017 a blank prescription pad had been left out in a treatment room; on 8 July 2017 a blank prescription was missing from an OOH site and on 19 July 2017 two blank prescriptions were unaccounted for at an OOH site. The Wellington House performance and operations report for June 2017 details prescription pads not being securely stored at one OOH site. These incidents meant prescriptions were not being recorded, handled or stored securely.
- Prior to our inspection we were notified by NHS England that prescriptions were being used fraudulently and that these prescriptions had been obtained from the Somerset OOH service (Wellington House). We received a Statutory Notification from the provider six weeks after they had been alerted to fraudulent use of prescriptions.

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We requested further information regarding the incident which was not received prior to our inspection. The service later notified us that additional prescriptions had been stolen from an OOH site. This demonstrated prescriptions were not being handled or stored securely allowing them to be obtained by members of the public.

- On the day of this inspection we spoke to staff at the host site for one of the OOH services. They advised us their reception staff had found the key to the medicines cupboard at the OOH site in the door and the cupboard unlocked. This was confirmed via the incident reporting system, and by the Wellington House performance and operations report for July 2017. During our visit to this site we saw there was no process in place whereby OOH staff checked the rooms prior to leaving. We looked at the administrative system for incident reporting within the service and saw records which indicated that medicines had also been left unsecured at other OOH sites. For example, on 7 June 2017 medicines had been left out in a consulting room. This further demonstrated medicines and prescriptions were not stored securely.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. The provider held a Home Office licence to permit the possession of controlled drugs within the service. Previously we had found the record books for the controlled drugs register for Schedule 2 medicines at the OOH sites were not always completed correctly and in line with legislation for managing and using controlled drugs. At one site we saw inconsistencies with reconciliation of an ampoule of Diamorphine which had been given to another site. During this inspection we found the registers for controlled drugs (CD) of Schedule 2 medicines at OOH sites we visited were not always completed correctly and in line with legislation for managing and using controlled drugs.
- Medicines identified as at risk of misuse, were subject to additional security. However at one OOH site we saw inconsistencies with the completion of the blue medicines record books for scheduled medicines such as Diazepam and Tramadol. We looked at the administrative system for incident reporting within the service and saw incidents relating to missing medicines. For example, we saw two entries where boxes of codeine tablets were missing from stock and one entry where Tramadol was found to be missing from a sealed envelope. The CQC have not received statutory notifications with regards to these incidents and there is no evidence that they were reported to the Police. This meant incidents, which may affect someone's health, safety and welfare or could require a criminal investigation were not reported appropriately.
- We looked at the medicines stock including emergency medicines at the OOH sites we visited and within the vehicles. We saw that clinicians prescribing and supplying medicines were giving patients medicines in their original packaging which meant patients were receiving medicines which were easily identified with the name and dose. All medicines we checked were in date and stored appropriately in tamper evident boxes.

Monitoring risks to patients

Previously we had found that the provider did not have an oversight of risk assessments and safety checks for monitoring and managing risks to patient and staff safety. During this inspection we saw:

- There was a health and safety policy available with a poster in an area accessible to all staff. Risk assessments and health and safety documentation were easily located and Control of Substance Hazardous to Health (COSHH) sheets and product data sheets were in place. A health and safety lead was not in post however, we saw the service had an interim lead and plans for a new member of staff to undertake comprehensive health and safety training.
- Fire drills had taken place at the Wellington House location and the provider had been able to evidence how many staff had attended these. Staff at Out Of Hours (OOH) sites had previously advised us they had not participated in host site training around fire evacuation and safety. At this inspection there was no evidence that staff at OOH sites had undertaken the necessary fire evacuation training in order for them to identify alarm systems and evacuation processes specific to locations. The staff we spoke to on the day were unable to tell us what the procedure was. We saw the OOH sites had the host organisations overarching fire evacuation & shelter policy but this was not specific

Are services safe?

to each hospital. The provider's action plan against our warning notices stated there would have been 1:1 communication on fire evacuation with all staff however we found no evidence this had happened.

- At our previous inspection staff working within the OOH sites had told us they felt unsafe as there was a lack of a clear arrangement for lone working for the OOH sites and some of the safety measures in place such as intercom systems and security shutters did not work effectively. Following that inspection an independent health and safety risk assessment had taken place at each of the OOH sites. Resulting actions included a lone working plan however, the completion date for the actions were September 2017 which was after the date we have told the provider they must be compliant.
- There was a system in place to ensure non-clinical and clinical equipment was maintained to an appropriate standard and in line with manufacturers' guidance such as annual servicing of electrical equipment at the headquarters at Wellington House and for the equipment used at OOH sites. On our site visits we found some equipment without evidence of calibration for example, a thermometer and an otoscope. We observed there was equipment missing from one box such as a lubricating sachet, eye drops and urine testing sticks. We also found out of date urine testing sticks within one of the cars. There was no system to calibrate the blood glucose monitors which meant readings may not be accurate.
- All incident forms for accidents that occurred locally were accessible to staff and records reviewed by us had been completed in full and appropriate action had been taken as required.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups. The service had difficulties recruiting GPs. They employed 21 salaried GPs and relied on sessional GPs for additional shift fill.
- We reviewed the OOH rota and saw vacancies within the rota for OOH clinicians; the workforce shift analysis confirmed there were unfilled shifts and gaps within clinical staffing which impacted on the service being able to provide a timely service. For example, one OOH site had a fill rate of 81.5% and 73.8% for June and July 2017 respectively. At other OOH sites the fill rates were 88% and 87.7%, and 62% and 72.9% respectively. We looked at the shift rota and found unfilled shifts which led to sporadic shift cover. For example, on a Saturday in August 2017 three out of the four 4pm until 10pm shifts for one OOH site were unfilled. Another OOH site was closed and another had no GP cover from 8am until 11pm. In addition patients could not be directed to a fourth OOH site between 4pm-2am as there was no cover. The daily shift supervisor report for that day stated there were not enough GPs to undertake home triage. For patients this could mean further travel to other OOH sites or the unavailability of a face to face consultation. The service had produced a remedial action plan where shortfalls had been identified however the governance processes for the service had failed to address some of the issues the service faced in a timely manner, such as performance targets, and they had failed to support sustained improvement.
- Staffing for the NHS 111 service also faced recruitment difficulties. Data for the June 2017 monthly performance report showed that the NHS 111 service should have 26 whole time equivalent (WTE) call advisors. 22.8 WTE call advisors were employed in the service (excluding agency) with a 47 % absent rate. For clinical advisors 5.5 WTE were employed out of the 10.6 WTE required. In June 2017 there was an absence of 35%.
- The impact of low staffing levels led to breaches of NQR 12: whereby providers must ensure that face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed: Emergency: Within 1 hour; Urgent: Within 2 hours; less urgent: Within 6 hours. The inspection team looked at data for NQR12 which covered the period May to July 2017. Although there was some improvement in some areas such as NQR12 c: a clinical assessment at an OOH site for all urgent care patients within 6 hours. Other areas such as NQR12e: Clinical assessment for all urgent care patients at home within 2 hours showed deterioration. We saw the operations and performance reports for May 2017 reported 170 breaches of the target, in June 2017 there had been 190 breaches. Targets for NQR12b, c, e, and f remained below the 95% contracted target. For example, the July 2017 performance and operations report showed 87.2% of the target for patients to be

Are services safe?

seen within two hours at an OOH site (NQR12b) and 75.6% for patients requiring a home visit to be seen within two hours. This meant patients may not receive timely safe, clinically effective and responsive care.

- On arrival at Wellington House we observed the windows on the ground floor to be open. The building is situated in a public area with a pedestrian pavement around the edge of the building. Staff from the NHS111 service could be heard speaking to patients on the telephone and computer screens were visible. We spoke to the Registered Manager about our concerns for confidentiality. We were advised that window screens were due to be installed however potentially confidential conversations would still be heard by people passing the open windows. During our inspection the windows were not closed. This demonstrated that by their actions Vocare failed to take appropriate action to protect confidential patient information.

Arrangements to deal with emergencies and major incidents

- At our previous inspection non-clinical staff we spoke to had told us they had not received basic life support training (BLS), including use of an automated external defibrillator. Since our previous inspection defibrillators had been made available at each OOH site in addition to those carried within the vehicles.
- During this inspection we looked at the training system data and saw not all staff had received BLS training. For example, 46% of drivers had received e-learning training. The e-learning system included information on defibrillator usage. However staff we spoke to told us they had not received training to use the defibrillators, some of which are new following our previous inspection.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

At our previous inspection on 24 & 25 April 2017 we rated the service as inadequate for providing well-led services for the Out Of Hours and NHS 111 services as the delivery of high-quality care was not assured by the leadership and governance in place at the service. There was no contingency to ensure governance arrangements were managed effectively when key management staff were absent such as health and safety. Significant issues that threaten the delivery of safe and effective care were not adequately managed.

Our substantial concerns with some aspects in the well-led domain led us to take further steps to ensure that the provider made changes to the governance of the service to reduce or eliminate the risks to patients. The provider was required to make improvements in respect of these specific deficits, as outlined in the warning notices by 18 August 2017.

We issued warning notices in regard to:

• Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

• Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.

During our follow up inspection of 24 August 2017 we saw some improvements however, the provider was not always operating and implementing effective systems or process to assess, monitor and improve the quality and safety of the services. There were not always effective systems for assessing, monitoring and mitigating risks relating to the health, safety and welfare of service users and others who may be at risk.

Governance arrangements

Wellington House Out Of Hours (OOH) and NHS 111 is a registered location for Vocare Limited, a large national organisation, with strategic and operational policies and procedures in place. The service had an overarching governance framework that supported the delivery of the national strategy. This outlined the structures and procedures in place. Locally clinical governance procedures and reporting pathways were established and regular clinical governance meetings were undertaken by the senior management team. However, during our previous inspection we found the governance processes for the service had failed to address some of the issues the service faced in a timely manner, such as performance targets, and risks to patients where they had failed to support sustained improvement.

- The provider had a good understanding of their performance against National Quality Requirements but they had not responded in a timely manner to the staffing shortages that resulted in them failing to attain the requirements. Performance monitoring arrangements were in place with the clinical commissioning group. Somerset Clinical Commissioning group had previously issued a Contract Performance Notice on 27th March 2017 relating to the non-compliance of NQR12b, c, e and f and shift fill levels.
- A recovery action plan had been developed by Vocare however the clinical commissioning group had not signed this off due to continued staff vacancies within the service.
- At our previous inspection we saw evidence of a provider-level programme of clinical and internal audit, used to monitor quality and to make improvements however audits of the service did not always support improvement such as comfort calling. Comfort calling rates continue to remain below the 95% target.
- We continued to see little evidence of additional measures being put in place to improve expected outcomes and saw evidence that staffing rates for NHS 111 and for clinicians within the Out Of Hours (OOH) service remained low with high absences in some areas.
- We looked at the available clinical audits which should be improved. An audit of the quality of post event messages indicated poor safety netting. We saw evidence a message around safety netting was within the July clinical newsletter however quality improvement actions had not been recorded within the audit.
- At our previous inspection we were told fifty face to face patient records are audited each month and Out Of Hours clinicians had five calls to patients audited every six months. We told the provider this level of activity was insufficient to effectively monitor the quality of work of each clinician working within the service. We were told the service had reviewed the regularity by which the GP call audits were carried out however evidence looked at showed call auditing levels remained the same. There had been no increase in activity of monitoring or risk

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

assessments in place to evidence the provider's decision making. There continued to be little evidence that clinical audit processes were driving improvement in patient outcomes or those improvements were implemented and monitored.

- We saw there had been an improvement in the backlog of call auditing for the NHS 111 service with reviews for call handlers now being achieved.
- Prior to our inspection the CQC had met monthly with Vocare to discuss actions in relation to the warning notices dated 17 May 2017 and the CQC NHS 111 and Out Of Hours (OOH) reports published 4 August 2017. The service had produced an action plan where shortfalls from our previous inspection had been identified. We reviewed the most up to date version of the action plan where actions had been marked as green to indicate they were met. However during our inspection we found evidence that actions had not always been completed, which was contradictory to the evidence supplied prior to inspection.
- The provider offered a wide range of statutory and mandatory training with a new and improved e-learning management system and a focus on continuous learning and improvement at all levels within the service. The training system data showed some improvements in staff completing the required training. Whilst we saw improvement to the number of staff completing the appropriate training, overall not all staff had fully completed their mandatory e-learning. Compulsory training is essential for the safe and efficient delivery of care and poor completion rates equate to an increase to organisational risks and in some cases non-compliance with national policies and government guidance.
- The governance systems and processes to identify and manage risks and issues were not always robust. This meant there was not an effective system or process to assess, monitor and improve the quality and safety of the services provided or to assess monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk arising from the carrying on of the regulated activities. For example, the provider could not provide evidence of some recruitment checks in a timely manner and therefore could not demonstrate the suitability and qualifications of their workforce. Reported significant events such as loss of blank prescriptions from the service had not led to an overall improvement in the safety and security of blank prescriptions.
- We found the detail within the complaint system was consistent and all sections of the reporting system were completed.
- Prior to and during this inspection we saw evidence that serious incidents including safeguarding referrals, had not resulted in statutory notifications to the Care Quality Commission.

This section is primarily information for the provider

Enforcement actions

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not ensured the privacy of service users.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Somerset County Council
Scrutiny for Policies, Adults and Health Committee
6 December 2017

Report on NHS Waiting Times for Somerset Patients

Lead Officer: Alison Henly, Chief Finance Officer and Director of Performance Somerset CC
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Cabinet Member:
Division and Local Member:

1. Summary

1.1. To provide an update to Scrutiny Committee upon Somerset Clinical Commissioning Group's performance against the key constitutional standards to period ending September 2017. The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. The focus of this report is upon the performance of these key access standards and the remedial actions in place to recover any performance shortfall.

2. Issues for consideration / Recommendations

2.1. The Scrutiny Committee are asked to note the following report.

3. Background

3.1. Introduction

3.2. Somerset Clinical Commissioning Group is not currently meeting a number of the key constitutional Access Standards, namely:

- RTT 18 Week Waiting Times
- A&E 4 Hour to Admission or Discharge
- Diagnostic 6 Week Waiting Times
- 62 Day Wait to First Definitive Treatment Following Urgent GP Referral

3.3. Referral to Treatment (RTT)

3.4. RTT The total number of Somerset patients awaiting treatment as at 30 September 2017 was 36,138 of which 4,769 experienced a wait in excess of 18 weeks and the number of patients awaiting treatment at Taunton and Somerset NHS Foundation Trust was 19,290 of which 3,329 are waiting in excess of 18 weeks.

3.5. The table below reports the monthly performance for 2017-18 (April-September 2017) for the Providers whereby Somerset CCG is the Lead Commissioner, alongside SCCG total commissioned performance:

Provider	Measure	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Taunton & Somerset NHS Foundation Trust	Plan	84.4%	84.6%	84.7%	84.9%	85.1%	85.4%	85.6%	85.9%	86.2%	86.5%	86.8%	87.2%	85.6%
	Actual	84.9%	85.1%	85.6%	85.2%	85.1%	84.3%							85.0%
	Variance	0.4%	0.5%	0.9%	0.2%	0.0%	-1.0%							-0.6%
Yeovil District Hospital NHS Foundation Trust	Plan	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
	Actual	93.2%	94.5%	95.0%	95.1%	95.3%	95.0%							94.6%
	Variance	1.2%	2.5%	3.0%	3.1%	3.3%	3.0%							2.6%
Somerset Partnership NHS Trust	Plan	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
	Actual	97.7%	99.6%	99.5%	99.3%	99.3%	98.9%							99.1%
	Variance	5.7%	7.6%	7.5%	7.3%	7.3%	6.9%							7.1%
Somerset Clinical Commissioning Group	Plan	88.8%	88.4%	88.0%	88.0%	88.0%	86.8%	86.5%	86.1%	85.7%	85.3%	85.0%	84.6%	86.8%
	Actual	88.2%	88.8%	89.1%	88.9%	89.0%	88.4%							88.8%
	Variance	-0.5%	0.4%	1.1%	0.9%	1.0%	1.6%							2.0%

3.6. Somerset CCG met the operational planning trajectory in September and has met the ambition in every month of 2017-18, with the exception of April 2017. However, in September as a result on an increase in the backlog and reduction in clock stops at Taunton & Somerset NHS Foundation Trust, the local planning ambition was not met.

3.7. Taunton and Somerset NHS Foundation Trust has updated their RTT Remedial Action Plan (which is underpinned by NHSI approved Demand and Capacity modelling) which outlines the improvement actions required to return specialities to operational compliance.

3.8. The specialities with the greatest level of backlog are: General Surgery, Trauma and Orthopaedics, Ophthalmology, Gastroenterology and Other Specialities (which is a combination of other smaller (generally medical) specialities) and have accumulated due to a combination of increased demand (particularly cancer), sub-speciality demand, workforce shortfalls (and reliance upon Locum workforce) and inability to sub-contract with the Independent Sector (case mix) and ability to carry out waiting list initiative works.

3.9. Patients in Somerset experienced a median RTT waiting time of 30 weeks in September 2017; this reports the accumulated waiting times for all patients who have completed treatment during the month and includes the combined wait of the first out-patient appointment, diagnostic test and in patient procedure.

3.10. Somerset CCG is meeting with Taunton and Somerset NHS Foundation Trust on a monthly basis to review progress against the specialty level actions detailed within the Remedial Action Plan. A monthly Access and Performance Group meeting also attended by the Regulators takes place on a monthly basis to review performance and to agree additional improvement for the key access standards.

3.11 The number of patients whose waiting time exceeds 40 weeks has increased at Taunton and Somerset NHS Foundation during 2017-18 although the number patients exceeding 52 weeks has stabilised and started to reduce due to the proactive management of these long wait pathways. The Trust reported 20 patients who exceeded 52 weeks as at 30 September 2017 and occurred due to a combination of clinical complexity, patient choice and capacity. All patients have treatment plans in place and are clinically reviewed for harm once they reach 38 weeks if they have either not been seen by a consultant in the past month or do not have a consultant appointment scheduled within the next month; patients are also re-assessed again at week 52. Focused actions to reduce this tail of long waits have been incorporated into the new 52 Week Improvement Plan and specific speciality actions incorporated into the RTT improvement plan. The Trust has introduced an RTT Expert Panel that meets fortnightly; this group of RTT experts review long wait complex pathways with the specialities in order to identify the required next steps. In addition, a new 'RTT Tracker' post has been created to facilitate the progress of these long wait pathways with the Directorates and Somerset CCG has established an internal group across the Commissioning, Quality and Performance teams to continually review the Trust's improvement plan and trajectory to deliver zero tolerance of over 52 week waits and will continually work with the Trust with the outcomes of these discussions to be assured of delivery.

3.12. Where patients wait has exceeded 52 weeks a formal review process for each patient is conducted by the service provider. The CCG as commissioner receives copies of the reviews for oversight. The review seeks to identify whether the individual has been harmed by the extended wait. The process also presents another opportunity to uncover and learn from shortfall in operational systems which have caused or contributed to the extended wait. Currently these reviews have not identified clinical harm arising from extended waiting. The reviews have been helpful in identifying issues causing delays to completing treatment pathways. For example, it was discovered through this route that completion of calprotectin tests (faecal matter sample) as a final confirmatory all clear test was often slow to be completed. Patients are advised this is a "belt and braces" test at the end of treatment / diagnosis confirmation, just to be sure and not seen as a priority to return the sample to the hospital.

3.13. The CCG is seeking to extend the scope of these 52 week wait reviews to include:

- a review of any additional appointments connected with the extended wait which may have been avoided, and
- consideration of the social impact of the extended wait on the individual and their family

Alternatively a better resolution will be the elimination of these extended waits.

3.14. From September 2017, Taunton and Somerset Trust has facilitated the transfer of up to 25 trauma and orthopaedic cases per month to Yeovil District Hospital NHS Foundation Trust in order to reduce the backlog and is in discussion to transfer gastroenterology (diagnostic) cases.

3.15. Yeovil District Hospital NHS Foundation recovered RTT performance from January 2017, and has continued to deliver improved performance throughout 2017-18 resulting in Trust to Somerset performance in September of 95.0%.

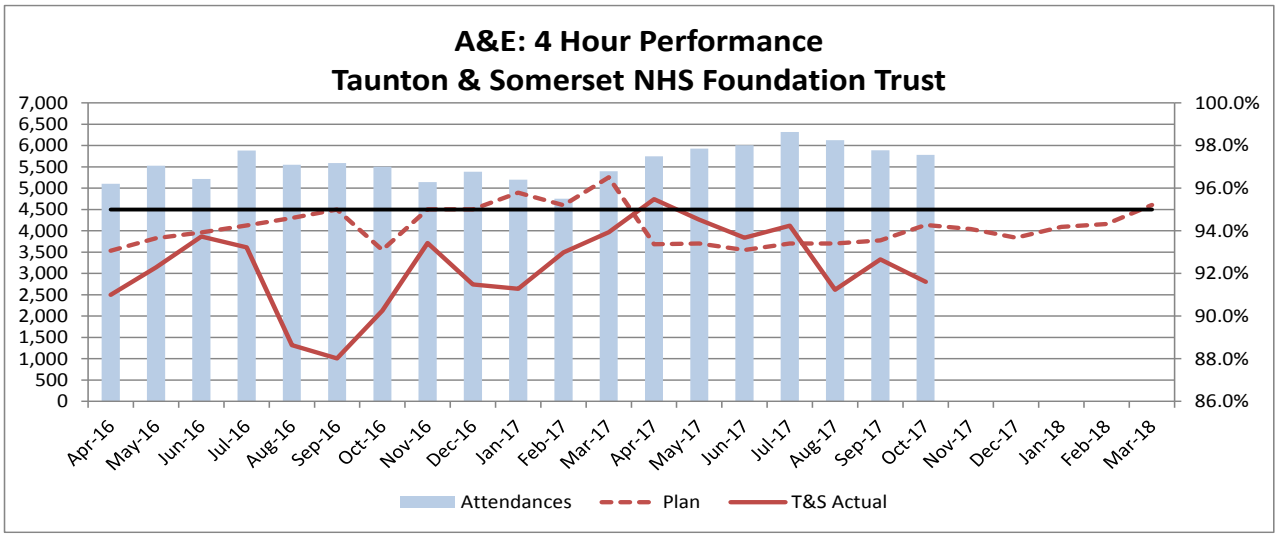
3.16. A&E 4 Hour Wait To Admission Or Discharge

3.17. A&E 4-hour performance is reported nationally on a Trust-wide basis by Type 1 (Acute) and Type 3 (MIU) Providers on a monthly basis; however daily reporting is also in place in order to monitor daily, weekly and monthly performance on a local basis.

3.18. The table below reports the monthly performance for 2017-18 (April-October 2017) for the Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust. (Please note, daily A&E attendances are also received from Weston Area Health NHS Trust and Royal United Hospital Bath NHS Foundation Trust, where Somerset's weighted performance is 16% and 12% respectively).

Provider	Measure	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Taunton & Somerset NHS Foundation Trust	Plan	93.4%	93.4%	93.1%	93.4%	93.4%	93.6%	94.3%	94.1%	93.7%	94.2%	94.3%	95.2%	93.8%
	Actual	95.5%	94.5%	93.7%	94.2%	91.2%	92.7%	91.6%						93.3%
	Variance	2.1%	1.1%	0.6%	0.8%	-2.2%	-0.9%	-2.7%						-0.5%
Yeovil District Hospital NHS Foundation Trust	Plan	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
	Actual	98.2%	98.7%	97.6%	97.9%	98.2%	97.7%	98.1%						98.1%
	Variance	3.2%	3.7%	2.6%	2.9%	3.2%	2.7%	3.1%						3.1%

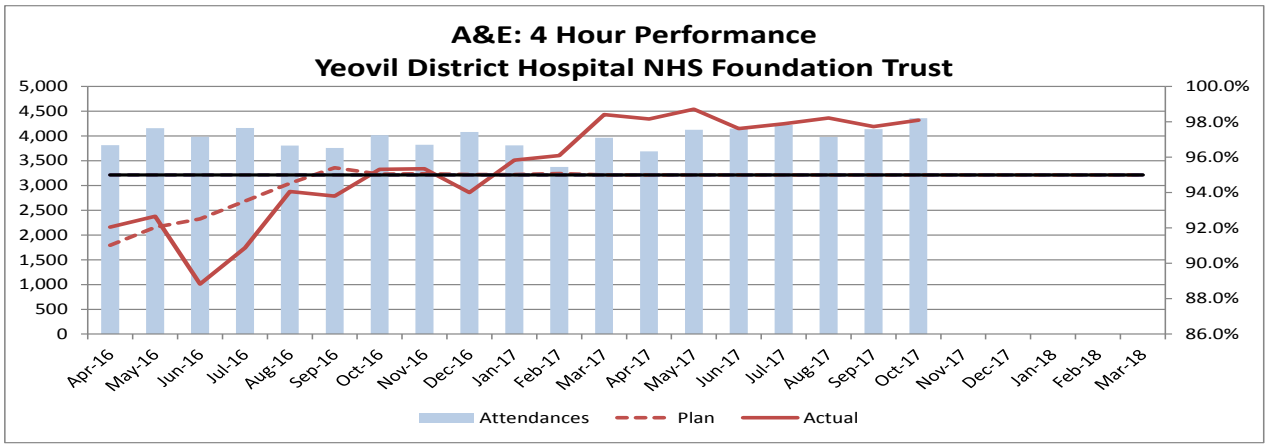
3.19. With the exception of April 2017 Taunton and Somerset NHS Foundation Trust have not met the operational standard since July 2015.



3.20. Taunton and Somerset NHS Foundation Trust has experienced a 9.97% increase in attendance when comparing April-October 2017 to the same period of the previous year and the level of attendance during October 2017 has increased upon the previous month. A detailed analytical review has been undertaken in order to understand the key drivers of growth; the reasons are multi-factorial and include an increase in the local population, changes healthcare provision (including the temporary overnight closure at Weston) and patient acuity. The Access and Performance Group taking place on

Tuesday 21st November 2017 is focused upon Urgent Care and Winter Planning and a further update report will be provided following this Trust, CCG and Regulator discussion.

3.21. With the exception of December 2016 Yeovil District Hospital NHS Foundation Trust has met the operational standard since October 2016.



3.22. Yeovil District Hospital NHS Foundation has experienced a 3.98% increase in attendance when comparing April-October 2017 to the same period of the previous year. The level of cumulative growth has further increased on the previous month as a result of a further increase in attendance when comparing September 2017 to October 2017. Whilst this increase coincides with the closure of the Yeovil walk in centre from 31st August 2017 there has been a sustained increase in the level of ambulance arrivals over the past 2 months which is suggestive of an increase in patient acuity.

3.23. Despite this increase in attendance, the 4-hour performance remains strong at Yeovil District Hospital NHS Foundation Trust and is in the top 5 of top performers nationally. There is a strong link between the improvements within the Ambulatory Emergency Care (AEC) and Frail Older Persons Assessment Service (FOPAS) pathways and the improvement in A&E performance.

3.24. Diagnostic Waiting Times

3.25. Somerset Clinical Commissioning Group has not met the six week waiting time national standard of 99% since November 2013 as a consequence of underperformance predominantly at Taunton and Somerset NHS Foundation Trust. The table below reports the monthly performance for 2017-18 (April-September 2017) for the Providers whereby Somerset CCG is the Lead Commissioner, alongside SCCG total commissioned performance:

Provider	Measure	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Taunton & Somerset NHS Foundation Trust	Plan	95.3%	95.5%	95.8%	96.4%	96.5%	97.0%	97.2%	97.4%	97.6%	97.9%	98.0%	98.1%	96.9%
	Actual	93.5%	94.7%	91.5%	93.6%	94.0%	93.8%							93.5%
	Variance	-1.7%	-0.9%	-4.3%	-2.7%	-2.5%	-3.1%							-3.3%
Yeovil District Hospital NHS Foundation Trust	Plan	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%
	Actual	98.8%	98.3%	99.5%	99.2%	99.6%	98.8%							99.0%
	Variance	-0.2%	-0.7%	0.5%	0.2%	0.6%	-0.2%							0.0%
Somerset Clinical Commissioning Group	Plan	97.1%	97.3%	97.5%	97.5%	97.5%	98.1%	98.4%	98.6%	98.8%	99.0%	99.0%	99.0%	98.2%
	Actual	95.8%	96.0%	94.6%	95.8%	95.4%	95.7%							95.6%
	Variance	-1.4%	-1.3%	-2.9%	-1.7%	-2.2%	-2.4%							-2.6%

3.27. Somerset CCG met the operational planning trajectory in September and has met the ambition in every month of 2017-18, with the exception of April 2017. However, in September as a result on an increase in the backlog and reduction in clock stops at Taunton & Somerset NHS Foundation Trust, the local planning ambition was not met.

3.28. Taunton and Somerset NHS Foundation Trust did not meet their diagnostic waiting times improvement ambition (as included within the Diagnostic Remedial Action Plan) during September 2017; whilst the number of 6 week breaches are comparable to the previous month capacity issues continue within the CT and MRI services accounting for approximately 60% of diagnostic waiting time breaches. The agreed improvement trajectory shows incremental performance improvement throughout 2017/18; however there are ongoing challenges as a consequence of the increased cancer demand, workforce constraints and the vulnerability of the endoscopy service. The Remedial Action Plan outlines actions, which include securing additional activity and strengthening the workforce and is reviewed on a monthly basis where Somerset CCG is in attendance. SCCG has explored through the Policy Forum potential demand management opportunities with a focus initially upon DEXA and Non-Obstetric ultrasound and in addition, a benchmarking exercise has been undertaken in order to compare the level of elective and unscheduled demand against other similar sized providers to identify if there are any other opportunities to reduce the overall level of demand. The Trust is reviewing all patient choice breaches; this type of breach accounts for approximately one third of the overall breaches (100 per month) and different approaches to agreeing appointments with patients when they are unavailable by telephone are being explored and trialled to reduce this type of breach.

3.29. Yeovil District Hospital marginally missed the 6 week operational standard in September as a result of an increase in breach in the audiology and echocardiography services. The factors leading to an increase in breach in respect of echocardiography is linked to a workforce shortfall; although the Trust have secured the services of a Locum additional support is required and the Trust is exploring further options to reduce the level of breach. The factors impacting upon audiology performance has been two-fold; there has been an increase in demand which has been further compounded by unexpected long term sickness in the Team. Additional sessions are being scheduled to swiftly reduce the backlog but the Trust anticipates that the operational standard will be missed in October due to these factors but are doing all they can to mitigate the risk of this.

3.30. The waiting times for a diagnostic test or procedure at other Providers is being closely monitored and any unexpected incidence of breach is explored with remedial actions put in place as required.

3.31. Cancer 62-Day to Treatment Waiting Times

3.32. Somerset Clinical Commissioning Group has not met the 62-Day Operational Standard during 2017-18, with under-performance (to varying degrees) occurring at all Somerset Providers.

Measure	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	1568	1760	1890	1932	1918	1659
		141	113	125	141	163	128
		1427	1647	1765	1791	1755	1531
		91.01%	93.58%	93.39%	92.70%	91.50%	92.28%
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially	93%	99	97	93	74	69	82
		8	9	11	6	7	9
		91	88	82	68	62	73
		91.92%	90.72%	88.17%	91.89%	89.86%	89.02%
62 day wait - % treated in 62 days from GP referral	85%	120	173	159	159	180	159
		20	34	26	28	33	33
		100	139	133	131	147	126
		83.33%	80.35%	83.65%	82.39%	81.67%	79.25%
62 day wait - % treated in 62 days from screening programme	90%	16	19	22	23	20	17.5
		1	2	0	1	1	0
		15	17	22	22	19	17.5
		93.75%	89.47%	100.00%	95.65%	95.00%	100.00%
62 day wait - % treated in 62 days from consultant upgrade	90%	20	30	32	24	35	17.5
		0	7	4	3	5	1
		20	23	28	21	30	16.5
		100.00%	76.67%	87.50%	87.50%	85.71%	94.29%
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	96%	221	299	307	284	316	280
		5	11	12	8	4	8
		216	288	295	276	312	272
		97.74%	96.32%	96.09%	97.18%	98.73%	97.14%
31-Day Standard for Subsequent Cancer Treatments-Surgery	94%	62	71	86	73	69	57
		7	4	3	2	2	2
		55	67	83	71	67	55
		88.71%	94.37%	96.51%	97.26%	97.10%	96.49%
31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens	98%	80	118	124	126	131	106
		0	0	0	0	0	0
		80	118	124	126	131	106
		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a	94%	112	101	96	107	100	86
		3	3	1	2	2	4
		109	98	95	105	98	82
		97.32%	97.03%	98.96%	98.13%	98.00%	95.35%

3.33. In September 2017 Taunton and Somerset NHS Foundation Trust did not meet the 62 day to definitive treatment following urgent GP referral standard; the primary reasons for breach were:

- capacity constraints within the 2 week pathway (namely CT and MRI)
- increase in the number of patients with multi-site cancer or co-morbidities
- medical deferral
- referrals to specialist centres for diagnosis or treatment

3.34. Taunton and Somerset NHS Foundation Trust is sharing with the CCG a weekly monitoring report which reports the number of un-dated patients who have exceeded the 62-day waiting time standard and consistent with the Trust's plan to address this backlog, the numbers of both diagnosed and un-diagnosed over 62-day GP waits are reducing. The Trust anticipates delivery of the operational standard from Q4 2017-18.

3.35. In September 2017 Yeovil District Hospital NHS Foundation Trust did not meet the required level of performance for the 62 day to treatment standard and the reasons are multi-factorial; the first is linked to a manual pathway for recall in Endoscopy as a result of an identified issue tracking patients within their PAS system. The position was immediately addressed and rectified with controls put in place to prevent a reoccurrence. The second issues relates to urology whereby the Trust has been unable to recruit 2 urologists. The Trust's 62-Day Improvement Plan is currently being updated and will be shared in due course; the Trust is also working with the national team as part of the cancer diagnosis initiative to drive improvements in performance.

4. Consultations undertaken

4.1. Not applicable

5. Implications

5.1. Not applicable

6. Background papers

6.1 Not applicable

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

Somerset Suicide Prevention Scrutiny Report

Lead Officer: Christina Gray, Consultant in Public Health
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Cabinet Member: Christine Lawrence
Division and Local Member: NA

1. Summary

1.1. Suicide is a major issue for society and a leading cause of years of life lost. In Somerset, the suicide rate is 10.7 per 100,000 (2014 – 16). This means an average of 50 people have died each year by suicide in Somerset between 2014-2016. Public Health England estimate that the number of years of life lost due to suicide in Somerset was 131 years (or 31.7 years per 10,000 people). https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

1.2. A death by suicide is usually the end point of a complex history of risk factors and distressing events. Action to prevent suicide has to address this complexity. Issues of depression, self-harm and substance misuse are all common factors, with relationship breakdown or loss of employment being common triggers in Somerset, as elsewhere.

1.3. The prevention of suicide is the responsibility of every organisation, and of every function within each organisation. There is also a role for every individual. No one agency or individual can address this issue alone.

1.4. Somerset County Council, through its health and wellbeing duties holds responsibility for ensuring that appropriate and sufficient local arrangements are in place to prevent suicide. This report provides an overview of Suicide Prevention arrangements in Somerset, which are overseen by the Somerset Suicide Prevention Advisory Group.

2. Issues for consideration / Recommendations

2.1. Members are asked to note the Suicide Prevention Strategy and action plan for Somerset; and the need for this to be refreshed during 2018 – 19.

2.2. Members are asked to acknowledge and endorse the role of a multi-agency partnership to reduce the number of suicides and to support people who have been bereaved by suicide.

3. Background

3.1. Statutory Duties and Responsibilities

In the UK, suicide is defined as; *deaths given an underlying cause of intentional self-harm or injury/ poisoning of undetermined intent*. When someone dies it is referred to as 'completing suicide' or 'taking their own life'.

From 2013, with the transfer of public health duties into local authorities, upper tier and unitary authorities assumed additional responsibility for oversight and leadership in relation to suicide prevention working closely with clinical commissioning groups, police, other authorities and the voluntary sector. Part of this responsibility includes collecting and analysing suicide data to inform the development of the suicide prevention strategy and action plans.

The government's national strategy for England, *Preventing suicide in England: a cross-government outcomes strategy to save lives* sets out the recommendation *to* develop a local suicide prevention strategy, and to have in place an action plan with a multi-agency partnership to oversee the delivery of the plan.

This recommendation is further supported by the requirements and ambitions set out in the more recent, *Five year forward view for mental health (NHS England).*

The Public Health Outcomes Framework (PHOF) and NHS Outcomes Frameworks include specific indicators for suicide as well as a range of other indicators that are likely to have an impact on suicide. These indicators should be used to inform action to be taken by local government and health services that have a mandatory duty to report against these indicators.

No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages advocate that suicide prevention starts with better mental health for all and that local prevention strategies should be informed by people who have been affected by suicide. This ambition is reflected in the local *Positive Mental Health for Somerset Strategy (3)*, and will inform Somerset's response to the recently launched *National Prevention Concordat for Better Mental Health.*

3.2. Action to Prevent Suicide in Somerset

Somerset has had a local Suicide Prevention Strategy (see appendix one) , action plan and partnership in place for over ten years. The Somerset Suicide Prevention Strategy, in line with the national strategy, 'Preventing Suicide in England' – a cross-governmental strategy to save lives has two principle objectives:

- To reduce the suicide rate in the general population
- To provide better support for those bereaved or affected by suicide

To support the objectives there are six areas of action, based on recommended best practice for preventing suicides.

Below is a summary of activities against these areas of action in the last year:

1. Reduce risk of suicide in high risk groups

The national strategy identifies a number of groups, communities and settings which are known to carry a higher risk of suicide and where focused action is recommended.

People in the care of mental health services, including inpatient clients are one of these higher risk groups. Somerset Partnership NHS Foundation Trust has its own suicide prevention plan which is reviewed and monitored regularly. One

aspect of this work are weekly safety audits within in-patient settings and meeting 48 hour follow up visits after discharge.

In response to findings from the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (2016). The CCG is undertaking a full review of the Crisis Response and Home Treatment Team (CRHTT) with Somerset Partnership Trust as part of a wider review of mental health services in the county. This will need to address an assessment of appropriateness of the location of care, criteria for accessing the service, clinical pathway and access onwards to specialist inpatient services. Equally to this, the role of the Community Mental Health Services (CMHS) in respect to the wider health and social care system, will need to be explored, as these patients will more often require multi-agency input into safeguarding and suicide prevention.

To address the higher risk for men a Somerset Men and Boys mental health network has been launched with series of activities and training.

Self-harm can be a risk factor for suicide, and a multi-agency steering group has been established to develop a whole system pathway to reduce self-harm admissions. This will be a particular focus for the Suicide Prevention partnership during 2018.

Farmers and agricultural workers are one of identified high risk occupational groups. Farmers Community Network is a member of the Somerset Advisory Group and is currently working with Somerset Partnership to identify a link worker with a background in farming. Special suicide prevention training sessions have taken place with the Network volunteers and a 'Fit for Farming' briefing written with a local GP.

2. Tailor approaches to mental health support in specific groups

Depression is one of the most important risk factors for suicide. The early identification and prompt, effective treatment of depression has a major role to play in preventing suicide across the whole population.

Primary Care has a key role to play and the CCG has focused on a number of to improve the quality of suicide prevention in primary care, these include:

- Supporting practices to embed the use of the Little Book of Mental Health, the Samaritans leaflets and the Help is at Hand leaflet into practices;

- Somerset GP Education Trust Mental Health Study Day to 80- GPs, including a one hour session to introduce GPs to formalised assessment and safety planning;

- Embedding the Connecting with People Training and Suicide Prevention Assessment Framework SAFETool in all EMIS systems. The SAFETool supports an evidenced based compassionate assessment in healthcare,

including Primary Care. The SafeTool helps identify risk and supports the construction of a SAFETY Plan together with the client. This implementation will fulfil one of the Key recommendations from DHR 013 to be published soon (DHR – Domestic Homicide Review) and will also satisfy a learning point raised by the Coroner around the consistency of documentation in Primary Care;

- The CCG is also investing in a clinical trainer to support the correct use of SAFETool;

An extensive programme of Specialist Suicide Prevention Skills Training is delivered in Somerset, commissioned by Public Health. This is a nationally accredited programme which is highly recommended best practice. The training is multi-disciplinary and post course evaluations have shown examples of interventions that have saved lives. It is particularly targeted at those staff working with high risk groups or vulnerable people such as social workers, police, early help, mental health nurses, housing support, drug and alcohol support workers, probation and One Team members etc...

The Suicide Prevention Advisory Group produced a newsletter to showcase some of the work being carried out to mark Suicide Prevention Day (see appendix two).

Deaths by suicide of children under 15 years old are, fortunately, a rare occurrence however when these do occur they are particularly distressing and can have a huge impact on peers. Post-suicide community-level interventions can help to reduce the impact and prevent further suicides. In Somerset, the Suicide Prevention Advisory Group has worked with Educational Psychologists and Samaritans to revise and improve the Critical Incidence Guidance for schools following a suicide. The Suicide Bereavement Support Service is developing a peer support group for children and young people.

3. Reduce access to the means of suicide

One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. Location and means of suicide are monitored quarterly by the Suicide Audit Group and any necessary preventative action taken.

Revised national guidance on ‘Preventing suicides in public places’ has been circulated.

Samaritans and Network Rail are working together in Somerset with good co-operation around Taunton Station.

A new piece of work has started and focuses on signs at pedestrian railway crossings, and the Environment Agency on waterways access.

4. Provide information and support to individuals bereaved by suicide

Effective and timely emotional and practical support for families bereaved by suicide is essential to help the grieving process and support recovery.

Somerset’s Suicide Bereavement Support Service has been available since 2012 and is delivered by Mind in Taunton and West Somerset, Cruse and the

Samaritans. Last year 40 people wanted individual support and 21 different people attended the peer support group. 30 people were given suicide bereavement support by Cruse. This service was one of the first to be established in the region.

A new focus group for people who have been affected by suicides has been set up to inform the action plan and carry out community awareness activities.

5. Support the media to report appropriately on incidents of suicide

The media have a significant influence on behaviour and attitudes in relation to the reporting of Suicide. Locally the role of the Suicide Prevention Advisory Group is to promote the national media guidelines for suicide reporting and to support the local press and media to understand the important role that they play in preventing suicide.

BBC Somerset have been an active partner in supporting and promoting appropriate reporting and have worked with the Suicide Prevention Advisory Group on a number of programme focussing on suicide and mental health.

On-going monitoring of local media reporting is undertaken. There has been some success in getting inappropriate reporting acknowledge and changed.

A well-attended local workshop focusing on Suicide and Mental Health in the Media was held with national speakers and chaired by Ben McGrail, ITV News West Country.

In 2015 Ben McGrail won a national MIND Media Award in the best radio programme category, for a three hour programme focusing on suicide prevention. Ben continues to be a great champion and advocate for positive mental health and Suicide prevention in Somerset.

6. Implement research, data collection and monitoring

It is important that we monitor trends and variation in suicide rates. This can help early identification of issues in specific areas or unexpected increases. This in turn allows for further, more detailed investigation and facilitates more effective and proactive prevention approaches

Somerset Public Health Department is responsible for undertaking the local suicide audit. The Somerset Suicide Prevention Audit Group meets throughout the year to review available information and initiate action.

Due to the retrospective nature of the official statistics, a local case audit system has been implemented to provide more timely information on deaths across Somerset. The Suicide Audit Group looks at cases prior to the coroner's verdict, which are thought likely to be the consequence of suicide. The case audit seeks further information on the circumstances surrounding each death, from GPs and other agencies and uses this information to inform the local action plan.

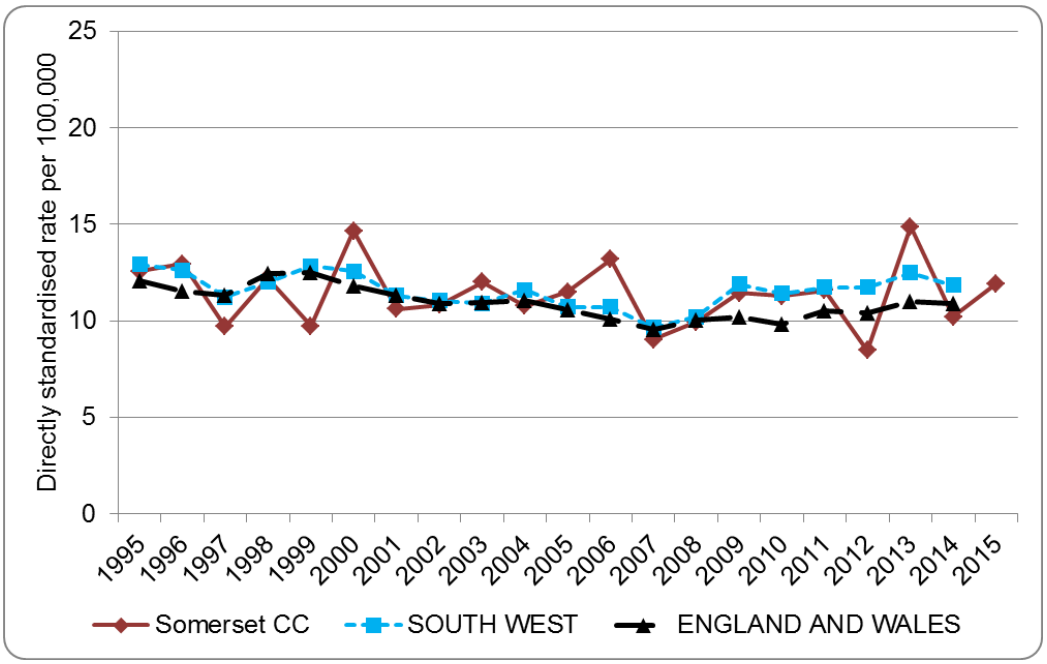
3.3. Suicide statistics for Somerset

Due to fluctuations in the number of suicide deaths, year on year, the suicide rate is calculated as a three year average. Local rates are subject to greater variation than national rates, due to the smaller numbers involved.

The suicide rate in Somerset of 10.7 per 100,000 (2014 – 2016).

The rate for Somerset, although higher, remains statistically similar to the rate for all of England (9.9 per 100,000) and to the rest of the South West (10.8 per 100,000).

The graph below illustrates the annual trends in mortality from suicide and undetermined death in Somerset, the South West and England & Wales, 1995 to 2015. This is for people aged 15 and over, and is the directly standardised rate per 100,000. This shows that although there has been variation within individual years, with some years having a higher number of deaths than other years. Overall, Somerset rates have remained reasonably stable and in line with the national rate.



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This Somerset rate of 10.7 per 100,000 equates to around 50 deaths by suicide each year. In line with the rest of England, around 70% of deaths are male.

The highest rates of suicide in Somerset are currently within the 35 – 64 age groups.

Deaths by suicide of children under 15 years old are, fortunately, a rare occurrence and these, as with all unexpected deaths of children under 18 years, will prompt a multiagency review and response.

The most common method of death is hanging and the most common place of death (over 50%) is at home. This is the same as the national picture.

There is a strong association between suicide rates and levels of deprivation. The rate of suicide and undetermined death for residents living in the 20% most deprived areas in the county is significantly higher than for Somerset as a whole.

There is variation in suicide and undetermined death across Somerset's five district council areas and action is taken accordingly when patterns are observed. However the variation is not statistically significant.

The suicide data is used to inform where any planned or reactive focus of intervention needs to be for Somerset.

3.4. Understanding suicide

Suicide is usually the end point of a complex history of risk factors and distressing events. Action to prevent suicide has to address this complexity. Issues of depression, self-harm and substance misuse are all common factors, with relationship breakdown or loss of employment being common triggers in Somerset, as elsewhere. Action to prevent suicide has to address this complexity and the commonly known factors that can influence a person to have suicidal thoughts and which can lead to attempts and final completion.

The effect of a death resulting from suicide on family and friends is devastating. Others connected to the person through work or education, or who were involved in providing support and care, may also feel the impact profoundly. Suicides are not inevitable. Each suicide is a personal tragedy. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

4. Consultations undertaken

4.1. The Suicide Prevention Advisory Group is made up of over 20 different organisations. The suicide prevention action plan is developed by this multi-agency group, which has carried out informal consultations within their own organisations. This is supported by a Community Forum made up of people with lived experience.

4.2. The Suicide Bereavement Support Service encourages feedback and this is included as part of the grant review process.

5. Implications

5.1. Suicide remains the biggest killer of men aged 49 and under, and the leading cause of death in people aged 15-24(1)

5.2. Suicide is now a leading cause of death directly related to pregnancy in the year after a mother gives birth (2)

5.3. Suicide is a health inequality issue. There are well established links between

suicide and social fragmentation and socio economic circumstances (1).

5.4. Promoting positive mental health and wellbeing and in particular fostering the emotional health and wellbeing of children and young people can help build individual and community resilience and help prevent suicide.

6. Background Papers

6.1. Appendix 1: Somerset Suicide Prevention Strategy
Appendix 2: Suicide Prevention Newsletter for World Suicide Prevention Day on 10 September.

7 References

7.1

1. House of Commons Health Committee, Suicide Prevention Sixth Report of Session 2016-2017
2. Confidential Enquiry into Maternal Deaths, December 2016
3. Somerset Positive Mental Health Strategy

SOMERSET SUICIDE PREVENTION STRATEGY

Somerset Suicide Prevention Advisory Group

SOMERSET SUICIDE PREVENTION STRATEGY

Document Status:	
Version:	

DOCUMENT CHANGE HISTORY

Version	Date	Comments
1.0	June 2004	Initial Version
1.1	November	2nd Draft following consultation
1.2	January 2005	Joint Executive Team
1.3	January	Joint Strategic Commissioning Board
1.4	March	Final Version
2.0	May 2008	Initial draft following review of Strategy
2.1	October 2009	Revised draft for stakeholder consultation workshop
2.2	February 2010	Version for PEC
2.3	November 2011	Document reviewed and action plan updated
2.4	November 2012	Consultation on refreshing the strategy
2.5	April 2013	Initial draft following review of strategy
2.6	September 2013	Revisions added due to period of transition and staff changes
2.7	April 2015	Revisions added to the action plan through consultation with the Suicide Prevention Advisory Group
2.8	April 2016	Revisions added to the action plan through consultation with the Suicide Prevention Advisory Group
2.9	April 2017	Revisions added to the action plan through

		consultation with the Suicide Prevention Advisory Group. The Revision of the strategy was put back to April 2018 due to prioritising updating the action plan and commitments of the multiagency partners.
3.0	April 2018	Consultation and Refresh the Strategy

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A COLLABORATIVE PREVENTION OF SUICIDE STRATEGY FOR SOMERSET

CONTENTS

1 EXECUTIVE SUMMARY

1.1 Suicide is a major issue for society and a leading cause of years of life lost. During 2010 in Somerset someone died from suicide approximately every 8 days. In the same year in England, as a whole, suicide claimed a life every 2 hours; this equates to over 4,200 deaths [(1)].

1.2 The national suicide prevention strategy is clear that suicide prevention is not the sole responsibility of any one sector or of health services alone. Indeed, only around a quarter of people who die from suicide in Somerset have been in contact with specialist mental health services during the previous year.

1.3 In the most recent national data, there were 4,507 suicides among people aged 15 and over in England in 2012. The age-standardised suicide rate remained static between 2011 and 2012, at 10.4 deaths per 100,000 population. It is interesting to see that when broken down by gender there is an approximate 3:1 ratio of deaths. 3,483 male suicides in 2012 and 1,024 female suicides.

1.4 The overall Somerset rate in 2012 stands at 8.2 deaths per 100,000 compared to England at 10.4 deaths per 100,000. The present overall south west rate is 11.9. The Somerset suicide rate is ranked fifth in the south west (from low to high). Approximately 70% of Somerset suicides were male in 2012. The rate of completed suicide is very similar for all age groups over 35, with the highest rates being in those aged over 75 for both men and women.

1.5 Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

1.6 Suicide affects all age groups and communities in our society. In fact, few people escape being touched by the devastating effects of suicidal behaviour in their lifetime. The emotional, social and practical repercussions of suicide are felt by family members, friends, neighbours, colleagues and people working in a wide range of services and agencies.

1.7 In September 2012, the Government launched the current national policy; *'Preventing Suicide in England: a cross-government outcomes strategy to save lives*'. This replaced the 2010 Strategy following a public consultation on the national strategy which took place between July-October 2011.

1.8 This document represents a second revision of the Somerset Suicide Prevention Strategy, first developed in 2004 and reviewed and revised 2010-2013. This 2013-2016 strategy provides a further update reflecting the progress made, emerging evidence and the current national strategy.

1.9 In Somerset, the specialist suicide prevention activities are monitored by The Somerset Suicide Prevention Advisory Group (see appendix B). It

has brought together all key stakeholders and enabled an increase in joint working such as Samaritan sessions in A&E Departments and liaison with police custody suites. The Distress Cards for professionals have been reported as an innovative programme[5] and the annual suicide prevention awareness workshop and suicide prevention skills training are highly valued.

1.10 The overall aim of the 2013-2016 Somerset Strategy is to achieve:

1. A reduction in the suicide rate in the general population in Somerset

2. Better support for those bereaved or affected by suicide.

1.11 The strategy includes a jointly developed action plan to reduce the incidence of suicide. It follows a similar framework to the National Preventing Suicide in England outcomes strategy and sets out an action plan based on six areas for action:

1.12 Reduce the risk of suicide in high risk groups:

These have been identified as; people in the care of mental health services, young and middle aged men, people with a history of self-harm, people in contact with the criminal justice system and specific occupational groups identified locally which includes farmers in Somerset. Individual plans for each risk group will be developed and includes implementation of good practice guidelines.

1.13 Promote mental health and wellbeing in the population as a whole:

As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the population as a whole. In Somerset we will implement the Public Mental Health and Wellbeing action plan to help build individual and community resilience, promote mental health and wellbeing and challenge health inequalities where they exist. This area of action will include continuing to role at suicide prevention skills training and also include tailored measures for groups with particular vulnerabilities or problems with access to services such as; children and young people, unemployed and people who misuse drugs and alcohol.

1.14 Reduce access to the means of suicide:

This will involve a partnership approach being led by Somerset Partnership Foundation Trust, emergency services and Somerset County Council as we look to undertake ligature point auditing, implementing health and safety risks when designing high rise structures and identifying hotspots often found in areas of outstanding natural beauty. The new NICE quality standard on ‘safe prescribing’ as related to reducing self-poisoning will also be promoted and disseminated.

1.15 Provide better information and support to those bereaved or affected by suicide:

Somerset's bespoke Suicide Bereavement Support Service will continue to provide emotional and practical support to those bereaved by suicide, including counselling and a peer support group. This service is delivered through a partnership between Mind in Taunton and West Somerset, Cruse, Barnardos and the Samaritans.

1.16 Support the media in delivering sensitive approaches to suicide and suicidal behaviour:

This will include the development of a communications strategy to help ensure the media understands and supports the need to take a sensitive approach. Monitoring local media reporting and disseminating the national Suicide Reporting Guidelines will be part of the action plan.

1.17 Support research, data collection and monitoring:

The Somerset Suicide Prevention Advisory Group oversees the implementation and monitoring of this action plan. Progress against its objectives will be recorded in the Somerset Audit Report.

1.18 Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. Achieving a reduction in suicide involves all agencies working together to reach more people who may be at risk of taking their own lives; which can only be achieved by understanding which groups of individuals are particularly at risk of suicidal thoughts and behaviours[17].

1.19 The economic impacts of suicide are profound, although comparatively few studies have sought to quantify these costs. In a recent London School of Economics Report[4], it is estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices). This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.

1.20 An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides. Statutory and voluntary services have a role to play. We can build individual and community resilience. We can ensure that vulnerable people in the care of health and social services and at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis.

1.21 This strategy is intended to provide an approach to suicide prevention that recognises the need to address these challenges through a multidisciplinary approach which will share the responsibility of reducing

suicides. It draws on local experience, research evidence and the national strategy.

SOMERSET SUICIDE PREVENTION STRATEGY

1 INTRODUCTION

1.1 Suicide is a major public health issue and is a devastating event for families and communities.[1] On average someone dies in England every two hours as a result of suicide. In 2011 there were 4,509 deaths from suicide.[1] Suicide is often the end point of a complex history of risk factors and distressing events. The prevention of suicide therefore needs to address this complexity. This strategy is intended to outline the local approach to suicide prevention and it recognises the contributions that can be made across all sectors of society. The strategy draws on local experience and expertise and national research evidence and guidance.

1.2 The government's mental health strategy *No Health without Mental Health*[5] was published in 2011 to improve mental health outcomes. It is important to acknowledge that suicide prevention starts with better mental health for all.

1.3 In September 2012, the current national policy, *'Preventing Suicide in England: a cross-government outcomes strategy to save lives*' was launched.[1] This replaced the 2010 Strategy on the back of the National Service Framework for Mental Health. This new strategy aims to reduce the suicide rate and improve support for those affected by suicide. The new national strategy emphasises local action and supports this by bringing together knowledge about groups at higher risk of suicide, identifying evidence of effective interventions and highlighting available resources.

1.4 This document represents a second revision of the Somerset Suicide Prevention Strategy, first developed in 2004. This 2013-2016 strategy provides a further update reflecting the progress made, emerging evidence and the current policy climate. The strategy includes a plan which contains six areas for action to reduce the incidence of suicide. It follows a similar framework to the National Preventing Suicide in England outcomes strategy and sets out an action plan based on six goals:

1. Reduce the risk of suicide in high risk groups
2. Promote mental health and wellbeing in the population as a whole
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

1.5 The Somerset Suicide Prevention Advisory Group oversees the implementation and monitoring of this action plan. Progress against its objectives will be presented to the Safer Somerset Partnership Board and recorded in the Somerset Audit Report.

1.6 Suicides are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides.[1] Statutory and voluntary services have a role to play. We can build individual and community resilience. We can ensure that vulnerable people in the care of health and social services and at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis.

2 DEFINITION AND TERMS

2.1 This Strategy covers a range of behaviours brought together under the heading "suicidal behaviour". It distinguishes between:

- **'Suicide'**: There is no universally accepted definition of suicide, as there are difficulties in determining the exact intent of a person who dies. However, a broad definition is: *'a fatal act of self-harm with a conscious intent to end life.'*[6] Not all suicides are preceded by suicidal behaviour. Sometimes they are an impulsive act or occur in a state of panic.

- **Deliberate self-harm:** Self-harm is: *'a deliberate non-fatal act whether physical, drug overdose or poisoning, done in the knowledge that it was potentially harmful and in the case of drug overdose that the amount taken was excessive.'*[6]

2.2 Injuring oneself is the objective and not a means to kill oneself. The intent of self-harm may be to stop conscious experience, interrupt conscious experiences, or be an appeal, or request, for help. It may be a way of coping, or surviving. It can take many forms, including poisoning and cutting. For many, it is focused on improving the situation and remains a way of coping with those feelings they cannot express.

2.3 Those who harm themselves in some way may or may not have had a suicidal intent. We are using "deliberate self-harm" as an umbrella term and it would encompass the terms "attempted suicide" and "parasuicide"

2.4 Effective strategies to reduce suicide within a population need to be mindful of the overlap between suicidal behaviour and deliberate self-harm. A proportion of the people who deliberately harm themselves are at increased risk of subsequently completing suicide; Hawton and Fagg suggest that people who self-harm are 20 times more likely to commit suicide within eight years than those who do not self-harm.

2.5 It is crucial that incidents of self-harm are properly recorded and the relevant information elicited. History of deliberate self-harm is a predictor of future injury. Repeated episodes, as distinct from a "one-off" impulsive response to an upsetting event, are a major risk factor for future serious self-harm and suicide. [7]

2.6 However, the relationship between suicide and self-harm is complex:

Some deaths which are classified as suicide may result from acts which were not intended to cause death or where the motivation (suicidal intent) was equivocal.

2.7 Likewise, some acts of deliberate self-harm may have been intended to result in death, but may have been foiled through rescue by others, imperfect knowledge, the choice of method, or some other reason.

2.8 Many acts of deliberate self-harm are not intended to end the person's life. Because of this overlap between the two behaviours, deliberate self-harm needs to be regarded as one of a range of risk factors associated with suicide. It would, however, not be appropriate to regard all deliberate self-harming behaviour as suicidal behaviour. Indeed, the majority of people who self-harm do not go on to take their own life.

2.9 This Strategy includes only those aspects of self-harming behaviour that might be considered as an indication of risk of suicide. It is recognised that there are other dimensions and manifestations of deliberate self-harm that are not covered within the Strategy's scope.

3 NATIONAL CONTEXT

3.1 In September 2012 the Department of Health launched *'Preventing* Suicide *in England: a cross-government outcomes strategy to save lives'.* This strategy aims to reduce the suicide rate and improve support for those affected by suicide and was informed by an earlier consultation on preventing suicide in England. The new strategy outlines six areas for action including: reducing the risk of suicide in key high-risk groups (for example, people in the care of mental health services, people with a history of self-harm, people in contact with the criminal justice system, and men aged under 50); reducing access to the means of suicide; and supporting research, data collection and monitoring.

3.2 There are two further key strategy documents that, in combination with *Preventing Suicides in England,* take a public health approach using general and targeted measures to improve mental health and wellbeing and reduce suicides across the whole population.

3.3 *Healthy Lives, Healthy People: Our strategy for public health in England* (2010)[8] gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. The inclusion of suicide as an indicator within the Public Health Outcomes Framework will help to track national progress against the overall objective to reduce the suicide rate[9].

3.4 *No health without mental health: A cross-government outcomes strategy for people of all ages* (2011) is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services [5]. The first agreed objective of *No health without mental*

health aims to ensure that more people will have good mental health. To achieve this, we need to:

- Improve the mental wellbeing of individuals, families and the population in general;
- Ensure that fewer people of all ages and backgrounds develop mental health problems;
- Continue to work to reduce the national suicide rate.

3.5 *No health without mental health* includes new measures to develop individual resilience from birth through the life course, and build population resilience and social connectedness within communities. These too are powerful suicide prevention measures.

3.6 From April 2013 local responsibility for coordinating and implementing work on suicide prevention became an integral part of local authorities' new responsibilities for leading on local public health and health improvement. Health and Wellbeing Boards will support effective local partnerships and will be able to support suicide prevention as they determine local needs and assets.

3.7 Public Health England, the new national agency for public health, will also support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing, including work on suicide prevention.[10]

3.8 The impact of stigma associated with mental health problems can also act as a barrier to people seeking and accessing the help that they need, increasing isolation and suicide risk. The need to address this is recognised through the Government and local authorities supporting the national mental health anti-stigma and discrimination Time to Change programme.[11]

3.9 There are a number of other national initiatives and sources including *Avoidable Deaths,* a five year inquiry into deaths from suicide and homicide among people suffering mental illness; studies into self-harm; a revised care planning system for at-risk prisoners; and publication of *Help is at Hand* – a resource for people bereaved by suicide.

4 KEY NATIONAL STRATEGIES

- Preventing Suicide in England: A cross-government outcomes strategy to save lives, HM Government 2012.[1]
- Preventing Suicide in England: Assessment of impact on equalities, HM Government 2012.[14]

- Preventing suicide in England: Prompts for leaders on suicide prevention, HM Government 2012.[15]

- Sources of information for families, friends and colleagues who may be concerned about someone at risk of suicide, HM Government 2012.[16]

- Preventing Suicide in England: Statistical update on suicide, HM Government 2012.[17]

- Public Health Outcomes Framework : Improving outcomes and supporting transparency, 2012.[18]

- No Health Without Mental Health: A cross government outcomes strategy for people of all ages, 2012.

- Healthy Lives, Healthy people: Update and way forward, 2011.[20]

- Avoidable Deaths: Five-year report of the national confidential inquiry into suicide and homicide by people with mental illness.[21]

- Inquiry into suicide and homicide by people with mental illness: Annual report for England and Wales, University of Manchester, 2013

5 NATIONAL SUICIDE RATES & TRENDS

5.1 Suicide rates in England are low compared to those of many other European countries. The latest figures reveal a rate of 10.4 deaths per 100,000 population. In the most recent data available from ONS 2012, there were 4,509 suicides among people aged 15 and over in England and Wales.[1]

5.2 The age-standardised suicide rate has remained static between 2011 and 2012 at10.4 deaths per 100,000 population. It is interesting to see that when broken down by gender there is an approximate 3:1 ratio of deaths. 3,483 male suicides in 2012 and 1,024 female suicides.[1]

5.3 The past five years of data shows a levelling off of suicide rates and a sharp drop in the rate in Somerset. See Figure 1.[1]

5.4 There has been a sustained reduction in the rate of suicide among young men under the age of 35, which reverses the upward trend which began over 30 years ago.[1]

5.5 Currently, around three-quarters of deaths from suicides are men; in 2011 in England, the highest suicide rate was in males aged 45-59 (22.2 deaths per 100,000 population) representing a total of 1,354 suicides. Female suicide rates were also highest in the 45 to 59-year-olds (7.3 deaths per 100,000 population), representing a total of 455 suicides.[1]

5.6 Rates of suicide in men aged over 75 are also relatively high, which is a recent trend; risk factors such as loneliness and physical illness may be contributing factors.[1]

5.7 In 2011 the suicide rate was highest in the North East region at 12.9 deaths per 100,000 population and lowest in London at 8.9 per 100,000 (see Table 1)

5.8 The suicide rate fell in two regions in between 2010 and 2011 (West Midlands and London), and rose in seven regions (South West, South East, North West, East of England, East Midlands, North East and Yorkshire and the Humber). The largest increase was in Yorkshire and the Humber, where the suicide rate increased by 21% in 2011.[13]

Table 1

Number of deaths and age-standardised suicide rate: by sex, country and region, England and Wales, 2011[1],[2],[3],[4],[5]

	Male		Female		Persons	
	Deaths	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**
England	3,415	16.1	1,094	4.9	4,509	10.4
North East	218	21.5	55	4.7	273	12.9
North West	525	18.9	148	5.0	673	11.9
Yorkshire and The Humber	359	17.0	104	4.7	463	10.8
East Midlands	281	15.6	84	4.4	365	9.9
West Midlands	324	14.4	106	4.6	430	9.4
East of England	364	15.9	119	4.8	483	10.3
London	427	13.2	156	4.7	583	8.9
South East	525	15.1	198	5.4	723	10.1
South West	392	18.6	124	5.5	516	11.9
Wales	270	22.5	71	5.6	341	13.9

1 The National Statistics definition of suicide is given in the 'Suicide definition' tab.

2 Figures are for persons aged 15 years and over.

3 Age-standardised suicide rates per 100,000 population, standardised to the European Standard Population. Age-standardised rates are used to allow comparison between populations which may contain different proportions of people of different ages.

4 Figures are for persons usually resident in each area, based on boundaries as of August 2012.

5 Figures are for deaths registered in 2011.

Source: Office for National Statistics Office for National Statistics and Department of Health (2010) DH Mortality Monitoring Bulletin (Life expectancy, all-age-all-cause mortality, and mortality from selected causes, overall and inequalities).

5.9 Suicide rates can be volatile as new risks emerge. Previously, periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide[15] Evidence is emerging of an impact of the current recession on suicides in affected countries. A recent study by the University of Liverpool suggests the economic recession is having an impact on suicide rates. Researchers calculated that more than one thousand suicides, between 2008-2010, could be attributed to unemployment.[16] Suicide risk is complex and for many people it is a combination of factors, outlined in figure 7, that determines risk rather than any single factor.

5.10 Understanding some of the issues behind suicide patterns is key to making a difference:

- Up to half of all suicides have previously made failed attempts.
- Only a quarter of people (nationally) who die by suicide are under psychiatric care in the year before their death (i.e. 75% are not). In Somerset in 2011 37% of people who died by suicide were under the mental health services.
- 5-10% of all suicides happen in the four weeks after discharge from psychiatric hospital, making this a time of high risk.
- More men die from suicide than women, but suicidal thoughts and self harm are more common in women.
- Groups who have more frequent thoughts of suicide are:
    - Women
    - Those aged 16 to 24
    - Those not in a stable relationship
    - Those with low levels of social support
    - Those who are unemployed.
- Suicide is often precipitated by recent adverse events. These include relationship breakdowns, conflicts, legal problems, financial concerns, and interpersonal losses. There is also research into the links between suicide and terminal or chronic illness[19]
- Suicide is estimated to be under-reported for reasons of stigma, religion and social attitudes. Many suicides are hidden among other causes of death, such as road traffic accidents and drowning.[19]

6 SOMERSET SUICIDE RATE & TRENDS

6.1 The target is to reduce the death rate. The overall Somerset rate in 2012 stands at 8.2 deaths per 100,000 compared to England at 10.4 deaths per 100,000. The present overall south west rate is 11.8[13] **Figure 1** provides a comparison between the directly age standardised suicide rates in England, South West and Somerset.

6.2 Between 2007-2012 Somerset recorded 269 suicides or open verdicts with an average of 45 deaths per year. The highest number of deaths occurred in 2010 and 2011 at a total of fifty deaths. **Figure 2** provides a breakdown of suicides per year in Somerset since 1993. **Table 2** provides the break down by district related to rates and numbers of suicides since 2007.

6.3 Of the total number of suicides in Somerset, between 2007-12, 76% were Male and 24% were Female. This is consistent with the 3:1 ratio reported nationally. **Figure 3:** provides a comparison of suicide numbers by gender.

6.4 Men aged 75+ and women aged 75+ were most at risk of completing suicide. **Figure 4** shows the suicide rate by age and gender for 2007-2012 indicating that, while more deaths are in people aged 35-64, there are reasonably similar rates for all age groups above 24.

6.5 The most common means of completing suicide is hanging followed by overdosing. Women use both methods equally often. Hanging is the most common method for men and they tend to use more violent methods such as jumping and the use of firearms **Figure 5** provides details of cause of death by gender.

6.6 **Figure 6** provides details of cause of death by age group. Hanging is the most common method for each age group. Those aged over 75 use a wider variety of methods such as intentional self-poisoning by exposure to unspecified chemicals.

6.7 The data provides an interesting overview to a complex problem. Developing the audit information is essential together with bringing together more narrative surrounding suicide reviews to help build a more detailed picture of trends and patterns that can be used to influence commissioning and service delivery.

Figure 1: Directly standardised suicide rate in England and Somerset

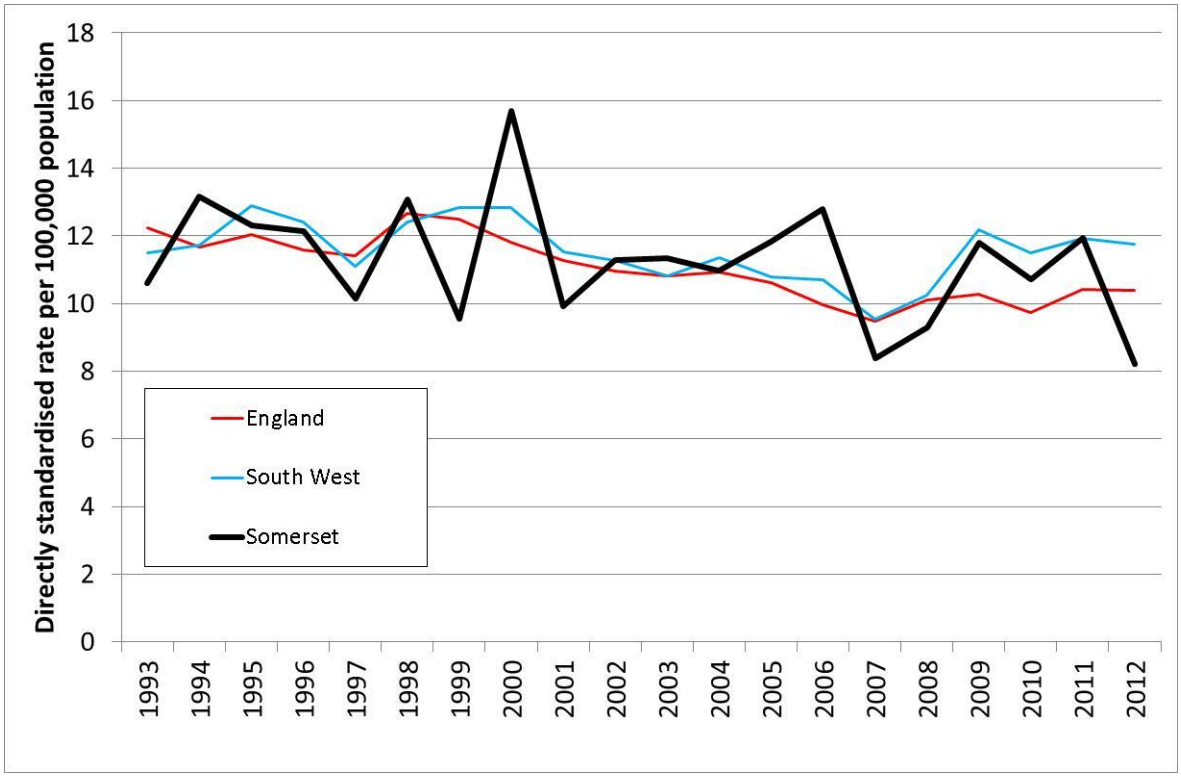


Figure 2

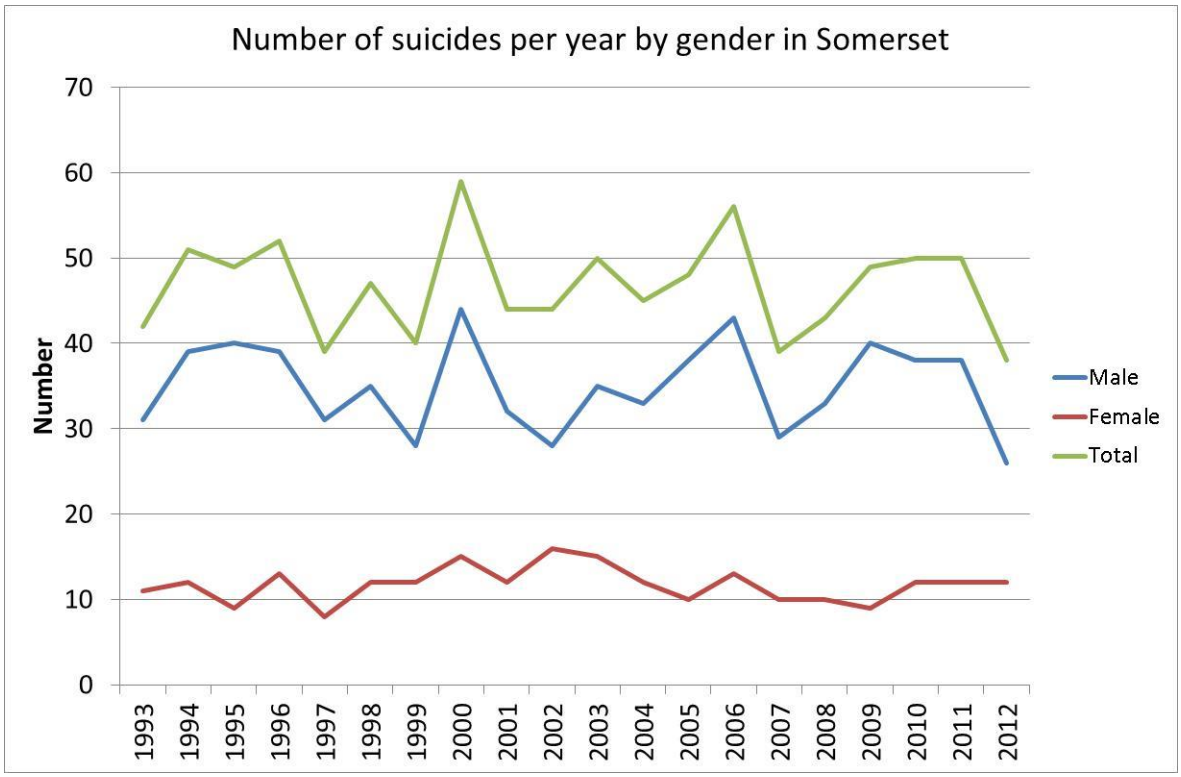


Table 2: Comparison of Mortality from suicide and injury undetermined *(aged15+)*

Directly standardised rate per 100,000

Persons	2007	2008	2009	2010	2011	2012
England	9.48	10.11	10.28	9.75	10.42	10.40
South West	9.52	10.24	12.17	11.49	11.94	11.75
Somerset	8.38	9.30	11.81	10.72	11.93	8.21
Mendip	9.41	6.46	4.16	7.72	6.71	14.50
Sedgemoor	9.47	7.62	13.62	12.16	6.79	5.45
South Somerset	5.21	12.30	12.97	12.35	18.30	6.23
Taunton Deane	8.79	8.56	17.53	10.80	11.38	8.54
West Somerset	14.05	15.90	5.45	7.45	22.46	7.02

Numbers

Persons	2007	2008	2009	2010	2011	2012
England	3,988	4,275	4,379	4,193	4,509	4,507
South West	416	441	514	494	516	519
Somerset	39	43	49	50	50	38
Mendip	7	8	3	9	6	14
Sedgemoor	9	9	12	14	6	5
South Somerset	8	16	16	16	22	10
Taunton Deane	9	7	16	9	11	8
West Somerset	6	3	2	2	5	1

Figure 3: Comparison of suicide *numbers* by gender

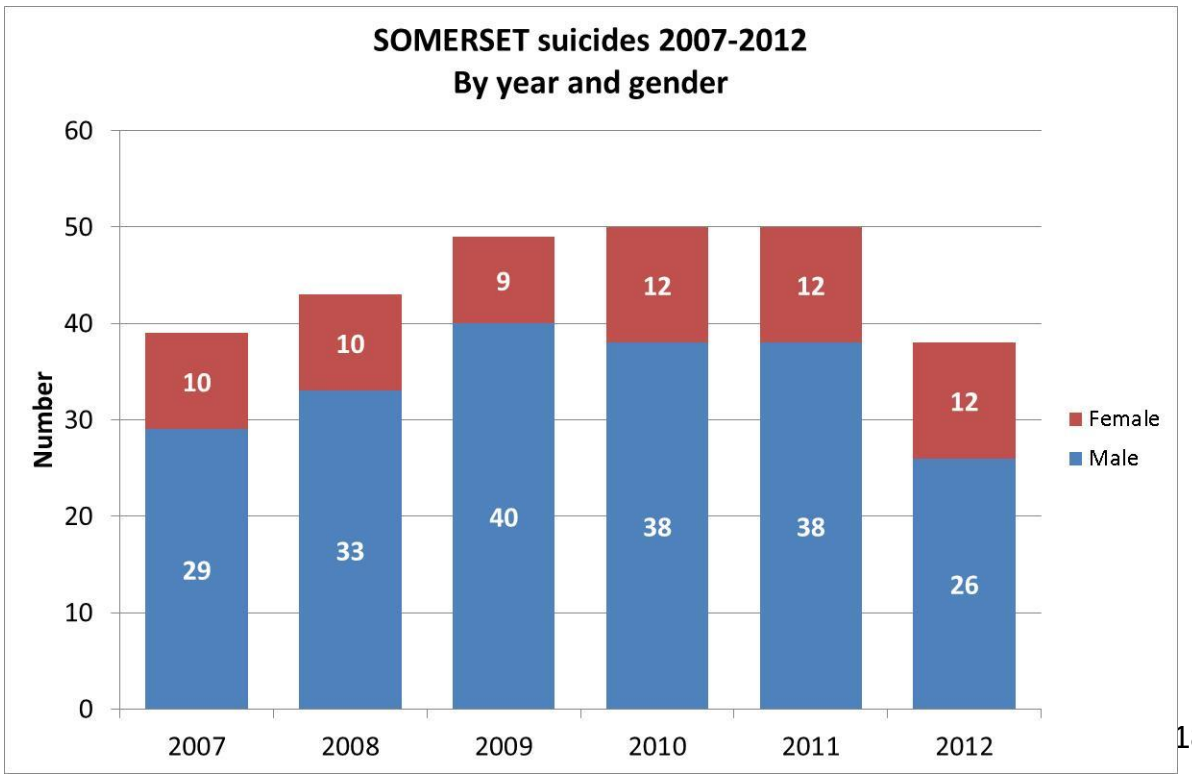


Figure 4: Comparison of suicide *rates* by gender and age group

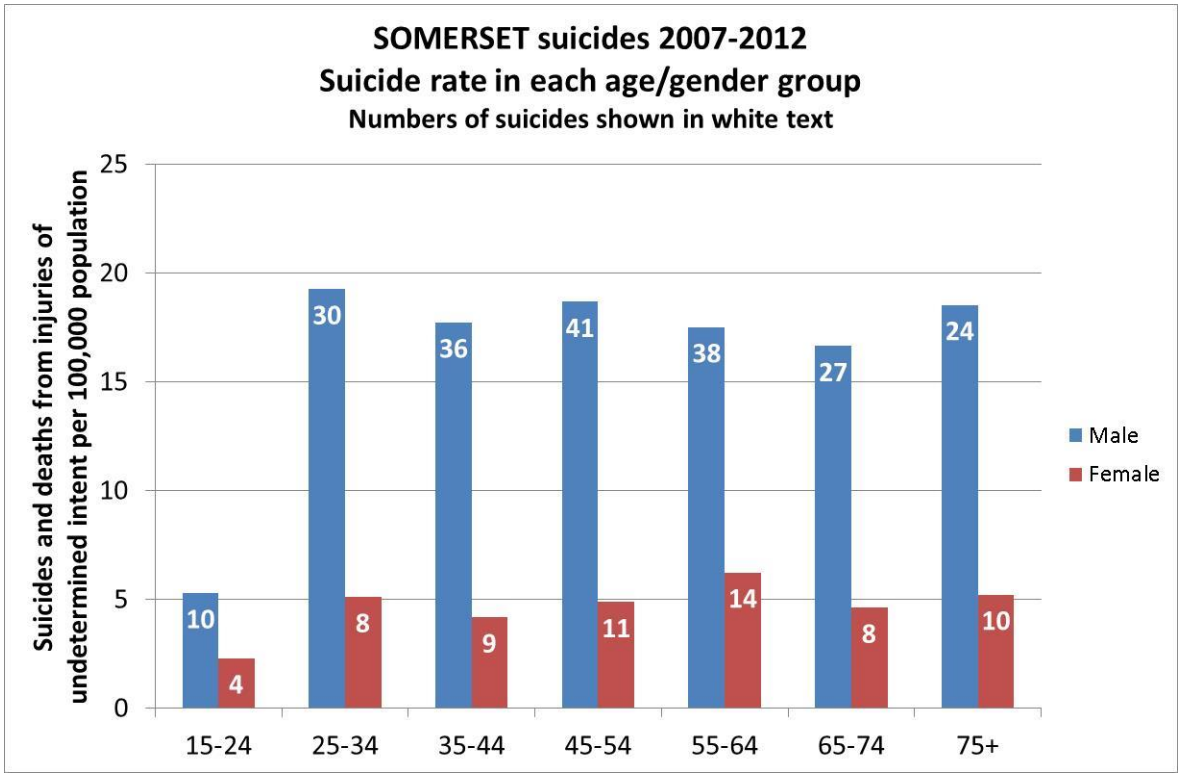


Figure 5: Cause of death by gender

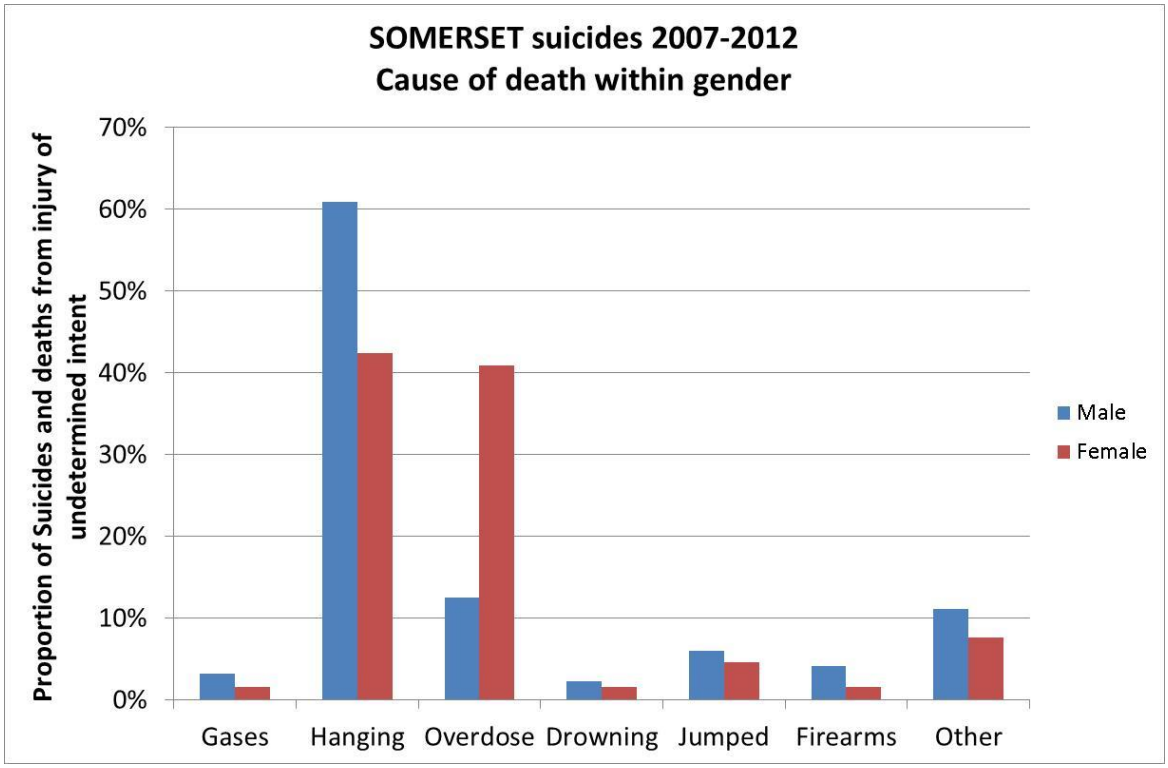
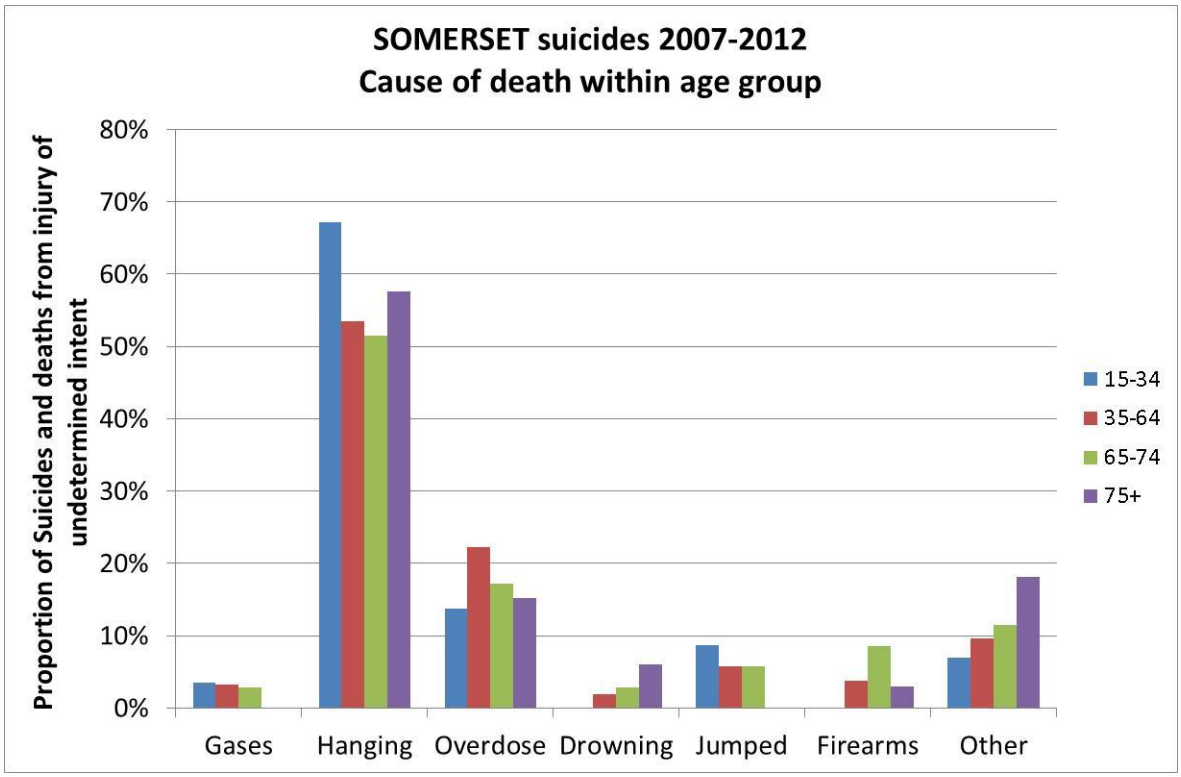


Figure 6: Cause of death by age group



7 LOCAL SUICIDE AUDIT

7.1 The process to collect suicide data began through Somerset Health Authority in 1993. This was initially in line with standard seven of the National Service Framework for mental health which required audits to be undertaken to learn lessons and take any necessary action.[6] This practice also became a requirement under the National Suicide Prevention Strategy.

7.2 In 2003/04, South Somerset Primary Care Trust assumed responsibility for the Somerset Suicide Audit from the Somerset Health Authority function. After the merging of the Primary Care Trusts in 2006, the Public Health and Nursing and Patient Safety Directorates of NHS Somerset took on joint responsibility for the Somerset Suicide Audit. In 2009, the Public Health Directorate appointed a Suicide Audit Coordinator and took on the entire role for suicide audit.

7.3 Audit reports have been produced every three years, with five years data included. An interim one year update was published in 2009, covering the 2006 data period The next full report was published in 2010, including data for the three-year period 2006-2008.

7.4 In April 2013, local responsibility for coordinating and implementing work on suicide prevention was transferred to local authorities' as an integral part of local authorities' new responsibilities for leading on local public health and health improvement. During the transition, co-ordination of the audit was delayed and the next report due out will cover the period from 2009 – 2012. The two year delay is a result of the time taken for inquests to be completed and the suicide audit tool questionnaire being circulated and completed by the professionals involved.

7.5 When the figures are broken down to produce a yearly suicide/ undetermined death rate across Somerset, the numbers are small. This means that small changes in numbers will result in a large variability in the rate. The average rate over three years is more stable than that over a single year, although at a local level even three year averages can be volatile and looking at trends is not helpful.

7.6 In view of the sensitivity of "trends", it is important not to get too "hooked" into the data. Hawton and Van Heeringen comment that it is not necessarily meeting a suicide prevention target that is important…"Rather, it is the role of a target as a guiding beacon that can lead to the problem of suicidal behaviour being taken more seriously and galvanise more active planning of national policy to improve mental health and mental health care.[1]"

7.7 To help develop understanding of effective interventions to reduce suicides, the Somerset Suicide Prevention Advisory group intends to bring together information from the different suicide review processes undertaken and to include these finds as part of the audit report in future years.

8 STRATEGIC APPROACH – THE CHALLENGE OF SUICIDE PREVENTION

8.1 Suicide prevention is not the sole responsibility of any one sector of society, or of the health services alone. Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.

8.2 This strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience, research evidence and the national strategy, *Preventing Suicides in England and Wales.*

8.3 A number of factors can increase an individual's vulnerability to suicide. Table 2 highlights common causes and risks to suicidal behaviour from within society, communities, for the individual and the quality of services available to help. For many people, it is the combination of factors which is important rather than one single factor. Figure 7 offers a framework to explore these factors.

8.4 We need to consider ways in which policies and actions to prevent suicide can be made sensitive to the specific circumstances and needs of particular groups on the basis of age, gender, ethnicity, sexual orientation, disability and in particular settings such as schools, workplaces, urban and rural areas.

8.5 The risk factors for suicide:

A number of factors can increase an individual's vulnerability to suicide these include[1]:

- Young and middle-aged men
- People in the care of mental health services, including inpatients and those recently discharged from psychiatric care
- People with a history of self-harm
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
- The following points are also important in terms of suicide prevention.(10)
- A number of occupational groups - doctors, farmers, vets, dentists and pharmacists - are at increased risk of suicide, although deaths in these groups make up only 1-2% of all suicides. One important factor influencing the increased risk in these occupations is their access to lethal means of suicide

8.6 The greatest impact is likely to result from a combination of preventative strategies directed at:

- The factors which increase risk of suicidal behaviour in a population e.g. availability of means, knowledge and attitudes concerning the prevalence, nature and treatability of mental disorders, and media portrayal of suicidal behaviour

- Recognised high risk groups - e.g. people with recurrent depressive disorders, previous suicide attempters, people who misuse alcohol, the unemployed, people with certain co-morbid mental and personality disorders and people recently discharged from psychiatric in-patient care

8.7 This Strategy takes a broad approach based on the priority areas for action identified within the National Suicide Prevention Strategy and through discussions locally around unmet needs.

8.8 The Strategy values the importance of general measures to improve the mental health of all, and to address aspects of people's life experiences that may damage their self-esteem and their social relationships. It recognises the need to tackle health inequalities and to combat discrimination against individuals and groups with mental health problems, thereby promoting their social inclusion.

8.9 Achieving a reduction in suicides; the overall vision of this Strategy is:

1. To contribute towards the continued reduction in the death rate from suicide

2. To provide better support for those bereaved or affected by suicide.

8.10 The Strategy works to the themes of:

- **prevention** of suicidal thoughts – promotion of wellbeing and reducing risk factors that can lead to suicidal thoughts

- **provision** of appropriate and effective support and treatment – availability of effective support, treatment and antidotes to enable people to continue with their lives

- **protection** to help keep people safe – related to influences such as the media, culture and reduced availability and lethality of suicide methods

8.11 There are six key priority goals for action:

1. Reduce the risk of suicide in key high-risk groups

2. Tailor approaches to improve mental health in specific groups

3. Reduce access to the means of suicide

4. Provide better information and support to those bereaved or affected by suicide

5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour

6. Support research, data collection and monitoring.

8.12 To ensure the effective delivery of the Strategy, it will involve contributions from health, social care agencies, local authority and voluntary and private sector organisations. It will need to harness the energy of the voluntary and community sectors and utilise their experience of working with local community interests and networks, alongside those of statutory agencies. The concepts of partnership working and shared responsibility also applies to sharing decisions about the investment and targeting of resources to achieve national and local objectives.

8.13 There is a strong recognition that any suicide prevention strategy has to be grounded in the need to promote mental wellbeing in the wider population. As such, the Somerset Suicide Prevention Strategy will work in partnership with the Public Mental Health action plan as part of the Somerset Mental Health and Wellbeing Strategy that is in draft at the time of writing.

8.14 Improving the mental wellbeing of the general population requires action on three main levels:

Level One: promoting mental wellbeing and reducing the risk factors for poor mental health

Level Two: targeting interventions to those that are at risk of developing mental health problems

Level Three: promoting recovery and better outcomes for people who have mental health problem

Challenge of Suicide Prevention- Causes and Risks of Suicidal Behaviour

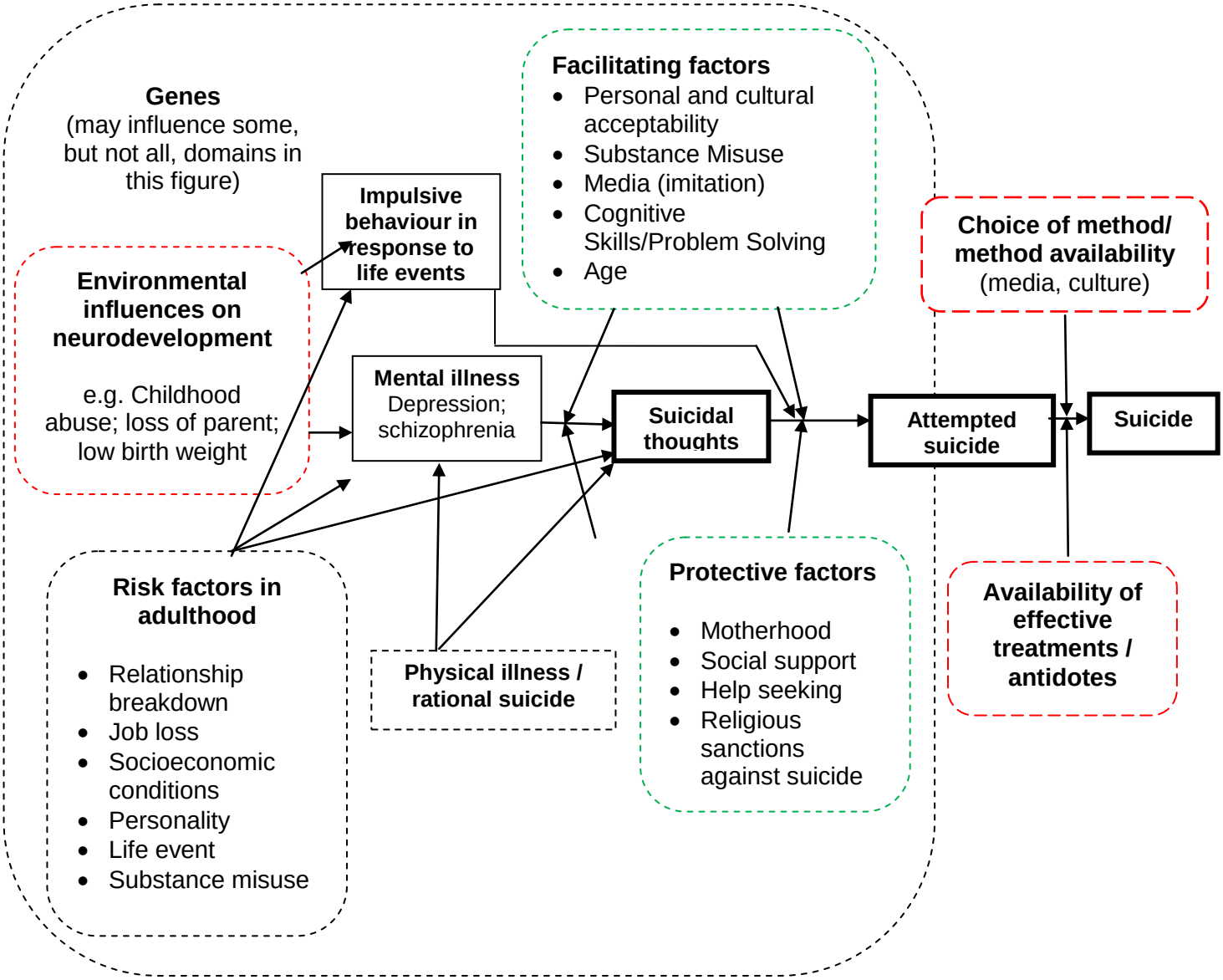
Table 3

Risks and pressures within society	**Risks and pressures within community**	**Risks and pressures for individuals**	**Quality of response from services**
Availability of, and easy access to, methods for suicide	Low level of trust in the community such as poor social cohesion or integration	Inadequate social support such as low levels of practical, emotional and other forms of assistance from family, friends and neighbours	Insufficient focus on the prevention, identification and assessment of needs and provision of care and support by services such as health, social work, education, criminal justice, housing and others.
Changing trends in society such as increase in marital breakdown, divorce and single person households	High level of social exclusion such as neighbourhood poverty and deprivation	Socio-demographic characteristics, such as Age - people aged 35-49 now have the highest suicide rate Gender - males are three times as likely to take their own life as females marital status (non-married), (lower) socio-economic status and (certain types of) occupation	Insufficient focus on the identification of those at risk and assessment of their needs and treatment requirements by health, social care and other services
High prevalence of alcohol problems and substance misuse	Communities which are faced with multiple disadvantages and are low on resources and resilience	Lack of care, treatment and support towards recovery from serious recurring mental illness such as schizophrenia and depression	The treatment and care received after making a suicide attempt
Social values and attitudes to mental illness and mental health, suicidal behaviour, heterosexism, gender stereotyping, racism, domestic	Feelings of fear or lack of safety	Stressful life events including: • the loss of a job; • debt; • living alone, becoming socially excluded or isolated;	

Risks and pressures within society	Risks and pressures within community	Risks and pressures for individuals	Quality of response from services
abuse, stigma, poverty and inequality		• bereavement; • family breakdown and conflict including divorce and family mental health problems; and • imprisonment	
Discrimination and stigma suffered by people with mental health problems	Inadequate access to local services, particularly at times of crisis	Substance misuse and alcohol problems in particular	
Irresponsible reporting and representation of suicidal behaviour by the media	Isolation associated with living in rural areas.	Previous deliberate self-harm	
Adverse labour market conditions such as insecurity of employment		Experience of abuse (sexual and physical) or bullying	
Adverse economic conditions such as level of unemployment and business confidence		Low self-esteem, lack of confidence	
		Low educational qualifications, poor life skills and interpersonal skills	
		Life crises, especially interpersonal loss such as bereavement or divorce, or issues relating to sexual orientation (including experience/fear of societal reaction)	
		Inability to access appropriate services and support at times of need	
		Physically disabling or painful illnesses including chronic pain	

Risks and Protective factors for suicide and suicide behaviour: A Literature Review, Scottish Government Social Research 2008

Fig 7: UNDERSTANDING SUICIDE



From a presentation by Professor David Gunnell, University of Bristol 2009 at Raising Hopes, Reducing Fears Conference.

9 IMPLEMENTATION

9.1 The Implementation Plan (Appendix A) has been developed from the Somerset Suicide Prevention Strategy 2010-2013, building on progress to date. To ensure delivery of the objectives, a number of relevant actions have been identified, together with indicators to monitor progress. In order for the Implementation Plan to "work", organisations will need to consider how the strategy impacts on them and to agree and accept responsibility for achieving the relevant outcomes. It has been important to establish realistic timescales for delivery and to monitor progress on a regular basis.

9.2 To further assist in delivery at local level, the Somerset Suicide Prevention Advisory Group (Appendix B) will continue to oversee the delivery of the Implementation Plan.

9.3 The Somerset Health and Wellbeing Board will offer leadership to support suicide prevention as they determine local needs and assets.

9.4 The challenge is in how we make the Strategy relevant and workable to the many people who are at risk. It will involve:

- Shared responsibility - supporting the improved coordination of efforts between and by local agencies

- Continuous Quality Improvement - A strategic approach to suicide prevention has to be informed by drawing on, and developing, better information and evidence of what works. We need to identify outcomes that we can measure and monitor, constantly evaluate progress and make necessary adjustments to confirm that our actions are being effective and take the necessary actions to improve future work

- Shared evidence base - The Suicide Prevention Strategy for Somerset has relied on the National Strategy for examples of evidence and good practice, drawing on published research wherever possible

- Developing and implementing policies and procedures for suicide prevention and intervention

- Encouraging and supporting more innovative local voluntary, community-based and self-help initiatives that address suicide reduction and prevention

- Developing knowledge and understanding - Raising awareness and understanding about suicide across the many stakeholders remains a critical approach within the Strategy. Most people considering suicide share their distress and their intent. Few professionals receive training on how to approach this work. Training can help us

see and respond to these invitations for help, which are often subtle and unexpected

10 CONCLUSION

1.1 A detailed Implementation Plan is outlined in Appendix A. Named organisations or groups have been identified against each action and they will have responsibility for ensuring the implementation of each action identified.

1.2 The Suicide Prevention Advisory Group will take responsibility for collating a yearly monitoring form and will report on progress to Somerset Community Safety Partnership, who will report back to the Health and Wellbeing Board

1.3 Suicides tend to rise at times of unemployment and economic problems. The current recession focuses our thoughts on implementing this Strategy.

1.4 With the arrival of a new national vision for mental health, 'No health without mental health', there is growing support for promoting mental wellbeing. This recognition and interest needs to be harnessed by the Health and Wellbeing Board and Clinical Commissioning Group to assist in the delivery of this Strategy.

1.5 The agreement and implementation of this Strategy will ensure Somerset is well placed to respond to *No health without mental health* and the Public Health Outcomes Framework Domain 4 target to reduce premature death.

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APPENDIX A

Somerset Suicide Prevention Strategy
Draft Implementation Plan 2013-2016

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
1 Action area one: Reduce the risk of suicide in high risk groups						
	1.1 To disseminate and promote the revised suicide prevention strategy to local **stakeholders** including the Community Safety Partnership, Children and Adults' Safeguarding boards and the Clinical Commissioning Group	Consultant in Public Health	Strategy acknowledged by key strategic groups	30 June 2013		
	1.2 To produce, disseminate and evaluate the use of a pocket size 'distress card' to emergency services and people on the frontline supporting vulnerable people	Health Promotion Manager – Mental Health	Distress cards distributed	30 June 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
People in the care of mental health services	1.3 To disseminate and implement NCI checklist of 'Twelve Points to a Safer Service'	Somerset Partnership Suicide Prevention Group	All 12 points have been implemented. and monitored quarterly	Somerset Partnership Suicide Prevention Group to be established by 31 March 2013. Group will develop a plan for dissemination, implementation and monitoring by 31 July 2013.		
	1.4 To implement the NPSA's "*Preventing Suicide: a toolkit* for *mental health services"*	Somerset Partnership Suicide Prevention Group	Monitoring reports produced demonstrating extent Somerset Partnership met the best practice measures on suicide prevention	Reports, including for young people, to be requested from Kay Southway.		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
Young and middle aged men	1.5 To work with the custody and courts scheme to promote access to mental health support as early as possible	Somerset Partnership, Samaritans and Custody Service Working Group		Regular audits on Court Liaison Scheme to be requested from Karen Gough (Forensic Team)		
People with a history of self harm	1.6 To review and disseminate the NPSA Prevention of Suicide: *a toolkit for community mental health*	Somerset Partnership – Community Services	Action plan for reducing gaps in NHS primary care relating to self harm is developed and implemented.	Annually		
	1.7 To identify the options for delivering training and information to GP"s and GP Trainees regarding how to identify signs and talk about suicidal feelings with patients	GP Patient Safety lead	Briefing sheets disseminated to all GP's and training plan developed and implemented	October 2013		
	1.8 Analyse Somerset self-harm data to monitor rates and patterns of self−harm, including risk factors for repetition and data to help with operational plans and medicines taken in overdose.	Reduction in Self Harm Working Group	Self harm data report produced on an annual basis	30 June 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	1.9 Review existing care pathways and revise to ensure good service provision and practice for all patients attending A&E/acute trusts following self-harm.	Reduction in Self Harm Working Group	Revised care pathways for children and adolescent and adults and older people in place	September 2013		
	1.10 Ensure timely comprehensive psychosocial assessments for patients in acute hospitals following deliberate self-harm	Somerset Partnership Crisis Intervention Teams – East and West	80% of assessments undertaken within 48 hours of referral Somerset Partnership Suicide Prevention Group to evidence performance.	Annually		
	1.11 Review and develop care for 'at risk' patients on discharge., including how the care may vary depending on number of admissions for self harm and the use of social media to offer support	Reduction in Self Harm Working Group	Care pathways implemented, monitored and reported on for at risk patients at discharge	April 2015		
	1.12 To ensure training is available around self harm in line with the NICE	Somerset Partnership Suicide	Self Harm training events offered to a wide range of	On-going		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	Guidelines on self harm for frontline staff outside of specialist mental health services	Prevention Group	practitioners and courses monitored and evaluated			
People in contact with the criminal justice system	1.13 Ensure Criminal justice system has representation at the Suicide Prevention Advisory Group for both youth and adult services	Somerset Suicide Prevention Advisory Group	Criminal Justice System representative attending Advisory Groups	Karen Gough (Forensic Team) or a representative to be invited to attend the Suicide Prevention Advisory Group		
	1.14 Set up a working group to develop specific actions related to the *offender mental care pathway* for both people involved in the youth and adult offending systems. The actions will also relate to improved access to services and improved recognition and early intervention of mental health problems in criminal justice settings.	Criminal Justice and Somerset Partnership Suicide Working Group	Action plan to improve offender mental health	April 2015		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
Specific Occupational Groups	1.15 To work with the high risk groups locally as identified through the suicide audit ensuring they are involved with the Suicide Prevention Advisory Group and to produce and distribute a list of relevant support agencies.	Somerset Suicide Prevention Advisory Group	Support agencies list distributed to high risks occupational groups	31 March 2016		
	1.16 To liaise with the local Farm Crisis Network to raise suicide awareness and support available	Somerset Suicide Prevention Advisory Group	Suicide awareness and support information disseminated to local farmers networks	Ongoing		
	1.17 Continue support of A & E Samaritans initiative in YDH and explore options for Musgrove A&E	Samaritans	Samaritans run a regular A&E support service	Ongoing		
2 Action area two: Promote mental health and wellbeing in the population as a whole						
	2.1 To implement the mental health and wellbeing strategy to promote mental health and wellbeing	Health Promotion Manager – Mental Health	Strategy endorsed and action plan implemented	April 2014		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	2.2 To offer suicide prevention skills training through the ASIST programme to improve risk management skills in frontline staff in education, health and social care	Health Promotion Manager – Mental Health	ASIST Training courses are made available and evaluation recorded	Ongoing		
Tailored approach for children and young people	2.3 To promote suicide prevention within the Somerset Health & Wellbeing in Learning programme (SHWiLP) by including appropriate resources and links on the programme's website and via its regular communication with schools	SHWiLP team	Up to date details of suicide prevention work on the website	31 March 2016		
	2.4 To distribute information about suicide awareness to all secondary and further education colleges	SHWiLP team	Information distributed to schools to coincide with World Suicide Prevention Day	Annually		
	2.5 Samaritans to continue its work in Schools and Colleges	Samaritans	Samaritans education information distributed to Somerset Schools	Ongoing		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	2.6 To develop an action plan to promote *social media safety* around managing the promotion of grooming suicide and self harm sites	Health Promotion Manager – mental health	Social Media Safety Plan developed	March 2014		
	2.7 To set up an emotional health - practitioner group to include key leads within delivery organisations working in and alongside schools; which will include supporting them to promote and develop effective school based suicide prevention strategies	SHWiLP team	Meetings to be held every six months	November 2013		
Identify local actions for high risk groups	2.8 High risk groups identified by the national strategy include: children and young people, survivors of domestic abuse or violence, people living with long term physical health, people with untreated depression, people	Somerset Suicide Prevention Advisory Group	Existing actions reviewed and discussed at Suicide Prevention Advisory Group	31 March 2016		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	especially vulnerable due to social and economic circumstances, people who misuse drugs and alcohol, lesbian, gay, bisexual and transgender people, Black, Asian and minority ethnic groups and asylum seekers.					
	2.9 Review and identify high risk groups in Somerset to reflect local demographics and larger proportion of older adults in Somerset than the national average consider what further SMART actions can be taken with each group					
World Suicide Prevention Day	2.10 To develop an annual multi-agency campaign to raise awareness on World Suicide Prevention Day 10 September.	Somerset Suicide Prevention Advisory Group	Annual activities planned around World Suicide Prevention Day	Annually		
3 Action area three: Reduce access to the means of suicide						
	3.1 Using the good practice guidelines available,	Somerset Partnership	Ligature point audits undertaken custody	Annually		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	develop awareness raising training amongst relevant service providers to reduce access to the means of suicide especially ligature points. This will include; custody suites, supported housing providers and acute general hospitals	Suicide Prevention Group	suites, supported housing providers and acute general hospitals across Somerset			
	3.2 After publication, promote and disseminate the new NICE quality standards on 'safe prescribing' as related to reducing self-poisoning	Consultant in Public Health and GP Patient Safety Lead	Safe Prescribing to Reduce Self Poisoning disseminated to stakeholders	31 March 2014		
	3.3 To work with the Somerset Medicines Management Group and Pharmacy Local Professional Network to review and develop local actions to comply with the Commission on Human Medicines review of current guidelines for the management of paracetamol overdose, including the specific	Consultant in Public Health and GP Patient Safety Lead	Action plan developed to implement new guidelines on management of paracetamol overdoses.	31 March 2014		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	guidelines for the management of paracetamol overdose for young people					
	3.4 To work with relevant local authority departments at both local and county level, to raise awareness of suicide risk in health and safety considerations when designing car parks, bridges, roads and high rise buildings, including guidance on the HSE 'Falls from windows'. Departments will include Planning, Highways and Architectural Liaison	Safer Communities Manager, SCC	Special task and finish group set up to review local planning practices linked to ways to reduce access to means of suicide. Action points included in *Designing out crime and promoting community safety* programme	31 March 2014		
	3.5 To review the *Guidance on action to be taken at suicide hotspots* with local suicide audit data. Consider appropriate steps to improve safety and deter acts of suicide at those locations e.g. providing emergency telephone numbers on	Safer Communities Manager, SCC	Action plan developed and implemented relating to, reducing the means of suicide at local hotspots.	31 March 2014		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	information boards.					
4 Action area four: Provide better information and support to those bereaved or affected by suicide						
Somerset Suicide Bereavement Service	4.1 To maintain the Somerset Suicide Bereavement Service to provide: • A telephone helpline, linked up to the Samaritans for 24 hour support • Information and guidance for both emotional and practical needs • A peer suicide bereavement support group • Individual face to face bereavement support • Advocacy and support through the inquest process • Work with schools that have experienced a suicide bereavement • Support for children through offering guidance for parents and a special group	Health Promotion Manager – mental Health	Service Annual reports are disseminated to stakeholders.	31 October 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	support session • A new Bereavement Services Network					
Action area Five: Support the media in delivering sensitive approaches to suicide and suicidal behaviour						
Promote responsible reporting of suicide in the local media	4.2 Monitor local media reporting of suicide and take action to improve reporting.	Public Health and Somerset Partnership Communication Managers	Monitoring of local media recorded within outcomes of the Suicide Prevention Communications Strategy	31 March 2016		
	4.3 Distribute annually the Shift or Samaritans, mental health and suicide reporting guidelines to all local and regional newspapers and radio stations	Health Promotion Manager – Mental Health	Guidelines distributed annually	Annually		
	4.4 To develop a Communications Strategy to address effective ways to raise awareness amongst stakeholder groups and members of the public, e.g. web based information and *art of conversation* guidance	Health promotion Manager – Mental Health and NHS Communications Team	Suicide Prevention Communications Strategy endorsed and implemented	31 December 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
5 Action area six: Support research, data collection and monitoring						
	5.1 To maintain the Somerset multi-agency Suicide Prevention Advisory Group to oversee the implementation of the Suicide Prevention Strategy	Health Promotion Manager – Mental Health	Quarterly meetings held and notes at each meeting are taken	31 March 2016		
	5.2 Produce annual audit report in line with "*Suicide Audit in Primary Care Trust Localities*	Consultant in Public Health & Public Health Audit Coordinator	Annual Audit Report produced	30 September 2013		
	5.3 Organise an annual review of the strategy and audit data	Health Promotion Manager – Mental health & Public Health Audit Coordinator		Annually		
	5.4 To review options to undertake timely learning reviews of suicide deaths that are not known to the secondary services.	Public Health Consultant	Options for timely reviews tabled at Suicide Prevention Advisory group meeting	30 June 2013		
	5.5 Maintain links between the Suicide Prevention Advisory Group and the	Public Health Consultant & Public Health	Relationship between the panel discussed and	30 June 2013		

Area for Action	Action	Lead	Indicator	Timescale	RAG Score	Comments
	Child Death and the Drug Related Deaths Panel to share information and consider ways to disseminate learning and good practice to prevent future suicides.	Audit Coordinator	actions agreed at Suicide Prevention Advisory group meeting			
	5.6 Disseminate Dr Jason Hepple annual paper reporting local data and trends	Somerset Partnership Suicide Prevention Group	Advisory group members have received the annual Partnership report.	Annually		

Appendix B

TERMS OF REFERENCE
SUICIDE PREVENTION ADVISORY GROUP

1 PURPOSE

1.1 To co-ordinate the planning on suicide prevention in Somerset.

2 AIMS

2.1 Identify priorities and make recommendations for action through the Somerset Suicide Prevention Strategy and Local Area Agreement Frameworks (taking into account any national guidance and priorities for action).

2.2 To monitor the Somerset Suicide Prevention Action Plan.

2.3 To oversee the process of gathering individual case audits and agree the most appropriate format and timescale for the production of audit reports.

2.4 Receive an annual suicide audit update showing trends and progress against targets and ensure these findings influence the development of the Suicide Prevention Strategy.

2.5 Produce and disseminate an annual report on the nature and extent of work taking place in Somerset

3 MEMBERSHIP

3.1 The membership of the group should include the following:

- Public Health Lead - Chair
- Public Health Audit Coordinator
- Two representatives from Somerset Partnership including CAMHS
- Mental Health Promotion Specialist
- Mental Health Commissioning Lead
- GP representative
- County Council representative from vulnerable adults/safeguarding adults domain
- Member of Psychiatric Liaison Team (Somerset Partnership)
- Third sector Involvement
- Accident and Emergency services representative
- Drug and Alcohol Team representative
- Somerset Coroner Service representative
- Police Representative
- SW Development Centre representative
- Involvement of individual Service User or Carer affected by suicide

3.2 Other members may be co-opted as required.

4 QUORUM

4.1 The group is quorate when three members (plus the Chair) are present. If such a quorum is not present within quarter of an hour of the appointed time, or if during the meeting ceases to be present, the meeting will stand adjourned.

5 FREQUENCY OF MEETINGS

5.1 The group shall meet as a minimum on a quarterly basis or more frequently if required.

6 CONDUCT OF MEETINGS

6.1 Meetings will be conducted on an informal basis.

6.2 The Public Health Audit Coordinator will provide the administrative support and keep notes of the meetings.

6.3 The agenda and papers will normally be sent out electronically at least 7 days before the meeting date.

7 ACCOUNTABILITY

7.1 The Suicide Prevention Advisory group will be accountable to the Safer Somerset Partnership.

7.2 The Suicide Prevention Advisory Group will produce an annual Suicide Audit Update and an annual report on the nature and extent of work taking place in Somerset

8 FREEDOM OF INFORMATION/DATA PROTECTION

8.1 These terms of reference have been complied with the requirements of the Freedom of Information Act 2000, which allows a general right of access to recorded information held by Somerset Primary Care Trust, subject to the specified exemptions, including Data Protection and Caldicott Guardian principles.

December 2009
Revised September 2013

APPENDIX C

STATISTICS

1 INTRODUCTION

This appendix contains facts and figures on completed, and attempted, suicides.

2 AMONGST THE GENERAL POPULATION

2.1 In the general population 13% reported suicidal thoughts, 4% attempted suicide and 2% deliberately self-harmed at some time in their lives.

3 PEOPLE WITH EXPERIENCE OF A DIAGNOSIS OF "PSYCHOTIC ILLNESS"

3.1 Over two thirds (70%) of the sample of people with a diagnosis of a psychotic illness had thought about suicide at some time in their lives and 45% had attempted suicide. In addition, 21% had harmed themselves without intending to commit suicide.

4 FACTORS ASSOCIATED WITH SUICIDAL THOUGHTS

4.1 Events or factors for which the prevalence of suicidal thoughts was particularly high include having a major financial crisis (29%), having a problem with the police or a court appearance (27%) and having looked for work for one month or over (23%).

4.2 Higher rates of lifetime suicidal thoughts were found among groups who reported ever having been homeless (48%), running away from home (45%), experiencing violence in the home (44%) and being expelled from school (41%).

4.3 Over half of those who reported experience of sexual abuse also reported having had suicidal thoughts during their lifetime.

4.4 Compared with people who had never experienced a stressful life event, those who reported three or more events were over three times more likely to have had suicidal thoughts and the group who had experienced six or more events were over nine times more likely to have had such thoughts.

5 ATTEMPTED SUICIDE – SOME MAJOR RISK FACTORS

5.1 12% of people who had experienced a problem with the police or a court appearance, 10% of those who had experienced a major financial crisis and 8% of those who had looked for work for one month or more had attempted suicide at some time in their life.

5.2 Around a quarter of people who reported running away from home, being homeless, having experienced sexual abuse and having experienced violence in the home had attempted suicide at some time in their life.

5.3 Women with a severe lack of social support were over five times more likely than those with social support to have attempted suicide in their lifetime (16% compared with 3%) and twice as likely to have attempted suicide than men (8%).

5.4 12% of all respondents with a primary support group of three or less had attempted suicide in their lifetime, compared with only 3% with a social group of nine or more people.

6 SUBSTANCE MISUSE

6.1 In a recent survey (2002) carried out by the Office for National Statistics, 4% of people who were non-alcohol dependent had at one time thought about suicide. This proportion increased to 9% among those moderately dependent on alcohol and rose to 27% of the severely alcohol dependent group.

6.2 Those who were dependent on drugs (other than cannabis) were around five times more likely than the non-dependent group to have ever attempted suicide, 20% compared with 4%.

6.3 Research comparing the relationship between cannabis abuse/ dependence and risk of medically serious suicide attempts indicates that there is a marginally significant association between cannabis abuse/dependence suicide attempt risk. Much of the association arises because: (a) those that develop cannabis abuse tend to come from disadvantaged backgrounds, which independently of cannabis abuse, are associated with higher suicide attempt or (b) because cannabis abuse is co-morbid with other mental disorders which are independently associated with suicidal behaviour.

6.4 Of 332 drug-related deaths in Scotland in 2001, 34 (10%) were as a result of intentional self-poisoning: in a further 52 deaths (16%) it was not clear if the death was accidental or suicide.

7 PEOPLE WHO EXPERIENCE NEUROSIS

7.1 The presence of significant levels of neurotic symptoms, as shown by a CIS-R[#] score of 12 or over, was associated with a four-fold increase in the likelihood of reporting suicidal thoughts at some time. In contrast, having a long-standing psychotic disorder was associated with a decreased likelihood of reporting suicidal thoughts once other factors had been taken into account. High levels of neurotic symptoms were also associated with

[#] CIS-R (Clinical Interview Schedule –revised version) is an instrument designed to measure neurotic symptoms and disorders, such as anxiety and depression

suicide attempts and in this case the number of stressful life events also showed a very strong association.

8 COMPLETED SUICIDES BY PEOPLE IN CONTACT WITH MENTAL HEALTH SERVICES

8.1 Approximately one-quarter of people who completed suicide in England and Wales, Scotland and Northern Ireland had been in contact with mental health services in the year before death; this represents around 1,500 people per year in the UK.

8.2 The commonest methods of suicide were hanging and self-poisoning by overdose.

8.3 Younger people who were in contact with services and who completed suicide more often had a history of schizophrenia, personality disorder, drug or alcohol misuse and violence.

8.4 Most people with schizophrenia who committed suicide were unemployed and unmarried.

8.5 4% of people in contact with mental health services who completed suicide were the lone carers of children.

8.6 Mental health teams in England and Wales regarded 22% of completed suicides as preventable, with lower figures in Scotland (62 cases, 13%) and Northern Ireland (19%) but around three-quarters identified factors which could have reduced risk, mainly improved patient compliance with medication and closer supervision

9 COMPLETED SUICIDES BY PEOPLE IN PSYCHIATRIC IN-PATIENT UNITS

9.1 16% of suicide inquiry cases in England and Wales, 12% in Scotland and 10% in Northern Ireland were psychiatric in-patients.

9.2 In-patient suicides, particularly those occurring on the ward, were most likely to be by hanging, most commonly from a curtain rail and using a belt as a ligature.

9.3 Around one-quarter of in-patient suicides died during the first week of admission.

9.4 Around one-fifth of in-patient suicides in England, Wales and Scotland and almost half of in-patient suicides in Northern Ireland were on agreed leave from the hospital at the time of death.

9.5 Mental health teams more often regarded in-patient suicides as preventable.

10 COMPLETED SUICIDES WITHIN THREE MONTHS OF DISCHARGE FROM A PSYCHIATRIC IN-PATIENT UNIT

10.1 23% of suicide inquiry cases in England and Wales, 26% of cases in Scotland and 30% of cases in Northern Ireland died within three months of discharge from in-patient care.

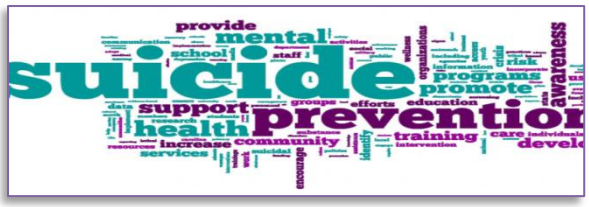
10.2 Post-discharge suicides were at a peak in the first 1-2 weeks following discharge.

10.3 40% of post-discharge suicides in England and Wales, 35% in Scotland and 66% in Northern Ireland occurred before the first follow-up appointment.

10.4 Compared to all community cases, post discharge suicides were associated with final admissions lasting less than seven days, re-admissions within three months of previous discharge and self-discharge.

11 COMPLETED SUICIDES BY CHILDREN AND YOUNG PEOPLE

11.1 In an analysis of the circumstances of 50 looked-after children who died between 1997 and the end of 2001, 11 were completed suicide.



APPENDIX TWO

Editorial –

This newsletter has been compiled to mark World Suicide Prevention Day. I am writing this editorial from a number of perspectives; as the Chair of the Somerset Suicide Prevention Advisory Group, as a social care professional who has worked in mental health services for many years and as someone who has witnessed the devastating impact of suicide on the lives of people I have known personally over a number of years. I suspect many of you reading this briefing will also have lost a family member, friend or colleague from suicide, yet despite the prevalence of suicide, it continues to be surrounded by stigma.

The statistics are shocking.

- Men 20 to 49 years are more likely to die from suicide than any other cause of death
- More than 6,000 people in the UK die from suicide each year or one person every two hours across the whole of Europe
- In Somerset, we have around 50 deaths per year with a ratio of 3:1 suicides being completed by men. This is roughly one suicide every week

The reasons for this are complex, and include socio-economic and health problems such as poverty, relationship breakdown, isolation, chronic ill-health and drug and alcohol misuse. Stigma is arguably one of the biggest contributory factors. We know that men are less likely to ask for help than women. We also know that talking is a very powerful way of helping people when they are experiencing emotional distress. If you haven't seen the Channel 4 documentary 'The Stranger on the Bridge' I recommend it. It shows how a total stranger saved the life of a young man, Jonny Benjamin, by talking to him on London Bridge. Talking to someone about how they are feeling does not increase the risk of suicide. This is a myth. Talking can help.

I hope to be able to provide future briefings but in the meantime, please do reflect on what you might be able to do to help reduce suicide both in your workplace and community. Most importantly, do stop to take the time to talk with people who may be struggling with their emotional wellbeing and the pressures of modern life.

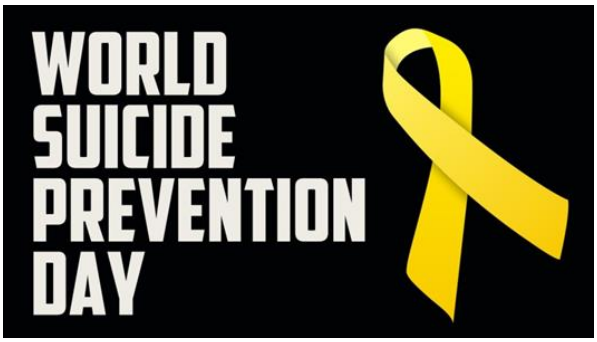
With thanks Carolyn Smith

Strategic Manager Mental Health & Safeguarding and Chair, Suicide Prevention Advisory Group.
CBSmith@somerset.gov.uk

Suicide and Mental Health in the Media

An inspiring workshop took place for local media and champions to learn about the latest research and media approaches to reporting on suicides and mental health.

Speakers at the workshop from L to R: Ben McGrail from ITV News West Country; Lorna Fraser, Samaritans and Sue Baker OBE, Time To Change



What is World Suicide Prevention Day?

World Suicide Prevention Day is held each year on 10 September. It's an annual awareness raising event organised by International Association for Suicide Prevention (IASP) and the World Health Organisation (WHO). This year's theme is about connecting with others and letting people know that #ITSOKAYTOTALK.

Why is it important

More than 800,000 people take their lives each year across the world.

Reaching out to people who are going through a difficult time can be a game changer. People who are feeling low or suicidal often feel worthless and think that no-one cares. Small things like hearing from friends or family, feeling listened to or just being told that 'it's ok to talk' can make a huge difference.

What you can do

Start a conversation today if you think a friend, colleague or family member may be struggling.

You can also join us on Twitter to spread the word.

World Suicide Prevention Day 10th September 2017 in Taunton

Sunday was a windy cloudy day but this did not stop a brave group of volunteers setting up their stall on Taunton High Street to mark World Suicide Prevention Day. The Suicide Bereavement Support Service Focus Group wanted to mark the day with a stall to raise awareness of the issues and support that is available. Volunteers from Cruse, Samaritans and Mind in Taunton and West Somerset, joined the Focus Group members. Despite the weather, volunteers spoke meaningfully to about sixty people, some of whom were in need of emotional support. The general feedback was that people were grateful to be informed about something they knew very little about in all its forms. It highlighted the need for more community awareness and a need to promote what support is available.

Thanks to Taunton Deane Borough Council for their support on the day

Samaritans from Taunton and Yeovil branches work closely with the Suicide Prevention Advisory Group to raise awareness and support people who are in emotional distress. Our two branches took over 82,000 calls last year and responded to 4920 emails and 1960 texts, demonstrating our continuing commitment to suicide prevention.

Some highlights of Samaritan projects this year:

- ✓ **GP Surgeries** – with the support of the Somerset Clinical Commissioning group, distributed Samaritan information to all GP surgeries. GP's with a patient's permission, can also arrange a call back service for additional emotional support
- ✓ **Postvention** – this provides support for schools and Colleges that have experienced a suicide; our work there helps all of those affected and is aimed at preventing further suicides. Somerset has been leading the way with this work.
- ✓ **Emergency Department presence** - Yeovil branch offers emotional support at Yeovil District Hospital Accident and Emergency Department. Our volunteers spend time listening to concerns and anxieties which includes talking to people who have self-harmed or tried to kill themselves
- ✓ **HMP Guy's Marsh** – Yeovil branch train and support the Listener team at HMP Guy's Marsh, visiting the prison weekly for their debrief.
- ✓ **Bereavement support** - Yeovil branch has a partnership with Cruse and Somerset Suicide Bereavement Service, supporting clients whilst they are waiting for this specialist bereavement support.
- ✓ **Campaigning** - 24th July (24/7) represents the round the clock support Samaritans offer. This year we:
    1. Lit up County Hall as a visual reminder of the emotional support we offer
    2. Held a 'Big Listen' event at Taunton Railway station. Listening tips were shared via the press and social media and, at stations, rail users were engaged by volunteers throughout the day. The message was simple; take a moment to speak to family, friends, colleagues or even a stranger and concentrate on listening and listening well. Knowing how to listen can make a real difference and perhaps save a life.

Railways - Samaritans has been working with Network Rail, the British Transport Police (BTP) and the rail industry for the past seven years to prevent suicide on the railway. Some 15,000 people in the industry have completed the suicide prevention course offered to staff through the programme and a good number of these have gone on to save lives on the rail network. A course was held for local rail staff and BTP officers at the Taunton branch of Samaritans.

Contact Samaritans on 116 123 or email jo@samaritans.org

Somerset Public Health was the first in the South West to offer ASIST (Applied Suicide Intervention Skills Training) training back in 2009. It is the most widely used suicide intervention model in the world, developed in Canada by LivingWorks Education. Public Health has worked in partnership with Somerset Partnership NHS Foundation Trust who has released staff to be trained as ASIST accredited trainers and to then deliver local courses.

ASIST will provide practical training for caregivers and is suitable for anyone in a caring role, working with vulnerable people, from teenagers upwards.

The Suicide Intervention Model improves the quality of information and communication between agencies and individuals, especially where referrals to secondary health services are necessary. Post course evaluations have taken place and have shown that the training increases knowledge and confidence to respond to a person at risk and intervention skills are retained over time and are put to use to save lives.

Quotes from course participants

"If it wasn't for the course I would have probably avoided the question and just skated around the edges, thinking I was doing a good job, but not really getting to the core."

"Two days after finishing the course I had concerns for a young person I was working with who had run off from an appointment…I eventually caught up with him I was able to ask the question and use the framework (to keep him safe)."

Email: louise.finnis@somerset.nhs.uk

SOMERSET BEREAVEMENT NETWORK

The effects of bereavement on mental health are well documented, and yet bereavement is a topic that often does not get a lot of focus. Two years ago a new Bereavement Network was set up in Somerset to give organisations that deals with bereavement an opportunity to come together and share and support each other. The meetings are a mixture of topic based discussions and 'open' space to share experiences, working practises and insights.

Themed meetings bring a greater depth to the conversations without detracting from the openness of sharing about individual services, practises or client base.
Topics covered include;

· Children and young people
· Helping men to grieve
· Peer support groups
· Disenfranchised and ambiguous loss
· Bereaved by suicide
· Loneliness after a bereavement – especially in the older community

The themed topics are usually delivered by network members. The meetings have been quarterly. Membership is very diverse from Marie Cure Cancer Care to Winston's Wish for children.

The group has produced a leaflet of known bereavement services in Somerset. To join the mailing list for future events and or receive a copy of the **Bereavement Leaflet**, please email **Susan Hoyle at bereaved@mindtws.org.uk**

The Farming Community Network (FCN) is a national charity working alongside the Royal Agricultural Benevolent Institute (RABI) and the Addington Fund to help farmers and their families who are going through difficult times. FCN is available to anyone in the farming community. We listen to concerns whatever they may be. We respond quickly and confidentially to any requests of help. FCN gives pastoral and practical help, RABI gives domestic grants and the Addington Fund helps with housing in retirement and emergencies. All our volunteers have farming experience and pastoral understanding.

FCN is a member of the local Suicide Prevention Advisory Group. Farmers are a targeted group for suicide prevention work. Farming is a unique way of life and everything is tied up on the farm – it is a farmer's business and livelihood, their identity and lifestyle. Their home is on the farm so is difficult to get away from their problems, and family relationships can often become very difficult. Financial, inheritance or health problems can put an enormous strain on the whole family and have a huge effect on the mental wellbeing of everyone. It is also a very isolated, and isolating, occupation. Often the partner has to work outside the farm and the farmer can spend all day completely on their own with no one to share their thoughts and worries. They may get up in the morning feeling tired, depressed and unable to make decisions…. And the downward spiral begins.

FCN is seeing an increase in stress and mental illness. We are there to listen to any concerns farmers may have and help with practical problems. We are able to act as a third party in resolving issues with cattle passports and animal health inspections with the British Cattle Movement Service. We talk to the Rural Payments Agency when the subsidies, which farmers now rely on, have not been paid. We negotiate with Trading Standards and RSPCA when animal health issues arise. We mediate with bank managers when there are financial or overdraft problems. We talk to utility companies and animal feed merchants to help with payment plans when farmers are unable to pay their bills.

Funding is difficult in many organisations at the moment so we find working together with agencies like Somerset Village Agents, Somerset Community Foundation, CAB, the National Farmers Union, MIND and others can provide huge benefits for all.

Recently we supported a young father whose relationship had broken down with his wife and child due to the excessive working hours. He was in a desperately dark place saying he could not go on living, feeling so worthless, rejected and alone. All day these dark thoughts were going through his mind as he was crying in his tractor cab with no-one to share his misery. FCN volunteer supported him and talked to him while in his cab and worked with the GP and local church. Now he has become stronger and able to make decisions. He has given up working on his own and is now working with a family member.

FCN national helpline is available 7am – 11pm.
Tel: 03000 111 99
Written by Suzie Wilkinson, Local Co-ordinator, Farming Community Network

Somerset Partnership NHS Foundation Trust

Suicide Prevention Work – 48 hour follow up:

Somerset Partnership NHS Foundation Trust provides mental health services across the county from Talking Therapies and Community Mental Health Teams through to Home Treatment Teams and Psychiatric In-patient units. The assessment and management of suicide risk is central to the work of all of these services and we are constantly looking to learn and improve the way we engage with our patients and their families to help them keep themselves safe and to prevent future suicides.

One important piece of work taking place between the in-patient ward and the Home Treatment Teams has been the 48 hour follow up after discharge. This is a direct response to the evidence from the National Confidential Inquiry that found that the risk of suicide was greatest for patients in the two days after discharge from hospital. In response our Home Treatment Teams have implemented new criteria to identify those at highest risk and to ensure that the right level of support is provided to patients at that most vulnerable time.

We know that there are a range of factors that increase risk and the in-patient and community teams work together to build a comprehensive picture. Some of the factors that might indicate an increase in the risk include:

- Men between 45 and 55
- The misuse of alcohol
- Living alone (40% of completed suicides are by people who live alone);
- Financial difficulties/pressures;
- Social isolation including disengaging from society and
- Chronic physical illness.

While the teams are guided by the evidence and broader risk indicators they will work closely with patients and those close to them to understand their individual circumstances and needs.

Laura Hopkins, Team Manager of the Taunton Home Treatment Team, has been involved in rolling out the new way of working. She explained: ‘the 48 hour follow ups seem to be working well. Patients have told us that they can often find the transition from hospital back home again really daunting, particularly after a longer admission. Knowing that they will be seen by our staff within two days provides them with a lot of reassurance and the feedback we have had so far suggests that it is appreciated’.

Claudine Brown – chair of the Somerset Partnership Trust Suicide Prevention Steering Group
Claudine.Brown@sompar.nhs.uk

Local Suicide Prevention Planning

The recent, Five Year Forward View for Mental Health, set a target to reduce suicide by 10 per cent by 2020/21. Somerset local suicide prevention planning is co-ordinated by Public Health, Somerset County Council, through the Suicide Prevention Advisory Group. It is made up of over twenty different statutory and voluntary organisations since 2008. The local strategy is based on the government's national strategy for England, '*Preventing suicide in England: a cross governmental outcomes strategy to save lives'*. The strategy is based on the latest evidence and emphasises the importance of working together, as no one agency has the sole responsibility to manage suicide prevention plans.

The **Somerset Suicide Prevention Strategy aims** are; to achieve a reduction in the suicide rate in the general population in Somerset and to provide better support for those bereaved or affected by suicide.

To support the aims, there are six overarching areas of action. Below are some highlights of activities in the last year:

1.Reduce risk of suicide in high risk groups

- Somerset Partnership NHS Foundation Trust carrying out weekly safety audits within patient settings and meeting 48 hour follow up visits after discharge. The suicide prevention in-house action plan is reviewed and monitored regularly.

- Men and Boys mental health network launched with series of activities and training.

- Farming Community Network working with Somerset Partnership to identify a link worker with a background in farming.

2.Tailor approaches to mental health support in specific groups

-*Positive Mental Health for Somerset* strategy has been approved by the Health and Wellbeing Board

- Eighty GP's undertook suicide awareness training. Risk assessment tools for primary care are being developed.

3.Reduce access to the means of suicide –

-Revised national guidance on 'Preventing suicides in public places' has been circulated.

- Focus on signs at pedestrian railway crossings, and the Environment Agency on waterways access.

4.Provide information and support to individuals bereaved by suicide

- Somerset's bespoke Suicide Bereavement Support Service has been available since 2012. This service was one of the first in the region.

-A new Focus group of people bereaved by suicide set up to inform the action plan and carry out community awareness activities.

5.Support the media to report appropriately on incidents of suicide

- On-going monitoring of local media reporting and Suicide and Mental Health in the Media workshop organised with national speakers and chaired by Ben McGrail West Country ITV.

6.Implement research, data collection and monitoring

- Somerset Public Health Department is responsible for the local audit process. The Somerset Suicide Prevention Audit Group meets throughout the year to review available information and initiate action. In addition, official data is analysed annually, providing trend patterns.

Contact Louise Finnis lfinnis@somerset.gov.uk
Health Promotion Manager – mental health

Somerset Suicide Bereavement Support Service

For every suicide it has been estimated that ten people will experience intense grief, which extrapolates to around 35,000 persons in the UK annually. Promoting the mental health of people bereaved through suicide is a key aim of the national and local Suicide Prevention Strategy.

Bereavement after suicide can be particularly difficult to cope with, and many people who are bereaved in this way find it hard to get the help and support they need. The loss of someone through suicide often results in different responses and emotions. Bereavement by suicide is prolonged. Shock, social isolation and guilt are normal emotional responses. Stigma and shame can also come into play leaving people feeling very isolated. There is often unwanted media attention and practical matters to deal with. People bereaved by suicide are also recognised as a group who are at risk of suicide themselves. The provision of early and appropriate support following bereavement by suicide is essential to facilitate the complex bereavement process but also to reduce the long term risks of on-going mental health problems.

"After watching a documentary on television I realised that my Dad's suicide had an impact so deeply traumatic to me that it was affecting my relationship with my son. After the support you got for me and staying with me through the journey we are now on a wonderful path together"

Public Health commissioned a bespoke Somerset Suicide Bereavement Support service back in 2012. The service is coordinated by Mind in Taunton and West Somerset (MindTWS) and supported by Cruse and the Samaritans. Overall outcome for the service is that people directly affected by a suicide will feel supported and show signs of less distress.

"You helped me in the beginning to get support when he first killed himself and a year on you are still around helping me with the inquest."

Features of the service include:

- Telephone Service. They have the option to stay on the line and talk to Samaritans out of hours.
- One to one or group support by phone or in person to talk through any emotional or practical issues
- One to One bereavement support via Cruse
- Monthly Peer Support Group
- Somerset Suicide Prevention Community Group
- Bereavement Network
- Resources and Contacts
- Monitoring media reporting
- Member of Southwest and National Suicide Prevention Alliance

The approach of the service is to listen and support people as they work through their grief and mixed emotions. The service will attend meetings with clients, including the inquest and act as an advocate when talking to agencies such as schools or employers. The service will also talk to community groups affected by a suicide which may include friendship groups.

Contact Susan Hoyle bereaved@mindtws.org.uk

"Thank you for dealing with the complicated family issues that followed after my husband took his own life. Without such delicate handling of all family issues I am sure we all would still be very stuck, hating and blaming each other and suffering"

Suicide Bereavement Support Group – a personal reflection

I had a tortuous journey trying to find a suicide bereavement support group. I phoned various number only to be told to redial another number. Or was told due to funding cuts the groups are no longer functioning. Eventually I found Taunton Suicide Bereavement Group and thank goodness because it has been my life line.

The support group is the only opportunity I have to talk about my feelings about the loss of my loved one by suicide. It provides me with the opportunity to meet and listen to others who have also lost loved one from a suicide. I no longer feel so lonely and isolated by this experience because of the support from the group meetings. The group meetings have helped improve my emotional and psychological wellbeing. The group facilitators understanding and gentle guidance supports us to inch a little more forward each time. I hope no one experiences the loss of their loved one from a suicide, but if they do, the need for help from such groups has Taunton Suicide Bereavement Group is so crucial. The shock, pain, turmoil, mental anguish has our world has just turned upside down is only made bearable with life line support from Taunton Suicide Bereavement Group.

Suicide Bereavement Support Group is part of the Suicide Bereavement Support Service. The support group meets the first Thursday of the month 19:30- 21:30,

Tel: 0300 330 5463

Email@ bereaved@mindtws.org.uk

Helplines and support

- Farming Community Network 03000 111 999
- Mindline Somerset 01823 276 892
- Somerset Integrated Domestic Abuse Service 0800 69 49 999
- Somerset Suicide Bereavement Support Service 0300 330 5463
- Samaritans (116 123) operates a 24-hour service available every day of the year. If you prefer to write down how you're feeling, or if you're worried about being overheard on the phone, you can email Samaritans at jo@samaritans.org.
- Childline (0800 1111) runs a helpline for children and young people in the UK. Calls are free and the number won't show up on your phone bill.
- PAPYRUS (0800 068 41 41) is a voluntary organisation supporting teenagers and young adults who are feeling suicidal.
- **Students Aganist Depression** is a website for students who are depressed, have a low mood or are having suicidal thoughts.
- A support group called the Campaign Against Living Miserably **(CALM)** is an excellent resource for young men who are feeling unhappy. As well as their website, CALM also has a helpline (0800 58 58 58).
- Somerset Partnership NHS Trust

A varied collection of some useful Mental Health apps*

Stay Alive **Free to use.** This app is a pocket suicide prevention resource, packed full of useful information to help you stay safe. You can use it if you are having thoughts of suicide or if you are concerned about someone else who may be considering suicide.

Elefriends **Free to use. For over 17's only** Supportive online community from the mental health charity Mind. We all know what it's like to struggle sometimes, but now there's a safe place to listen, share and be heard. Whether you're feeling good right now, or really low, it's a place to share experiences and listen to others. Moderated by the 'Ele handlers' from 10am until midnight.

Happier **Free to use** Happier helps you stay more present and positive throughout the day. Its Apple Watch app is like your personal mindfulness coach -- use it to lift your mood, take a quick meditation pause, or capture and savour the small happy moments that you find in your day. Connect with other happier users in a positive and supportive environment

Did you know… Business in the Community has teamed up with Public Health England to produce Reducing the risk of suicide: a toolkit for employers. This toolkit offers best practice support and should be used in conjunction with the Public Health England-Business in the Community Mental health toolkit for employers as an effective way to prevent and manage mental health and suicide at work.

Mental Health Recovery Guide

Free to use.

There are 17 essential things you need to know to fast track your recovery from mental illness. The Mental Health Recovery Guide (MHRG) will tell you what they are.

If you suffer from depression, schizophrenia or bipolar disorder, and if you are a mental health outpatient, or a newly discharged psychiatric in-patient at the UK's NHS or elsewhere in the world, MHRG will help you to get well and stay well.

What's Up **Free to install** but include in-app purchases

What's Up? is a popular free app utilising some of the best CBT (Cognitive Behavioural Therapy) and ACT (Acceptance Commitment Therapy) methods to help you cope with Depression, Anxiety, Anger, Stress and more! With a beautiful, modern design, simple heading and easy-to-follow methods, you can get to what helps you the most in seconds!

***Whilst these apps may be useful, they are not a replacement for seeking medical advice if you have concerns about symptoms you may be experiencing.**

Keeping safe on line

Here are some useful on-line safety tools related to mental health aimed at children, parents, carers and professionals.

Child Exploitation and On-line Protection **'Think You Know' guide to online safety**. **MIND's online safety page** that contains helpful advice as well as their **'How To' Stay Safe Online B**

10 things everyone needs to know about suicide prevention

Suicides take a high toll	There were 4,882 deaths from suicide registered in England in 2014 and for every person who dies at least 10 people are directly affected.
There are specific groups of people at higher risk of suicide	Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.
There are specific factors that increase the risk of suicide	The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides.
Preventing suicide is achievable	Agencies across the public and voluntary sector, need to work together to build robust plans to promote mental health and prevent mental illness. Working together to offer services that build community resilience and target groups of people at heightened risk of suicide can help reduce suicides. Support is needed at the highest level within all organisation.
Suicide is everybody's business	A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play.
Restricting access to the means for suicide works	This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.
Supporting people bereaved by suicide is an important component of suicide prevention strategies	Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depressio psychiatric admission as well as poor social functioning.
Responsible media reporting is critical	Research shows that inappropriate reporting of suicide may lead to imitation or 'copycat' behaviour.
The social and economic cost to suicide is substantial and adds to the case for suicide prevention work	The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associate pain, grief and suffering.
Local suicide prevention strategies must be informed by evidence	Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

The newsletter has been produced by Somerset Suicide Prevention Advisory Group
Email@ bereaved@mindtws.org.uk.

September 2017

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Somerset County Council
Scrutiny for Policies, Adults and Health Committee
– 6 December 2017

Adult Social Care Performance Update

Lead Officer: Stephen Chandler
Author: Jon Padfield
Contact Details: jpadfield@somerset.gov.uk
Cabinet Member: David Huxtable
Division and Local Member:

1. Summary

1.1. This is the second quarterly performance update report produced for Scrutiny Committee.

1.2. The purpose of the report is to provide an update on Somerset's performance in Adult Social in comparison to national and comparator benchmarks. As with the previous report in June, this report focuses on the measures included in the Adult Social Care Outcomes Framework (ASCOF) and Delayed Transfers of Care (DToC).

1.3. This report also includes an update on the Promoting Independence Strategy currently being produced within Adult Social Care.

2. Issues for consideration / Recommendations

2.1 Appendix A provides a series of charts showing detailed comparative information for Somerset against a selection of measures along with a commentary which highlights the direction of travel.

2.2 Section 5 of this report provides a brief summary of the current position on Delayed Transfers of Care (DToC) and Appendix B provides a series of detailed charts showing how Somerset's performance on DToC compares both nationally and across the South West region.

3. Background - ASCOF

3.1. ASCOF is now in its fourth year and measures both national and local (Council level) performance against the ambition to help the most vulnerable people in our society lead better and more comfortable lives.

3.2. ASCOF is split into four domains as follows:

- Ensuring quality of life for people with care and support needs,
- Delaying and reducing the need for care and support,
- Ensuring that people have a positive experience of care and support,
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

There are a series of outcome measures within each of these domains that pull information from a variety of sources including; local data returns (Safeguarding Adults Collection [SAC], Short and Long Term Care [SALT] and the annual Adult Social Care Survey.

3.3. The Adult Social Care Survey is an annual survey sent to a random sample of service users. It is designed to help the sector understand more about how services are affecting lives. User experience information is critical for understanding the impact of services and for enabling choice and informing service development.

4. Analysis of results - ASCOF

4.1. The 2015/16 ASCOF report produced by the Department of Health shows that year on year there have been improvements across almost all measures. This includes a decrease in permanent admissions to residential and nursing homes and an increase in overall satisfaction of people who use services with their care and support and social-care related quality of life. Both of these are reflected in Somerset's performance.

The 2016/17 ASCOF report has only just been released and so appendix A provides some initial benchmarking against Somerset's family group.

4.2. Somerset's performance against the two measures concerned with clients with learning disabilities (Tables C and D in Appendix A) is good. In both cases Somerset's performance at the end of 2016/17 was ahead of the national and comparator group average. In both cases initial projections for 2017/18 show further improvements.

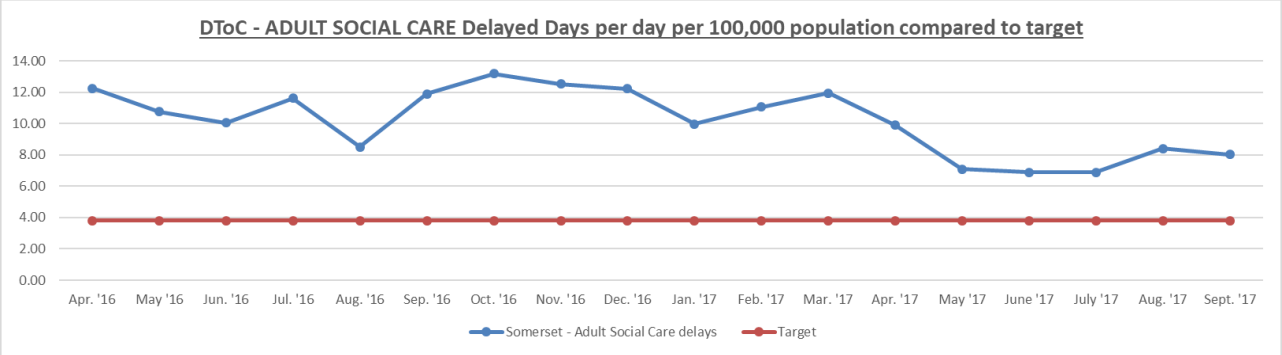
4.3. However, the ASCOF report also highlights areas for improvement. A key measure of personalisation is the proportion of eligible users who receive a personal budget. In this measure Somerset's performance is poor and well below the national average. Performance during 2016/17 increased slightly from 2015/16 and 2017/18 to date shows a further improvement but Table A in Appendix A shows that Somerset remains an outlier on this measure.

4.4. In terms of placements in residential and nursing homes, in 2016/17 Somerset placed more younger adults (aged 18-64) than both the national and comparator group average. The projected outturn for 2017/18 suggests performance will show a further increase from 2016/17. Somerset's performance in 2016/17 was better than the national average for older people (aged 65+) where our placement numbers were amongst the lowest in the family group. However, the projected outturn for 2017/18 (based on placements made between April and October) shows a marked increase in placement numbers.

5. Delayed Transfers of Care (DToC)

5.1. A delayed transfer of care occurs when a patient is medically fit for discharge from acute or non-acute care and is still occupying a bed. *Definition taken from LGA 'Delayed Transfers of Care Statistics for England 2016/17' report.*

5.2. The chart below shows Somerset's performance against the DToC target for delays attributable to Adult Social Care. The target is stated as a number of delayed days per calendar day per 100,000 population. For Somerset the target is 3.8 and this was meant to be achieved by November 2017. Somerset's performance at the end of September was 8.03.



5.3 Appendix B provides some further analysis and benchmarking data as well as a summary of 'what good looks like' in terms of hospital flow.

6. Promoting Independence Strategy

6.1. A new strategy has been drafted setting out the 6 key areas of work Adult Social Services are concentrating their efforts on in order to achieve improved outcomes for those people we support to better promote independence, manage demand and understand the impact of our interventions.

6.2 The strategy concentrates on the following objectives, each of which are underpinned by key performance metrics:

1. Early help and prevention
2. Customer Focus through the front door of the Council and from acute hospitals
3. Effective short-term interventions for people from the community
4. Designing the care system for people with long-term care and support needs
5. Developing a workforce that promotes independence and community-led solutions
6. Governance and management arrangements to sustain improvements.

6.3 In practice, this strategy is about:

- Maximising independence to support people to remain in their homes and communities, without formal social care support wherever possible
- A changed relationship with the public where we manage expectations and are realistic about what we can do and what we expect from individuals, families and communities
- Working differently with partners to support people to get the right level and type of support at the right time
- Asking staff to think and practice in new and different ways

- Ensuring we have the right enablers in place to achieve our ambitions.

6.4

The Strategy will be finalised shortly, at which point it will be communicated widely with relevant stakeholders, including elected members and via Scrutiny. Future performance updates and reports from Adult Services are anticipated to be structured in a way that aligns to the Strategy and captures progress against performance measures.

7. Action Plan

7.1 The table below formed part of the paper presented in March 2017 and summarises the key actions to be undertaken in order to improve performance in Adult Social Care. Updates are included for each action:

	WHAT IS THE ACTION?	**WHO IS RESPONSIBLE?**
1.	Continue to push for performance improvement through PIMs process. Focus on data, what is working, what needs improving and rapid improvement cycle to ensure actions result in positive and enduring change. Update – June 2017: at the quarterly PIMS meeting at the beginning of June it was agreed that a new performance framework will be produced utilising the "Six steps to managing demand…" publication from the IPC. Update – November 2017: see section 6 above re Promoting Independence Strategy.	Stephen Chandler
2.	Continue to focus on ASCOF measures and benchmarking data at regular monthly ASC management meetings. Update – June 2017: performance has a regular monthly agenda slot at ASC management meetings. Update – November 2017: performance continues to be a regular monthly agenda item at ASC management meetings.	Business Manager, Adult Social Care
3.	Utilising the ASCOF benchmarking data, identify the high performing authorities for each measure and make contact with them to assimilate learning. Update – June 2017: see above, the focus of ASC management meetings over the last few months has been on understanding Somerset's performance. We will now need to start to link with high performing authorities during 2017/18. Update – November 2017: we are awaiting the publication of the ASCOF report for 2016/17. This is normally published in early October but we are awaiting confirmation of the release date from the Department of Health.	ASC Management Meeting

4.	Complete the actions identified in the action plan for the recent 'Data Quality' audit completed by South West Audit Partnership. Update – June 2017: action plan is being worked through. However, system limitations mean that not all actions can be completed. Update – November 2017: an update was provided to Audit Committee in September explaining that system limitations meant not all actions were achievable but also explaining that a process for procuring a new Adult Social Care system was starting.	Business Manager, Adult Social Care
5.	Continue to train and then support front line staff to input data at source in AIS and ensure checks in place to maintain that integrity of data. Update – June 2017: phase A of this work is almost complete with the majority of front line staff receiving training to input assessments and reviews. Phase B will see training to record appropriate outcomes on triage/duty. Update – November 2017: new triage arrangements are now live in all 4 areas with operational staff recording contact outcomes.	Business Manager, Adult Social Care
6.	Adult Social Care Systems Review to increase efficiency, effectiveness and quality of data. Update – June 2017: Systems Review continues and is also now linking with innovation work in Taunton. Performance modelling is now underway. Update – November 2017: the Systems Review has now developed a model with 7 key metrics. Work continues to test this model.	TAP Programme – currently being piloted in Taunton and Sedgemoor & West Somerset (SAWS)
7.	Following the completion of the 2016/17 Adult Social Care survey, produce an action plan to ensure the results are properly understood and that improvement actions are put in place. Update – June 2017: although results of the survey are available in draft we will wait until final results are confirmed before formulating this action plan. Update – November 2017: finalised results for the 2016/17 Adult Social Care Survey have only just been released and we are currently analysing, after which an action plan will be produced.	Stephen Chandler

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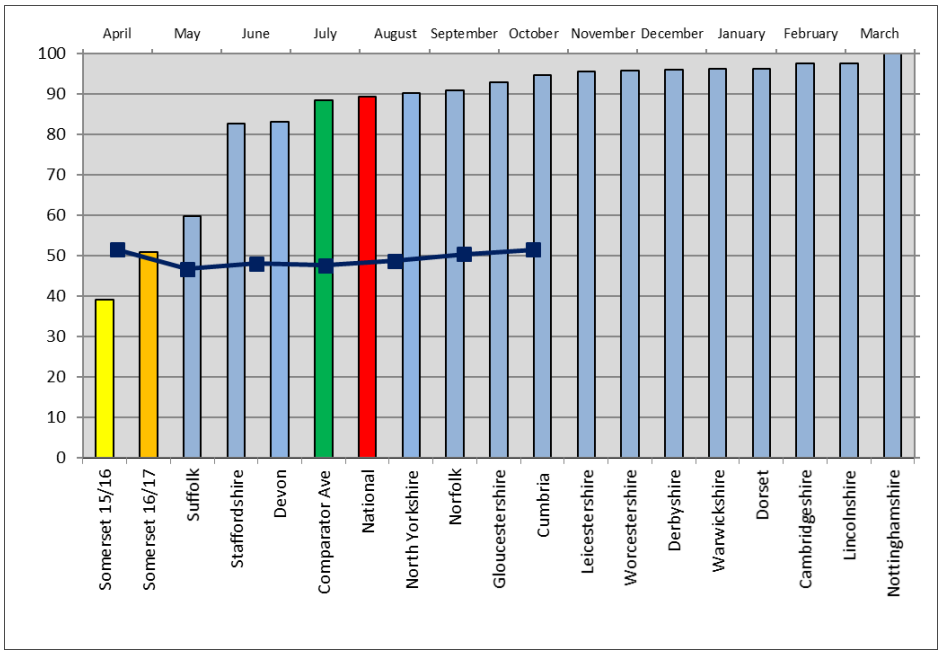
Scrutiny Report – Adult Social Care Performance: Appendix A

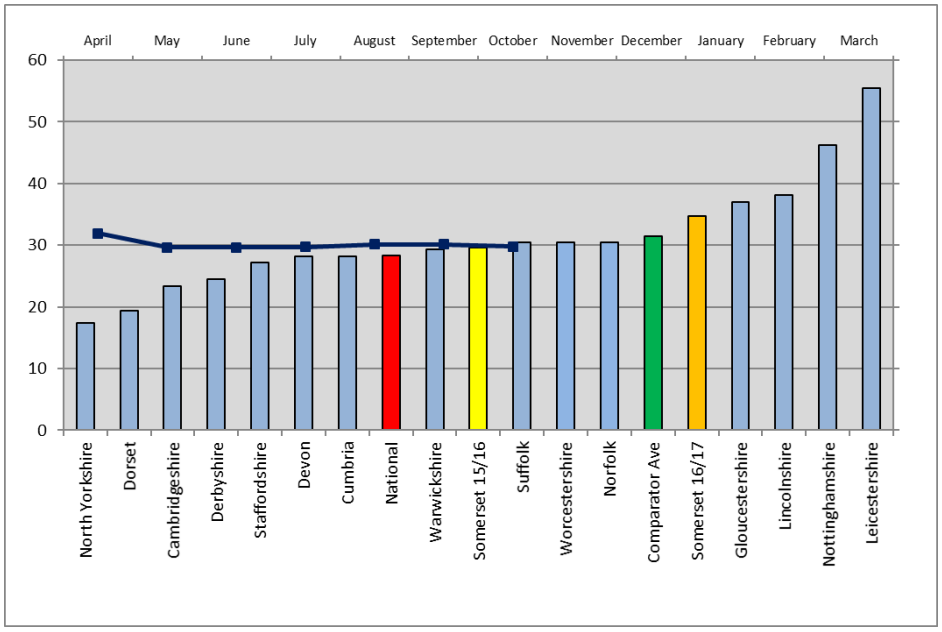
Tables A to F below show the 2015/16 (yellow bar) and 2016/17 (orange bar) outturn performance measures from ASCOF for Somerset and the 2016/17 outturn for Somerset's family group (blue bars). The red bar shows the national average for 2016/17 and the green bar shows the average for our family group. The line shows Somerset's performance to date in 2017/18 (using the top axis).

A. Proportion of people using social care who receive self-directed support (ASCOF 1C(1)a):



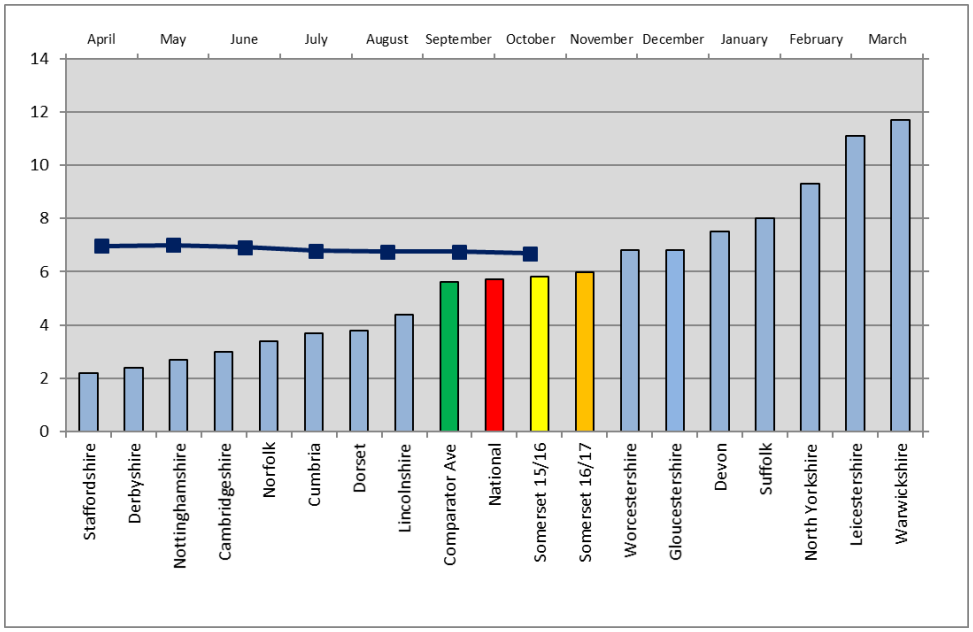
Commentary: Higher is better. Somerset's performance against this measure is poor and is significantly below both the national and comparator group average.

B. Proportion of people using social care who receive direct payments (ASCOF 1C(2)a):



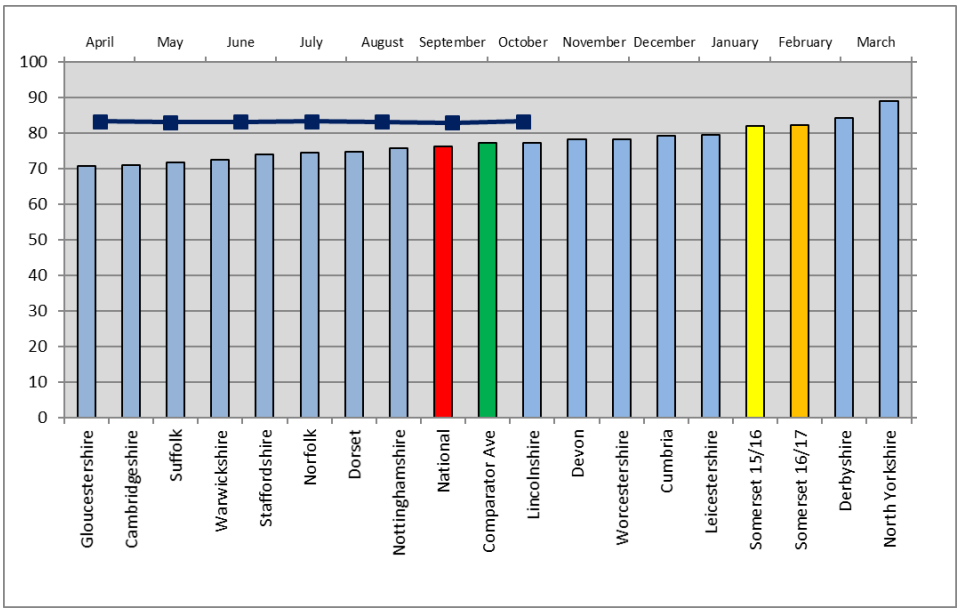
Commentary: Higher is better. Somerset's performance is good. It is above both the national average and the comparator group average. 2016/17 performance was an improvement on performance in 2015/16.

C. Proportion of adults with learning disabilities in paid employment (ASCOF 1E):



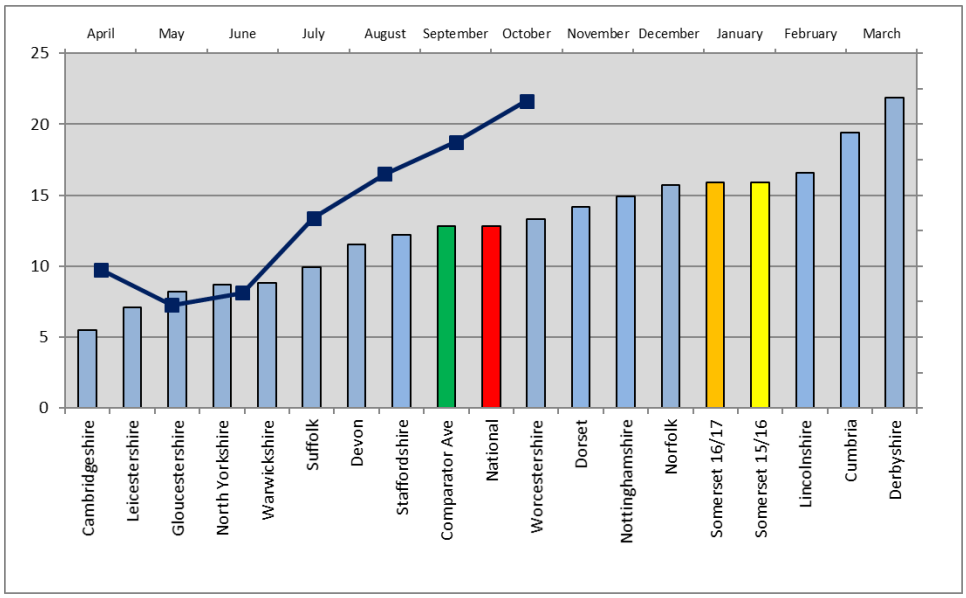
Commentary: Higher is better. Somerset's performance is slightly above both the national average and the average for the comparator group. 2017/18 performance shows further improvement.

D. Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G):



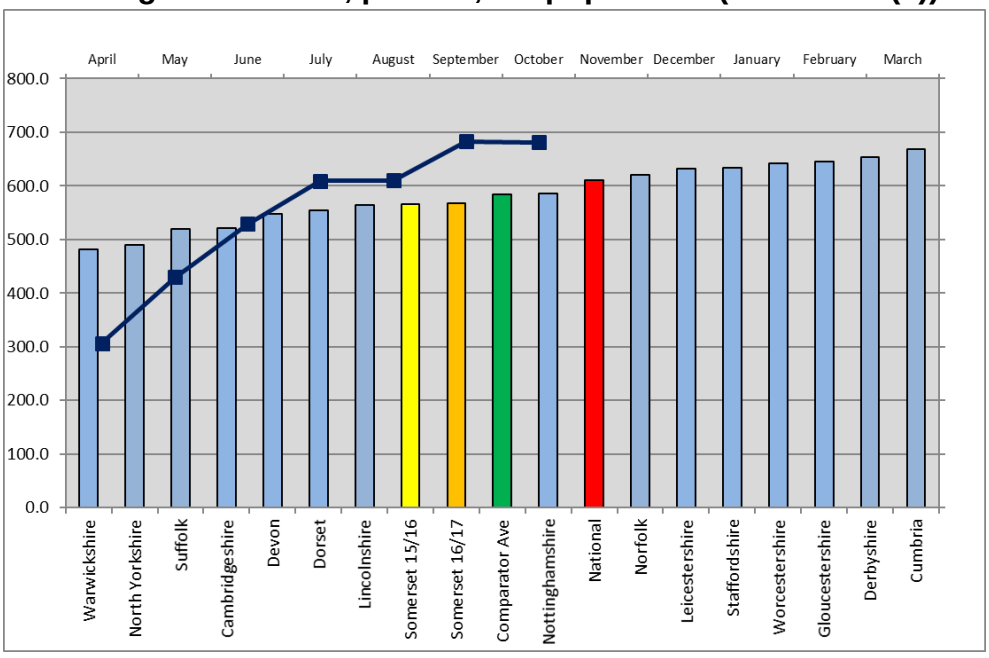
Commentary: Higher is better. Somerset's performance is good and is above both the national and comparator group averages.

E. Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population (ASCOF 2A(1)):



Commentary: Lower is better. Somerset's performance in 2015/16 was poor. Placement numbers were above the national and comparator group averages and Somerset was one of the highest placing councils in the comparator group. Performance in 2016/17 was in line with 2015/16 performance.

F. Permanent admissions of older people (aged 65+) to residential and nursing care homes, per 100,000 population (ASCOF 2A(2)):



Commentary: Lower is better. Somerset's performance in 2015/16 was better than the national and comparator group averages. Performance in 2016/17 showed a very slight deterioration compared to 2015/16. The forecast outturn for 2017/18 shows a further deterioration in performance.

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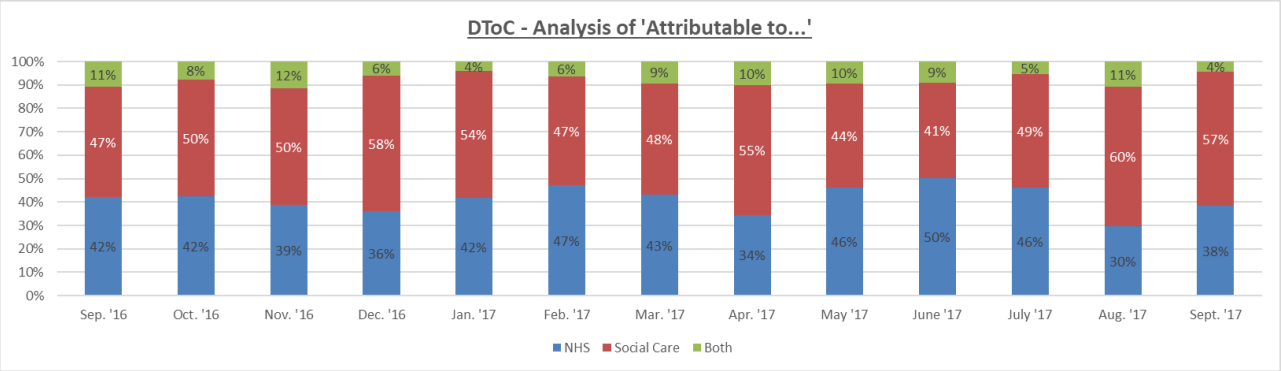
Scrutiny Report – Adult Social Care Performance: Appendix B

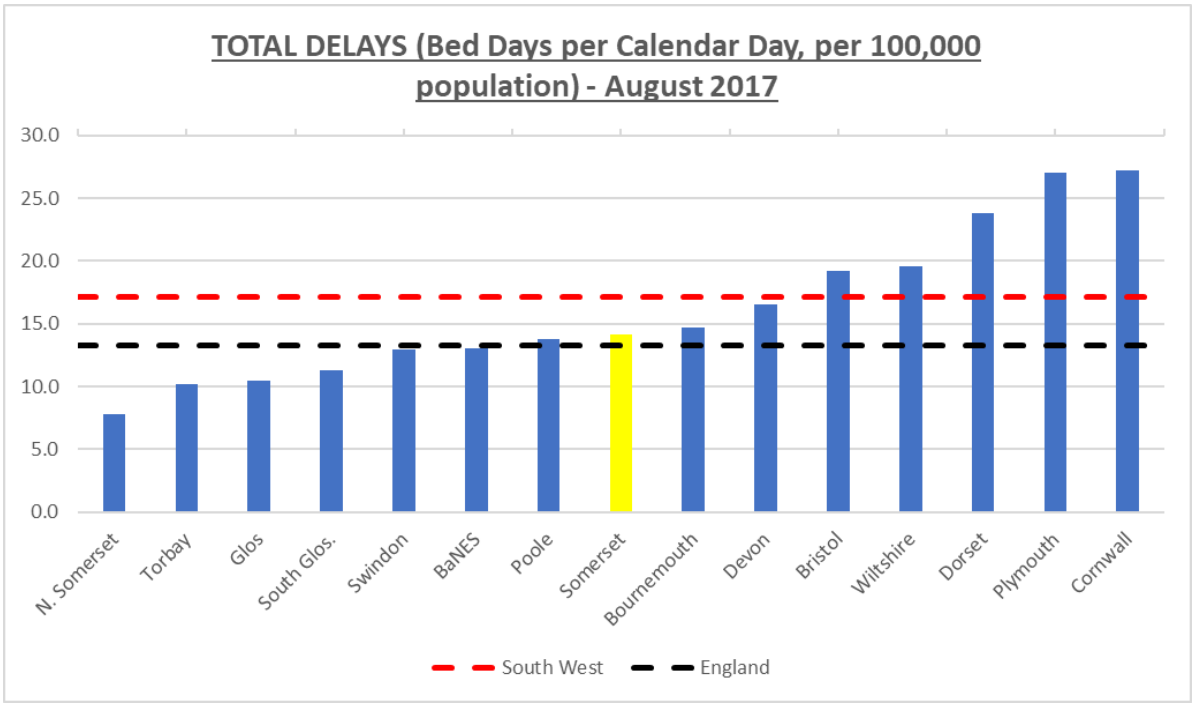
The charts below show how Somerset's performance on DToC has changed over the past 12 months and also provides some comparison both nationally and regionally.

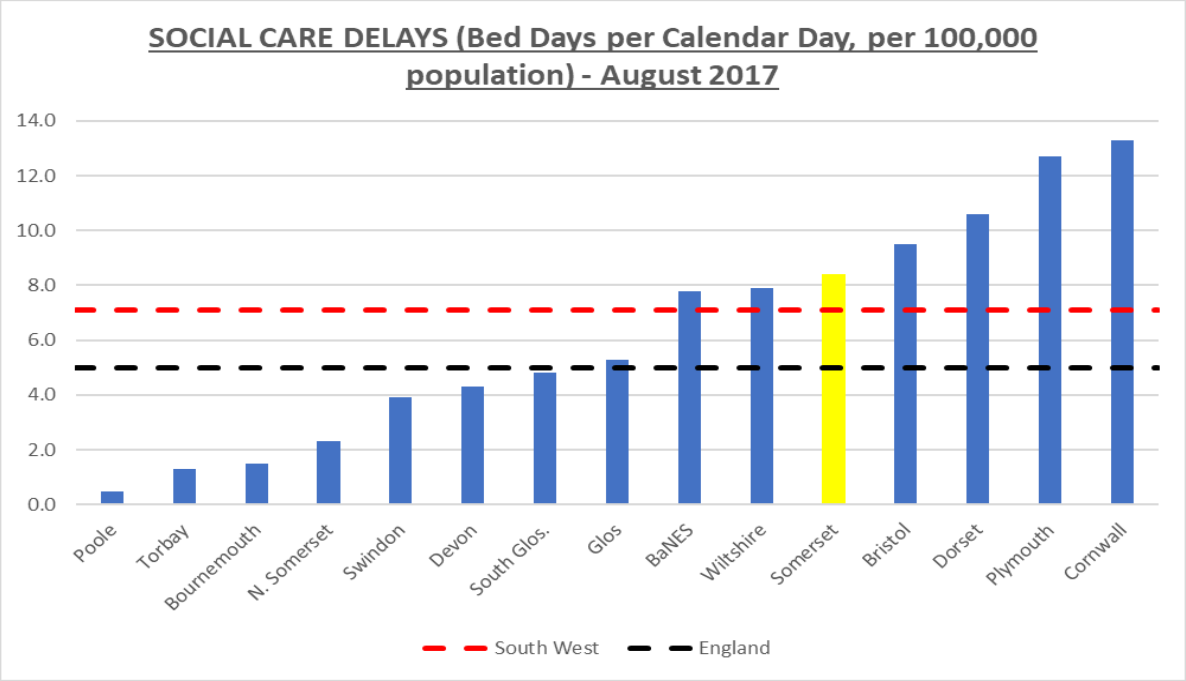
A. Analysis of 'Attributable to…' – all delays are attributable to either; NHS, Social Care or Both. This chart shows how this breakdown has changed over the last 12 months:



Commentary: The statistical release from the Department of Health that accompanied the publication of the September data shows that on average 36.3% of delays were attributable to Adult Social Care. Somerset's August performance makes us an outlier.

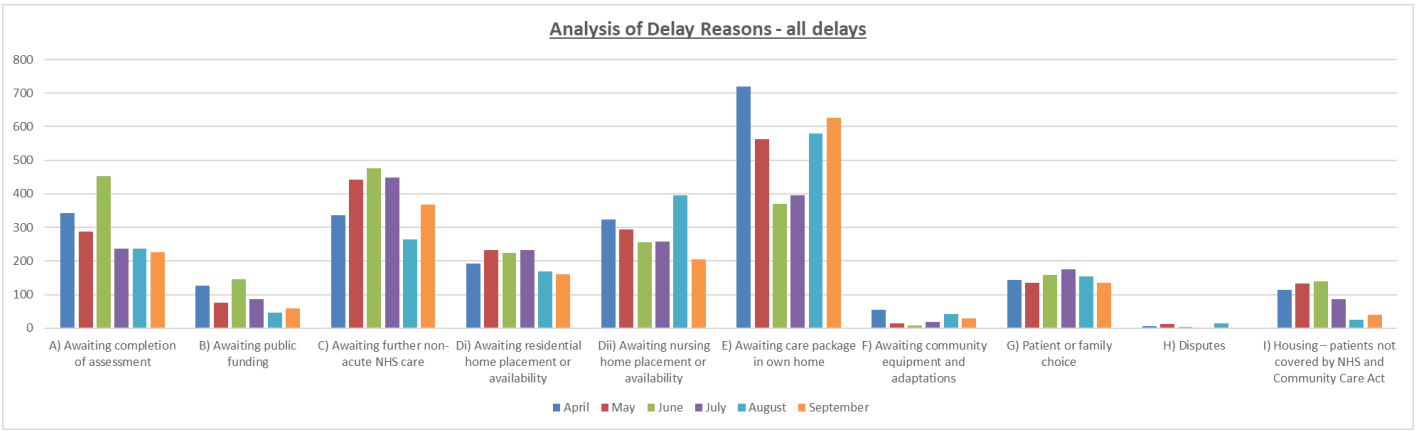
B. South West Region comparison of Delayed Bed Days (average number of delayed days per calendar day) per 100,000 population for August 2017:





Commentary: For all delays (NHS, Social Care and Both) Somerset's August performance puts us 8th out of 15 South West LAs and 107th Nationally. For Social Care attributable delays Somerset are ranked 11th in the South West and 130th Nationally.

C. Analysis of Delay Reasons – April to August 2017:



Commentary: Across these 6 months an average of 26% of delays were due to 'Awaiting Care Package in Own Home'. The statistical release from the Department of Health in September states that nationally this is the number one reason for Social Care delays.

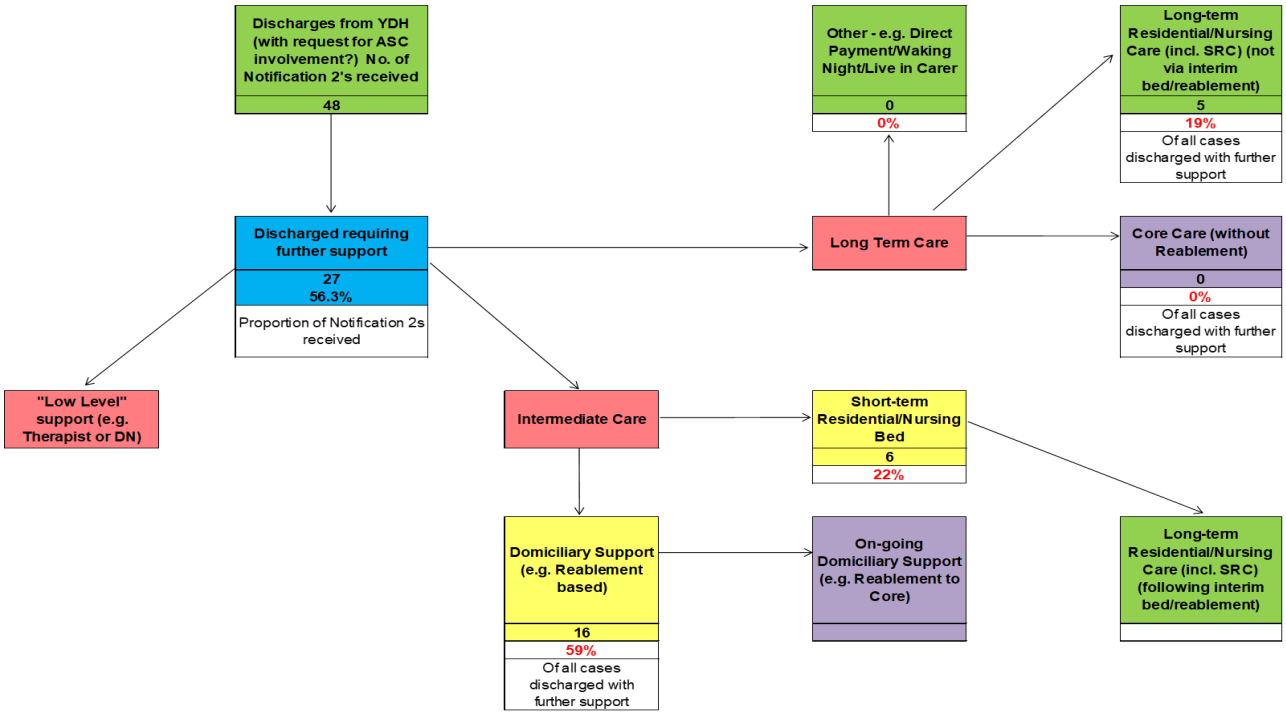
D. What does good look like?

We now have a clear definition of what good looks like in terms of hospital flow and are monitoring each of these measures on a monthly basis:

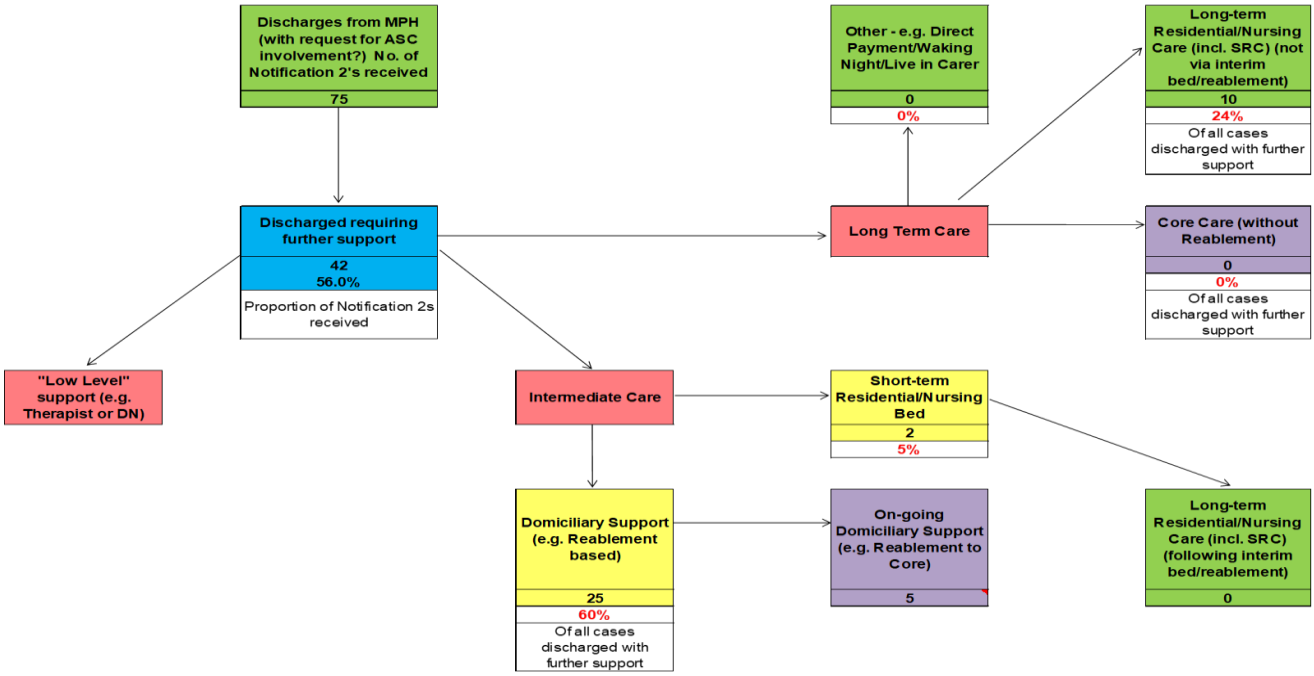
- 300 out of every 1,000 (approx.. 30%) of older people (65+) admitted to hospital are discharged requiring further support,
- Of these 300 admissions, 250 of them should be discharged into Reablement services (either bed based [25] or domiciliary [225]),
- Approx. 86 people discharged into reablement support (either bed based or domiciliary) require on-going (core) domiciliary support. This equates to 8.6% of total hospital discharges and approx. 34% of discharges into reablement,
- Approx. 8 people discharged into reablement support (either bed based or domiciliary) require long-term residential/nursing placements. Less than 1% of total hospital discharges and approx. 3% of discharges into reablement.
- Zero discharges direct to long-term residential/nursing placements,
- Zero discharges direct to core domiciliary care.

An example of how we are monitoring patient flow is shown in the diagrams below – these are for Musgrove Park Hospital and Yeovil District Hospital for September 2017.

Snapshot - Yeovil District Hospital - September 2017:



Snapshot - Musgrove Park Hospital - September 2017:



Somerset County Council
Scrutiny for Policies, Adults and Health Committee
– 6th December 2017

Council Performance Report – End of September (Q2) 2017/18

Lead Officer: Emma Plummer / Strategic Manager - Performance
Author: Emma Plummer / Strategic Manager - Performance
Contact Details: (01823) 359251
Cabinet Member: Cllr D Fothergill, Leader of the Council & Cllr David Hall
Division and Local Member: All

1. Summary

1.1. This performance monitoring report provides an overview of the Council's performance across the organisation.

1.2. The report is based on the content of the County Plan.

2. Issues for consideration / Recommendations

2.1. Consider and comment on the information contained within this report specifically those areas identified as a potential concern under section 4 of this report and the "issues for consideration" section of Appendix A

2.2. Members are asked to review and comment on actions undertaken at Cabinet, to ensure that appropriate consideration has been given to the work being undertaken to address performance concerns.

3. Background

3.1. This report provides members and senior officers with the information they need to lead and manage the performance of the organisation and increase levels of public accountability.

3.2. The report has been updated to reflect the County Plan that was adopted by full Council in February 2016 and a review of the priorities and the performance information that contributes to them has been carried out.

Appendix A – the Performance Wheel now has seven segments which reflect the "People's Priorities" which are widely consulted upon through the Listening Learning, Changing Roadshows. There are four "Council" segments which seek to measure how well the council manages its relationships with partners, staff and the public and how good its 'internal management' processes are. There is one segment that seeks to reflect the performance of the Vision Projects being undertaken by the Vision Volunteers.

3.3. The Vision Volunteer segment is a quarterly update evidenced by the Core Council Board Papers.

3.4. This report provides the latest information available in the period up until 30th September 2017. As such some of the data may be a little historical in nature; discussions regarding "performance issues" will take account of any additional information that may be available following production of this report

3.5. This report has been presented to Cabinet on Wednesday 15th November 2017.

3.6. This report has been presented to Scrutiny for Policies and Place Committee on Tuesday 5th December 2017.

3.7. This report is being presented to Scrutiny for Policies, Adults and Health Committee on Wednesday 6th December 2017.

4. Our Performance

4.1.

- Sections that are preceded by 'A&H' are of particular interest to Scrutiny Policies, Adults & Health.
- Sections that are preceded by 'P' are of particular interest to Scrutiny Policies and Place.
- Sections that are preceded by 'C&F' are of particular interest to Scrutiny Policies, Children & Families.

4.2. This quarter there are two red segments:

- **(C&F) P3 Safer Children and Better Care** - The Children's Trust Executive are pleased with the progress against the 7 Improvement Programmes, but recognises there is still much to do. Action Plans for 2017/18 are in place and Q2 performance against the CYPP was considered by the Policies, Children and Families Scrutiny Committee on 17th November 2017. Ofsted quarterly monitoring visits have concluded adequate progress is being made and DfE intervention has confirmed a "significant improvement" in Somerset's Children's Services, including more manageable case-loads, a more stable workforce and better partnership working as reported by the Minister in 2016. Despite this, until the re-inspection concludes, services are judged inadequate and there is a corporate risk for Safeguarding Children that has a very high-risk rating. Change is evident but universal improvement remains a challenge.

- **(P) C4 Managing our Business** - The segment is red because of the Authority's financial position but this disguises some good performance across other aspects of the County's business. The majority of indicators under C4 in corporate and support services are green or amber but with the significance of the budget overspend, the C4 segment has been judged as Red.

4.3. Performance Summary

The latest performance information is set out in Appendix A and summarised in the table below:

Direction of Performance indicators have been assessed based on whether current performance is improving or deteriorating as opposed to comparing performance with the previous report.

Metric Segment	Number of objectives			Direction of Performance		
	Green	Amber	Red	Up	Stable	Down
The People's Priorities	3	3	1	5	2	0
The Council	2	1	1	1	3	0
Vision Volunteers	1	0	0	0	1	0
Totals	6	4	2	6	6	0
As Percentage	50%	33%	17%	50%	50%	0%

4.4. As requested by Scrutiny the table below compares performance between quarters at the objective level and a link is also available to the previous quarterly reports in the Background Papers section at the end of this report.

Wheel Segment		RAG Status 2017/18			
		Apr - Jul	Q2	Q3	Q4
The People's Priorities	P1	R	A		
	P2	A	A		
	P3	R	R		
	P4	A	A		
	P5	G	G		
	P6	G	G		
	P7	G	G		
The Council	C1	G	G		
	C2	G	G		
	C3	A	A		
	C4	R	R		
Vision Volunteers	V1	G	G		

It is important when managing performance that consideration be given to the overarching vision statements set out in the County Plan

5. Consultations undertaken

5.1. The key messages within this monitoring report have been provided by Management Teams and reviewed by relevant Lead Cabinet Members.

6. Implications

6.1. If addressing performance issues requires changes in the way services are delivered through formal decisions, these must be supported by an appropriate impact assessment which will need to be duly considered by decision makers in line with our statutory responsibilities before any changes are implemented.

7. Background papers

7.1. County Plan - http://somersetcountyplan.org.uk/

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

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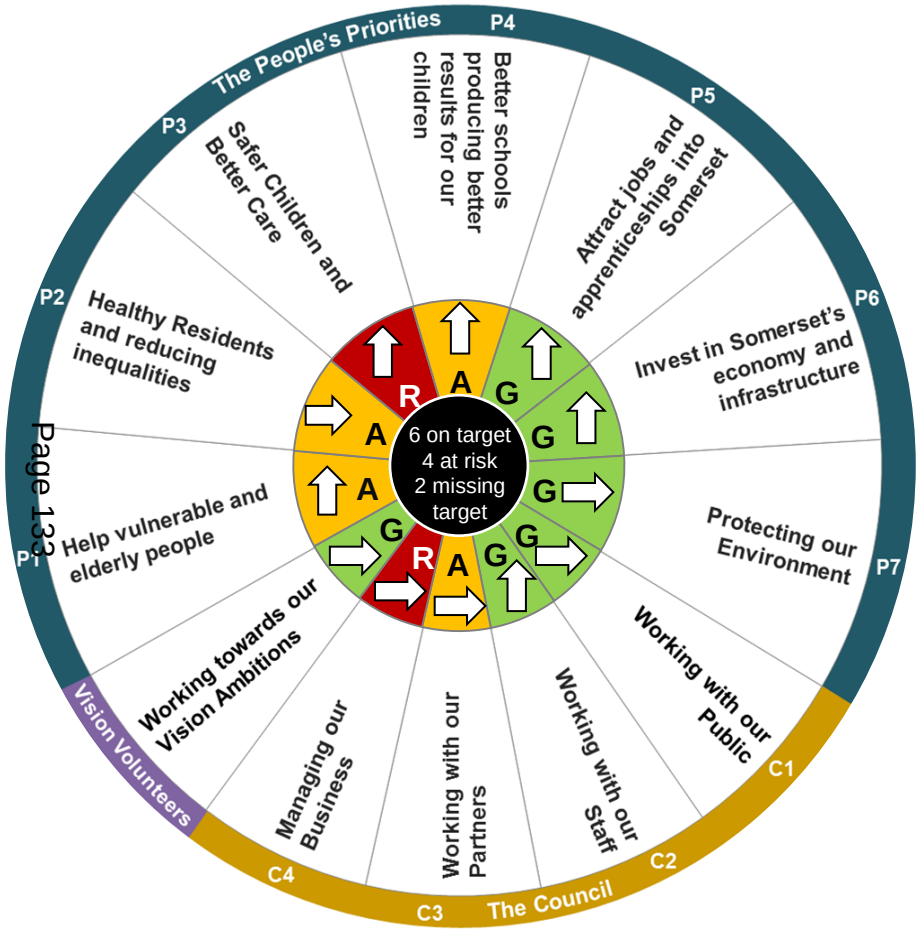
Appendix A – Corporate Performance Report
End of September 2017/18

Date of Report: 6th December 2017
Report Forum: Scrutiny for Policies, Adults and Health Committee



⇧	Performance Improving
⇩	Performance Deteriorating
⇨	Performance Stable
G	On target
A	At risk of missing target
R	Missing target

Issues for consideration

P3 Safer Children and Better Care - (red but improving)

- The Children's Trust Executive are pleased with the progress against the 7 Improvement Programmes, but recognise there is still much to do. Action Plans for 2017/18 are in place and Q2 performance against the CYPP was considered by the Policies, Children and Families Scrutiny Committee on 17th November 2017. Ofsted quarterly monitoring visits have concluded adequate progress is being made and DfE intervention has confirmed a " significant improvement " in Somerset's Children's Services, including more manageable case-loads, a more stable workforce and better partnership working as reported by the Minister in 2016. Despite this, until the re-inspection concludes, services are judged inadequate and there is a corporate risk for Safeguarding Children that has a very high risk rating. Change is evident but universal improvement remains a challenge.

C4 Managing our Business – (red but stable)

- The segment is red because of the Authority's financial position but this disguises some good performance across other aspects of the County's business. The majority of indicators under C4 in corporate and support services are green or amber but with the significance of the budget overspend, the C4 segment has been judged as Red.

P1 Help vulnerable and elderly people – (moving from red to amber)

- The Performance Improvement processes and improved use of data to support performance improvement is now being used consistently across all teams. This is in conjunction with a focused and improved use of technology. Management actions are in place for all performance targets and are being monitored closely. The implementation of the new management structure will improve and strengthen the approach further.

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SOMERSET COUNTY COUNCIL - ADULTS AND HEALTH SCRUTINY COMMITTEE

TERMS OF REFERENCE FOR THE LEARNING DISABILITY SERVICES TASK AND FINISH GROUP

Background

On 8th November 2017, the Adults and Health Scrutiny Committee ('the Committee') agreed to form a Task and Finish (T&F) Group to conduct further scrutiny of the delivery of SCC's contract for Learning Disability (LD) services in Somerset. LD services are delivered through Discovery, a Social Enterprise Vehicle created by Dimensions. Discovery started delivering LD services to Somerset people in April 2017.

Authority

The Committee delegates its authority, within these Terms of Reference, to the T&F Group for this task. The T&F Group's authority cannot exceed that of the Committee, to which the T&F Group is to report.

Task and Purpose

The T&F Group is to investigate specific concerns of the Committee, assess its findings and make recommendations to the Committee in order to improve the Committee's scrutiny of LD services.

Scope

In Scope. The concerns the T&F Group is to investigate and assess are the adequacy of:

- Discovery's governance arrangements for its contractual delivery of LD services;
- arrangements for Discovery's management chain to continuously hear the 'voice of the customer' (including LD service users, their carers and families) and the voice of Discovery staff;
- Discovery's staffing (turnover, loss, recruitment, and retention) and staff training and experience, and Discovery's HR planning to ensure that staffing will not compromise the standard of service;
- measures of Discovery's contract performance, including Key Performance Indicators, that provide good evidence for the Committee to scrutinise Discovery's delivery of LD services.

Out of Scope. The T&F Group is not to investigate or comment on the terms of the contract, including staff terms and conditions.

If in Doubt. Any doubt about the scope of the task is to be referred to the Chair of the T&F Group and, if necessary, to the Chair of the Committee.

Time

The T&F Group is to present its report, with recommendations, to the Committee Meeting scheduled for 7th March 2018, or the nearest date if re-arranged.

Composition

The T&F Group is to be: Councillor Rod Williams (Chair); Councillor Mandy Chilcott; and Councillor Bill Revans. They are to be supported by the Democratic Services team. A quorum will be 2 T&F Members.

Modus Operandi

The Chair of the T&F Group is to liaise between the T&F Group and the Committee, organise the work of the T&F Group and arrange support by the Democratic Services team in order to deliver the task. Councillors Chilcott and Revans are to support the Chair of the T&F Group. The T&F Group is to interview selected stakeholders, visit locations, assess its findings and make recommendations in a single report. The report is to be presented by the Chair of the T&F Group to the Chair of the Committee.

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Scrutiny for Adults and Health Work Programme – December 2017

Agenda item	Meeting Date	Details and Lead Officer
	12 January 2018 (Joint committee with Children's Scrutiny)	
	Children and Young People's Mental Health issues	
Public Health Children's emotional wellbeing report		Alison Bell
	24 January 2018	
Patient Safety & Quality Report – Q2 2017		Sandra Corry (CCG)
Medium Term Financial Plan 2018-19		Kevin Nacey
Update on Domestic Abuse Services		Lucy Macready
KPI update on LDPS contract		Steve Veevers
South Western Ambulance Service NHS Foundation Trust		John Dyer
	7 March 2018	
Somerset Sustainability and Transformation Plan		Pat Flaherty/Paul Goodwin, CCG
Proposal for Joint Commissioning		Trudi Grant
Community Hospitals Update		Phil Brice, Sompar
KPI update on LDPS contract		Steve Veevers
Report of the Learning Disability Contract Task and Finish Group		Cllr Rod Williams

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:

- CQC Inspection findings (as applicable)
- Community Safety Conference
- Shared Maternity & Paediatric Services (as applicable)
- Mental Health Promotion and new Prevention Concordat
- Update on the Health & Wellbeing Strategy
- Update on the County Plan
- Drugs and Alcohol services in Somerset update
- Weston Hospital

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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 Michael Bryant in the Democratic Services Team by telephoning (01823) 357628 or 359500.

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/17/09/01 First published: 11 September 2017	6 Dec 2017 Cabinet Member for Children and Families	Issue: Prescribed Alteration to Selworthy School - Implementation Decision: To implement the proposal to expand Selworthy School on to a second site in Taunton	Selworthy Prescribed Alteration Implementation Statutory Proposal - Prescribed Alteration - Expansion - Selworthy		Phil Curd, Service Manager: Specialist Provision and School Transport Tel: 01823 355165
FP/17/02/01 First published: 14 February 2017	6 Dec 2017 Cabinet Member for Children and Families	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 Court Fields School Wellington Award of Contract	Part exempt	Carol Bond, Project Manager, Property Programme Team Tel: 01823 355962
FP/17/09/03 First published: 11 September 2017	Not before 6th Dec 2017 Director of Commissioning for Economic and Community Infrastructure, Finance & Performance Director	Issue: iAero (Yeovil) Aerospace Centre (2,500 sq m) Acceptance of Growth Deal Funding Decision: The acceptance of the offer of Heart of the South West LEP Growth Deal funding, commence the procurement process for a management operator the the iAero (South) Centre, and commence procurement process for the construction of the iAero (South) Centre			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/17/09/06 First published: 13 September 2017	Not before 6th Dec 2017 Cabinet Member for Children and Families	Issue: The transfer of Educational services within North Somerset to SCC's Support Services for Education Decision: The transfer of Educational services within North Somerset and associated staff to Support Services for Education from April 2018.	Transfer of North Somerset education support services to SSE Appendix 2 - Educational Excellence Everywhere; the Future for the delivery of traded education services		Ian Rowswell
FP/17/07/03 First published: 10 July 2017	Not before 11th Dec 2017 Cabinet Member for Highways and Transport	Issue: To agree to the purchase of the land for the construction of the M5 Junction 25 Highways Improvement Scheme. Decision: The Cabinet Member for Highways and Transport agrees to: • the acquisition of land required for the construction of the M5 Junction 25 highways scheme • the continued development of the scheme.	Cabinet Member Key Decision - M5 Junction 25 – decision to proceed with consultation, design, planning and procurement – 19 Aug 2016 Cabinet Member Key Decision - To agree to enter into a funding agreement with the Heart of the South West Local Enterprise Partnership (HotSW LEP) for the M5 J25 Improvement scheme – 13 Jan 2017	Part exempt	Sunita Mills, Service Commissioning Manager Tel: 01823 359763
FP/17/04/08 First published: 24 April 2017	Not before 11th Dec 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 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/17/09/13 First published: 26 September 2017	13 Dec 2017 Cabinet	Issue: Decision to conclude the award of a contact for the provision of highway improvements at Colley Lane Southern Access Road Decision: Agree to let a contract for highway bridge construction and associated works at Colley Lane Southern Access Road			Sunita Mills, Service Commissioning Manager Tel: 01823 359763
FP/17/11/07 First published: 22 November 2017	13 Dec 2017 Cabinet	Issue: Schools National Funding Formula Decision: to consider the new national funding formula for schools, the process and recommendations from Schools Forum			Martin Young, Finance Strategy Manager Tel: 01823 359057
FP/17/09/18 First published: 10 October 2017	Not before 13th Dec 2017 Cabinet Member for Highways and Transport	Issue: West Somerset Railway - Funding of Phase two of the level crossing upgrade at Seaward Way, Minehead Decision: That the Cabinet Member for Highways and Transport authorises the expenditure of £850,000 for Phase Two of the West Somerset Railway (WSR) level crossing upgrade at Seaward Way, Minehead			Neil Guild, Highways Asset Improvement Officer

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/17/10/03 First published: 19 October 2017	Not before 14th Dec 2017 Cabinet Member for Children and Families	Issue: Proposed ASD Base at Holway Park Primary School, Taunton Decision: To approvie the appointment of a contractor			Carol Bond, Project Manager, Property Programme Team Tel: 01823 355962
FP/17/08/01 First published: 9 August 2017	Not before 18th Dec 2017 Cabinet Member for Resources and Economic Development	Issue: Disposal of Surplus Land at Castle Cary Decision: Authority to conclude negotiations for the disposal of surplus (former) farm land (13 acres, land only) at Castle Cary. Authority to conclude negotiations for the disposal of surplus (former) farm land (13 acres, land only) at Castle Cary.	Disposal of Surplus Land		Richard Williams, Commercial & Business Services Director Tel: 01823 359007
FP/17/11/05 First published: 16 November 2017	18 Dec 2017 Cabinet Member for Strategy, Customers and Communities	Issue: Customer Feedback Annual Reports 2016/17 Decision: Sign off of the annual customer feedback reports for year from 1 April 2016 – 31 March 2017			Rebecca Martin Tel: 01823 356257
FP/17/09/02 First published: 11 September 2017	Not before 18th Dec 2017 Director of Commissioning for Economic and Community Infrastructure	Issue: Low Carbon Hub - Somerset Energy Innovation Centre - Building 2 (2,000 sq m) 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

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/17/11/03 First published: 9 November 2017	Not before 20th Dec 2017 Director of Commissioning for Economic and Community Infrastructure	Issue: Decision to approve the appointment of a supplier to deliver the Wiveliscombe Enterprise Centre Decision: To approve the appointment of a supplier to deliver the Wiveliscombe Enterprise Centre			Nathaniel Lucas, Senior Economic Development Officer Tel: 01823359210
FP/17/11/04 First published: 9 November 2017	Not before 20th Dec 2017 Director of Commissioning for Economic and Community Infrastructure	Issue: Decision to approve the appointment of a supplier to deliver the Wells Technology Enterprise Centre Decision: To approve the appointment of a supplier to deliver the Wells Technology Enterprise Centre			Nathaniel Lucas, Senior Economic Development Officer Tel: 01823359210
FP/17/09/04 First published: 11 September 2017	Not before 15th Jan 2018 Finance & Performance Director, Director of Commissioning for Economic and Community Infrastructure	Issue: iAero (Yeovil) Aerospace Centre (2,500 sq m) Acceptance of ERDF Funding Decision: The acceptance of the offer of ERDF funding (£2.8 million), for the iAero (Yeovi) Aerospace Centre			Lynda Madge, Commissioning Manager – Economy & Planning Tel: 01823 356766
FP/17/09/05 First published: 26 September 2017	17 Jan 2018 Cabinet	Issue: South West Peninsula Framework Contact for Independent Fostering Decision: Cabinet will be asked to agree Officer recommendations on award of the contract			Louise Palmer, Strategic Commissioner

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/17/11/07 First published: 22 November 2017	17 Jan 2018 Cabinet	Issue: Schools National Funding Formula Decision: to confirm funding allocations following confirmation from DfE			Martin Young, Finance Strategy Manager Tel: 01823 359057
FP17/09/07 First published: 13 September 2017	Not before 29th Jan 2018 Cabinet Member for Children and Families, Commercial & Business Services Director	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 - King Alfred School and Pawlett Primary School. This is a technical decision to faciliate the transfer of land and non fixed assets			Elizabeth Smith, Service Manager – Schools Commissioning Tel: 01823 356260
FP/17/09/16 First published: 10 October 2017	Not before 5th Feb 2018 Commercial & Business Services Director, Cabinet Member for Children and Families	Issue: Creation of a new Academy in Somerset Decision: West Buckland Community Primary School - Thiis is a tachnical decision to facilitate the transfer of land and non fixed			Elizabeth Smith, Service Manager – Schools Commissioning Tel: 01823 356260
FP/17/08/09 First published: 16 August 2017	12 Feb 2018 Cabinet	Issue: 2018/19 - 2021/22 Medium Term Financial Plan Decision: to consider and recommend the 2018/19 MTFP and Annual Revenue Budget proposals to February's Full Council meeting			Elizabeth Watkin, Service Manager - Chief Accountant Tel: 01823359573

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/17/08/12 First published: 6 November 2017	12 Feb 2018 Cabinet	Issue: County Vision 2017-20221 Decision: to consider the proposed County Vision to recommend to February's Full Council			Simon Clifford, Customers & Communities Director
FP/17/08/08 First published: 16 August 2017	12 Feb 2018 Cabinet	Issue: Quarter 3 2017/18 Revenue and Capital budget monitoring report Decision: to consider the quarter 3 update for the 2017/18 revenue and capital budgets			Elizabeth Watkin, Service Manager - Chief Accountant Tel: 01823359573
FP/17/08/08 First published: 16 August 2017	12 Feb 2018 Cabinet	Issue: 2017/18 Quarter 3 Performance Update Decision: to receive the quarter 3 performance update			Emma Plummer, Strategic Manager Performance Tel: 01823 359251
FP/17/09/17 First published: 10 October 2017	12 Feb 2018 Cabinet	Issue: Proposed new secondary provision for Selworthy School on the former St Augustine's School site Decision: To approve the appointment of a contractor at gross maximum expenditure	Financial Report Capital Programme Paper		Carol Bond, Project Manager, Property Programme Team Tel: 01823 355962

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
FP17/08/14 First published: 29 August 2017	12 Feb 2018 Cabinet	Issue: Retendering for insurance cover for all external policies and for South West academies. Decision: To approve the appointment of the successful tenderer following an OJEU procurement process for insurance cover. To approve the tender for an all-encompassing insurance policy for academies in the South West (to be administered by SCC but full external cover).	CIPFA Insurance Benchmarking Club 2017 Report Gallagher Bassett Audit for Somerset County Council May 2017	Part exempt	Martin Gerrish, Strategic Manager - Financial Governance and Finance Officer for SWP Tel: 01823 355303
FP/17/08/13 First published: 25 August 2017	12 Feb 2018 Cabinet	Issue: Family support services for Somerset - Final report on recommendations for the service model Decision: to consider the consultation results, business case and the proposed service model			Philippa Granthier, Assistant Director - Commissioning and Performance, Children's Services Commissioning Tel: 01823 359054
Fp/17/11/06 First published: 22 November 2017	12 Feb 2018 Cabinet	Issue: Family support services for Somerset - Final report on recommendations for how the service will be delivered Decision: to consider the consultation results and the proposals for how the service will be delivered			Philippa Granthier, Assistant Director - Commissioning and Performance, Children's Services Commissioning Tel: 01823 359054

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/17/11/01 First published: 6 November 2017	12 Feb 2018 Cabinet	Issue: Treasury Management Strategy 2018/19 Decision: Recommend the proposed Treasury Management Strategy 2018/19 to Council for approval			Alan Sanford, Principal Investment Officer Tel: 01823 359585
FP/17/11/02 First published: 6 November 2017	12 Feb 2018 Cabinet	Issue: Admission Arrangements for Voluntary Controlled and Community Schools for 2019/20 Decision: seeks authority for Cabinet to determine the Local Authority admission arrangements for all VC and community schools for 2019/20 as required by the School Admissions Code			Jane Seaman, Access and Admissions Manager Tel: 01823 355615
FP/17/08/12 First published: 17 August 2017	21 Mar 2018 Cabinet	Issue: Full Business Case for proposed Joint Strategic Commissioning Function Decision: to consider the full business case for establishiong a new Joint Strategic Commissioning Function with NHS England and Somerset CCG			Trudi Grant, Public Health Director Tel: 01823 359015

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