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Somerset Health and Wellbeing Board

Thursday 13 July 2017
11.00 am Luttrell Room - County Hall, Taunton

To: The Members of the Somerset Health and Wellbeing Board

Councillor Christine Lawrence (Chairman)
Councillor Frances Nicholson (Vice-Chairman)
Councillor David Huxtable
Councillor Linda Vijeh
Councillor Amanda Broom
Councillor Sylvia Seal, South Somerset District Council
Councillor Gill Slocombe, Sedgemoor District Council
Councillor Jane Warmington, Taunton Deane Borough Council
Councillor Keith Turner, West Somerset District Council
Lou Evans, Clinical Commissioning Group
Dr Ed Ford, Clinical Commissioning Group
Dr David Slack, Clinical Commissioning Group
Mr Mark Cooke, NHS England
Judith Goodchild, HealthWatch
Stephen Chandler
Trudi Grant
Julian Wooster

Issued By Julian Gale, Strategic Manager - Governance and Risk - 5 July 2017

For further information about the meeting, please contact Julia Jones or 01823 359027
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 Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

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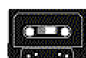
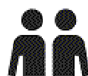

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AGENDA

Item Somerset Health and Wellbeing Board - 11.00 am Thursday 13 July 2017

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

1 **Apologies for absence**

To receive Board Members' 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 **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.

4 **Joint Strategic Needs Assessment (JSNA) 2017** (Pages 5 - 108)

To consider the report and presentation.

5 **Better Care Fund draft Plan 2017/19** (Pages 109 - 112)

To receive the report and presentation

6 **Health and Wellbeing Performance Report 2016/17** (Pages 113 - 126)

To receive the report

7 **Somerset Health and Wellbeing Board Annual Report** (Pages 127 - 152)

To receive the report

8 **Devon and Somerset Fire and Rescue Service updates** (Pages 153 - 164)

To receive the report

9 **Somerset Health and Wellbeing Board Forward Plan**

To discuss any items for the work programme. To assist the discussion, attached is the Board's current work programme.

10 **Any other urgent items of business**

The Chairman may raise any items of urgent business.

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 Board's Administrator Jamie Jackson. Telephone: (01823) 359040 or email jajackson@somerset.gov.uk . They can also be accessed via the council's website on **www.somerset.gov.uk/agendasandpapers**

2. **Minutes of the Meeting**
Details of the issues discussed and recommendations made at the meeting will be set out in the Minutes, which the Board will be asked to approve as a correct record at its next meeting. In the meantime, information about each meeting can be obtained from Jamie Jackson. Telephone: (01823) 359040 or email jajackson@somerset.gov.uk

3. **Public Question Time**

If you wish to speak, please inform Julia Jones, the Board's Clerk, by 12 noon the (working) day before the meeting - (01823) 359027 or email jjones@somerset.gov.uk

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

4. **Exclusion of Press & Public**

If when considering an item on the Agenda, the Board 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.

5. **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 Board's Administrator and return it at the end of the meeting.

6. **Recording of Meetings**

The Council supports the principles of openness and transparency, it allows filming, recording and taking photographs at its meetings that are open to the public providing it is done in a non-disruptive manner. Members of the public may use Facebook and Twitter or other forms of social media to report on proceedings and a designated area will be provided for anyone who wishing to film part or all of the proceedings. No filming or recording will take place when the press and public are excluded for that part of the meeting. As a matter of courtesy to the public, anyone wishing to film or record proceedings is asked to provide reasonable notice to the Council's Monitoring Officer (Mr Julian Gale on 01823 359047) so that the Chairman of the meeting can inform those present.

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.

Somerset Health and Wellbeing Board

Report for information

Somerset: Our County - Joint Strategic Needs Assessment (JSNA) 2017
Lead Officer: Trudi Grant, Director of Public Health
Author: Pip Tucker, Public Health Specialist/Jo McDonagh, JSNA Project Manager
Contact Details: 01823 359 449/01823 357 275

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Trudi Grant	4.07.17
	Cabinet Member / Portfolio Holder (if applicable)	Christine Lawrence	4.07.17
	Monitoring Officer (Somerset County Council)	Julian Gale	4.07.17
Summary:	Somerset's draft JSNA 2017 has been produced; this includes updating existing JSNA website information as an on-going process and a focus this year on ageing well. The final version is presented for approval by the Health and Wellbeing Board. This is also an opportunity to discuss how the next JSNA (2018) could inform the refresh of the Health and Wellbeing Strategy.		
Recommendations:	**That the Somerset Health and Wellbeing Board approves the final version of the Joint Strategic Needs Assessment Summary 2017 and accompanying qualitative report.**		
Links to Somerset Health and Wellbeing Strategy	Links to all three priorities: **Priority One**: People, families and communities take responsibility for their own health and wellbeing **Priority two**: Families and communities are thriving and resilient **Priority three**: Somerset people are able to live independently		
Financial, Legal and HR Implications:	Identified within future commissioning plans of Somerset County Council, NHS Somerset, CCG and partners. There is no additional funding to support specific pieces of work required for the JSNA and this year because of further cost restrictions there will be no printed public summary. Work to produce the JSNA must be mitigated by staff capacity.		

Equalities Implications:	The JSNA pays due regard to protected groups to identify health and social inequalities within the Somerset population. The focus on ageing well provides an insight into forms of inequalities that are particularly pertinent to the county.
Risk Assessment:	Any failure by commissioners to fully take into account the results of JSNAs when taking commissioning decisions across agencies is very likely to have detrimental impacts on service improvement and delivery and the reduction of inequalities.

1. Background

1.1 Somerset's JSNA continues to be reviewed and updated to provide an accessible on-line e-tool resource for commissioners.

1.2 Health need data have been produced to reflect inequalities related to ageing in the county.

1.3 The JSNA draft summary for 2017 has been discussed by the Health and Wellbeing Board in a development session, by the Clinical Operations Group of the Clinical Commissioning Group, Adult Health Scrutiny, Health and Wellbeing Executive in a development session and Cabinet/SLT. It will go to Cabinet to note in August.

1.4 The production of the JSNA for 2018 has the opportunity to underpin priorities in the Health and Wellbeing Strategy, looking at evidence and trends to identify inequalities that impact on the population of Somerset as a whole and ways to address these.

2. Options considered and reasons for rejecting them

2.1 The Health and Wellbeing Board is required to produce a JSNA. This has been, in the past, a printed document. The JSNA is now a fully web-based resource with a short summary to make information for commissioners more accessible.

2.2 It is always the intention to utilise existing work to support the JSNA and include a resource of linked supporting documents on the JSNA webpages.

3. Consultations undertaken

3.1 A specific piece of qualitative work has been undertaken to support this JSNA and provide insight and experience regarding ageing well. The results are summarised in a separate report to compliment the JSNA summary. Detail of all the discussions will be linked from the qualitative report on the Somerset Intelligence website.

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

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

4. Implications

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

5. Background papers

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

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Somerset: Our County

Joint Strategic Needs Assessment

Summary 2017
Ageing Well

Somerset Health and Wellbeing Board

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INTRODUCTION

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

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

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

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

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

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

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

Christine Lawrence

Chair of Somerset Health and Wellbeing Board

Trudi Grant

Director of Public Health

EXECUTIVE SUMMARY AND IMPLICATIONS FOR COMMISSIONERS

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

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

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

Remaining healthy

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

Remaining independent

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

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

Remaining active and included in community life

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

MAIN SUMMARY - BACKGROUND AND CONTEXT

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

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

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

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

The United Nations describes population ageing as 'one of the most significant social transformations of the twenty-first century'[i] and its consequences are unsurprisingly wide ranging. A wealth of information on the social circumstances in Somerset is available on the Somerset Intelligence website (www.somersetintelligence.org.uk/jsna , links to relevant individual pages are also shown throughout this summary. All the webpages relating to ageing well are collected in a single document at (www.somersetintelligence.org.uk/jsna/ageingwell2017.pdf). The web site *is the JSNA*. This document is a summary of its implications.

Definitions and Scope

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

Demography – general overview

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

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

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

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

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

SECTION I: REMAINING HEALTHY

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

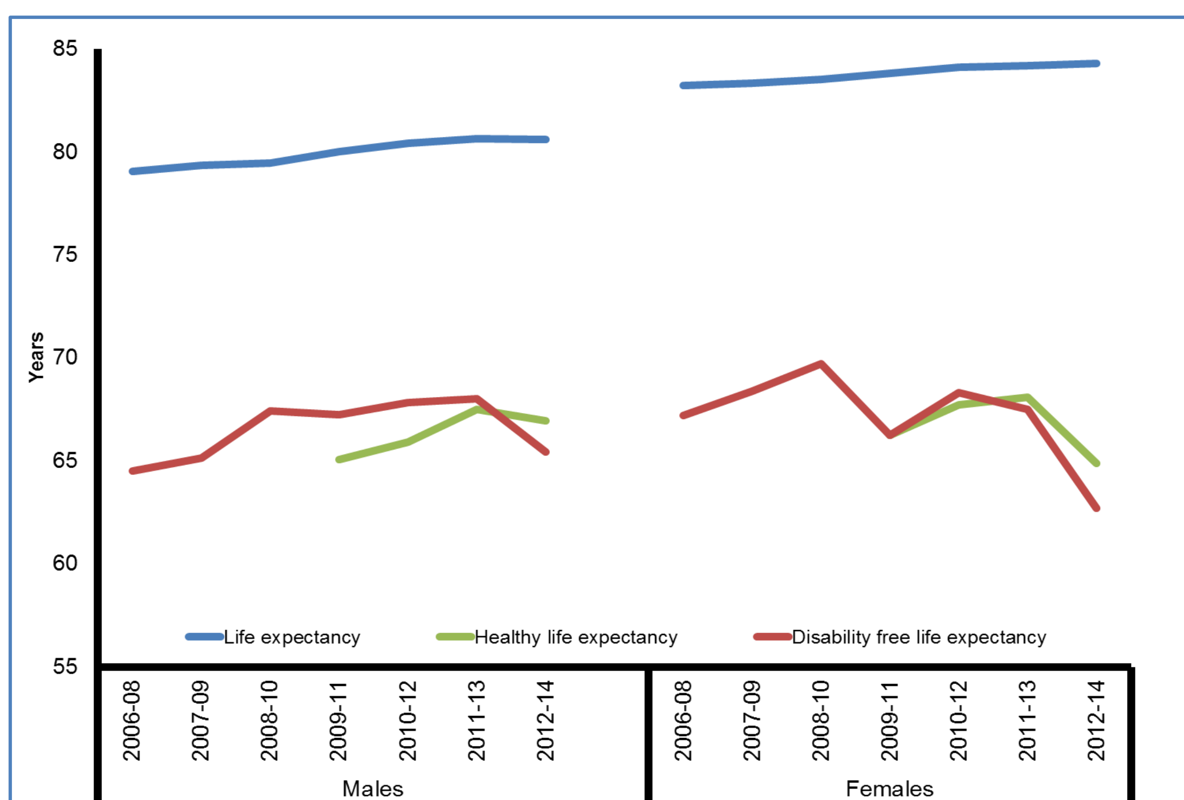


Figure 2 - Life Expectancy and Healthy Life Expectancy, Somerset

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

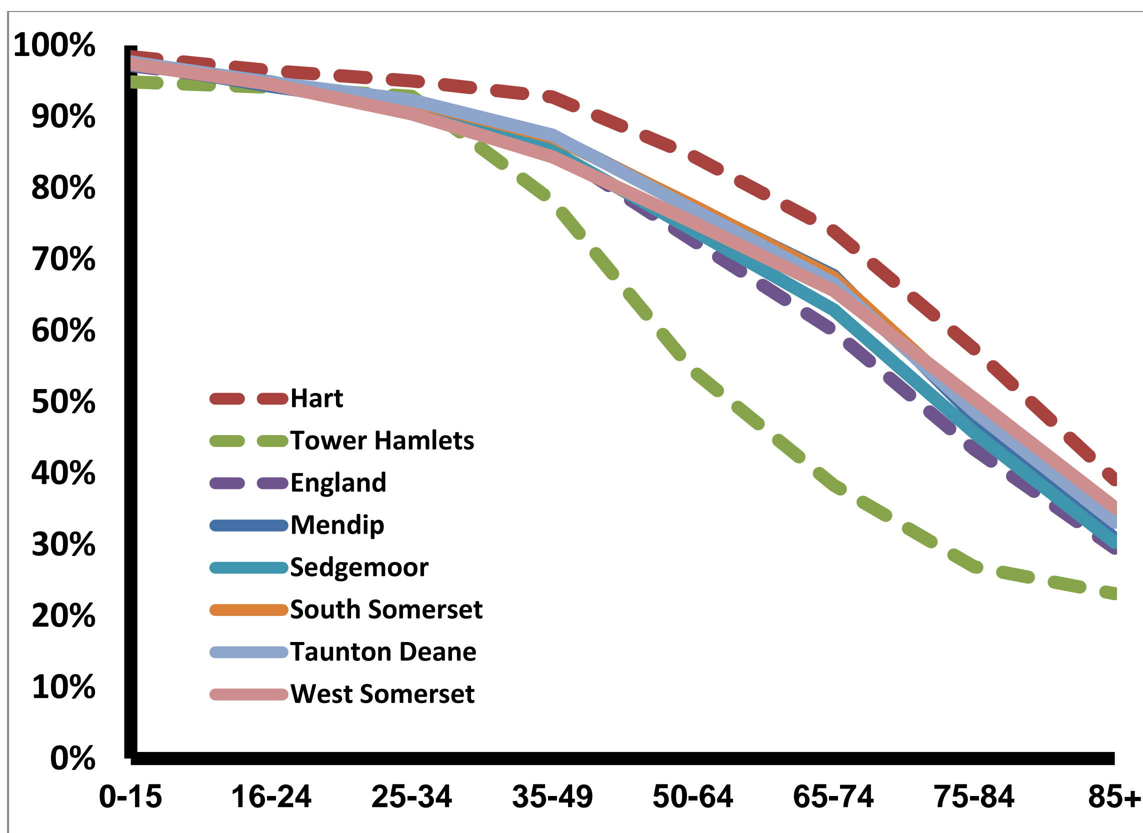


Figure 3 - Self Reported Health (2011 census)

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

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

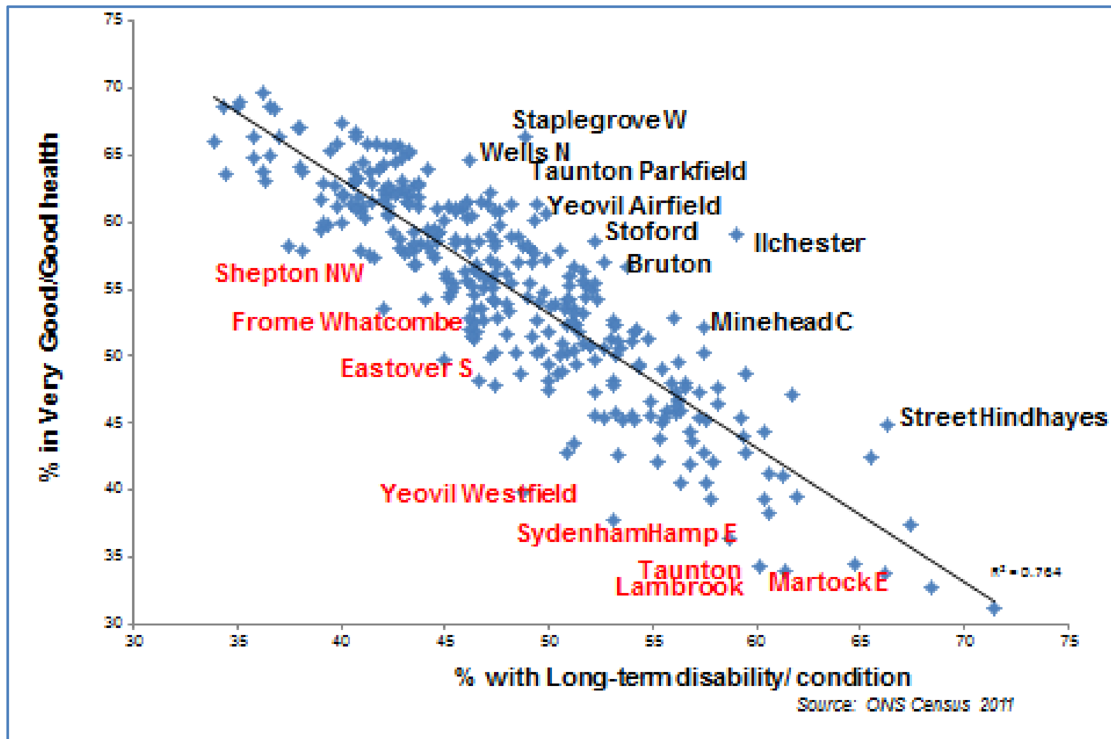


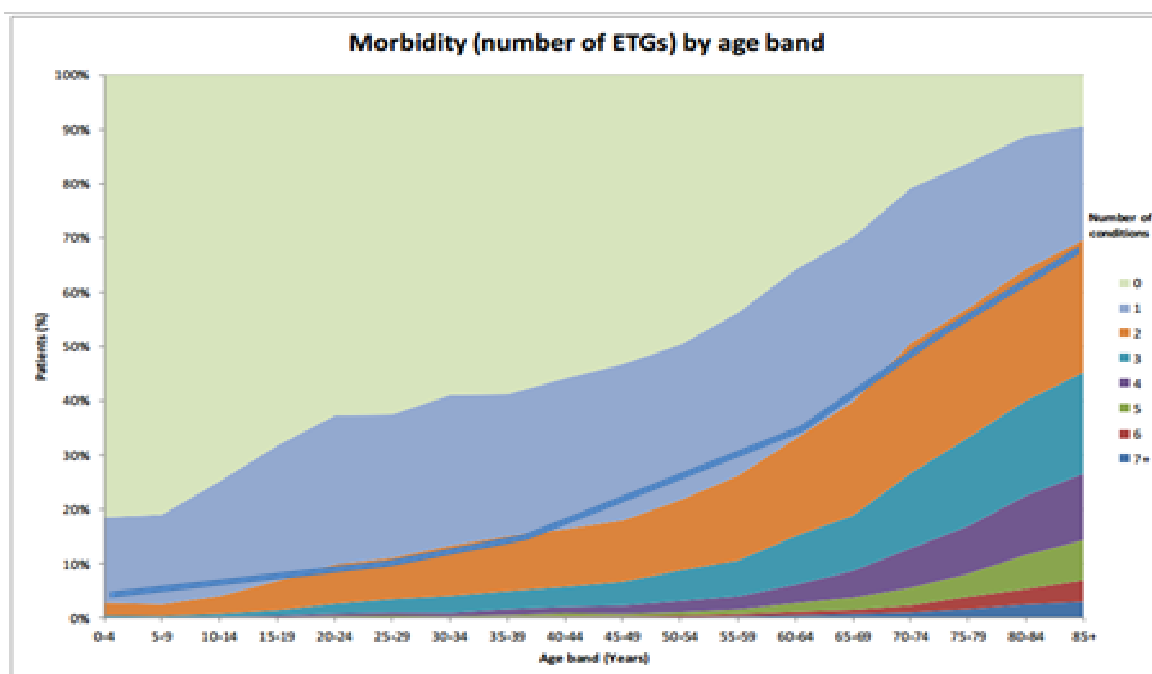
Figure 4 - Age 65+ Good health vs Long-term Condition

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

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

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

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



Somerset percentage reporting health as neither good nor very good

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

Long-term conditions and multi-morbidity

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

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

Discussion group snapshot

We asked: What motivates you to keep well?

Somerset people said:

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

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

Table 1 - Observed and Expected Numbers with Long Term Conditions

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

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

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

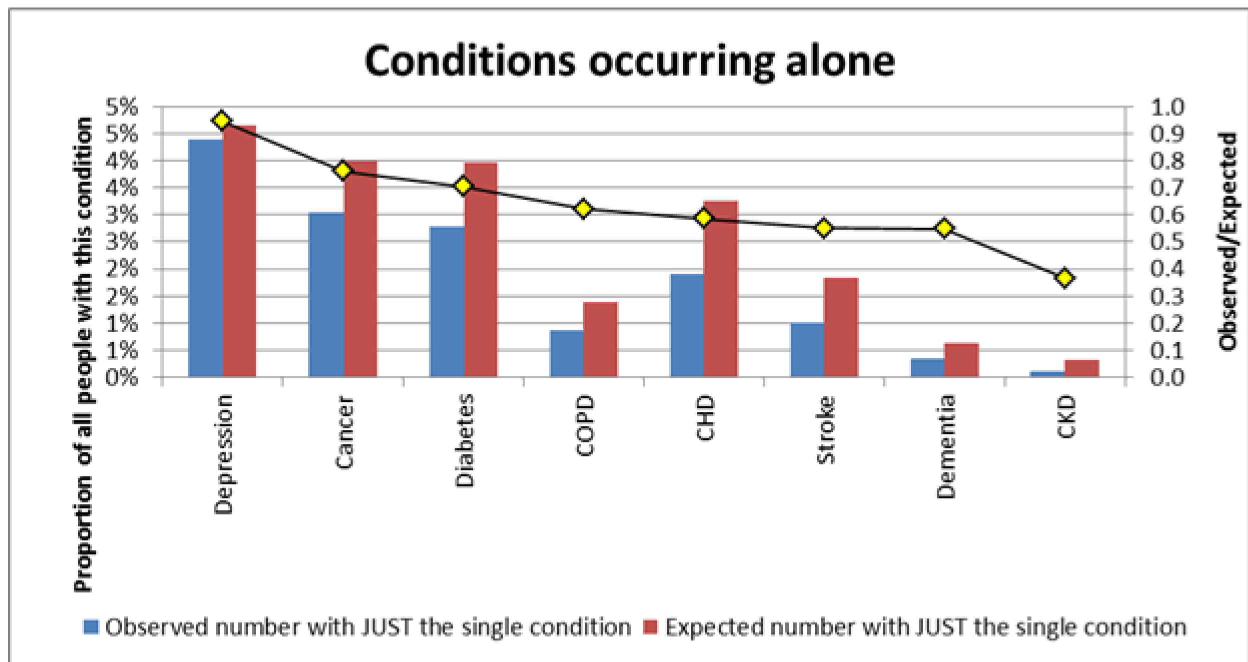


Figure 6 - Long Term Conditions Occurring Alone

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

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

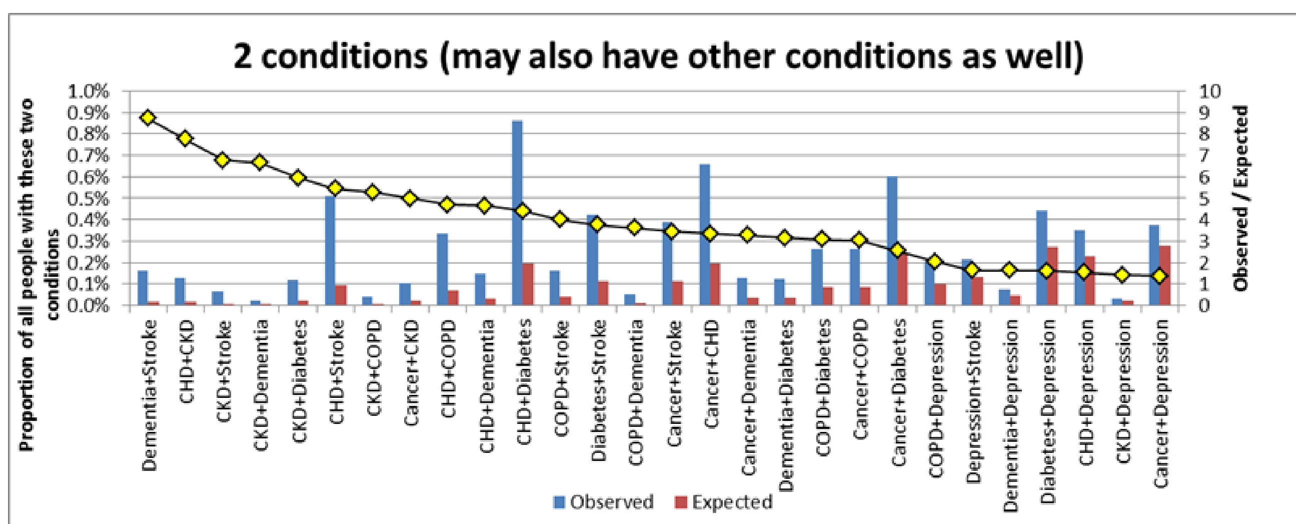


Figure 7 - Prevalence of Two Long Term Conditions Occurring Together

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

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

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

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

Inequality in Multimorbidity

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

Projections of Multimorbidity

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

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

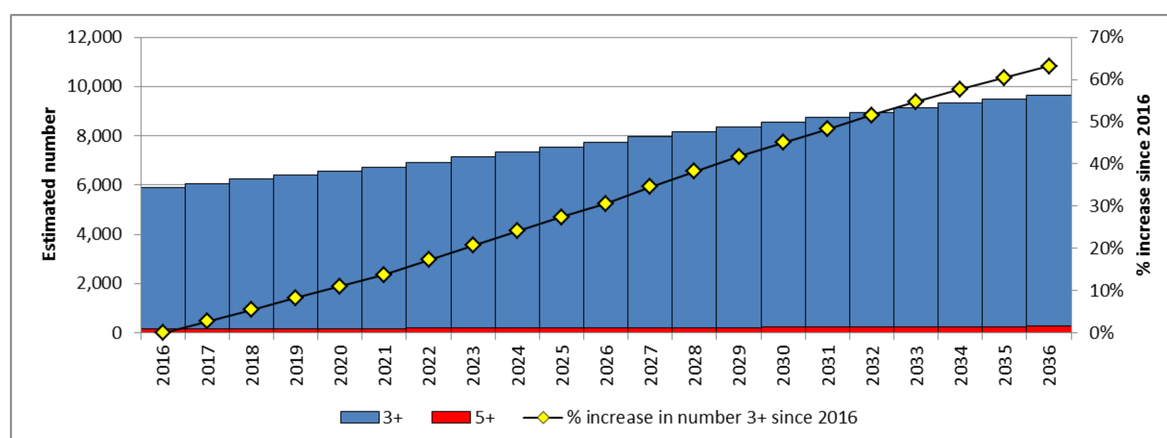


Figure 8 - Projections of Numbers with 3+ and 5+ Long Term Conditions

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

Cause of death

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

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

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

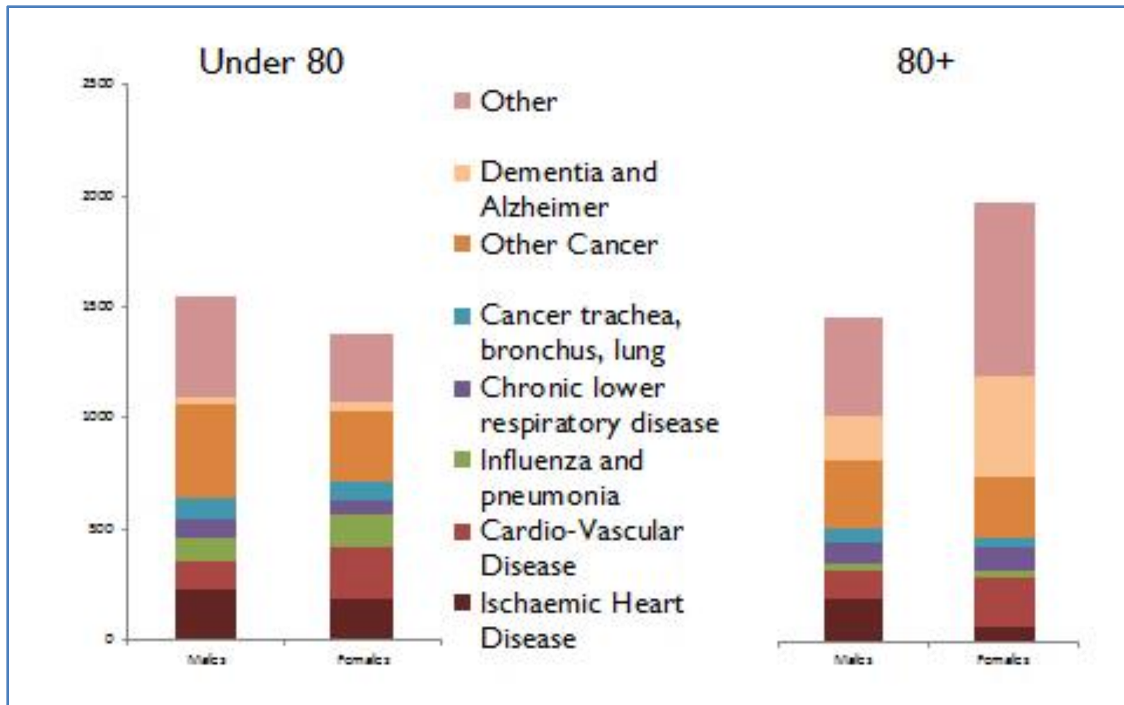


Figure 9 - Cause of Death, Somerset 2015

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

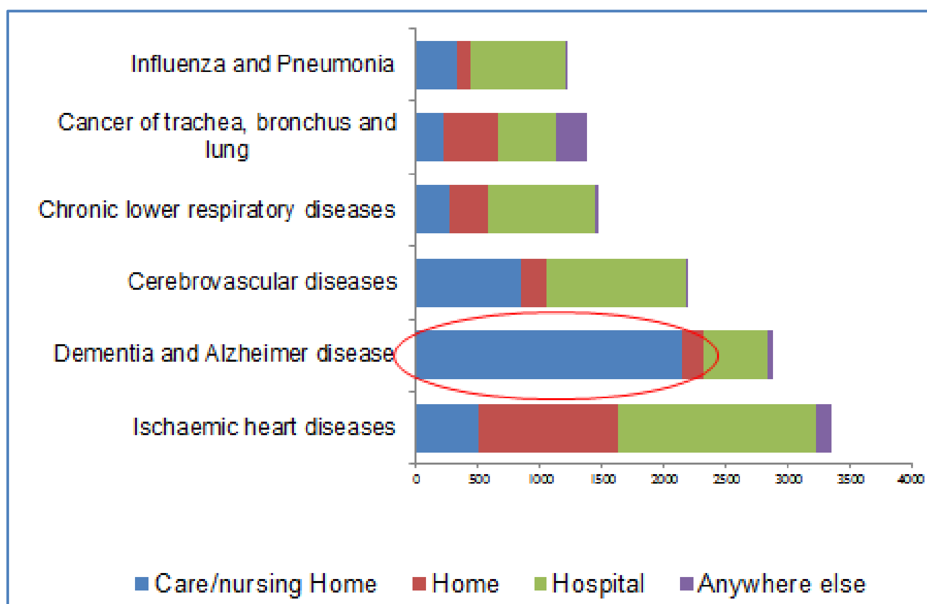


Figure 10 - Place of Death, Somerset

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

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

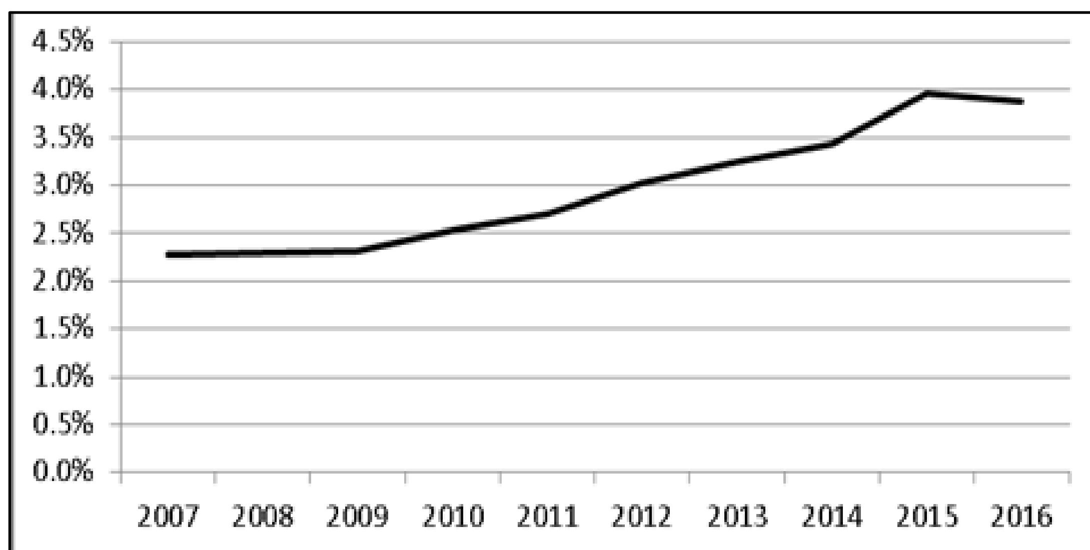


Figure 11 - Dementia Recorded Prevalence 65+, Somerset Registered Population

Lifestyles and prevention

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

Discussion group snapshot

Diet

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

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

Screening, too, has a role in prevention, with health checks a way of identifying conditions early. Nationally, the uptake of bowel screening amongst 50-70 year olds is less than 70%, and less than 50% in men aged 60-64, even though this is the second most common form of cancer in the whole population [xii].

Physical activity

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

CASE STUDY FROM THE COMMUNITY COUNCIL FOR SOMERSET

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

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

Summary

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

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

SECTION II: REMAINING INDEPENDENT

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

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

Care

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

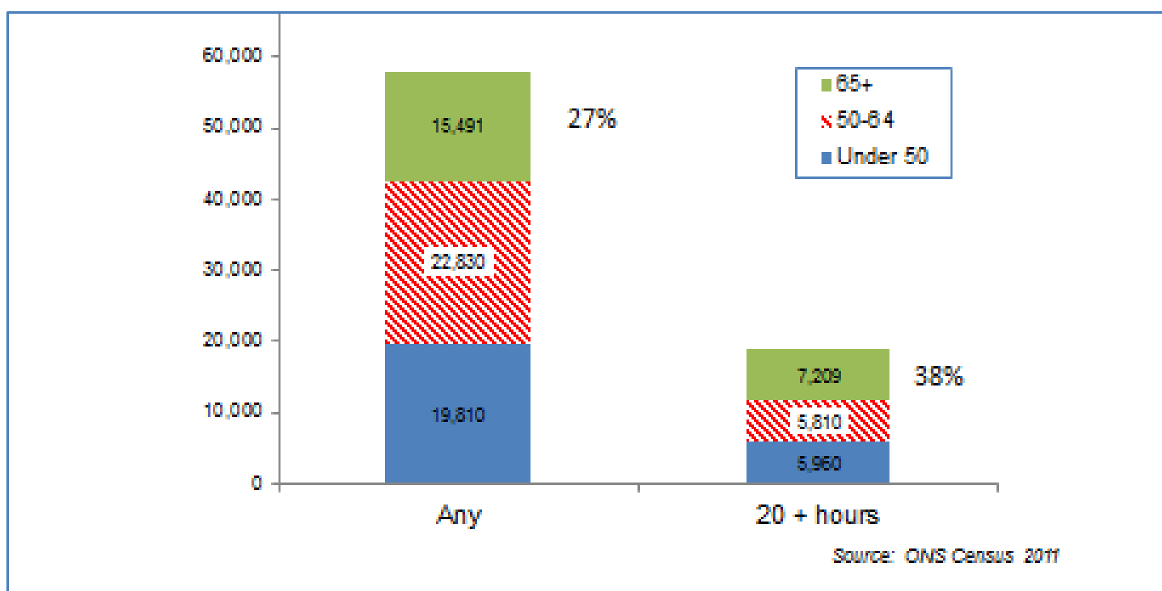


Figure 12 - Providing Unpaid Care in Somerset

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

Discussion group snapshot

Carers

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

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

Discussion group snapshot

Attitudes to older people

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

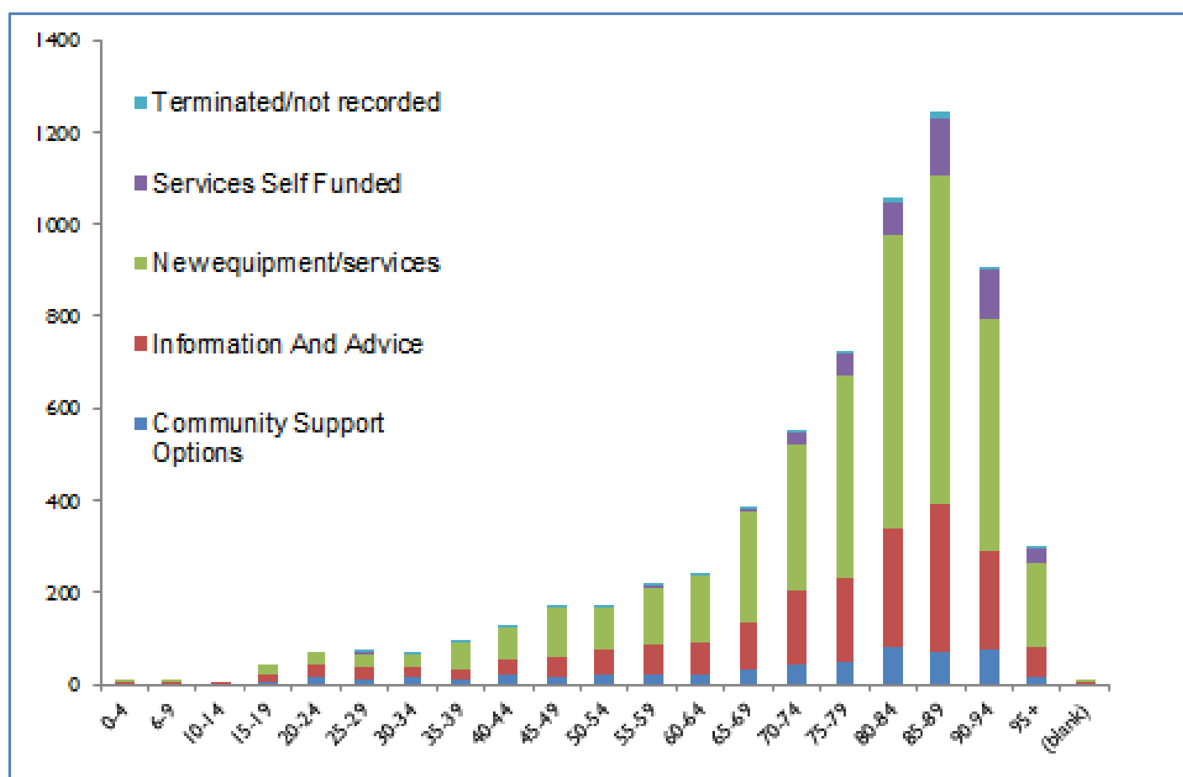


Figure 13 - Social Care Assessment Outcome

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

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

Case study from 'Our Place', Martock:

Grace, 80 – Martock

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

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

Discussion group snapshot

Promoting independence

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

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

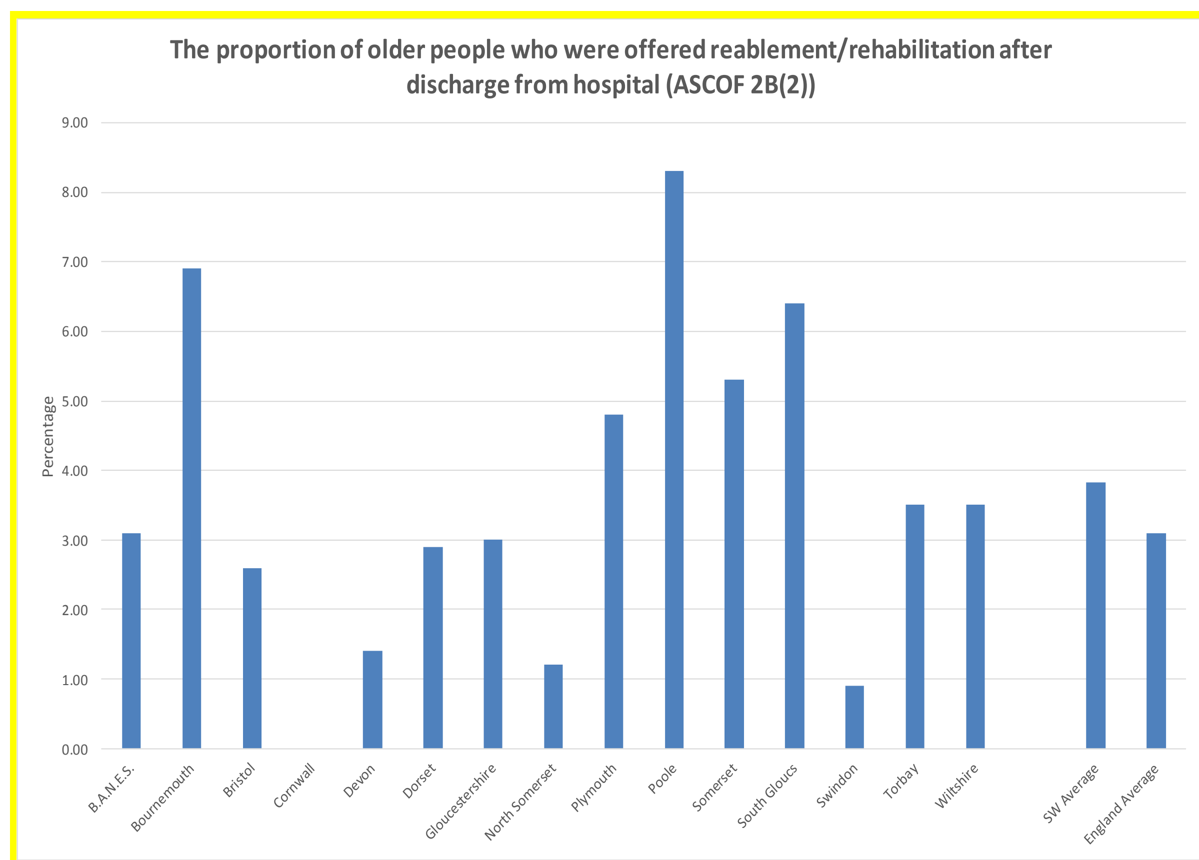


Figure 14 above shows that Somerset is one of the highest in the South West for reablement following discharge from hospital. In principle, this would appear positive, however Figure 15 following compares the outcomes of reablement in Somerset with the rest of the South West. The numbers entering into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

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

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

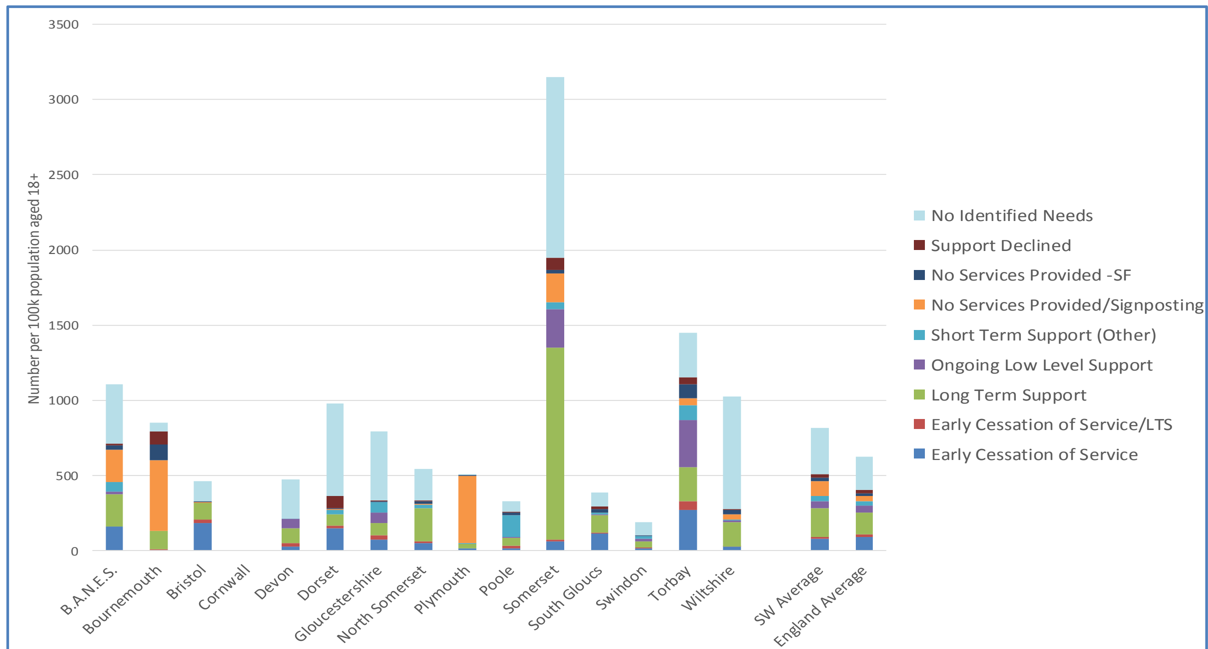


Figure 15 - New and Existing Customers Receiving Reablement 2014/15, Showing Sequels

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

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

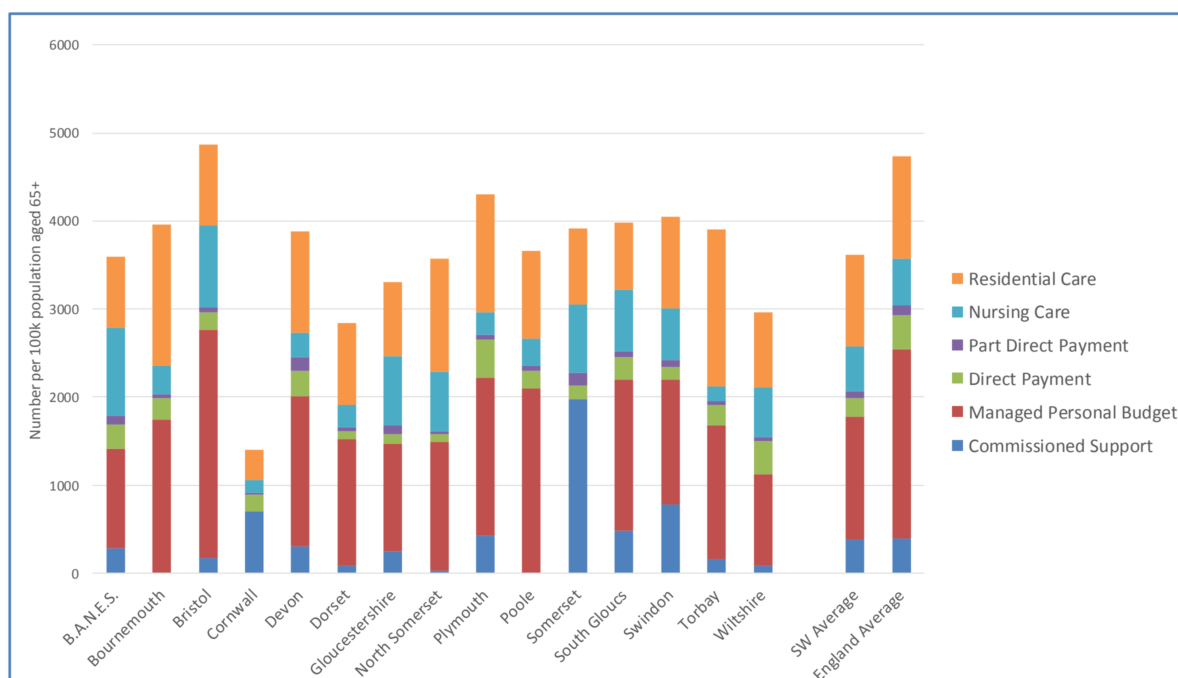


Figure 16 - Number of People Aged 65+ Receiving Long-term Support at Year End 2014/15 by Service Type

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

Housing

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

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

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

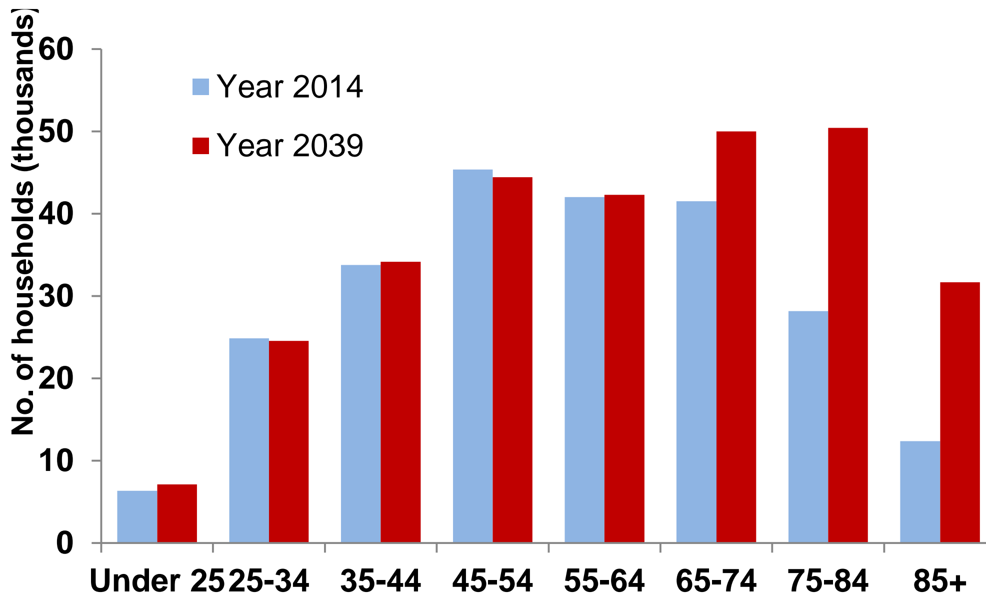


Figure 17 - 'Heads of Household' by Age

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

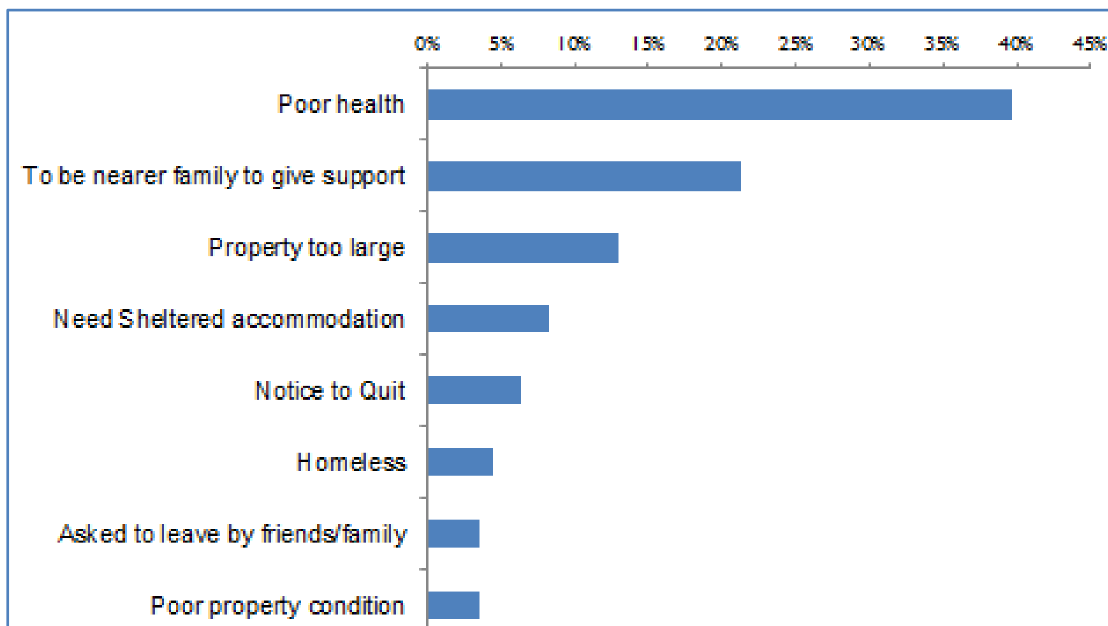


Figure 18 – Homefinder – Reasons for Moving

Discussion group snapshot

Housing

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

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

Transport

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

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

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

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

Table 2 - Older people (aged 65+) With No Car, by Rural-Urban Classification % Based on Those Living in a Residential Household, Not Communal Establishments
Source: ONS Census 2011

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

Discussion group snapshot

Transport

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

Section III: REMAINING ACTIVE AND INCLUDED IN COMMUNITY LIFE

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

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

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

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

Social contact and loneliness

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

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

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

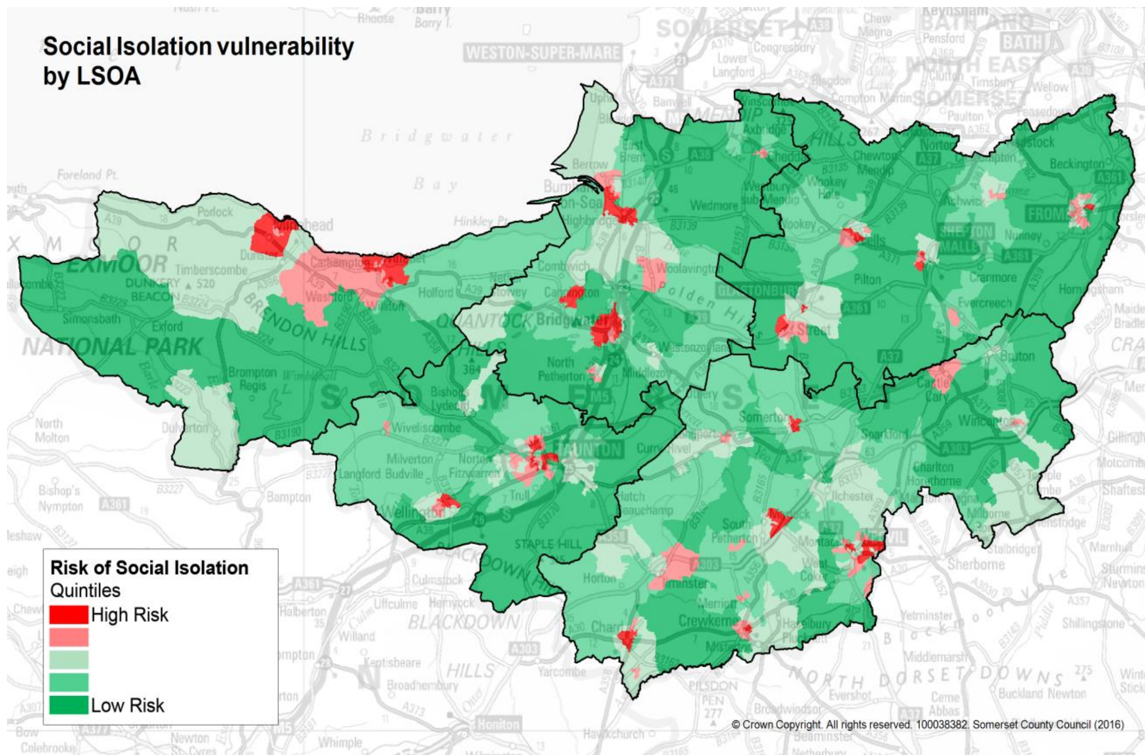


Figure 20 - Risk of Social Isolation (All Ages)

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

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

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

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

Discussion group snapshot

What helps people to age well?

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

Work and Income

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

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

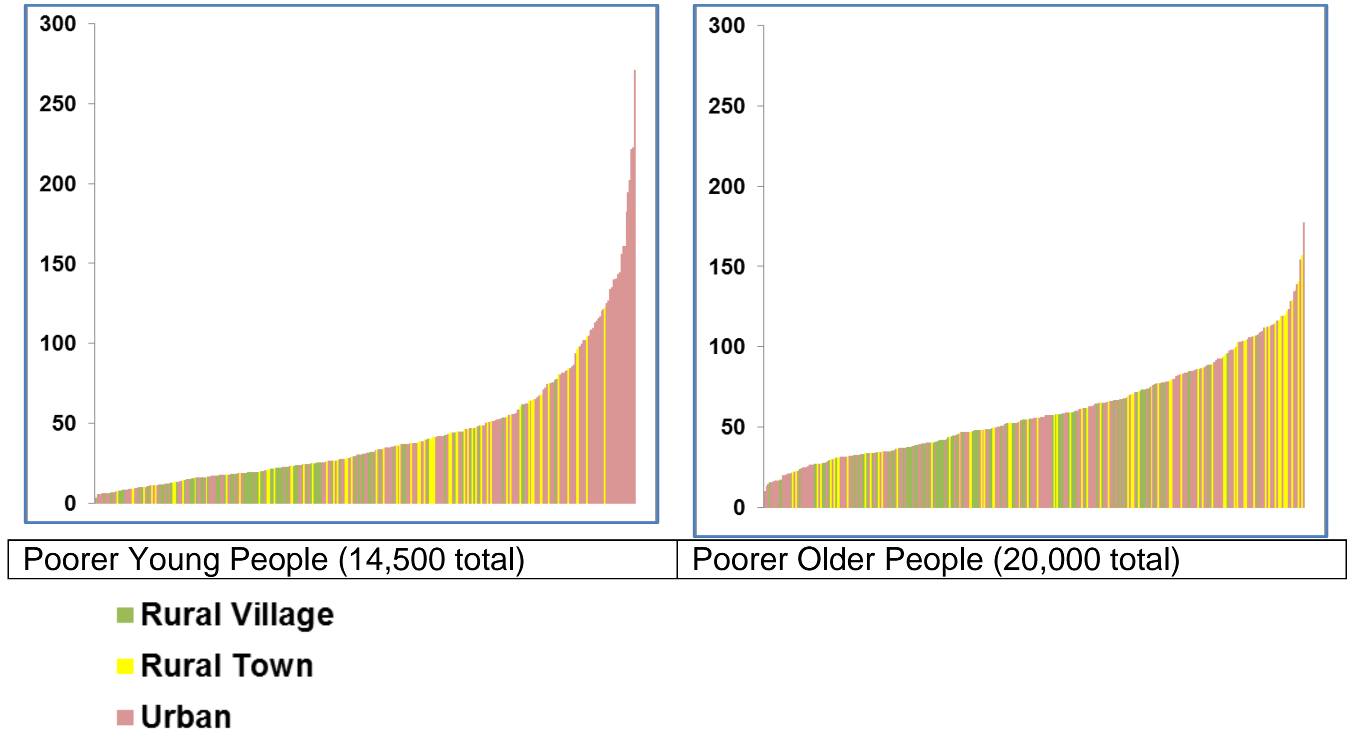


Figure 21 - Numbers of Poorer Children and Older People by LSOA

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

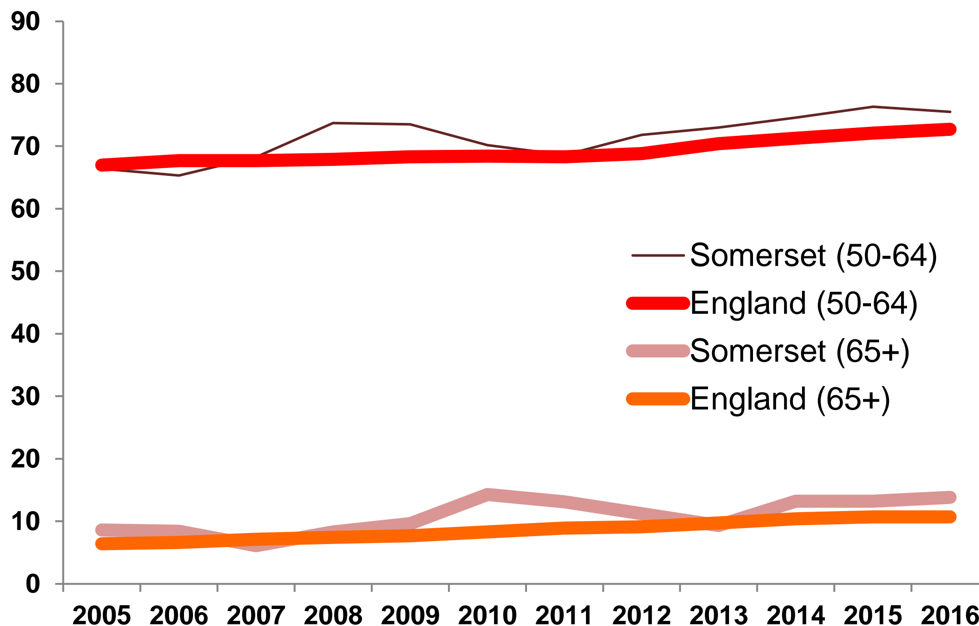


Figure 22 – Economic Activity Rates – Somerset and England

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

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

Discussion group snapshot

The value of work

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

Volunteering

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

Benefits can include:

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

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

Case study

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

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

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

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

CONCLUSION

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

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

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

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

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

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

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

Endnotes

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

AGEING WELL

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

Terry Pratchett

Qualitative report 'Ageing Well'

Somerset: Our County

Joint Strategic Needs Assessment 2017

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Introduction and background

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

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

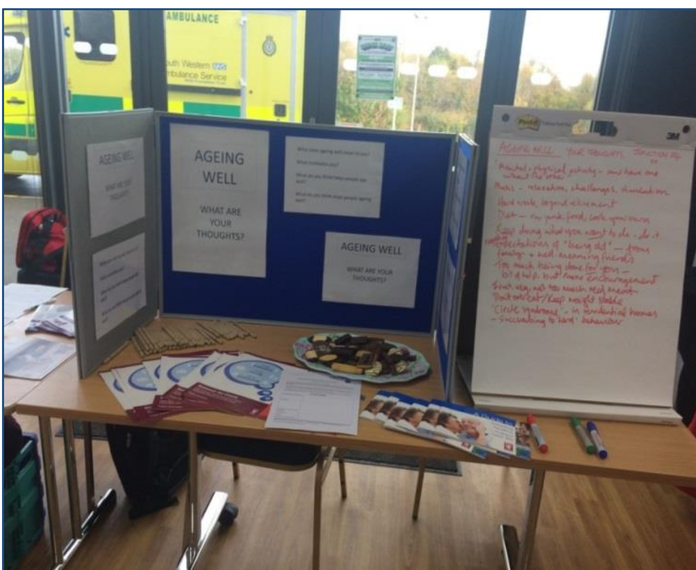
We've talked to over 100 people, from different areas and walks of life to see what ageing well in Somerset means to them. As you might imagine, there is some good and some bad, with useful insight in-between reflecting real life about getting older.

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

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

Report structure

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



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

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

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

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

All responses are anonymised.

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

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

List of participants

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

- Four individual interviews

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

Engagement events with:

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

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

Acknowledgements

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

Thank you also to these key contacts for their support:

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1. Ageing Well Summary

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

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

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

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

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

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

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

2. What does ‘ageing well’ mean to you?

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

Other comments:

“A sense of independence and safety”

“A sense of community, being valued.”

“Still using the skills, knowledge and experience you’ve gained working – into your retirement.”

“Knowing that people need you.”

“Not being lonely.”

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

Diet

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

were seen as positives for older life.

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

“We couldn’t eat too much of anything!”

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

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

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

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

“If you’re isolated or lonely, you don’t cook so much.”

“Eating alone – there’s not so much enjoyment so you don’t eat so well and don’t cook so much.”

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

“Get past sixty; don’t give a damn about what you eat!”

Exercise

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

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

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

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

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

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

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

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

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

Leisure activities

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

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

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

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

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

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

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

Transport

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

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

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

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

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

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

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

Technology

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

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

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

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

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

"Computers are a means to an end."

Employment and retirement

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

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

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

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

Other comments included:

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

"Losing your job can take away your identity."

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

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

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

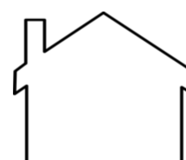
2.14 Although the majority of participants (but certainly not all) were retired, it was obvious that although work connections were often lost and in many cases money was tight, most were involved with other activities such as the University of the Third Age ([2]U3A), volunteering, Active Living Centres,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

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

Housing

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

Caring

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attitude and personal resilience

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

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

Others commented:

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

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

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

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

"I am a positive person."

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

Family

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

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

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

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

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

Communities

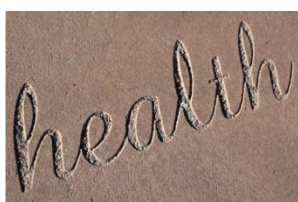
2.30 Voluntary community support is a valuable and valued asset in the course of ageing well and a lack of it was perceived to increase isolation. Many participants volunteered in their communities or were active in community groups (eg. in sheltered housing or through pastoral care, outreach and community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

the importance of social contact.

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

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

Health services

2.33 

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

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

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

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

Independence

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

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

"Having a sense of control over something."

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

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

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

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

Isolation and loneliness

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

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

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

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

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

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

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

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

"Being unwell makes you isolated."

Bereavement

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

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

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

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

Media

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

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

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

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

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

"The media divides us." [generations]

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

Motivation

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

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

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

"You have to cope and not give up!"

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

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

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

Young people

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

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

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

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

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

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

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

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

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

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

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

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

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

'Anything else?' Additional comments:

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

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

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

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

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

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

3. Conclusion

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

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

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

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

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

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

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AGEING WELL

Somerset: Our County

Joint Strategic Needs Assessment (JSNA) 2017

Pip Tucker – Public Health Specialist

Jo McDonagh – JSNA Project Manager

SOMERSET'S JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2017

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

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

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

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

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

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

AGEING WELL

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

Terry Pratchett

AGEING WELL

Informal engagement (3)
Individual interviews (4)
Discussion groups (6)

Over 100 people involved

AGEING WELL

Burnham on Sea Active Living Centre
Priorswood Community Centre
Taunton Deane Sheltered Housing Forum
Service Users' Engagement Group (social care)
District and County Councillors
Over 60s Health Fair at Junction 24
Somerset Engagement and Advisory Group members (CCG)
Sedgemoor Older Persons' Forum
The Men's Shed – Burrowbridge
+ four individual interviews

AGEING WELL

What does ageing well mean to you?

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

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

AGEING WELL

What helps people to age well?

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

Socialising, community, personal resilience

AGEING WELL

What motivates you?

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

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

AGEING WELL

What doesn't help people to age well?

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

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

Social and physical isolation, lack of confidence, negative media

AGEING WELL

Some additional points:

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

Implications for Commissioners

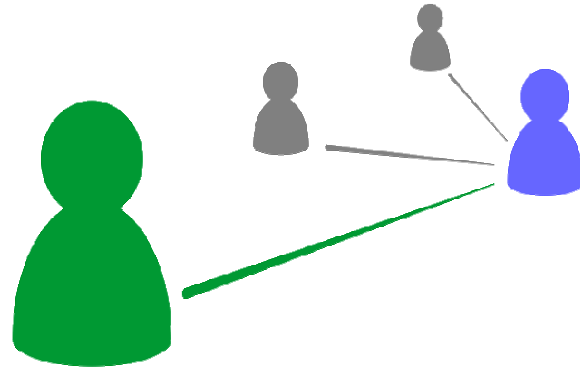
Promoting good health

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

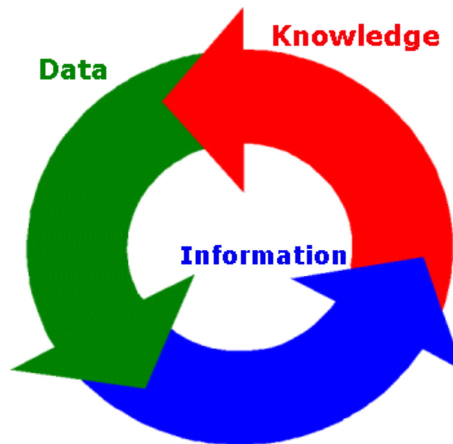
Connected and independent

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

AGEING WELL

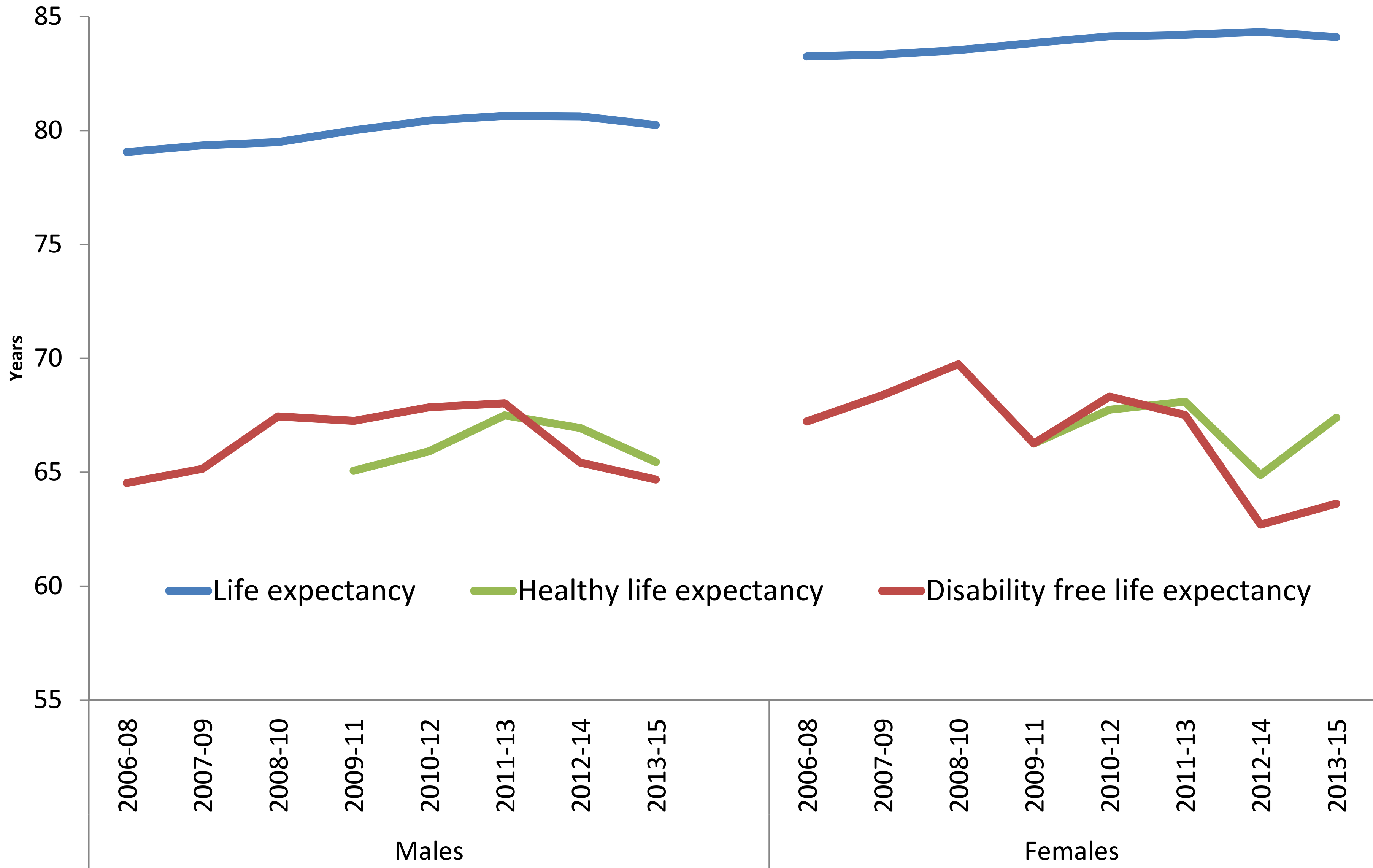


What the data tell us……



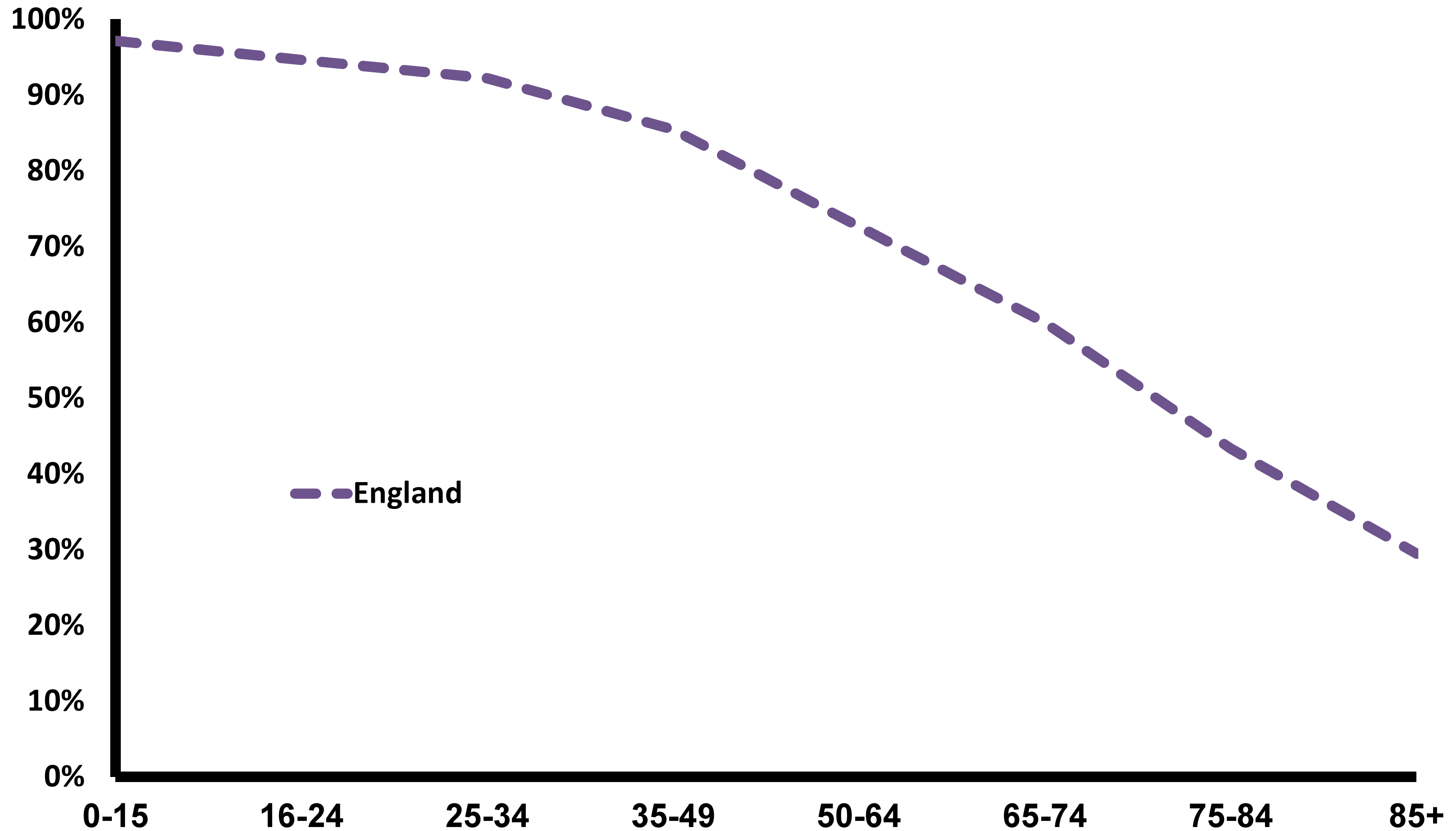
Healthy

Connected and independent

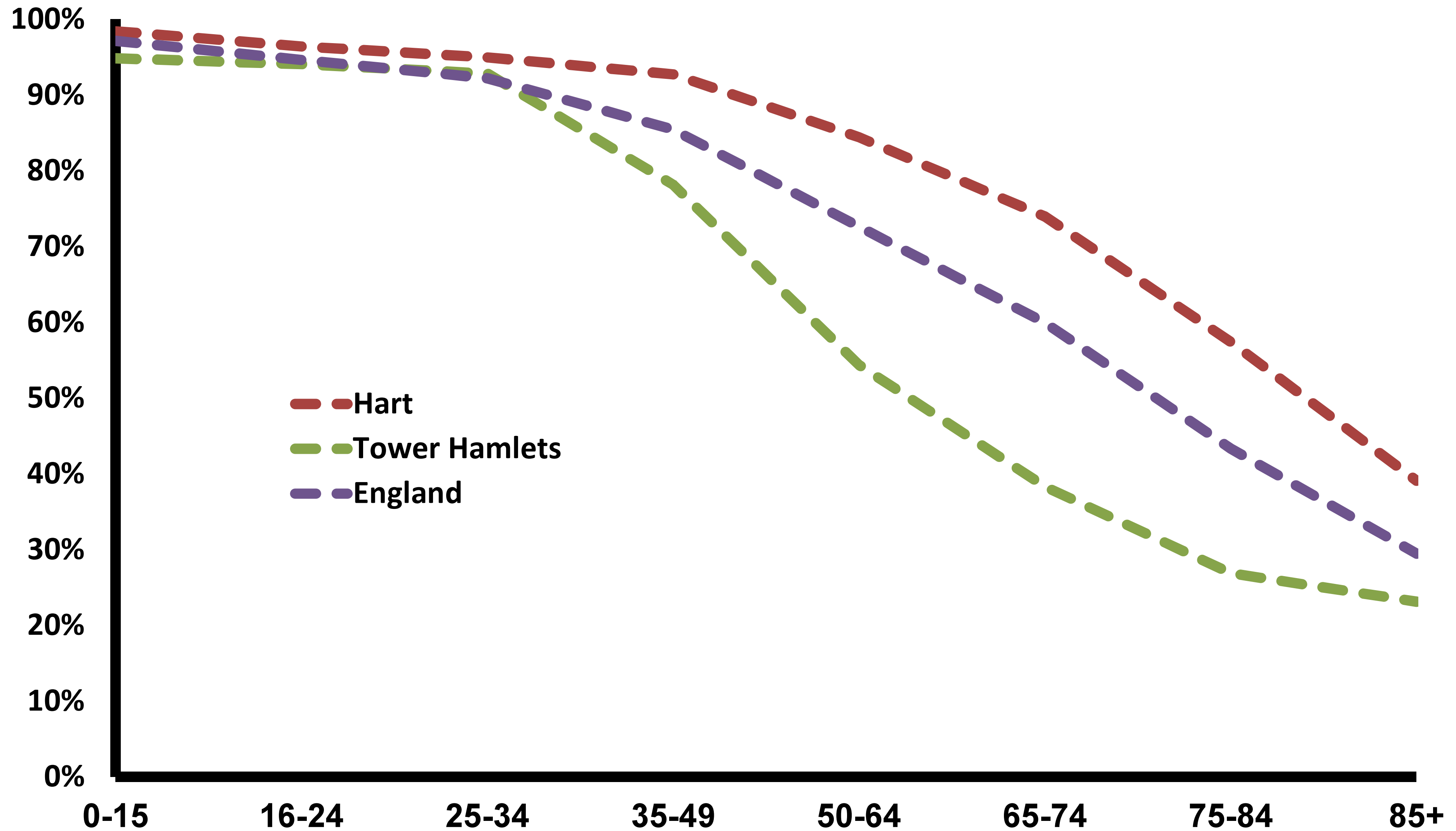


Healthy Life Expectancy - Somerset
Years
85
80
75
70
65
60
55
Life expectancy
Healthy life expectancy
Disability free life expectancy
2006-08
2007-09
2008-10
2009-11
2010-12
2011-13
2012-14
2013-15
Males
2006-08
2007-09
2008-10
2009-11
2010-12
2011-13
2012-14
2013-15
Females

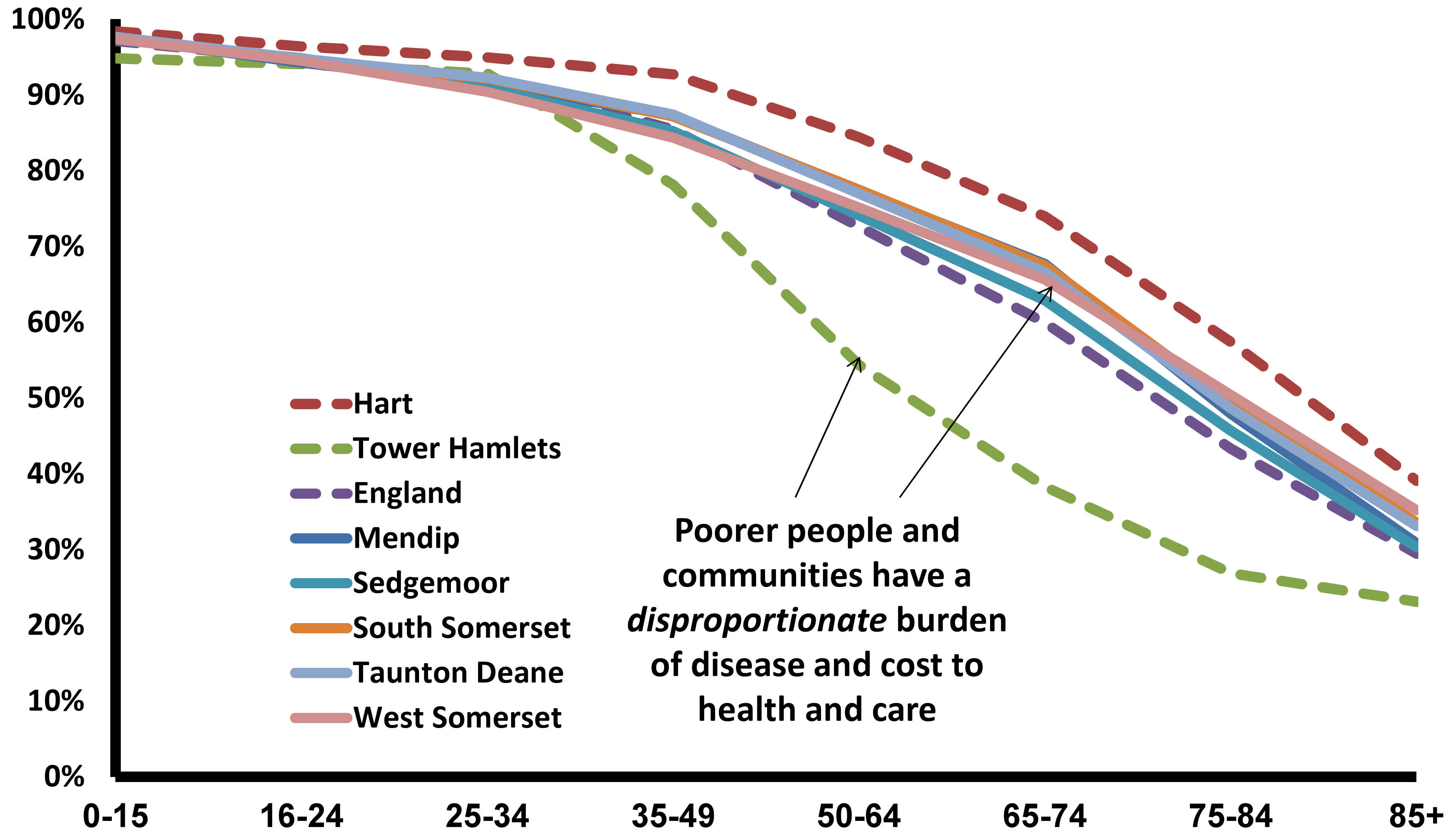
Self-reported ‘Good health’



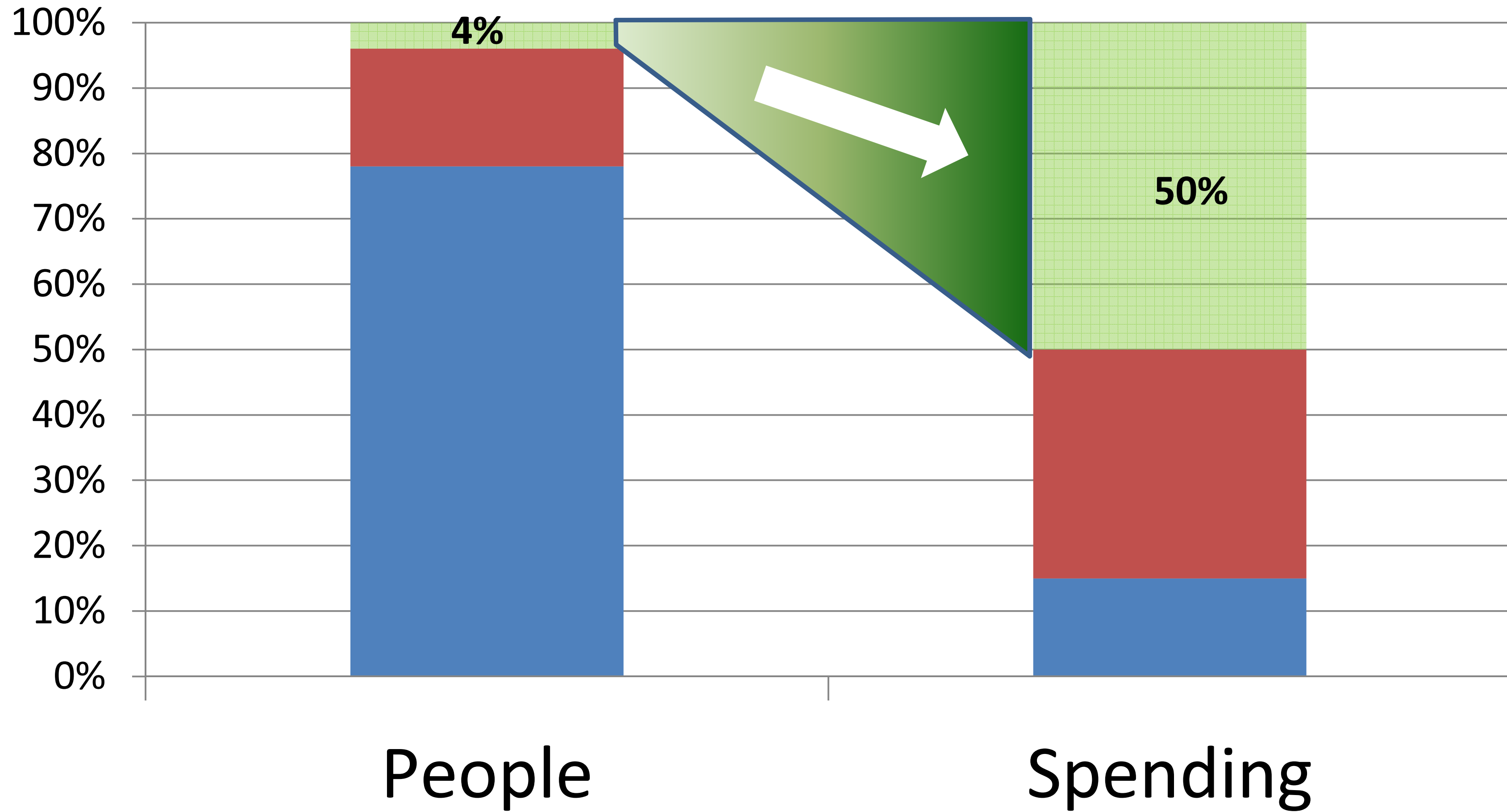
Self-reported 'Good health'



Self-reported 'Good health'

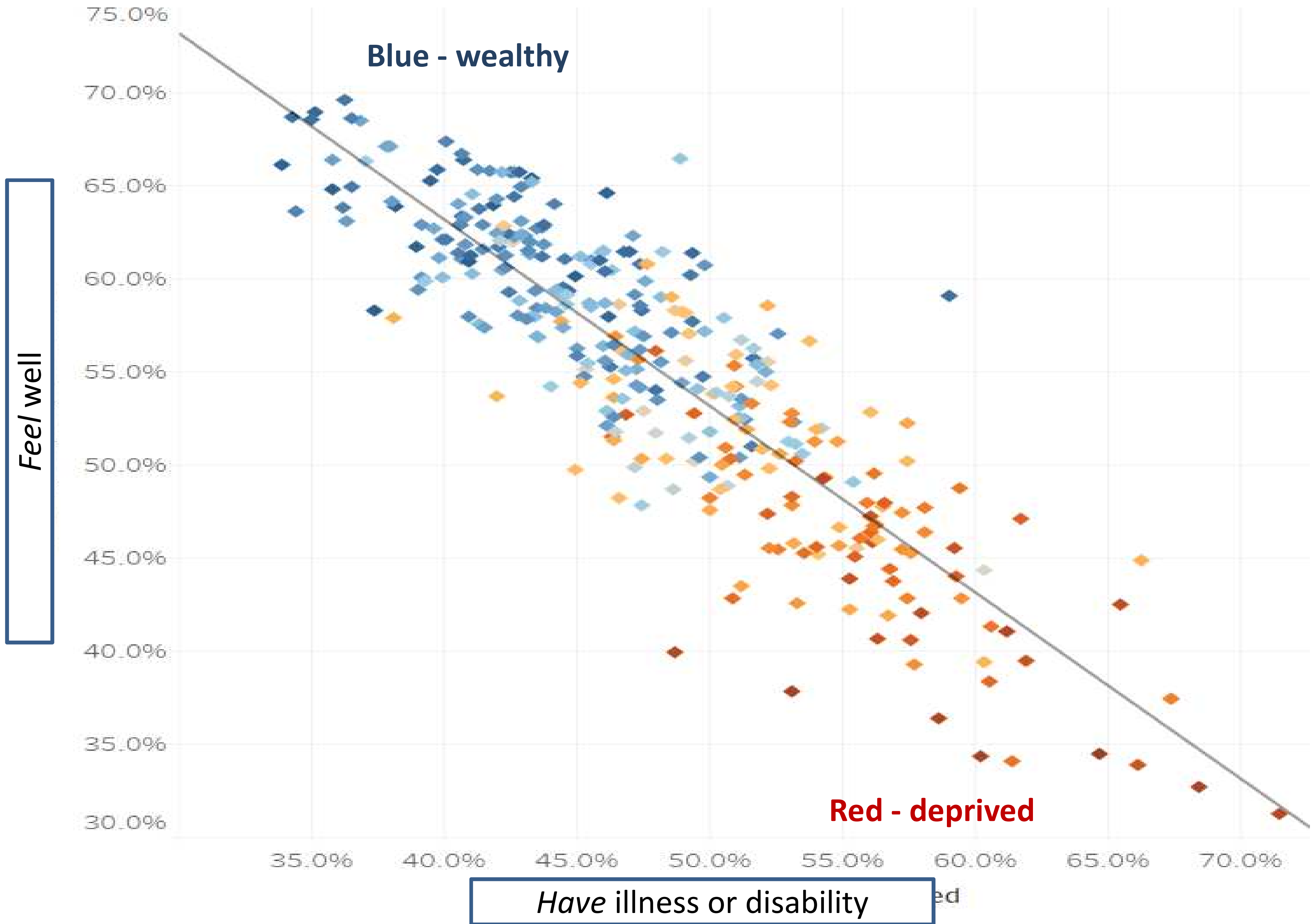


Health and Care Spending (Symphony data)

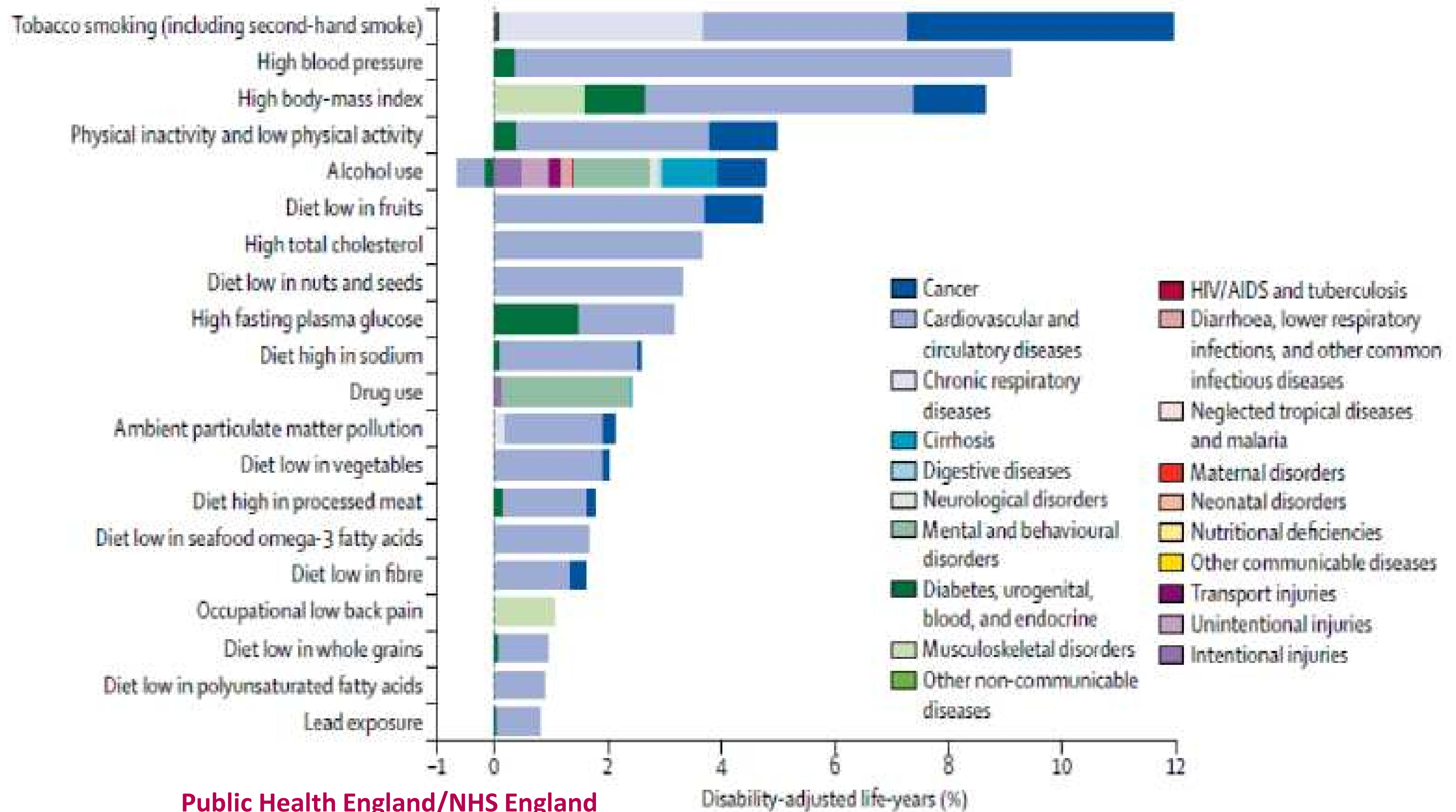


Healthy (communities)

Connected and independent


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

What to prevent?



Public Health England/NHS England
A call to action: commissioning for prevention **2013**

PREVENTION

Diet

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

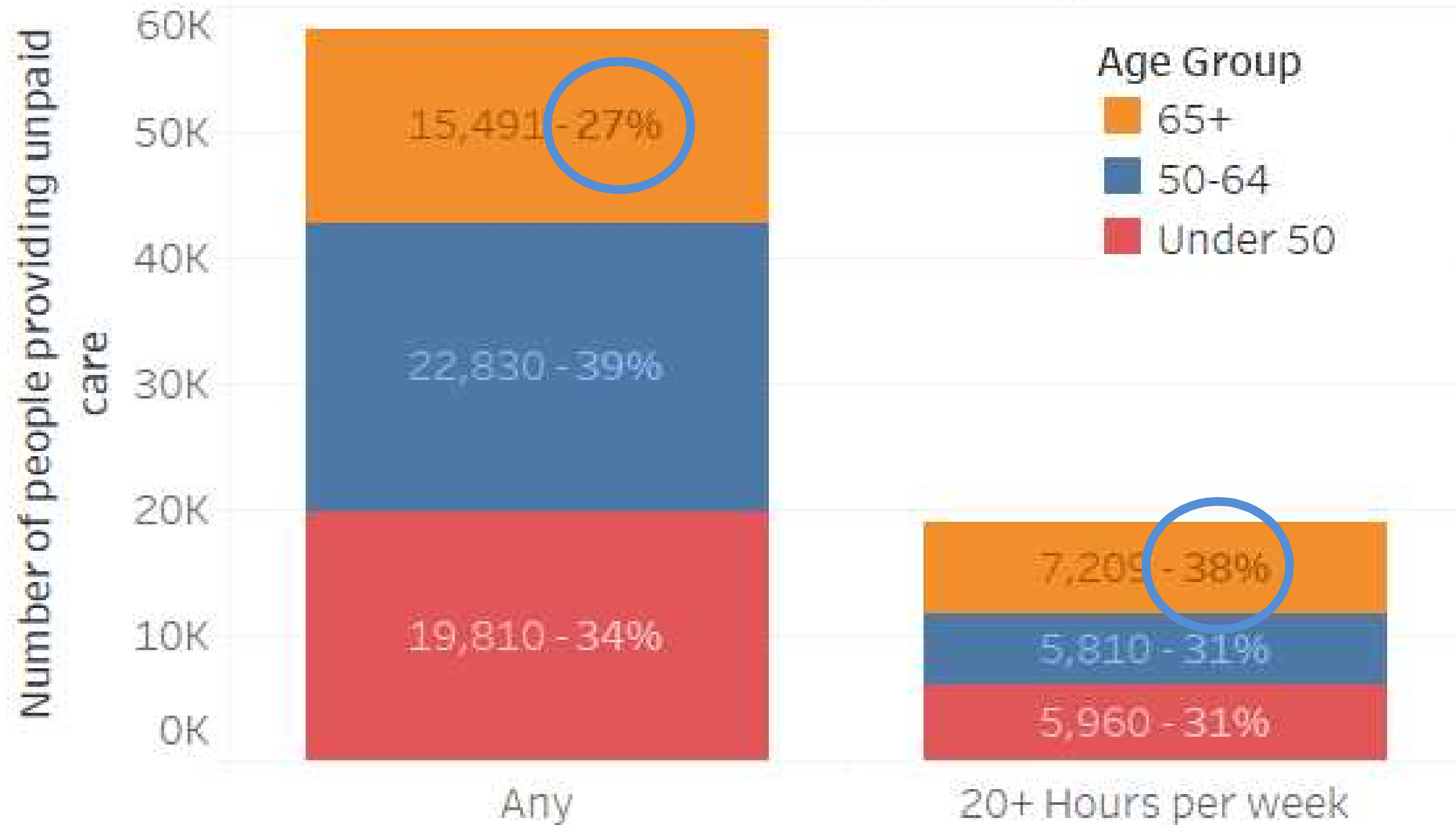
Healthy

Connected and independent

Healthy

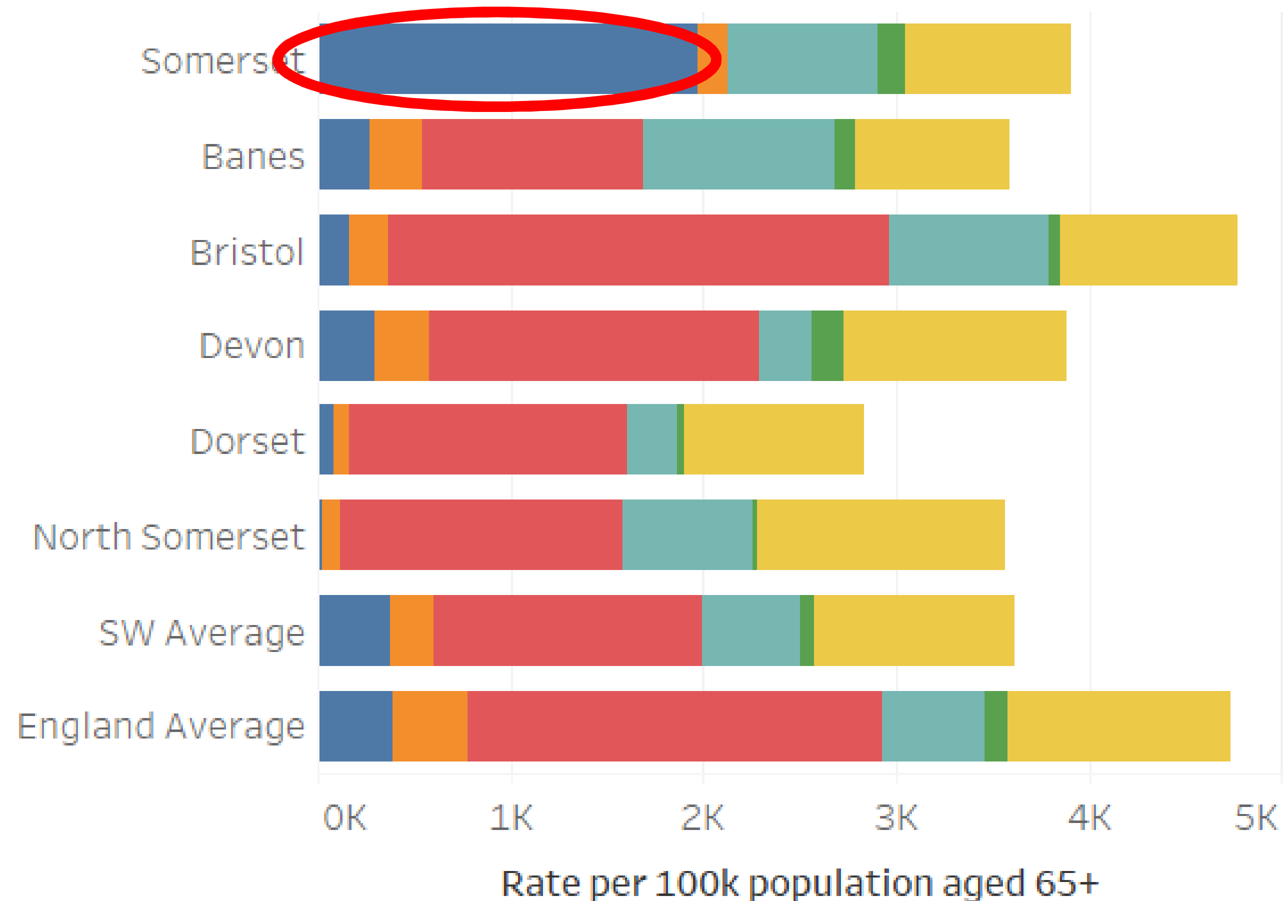
Connected and independent

Caring responsibilities



Source: ONS Census 2011

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



COMMUNITY SUPPORT

Grace, 80 – Martock

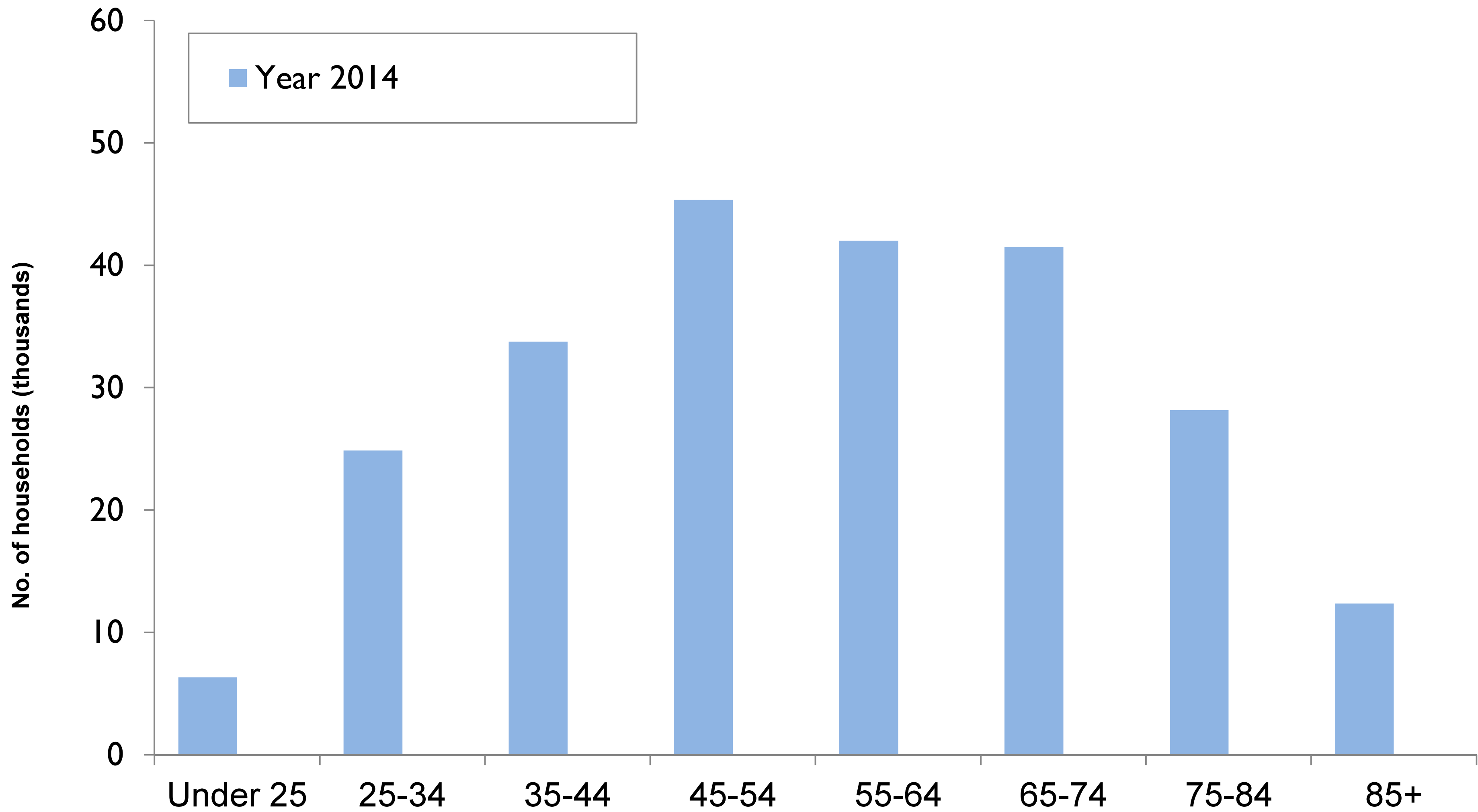
- She fell and spent time in hospital. Before, she was highly independent. After, she was fearful of going out and had become isolated and lonely.

- The GP asked the seniors' support coordinator to arrange a volunteer befriender, for visits once or twice a week.

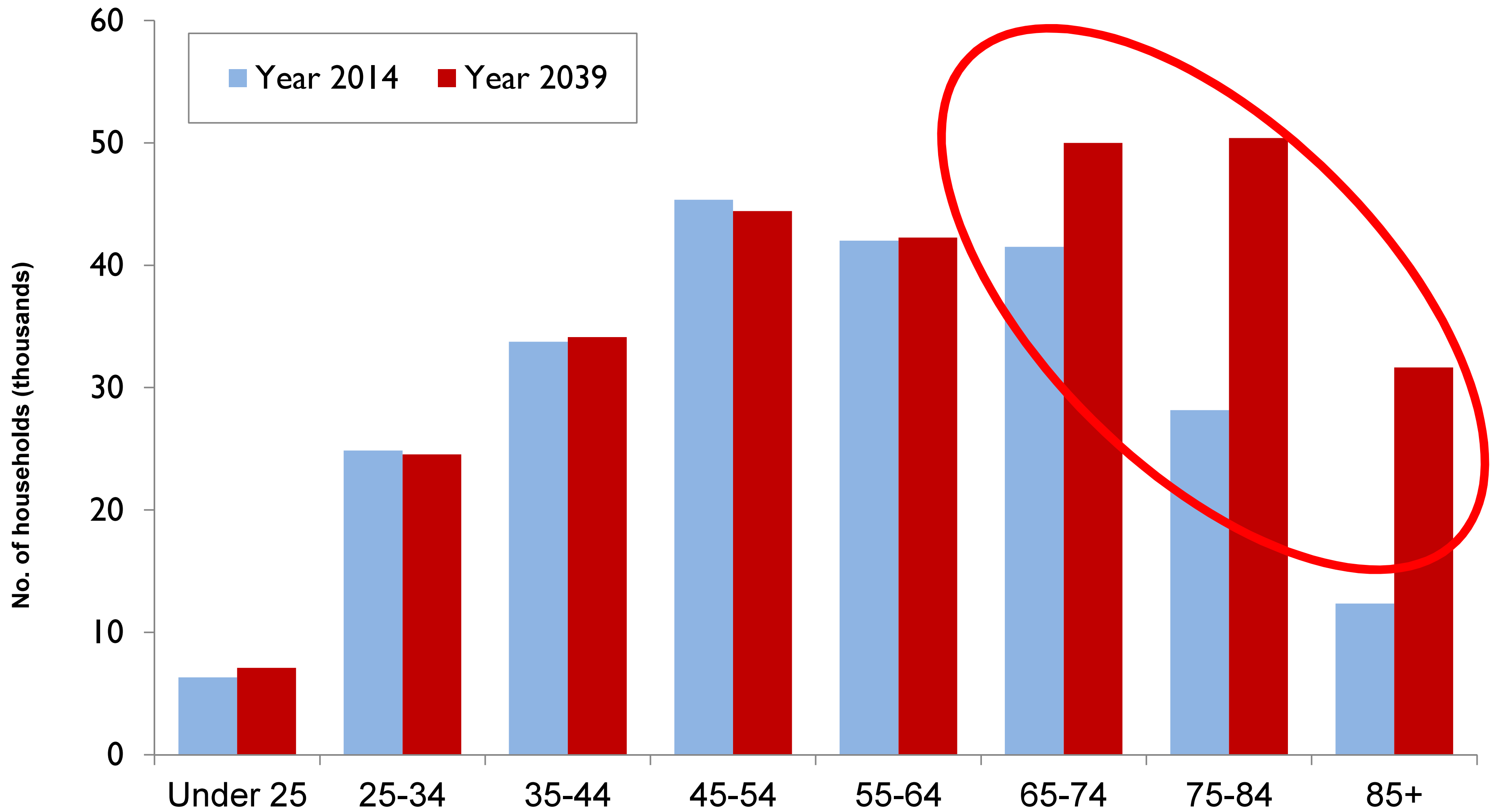
- They started with a walk in the garden, slowly progressing to the local shops. She is now confidently back walking to the shops, and has resumed her social life.

Healthy

Connected and independent (housing)



‘Heads of household’ by age



‘Heads of household’ by age

Healthy

Connected and independent (transport)

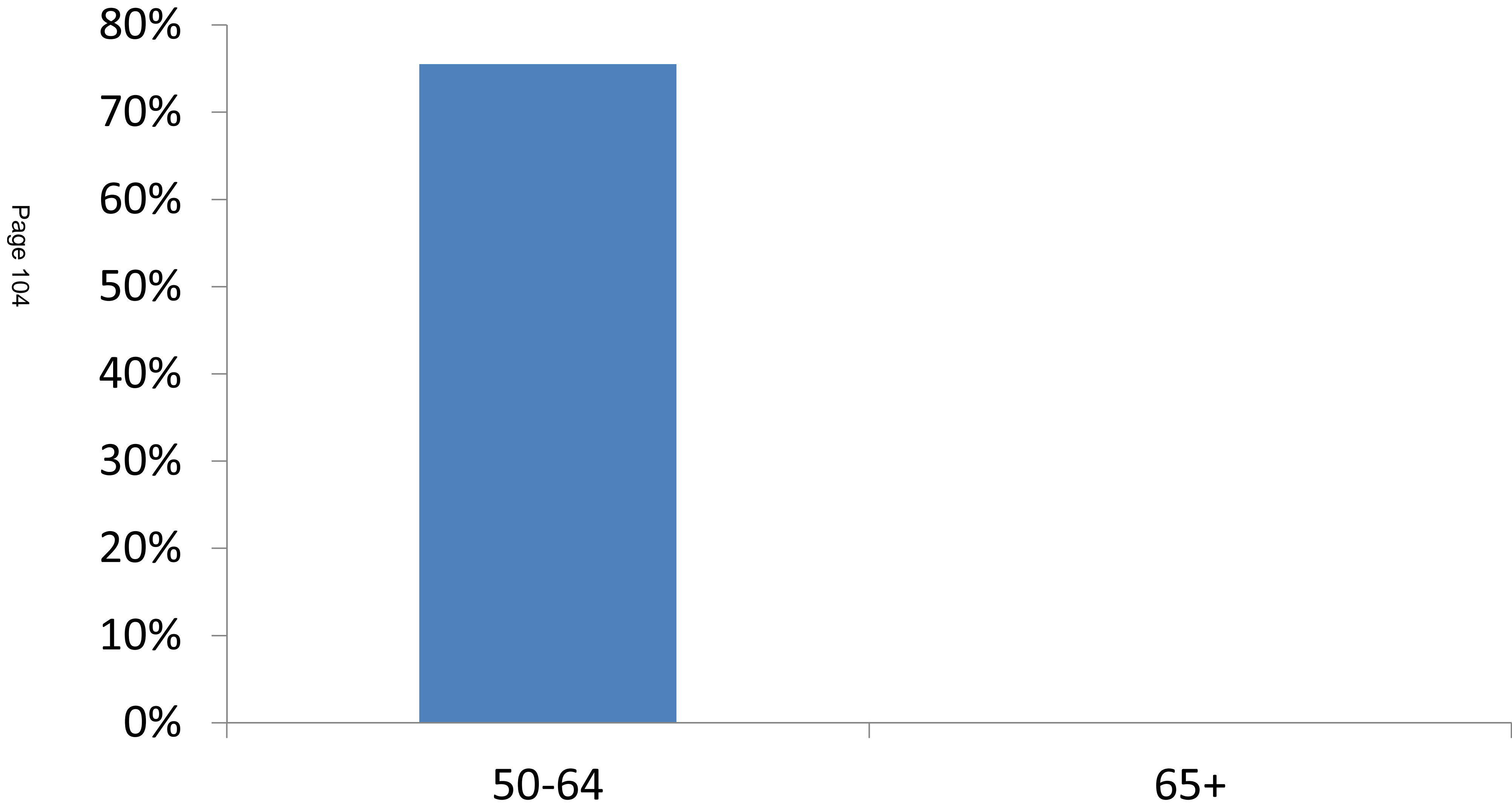
TRANSPORT

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

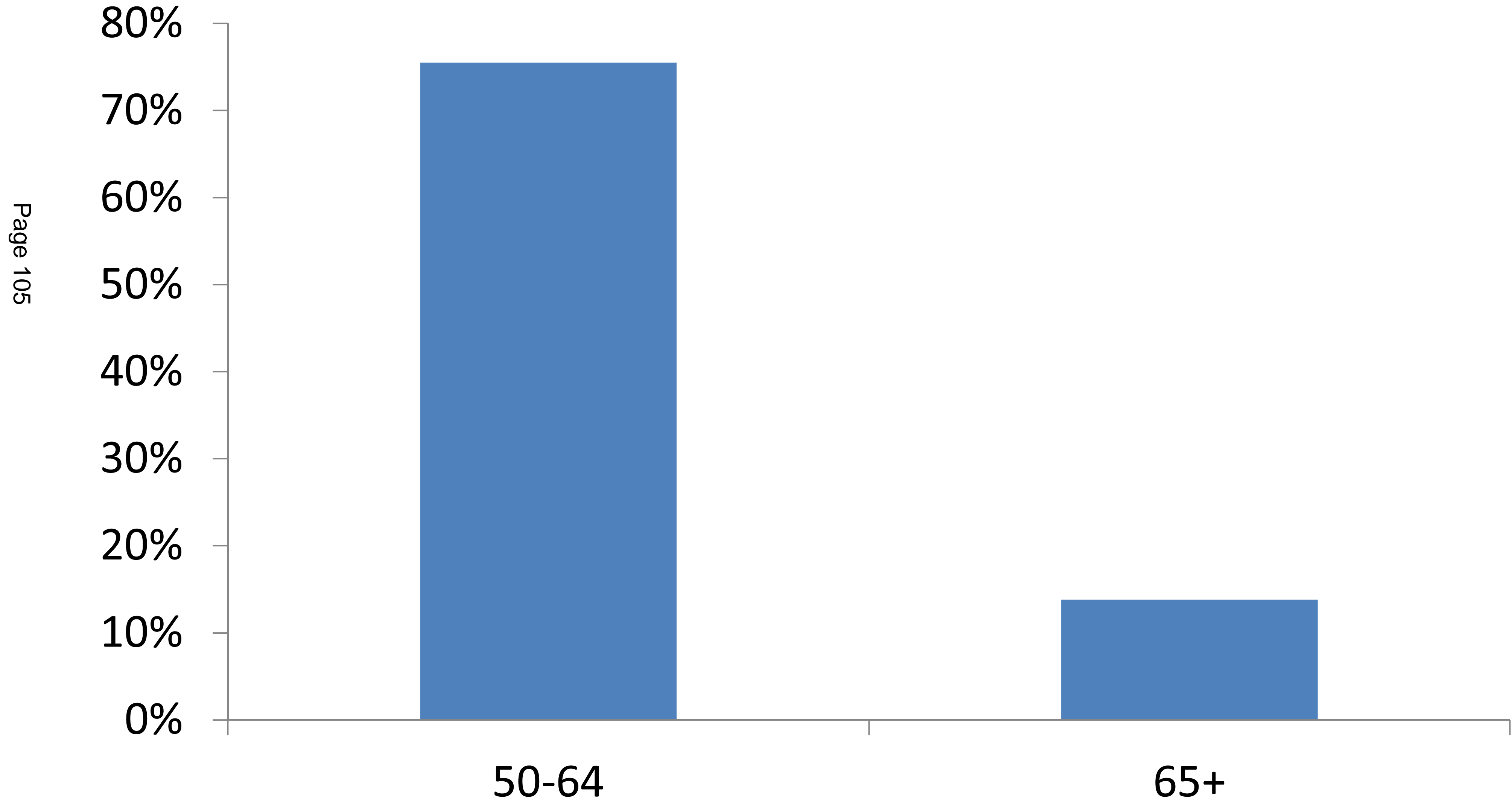
Healthy

Connected and independent (work)

Somerset Economic Activity Rates 2016



Somerset Economic Activity Rates 2016



IMPLICATIONS FOR COMMISSIONING

Connected and independent

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

Healthy

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

JSNA 2017-18
PRIORITIES FOR THE NEW HEALTH AND WELLBEING STRATEGY (proposed)

- Communities
- Conditions and illnesses
- Behaviour change
- Inequality
- Wrong direction of travel
- Where we do badly compared to others
- Population groups

Somerset Health and Wellbeing Board

Report for Somerset Health and Wellbeing Board

Better Care Fund draft Plan 2017/19

Lead Officer: Author: Paul Goodwin, Director of Commissioning and Governance
Stephen Chandler, Director for Adult Social Services

Contact Details: Tracey Tilsley, Head of Business and Strategy (tracey.tilsley@nhs.net)

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Office (Director Level)	Paul Goodwin, Director of Commissioning and Governance Stephen Chandler, Director for Adult Social Services	3.7.17
	Cabinet Member / Portfolio Holder (if applicable)	N/A	
	Monitoring Officer (Somerset County Council)		4.7.17

Summary:	The Better Care Fund is aimed at supporting the integration of health and social care. The fund is an opportunity for local services to transform and improve the lives of people that need it the most. The BCF provides a framework for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF). The presentation outlines the draft Better Care Fund Plan for 2017/19.
Recommendations:	**That the Health and Wellbeing Board** **1. Consider and comment on the presentation of the draft BCF plan subject to the BCF planning guidance being formally released.** **2. Continue to monitor the progression and implementation of the BCF plan 2017/19.**
Reasons for Recommendations:	The Local Authority and Clinical Commissioning Group are continuing to progress the BCF plan for 2017/19.

Links to Somerset Health and Wellbeing Strategy:	We have been working together as a health and care system for some time and have an aligned vision and approach for our population. This vision outlines the need for a patient population to be able to access care or support that is joined up. This is further supported by the Somerset Health and Wellbeing Strategy which outlines our commitment to supporting people to live healthy and independent lives, supported by thriving and connected communities with timely and easy access to high-quality and efficient public services when they need them. The Better Care Fund plan aims to improve care and support for people by providing a framework to support creating a more integrated approach across health and social care.
Financial, Legal and HR Implications:	The indicative funding for 2017/18 in summary is: • Community Reablement and other social care schemes, including carers breaks (£17.628m) • Person Centred Care (£18.246m) • Improved Discharge Arrangements (linked to IBCF funding scheme) • Disabled Facilities Grant (£3.756m) The CCG and LA are currently in discussions to agree an approach to the use of the Improved Better Care Fund money.
Equalities Implications:	None
Risk Assessment:	In common with all aspects of the health and social care economy there is a risk that the fund will not be sufficient to meet the rising demand associated with local demographic changes.

1. Background

1.1. The Better Care Fund is aimed at supporting the integration of health and social care. The fund is an opportunity for local services to transform and improve the lives of people that need it the most. The BCF provides a framework for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF). The 2017 Budget announced an additional £2 billion to support social care in England. This money is included in the IBCF grant to Local Authorities and will be included in local BCF pooled funding and plans.

1.2. The Better Care Fund policy framework was released by the Department of Health and the Department for Communities and Local Government in March 2017. The policy framework forms part of the NHS England Mandate for

2017/18. It requires NHS England to issue further detailed requirements to local areas on the developing BCF plans for 2017/19. However, the Better Care Fund planning guidance has not yet been released. However, a draft version was released on the Local Government Authority (LGA) website in April 2017 but it should be noted that this was not formally cleared by NHS England or the LGA.

1.3. Key changes to the policy framework since 2016/17 include:

- A requirement for plans to be developed for the two year period 2017 to 2019 rather than a single year
- The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four

1.4. Both the Local Authority and the Clinical Commissioning Group continue to progress plans in the absence of the formal release of the Better Care Fund Planning Guidance for 2017/19.

2. Options considered and reasons for rejecting them

2.1. The BCF is a mandatory requirement from central government and NHS England; therefore, there is no option not to adopt a Better Care Fund plan, although feedback from the Health and Wellbeing Board on the development of the plan is welcomed.

3. Consultations undertaken

3.1. Somerset County Council and the Somerset Clinical Commissioning Group continue to engage and work together on the development of the plan.

4. Financial, Legal, HR and Risk Implications

4.1. Central government has introduced the Better Care Fund and the subsequent Care Bill by statute and Somerset would be in breach of this were it not to agree a plan. The CCG and Somerset County Council will need to re-enter into an agreement under Section 75 of the NHS Act 2006 for the Better Care Fund for 2017/19. The Act gives powers to the CCG and Local Authority to establish and maintain pooled funds, out of which payment may be made towards expenditure incurred in the exercise of prescribed Local Authority and NHS functions. The budgets which create the BCF will be pooled under this Agreement and jointly commissioned by the parties.

4.2. The indicative funding for 2017/18 in summary is:

- Community Reablement and other social care schemes, including carers breaks (£17.628m)
- Person Centred Care (£18.246m)
- Improved Discharge Arrangements (linked to IBCF funding scheme)
- Disabled Facilities Grant (£3.756m)

The CCG and LA are currently in discussions to agree an approach to the use of the Improved Better Care Fund money.

5. Background papers

5.1. The 2017/19 Integration and Better Care Fund Policy Framework can be found:

https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019

5.2. The draft Integration and Better Care Fund planning requirements for 2017/19 can be found:

https://content.govdelivery.com/accounts/UKLGA/bulletins/1970999

Agenda item 6

Somerset Health and Wellbeing Board

13th July 2017

Health and Wellbeing Performance Report

Lead Officer: Trudi Grant, Director of Public Health
Author: Amy Shepherd, Corporate Performance Officer
Contact Details: aashepherd@somerset.gov.uk 01823 359225

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Office (Director Level)	Trudi Grant Director of Public Health	3/7/2017
	Cabinet Member / Portfolio Holder (if applicable)	Christine Lawrence	3/7/2017
	Monitoring Officer (Somerset County Council)	Julian Gale	29/6/2017
Summary:	This report provides; an overview of 2016-17 performance in relation to the Health and Wellbeing (HWB) Board Priority Workstreams and duties and requirements, the refreshed HWB Board Plan on a Page for 2017-18 and performance information up to 31st May 2017 in respect of the refreshed priority workstreams actions and metrics.		
Recommendations:	**That the Health and Wellbeing Board:** • **Consider and note the 2016/17 outturn Performance Information available in Appendix A and overview of progress provided by each Workstream Lead at paragraphs 2.3 to 2.8** • **Consider and note the performance information as at 31st May 2017 for the 2017/18 revised workstream actions and metrics in the Somerset HWB Board Scorecard, available at Appendix B**		
Reasons for Recommendations:	The Priority Workstreams outlined in the Plan on a Page are a key means of delivering the HWB Strategy. It is important that the Board understands what progress is being made in relation to the Priority Workstreams and in turn in the delivery of the HWB Strategy whilst also ensuring that the Board's duties and requirements are being met. The HWB Board Scorecard provides a performance update in relation to each of the Priority Workstreams and the Board's Duties and Requirements.		
Links to Somerset Health and Wellbeing Strategy:	Links to delivery of all areas of the HWB Strategy		

Financial, Legal and HR Implications:	There are no direct financial implications arising from this report. However in reviewing performance reports, if performance is not at the expected or desired level then resources may need to be reviewed by appropriate organisations to enable improved performance.
Equalities Implications:	If addressing performance issues requires changes in the way services are delivered, these must be supported by an appropriate impact assessment which will need to be duly considered by decision makers in line with statutory responsibilities before any changes are implemented.
Risk Assessment:	Performance should be monitored regularly to manage any potential risk of workstream actions not being achieved. There are no identified risks from the successful delivery of the priority workstreams.

1. Background

1.1. The HWB Strategy for Somerset was adopted in 2013, setting out a shared vision for health and wellbeing across the County. The Strategy sets out three priority themes identified as being the most important things that would improve health locally.

1.2. Alongside the HWB Strategy, a HWB Board Plan on a Page is developed on an annual basis setting out the Boards Statutory Duties and functions, Priority Workstreams, what the Board must have oversight and influence of and the themes for Board Development Workshops.

During 2016/17 six priority workstreams were in existence, through which delivery of the HWB Strategy was enabled, these were:

The HWB Board to:

1. Provide shared leadership to increase the focus on prevention for Somerset
2. Give system leadership to build strong, resilient and healthy communities
3. Drive and oversee integrated and sustainable models of care across the county
4. Lead a programme of work to improve the identification and early intervention to prevent Hidden Harm of children
5. Identify and address the impacts of housing on health
6. Increase use of licensing powers to promote health, wellbeing and reduce harm.

2. Outturn 2016/17 Performance Information and Overview of Performance

2.1 At the beginning of 2016/17, in consultation with the Lead Managers, actions, metrics (including numeric measures and supporting project and programme progress milestones) and national data set indicators were agreed in respect of

each of the workstreams.

On a bi-monthly basis throughout 2016/17 performance information in relation to the agreed actions and metrics for each of the priority workstreams was collected from Lead Managers and reported to the HWB Executive Officers Group. This information was also presented to the HWB Board on a twice yearly basis; the most recent was an interim performance report on 24th November 2016.

2.2 Performance information has been gathered from Lead Managers at year-end on 31st March 2017 to provide the outturn position in relation to each of the workstreams. This performance information is summarised in the HWB Scorecard, available at **Appendix A**. The HWB Board is asked to consider and note the performance information.

An overview of the Boards achievement of its duties and requirements is also included in the scorecard.

Overview of Performance
The table below summarises performance:

	RAG Status				Direction of Travel			
	Red	Amber	Green	N/A (Not started)	Up	Down	Stable	N/A (New)
Workstream Actions	0	3	13	0	1	0	15	0
Local Measures and Milestones	2	8	38	0	6	5	37	0
Totals	2	11	51	0	7	5	52	0
As Percentage	3%	17%	80%	0%	11%	8%	81%	0%

80% of statuses for workstream actions and local measures and milestones are rated green and are therefore on track to being achieved.

92% of workstream actions and local measures and milestones are improving or maintaining stable levels of performance.

Commentary providing an explanation in relation to those actions and local measures and milestones with a Red or Amber status has been provided by the respective Workstream Lead and is available in the Headlines / Exception Reporting box of the HWB Board Scorecard.

In addition to the outturn performance information, Lead Managers have also provided a summary of progress in relation to the workstream during 2016/17. These contributions are available below:

2.3 **Workstream 1: To provide joint leadership for prevention across the county** (Lead Manager – Trudi Grant)

The purpose of this theme was to support all HWB Board partners to adopt a common understanding and approach to prevention and to encourage each

organisation and sector to identify and to take action to intervene early and to take preventative action

A Prevention Framework was developed and endorsed by the Board. Somerset Organisations are currently demonstrating their commitment by signing a Somerset Prevention Charter, which will be supported by individual prevention plans.

All actions and targets have been achieved for 2016-17 with the exception of the action *'To produce and oversee the delivery of the Prevention plan to support the NHS Sustainability and Transformation Plan'*. This remains amber as STP Prevention Plans are not yet implemented.

2.4 Workstream 2: To give system leadership to build strong, resilient and healthy communities
(Lead Manager – Teresa Harvey)

The actions for this work stream have progressed steadily. All District Councils have a Health and Wellbeing page on the Website. Districts Councils held a Loneliness conference and now working to implement the resultant Action Plan. The VCSE research is complete and is ready to inform a project proposal and funding applications. The proposal will include a communication plan which will be developed collaboratively by VCSE and Local Authorities. District Councils have either attained Dementia Friendly Status or are in the progress of doing so.

2.5 Workstream 3: To drive and oversee new, integrated and sustainable models of care across the county
(Lead Manager – Steven Chandler)

The Somerset Sustainability and Transformation (STP) Plan was developed in good time and endorsed by the Health and Wellbeing Board. It was also discussed by the CCG, SCC Cabinet and Somerset NHS Foundation Trust boards in November and December. It sets the way forward for the next five years and its launch marks the start of wide-ranging discussions with local people before firm proposals are drawn up.

A period of engagement, communication and consultation about the STP will continue over the Summer following which the plan will be changed and refined to reflect the consultation before transition to implementation from October 2017.

Prevention is a strong theme within the STP. Good progress has been reported on Somerset County Council's Adults Services transformation programme, with the Community Connect approach developed initially in Sedgemoor and West Somerset having now been rolled out across the County. This approach changes the nature of conversation from a focus on assessment to a discussion about the things which matter to keep people independent and well. The number of people who receive this kind of community based conversation, support or information is expected to increase over the coming year.

2.6 Workstream 4: To further develop work to improve identification and early intervention to prevent Hidden Harm of Children
(Lead Managers – Alison Bell and Deborah Howard)

<u>Action 1 (Audit if adult mental health patients are being identified as being parents</u>

with dependent children):

Following changes to the RIO system, snap shot audits commenced during February 2017 to show month by month numbers of patients on Community Mental Health Service care loads who are parents. This is known as the parental link. A RIO Risk Assessment form, asks if the patient has regular contact with a child. This enables other family members, carers etc to be picked up. These two methods do not double-count each other. Because the parental link flag on RIO is new, we would expect over the coming months to see an increase in numbers of patients who are recorded as being parents as practitioners update records.

Action 2 (To implement the new joint protocol for Hidden Harm, across adult mental health, domestic abuse and drugs and alcohol service) and Action 3 (Ensure early help professionals have accessed identification and brief intervention training for domestic abuse and substance misuse):

Progress against the Children and Young People's Plan (CYPP) for Somerset is being reported through the Children's Trust Executive. Priority 7 with the CYPP is 'Embedding a think family approach across the workforce'. This year's priority aim is to ensure 'All professionals and staff who work with adults and children and young people understand the concept of 'think family' and are alert to the effects of adult behaviours on children and young people and know how to take action to respond appropriately'.

The CYPP workstream lead – Chris Squire – Director of HR at SCC – has developed a Children's Workforce Development Strategy (focusing on Children's Social Care), it is recognised that this will need to be expanded to incorporate wider Children's Services during year two and can then be embedded across the whole workforce. Work has begun to embed a think family approach within CSC – planning is in progress for actions beyond this to broaden the 'think family' approach.

The HWBB workstream continues to address joint working between the specialist services that meet the needs of adults and ensure that they are addressing the impact of adult behaviours on children within the household. The evaluation was undertaken on 30th September 2016, and as part of the follow up evaluation, the 3 services (with commissioners) agreed to strengthen the working group to progress with the implementation and further development of the joint working protocol.

Following presentation of the Hidden Harm needs assessment to SSAB, this has continued to influence their work. 'Think Family' remains one of the four identified priorities for the SSAB over the three year period, 2016-17, and includes exploring issues of 'hidden harm' as a specific objective.

Progress against embedding competencies around early help for families affected by substance misuse or domestic abuse within an early help competency framework has stalled. This will be picked up as part of the CYP plan workstream in the workforce development strategy that will next year widen to cover the whole children's workforce.

2.7 Workstream 5: To identify and address the impacts of housing on health
(Lead Manager – Tracy Aarons)

Performance for the year has been good with some positive results regarding integration of Joint Strategic Needs Assessment (JSNA) data into strategic housing. There have also been strong improvements in understanding between health and housing although pilots have shown that signposting is the preferred method of sharing for health professionals rather than having housing staff working within practices. This has shown that awareness raising amongst health staff is key to better outcomes for residents and this will be focused on as part of future work.

2.8 Workstream 6: To increase use of licensing powers to promote health, wellbeing and reduce harm
(Lead Manager – Rina Singh and Nigel Marston)

In 2015, the HWB Board introduced workstream 6 as part of their on-going work in reducing alcohol harm across Somerset. A pilot was run by South Somerset District Council (SSDC), researching work elsewhere in the UK concluded that sharing Emergency Departments data with Public Health and other bodies helped bring about more informative and factual representations in Licensing applications. This resulted in applications either being withdrawn, refused or more conditions imposed than before.

This also ensures the Licensing Department and local police force can target premises more accurately using this data to ensure conditions are being met, review their licence, impose more conditions or even have it withdrawn. This should improve the quality of night time entertainment, making it safer and more attractive to customers. If proved successful, then this can be rolled out across Somerset.

The pilot project was broken down into distinct categories:
1. Research into other areas
2. Training day for partner authorities
3. Establish partnership in data sharing with regular meetings for feedback
4. New licensing policy to incorporate the data sharing as part of the Licensing Application process.
5. Roll out to other districts in Somerset.

1. Research/Evaluations

Research began with the work that originated with the Cardiff Violence Research group based at Cardiff University Hospital. Dr Jonathan Shepherd, is a maxofacial surgeon who was concerned about the levels of injuries he was operating on that were a result of alcohol related injuries. He could see a steady increase in levels of these injuries and investigated the reasons for the increase. His findings showed that the police were only aware of between approximately 20-50% of injuries seen in emergency departments. It was apparent the police weren't being informed and Dr Shepherd brought about the "Cardiff model" which started data sharing between relevant organisations to reduce alcohol related harm.

The results of this data sharing were outstanding and Cardiff A&E violence related attendances reduced by 50% from January 2000 to January 2015. Many other city hospitals have started sharing their data with local partners because of this. The Trauma and Injury & Intelligence Group (TiiG) based at Liverpool John Moores University have been gathering data across the North West since 2001. They take data from all the hospitals with emergency departments and

Ambulance services from Cheshire, Lancashire & Cumbria and report across the regions with the data collected. TiiG research has proven that Ambulance Service data is also crucial to improving local knowledge, quite often they have very accurate location information and the patients don't necessarily transfer to hospital and are treated at the scene. This important information would be missed by both hospitals and police.
An excellent example in using good quality data to influence decisions is Medway Councils updated Licensing Policy. This uses hospital and ambulance data to argue the need for several Cumulative Impact Policies throughout the area and the policy was agreed unanimously.

2. Training day

SSDC invited colleagues from neighbouring Licensing departments, Lead Sisters from the local A&E department, Paramedics from SWAST and Public Health colleagues to this training day. It was facilitated by Mr James Button, a leading expert in Licensing Law. Colleagues were able to understand what the pilot project was aiming for and the benefits it could achieve if successful.

3. Establish partnership in data sharing with regular meetings for feedback

In March 2016 SSDC had a meeting with the A&E Business Manager who informed SSDC that A&E were to have a new IT System that was to go live in the summer of 2016. Once the system was up and running, we met with the A&E business manager alongside colleagues from Public Health and the Ambulance Service to clearly establish the data required, reiterate the ambitions of the project and the impact this could have for the hospital and the wider area.

Unfortunately, SSDC have now been informed that the data collected is not sufficient in quality or quantity to be of any real use. There is still an on-going dialogue regarding the sharing of this data and also the incorporation of ambulance data. SSDC need to have this agreed before any meetings take place. The hospital management are aware that the Royal College for Emergency Medicine have made this data collection mandatory, yet since the implementation of the new IT system the A&E department have only taken 10% of the information required at best and in February & March of this year no data collection was taken at all.

4. New Licensing policy to incorporate the data sharing as part of the Licensing Application process

Due to the difficulties acquiring any data, SSDC cannot incorporate this into the Licensing policy or as part of the application process. SSDC's Licensing committee are eager to see more data based evidence from the responsible authorities, and until the data sharing issues are resolved then this cannot be offered.

Conclusion

We are unable to determine any success from data sharing due to issues concerning Yeovil District Hospital. The delay in the hospital getting on board with this project and subsequent high levels of staff changes have resulted in significant setbacks throughout the whole timeline of this project.

Yeovil District Hospital have agreed to incorporate all the necessary fields into their new IT system in A&E - to be used when the system went live in July 2016. They have recently acknowledged that there is a setback with the data collection

in both qualitative and quantitative terms.

Hopefully, once the data quality improves and the information sharing is put in place, then this data can start helping to reduce alcohol related admissions to the hospital. There has been no timeline given to when this will improve.
We cannot complete this project, nor can it be rolled out to other districts in Somerset as it stands without the information required from Yeovil Hospital.

3 2017/18 HWB Priority Workstreams

3.1 A review has taken place of each of the 2016/17 priority workstreams to establish whether they should continue into 2017/18 or end.

Workstream 6 has come to an end as described in the conclusion of paragraph 2.8 above. The remainder of the workstreams will continue into 2017/18 and work has taken place with Lead Managers to develop new workstream actions for 2017/18

4 2017/18 Overview of Performance as at 31st May 2017

4.1 Worksteam Lead Managers have refreshed the existing measures and milestones and/or identified new ones to be used to report workstream progress during 2017/18.

Further measures and milestones will be added to Workstream 3 'To drive and oversee new, integrated and sustainable models of care across the county' to enable the HWB Board to have oversight of the progress of the STP, in particular in relation to models of care, will be provided by the STP Board over the next few months for inclusion.

The updated workstream actions, measures and milestones alongside performance information up to 31st May 2017 are included in the Somerset HWB Scorecard 2017/18 available at Appendix B. This provides the HWB Board with the first performance update on the workstreams for 2017/18.

The HWB Board is asked to consider and note the performance information.

5. Options considered and reasons for rejecting them

5.1 N/A

6. Consultations undertaken

6.1 Meetings have been held with Lead Managers relating to each of the workstreams to establish the set of metrics.

6.2 Scoping and progress meetings have been held with the Director of Public Health.

6.3 Appropriate data sets including The Public Health Outcomes Framework and National Health Outcomes Framework have been referenced in identifying proposed indicators.

7. Financial, Legal, HR and Risk Implications

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

8. Background papers

8.1 Health and Wellbeing Strategy for Somerset

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Somerset Health and Wellbeing Board Scorecard

The Vision for health and wellbeing in Somerset is: 'People Living healthy and independent lives, supported by thriving and connected communities, with timely and easy access to high quality and efficient pubic services when they need them'

Reporting Period: 2016/17 Outturn - up to 31st March 2017

Health and Wellbeing Board Duties / Requirements

Statutory Duties and Functions	RAG
Undertake a Joint Strategic Needs Assessment	G
Undertake a pharmaceutical needs assessment	G
Develop a joint Health and Wellbeing Strategy for the County	G
To encourage integrated working between health, social care and public health including oversight of the Better Care Fund	G

Reports received:	RAG
Director of Public Health Annual Report 2014/15 (2015/16 HWBB 29/9/16)	G
Somerset Children's Trust - Children and Young People's Plan 2016-19	G
Somerset Safeguarding Children Board - Annual Report 2014/15 (2015/16 HWBB 29/9/16)	G
Somerset Safeguarding Adults Board - Annual Report 2014/15 (2015/16 HWBB 29/9/16)	G
Safer Somerset Partnership 2015/16	G
Joint Strategic Needs Assessment 2016	G
Health Protection Forum Report 2014/15 (2015/16 HWBB 24/11/16)	G
Healthwatch Somerset Annual Report 2014/15	G

Public Engagement	RAG
Annual Health and Wellbeing Conference	G
Involvement and encouragement with Healthwatch Somerset	G
HWB Newsletter / briefing notes	G
HWB Website	A

Headlines / Exception Report

Workstream 1:
Action 1 (To produce and oversee the delivery of the Prevention Plan to support the NHS Sustainability and Transformation Plan) currently has an Amber RAG status as the STP Prevention Plans are not yet implemented.

Workstream 2:
Two metrics have an Amber RAG status;
'Develop a communication plan, project plan and a case for support as the basis for funding proposals'. A bid was made to the DCLG Communities Fund in January 2017 which was unsuccessful in April 2017. The outline Project Proposals are in the process of being updated and re-written and initial discussions have been held with potential funders.
'Each District Council to achieve Dementia Friendly Status'. The RAG status will turn green when all District Councils have Dementia Friendly Status.

Workstream 3:
The RAG Status for the Adults Transformation Programme remains Amber at Quarter 4.
The RAG Status for the measure 'Proportion of contacts that result in Community Based Support or Information and Advice (with no funded service)' remains red. Performance has improved but it did not hit the 60% year end target. The Community Connect initiative in Sedgemoor and West Somerset has now been rolled out across the County and performance is expected to improve more noticeably over the coming months .

Workstream 4:
Action 3 (To ensure early help professionals have accessed identification and brief intervention training of domestic abuse and substance misuse) continues to have an Amber RAG Status. This is because progress in relation to this has stalled but will be picked up as part of the CYP plan workstream in the workforce development strategy that next year will widen to the whole of children's workforce.
One metric 'Numbers of early help professionals accessing brief intervention training on substance misuse' also continues to have an Amber RAG status. This is because progress with commissioning future programme of training has been delayed due to work needed to make savings in year. The programme remains a priority and a process is in place to enable stability of training programme delivery for future years as part of the wider drug and alcohol system review.

Workstream 5:
All Actions and Local Measures and Project Milestones have Green RAG Statuses and performance is improving or stable.

Workstream 6:
An overview of performance in relation to this workstream, which explains the Amber and Red RAG statuses is included in the HWB Board Covering Report.

Priority Workstreams

Workstream 1: To provide joint leadership for prevention across the County

Lead Manager: Trudi Grant

Actions	Trend	RAG
Produce and oversee the delivery of the Prevention Plan to support the NHS Sustainability and Transformation Plan	⇔	A
Develop a Prevention Charter for Somerset which addresses the health and wellbeing gap	⇔	G
To produce a minimum of three prevention case studies using the prevention framework to describe the type and level of the intended prevention and its actual outcomes	⇔	G
Local Measures:		
Initial STP Prevention Plan published	⇔	G
Board Member and Partner Prevention surgeries development sessions held and briefings on Prevention produced throughout the year	⇔	G
Prevention case studies produced and disseminated	↑	G
National Measures		
National Measures to be added once Prevention Plan Developed		

Workstream 2: To give system leadership to build strong, resilient and healthy communities

Lead Manager: Teresa Harvey

Actions	Trend	RAG
To further develop the Lets End Loneliness in Somerset Programme through the District Councils	⇔	G
To further develop the Lets End Loneliness in Somerset Programme through the Somerset VCS Forum	⇔	G
To continue to raise the profile of loneliness through the media	⇔	G
Local Measures:		
Focused publicity campaigns to raise awareness through local media and press	⇔	G
Each District to implement the action plan from their loneliness conference	⇔	G
Research regional / national best practice with an emphasis on collaborative asset based community development approaches	⇔	G
Collate existing evidence of the impact of loneliness on individuals and communities in Somerset (JSNA, Red Cross research etc)	⇔	G
Develop a communication plan, project plan and a case for support as the basis for funding proposals	⇔	A
Each District Council to achieve Dementia Friendly status	⇔	A
National Measures		
PHOF 1.18i Percentage of adult carers who have as much social contact as they would like (Adult Social Care Users Survey)	⇔	A
PHOF 2.23iii Self-reported wellbeing - people with a low happiness score	↑	A

Workstream 3: To drive and oversee new, integrated and sustainable models of care across the county

Lead Manager: Stephen Chandler

Actions	Trend	RAG
To develop and drive a shared vision for a more sustainable and integrated model of commissioning and provision of health and social care across Somerset	⇔	G
To influence the development of new models of care across Somerset	⇔	G
Local Measures:		
To develop and achieve HWBB sign off of:		
Prevention Framework	⇔	G
Draft Prevention Charter	⇔	G
Final Prevention Charter	⇔	G
To achieve HWBB sign off of the Better Care Fund.	⇔	G
Sustainability and Transformation Plan Submissions:		
STP Submission (September 2016)	⇔	G
STP Submission (October 2016)	⇔	G
Engagement and Communication (Feb 2017)	⇔	G
Consultation (August 2017)	⇔	G
Transition to implementation (October 2017 onwards)	⇔	G
Status of Adults' Transformation Programme	⇔	A
Proportion of contacts that result in Community Based Support or Information and Advice (with no funded service)	↑	R

Workstream 4: To further develop work to improve identification and early intervention to prevent Hidden Harm of Children

Lead Manager: Alison Bell / Deborah Howard

Actions	Trend	RAG
Audit if adult mental health patients are being identified as being parents with dependent children	↑	G
To implement the new protocol of Hidden Harm, across adult mental health, domestic abuse and drugs and alcohol services	⇔	G
To ensure early help professionals have accessed identification and brief intervention training of domestic abuse and substance misuse	⇔	A
Local Measures:		
Hidden harm in multiagency safeguarding children training	⇔	G
Hidden harm in multiagency safeguarding adults training	⇔	G
Joint working protocol and information sharing in place, enabling individual care plans contain input from all relevant services in one plan	⇔	G
Evaluation of impact of joint working protocol	↑	G
Service specifications for Drugs and Alcohol services include requirement to incorporate the assessment of parental factors into performance indicators and outcomes	⇔	G
Service specification for Adult Mental Health services include requirement to incorporate the assessment of parental factors into performance indicators and outcomes	⇔	G
Numbers of early help professional accessing brief intervention training on substance misuse	⇔	A
Number of early help professionals accessing brief intervention training on domestic abuse	↑	G
National Measures		
Percentage of re-referrals to Children Social Care	⇔	G
PHOF 1.11 Rate of domestic abuse incidents recorded by the police per 1,000 population	↓	G

Workstream 5: To identify and address the impact of housing on health

Lead Manager: Tracy Aarons

Actions	Trend	RAG
To build a stronger connection between the JSNA, in particular the need for sustainable communities and local housing policy	⇔	G
To drive improvements between health providers and the district housing function where housing standards are affecting health	⇔	G
Local Measures:		
JSNA used in review of Somerset Housing Framework	⇔	G
Commence pilot 'housing surgeries' in Glastonbury	⇔	G
Review and report on effectiveness of pilot	⇔	G
Commence use of housing contacts list by central Mendip and also use by health connections Mendip to test best result	⇔	G
Report on effectiveness of two approaches and roll out best approach in single district	⇔	G
Somerset Housing Framework data review completed using JSNA	⇔	G
Assess increase in referrals to PSH by health practitioners	⇔	G
Roll out learning on PSH referrals to other parts of county	⇔	G
New Strategic housing framework incorporates JSNA data	⇔	G
National Measures		
PHOF 1.15 Statutory homelessness	⇔	G
PHOF 4.11 Indirectly standardised percentage of emergency admissions to any hospital within 30 days of the previous discharge from hospital	↑	G
NHSOF 3.2 Emergency readmissions within 30 days of discharge from hospital	↑	A
PHOF 4.15i Excess Winter Deaths Index (Single year, all ages)	↓	A

Workstream 6: To increase use of licensing powers to promote health wellbeing and reduce harm

Lead Manager: Rina Singh / Nigel Marston

Actions	Trend	RAG
To complete work looking at greater local use of licensing to protect and improve population health and wellbeing with a specific focus on alcohol	⇔	G
Research and prepare business cases for town centre schemes and initiatives that promote responsible drinking or reduce the impact of alcohol on public services including hospitals, police and ambulance services	⇔	G
Bring together partners to fund and initiate pilot schemes in Yeovil with learning to be shared with HWBB partners to that similar schemes could be rolled out elsewhere if appropriate (** extension to take forward into 2017 and business case being developed)	⇔	A
Local Measures:		
Initial findings from review of best practice to be presented to the HWBB	⇔	G
Workshop held to develop better information links	⇔	G
Training workshop help with key partners identified	⇔	G
Changed processes agreed by key partners	↑	G
New procedures and practices drafted and agreed through SSDCs processes	⇔	G
Seek funding from partners to continue research officer post for Phase 2 of this workstream	↓	A
Suite of recommendations shared with HWBB / Executive and other councils in Somerset following initial review of their effectiveness	↓	R
Research of town centre initiatives that can reduce harm from alcohol and reduce impact on public services in general	↑	G
Seek funding from partners to pilot schemes in Yeovil following research (2017 ** as above)	↓	A
Document roll out in Yeovil schemes to allow easy roll out elsewhere (2017)	↓	A
Evaluation of any pilot schemes (2017)	↓	A
National Measures		
PHOF 2.18 Alcohol related admissions to hospital	↑	A

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Somerset Health and Wellbeing Board Scorecard

The Vision for health and wellbeing in Somerset is: 'People Living healthy and independent lives, supported by thriving and connected communities, with timely and easy access to high quality and efficient pubic services when they need them'

Reporting Period: 2017/18 - Up to 31st May 2017

Health and Wellbeing Board Duties / Requirements

Statutory Duties and Functions			Better Care Fund National Indicator Set:			Reports received:			Public Engagement		
Undertake a Joint Strategic Needs Assessment	↔	G	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	TBC		Director of Public Health Annual Report 2015/16	↔	G	Annual Health and Wellbeing Conference	↔	G
						Somerset Children's Trust - Children and Young People's Plan 2016-19	↔	G			
Undertake a pharmaceutical needs assessment	↔	G	Proportion or f older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	↑	G	Somerset Safeguarding Children Board - Annual Report 2015/16	↔	G	Involvement and encouragement with Healthwatch Somerset	↔	G
						Somerset Safeguarding Adults Board - Annual Report 2015/16	↔	G			
Develop a joint Health and Wellbeing Strategy for the County	–	G	Delayed transfers of care from hospital per 100,000 population	↑	G	Safer Somerset Partnership 2015/16	↔	G	HWB Newsletter / briefing notes	↔	G
						Joint Strategic Needs Assessment 2016	↔	G			
To encourage integrated working between health, social care and public health including oversight of the Better Care Fund	↔	G	Avoidable emergency admissions	TBC		Health Protection Forum Report 2015/16	↔	G	HWB Website	↔	A
						Healthwatch Somerset Updates	↔	G			

Headlines / Exception Report

Workstream 1: Four STP prevention proposals have been given authorisation to proceed to full business case - these are Fall Prevention, Smoking in Pregnancy, Make Every Contact Count and Social Prescribing. In addition, Prevention is a key theme for the STP Commissioning Academy. Local Organisations are adopting the Charter. All NHS Organisations have adopted the Charter. All District Councils have prevention plans in place. Two new case studies have been developed, hope to see more case studies relating to health care settings going forward.

Workstream 2: One measure currently has an Amber RAG status 'Each District Council to achieve Dementia Friendly Status' - the RAG will turn green when all District Councils have Dementia Friendly Status

Workstream 3: Further work is needed to determine the 2017/18 local measures and project milestones for this workstream

Workstream 4:

Action 1 (Embed the ability of adult mental health services (crisis team, community MH services and mental health social work service) to identify if patients are being identified as parents with dependent children) has an Amber RAG Status this is because the parental flag is now in place on RIO but staff need to retrospectively use the flag).

Action 2 (Embed the protocol of Hidden Harm, across adult mental health, domestic abuse and drugs and alcohol services) has an Amber RAG status - this is because xxxx

Action 3 (Review Early Help Assessments (EHA) that identify adult mental health, substance misuse or domestic abus needed) has a Red RAG status - this is because the screening tool (referred to in the local measures) is not in use to assess the risk of behavious on adults and children - this work is expected to be undertaken in quarter 2.

A further metric 'Number of staff within SIDAS accessing MHFA and ASSIST training and screening and brief intervention for substance misuse' has an amber status. This is because no staff have had any specialist MH training, but all have done Safeguarding as an ongoing rolling programme and 1 member of staff has done dementia training. This training is done internally by Knightstone. Four staff have completed the Assist Training and two further member of staff have signed up. No staff have received substance misuse training. There hasn't been any training given or offered by SDAS / Associated services.

Workstream 5: All Actions, Local Measures and Project Milestones have Green RAG statuses. Where are (-) is placed in the RAG Status box this indicates that work has not started in respect of this metric yet.

Priority Workstreams

Workstream 1: To provide joint leadership for prevention across the County

Lead Manager: Trudi Grant

Actions		
Ensure that prevention is effectively addressed in the implementation of the Somerset NHS Sustainability and Transformation Plan	–	A
Promote the Somerset Prevention Framework and Charter to local organisations	–	G
Support organisations who adopt the charter to develop plans and actions to deliver prevention outcomes	–	A
Produce further three prevention case studies using the prevention framework to describe the type and level of the intended prevention and its actual outcome	–	A
Local Measures:		
Evidence of prevention outcomes and plans within the STP	–	A
All local authorities in Somerset to adopt the prevention charter	–	A
All Foundation Trusts and other Health and Care Providers in Somerset to adopt the Prevention Charter	–	G
Number of organisations who have adopted the Prevention Charter who also have a Prevention Plan in place	–	A
Minimum of three further prevention case studies produced and disseminated	–	A
National Measures		
None		

Workstream 2: To give system leadership to build strong, resilient and healthy communities

Actions		
To further develop the Lets end loneliness in Somerset Programme through the District Councils	–	G
To further develop the Lets end loneliness in Somerset Programme through the Somerset VCS Forum	–	G
To continue to raise the profile of loneliness through the media	–	G
Submit a funding bid to the BIG lottery (or other appropriate funding bodies) to implement a Somersetwide Lets end loneliness in Somerset programme	–	G
Local Measures:		
Focussed pu blicity campaigns to raise awareness thorught local media and press.	↔	G
Each District to implement the action plan from their loneliness conference	↔	G
Develop a comunication plan, project plan and a case for support as the basis for funding proposals	↑	G
Seek broader VCSE sector support regarding the proposal and the need to consider common language and the development of a pledge / commitment and continue to develop a more coordinated / joined up approach to support initiative.	–	G
Using the information gathered from best practice research in 2016/17 develop a project proposal and submit funding applications	–	G
Each District Council to achieve Dementia Friendly Status	↔	A
National Measures		
PHOF 1.18i Percentage of adult carers who have as much social contact as they would like (Adult Social Care Users Survey)	↔	A
PHOF 2.23iii Self-reported wellbeing - people with a low happiness score	↑	A

Workstream 3: To drive and oversee new, integrated and sustainable models of care across the county

Lead Manager: Stephen Chandler

Actions		
To develop and drive a shared vision for a more sustainable and integrated model of commissioning and provision of health and social care across Somerset	–	G
To influence the development of new models of care across Somerset	–	G
Local Measures:		
Status of Adults' Transformation Programme	↔	A
Proportion of contacts that result in Community Based Support or Information and Advice (with no funded service)	↑	R
Suitable STP board metrics will be provided to give the HWB Board and Exec with oversight of the progress of the STP. In particular main deadlines / milestones in relation to models of care. These will be provided in a few months.		
National Measures		
To be determined		

Workstream 4: To further develop work to improve identification and early intervention to prevent Hidden Harm of Children

Lead Manager: Alison Bell / Deborah Howard

Actions		
Embed the ability of adult mental health services to identify if patients are being identified as parents with dependent children	–	A
Embed the protocol of Hidden Harm, across adult mental health, domestic abuse and drugs and alcohol services	–	A
Review Early Help Assessments (EHA) that identify adult mental health, substance misuse or domestic abuse needs	–	R
Local Measures:		
Quarterly report of the number of parents being supported by each service individually and collectively	–	G
Number of staff within SDAS accessing MHFA and ASSIST training and screening and brief intervention for domestic abuse	–	G
Number of staff within SIDAS accessing MHFA and ASSIST training and screening and brief intervention for substance misuse	–	A
Percentage of EHAs that identify mental health, substance misuse or domestic abuse where appropriate screening tool used	–	A
Percentage of EHAs that identify mental health, substance misuse or domestic abuse where an appropriate referral has been made and accepted by specialist services	–	A
National Measures		
Percentage of re-referrals to Children Social Care	↑	G
PHOF 1.11 Rate of domestic abuse incidents recorded by the police per 1,000 population	↓	G

Workstream 5: To identify and address the impact of housing on health

Lead Manager: Tracy Aarons

Actions		
Create more effective housing outcomes for people living with mental health issues	–	G
Support the work of the Positive Lives Programme to improve the health of adults with complex needs through more appropriate housing related supported solutions	–	G
Local Measures:		
Work with Mental Health Commissioners and providers to map mental health pathways	–	–
Work with housing authorities and providers to map housing pathways	–	G
Hold a joint workshop to share an understanding between housing and mental health practitioners of each other and collectively identify areas for improvement	–	–
Produce a Positive Lives Strategy	–	G
Deliver the actions coming from the Positive Lives Strategy	–	–
National Measures		
PHOF 1.15 Statutory homelessness	–	–
PHOF 4.11 Indirectly standardised percentage of emergency admissions to any hospital within 30 days of the previous discharge from hospital	↑	G
NHSOF 3.2 Emergency readmissions within 30 days of discharge from hospital	↑	A
PHOF 4.15i Excess Winter Deaths Index (Single year, all ages)	↓	A

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Agenda item 7

Somerset Health and Wellbeing Board

Report for 13th July 2017

Somerset Health and Wellbeing Board Annual Report

Lead Officer: Trudi Grant, Director of Public Health
Author: Christina Gray, Consultant in Public Health
Contact Details:

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Office (Director Level)	Trudi Grant	30.6.2017
	Cabinet Member / Portfolio Holder (if applicable)	Cllr Ann Bown Cllr Christine Lawrence	21.6.2017 30.6.2017
	Monitoring Officer (Somerset County Council)	Julian Gale	4.7.2017
Summary:	Health and Wellbeing Boards are an important feature of the reforms introduced by the Health and Social Care Act (2012). These Boards are constituted as formal committees of all upper tier and unitary local authorities and form part of the role that local authorities now have to improve the health of their population. This Annual report for 2016 – 17 sets out the progress made under each of the following Board functions: • Fulfilment of Statutory Duties • Health Improvement Workstreams • System oversight and Influence		
Recommendations:	**That the Health and Wellbeing Board receives and endorses the Health and Wellbeing Board Annual Report for 2016 – 17**		
Reasons for Recommendations:	This report provides an overview of the work and achievements of the Health and Wellbeing Board during the year 2016 – 17.		
Links to Somerset Health and Wellbeing Strategy:	This annual report describes progress against the Health and Wellbeing Strategy.		
Financial, Legal and HR Implications:	N/A		
Equalities Implications:	Health is unequally distributed across the population with some groups and communities experiencing disproportional poor health. The Health and Wellbeing Board and the Health and Wellbeing Strategy are required to address the health impacts of inequality and unequal treatment.		

Risk Assessment:	N/A

1. Background

1.1. Health and Wellbeing Boards are an important feature of the reforms introduced by the Health and Social Care Act (2012). These Boards are constituted as formal committees of all upper tier and unitary local authorities and form part of the role that local authorities now have to improve the health of their population. The Health and Wellbeing Board has the following four statutory duties:

- The Board must have in place a Health and Wellbeing Strategy for its population.
- The Board must produce a Joint Strategic Needs Assessment to inform planning and commissioning.
- The Board must produce a Pharmaceutical Needs Assessment for the area.
- The Board must oversee the Better Care Fund and promote the integration of Health, Public Health and Social Care where appropriate.

1.2. In addition to fulfilling its statutory duties the Somerset Health and Wellbeing Board undertakes to progress health improvement though a number of specific workstreams each year as well as taking an oversight and influencing role across the whole health and wellbeing system. The work of the Board for 2016 – 17 can be seen summarised on the plan on a page in Appendix 1.

1.3. This report sets out the progress made under each of the following Board functions:

- Fulfilment of Statutory Duties
- Health Improvement Workstreams
- System oversight and Influence

2. Options considered and reasons for rejecting them

2.1. n/a

3. Consultations undertaken

3.1. n/a

4. Financial, Legal, HR and Risk Implications

4.1. n/a

5. Background papers

5.1. 2016 – 17 Annual Report of the Somerset Health and Wellbeing Board

Somerset Health and Wellbeing Board Annual Report 2016-17

Somerset Health and Wellbeing

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MESSAGE FROM THE CHAIR

It is a pleasure to present to you the annual report of the Somerset Health and Wellbeing Board 2016/17. The Board has had some notable achievements in the past year and has made good progress in achieving improvements in health and wellbeing in Somerset.

The Board has strengthened its role to champion prevention, putting prevention at the heart of all we do throughout public services in Somerset. Ten Somerset organisations have now signed up to a *Prevention Charter*, demonstrating a real commitment to Somerset becoming a 'prevention first' county.

One of the notable impacts of the Board in 2016/17 has been the development of a well-received *'Lets End Loneliness in Somerset'* campaign, led by the voluntary sector and our District Councils. BBC Radio Somerset and the local press have taken a great interest, helping to raise awareness and to promote the campaign.

An important annual event for the Board each year is undoubtedly the Health and Wellbeing Conference. This is one of the ways in which the Board engages with local partners including the voluntary sector and town and parish councils. This year the event focused on mental wellbeing, with over eighty delegates considering issues such as approaches to developing stronger communities and improving the emotional health and wellbeing of children in our schools. This was also an opportunity to listen to the issues and concerns of our wider partners and we will use this information to inform work of the Board.

This year, there has been a focus on Sustainability and Transformation Plans (STP) both nationally and locally. Sustainability and Transformation is a new planning framework for NHS and social care services. It is intended to be a blueprint for delivering the ambitions for improved local services, as set out in a national document called The NHS Five Year Forward View. The Health and Wellbeing Board plays an important role is setting the shared strategic direction of the plan and ensuring that the proposals address prevention and are in line with the needs of the local population. The Sustainability and Transformation Plan will form an ever-increasing part of the work of the Health and Wellbeing Board going forwards.

I would like to take this opportunity to thank all the Board members and all those who contribute to the work of the Board. I have very much enjoyed my time as Chair and I wish the Board every success in the future, building on the excellent achievements of the past year.

A Bown

Cllr Ann Bown
Chair Health and Wellbeing Board 2015–2017

INTRODUCTION

Health and Wellbeing Boards are an important feature of the reforms introduced by the Health and Social Care Act (2012). These Boards are constituted as formal committees of all upper tier local authorities and form part of the role that local authorities now have to improve the health of their population.

The Health and Wellbeing Board has the following four statutory duties:

The Board must have in place a Health and Wellbeing Strategy for its population.

The Board must produce a Joint Strategic Needs Assessment to inform planning and commissioning.

The Board must produce a Pharmaceutical Needs Assessment for the area.

The Board must oversee the Better Care Fund and promote the integration of Health, Public Health and Social Care where appropriate.

In addition to fulfilling its statutory duties the Somerset Health and Wellbeing Board undertakes to progress health improvement though a number of specific workstreams each year as well as taking an oversight and influencing role across the whole health and wellbeing system.

The work of the Board for 2016/17 can be seen summarised on the plan on a page in Appendix 1.

This report sets out the progress made under each of the following Board functions:

- Fulfilment of Statutory Duties
- Health Improvement Workstreams
- System Oversight and Influence

COMMUNICATION AND ENGAGEMENT

In order to carry out its duties and functions, the Health and Wellbeing Board needs to develop ways and means of listening to and engaging with partners and the public.   The diverse voices, views and experiences of the people of Somerset are important in shaping the work of the Board; and the Board needs to communicate with a wide range of partners who are keen to know about the strategic direction for health and wellbeing in Somerset. This happens in a number of ways.

Members of the public are able to attend the board in person to make a short statement. The Board welcomes this and this year statements have been received on autism, the needs of carers and stroke services.

Healthwatch, as a member of the Board, brings the patient and public voice directly to the Board through regular thematic reports and constructive challenge.

District Health and Wellbeing Networks and NHS Patient Forums provide opportunities for more local engagement and, when required, consultation.

The annual Health and Wellbeing Board Conference is a high point of the year, bringing together Board members with partners from the statutory and voluntary sectors. This year the event was jointly hosted with the Somerset Towns Forum on the theme of Building Mental Capital for Health and Wellbeing. Beginning with a challenging presentation about the impact of allowing communities the control to develop their own solutions, the day progressed with presentations about innovative community programmes being led, and funded, by Parish Councils; and inspiring and effective work taking place in schools using an approach called Emotion Coaching. During the conference we began to collect stories on how investing in mental and social capital makes a real difference.   These stories are published on the Health and Wellbeing webpage.

Finally, addressing the fact that formal meetings can be difficult to follow and the formal minutes of such meetings equally challenging, we have been experimenting this year with a plain English, short, one page summary version of Board meetings. This is published on the Health and Wellbeing Board webpage and is made available to members for circulation.

SECTION 1 – FULFILMENT OF STAUTORY DUTIES

Somerset Health and Wellbeing Strategy 2013–18

The Somerset Health and Wellbeing Strategy sets out the shared vision for improving health and wellbeing locally. The strategy is not meant to cover everything that impacts on health and wellbeing. Three themes have been selected to reflect what many people and organisations have said are the most important things that would improve health and wellbeing locally. Information and data which are available for Somerset and local areas has also been used to help agree these priorities. The Strategy sets the scene for Health and Wellbeing Board to make the vision for health and wellbeing in Somerset a reality through its work programme. During the coming year, the Board will begin work on a new strategy for Somerset.

Vision for Health and Wellbeing in Somerset

People live healthy and independent lives, supported by thriving and connected communities with timely and easy access to high-quality and efficient public services when they need them.

Our Priorities

Theme 1: People, families and communities take responsibility for their own health and wellbeing.

Theme 2: Families and communities are thriving and resilient.

Theme 3: Somerset people are able to live independently.

Joint Strategic Needs Assessment (JSNA)

The Joint Strategic Needs Assessment (JSNA) is a web-based resource, which is part of the Somerset Intelligence Website (www.somersetintelligence.org.uk/jsna) and includes up to date information on health and care needs, as well as the wider determinants of health such as housing and transport.

In addition a thematic report is produced each year on a topic selected by the Board. The thematic report for 2016/17 was on Vulnerable Children and Young People, and written not only to inform the activities of the Board but also to support the production of the Children and Young People's Plan for Somerset. This report found that the majority of children and young people lead healthy and productive lives, but that there are considerable inequalities. The report showed that several thousand

children, concentrated in the most deprived areas of Taunton, Yeovil and Bridgwater, bear a disproportionate burden of illness, poverty and crime in the county. This information identifies an opportunity for focused, place-based services to deliver significant improvements. There are some needy children everywhere, of course, and it was clear that those small numbers of children at risk who are dispersed across the wide rural areas of Somerset require careful, joined-up attention from agencies if they are not to fall through the net.

The thematic report for 2017/18 was presented to the Board in draft in January 2017. This examines what helps people in Somerset to 'age well'. The themes of physical and mental health, personal independence and good social contact in strong communities have emerged as important. The next Joint Strategic Needs Assessment will focus on the development of the new Health and Wellbeing Strategy.

Pharmaceutical Needs Assessment

A Pharmaceutical Needs Assessment must be produced every three years. The last was published in 2015 and the next is due before April 2018. Unlike the Joint Strategic Needs Assessment, which is a report *to* the Board, this is a report *from* the Board to NHS England (NHSE), intended to be the evidence base required by NHS England to make decisions in the 'market entry' process for pharmacies.

The Board is required to state whether there are gaps in access to pharmacies (or pharmaceutical services provided by dispensing GPs), or particular types of pharmaceutical service; if commercial pharmacy providers do not fill the gaps, then NHS England is required to commission services to fill them. In 2015 the only gap found was the provision for palliative care in the Chard, Ilminster and Crewkerne commissioning locality, and this service was duly commissioned by NHS England.

Preparation of a Pharmaceutical Needs Assessment takes approximately 12 months, including a statutory 60 day consultation on a draft. The Board therefore began the process of production in January 2017 by setting up a working group, including Somerset CCG, Healthwatch, the Somerset Local Pharmaceutical Committee, the Somerset Local Medical Committee, and Somerset County Council consultation and public health teams, as well as NHS England.

The Better Care Fund 2016/17

The Better Care Fund brings together health and social care funding to support the integration of health and social care. The fund is an opportunity for local services to transform services and improve the lives of the people who need it the most. The Health and Wellbeing Board has an oversight and assurance role around health and care integration and must sign off the annual Better Care Fund plan. During 2016/17 four key Better Care Fund Schemes were identified and there have been achievements in all of these schemes.

Reablement
Two new reablement schemes were piloted, and funding of home-based reablement care was continued: the purchase of block-booked nursing home beds and a reablement/homecare service provided by Somerset Partnership NHS Foundation Trust. Both schemes were intended to assist with winter pressures and have had a positive impact on delayed transfers of care, seen by a reduction in the total number of lost bed days since October 2016

Person-centric care and support
Building on the well-established new models programme in Somerset; this was developed out of the insights provided by the Symphony dataset (an integrated service utilisation and patient characteristic analysis). These pilots targeted people who benefitted from a health coaching/connecting intervention and/or proactive multi-disciplinary care management for complex conditions. Local dataset analysis is beginning to show that these approaches have reduced individual's overall need for services, as well as improved the working lives of those in primary care.

Improving Discharge from Hospital
A collective effort to improve delayed transfers of care has resulted in:

- Multi-agency Practice Development Forums taking place in both acute trusts and community hospitals, enabling a multi-disciplinary approach to early identification of potential issues

- An improved and streamlined discharge process

- A community-based discharge manager within each trust to facilitate and oversee timely transfers to community hospitals

- Development of a county-wide reluctant discharge policy that is consistently applied

- Work towards two joint pathway managers (acute and social care) at Musgrove Park Hospital and Yeovil District Hospital.

Housing adaptations (Disabled Facilities Grant)
This scheme enables people to remain living independently by making adaptations to their home. These are adaptations such as ramps and handrails, enabling access by widening doors or installing accessible washing facilities. These adaptations can support people to live independently; making caring for someone at home more possible; preventing unnecessary hospital admission and support timely discharge home from hospital. The provision of the Disabled Facilities Grant has enabled many people to have access to essential facilities.

SECTION 2 – PRIORITY WORKSTREAMS 2016–17

Workstreams are one of the means by which the Board implements the Health and Wellbeing Strategy. Progress on workstreams is monitored through a performance score-card. This is considered bi-monthly by the Health and Wellbeing Board Executive Group and twice yearly by the full Board. Each Workstream has a nominated officer lead and Board Member Champion.

Worksteam 1: To provide joint leadership for prevention across the county

Aims of the workstream

- To produce and oversee the delivery of the Prevention Plan to support the NHS Sustainability and Transformation Plan.
- To develop a Prevention Charter for Somerset which addresses the health and wellbeing gap.
- To produce a minimum of three prevention case studies.

Key achievements in 2016/17:

The Board has developed and agreed a Prevention Framework for Somerset to support a shared understanding of what prevention means to people working in different parts of the system and addressing different levels of need. This was followed by the publication of a Somerset Prevention Charter (see Appendix 2). All organisations represented on the Board, as well as other organisations within the health and wellbeing system, have signed or are signing up to the Prevention Charter at the highest level of their organisation.

The Charter commits the organisation to take action to address prevention in different ways and by different means as part of their everyday business. Partners are invited to send in case study examples of prevention in action and these are currently published on the Health and Wellbeing Board web page along with partner health and wellbeing action plans.

Officer Lead and Board Member Champions for 2016/17:
Trudi Grant, Cllr Anna Groskop, Cllr Jane Warmington

Workstream 2: To give system leadership to build strong, resilient and healthy communities

'Loneliness is as damaging to health as smoking 15 cigarettes a day'

Aims of the workstream

- To further develop the *Let's end Loneliness in Somerset* Programme through the District Councils and the Somerset Voluntary Community and Social Enterprise (VCSE) forum.

- To continue to raise the profile of loneliness through the media.

Key achievements in 2016/17:

This theme was identified by members of the public as being vital for health and wellbeing and is specifically described in the Health and Wellbeing Strategy. Building resilient communities through the development of individual mental and social capital was the theme for the Board's annual conference this year.

Let's End Loneliness in Somerset events have been held within each district council area and followed by local *Let's End Loneliness* plans. These focus on simple ways of making connections between people, encouraging projects and groups to be inclusive and mindful of loneliness. The Somerset Voluntary Community and Social Enterprise (VCSE) Forum has led work to promote the campaign through the sector and to inform a future funding bid for Somerset. The national campaign provides useful information and resources, https://www.campaigntoendloneliness.org/ but the focus is on older age and the Somerset Health and Wellbeing Board, while recognising that age can be a risk factor in loneliness, wanted to focus the local campaign more broadly, recognising that loneliness can happen at any age.

Officer Lead and Board Member Champions for 2016/17:
Teresa Harvey, Cllr Sylvia Seal, Cllr Ross Henley

Workstream 3: To drive and oversee new, integrated and sustainable models of care across the county

Aims of the workstream

- To develop and drive a shared vision for a more sustainable and integrated model of commissioning and provision of health and social care across Somerset.

- To influence the development of new models of care across Somerset.

Key achievements in 2016/17:

The Sustainability and Transformation Plan for Somerset was developed in good time and endorsed by the Health and Wellbeing Board. Prevention is a strong theme within the Plan. Good progress has been reported on the Somerset County Council Adult Services Transformation Programme, with the Community Connect approach, developed initially in Sedgemoor and West Somerset now being rolled out across the county. This approach changes the nature of conversation from a focus on assessment to a discussion about the things which matter to keep people independent and well. The number of people receiving a community- based conversation, support or information is expected to increase over the coming year.

Officer Lead and Board Member Champions for 2016/17:
Stephen Chandler, Cllr William Wallace, Cllr Nigel Woollcombe–Adams

Workstream 4: To improve identification and early intervention to prevent Hidden Harm of children

Aims of the workstream

- Implement the new joint protocol for Hidden Harm and audit if adult mental health patients are being identified as parents.

- Ensure early help professionals have accessed identification and brief intervention training for domestic abuse and substance misuse.

Key achievements in 2016/17:

The behaviours of adults can harm children. The focus here is on a combination of drug and alcohol use, mental health problems and domestic violence. Improvements have been made in the identification of these risks to children, a multi-agency workshop has been held and further training and awareness- raising is planned. This work supports the development of a" think family" approach and a single approach to multiple vulnerability, both now key themes for Somerset.

Officer Leads and Board Member Champions2016/17:
Alison Bell, Deborah Howard, Cllr Frances Nicholson, Cllr Ann Bown

Workstream 5: To identify and address the impacts of housing on health and wellbeing

Aims of the workstream

- To build a stronger connection between the Joint Strategic Needs Assessment, in particular the need for sustainable communities, and local housing policy.

- To drive improvements between health providers and the district housing function where housing standards are affecting health.

Key achievements in 2016/17:

Positive results have been achieved in the integration of Joint Strategic Needs Assessment data into strategic housing work. There have also been improvements in developing a shared understanding between health and housing professionals and sectors. Pilot work suggests that signposting is the preferred method of sharing for health professionals rather than having housing staff working within practices. This suggests that raising awareness amongst health staff about housing issues supports better outcomes for residents and this will be focused on as part of future work. Health and housing is a key consideration in the development of the Strategic Housing Framework for Somerset which is being refreshed in 2017/18

Officer Leads and Board Member Champions 2016/17:
Tracy Aarons, Cllr Keith Turner, Cllr Nigel Woollcombe- Adams

Workstream 6: To increase use of licensing powers to promote health wellbeing and reduce harm

Aims of the workstream

- To complete work looking at greater local use of licensing to protect and improve population health and wellbeing with a specific focus on alcohol.

- Research and prepare business cases for town centre schemes and initiatives that promote responsible drinking or reduce the impact of alcohol on public services including hospitals, police and ambulance services.

- Bring together partners to fund and initiate pilot schemes in Yeovil with learning to be shared with Health and Wellbeing Board partners so that similar schemes could be rolled out elsewhere if appropriate.

Key achievements in 2016/17:

The aim of this workstream was to explore the use of licensing powers to reduce alcohol harms and the individual and social costs that follow. Research elsewhere in the UK, concludes that sharing emergency department data with public health and other bodies can help bring about more informed decisions in licensing applications.

This type of data sharing in Cardiff reduced violence-related attendances at their emergency department by 50% over a five year period. Many other hospitals have started sharing their data with local partners because of this. A Somerset workshop was held with colleagues from neighbouring licensing authorities, ward sisters from the local emergency department, paramedics from the South West Ambulance Service and public health colleagues. Further work is needed to establish this data collection in Somerset. Hospital admissions for alcohol-related harm remain an area of concern in Somerset.

Officer Lead and Board Member Champions:
Vega Sturgess (until Dec 2016), Rina Singh (from Dec 2016), Cllr Gill Slocombe, Cllr Keith Turner

Section 3 – System Oversight and Influence

A key role of the Board is to influence across the whole system to drive improvements in health and wellbeing and tackle health and social inequalities in line with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy. One of the primary responsibilities of the Board is to ensure that significant policy change, strategies and service changes take due consideration of the Joint Strategic Needs Assessment and are aligned to the strategic direction set out in the Health and Wellbeing Strategy.

Sustainability and Transformation Plan

2016/17 has seen the development of Sustainability and Transformation Plans nationally. This has required joint leadership and oversight from the Health and Wellbeing Board. The Board is required to provide the overall governance for the Sustainability and Transformation Plan. The Somerset Sustainability and Transformation Plan describes a vision for the future of healthcare in Somerset. Key priorities outlined in the plan are:

- To encourage and support everyone in Somerset to lead healthier lives and avoid getting preventable illnesses.

- To move care out of hospital beds and into people's homes wherever possible, providing care designed specifically for each patient's needs, supporting faster recovery and, in many instances, avoiding the need to go into hospital in the first place.

- To invest in GP teams to develop a mixture of skills and time to support the increasingly complex care that needs to be given.

- To make it easier for people to get services closer to home, when they need them, using modern technology that is already transforming other parts of our lives.

- To invest more money in frontline care by being more efficient with how we use our buildings, our equipment and our management and administration. We have recently published a detailed document which sets out some of the plans we have.

The Health and Wellbeing Board has ensured that the Somerset Sustainability and Transformation Plan is in alignment with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy. A key role of the Board has been to significantly influence the Sustainability and Transformation Plan to have a strong focus on prevention and this is reflected in the nature of the plans being developed, which include a focus on falls prevention, stopping smoking in pregnancy, mental health and stronger communities.

A full copy of Somerset's Sustainability and Transformation Plan proposals on the Somerset Clinical Commissioning Group's website at: www.somersetccg.nhs.uk

Strategic Oversight of Health and Wellbeing Strategies and Plans

In addition to the work on the Sustainability and Transformation Plan, this year the Board has also maintained oversight of the following strategies, ensuring alignment with the Joint Strategic Needs Assessment and Health and Wellbeing Strategy and providing an opportunity for the escalation of issues that can only be resolved through multi-agency collaboration or holding partners to account:

- Joint Mental Health Strategy
- Autism Strategy
- Carers' Strategy
- Dementia Strategy
- Personal Health Budgets
- Children and Young People's Plan
- Special Educational Needs and Disability

Progress has been made in developing a closer relationship and better joint working with other Strategic Boards through the adoption of a joint working protocol. This protocol commits the Chairs of Strategic Boards for Health and Wellbeing, Children and Adults Safeguarding, Community Safety, the Children's Trust and Corporate Parenting Boards to work together on issues of common interest. It also requires the annual reports of each of the boards to be shared, in order to raise awareness of prominent issues and to maximise opportunities to join work up where possible.

Health Protection Forum

The Director of Public Health has an assurance role in relation to health protection within Somerset. This duty is discharged on behalf of the Director of Public Health by the Health Protection Forum. Health protection work seeks to prevent or reduce harm caused by communicable diseases and minimise the health impact from environmental hazards. The Director of Public Health presents an annual report to the Health and Wellbeing Board.

In the December 2016 the Director of Public Health reported that she had a high degree of assurance that measures are in place to protect the health of the Somerset population. The overall resilience of the health and social care system to cope with increasing demand and additional winter pressures is stretched and it is recognised within the report that the work of the Sustainability and Transformation Plan is paramount in ensuring the future sustainability of services.

Declining attendance for cervical and breast screening is of concern and some aspects of newborn screening are below expected levels and are a point of discussion for NHS England. There is an ongoing need to improve uptake in the seasonal flu programme across all eligible groups, including vaccinating frontline health and social care staff.

Finally, climate change presents one of the greatest national threats to public health in the coming decades. There is a need to contribute effectively to the worldwide effort to reduce carbon emissions, and minimise the health and other impacts on the population. We are likely to see more heatwaves in summer, alongside warmer,

wetter winters, so planning arrangements for these will need revising as time progresses.

Annual Report of the Director of Public Health

The Director of Public Health is required to produce an annual report, with total freedom over its contents. This provides an opportunity for the DPH to raise any matters of concern, or to describe the broader context of health and wellbeing than may be covered by particular projects.

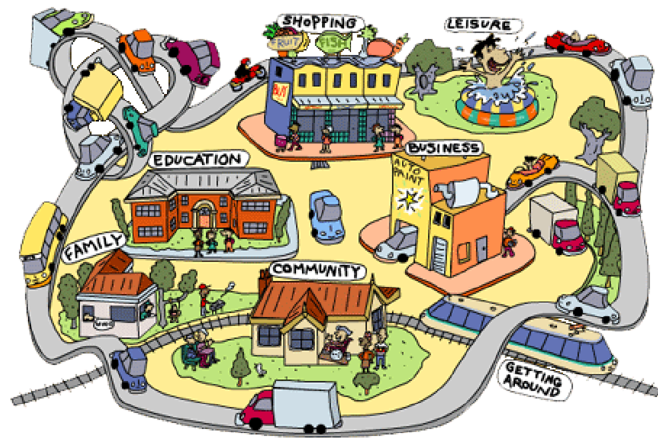
In 2016 the Annual Public Health report looked back to the reports issued by the first County Medical Officer of Health for Somerset, Sir William Savage, who served from 1909 to 1937. Looking back to 80 years earlier – about a lifetime ago – and comparing with the present, it was possible to gain real perspective on the state of health and wellbeing in Somerset today. It was striking that whilst Sir William Savage felt justifiably pleased in the improvements in health that he had seen during his time in office – on several occasions saying that little further improvement was likely – these pale in comparison to the huge achievements achieved since. Much of the improvement has been the result of better sanitation and central heating, more sophisticated care in childbirth and infancy, and the near-elimination of some infectious diseases through vaccination. In contrast, cancer and dementia have risen in importance as we generally live longer and develop these conditions in older age. Savage's approach shows us the importance of:

- A relentless focus, at pace, on the most significant areas of disease burden
- Action taken at "industrial scale", not just small patches of coverage, and
- Prevention activity built-in systematically to all existing processes

This approach is just as relevant now, and the story shows that we should not be complacent about the further advances we could make by tackling inequalities and harmful lifestyles in today's county.

The 2017 Director of Public Health Annual Report will focus on End of Life Care and how a public health approach to it can bring benefits to patients and carers, as well as the system of health and care.

WHAT NEXT FOR 2017-2018



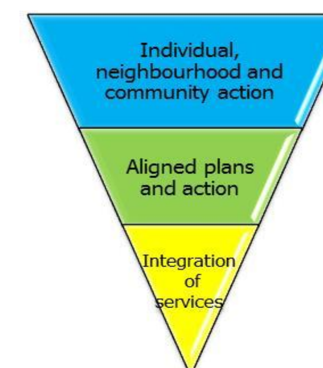
During the coming year the Board has a significant work programme and will be continuing to develop in order to undertake a more substantial role in relation to the health and care system as well as health and wellbeing.

The Board will be taking on increased responsibility for health and care integration through oversight of the Sustainability and Transformation Plan.

The Somerset Health and Wellbeing Strategy will be refreshed and will continue to have a number of visible priority workstreams to support the delivery of the strategy and to add value to complex areas where there are particular opportunities or challenges that require system leadership.

The Board will be revising its work programme to maintain progress on improving health and reducing health inequality.

Somerset Health and Wellbeing



Health and Wellbeing Board
Plan on a Page 2016 – 2017

People live healthy and independent lives, supported by thriving and connected communities, with timely and easy access to high quality and efficient public services when they need them.

Statutory duties and functions

- Somerset Health and Wellbeing Strategy
- Annual Joint Strategic Needs Assessment
- Somerset Pharmaceutical Needs Assessment
- Health and Social Care Integration including the Better Care Fund

Priority Workstreams 2016 - 17

Priority workstreams are informed by the Joint Strategic Needs Assessment and selected as an area of activity to which the Health and Wellbeing Board can bring added value. Priorities and Action is supported by or is designed to gather reliable evidence of effectiveness.

W1: To provide joint leadership for prevention across the county	W2: To give system leadership to build strong, resilient and healthy communities	W3: To drive and oversee new, integrated and sustainable models of care across the county	W4: To further develop work to improve identification and early intervention to prevent Hidden Harm of children	W5: To identify and address the impacts of housing on health and wellbeing	W6: To increase use of licencing powers to promote health wellbeing and reduce harm
Officer Lead and Board Member Champions: Trudi Grant Cllr Anna Groskop Cllr Jane Warmington (TBC)	**Officer Lead and Board Member Champions:** Teresa Harvey Cllr Sylvia Seal Cllr Ross Henley	**Officer Lead and Board Member Champions:** Stephen Chandler Cllr William Wallace Cllr Nigel Woollcombe –Adams	**Officer Leads and Board Member Champions:** Alison Bell Deborah Howard Cllr Frances Nicholson Cllr Ann Bown	**Officer Lead and Board Member Champions:** Tracy Aarons Cllr Keith Turner Cllr Nigel Woollcombe- Adams	**Officer Lead and Board Member Champions:** Vega Sturgess (until Dec 2016) Cllr Gill Slocombe Cllr Keith Turner
Actions: • Produce and oversee the delivery of the Prevention Plan to support the NHS Sustainability and Transformation Plan • Develop a Prevention Charter for Somerset which addresses the health and wellbeing gap • To produce a minimum of three prevention case studies using the prevention framework to describe the type and level of the intended prevention and its actual outcomes	**Actions:** • To further develop the *Lets end Loneliness in Somerset* Programme through the District Councils • To further develop the *Lets end Loneliness in Somerset* Programme through the Somerset VCS Forum • To continue to raise the profile of loneliness through the media	**Actions:** • To develop and drive a shared vision for a more sustainable and integrated model of commissioning and provision of health and social care across Somerset. • To influence the development of new models of care across Somerset.	**Actions:** • Audit whether adult mental health patients are being identified as being parents with dependent children • To implement the new joint protocol for Hidden Harm, across adult mental health, domestic abuse and drugs and alcohol services • Ensure early help professionals have accessed identification and brief intervention training for domestic abuse and substance misuse.	**Actions:** • To build a stronger connection between the JSNA, in particular the need for sustainable communities, and local housing policy. • To drive improvements between health providers and the district housing function where housing standards are affecting health.	**Actions:** • To complete work looking at greater local use of licencing to protect and improve population health and wellbeing with a specific focus on alcohol. • Research and prepare business cases for town centre schemes and initiatives that promote responsible drinking or reduce the impact of alcohol on public services including hospitals, police and ambulance services. • Bring together partners to fund and initiate pilot schemes in Yeovil with learning to be shared with Health and Wellbeing Board partners so that similar schemes could be rolled out elsewhere if appropriate.

Oversight and Influence

To ensure all HWB members are well-sighted on issues impacting on the health and wellbeing of Somerset and supporting the protection of vulnerable people and implementation of a safeguarding environment the board or its sub-groups will receive reports, at least annually on or from the following:

The Director of Public Health Annual Report	The Health Protection annual assurance report	The Somerset Strategic Housing Framework	Joint strategies and plans relevant to the health and wellbeing of children and adults	Healthwatch Reports	Annual Reports from Safeguarding Adult and Children Boards	Reports, at least annual from other strategic partnerships.

Themes for Board Development Workshops 2016 – 17

- Board Governance and Development
- Health Inclusion and Equality
- Prevention
- New models of care
- Sustainability and Transformation Plan for Somerset

Somerset Prevention Charter

OUR DEFINITION

Prevention means different things to different people.

It can be about:

- preventing harm,
- preventing the need for a service,
- preventing ill health and disease,
- preventing loss of independence,
- preventing risky behaviour
- preventing an existing problem becoming worse.

In essence it's all of these and more. We agree we need to keep a broad view of prevention so we do not miss opportunities to improve the lives of people in Somerset.

OUR VISION

People live healthy and independent lives, supported by thriving and connected communities with timely and easy access to high-quality and efficient public services when they need them.

OUR PRINCIPLES

We agree that:

- Prevention is **everyone's responsibility**; we want children, families, communities and agencies to work together and develop knowledge and skills to live healthily
- We will develop accountability at organisation level for delivery against the charter through regular measuring of progress and achievement
- We want to help everyone to have a **good birth, a good life and a good death**
- We want to provide people **with the knowledge, skills, confidence and environment** to enable healthy living and minimise unhealthy behaviours that can lead to dependence on health and social care services

- Strategically, **a place-based, population, approach to prevention** is better; joined up activity and shared investment funding achieves the best outcomes and best value for money
- Prevention activity needs greater shared investment
- Prevention is **equally important** for physical and mental health, social, environmental and economic issues
- Helping people, families and communities **build protective factors and resilience** to prevent situations escalating or recurring is an important part of our prevention activity
- Providing the **right service** when needed**, in the right place at the right time** helps prevent situations escalating and reduces waste
- Effective prevention needs **joined up information** so all the issues facing people can be understood together and people can receive joined up help.
- **Sharing data** to enable better care, and anonymised data to understand population health, with necessary privacy safeguards, is essential
- We will be clear on what our strengths and weaknesses are and **find practical ways to improve**

OUR ACTION

We agree that:

- **We all** have a responsibility to consider prevention opportunities **for everyone,** and will lead by example
- **We will enhance the skills** of our front line staff and volunteers, through training, to make every contact count in addressing risks to health
- We need to improve the lives of Somerset people overall but focus our work to **improve the lives of the worst off fastest**
- We will **join up our prevention approach and resources** to maximise impact at population level
- We will **increase and refocus resources** allocated for preventative activity over time
- For services, prevention will be **done systematically** and built into our systems.
- **No door is the wrong door**, all our staff have a responsibility to help people get the right service at the right time, redirecting supportively if .appropriate
- We will have **honest and open discussions** with individuals, families and communities about the issues, their responsibilities and that of public services.
- Where possible and appropriate we will **share information** to help provide people with better support. We will challenge each other and find practical solutions if appropriate information is not being shared.
- We will seek **change in local and national policies, or laws**, if such change would be most effective in improving prevention

OUR COMMITMENT

On behalf of

(insert organisation name)

I/ We endorse the Somerset Prevention Charter, committing our organisation to the Vision and Principles and to work with our co-signatories and others to deliver Our Actions.

………………………………..	…………………………..
Chair	Chief Executive

Somerset Health and Wellbeing Board Members 2016-17

Cllr Ann Bown (Chair), Somerset County Council

Cllr Frances Nicholson (Vice Chair) Cabinet Member CYP, Somerset County Council

Cllr William Wallace, Cabinet Member Adult Social Care, Somerset County Council

Cllr Anna Groskop, Somerset County Council

Cllr Ross Henley, Somerset County Council

Cllr Sylvia Seal, South Somerset District Council

Cllr Gill Slocombe, Sedgemoor District Council

Cllr Jane Warmington, Taunton Deane Borough Council

Cllr Keith Turner, West Somerset District Council

Cllr Nigel Woollcombe- Adams, Mendip District Council

Judith Goodchild, Health Watch

Trudi Grant, Director of Public Health

Stephen Chandler, Director Adult Social Care

Julian Wooster, Director Children's Services

Dr Matthew Dolman/ Dr Ed Ford Chair, Somerset CCG

David Slack, Managing Director, Somerset CCG

Mark Cooke, NHS England

Somerset Health and Wellbeing Board
July 2017

http://www.somerset.gov.uk/health-and-wellbeing/somerset-health-and-wellbeing-board/

Somerset Health and Wellbeing Board

Report for 13th July 2017

Devon and Somerset Fire and Rescue Service Updates

Lead Officer: Trudi Grant, Director of Public Health
Author: Christina Gray, Consultant in Public Health
Contact Details:

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Office (Director Level)	Trudi Grant	5.7.17
	Cabinet Member / Portfolio Holder (if applicable)	n/a	
	Monitoring Officer (Somerset County Council)	Julian Gale	4.7.17
Summary:	The Chief Officer of Somerset Clinical Commissioning Group requested that a statement is made on fire safety in the light of tragic fire and loss of life at Grenfell Tower in London. The attached statements from Devon and Somerset Fire and Rescue Services set out: • A press release (14th June) setting out responsibilities of landlords, explaining the stay put policy and the approach to high rise buildings • Specific advice for landlords and the public on fire safety on standards, necessary action and further sources o0f information. • A update report which summarises the risk assessments and actions undertaken by Devon and Somerset Fire and Rescue Service.		
Recommendations:	**That the Health and Wellbeing Board receives and notes the Fire Safety Statements**		
Reasons for Recommendations:	Health Protection is a responsibility of the Health and Wellbeing Board		
Links to Somerset Health and Wellbeing Strategy:	N/A		
Financial, Legal and HR Implications:	N/A		

Equalities Implications:	The residents who were affected by the Grenfell House fire were predominantly those from minority communities and / or experiencing health and wealth inequality. The communities lack of voice and powerlessness has been cited as a factor.
Risk Assessment:	All members and member organisations of the Health and Wellbeing Board have a duty to note and act on these statements providing by the Devon and Somerset Fire Service.

1. Background

1.1. The Chief Officer of Somerset Clinical Commissioning Group requested that a statement is made on fire safety in the light of tragic fire and loss of life at Grenfell Tower in London.

A number of she attached statements from Devon and Somerset Fire and Rescue Services are attached.

1.2. Key points in summary:

Fire safety legislation, (Regulatory Reform (Fire Safety) Order 2005), applies to a wide range of building occupancies; this includes the common areas of high rise residential premises.

The responsibility for ensuring that the requirements of the above legislation are met lies with the building owners.

Devon and Somerset Fire and Rescue Service (DSFRS) has a duty to enforce the Regulatory Reform (Fire Safety) Order 2005.

DSFRS have a robust, intelligence led, risk based, fire safety inspection strategy to ensure that a suitable of level of compliance is achieved in all buildings (where the legislation applies), especially where the risk of loss of life is highest.

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DSFRS operational crews prepare for fires occurring in high rise buildings, by continually familiarising themselves with operational procedures and they train regularly on how to deal with fires in a high rise building.

28 high rise exercises have been carried out over the last 12 months with 2 major multi-agency exercises carried out in Plymouth. The most recent exercise involved over 100 firefighters, comprising 17 fire crews, from all over Devon and Somerset. This was carried out at the 14 storey former Civic Centre building in Plymouth.

Learning from the exercises is incorporated in planning for real events and communicated to the building managers and occupants where necessary.

For advice on fire safety provision and emergency procedures for residential building please refer to the earlier press release

http://www.dsfire.gov.uk/news/newsdesk/PressReleaseArticle.cfm?ReleaseID=2000&siteCategoryId=3&T1ID=26&T2ID=36

2. Options considered and reasons for rejecting them

2.1. n/a

3. Consultations undertaken

3.1. n/a

4. Financial, Legal, HR and Risk Implications

4.1. n/a

5. Background papers

5.1.

- A press release (14th June) setting out responsibilities of landlords, explaining the stay put policy and the approach to high rise buildings
- Specific advice for landlords and the public on fire safety on standards, necessary action and further sources o0f information.
- An update report which summarises the risk assessments and actions undertaken by Devon and Somerset Fire and Rescue Service.

Update regarding Devon and Somerset Fire and Rescue Services actions following Grenfell Tower fire, London.

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DSFRS have a robust, intelligence led, risk based, fire safety inspection strategy to ensure that a suitable of level of compliance is achieved in all buildings (where the legislation applies), especially where the risk of loss of life is highest.

There is no reason to consider that this existing strategy is not suitable.

In light of the fire at Grenfell Tower, in London, fire safety risk information held by DSFRS, has been reviewed for all known high rise premises in Devon and Somerset. Following this review, a bespoke risk based inspection programme has commenced, with a view to confirming that the current status of the building, and to give assurance to residents with regards to the appropriate fire procedures for their building.

This activity is being completed in liaison with building owners and local authorities.

DSFRS operational crews prepare for fires occurring in high rise buildings, by continually familiarising themselves with operational procedures and they train regularly on how to deal with fires in a high rise building.

Information held by DSFRS is gathered and made accessible to operational crews at any time, by means of a mobile data terminal.

28 high rise exercises have been carried out over the last 12 months with 2 major multi-agency exercises carried out in Plymouth. The most recent exercise involved over 100 firefighters, comprising 17 fire crews, from all over Devon and Somerset. This was carried out at the 14 storey former Civic Centre building in Plymouth.

Each one of these training events is designed to familiarise crews with the layout of the building, and associated risks, the construction, fire safety features and the operational procedure to implement in the event of a fire.

Learning from the exercises is incorporated in planning for real events and communicated to the building managers and occupants where necessary.

For advice on fire safety provision and emergency procedures for residential building please refer to our earlier press release
http://www.dsfire.gov.uk/news/newsdesk/PressReleaseArticle.cfm?ReleaseID=2000&siteCategoryId=3&T1ID=26&T2ID=36

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DEVON & SOMERSET
FIRE & RESCUE SERVICE

Press Release

Release date 14 June 2017

Statement re: London tower block incident – Grenfell Tower

Our thoughts are with all of those affected, their families and friends and our London Emergency Service colleagues, following the tragic incident at Grenfell Tower in London. Whilst the incident is the subject of an investigation, Devon & Somerset Fire & Rescue Service would like to remind everybody within the Devon and Somerset area of our advice in the event of a fire in high rise flats.

Housing providers have a responsibility to comply with the fire safety legislation and give advice to their tenants on the fire safety arrangements and procedures for their particular building.

The Service would like to reassure residents that we have on-going arrangements with housing providers in the Devon and Somerset area, which aim to ensure the necessary fire safety standards are provided and maintained in all such buildings.

Not all buildings will be the same; some will have a procedure where on discovery of a fire or being alerted to a fire, the residents are told to evacuate the building, others, especially high rise buildings, will have a 'stay put' policy.

'Stay Put' policy

In certain premises and circumstances where the evacuation of the residents may pose a high risk during a fire, the building's fire safety provisions may allow for residents to delay evacuation from their rooms/flats in the early stages of a fire occurrence. This is commonly known as a 'Stay Put' policy.

Types of premises where a 'Stay Put' policy may be encountered

• Sheltered accommodation

• Blocks of flats

A 'Stay Put' policy involves the following approach

• When a fire occurs within a flat, the occupants alerts others in the flat, make their way out of the building to safety and summon the fire and rescue service

• If a fire starts in the common parts, anyone in these areas makes their way out of the building to safety and summons the fire and rescue service

• All other residents not directly affected by the fire, would be expected to delay their evacuation, and remain in their flat unless directed to leave by the fire and rescue service.

• It should not be implied that those not directly involved who wish to leave the building should be prevented from doing so. Nor does this preclude those evacuating a flat that is on fire from alerting their neighbours so that they can also escape if they feel threatened.

• All corridors and escape routes need to be kept free of obstacles/storage that could prevent or hinder the safe evacuation of people leaving the building.

• An approved fire alarm system is provided throughout and is properly maintained.

• Suitable notices informing visitors, residents and the fire service that the premises is operating a 'stay put' policy, this should be displayed in a conspicuous location for all to see.

We continue to undertake a range of training exercises in high rise buildings across the two counties to ensure crews are familiar with high rise building layout, however if anyone is concerned about their safety please call 0800 05 02 999 and continue to visit our website www.dsfire.gov.uk for updated information.

Note to Editors

Responsibility for fire safety arrangements in Local Authority housing falls to Local Authorities.

The Fire and Rescue Service has an enforcement role but also remains available to provide advice and guidance to those responsible for safety of buildings and occupants.

Following the tragic fire in a high rise flats building in London today, residents of flats may have concerns about their own safety in the event of a fire in a building.

The cause of the fire is still being investigated, and it would be unwise to comment at this time.

Ends

For more press information please contact:

Paul Slaven

PR Officer

01392 872259

pslaven@dsfire.gov.uk

Keep up to date and follow ‘dsfireupdates’ on twitter and Devon & Somerset Fire & Rescue Service on Facebook

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Advice to landlords on fire safety

Following the tragic fire in London Grenfell Tower on the 14th of June, landlords of residential buildings may feel it necessary to seek advice on the required standards for the varied premises they manage. The DSFRS leaflet 'Fire safety advice for landlords, managing agents, private dwellings, blocks of flats and owners of houses in multiple occupation and social housing.' is available by clicking on the link, and gives advice on the standards and direction to relevant national guidance. Advice to members of public on fire safety

Advice to members of public on fire safety

Following the tragic fire in London Grenfell Tower on the 14th of June, member of the community may have concerns about the fire safety provision in the premises they live. DSFRS have issued a press release (available here) which gives advice on 'stay put' policies. More detailed information on fire safety in the home can be found by clicking on this link Fire Safety In The Home

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Health and Wellbeing Board Work Programme – as at 5 July 2017

Agenda item	Meeting Date	Details and Lead Officer
H&WB Exec 10am – midday	**6th September 2017**	
Health and Wellbeing Board Meeting (11am start)	**28 September 2017**	
Adults Safeguarding report		Richard Crompton / Niki Shaw
Children's Safeguarding report		Sally Halls / Philippa Granthier
Children's Trust report		
H&WB Exec 10am – midday	**25th October 2017**	
Health and Wellbeing Board Meeting (11am start)	**23rd November 2017**	
Carers Strategy Update		Vicky Chipchase / Deborah Penny
Safer Somerset Partnership Report		Christina Gray / Lucy Macready

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