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Somerset Health and Wellbeing Board

Thursday 21 March 2019
11.00 am Taunton Library Meeting Room, Taunton Library, Paul Street, Taunton, TA1 3XZ

To: The Members of the Somerset Health and Wellbeing Board

Councillor Frances Nicholson, Somerset County Council (Vice-Chair)
Councillor David Huxtable, Somerset County Council
Councillor Linda Vijeh, Somerset County Council
Councillor Amanda Broom, Somerset County Council
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
Councillor Nigel Woollcombe-Adams, Mendip District Council
Dr Ed Ford, Clinical Commissioning Group (Vice-Chair)
Mr Mark Cooke, NHS England
Judith Goodchild, HealthWatch
Stephen Chandler, Somerset County Council
Trudi Grant, Somerset County Council
Julian Wooster, Somerset County Council
Mike Prior, Avon and Somerset Police

Issued by Scott Wooldridge, Strategic Manager - Governance and Risk - 13 March 2019

For further information about the meeting, please contact Jennie Murphy on 01823 357628 or email jzmurphy@somerset.gov.uk or or Julia Jones on 01823 359027 or email 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.

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AGENDA

Item Somerset Health and Wellbeing Board - 11.00 am Thursday 21 March 2019

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

1 **Apologies for absence**

To receive Board Members' apologies

2 **Declarations of Interest**

3 **Minutes from the meeting held on 17 January 2019** (Pages 5 - 10)

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

4 **Public Question Time**

The Chairman will allow members of the public to ask a question or make a statement about any matter on the agenda for this meeting.

5 **Somerset Housing Strategy** (Pages 11 - 56)

To consider the report.

6 **Annual Director of Public Health Report** (Pages 57 - 98)

To consider the report.

7 **Positive Mental Health** (Pages 99 - 104)

To consider the report.

8 **Health and Care Integration** (Pages 105 - 108)

To consider the report.

9 **Somerset Health and Wellbeing Board Forward Plan** (Pages 109 - 110)

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 Jennie Murphy on Tel: 01823 355059 or 357628 or Email: jzmurphy@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 Jennie Murphy on Tel: (01823) 355059 or email jzmurphy@somerset.gov.uk

3. **Public Question Time**

If you wish to speak, please tell Jennie Murphy the Committee's Administrator - by 5pm, 3 clear working days before the meeting (Friday 15 March 2019). All Public Questions must directly relate to an item on the Committee's agenda and must be submitted in writing by the deadline.

If you require any assistance submitting your question please contact the Democratic Services Team on 01823 357628.

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 Committee meeting rooms have infra-red audio transmission systems.

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 (Scott Wooldridge 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.

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SOMERSET HEALTH AND WELLBEING BOARD

Minutes of a Meeting of the Somerset Health and Wellbeing Board held in the Taunton Library Meeting Room, Taunton Library, Paul Street, Taunton, TA1 3XZ, on Thursday 17 January 2019 at 11.00 am

Present: Cllr C Lawrence (Chairman), Cllr D Huxtable, Cllr A Broom, Cllr S Seal, Cllr G Slocombe, Cllr K Turner, Cllr Woollcombe-Adams, Ed Ford (Vice-Chair), Rosie Benneyworth, Judith Goodchild, S Chandler, T Grant, J Wooster and Prior

Other Members present:

Apologies for absence: Cllr F Nicholson, Cllr L Vijeh, Cllr J Warmington, Mark Robinson and Mark Cooke

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

There were no declarations

364 **Minutes from the meeting held on 15 November 2018** - Agenda Item 3

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

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

There were no public questions.

366 **Health and Care Integration** - Agenda Item 5

The Health and Care Strategy supports the vision of the Somerset Health and Wellbeing Strategy, by encompassing its underlying principles and priorities in the development of the proposals. The report sets out the emerging proposals from the Fit for my Future programme and asks the Health and Wellbeing Board to consider the proposals and provide a view on appropriate engagement.

The Board received this report which had been the subject of extensive public consultation. The purpose of the presentation to the Health and Wellbeing Board was to seek their support in the next phase. The plan was to evaluate some of the proposals emerging from the consultation. These have been placed in two groups: - the first being improvements that did not require further consultation as they could be implemented as best practice and incorporated into continuous improvement plans. The second group did require further consultation, and these fell into three main areas: -

- Community Services – review of community-based support as this was considerably higher than the rest of the country and did not adhere to current best practice

- Urgent Treatment Centres – Minor Injuries Units and proper use of the 111 Service needed to be changed to reduce the pressure on Accident and Emergency Departments.
- Mental Health - standalone mental health units are not regarded as the most effective as they cannot offer the full range of support and treatment.
- Acute Services – Stroke Services and Obstetric units were last reviewed in 2014 and there have been significant changes that need to be incorporated.

All the options will be subject to wide public consultation in May/June 2019.

The discussion included a challenge as why the proposals were all being considered at the same time. The rationale for this was that significant transformation was necessary to ensure best outcomes for patients and best value for money. It was not possible to simply continue to provide the services that had always been there if they did not deliver the most modern and effective service.

There was a discussion about travel time from some of the rural parts of Somerset to hospitals based in the major towns. It was confirmed that a detailed model of both private transport and public transport to the major hospitals was being produced.

Further discussion covered: -

- Cessation of smoking and support at home rather than in hospital as this was the most effective was to support people to stop smoking,
- Staffing and the challenge in recruiting and retaining qualified staff in some areas,
- Knowing your patient as a key to supporting recovery and delivering the right outcomes.

The Somerset Health & Wellbeing Board:

- **Reviewed the proposals which formed part of the overarching strategy.**
- **Agreed the proposed approach to secure appropriate engagement**.

367 **Safeguarding Children Annual Report** - Agenda Item 6

This report set out how Somerset Safeguarding Children Board (SSCB) had working during 1017/2018 to meet its statutory objectives. SSCB works with partners to improve safeguarding arrangements. The report contains an updated Ofsted view on the progress made. The report also sets out the preparations being made to implement the new safeguarding arrangements heralded by the Children and Social Work Act 2017.

The Board considered the report and a presentation outlining the key themes. There were four key themes emerging: -

- Early Help – There needs to be a focus here combined with a multi-agency approach. Using the 'Think Family' notion; support and intervention can be offered at the first sign of possible need.
- Multi-agency Safeguarding – Make sure that the focus is on both children and families as a way of identifying safeguarding matters.
- Neglect – 50% of children on care plans are there because of neglect. Child sexual exploitation has now expanded to cover general exploitation because of County Lines activity and other exploitation.
- Emotional and Mental Health - Children are at risk of long term mental health harm by exploitation, coercion and not understanding informed consent.

The discussion included concerns about the regulation of tattoo/piercing parlours. A recent serious case review had highlighted the coercion of young women using the 'boyfriend' model based in such a parlour. Board members discussion possible action Regulatory Bodies could take. The Board was made aware of the Adverse Childhood Experiences and encourage and to view the Adverse Childhood Report available from Public Health Wales.

The Board asked about the recorded number of children held in custody overnight. It was informed that this number was inflated by 16/17 year olds being brought into custody after 11pm stay for over an hour, all these would be recorded as 'overnight' stays and did inflate the figures.

The Somerset Health & Wellbeing Board:

- **Reviewed the Somerset Safeguarding Children's Board 2017/18 Annual Report**
- **Noted the progress highlights, and**
- **Agreed to continue to promote children's safeguarding across the County Council and in the services that are commissioned.**

368 **Children and Young People's Plan 2016-2019** - Agenda Item 7

The report provides a progress update on the strategic commitment for children's services to be 'good' or 'better' in three years. (2016-2019). This report demonstrates the progress against each of the 7 Improvement Programmes designed to improve outcomes for vulnerable children and their families.

The Board received the report and were informed that this report reflected year two of a three-year programme. The highlights were: -

- 1000 babies were born smoke free,
- Increase in participation and attendance at Parenting courses by prospective new mothers,
- Single point of contact for mental health support has been established,
- GP's were now able to better support EHCP's and

- Kooth – the on-line counselling for young people; was given positive feedback.

The emerging concerns for future activity were discussed and these included, but were not limited to: -

- Support for parents to be better parents,
- Ensuring young people are healthy enough to be able to take advantage of education,
- Tackling bullying via social media and the need to have an on-line persona,
- The work being undertaken by the Children's Trust in Somerset.

The Board was interested to know why Somerset seemed to be out step with the national picture in some areas such as alcohol misuse leading to presentation at hospital and the number of young girls recorded as self-harming.

There was some discussion around the potential to be too 'paternalistic' and putting too much intervention in place. Somerset has the highest level of people with learning disabilities receiving support from the authority and it is not clear if this is the right thing, there is a case to be made that support should be targeted to encourage people to help themselves in the longer term.

The Board expressed concern about the high number of children being excluded from school and the high number of children being home educated. The Board wanted assurance that this was being kept under review.

The Somerset Health & Wellbeing Board:

- **Acknowledged the significant progress that has been made as a result of the work undertaken by those involved in the seven Improvement Programmes.**
- **The Board endorsed the very comprehensive and thorough report.**

369 **Health Protection Annual Report** - Agenda Item 8

The Board received the report and presentation. In summary the Health Protection Annual Report aimed to give reassurance that the following areas have been monitored, recorded and when necessary acted upon: -

- Communicable diseases,
- Environmental hazards,
- Infection Protection,
- Resilience and

- Screening and Immunisation.

The Board were informed that some of the reported incidents included air pollution and that 1 in 20 road journeys were in some way related to the NHS. The report recorded that although there had been a focus on hospital acquired infections in fact most infections were acquired in the community. Screening in Somerset was in line with national levels and these had seen a general decline. Vaccination against measles had dropped, and Somerset had two reported cases, in contrast Bristol had over 100 cases and there had been hospitalisation and deaths associated with measles.

The discussion included some concern about the very low treatment completion rate for TB. These were recorded at 50%. The levels of TB were low and the two cases that did not complete treatment were thoroughly investigated. The two cases that did not complete the treatment were investigated.

The Board expressed concern about this still widespread misconception that the 'Flu Jab could make you ill and undertook to encourage everyone who should have the vaccination to do so.

There was also some discussion about how to find out exactly what injections were required prior to visiting countries overseas.

The Somerset Health & Wellbeing Board:

- Endorsed the report and the priorities for 2018/19 as the following: -
    - Communicable Diseases,
    - Environmental Hazards,
    - Infection Prevention and Control,
    - Resilience, and
    - Screening and Immunisations.

370 **Director of Public Health Annual Report** - Agenda Item 9

This item was deferred to a later meeting as there was insufficient time to discuss this fully.

371 **Somerset Health and Wellbeing Forward Work Plan** - Agenda Item 10

The Somerset Health & Wellbeing Board**:**

- Agreed to defer the Annual Report from the Director of Public Health to the March meeting.
- Review the number of Items on the agenda for April with a view to moving some to later in the year.

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

There were no other urgent items of business.

(The meeting ended at 1.00 pm)

CHAIRMAN

Somerset Health and Wellbeing Board

21st March 2019
Report for decision

Somerset Housing Strategy – Adoption and Delivery

Lead Officer: Mark Leeman / Strategy Specialist – Taunton Deane and West Somerset Councils
Author: As above
Contact Details: m.leeman@tauntondeane.gov.uk

	Seen by:	Name	Date
Report Sign off	Cabinet Member / Portfolio Holder (if applicable)	Christine Lawrence	4 March 2019
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	4 March 2019

Summary:	The Somerset Housing Strategy (SHS) is the local response to the national housing crisis. It highlights key facts and challenges within the local housing market, before proposing a vision for homes and housing across Somerset that embraces strong and effective strategic leadership; a local economy that provides opportunity for all; homes in Somerset are good for your health: and a society that supports the vulnerable. To help resolve the housing crisis will require integrated systems leadership that embraces communities, housing, health and wellbeing, social care and town and country planning. It will require creativity and innovation (from all partners). It will necessitate solutions that are developed with residents, local businesses and communities. The preparation of the SHS began in July 2017, with the publication of district and countywide housing market profiles and a multi-agency workshop. A consultation draft was published in February 2018. The Health and Wellbeing Board considered the draft strategy on July 12th 2018. The consultation closed on 30th April 2018. During the Summer (2018) we considered the consultation response and have made various amendments to the SHS. The SHS is developed by the Somerset Strategic Housing Partnership (SSHP). Public Health are active members of SSHP. SSHP is within the governance structure of the Somerset Health and Wellbeing Board. The SHS (appendix A) was approved by SSHP on 22nd November 2018. The next stage is for SSHP to develop a multi-agency delivery plan (work is underway) and for SSHP partners (if they choose) to develop their own response in the form of strategic housing action plans.

Recommendations:	**That the Somerset Health and Wellbeing Board** **1. Endorses the content of the SHS (i.e. it's Vision, Themes, Priorities and Objectives)** **2. Supports and informs the production of a SHS Delivery Plan that seeks to tackle the key strategic housing issues across the county**
Reasons for recommendations:	Housing has a major impact on health inequalities. In an ideal world all homes would be: **Healthy:** warm, safe and free from hazards **Suitable:** suitable to household size, specific needs of household members e.g. disabled people, and to changing needs e.g. as they grow up, or age **Stable & secure**: to call your own, without risk of, or actual, homelessness or other threat e.g. domestic abuse And all situated within **Healthy communities and neighbourhoods** Unfortunately not all homes are like this. Unhealthy, unsuitable and insecure housing creates health inequalities and issues for the 'health system' by reason of fuel poverty, trips and fall hazards, overcrowding, mental health conditions (due to poverty and worry over rents/instability of tenure), domestic violence, homelessness etc The SHS seeks to help address these concerns for the benefit of the health and wellbeing of the Somerset population. It is essential that the Health and Wellbeing Board support the SHS and its implementation.
Links to Somerset Health and Wellbeing Strategy	The SHS is a cross cutting theme within Improving Lives
Financial, Legal and HR Implications:	There is no statutory duty to create a Housing Strategy There are no direct financial implications, but the development of the SHS is of direct interest to the Health and Wellbeing Board. The SHS envisages strong leadership that will be used to address the housing crisis, which could result in new and innovative areas of work consistent with our aspirations for Improving Lives e.g. closer collaboration between Public Health, CCG, Social Care, district councils and local housing providers on heath inequalities related to housing.
Equalities Implications:	There are significant equality and diversity implications. Understanding housing issues and the effect on those with protected characteristics, helps us to respond with interventions. The SHS is supported by a comprehensive EIA (see Appendix B) which has been used to help shape the priorities and objectives. The EIA is not a static document. Its content will

	continue to inform the development of projects / activity within the Delivery Plan, and any supporting partner action plans.
Risk Assessment:	Key risks as follows: 1. The production and delivery of the SHS is coordinated by a small team of officers from across the public sector. Resources are stretched and most organisations are facing disruption through cuts, Transformation and staff turnover. Capacity (and progress) may suffer as a result Mitigation: We have already seen slippage as a result of such factors. Strong project management, regular performance monitoring and review, and a realistic work programme, are essential. This is a key responsibility of SSHP 2. Key partners (e.g. some Registered Providers, housing developers) do not engage with the SHS, therefore jeopardising our ability to coordinate strategic housing activity and deliver improved outcomes for customers Mitigation: To continue to discuss the SHS at relevant partnership forums e.g. West Somerset Housing Forum, County Enablers, ENP Rural Housing Network etc. A launch event is planned for 6th March 2019, to which all local RPs will be invited. This event will be an opportunity to discuss delivery and partnership working. 3. The SHS is too aspirational, with too much content that will not be delivered with limited and diminishing resources Mitigation: SSHP will undertake an initial prioritisation of all content, to inform the draft Delivery Plan. We shall continue this conversation with RPs (and other interested parties) at the launch event (see above). The Delivery Plan will contain a prioritised list of activity, and will be reviewed on an annual basis 4. The needs of those with Protected Characteristics (i.e. those who may be vulnerable) are overlooked Mitigation: A comprehensive EIA has been developed. New projects will also be subject to EIA. SSHP will seek to improve the quality and robustness of housing intelligence, to inform EIA and project development

Background

1.1. The previous SHS was known as the Somerset Strategic Housing Framework (SSHF). It was prepared in 2013 and had an end-date of 2016. It contains priorities relating to the availability of affordable housing, making best use of the existing housing stock, and supporting the vulnerable.

1.2. The SHS is prepared by the Somerset Strategic Housing Officers Group (SSHG) which reports to the Somerset Strategic Housing Partnership (SSHP). SSHP is within the governance arrangements of the Somerset Health and Wellbeing Board (HWB). HWB representatives on SSHP are Cllr Woollcombe-Adams (MDC), Cllr Turner (WSC), Tracy Aarons (MDC), Mark Leeman (TDBC/WSC)

and Louise Woolway (Public Heath).

1.3. The process of review began in late 2016. TDBC/WSC agreed to provide the Project Management expertise.

1.4. The first task was to build the evidence base (working closely with Somerset Intelligence/Public Health) and build partnership arrangements around leadership and governance. The following was undertaken during 2017:

- Data collection resulting in the publication of a 'benchmarking report'
- Preparation of 5 x district based Housing Market Profiles and 1 x County-wide Housing Market Profile
- Engagement of the Somerset Health and Wellbeing Board on matters relating to health and housing
- Stakeholder Conference (July 2017) at Taunton Rugby Club, involving 100+ people representing the housing sector and associated services. This conference ran 8 themed workshops on different aspects of housing issues / challenges
- Consultation and engagement on all of the above
- Ongoing development of an Equalities Impact Assessment

1.5. The above, in addition to national housing policy, provided the evidence base to the content of the draft SHS, which was published in February 2018. Since then we have:

- Undertaken further consultation / engagement – for example, the draft SHS was considered by the 'scrutiny' functions of all district councils, as well as the Health and Wellbeing Board (x). We have also spoken to (and received support from) a range of partnerships such as the Safer Somerset Partnership, West Somerset Housing Forum, Exmoor National Park – Rural Housing Network, County Housing Enablers Forum etc etc
- Considered the consultation feedback and provided a response to each comment – this report can be viewed on request
- Refined the content of the SHS, and obtained 'sign-off' at SSHP on 22nd November 2018
- Began the development of a multi-agency delivery pla

1.6. Health and Wellbeing Board – the Housing Challenge

It is not an exaggeration to state that we are now in a national housing crisis. This is accepted by all main political parties. Other than Brexit, Housing, along with the NHS, are top national priorities. Indeed, housing and health are inter-related – a key theme of the SHS. Housing conditions (safety, security, stability etc) play out massively on health inequalities. We need to rise to this challenge and certainly, we can be rightly proud of some of the initiatives that we are

currently developing/running:

- Embedding the SHS within Improving Lives
- Seeking to integrate housing within the Health and Care Plan
- Somerset Independence Plus (the new 'prevention' focussed housing adaptations service)
- Cold Homes toolkit (in development)
- Districts / housing providers working alongside SCC commissioned services/grant funded programmes to integrate health, social care and housing e.g. Positive Lives, Creative Solutions for Complex Needs, Pathways to Independence (P2I) and the Somerset Integrated Domestic Abuse Service (SIDAS)

1.7. But, there is still much to do. There are challenges around the supply of homes (all tenures), the condition of some of our local housing, and how we support the most vulnerable in our society. These challenges will require HWB partners to continue to think creatively and radically.

1.8. A key theme of the SHS is leadership – that is, integrated systems leadership that incorporates housing, communities, health, social care and town & country planning. There is much work going on behind the scenes, involving conversations with (e.g.) Health and Wellbeing Board, the Clinical Commissioning Group, the Local Enterprise Partnership, Somerset Strategic Planning Conference and Somerset Academy.

1.9. Going forward it is suggested that the HWB support the following actions:

- SSHP (working with partners) to develop a multi-agency delivery plan that will seek to coordinate countywide housing activity and its integration with other systems such as health and social care. This will include a fresh look at systems leadership; who we need to be working with; barriers to effective working; and a review of current partnership arrangements. Particular pieces of project work are likely to include the following (among others):
    - The development of policy guidance for Health Impact Assessments
    - A review of the Youth Housing Strategy
    - The development of an Elderly Persons Housing Strategy
    - A county wide review of space standards, delivery of lifetime homes etc
    - Working to support the delivery of effective and sustainable support services
    - Working to integrate housing matters within the Health and Care

Plan

- A review of the Gypsy and Traveller Accommodation Assessment

- To encourage the district councils (i.e. partners with specific/statutory housing responsibilities) to produce district housing action plans that will articulate how they (at a local level) will work with partners to respond to the national housing crisis through creative and innovative housing activity.

- To support SSHP partners with the production of refreshed housing market profiles, and to jointly agree arrangements for the monitoring of the SHS delivery plan

2. Options Considered and reasons for rejecting them

2.1. The SHS was developed through an ongoing iterative/consultative process. There was no need to develop options.

3. Consultations undertaken

3.1. Extensive consultation was undertaken, as explained at paragraphs 1.4 and 1.5 above. The formal consultation response is available to view on the district council and county council websites

3.2. A significant consultation event is planned for 6th March 2019, where (approx) 100 delegates will gather to help us refine the content of the SHS delivery plan. Further relevant consultations will be undertaken to inform the development of various workstreams within the SHS delivery plan.

4. Implications

4.1. There is no longer a statutory duty to produce a Housing Strategy. However, without one, we run the risk of failing to grasp and coordinate the strategic housing issues across the county. Without HWB support to the SHS we run the significant risk of not being able to galvanise the necessary leadership to bring systems together, and of being unable to tackle these deeply complex and difficult issues. This moment is a significant opportunity to deliver integrated systems thinking, and to bring partners together to make a real difference to the people and communities of Somerset

5. Background papers

5.1. Appendix 1 Somerset Housing Strategy

5.2. Appendix 2 Equality Impact Assessment

2019 to 2023
#Somerset Housing

Somerset Housing Strategy 2019 - 2023

Somerset West and Taunton

Somerset Health and Wellbeing

Sedgemoor IN SOMERSET

MENDIP DISTRICT COUNCIL

EXMOOR NATIONAL PARK

Priorities and Ambitions for Homes and Housing in Somerset

SSDC planting, courtesy of SSDC and Stonewater

Housing in Taunton

Cottages in West Somerset

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National Citizens Service (NCS) Summer 2017 Project, Lyngford Park Children's Play Area, courtesy of TDBC

Blackthorn Gardens, 'Pocket Park', courtesy of TDBC

Foreword

Homes are a basic necessity. We all need one. Local authorities have a broad role to play in supporting and regulating the housing sector, and in facilitating the delivery of new homes. All agencies, including the NHS and Social Care are impacted by housing - its availability, quality and suitability. These factors play out in people and communities – poor housing leads to significant health inequalities. The economy relies on a sufficient supply of housing in order to attract and retain a skilled workforce.

Tackling our housing crisis is not something that one service or organisation can achieve alone. Local authorities, Registered Providers, developers, the NHS, social care and the voluntary and community sectors – all have important roles to play. However, budgets are under pressure, with demand for our services on the increase. Providing leadership and direction is now critical. It is also more important than ever to have effective partnerships built on trust and mutual respect.

We also aim to make our services simple to access and provide support that really works. At the same time, we have to be realistic about the challenges that we face and prioritise the limited resources that we have. We recognise that all communities have people assets: individuals or groups who understand their communities and have the talent to help build cohesion, support and social activity. We wish to work with more communities to help release that talent.

The Somerset Housing Strategy will help us to galvanise the necessary leadership skills; to develop strong, inclusive and effective partnerships; and make sure that we are supporting each other to achieve the housing ambitions for Somerset.

Ric Pallister OBE
South Somerset District Council,
Chair of SSHP

Keith Turner
West Somerset Council

Terry Beale
Taunton Deane Borough Council

Nigel Woollcombe-Adams
Mendip District Council

Andrew Gilling
Sedgemoor District Council

NB Taunton Deane Borough Council and West Somerset Council merged on 1st April 2019 to create a new council: Somerset West and Taunton

Developing the strategic housing priorities for Somerset

The Somerset Housing Strategy (SHS) is prepared by the Somerset Strategic Housing Partnership (SSHP), comprising representation from the four Somerset local housing authorities, Housing Associations, Exmoor National Park and the County Council (which includes Adult Social Care, Public Health and Strategic Planning).

The process of developing this Strategy began in 2017. We produced a 'Housing Benchmarking Report' that established key data and facts relating to the local housing market. We used this and other evidence to produce district based and county wide Housing Market Profiles. These were published in July 2017, which coincided with a 'stakeholder conference' where 100+ people representing the local housing market met to discuss key topics of concern, and to suggest possible priorities and ideas.

During the Autumn of 2017 we continued the conversation and met with a range of partners to discuss the latest data and intelligence, to consider latest Government policy, and to shape the ideas that were generated by the stakeholder conference. Gradually a vision and a refined set of priorities and ambitions began to emerge.

February 2018 saw the publication of the draft SHS which coincided with a three month period of public consultation. The draft SHS was scrutinised by housing forums, within council chambers, by parish councils and by a range of interested partnership bodies. Overwhelmingly the content received favourable support, as well as ideas as to how we may further shape and refine the draft priorities and objectives. These have all been considered resulting in many amendments to the content of this final document. Importantly, we also received many suggestions as to how we may take forward some of the priorities and objectives and many partners wish to be further involved in the delivery of the SHS.

We are excited by these prospects. Of course, not everyone was wholly supportive, and some had real concerns about our ability to deliver change. We understand these concerns and frustrations. Only time will tell whether we are able to truly make a positive difference to homes and housing in Somerset. By working together and with strong leadership, we are confident that we can.

All the documents referred to above, including a summary of the consultation comments together with our response, can be found on the district council and county council web sites.

Introduction

The Somerset Housing Strategy sets out the strategic direction for housing activity in the County, dealing with housing need, supply and our approach to quality and management of existing and new housing stock. It enables us to have clear multi-agency priorities and objectives on how to tackle the major housing issues that affect the people of Somerset. There are a range of partners involved to help solve these issues, including residents, local voluntary and community sector, housing associations, district councils, the county council (including public health, adult social care), developers, planning agents, private landlords and their agents, and government and their associated partners. The Strategy is supported by a multi-agency delivery plan that sets out how the priorities and objectives are to be achieved. Progress is monitored by the Somerset Strategic Housing Partnership. Each individual partner may also decide to have their own action plan.

The previous Somerset Housing Strategy (the Somerset Strategic Housing Framework) was published in 2013. Much has changed since then. The government has since recognised housing as a top national priority (aiming for the national delivery of 300,000 new homes per annum) and has recently introduced a flurry of legislation and policy (with more to follow) together with a range of associated funding streams:

- **Welfare Reform & Work Act (2016)** – universal credit; capping of benefits; 1% rent reduction on social housing; freeze on Local Housing Allowance; spare room subsidy etc
- **Housing and Planning Act (2016)** – empowered the Government to introduce Right to Buy for Housing Association tenants; phasing out of life-time tenancies; promoting the delivery of Starter Homes etc
- **Housing White Paper (2017)** – various measures to empower local authorities to deliver more homes through the town and country planning system; including the Housing Infrastructure Fund
- **National Planning Policy Framework (2018)** – introduces a number of important policy changes including a housing delivery test for Local Authorities (commencing November 2018) and a standardised method of calculating housing need (from January 2019)
- **Homelessness Reduction Act (2017)** – contains a big focus on prevention of homelessness, relief from homelessness and recovery/support. There is also more of a focus on single people and 18-25 year olds. Local authorities have 'new burdens' funding and access to flexible homeless support grant
- **Social Housing Green Paper (2018)** – contains proposals to improve: standards within the social housing sector; health and safety; tenant voice; protection from rogue landlords; improved complaints procedures; and new models of 'right to buy' designed to ease access to home ownership
- **Rough Sleeping Strategy (2018)** – contains a vison to halve rough sleeping by 2022, and ending it by 2027. It has three main themes of 'prevention', 'intervention' and 'recovery'. The strategy will be updated on an annual basis and the Government is also developing a wider homelessness strategy

Some of these changes have presented opportunities. The Homelessness Reduction Act will enable the delivery of more effective prevention services to support those at risk of homelessness. But funding remains a concern. The Housing and Planning Act provides additional powers to deal with rogue landlords. The Social Housing Green Paper presents a very welcome focus on the importance of Social Housing within local communities. Other initiatives such as 'Help to Buy' enable first time buyers to access a deposit for a mortgage.

However, many of these changes present real challenges. House prices have risen steadily faster than earnings during the past five years. Building activity from the Housing Association sector slowed down due to concerns around a number of issues such as reduced rental income, the impact of welfare reform and the availability of support services. However, recent evidence now suggest that building activity is now increasing. Meanwhile, homelessness and rough sleeping remain major concerns.

The local scene is also complicated by a number of factors including the rural nature of the county, and the impact of Hinkley Point C. Rurality makes it difficult and expensive to deliver services. It also makes Somerset a desirable location for internal in-migration, fuelling local property price increases and contributing to the ageing demographic among many of our rural communities.

Lack of affordable housing contributes to the challenges of retaining younger people, and their skills, within Somerset. This impacts on all sectors, including public services. Meanwhile, the sheer volume of workers at Hinkley Point C (5,600 on-site at peak construction) presents real challenges to the housing sector – private sector rents are steadily rising, as is the number of unlicensed Houses in Multiple Occupation. The site is also a major draw for local construction talent. How will this play out for local growth aspirations? To help mitigate these impacts EDF have provided £7.5m of funding towards additional housing capacity across Somerset West and Taunton, Sedgemoor and North Somerset. Meanwhile, the recent designation of Taunton as a Garden Town presents a real opportunity to deliver a step-change in how we plan for a more inclusive / healthy housing environment.

Finally, it is important to acknowledge that the Somerset Housing Strategy is an important tool that can help realise national housing policy. The Government have set a target of delivering 300,000 homes a year across England! But what are the implications of this for Somerset? Ultimately we are striving for sustainable growth, where a growing local economy is balanced by housing growth that is delivering homes that are affordable, healthy, suitable and stable.

To do this we need to consider demographic changes (which inform both the number and type of housing that are required) alongside realistic economic growth assumptions, that contain ambitions to grow the economy (within certain sectors) and increase productivity. We need to ensure that economic growth is inclusive and improves social mobility. Much of this is explained within the Somerset Strategic Housing Market Assessment and the Somerset Growth Plan. The economy and housing supply are fundamentally linked, and neither is considered in isolation.

Leadership

All major political parties agree that housing is a top national priority. That presents an opportunity for local authorities and their partners to deliver strong leadership, leadership that brings together communities, housing, town and country planning and health and social care. We are striving for a combined commitment to improve this complex system for the benefit of our residents. We are already positioning ourselves to ensure improved partnership arrangements around these inter-related agendas. Leadership features strongly in this Strategy. We hope that the delivery of the Strategy will be a catalyst for creative thinking, innovation and an approach that designs solutions alongside the residents and communities that we are seeking to help.

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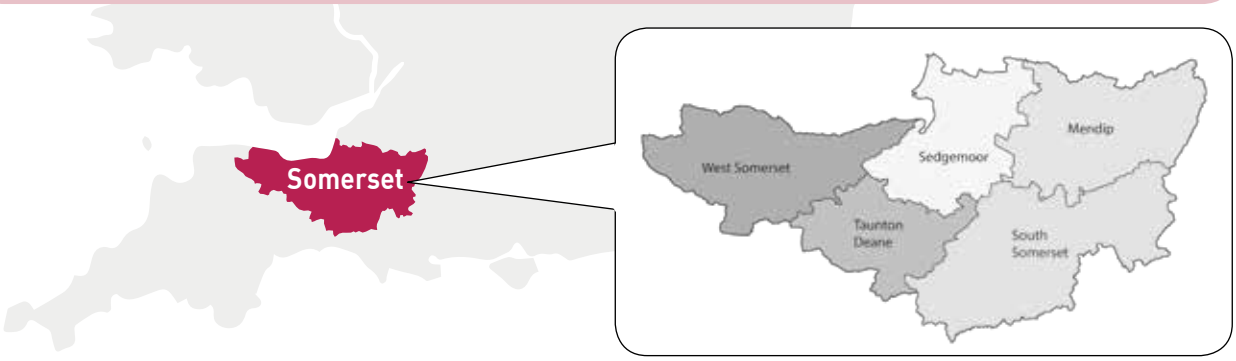
Key Facts

About Somerset

Somerset is one of the most rural counties in England with a population density of 1.5 people per hectare (4.1 hectare England average)



8,230 live applications as at 31 March 2017 (Homefinder Somerset)

24.2% of the population are aged 65 and over in 2017 (ONS 2017 mid-year estimate) and set to rise to **25.3%** in 2020 and then to **31.5%** in 2035 (ONS population projections)

99.5% increase in the private rented stock from 2001 to 2011 (Census)

Lambrook & Halcon in Taunton and **Sydenham Central** in Bridgwater are the top 3 most deprived areas in Somerset (Index of Multiple Deprivation 2015)

48% of Somerset live in rural areas (Census 2011)

The proportion of Somerset households in fuel poverty has decreased from **12.4%** in 2014 to **10.2%** in 2016, though localities such as West Somerset are still at 11.6% (Fuel poverty sub-regional statistics 2016)

244,000 (approx) **households in 2019 projected to rise to 285,000 in 2041** (ONS 2016- based household projections)

10% of children in income deprived families are concentrated in 0.07% of the County area (Somerset County Council)

555,195 population (ONS mid 2017 population estimates) and projected to rise **1.5%** by 2020 to **563,000** (ONS population projections)

2,600 new dementia cases in 2015 and it is projected to rise to **4,800** new cases in 2035 (Somerset Dementia Needs Assessment)

Autumn estimates of rough sleeping has increased to **57** (2017)- 48 in 2016 and **56** in 2015. The highest numbers were in Taunton Deane (23) and Mendip (19).

20,000 new homes by 2020. Exceeded growth plan of **2,857 by 54** in 2014 (Somerset Growth Plan)

£220,000 median price paid **£167,000** lower quartile price paid (House Price Statistics for Small Areas December 2017)

Average household size is projected to fall from **2.26** in 2014 to **2.13** in 2039, slightly below the national average of **2.35** in 2014 (ONS population projection)

Shortfall of **£145.86** between B&B charge and Housing Benefit paid per week

Almost **8,000** homes in Somerset are without central heating (Census 2011)

Median gross annual pay for full time workers in Somerset was **£26,532** (+ - 5.4%) in 2017 (ASHE)

Key Challenges

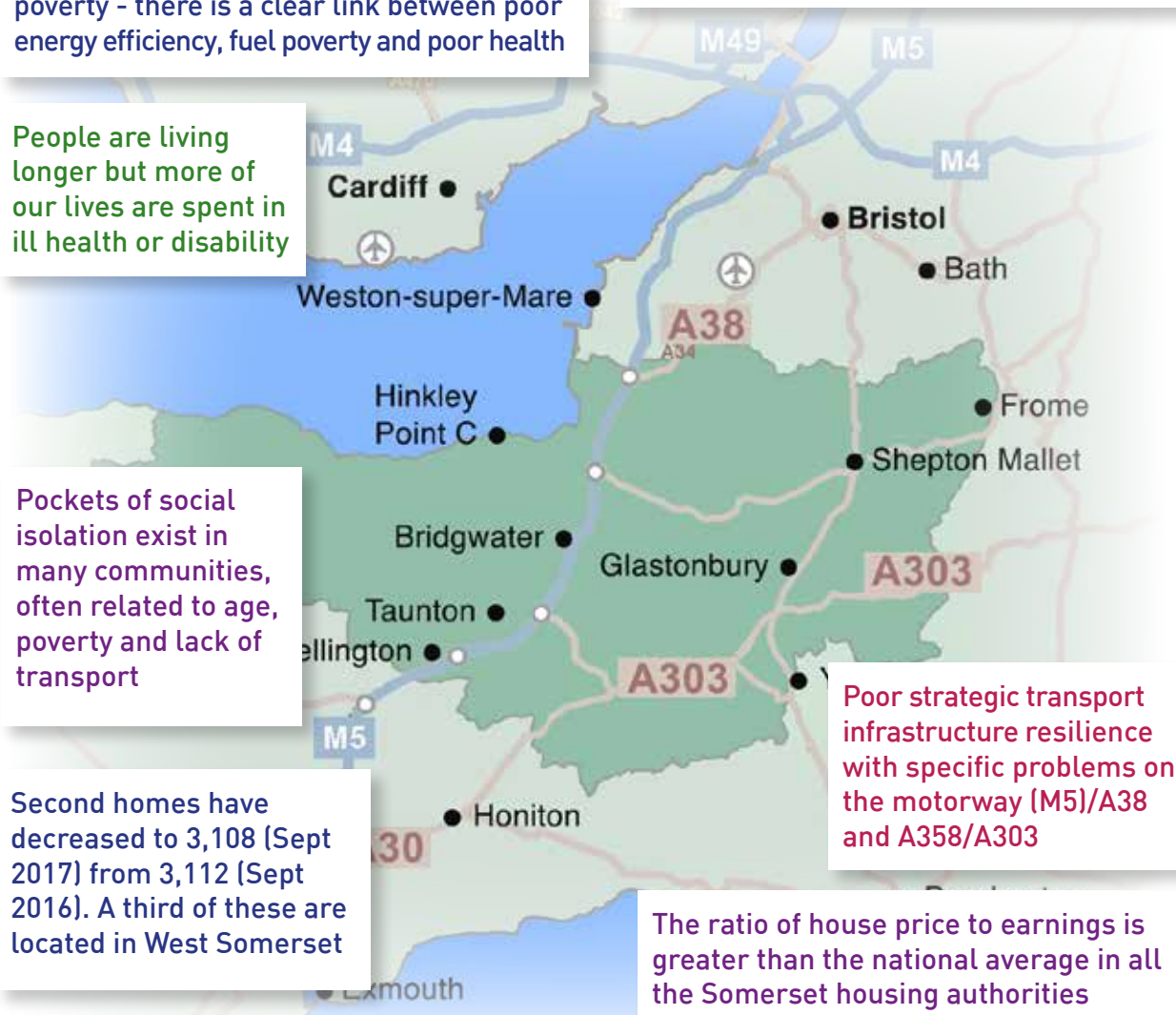
Hinkley causing an increased demand for all forms of accommodation within commutable distance of Hinkley Point C

The life expectancy gap between residents in the most and least deprived areas in Sedgemoor is significant at 8.1 years for men and 3.6 years for women (Sedgemoor Health Profile 2017, Public Health England)

High proportion of population aged over 65 - challenge of providing suitable housing of the right type and quality in the right locations

In migration of 40+ year olds seeking lifestyle change, using capital asset of homes in higher house price areas to outbid / out compete local people and out migration of younger people for education and work

24,391 households in Somerset are in fuel poverty - there is a clear link between poor energy efficiency, fuel poverty and poor health



People are living longer but more of our lives are spent in ill health or disability

Pockets of social isolation exist in many communities, often related to age, poverty and lack of transport

Poor strategic transport infrastructure resilience with specific problems on the motorway (M5)/A38 and A358/A303

Second homes have decreased to 3,108 (Sept 2017) from 3,112 (Sept 2016). A third of these are located in West Somerset

The ratio of house price to earnings is greater than the national average in all the Somerset housing authorities

Housing supply remains an issue, especially for one-bedroom properties due to increase of single-person households, especially older persons and the single under 35s

Low pay economy in comparison to other regions, causing a growing affordability gap with significant consequences for both young people and families

The upward trend in single-person households, coupled with private sector rents at record high levels, will potentially increase the number of households who apply for local authority assistance with their housing

All the net need for new housing in the next 20 years will be for the households over 65 necessitating the need for more flexible models of housing (including supported) which enable independent living

The Bigger Picture

The Somerset Housing Strategy has regard to the relationship of the local housing market with both the local economy and prevailing health inequalities. The Somerset Growth Plan and the Health and Wellbeing Strategy provide important context.

The Somerset Growth Plan provides a vision for a productive and innovative business community and economy, with a labour force that has the necessary skills, and a system that will deliver the required infrastructure. Importantly, it seeks that economic prosperity will be inclusive, to the benefit of all groups within the community. The Somerset Housing Strategy reflects the same objectives.

The Health and Wellbeing Strategy (Improving Lives) seeks to address health inequalities that exist between people, between communities, and within the economy. It seeks fairer life chances for all, improved health and wellbeing, more people living independently for longer, and safe, vibrant and well-balanced communities. The Somerset Housing Strategy also seeks to deliver these same outcomes.

The Somerset Growth Plan, Health and Wellbeing Strategy and this Housing Strategy should be read together to give a clearer picture of the interrelated strategic priorities and objectives for the county of Somerset. From these strategies flow a range of other plans and activities.

The diagram on page 12 shows the links between the Somerset Housing Strategy and the range of other important local strategies and plans.

Bridgwater Together 2017
Community Council for Somerset

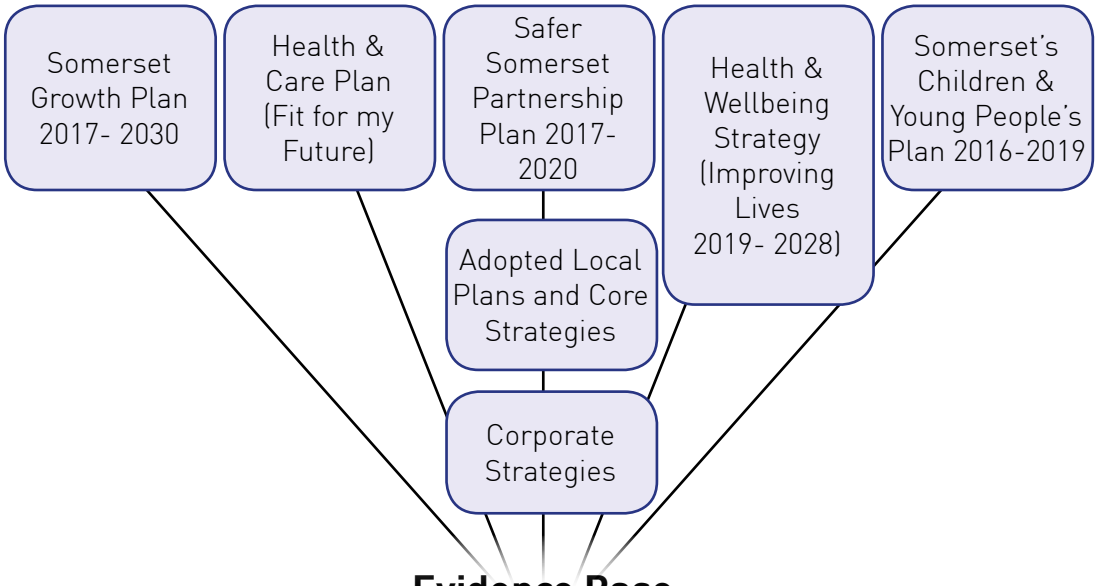
Equalities

The Somerset Housing Strategy has been supported and informed by an Equalities Impact Assessment (EIA). The EIA seeks to ensure that under-represented / vulnerable groups are considered within the development of strategy, policy and procedures. The process of developing an EIA (to directly inform the SHS) is ongoing. We are committed to preparing a SHS Delivery Plan. This will contain a range of activities, each of which will be supported and informed by their respective EIAs.

Community Land Trust tree planting at Norton Sub Hamdon, South Somerset, courtesy of Yarlington HA

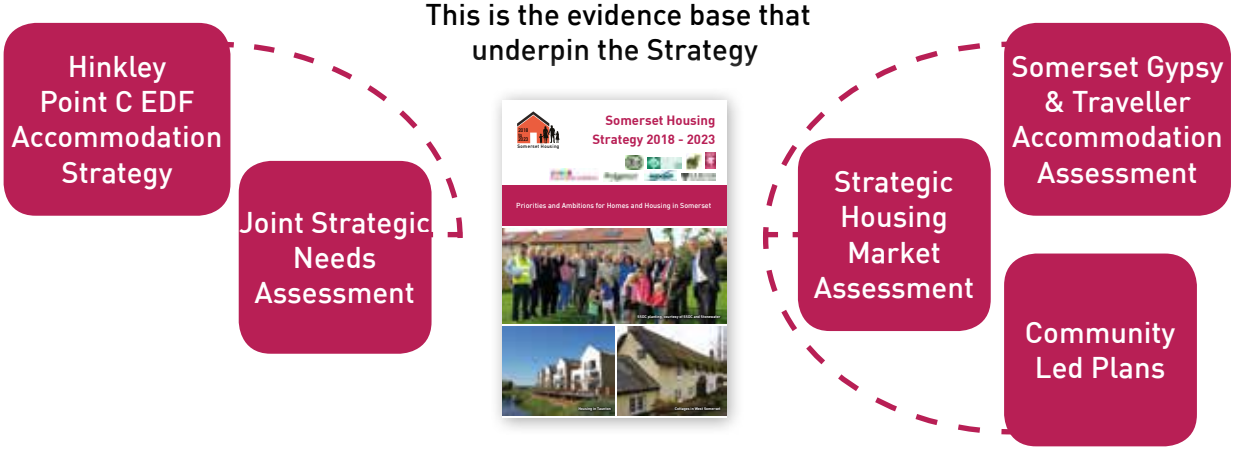
High Level Strategies

These are the high level strategies and plans that the Somerset Housing Strategy must conform with - i.e. they sit above the Strategy



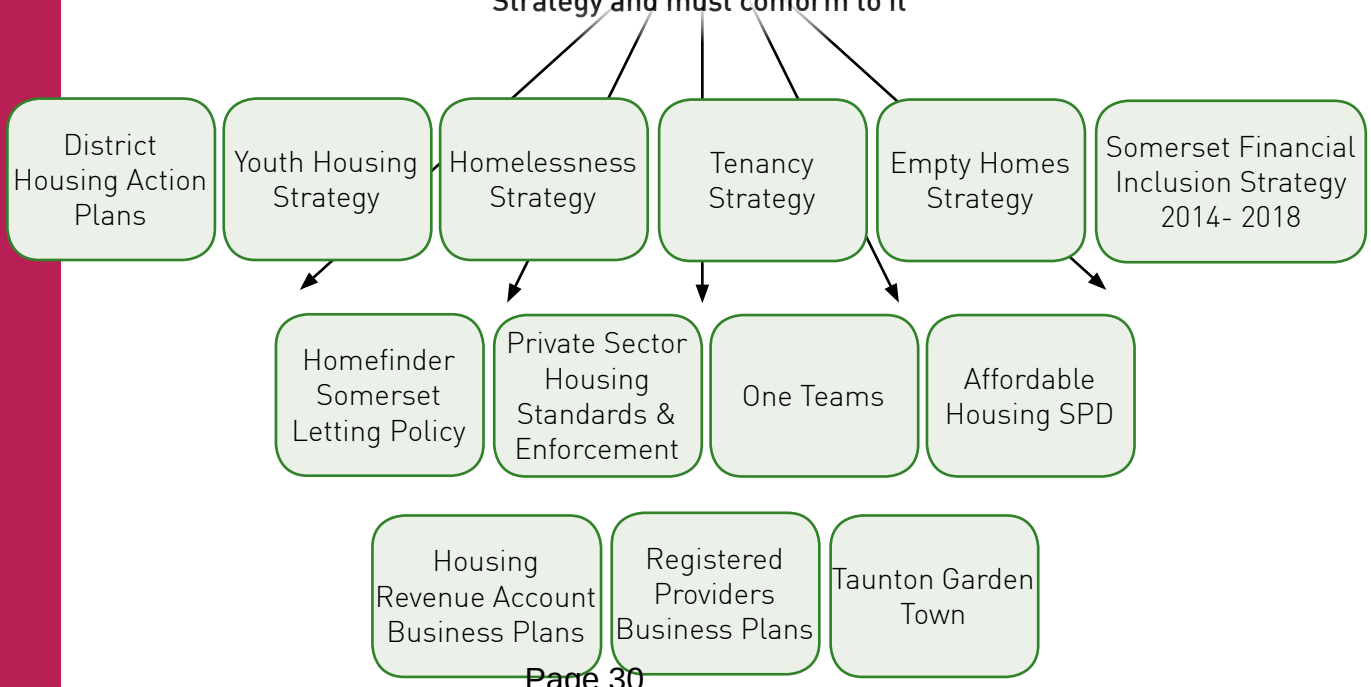
Evidence Base

This is the evidence base that underpin the Strategy



Strategies and Policies that sit beneath

These are the strategies and policies that sit beneath the Strategy and must conform to it



Our Vision for Housing within Somerset

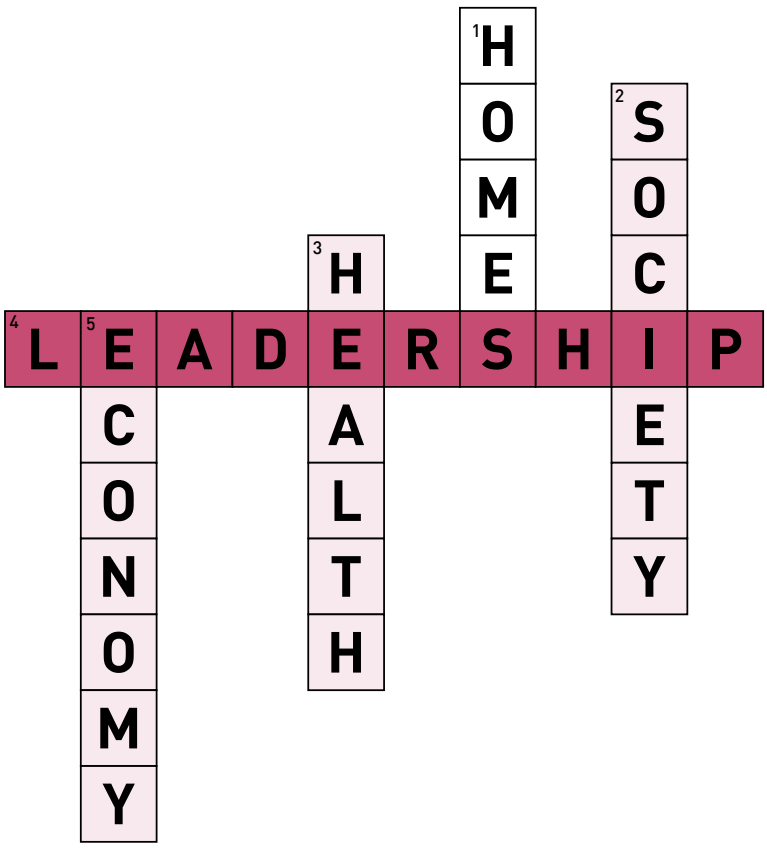
This Strategy establishes our vision for housing in Somerset. It sets out three major themes and under each one, the priorities and objectives that we want to achieve. Cutting across these themes is the drive for strong and effective strategic leadership across systems

Strong and effective strategic Leadership:
To deliver **leadership** across an integrated system that embraces communities, housing, health & wellbeing, social care and town & country planning

A local Economy that provides opportunity for all:
Increase housing supply across all tenures and **maximise the proportion of affordable homes** including **within rural communities**, to be constructed by a **skilled local labour force**

Homes in Somerset are good for your Health:
A **healthy living environment** with **secure and decent homes** that fosters **independent living** within **strong communities**

A Society that supports the vulnerable:
Coordinated support to individuals and communities to **reduce the impact of Welfare Reform**, to **prevent homelessness**, and to **facilitate a balanced housing stock** that meets the needs of all local people



Down

1. A 'basic need' – we need lots more of them (but more than just bricks and mortar)

2. A body of individuals living together as a community

3. The state of being free from illness or injury / a person's physical or mental condition

5. The production and consumption of goods and services and the supply of money – but interventions needed so that all can benefit

Across

4. Critical for addressing complex problems and for coordinating the delivery of 1, 2, 3 and 5 (Down)

Housing and Economy

Vision: A local Economy that provides opportunity for all

Context

- There are **not enough homes (all tenures)**
- A **growing affordability gap** with significant consequences for both young people and families
- A **growing private rented sector** that is getting more difficult to afford
- Increasing numbers of workers at **Hinkley Point C** are placing pressure on the private rented sector, fuelling rent increases (1 and 2 bed properties)
- There is **net out-migration of young people**
- **Net in migration of 40+** seeking lifestyle change, using capital asset of homes in higher house price areas to **outbid/out compete local people**
- Lack of opportunities for **social mobility** is a major issue across West Somerset
- **There is delay in construction** at key sites due to market financial changes
- There is a **skills shortage** within the construction sector
- **Poor transport infrastructure resilience** with specific problems on the motorway (M5) / A38 and strategic (A358/A303) network, and insufficient bus/rail link/A road links within much of the county

Priority 1: Maximise the number of affordable homes (all tenures)

Objective: Each Local Authority will prioritise the delivery of new affordable housing (all tenures) and provide community leadership at the highest level to make this happen

Objective: Make use of all available funding streams from Central Government such as the Housing Infrastructure Fund and other short term funding such as private rented sector access fund

Objective: Each Local Housing Authority to have current information about housing need across its locality

Objective: Each Local Authority will seek to deliver the necessary infrastructure and community facilities in a timely and phased manner to accelerate housing delivery

Priority 2: Provide more affordable homes to support rural economies and communities

Objective: Support the rural economy and the creation of sustainable rural communities by meeting demonstrably identified needs for affordable housing

Objective: Improve the percentage of affordable homes in rural developments tied to local plan allocations. Increase the number of supported housing units to ensure the need of some of the most vulnerable in society are more effectively met

Objective: Incentivise / promote land release for rural exception sites. Ensuring that provision remains affordable in perpetuity for future generations or for the subsidy to be recycled for alternative affordable housing provision

Objective: Increase the number of Community Land Trusts across Somerset, particularly within rural communities

Priority 3: Increase the supply of homes

Objective: Maintain up to date local plan coverage within each district area and Exmoor National Park and ensure a five-year housing land supply to meet housing targets

Objective: Maximise Hinkley Point C legacy and long term benefits

Objective: Work with One Public Estate and identify opportunities to reuse released land and buildings to meet housing needs

Priority 4: Upskill the local labour force

Objective: Align our activities with the Somerset Growth Plan and promote the establishment of a University, apprenticeships and a skills based academy for the construction sector

Objective: Increase rates of self-build and custom build

Objective: We will introduce off-site / modular construction

Priority 5: Creating sustainable homes and places in Somerset

Objective: The consideration of new housing developments will place sustainability at the heart of decision making

Objective: More homes will be provided that are healthy and affordable to run, integrating low carbon design and resilience to the predicted impacts of climate change

Rural scheme at Meare, courtesy of MDC

Opening of Creechbarrow Road Play Area, courtesy of SWT

Community Land Trust, Norton Sub Hamdon, South Somerset, courtesy of Yarlington Housing

Housing and Health

Vision: Homes in Somerset are good for your Health:

Context

- Growing **health inequalities** due to geography, age and financial capability
- An **ageing population** with specific housing requirements
- 75% of the elderly **own their homes**, but **12%** of older people aged 60+ **live in poverty**
- 10% of **children in income deprived families** are **concentrated in 0.07%** of the county area
- There are **14,300 children** and **20,000 older people in low income households** in Somerset
- **33,500** people in Somerset **aged 65 or older live on their own** (1 in 7 households)
- **27,000 one-person households** in which the resident has a **long-term health problem or disability**
- **30,000+ homes with Category 1 hazards** (and the **highest** proportion in the **Private Rented Sector**)
- **1 in 3** households do **not have gas central heating** (1 in 2 in **West Somerset**)
- **Average of 10.2% of households** living in **fuel poverty** with almost **18%** in our most deprived localities (**11.1%** England average)
- There are **major financial costs to health, social care and housing services** due to trips and falls, excess cold, damp, dementia, domestic violence, homelessness and delayed hospital discharges
- There is a need for flexible models of supported housing which **enable independent living**

Priority 1: Maximise positive health impacts through housing development and the lived environment

Objective: Develop and promote the use of Health Impact Assessments and ensure appropriate standards of design within housing development and the lived environment, so that new developments provide the opportunity for healthy living

Objective: Foster partnerships with developers around the delivery of lifetime homes / space standards to ensure well designed homes that are built for changing life circumstances and adaptability

Objective: Taunton Garden Town development will be an exemplar project that will deliver positive health impacts through creative design. Lessons will be learned to inform other major developments throughout the county

Priority 2: Improve the existing housing stock

Objective: Work with private rented sector landlords to improve the conditions of the homes which they let

Objective: There is a coordinated approach to combat poor quality or unsuitable homes of any tenure, specifically addressing fire risk, cold homes, disrepair, and accessibility. Members of the public know how to access support to combat poor housing conditions

Priority 3: Match lifelong independent living with appropriate property solutions

Objective: For those seeking an affordable home to rent, identify any further improvements to improve the matching of need (relating to physical/mental/learning disability) with available property through Homefinder Somerset

Objective: To ensure that all households in Somerset have access to coordinated information and advice and related services to enable them to live independently in a home which meets their needs

Objective: To ensure that individuals with particular, additional and / or complex support needs have the necessary support to live independently longer in a home that meets their needs. Consideration will include the potential of new technologies

Objective: To increase the range of housing providers that are willing to house individuals with additional and / or complex support needs

Priority 4: Collaborate with local residents to build healthy and strong communities

Objective: To identify the talent and skills of people within local communities. To work with the people 'assets' to design solutions to complex problems such as homelessness, addictive behaviours and poor mental health. To enable healthy, strong and self-supporting communities that are partnered by effective service delivery

Top left: New housing in South Somerset

Bottom left: Thriving and healthy families

Above: Neighbourhood and community facilities at Priorswood, Taunton

Housing and Society

Vision: A Society that supports the vulnerable

Context

- Significant levels of **homelessness** and **rough sleeping**
- Ongoing **welfare reform** and **Universal Credit** roll-out
- Particular concerns for the **under 35s** who often struggle to access housing due to challenging benefit regime and high cost of open market housing
- **Lack of supply of 1 bedroom properties** for which there is significant demand
- Some communities in rural areas (principally in West Somerset) have further pressures due to **high levels of second home ownership**
- There are very **high levels of long term empty homes** in West Somerset
- **Mismatch** between the provision of larger properties, increasingly smaller households and **changing demographics** (particularly within Exmoor National Park where there is a predominance of larger, detached homes)
- There is an **increased demand for all forms of accommodation** within commutable distance of **Hinkley Point C**
- There is **hidden housing need** particularly within **rural communities**
- There is **no strategic transit site for gypsies and travellers** and a general under-provision of all pitches across the county
- Further **rises in mortgage rates** could increase the number of repossessions
- There are significant numbers of **armed service / ex service personnel** and their families who are seeking accommodation via Homefinder

Priority 1: Support communities with the impact of welfare reform

Objective: Work as partners to share best practice and consolidate / improve awareness of benefit changes and what it means for families and individuals to help prevent incidence of debt and rent arrears

Objective: Develop suitable housing options for the under 35s

Objective: Housing and support services working with under 35s to have a focus on assisting people into work, and utilise initiatives such as Social Impact Bond to enable providers and landlords to build links with employment, education and training initiatives

Objective: Promote sources of advice and training that are available to private sector landlords, existing private tenants, and residents considering renting, to include 'accreditation'/'tenant ready' schemes

Priority 2: Reduce Homelessness and Rough Sleeping

Objective: Prepare and implement a new statutory county-wide Homelessness Strategy, to include the requirements of the Homelessness Reduction Act 2017, and to foresee changing economic circumstances including rising interest rates that could increase repossessions

Priority 3: Create and sustain thriving communities

Objective: Local Plan reviews will include appropriate policy responses that address the demands of changing demographics, including specialist needs

Objective: Communities are supported to develop community led plans (Neighbourhood Plans/Parish Plans) to help identify community housing needs, sites for future housing and promote inclusive high quality design

Objective: Revise and update the existing Somerset Gypsy and Traveller Accommodation Assessment and increase the amount of available Gypsy and Traveller pitches across the County, exploring opportunities to use public sector land to make residential and transit site provision

Objective: To refresh the Youth Housing Strategy and consider the impact on children and young adults (including those leaving care) of poor housing standards, overcrowding, affordability, and insecurity of tenure. To deliver safe housing solutions that protect vulnerable children and young adults

Objective: Commissioners and providers of housing and support services are to deliver social value and seek a social return on investment. This will enhance the value of the Somerset £pound and so expand the range and quality of service delivery for the benefit and opportunity of local residents and the voluntary / community sector

Objective: Seek to create a downward trend in the number of Long Term Empty homes across all districts

Objective: To work in partnership with housing providers and the charity / voluntary sector to improve housing options / support services for those serving and ex serving members of the armed forces and their families who find that they are in housing need

Top left: Ground Cutting, Northwick Road, Mark, courtesy of South-Western Housing Society and SDC

Top right: Working with local communities, Priorswood Community Centre, courtesy of TDBC

Bottom: Floral display of Mr & Mrs Beer, Woolavington, courtesy of Homes in Sedgemoor

Delivery and Performance

Governance

The Somerset Housing Strategy is the responsibility of the Somerset Strategic Housing Partnership (SSHP), comprising member and officer representation from each of the Somerset districts and the County Council. Public Health, the Clinical Commissioning Group, Homes England, and a local Registered Provider are also represented. The Exmoor National Park authority also provided valuable support to the preparation of the SHS.

SSHP sits within the governance arrangements of the Somerset Health and Wellbeing Board.

Delivery

A SHS multi-agency 'Delivery Plan' will be prepared. This will detail a range of prioritised actions / projects, together with information on expected outcomes, lead agency, key partners, timescales, resources, and deliverables.

The Delivery Plan will be reviewed and updated annually.

Each SSHP partner is encouraged to develop their own SHS Action Plans (or to embed activity within other appropriate plans e.g. corporate plans). Partner Action Plans will be the responsibility of the partner organisation (including delivery/governance).

Performance

Performance against the Delivery Plan will be monitored by SSHP.

Review of the Somerset Housing Strategy will occur in 2023.

Glossary

Affordable Housing: Affordable housing includes social rented, affordable rented and intermediate housing (including Low Cost Home Ownership options), provided to eligible households whose needs are not met by the market

- Affordable rented housing: Rented housing let by Registered Providers to households who are eligible for social rented housing. Affordable rent is subject to rent controls that require a rent of no more than 80% of the local market rent
- Intermediate rented housing: Housing at prices and rents above those of social rent but below market price or rents.
- Social rented housing: Rented housing owned and managed by Local Authorities and Registered Providers for which guideline target rents are determined through the national rent regime

Category 1 Hazard: Housing Standards - A category 1 hazard is a hazard that poses a serious threat to the health or safety of people living in or visiting a home. Examples can include a leaking roof, mould on the walls / ceilings, excess cold, exposed wiring or overloaded electrical sockets, a dangerous or broken boiler etc. There is a scoring system to assess whether any hazard is 'Category 1'. Councils must take action to remove or reduce Category 1 hazards

Community Land Trust: Community Land Trusts are a form of community-led housing, set up and run by ordinary people to develop and manage homes as well as other assets. CLTs act as long-term stewards of housing, ensuring that it remains genuinely affordable, based on what people actually earn in their area, not just for now but for every future occupier (National Community Land Trust Network)

Custom build: Custom build homes are where an individual or a group works with a developer to help deliver a home. The developer may help to find a plot, manage the construction and arrange the finance for the new home. This is more of a hands-off approach compared to self-build but the home will be tailored to match the individuals/ groups requirements

Empty Home (long term): A home that has been unoccupied for more than six months

Fuel poverty: Fuel poverty in England is measured using the Low Income High Costs (LIHC) indicator. Under the LIHC indicator, a household is considered to be fuel poor if

- They have required fuel costs that are above the average (the national median level), and
- Were they to spend that amount they would be left with a residual income below the official poverty line

Garden Town (Taunton): Taunton was designated a Garden Town in 2017 (the only one in the South West). The Taunton Garden Town proposals encompass the elements that are essential to maintaining a thriving and sustainable community, such as: the delivery of new homes, major town centre regeneration schemes, new open spaces for communities and wildlife, flood protection, locations for business and more efficient and sustainable ways of getting around. The Government has committed to work with the local district council to access funding to deliver essential infrastructure in line with or ahead of housing and the wider growth of Taunton.

GTAA (Gypsy and Traveller Accommodation Assessment): Councils across Somerset jointly commissioned this study from De Montfort University (2011) to assess the need for residential and transit pitches for the travelling community in the county, as required by national policy. It is now in need of updating

Health Inequality: Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes (World Health Organisation)

Health Impact Assessment: A Health Impact Assessment (HIA) is a process that ensures that the effect of development on both health and health inequalities are considered and responded to during the planning / development process. It is usually informed by locally adopted guidance. Countywide guidance is desirable to ensure consistency of application of HIA

Hidden Homelessness / Housing Need: People who are not entitled to help with housing, or who don't even approach their councils for help, will stay in hostels, squats or B&Bs, in overcrowded accommodation or 'concealed' housing, such as the floors or sofas of friends and family. This is hidden homelessness, as it is not counted in official statistics. Similarly, people who cannot afford their own home and who live with their family, is an example of 'hidden' housing need, as it is very difficult to quantify

Homefinder Somerset: Choice Based Lettings for Somerset. A partnership of Local Authorities and Housing Associations working together to make the process of finding a home to rent both simple and transparent for applicants
https://www.homefindersomerset.co.uk/

Lifetime homes: Homes that meet 16 design criteria that are intended to make homes more accessible and adaptable for lifetime use at minimal cost
http://www.lifetimehomes.org.uk/

Low income household: Commonly a household whose income is 60% or less of the average (median) British household income for that year

Local Housing Allowance (LHA): This is the way of working out Housing Benefit (HB) for people who rent from a private landlord

Local Plans: Planning Policy documents which contain a spatial strategy together with a range of local planning policies that aim to guide and control new development within a defined locality (e.g. within a district council boundary, or a National Park)

Modular construction: "Modular" is a construction method of building homes (and other buildings) that involves constructing sections away from the building site, then delivering them to the intended site. Installation of the prefabricated sections is completed on site

One Public Estate: One Public Estate (OPE) is a national initiative managed by central Government to enable public sector organisations to 'rationalise their asset and estates management'. In other words, Local Authorities were able to bid for project funding to facilitate the sharing of buildings and services with other public sector organisations
http://www.somerset.gov.uk/policies-and-plans/schemes-and-initiatives/customer-hubs-and-one-public-estate/

Self-build: Projects where someone directly organises the design and construction of their own home. This covers a wide range of projects from a traditional DIY self-build home to projects where the self-builder employs someone to build their home for them. Community-led projects can also be defined as self-build

SHMA – Somerset Strategic Housing Market Assessment: The Government's National Policy Planning Framework (NPPF) requires each Local Authority to undertake a SHMA as part of the evidence base required to inform district Local Plans. A SHMA seeks to assess the long term need and affordability of housing in the area, and is based on demographic and economic trends. The latest SHMA for Somerset was published in October 2016

Social Impact Bond: Social Impact Bonds (SIBs) are a commissioning tool that can enable organisations to deliver outcomes contracts and make funding for services conditional on achieving results. Social Investors pay for the project at the start, and then receive payments based on the results achieved by the project. There now exist many SIBs across the UK, supporting tens of thousands of beneficiaries in areas like youth unemployment, education / training, mental health and homelessness

Social Value: Social Value is the quantification of the relative importance that people place on the changes they experience in their lives. Often these changes cannot be given a financial value (or it is very hard to do so). Examples of social value include an individual whose confidence may be increased through interaction with a community group. Or whose health and wellbeing is improved through living next to (or having convenient access to) a park. An organisation can influence social value through its procurement and service delivery practices (see Social Return on Investment)

Social Return on Investment (SROI): SROI is a framework for measuring and accounting for a much broader concept of value i.e. beyond the monetary value of an investment / purchase. It seeks to reduce inequality and environmental degradation and improve wellbeing. SROI measures change in ways that are relevant to the people or organisations that experience or contribute to it. It does this by incorporating social, environmental and economic costs and benefits in to decision making around service delivery, and assigning each of these a monetary value. This enables a ratio of benefits to costs to be calculated. For example, a ratio of 3:1 indicates that an investment of £1 delivers £3 of social value. An example may be the outsourcing of some service delivery to community groups, who due to greater local knowledge of people and their circumstances, could deliver greater impact (for the same financial investment) and so enhance social value http://www.socialvalueuk.org/resources/sroi-guide/

Sustainability: In the context of new housing developments, this is to include flood mitigation and flood resilient building design, green infrastructure, sustainable travel, minimisation of waste and pollution, protection and enhancement of biodiversity, and notable measures to mitigate and adapt to climate change; providing homes and spaces that are healthy for occupiers and users

Universal Credit: A monthly benefit payment for people who are on low income or are out of work. It's being rolled out in stages across the UK and is replacing other benefits (as part of the government's Welfare Reform agenda). How much a person receives depends on their circumstances, including income and how many children they have

Communications and Contact

We are committed to having open dialogue on matters relating to strategic housing. We shall ensure that the following information is available on the district council and county council web sites:

- Somerset Housing Strategy (SHS)
- SHS Delivery Plan
- SHS Performance Scorecards
- Monthly newsletters

Each website contains relevant contact information.

We shall work towards delivering a single countywide resource for the above.

If you wish to write to us, please address any correspondence to 'Housing Strategy' at your local district council.

Equality Impact Assessment Form

Version 4 (Nov 2018)

What is being analysed?	**Somerset Housing Strategy**
Name body responsible for the analysis	**Somerset Strategic Housing Officers Group (SSHG)**

Sources of information used in this impact assessment

The Somerset Housing Strategy (SHS) sets out a sub-regional Housing Strategy for Somerset to be complemented by a multi-agency Delivery Plan and individual District Action Plans. This approach enables the coordination of partner interventions supported by specific actions within individual local authority areas supported by the overarching common priorities and ambitions identified within the Strategy.

The SHS has been developed by a project team consisting of representatives from the following organisations:

- Mendip District Council
- Sedgemoor District Council
- South Somerset District Council
- Taunton Deane Borough Council
- West Somerset Council

- Exmoor National Park Authority
- Somerset County Council – Somerset Strategic Planning Conference
- Somerset County Council – Public Health
- Somerset County Council – Adult Social Care

The process of developing this Strategy began in 2017. We produced a 'Housing Benchmarking Report' that established key data and facts relating to the local housing market. A number of partners provided help, including Somerset Intelligence Partnership, Public Health and Town Planners. We used the Benchmarking Report and other evidence to produce District based and County wide Housing Market Profiles. These were published in July 2017 and identified key facts, issues, challenges and opportunities. On July 8th 2017 we facilitated a Stakeholder Engagement Event where 100+ people representing the local housing sector and associated services met to discuss key topics of concern, and to suggest possible priorities and ideas. During February 2018 we published the draft Housing Strategy. This coincided with a period of public consultation and stakeholder engagement. Presentations were made to a variety of forums including the Health and Wellbeing Board, Safer Somerset Partnership, Compass Disability, VCS Strategic Forum and many others. All this background material (housing market profiles, speaker presentations, workshop material, & consultation feedback) can be accessed via each district council website. Once all the information had been gathered and analysed, it was used to shape the content of the Somerset Housing Strategy which seeks to identify the key priorities and ambitions for housing within Somerset.

Other sources of background information that supports this analysis include:

- Somerset Joint Strategic Needs Assessment http://www.somersetintelligence.org.uk/jsna
- Somerset Health & Wellbeing Strategy www.somerset.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=45804
- Strategic Housing Market Assessments https://www.sedgemoor.gov.uk/shma
- Somerset Homeless Strategy https://www.southsomerset.gov.uk/media/628572/homeless_strategy_appendix_1.pdf
- Somerset Youth Housing Strategy & Action Plan https://www.bing.com/search?q=somerset+youth+housing+strategy+and+action+plan&src=IE-SearchBox&FORM=IESR3N
- Avon & Somerset Rough Sleepers Steering Group Action Plan https://www.southsomerset.gov.uk/media/677668/ap_homeless_strategy_2013.xlsx

- Somerset Gypsy and Traveller Accommodation Assessment Update https://www.westsomersetonline.gov.uk/getattachment/Planning---Building/Planning-Policy/Evidence-Base-Information/Housing---Community-Evidence/Gypsy-and-Traveller-Accommodation-Assessment/Final-GTAA-update-October-2013.pdf.aspx
- Somerset Financial Inclusion Strategy http://www.somersetintelligence.org.uk/financial-inclusion.html
- Somerset Tenancy Strategy https://www.southsomerset.gov.uk/media/677783/tenancy_strategy_v1_1.pdf
- Somerset Sustainable Community Strategy http://www.somerset.gov.uk/policies-and-plans/plans/somerset-minerals-plan/minerals-plan/?entryid100=57149&cord=DESC&cid=1504978&p=9
- Local Development Frameworks and Key Strategies
  https://www.westsomersetonline.gov.uk/Planning---Building/Planning-Policy/Local-Development-Framework
  https://www.southsomerset.gov.uk/planning-and-building-control/spatial-policy/local-development-framework/
  http://www.mendip.gov.uk/localplan
  https://www.tauntondeane.gov.uk/planning-policy/taunton-deane-core-strategy/
  https://www.sedgemoor.gov.uk/corestrategy
- Somerset Dementia Strategy http://www.somersetintelligence.org.uk/somerset-dementia-strategy-priorities-2013-2016.pdf
- Somerset Extra Care Housing Strategic Review http://www.somersetintelligence.org.uk/downloads/Somerset%20Extra%20Care%20Housing%20Strategic%20Review%202008.pdf
- Somerset Growth Plan 2014 – 2020: Strategic Framework http://www.somerset.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=47709

Heart of the South West Productivity Strategy

The SHS has been adopted by the Somerset Strategic Housing Partnership (SSHP) that consists of representation from the District Councils, County Council (Adults Social Care, Strategic Planning & Public Health), the CCG, Homes & Community Agency and a Registered Provider partner (on behalf of the sector).

Identify the effect or potential effect of this policy on each of the diversity groups (Equality Act 2010). Refer to Equality Analysis Checklist if necessary.
(PCs of marriage and civil partnership and pregnancy and maternity to be considered if relevant)
Add new rows for repeating protected groups as required

Protected group	Effect Positive / negative / neutral	Comments / Recommendations	Actions
Age	Positive	The Somerset JSNA highlights that the population is ageing and that there will be a substantial increase in the proportion of older people in Somerset by 2025. Healthy life expectancy is not improving. The prospect is that people will be living longer but with long-term health conditions.	Consult with **older people** on their housing issues, needs and support. Evaluate existing supported accommodation units to help inform future planning for older people. Develop preventative services such as minor adaptations and repairs, information advice centres and Home Improvement Agency services that will help older people remain independent in their own homes for as long as possible. Improve home from hospital arrangements and develop social prescribing. Exploit the potential of new technology. Seek to list local services available to support a person in their own home (e.g. Somerset Choices); support agencies to help. Increase the supply of housing for older people and develop the right tenures and letting plans to allocate these, keeping in mind the rural housing needs of older people as well.
		The Somerset Homelessness Strategy recognises the high rate of tenancy failure amongst young people and includes actions to ensure that support will continue to be provided. The JSNA and the Youth Housing Strategy (to be superseded by the Children and Young People's Plan) highlight the difficulties that young people face when trying to access housing. Housing enforcement policy can make	Through P2i, strengthen prevention activities aimed at **young people** to better facilitate a planned progression into independent living. E.g. allow for improved access to housing advice and information, which is designed to meet the needs of younger people. Develop private rented sector access schemes to facilitate shared rented housing for single people aged under 35. E.g. Ensure there is adequate and affordable, good quality accommodation for people under 35, on the lowest level of Local Housing Allowance.

		a real difference to the quality of children's lives, especially those who are living in poor quality, overcrowded and inappropriate accommodation.	Further, the Strategy also seeks to achieve the following: - Support both the young people and the rural economy via the creation of sustainable rural communities by providing more affordable rural homes. - Develop suitable housing options for the under 35s due to welfare reform. - Align activities with the Somerset Growth Plan and promote the establishment of a University and apprenticeships to upskill the local labour force to provide better opportunities. - Housing and support services working with under 35s to have a focus on assisting people into work, and utilise initiatives such as the Social Impact Bond to enable providers and landlords to build links with employment, education and training initiatives. - Aim to ensure all housing, but particularly rented housing (in areas where there are concentrations of poor housing standards) is safe, does not give rise to injury or illness to the occupiers, and is warm and energy efficient. The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans, review of SCC commissioning contracts (various services), Health & Wellbeing Strategy, Private Sector Housing /Housing Standards Strategies, Somerset Choices, Children & Young People Plan, Registered Provider Business Plans and district based Local Plans.
Disability	Positive	Statistics data from the Home Improvement Agency, Homefinder Somerset and Health and Wellbeing Strategy indicates that there may be a shortage of accessible housing for some	Through a revised jointly commissioned Home Improvement Agency and Integrated Community Equipment Service and through cooperative working between local housing authorities, public health and adult social care achieved the following:

		disabled people, leading to a lack of choice and inappropriate housing. There are also issues in matching the correct adaptations on properties to the applicant's disabilities. There are particular challenges around accommodation provision for people with mental health problems or learning disabilities. The statistics also indicate that the independence of disabled people is restricted and that means instances of poverty, social exclusion and isolation among disabled people is higher than average, with many disabled people restricted to certain local areas.	- Maximized use of existing stock, ensuring that people are offered appropriate housing to meet their particular needs. - Improved access to adaptations and adapted stock, and improved efficiency in the current system for accessing adaptations, aids and support. - Include number of fully wheelchair accessible units alongside units suitable for ambulant disabled individuals in new builds. Further, the Strategy also seeks to achieve the following: - Increase the choice of supported accommodation. - Promote the use of Health Impact Assessments within housing development and the lived environment. - Foster the partnerships with developers around the delivery of lifetime homes/ space standards to ensure well designed homes that are built for adaptability. - Improve the matching of need with available property through Homefinder Somerset. - Ensure that individuals with additional and/ or complex support needs have the necessary support to live independently in a home that meets their needs. - Review pathways into employment for people with a mental or physical disability. - Work in partner agencies to tackle issues of social isolation and loneliness. The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans, review of SCC commissioning contracts (various services), Health & Wellbeing Strategy, Private Sector Housing /Housing Standards Strategies,

			Somerset Choices, Children & Young People Plan, Registered Provider Business Plans and district based Local Plans.
Gender reassignment	Neutral	Transgendered people may be particularly at risk of housing crisis and homelessness arising from transphobic reactions, hate crime and harassment by family, neighbours and members of their local community. Transgendered people may also fear disclosing their identity to housing officers for fear that they will not be treated with dignity and respect. The result can be that they do not receive the housing services that they need or receive a service inappropriate to their needs.	These issues are addressed to a degree in the Homelessness Strategy, which the SHS supports. Monitoring of hate crime and subsequent recommendation for action and ensuring this is linked to the allocation of housing through Homefinder and housing options teams. The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans, Homelessness Strategy, Homefinder Somerset and Safer Somerset Partnership.
Race	Neutral	BME groups may have differing housing needs due to multi-generational households for cultural or financial reasons. People from a different race or culture may be vulnerable to hate crime. Life expectancy for Gypsy and Traveller men and women is 10 years lower than the national average. Gypsy and Traveller mothers are 20 times more likely than the rest of the population to have experienced the death of a child. Unlawful pitches can have problems including	Facilitate for larger and cheaper private sector rented accommodation of varied types. Strengthened Housing Options arrangements will include a commitment to mitigating effects of language barriers that might hinder access to services. Monitoring of hate crime and subsequent recommendation for action and ensuring this is linked to the allocation of housing through Homefinder and housing options teams. The Gypsy and Traveller Accommodation (Assessment) 2011 & (Update) 2013 (GTAA) sets out the needs of this community and pitch requirements which the SHS supports and will seek to deliver. Further, there has been commitment by the Somerset Strategic Planning Group to update the GTAA. Exploring opportunities to use public sector land. Actions are to develop

		health hazards (such as contamination by vermin), decayed sewage and water fittings, poor-quality utility rooms, and failings in fire safety. Roadside stopping places, with no facilities and continued instability and trauma, become part of the way of life. Health deteriorates, while severe disruptions occur to access to employment opportunities. Racism towards Gypsies and Travellers is still common, frequently overt and seen as justified.	transit sites for gypsies / travellers households arriving in Somerset. There are several different races and ethnicities of Gypsy and Traveller Communities within Somerset and they cannot be grouped as one. Careful consideration must be made when allocating sites as well as being mindful of their accommodation needs. The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans, Gypsy and Traveller Accommodation Assessment Review, Homelessness Strategy, Registered Provider Business Plans, Homefinder Somerset and district based Local Plans.
Religion or Belief	Neutral	There could be concerns that different religious groups could be disadvantaged in seeking assistance due to particular cultural aspects. There could be concern that insufficient information is available on the housing needs and aspirations of people from minority faith groups.	In some religious cultures, it is more difficult for a female member of a household to seek her own accommodation. More liaison needs to be undertaken with support groups to assess the effectiveness of the Strategy in terms of assisting people/households from minority religions. An on-going dialogue will be created with representatives of community groups (SARI) who can provide information on the housing needs of minority faith populations. The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans and Homefinder Somerset.
Sex (Gender)	Neutral / Positive	- There may be a differential outcome in terms of allocations between genders. However, evidence does not support concerns in this area.	Monitoring information on gender will be collected e.g. through Choice Based lettings. Current allocations have to reflect other legislative requirements

		- LGBTX may be subject to discrimination and low-level anti-social behaviour leading to increased fear of crime. - Men are more at risk of rough sleeping. - More women suffer domestic violence.	that favour parental responsibility being given to the mother, rather than the allocations policy that have an adverse impact due to the applicants' gender. Monitoring of hate crime and subsequent recommendation for action and ensuring this is linked to the allocation of housing through Homefinder and housing options teams. Coordinated interventions between commissioned/non-commissioned domestic abuse services and Registered Providers. The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans, Homefinder Somerset, Safer Somerset partnership and the Somerset Homelessness Strategy.
Sexual orientation	Neutral	People who are gay/lesbian may be more vulnerable to homelessness and housing need because of being asked to leave by family or forced to leave their current property because of harassment.	All households who are forced to leave home by families or friends will be provided with appropriate housing advice and assistance. (Homelessness Reduction Act) Districts have policies and procedures in place to deal with harassment. A household suffering from harassment could be awarded priority for the allocation of accommodation under homelessness legislation. (District Action Plan) The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans, Homefinder Somerset and the Somerset Homelessness Strategy.

Poverty/ disadvantage/ location *(not a protected characteristic)*	Neutral	Potential adverse impact on low income / unemployed households if homelessness prevention services are inaccessible or standards in low cost private rented housing are driven down.	Target mortgage rescue advice and assistance at low-income households. Target welfare and money management advice at low-income households in social housing. Protect housing conditions and standards in low cost private rented housing by working with landlords. Maintain outreach services through core services and third party providers. Further, the Strategy also seeks to achieve the following: - Ensure a co-ordinated approach to combat poor quality or unsuitable homes of any tenure, specifically addressing cold homes, disrepair and accessibility which are usually caused by poverty/ disadvantage. - Adopt an asset-based approach to working with local communities, involving co-production to enable healthy and strong self-supporting communities that are partnered by effective service delivery. - Work as partners to share best practice and consolidate/ improve awareness of benefit changes and what it means for families and individuals to help prevent incidence of debt and rent arrears. The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans, Financial Inclusion Strategy, Homelessness Strategy, Private Sector Housing/Housing Standards Strategies and Somerset Academy.
All Groups **or** General Comments		- Plans for housing schemes for older people may not take into account the need for carers to live permanently or	Schemes, which are proposed in Action Plans, will incorporate excellent standards of design used by registered social landlords. These will include plans for two-bedroom

		intermittently with their dependants. - The housing needs of ex-offenders may not have been taken into account.	accommodation. An ex-offender's application for assistance under homelessness legislation and the housing register is considered on its own merits. The Homelessness Code of Guidance advises on the factors to consider when deciding whether an ex-offender is entitled to assistance. (Homelessness Reduction Act) Further, the Strategy also seeks to achieve the following: - As Local Plans are reviewed, they are to include appropriate policy responses that addresses the demands of changing demographics including specialist needs. - Communities are supported to develop community led plans (Neighbourhood Plans/ Parish Plans) to help identify community housing needs, sites for future housing and promote inclusive high quality design. The above actions will be coordinated by the SHS Delivery Plan and given further consideration in the following (among others): SHS District Action Plans, Homelessness Strategy and Homefinder Somerset.

Review (date or timeframe)	Update during the drafting of the Somerset Housing Strategy
Name of person/s completing (and involved in completing) form	Somerset Housing Strategy project team
Date analysis to be completed	27th November 2018
Name (and signature) of manager/board member approving	

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Somerset Health and Wellbeing Board

21st March 2019
Report for decision

Annual Report of the Director of Public Health 2018 – Emotional health and wellbeing: looking through the lens of self-harm
Lead Officer: Trudi Grant / Director of Public Health
Author: PNJ Tucker / Public Health Specialist
Contact Details: 01823 359449

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Trudi Grant / Director of Public Health	17/12/2018
	Cabinet Member / Portfolio Holder (if applicable)	Cllr Christine Lawrence – Cabinet Member for Public Health and Wellbeing	17/12/2018
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	17/12/2018

Summary:	This report analyses available data to help understand the apparent high rates of self-harm in Somerset. It finds that the picture is highly complex, with only hospital admissions easily measurable. Such admissions are typically the result of paracetamol overdoses by young women rather than self-cutting (as self-harm is often discussed). The report concludes that the most effective interventions are to promote and support the mental health and emotional wellbeing of all young people, but especially girls, rather than provide specialist services. This makes mental health a matter for all, not just the NHS.
Recommendations:	**That the Somerset Health and Wellbeing Board:** **1. endorse this report.** **promote cooperation between public and third sector bodies in providing prevention and early intervention wellbeing services for children and young people in Somerset.** **2. support the Prevention Concordat for Mental Health and the Prevention Framework for Somerset.** **3. plays host to a workshop on self-harm to discuss findings with partners**

Reasons for recommendations:	Evidence presented in this report suggests that investment in prevention will be more effective, and cost-effective, at reducing the incidence of self-harm – especially as seen in hospital admissions – than the provision of specialist services at tier 3 and 4.
Links to Somerset Health and Wellbeing Strategy	The report focuses particularly on Priority 2 of the Health and Wellbeing Strategy: • Families and communities are thriving and resilient.
Financial, Legal and HR Implications:	***There are no direct financial, legal or HR implications.*** ***It should be noted that:*** • The report has implications for the potential use of future NHS England funding for children and young people's mental health. Devoting resources to prevention of self-harm can reduce the financial cost of hospital admissions (finance). • The report has potential implications for the respecifying of school nurses' role (HR).
Equalities Implications:	The risk of self-harm is greatest amongst young people, young women in particular. Although the patterns are complex, the risk of self-harm is generally higher in minority groups. The report identifies inequalities in relation to self-harm and suggests how they can be reduced.
Risk Assessment:	***Not applicable.***

1. Background

1.1. In Public Health England's statistical profiles, Somerset has a 'red dot' for self-harm admissions to hospital, meaning that the rate of admissions is significantly higher than England as a whole. In the past, this we have assumed that this was simply the result of effective admission and assessment of self-harm at Somerset hospitals. In recent years the rates have risen, and Somerset has diverged further from the national average, and so this year's Annual Public Health Report has examined the statistics in detail to improve our understanding.

1.2. Analysis of the figures shows that the majority of self-harm admissions are for

overdoses, particularly of paracetamol and other painkillers, and are predominantly taken by young women. The majority of these admissions are 'one-off', implying that they are a response to a personal crisis rather than a symptom of longer term mental ill health. Evidence suggests that these overdoses are very rarely attempted suicides, and there is no simple link between self-poisoning and the bulk of 'low level' self-harm, which is predominantly self-cutting.

1.3. These patterns suggest that the response should be to strengthen the support available to young people, especially girls, at Tiers 1 and 2 (universal services and those for relatively common and low-level need). This will promote their resilience in the face of the unavoidable difficulties of adolescence; evidence suggests that availability of such support is patchy and uncoordinated in the county. Rather than being a health problem that needs treatment in the NHS, this support will often be through schools, although parents, GPs and other professionals would benefit from more available guidance and services to improve young people's wellbeing. In addition, we conclude that 'emergency admissions for self-harm' is an inadequate measure of the prevalence of self-harm.

2. Options Considered and reasons for rejecting them

2.1. The production of an annual report is a statutory requirement for all Directors of Public Health and there is no option not to produce it. The contents of the report are entirely at the discretion of the DPH.

3. Consultations undertaken

3.1. The report has been produced after discussions and contributions from a range of people in Somerset who have responsibilities for young people who have harmed themselves, or who are at risk of doing so. Because of the sensitivity of the subject these opinions are generally anonymized in the text.

4. Implications

4.1. Financial, HR and equalities implications are described above.

4.2. The findings of the report indicate an opportunity to improve mental health and emotional wellbeing of school age children, and thereby reduce the impact of self-harm admissions on acute care in Somerset.

5. Background papers

5.1. The Annual Report of the Somerset Director of Public Health 2018, 'Hospital Admissions for Self-Harm in Somerset', is published at:
http://www.somerset.gov.uk/organisation/departments/public-health/

5.2. The Prevention Concordat for Mental Health is published at

https://www.gov.uk/government/collections/prevention-concordat-for-better-mental-health

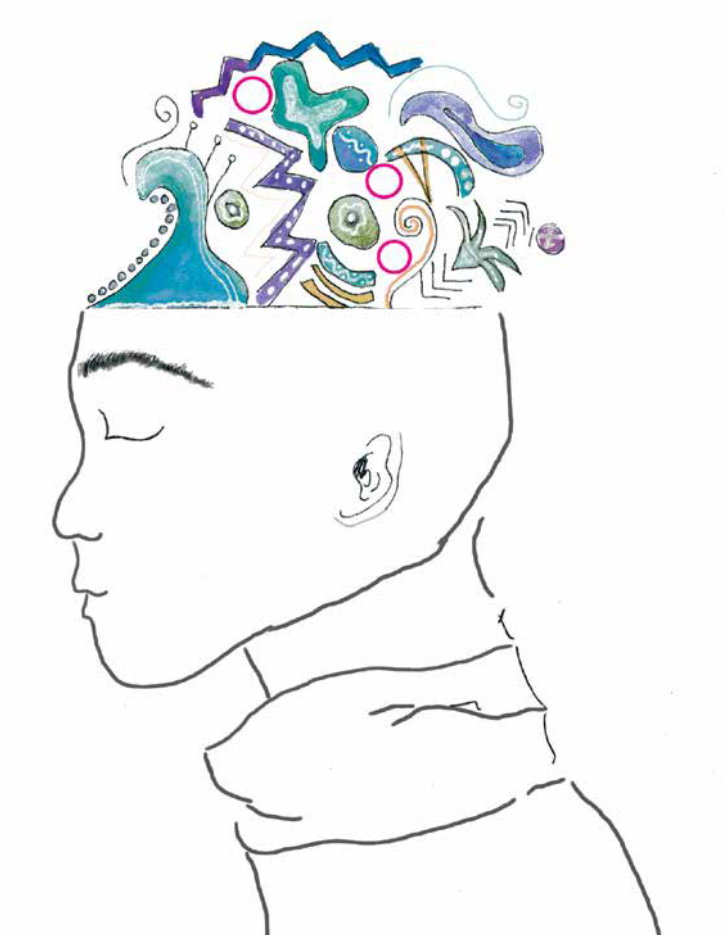
The Somerset Wellbeing Framework at:

https://www.cypsomersethealth.org/wellbeing_framework_-_getting_started

and the Prevention Framework for Somerset at:

- http://www.somerset.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=122999

Emotional Health and Wellbeing



Picture with thanks and acknowledgement to the Somerset young people who developed the LifeHacks resource.

Looking through the lens of self-harm

Annual Report of the Director of Public Health for Somerset 2018

Contents

Foreword

The emotional resilience of our population is important to us all. It is particularly important to the development of a young person progressing into adult life. The recent national focus on mental health has been a huge step forward in helping to dispel some of the myths and stigma associated with it, but there is still a significant way to go before mental health, and the services associated with it, are given the same level of attention as physical health.

Many of us can give a good account of what we should be doing to improve our physical health, but there has been far less focus on improving our emotional health and resilience and ensuring we have the skills to cope with the stresses and strains of everyday life and the responsibilities it holds.

One indicator of emotional resilience is the level of self-harm amongst the population. In 2016/17 there were 1,371 emergency admissions to hospital for self-harm across the whole Somerset population, but our understanding of the issue has been limited. Many people have a preconceived idea of what self-harm is and the possible reasons for it, but the issue is far from simple; in fact it's really complex. Because of this, it's important that we try to understand it more, starting with a definition that we could all use. The National Institute for Health and Care Excellence (NICE) uses the following definition:

"Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress."[1]

There are lots of facts and figures in this report and it does help with our understanding of self-harm in a small way, but the figures do not tell the whole story; they merely help us to raise the issue and indicate where there is a need for more work and more understanding.

In short, this is the first chapter of the story. Hopefully, it will capture the attention of the reader sufficiently to want to understand more, to want to help raise the profile of this largely hidden issue and to want to help do their bit to improve emotional resilience, particularly of our young people.

This year, I have used the Annual Public Health Report to try and achieve three things. Firstly, to gain a greater understanding of self-harm; secondly, to raise the profile of this issue in order to help tackle to stigma associated with it; and thirdly, to raise the importance of us all developing and maintaining our skills to cope appropriately with the stressors of everyday life.

The data supplement (APHR statistical annex) that accompanies this report can be found at the following link: http://www.somerset.gov.uk/organisation/departments/public-health/

Trudi Grant, MSc PH, UKPHR, FFPH
Director of Public Health, Somerset County Council

Executive Summary

Our ability to cope with stressful or traumatic situations, sometimes called our “emotional resilience”, can be different between individuals and at different times in our lives.

This report looks at the issue of emotional resilience, through the lens of self-harm. This is an indicator frequently used to help understand levels of distress and unhappiness within our community.

In Somerset we have seen an increase in presentations for self-harm in our hospitals and there is increasing concern from parents, schools and young people themselves about rising levels of self-harming behaviour.

This report has investigated emergency hospital admissions for self-harm and has found the increase in admissions is particularly driven by rising rates for girls and young women aged between 10 and 24. Rates were found to particularly peak at around the age of 15.

Rising emergency admission rates are, however, considered the tip of the iceberg. In a 2018 survey of Somerset secondary school pupils, 28% of females and 19% of males reported that they sometimes hurt themselves in some way when they feel stressed or worried.

The information contained in this report still only presents part of the picture. There is far more to be done to understand the level of emotional resilience, particularly that of our children and young people. There is a need to develop a greater understanding of self-harming behaviour, and what support is needed to help young people, their parents, teachers and others to better promote positive emotional health and wellbeing and resilience.

Fundamentally, we need to reduce the stigma associated with self-harm, and improve access to the support available. We need to help young people to develop the skills they need to cope with more stressful and traumatic situations in a less harmful way.

Perhaps the question we should be asking is not

“Why would you do that to yourself?”

but

“What led you to feel the need to hurt yourself?”

Introduction

Emotional resilience is our ability to adapt to stressful situations and cope with life's ups and downs. The word "resilience" actually comes from the Latin word "resilio" which means to "bounce back". Resilience does not take away life's difficulties, but it is what helps us to deal with problems and live through challenging times. A resilient person bends rather than breaks under pressure; is flexible and adaptable, rather than rigid and resistant. A resilient group or community also flexes and responds to adversity, supporting and protecting its most vulnerable members.

Positive indicators for community resilience include levels of social connectedness, which these days can include digital connectedness as well as people-to-people connectedness; the amount of support we have or feel we have from others around us, or conversely, how alone or isolated we feel; and levels of acts of kindness to others through formal or spontaneous voluntary actions.

Of course, things do not always turn out well, and there are some less positive measures we can look at to understand how resilient we are as a nation or a community. The most well-known indicator is the rate of death by suicide. Rates of suicide are monitored locally and nationally for just this reason. Whilst each individual death is a personal tragedy, the overall rate or trend of suicide tells a story about the health of our community and the hidden challenges which lie beneath the surface. Self-harm is another such indicator. Levels of self- harm also tell us a story. They tell us about levels of acute distress, about unhappiness and about a desire for things to be different. Each individual act of self-harm tells a story but all of those stories together say something very powerful.

What is self-harm?

The nature and context of self-harm

Self-harm is a significant health issue which impacts not only on the wellbeing of the individual, but also on friends, families and communities, together with an impact on health, education, social care and criminal justice services.

Definitions of self-harm

Definitions of self-harm are numerous and vary but a short definition is provided by the National Institute for Health and Clinical Excellence (NICE) defining self-harm as:

"an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress"

The Royal College of Psychiatrists state that at a wider level, self-harm *"may also take less obvious forms, including unnecessary risks, staying in an abusive relationship, developing an eating problem (such as anorexia or bulimia), being addicted to alcohol or drugs, or someone simply not looking after their own emotional or physical needs."*

Self-harm is a universal phenomenon which crosses all cultures, ethnicities, creeds and classes.

Self-harm is not usually an attempt to complete suicide (although it is considered a risk factor of suicide) or seek attention, but a way of expressing deep, emotional feelings, such as low self-esteem. It can also be a way to cope with traumatic events or situations, such as the death of a loved one, or an abusive relationship.

Self-harm may include:

- swallowing poisonous substances
- non-lethal overdoses
- cutting your skin
- burning your skin (usually with cigarettes)
- scratching or picking at your skin
- biting, including severe nail biting
- hitting or punching either yourself or an object
- punching and banging against things
- deliberately breaking your bones
- embedding items in the skin
- pulling out your hair

The National Preventing Suicide in England Strategy and the recent Public Health England Suicide Prevention Planning Guidance, highlights that self-harm, including attempted suicide, is the single biggest indicator of suicide risk. Similarly, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness indicated that self-harm was reported in 52% of under 20s who completed suicide[2].

The need to improve knowledge and good practice in supporting children and young people who self-harm needs to be a golden thread through all efforts to improve the mental health and emotional wellbeing of children and young people. This requires a whole system approach to look at self-harm both as a coping mechanism and as a risk factor to suicide.

Within this context, addressing self-harm in children and young people is recognised as a national priority[3]. A recent Young Minds report on "Talking self-harm"[4] reports that that:

- 1 in 12 children and young people are said to self-harm
- Over the past 10 years inpatient submissions for young people who self-harm has increased by 68%
- In females under 25 years admissions have increased by 77% in the last 10 years
- 77% of young people feel they don't know who to turn to with questions about self help
- 97% of young people believe that self-harm should be addressed in schools
- UK is thought to have the highest rates in Europe

'WHY I SELF-HARM'

- STATEMENTS FROM SERVICE USERS

Below are a series of statements provided by young people about why they self-harm:

"To convey feelings difficult to put into words"

"To express experiences as something visible"

"To replace emotional pain with physical pain"

"To escape traumatic memories"

"To stop feeling numb, disconnected or dissociated"

"To express suicidal feelings and thoughts, without completing suicide"

"To communicate severe distress"

Source: Salford University Training Day "Reducing and Identifying the Risk of Self-Harm"

The Somerset Transformation Plan for Children and Young People's Mental Health and Wellbeing (2015-2020) sets out the strategic direction, vision and principles for the changes to Child and Adolescent Mental Health Services. Self-harm is addressed within this plan as a key area for concern. The plan states that this should be seen within the context of mental health promotion, the emotional health and wellbeing agenda and action to prevent self-harming behaviours in the first place.

Reasons for self-harming behaviour

It is often difficult to understand why people self-harm, reasons can be complex and individual. Some people have said that by deliberately hurting themselves they are temporarily able to change their state of mind to better cope with painful feelings. Self-harm in these cases seems to provide a mechanism for dealing with intense emotional pain. Individuals report that the behaviour can help them to cope with negative feelings and to feel more in control. Others report feelings of wanting to punish themselves. Self-harm can be a way of relieving overwhelming feelings that build up inside, when people feel isolated, angry, guilty or desperate. However, acts of self-ham can also lead to a burden of emotional guilt and secrecy which can have a negative effect on a child, young person or adults' ability to build and maintain relationships. This compounds the problems even more. Self-harming can also become a pattern of addictive behaviour.

Some reasons given for self-harm among young people include:

- being bullied
- not getting on with parents
- stress and worry about academic performance and examinations
- parental separation or divorce
- bereavement and loss
- relationship breakdown
- illness or health problems
- unwanted pregnancy
- experience of abuse including sexual abuse
- difficulties with sexuality
- low self-esteem
- feelings of being rejected.
- pressure from social media

A person is more likely to harm themselves if they feel:

- people don’t listen to them
- hopeless
- isolated, alone
- out of control
- powerless – it feels as though there's nothing they can do to change anything.

People who self-harm usually try to keep it a secret from their friends and family. They often injure themselves in places that can be easily hidden by clothing, and they are very careful to hide the damage and scars.

Signs of self-harm include:

- signs of depression, such as low mood, tearfulness, a lack of motivation or interest in anything, or a lack of energy

- signs of low self-esteem, such as blaming themselves for any problems, or thinking they are not good enough for something.
- unexplained cuts, bruises or cigarette burns, usually on the wrists, arms, thighs and chest
- insisting on always keeping covered, even in hot weather

Dispelling the myths

Despite its prevalence and impact, our understanding of self-harm is incomplete and remains surrounded by myths and misconceptions.

Most commonly there is a belief that self-harm is an "attention seeking behaviour". Given that most self-harm is carried out in private and over a long period before help is sought, this is an unhelpful myth that often leads to a young person feeling more alone and not listened to.

Another belief is that people who self-harm must enjoy it. There is no evidence that people who self-harm feel pain differently from anyone else. The harming behaviour often causes people great pain. For some, being depressed has left them numb and they want to feel anything to remind them they are alive, even if it hurts. Others have described this pain as punishment.

The secrecy surrounding self-harm has led to a level of stigma that limits understanding and prevents a more open dialogue which would enable young people to access the support they need.

The Young Minds and Cello[5] report highlighted the following challenges:

- A third of parents would not seek professionals help if their child was self-harming
- Half of GPs feel they don't understand young people who self-harm and their motivations
- 1 in 3 teachers don't know what to say to a young person who self-harms

> *"You don't need to understand to listen and try to support me."*
>
> (Young Person with experience of self-harming)

5

What do we know about self-harm in Somerset?

Statistical definition of self-harm

Before moving on to discuss what we know about self-harm locally, it is important that we have a good understanding of what is measured.

In England, emergency hospital admissions are used as proxy for the prevalence of self-harm. It is, however, widely recognised that these hospital admissions do not reflect the true scale of self-harm. As discussed above, self-harm is often a hidden behaviour, which makes estimating the true prevalence difficult. It has been suggested that "community occurring self-harm" is far more prevalent than self-harm as measured by admissions[6].

In the self-harm statistics, admissions attributed to a different main cause, such as drugs and alcohol, are usually excluded in public health analysis, but there may be a fine line between these presenting issues for admissions.

Self-harm has been highlighted as an issue across the south-west region with only one upper-tier/unitary area, North Somerset, that is not significantly worse than England; this is true of all ages and of young people. Furthermore, it is a Somerset issue; the Somerset statistics for self-harm admissions are significantly higher than both the England and the south west average.

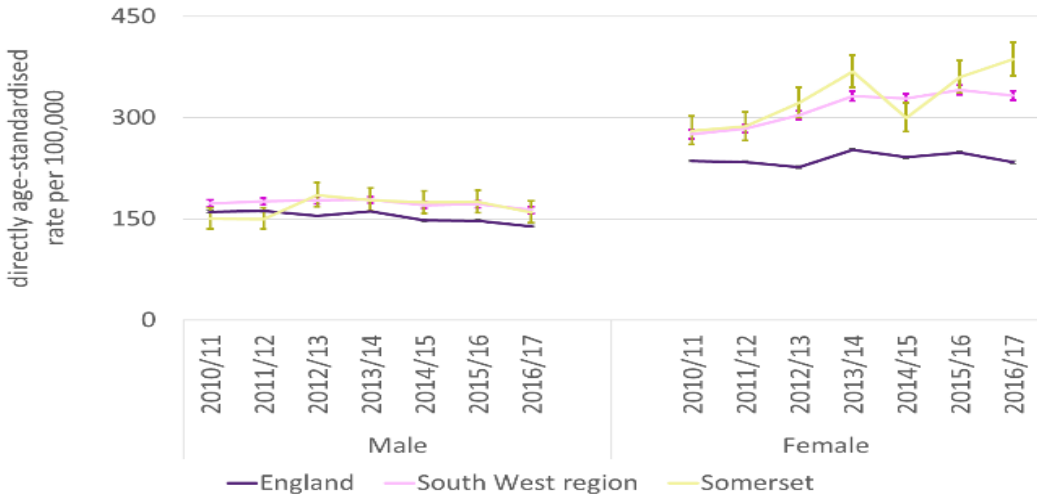
Self-harm admissions in Somerset

As can be seen from the graph below, many of the admissions are of younger age groups and this will be explored in more detail later. Probably as you would expect, almost all admissions for intentional self-harm were emergency admissions. We will focus the rest of this analysis predominantly on emergency admissions unless otherwise stated.

Published data from the Public Health Outcomes Framework (PHOF)[7] allows the Somerset levels of admissions for self-harm to be compared against national and regional data. Figure 1 shows Somerset's emergency self-harm admissions rates for all ages per 100,000 population. Somerset rates are significantly higher than the national rate for both males and females. The female rate is most concerning, being higher than the national and south-west rates and showing an increasing trend over time. Somerset had the 14th highest female rate of all upper tier local authorities in England (152 in total) for 2016/17, with the male rate being 55th.

Figure 1 illustrates that while the issue of self-harm is of concern for both males and females, the numbers and the rates are significantly higher for girls and women. In the next sections we have used other sources of data to investigate further.

Figure 1: Emergency hospital admissions for self-harm trend over time by sex, 2010/11 - 2016/17

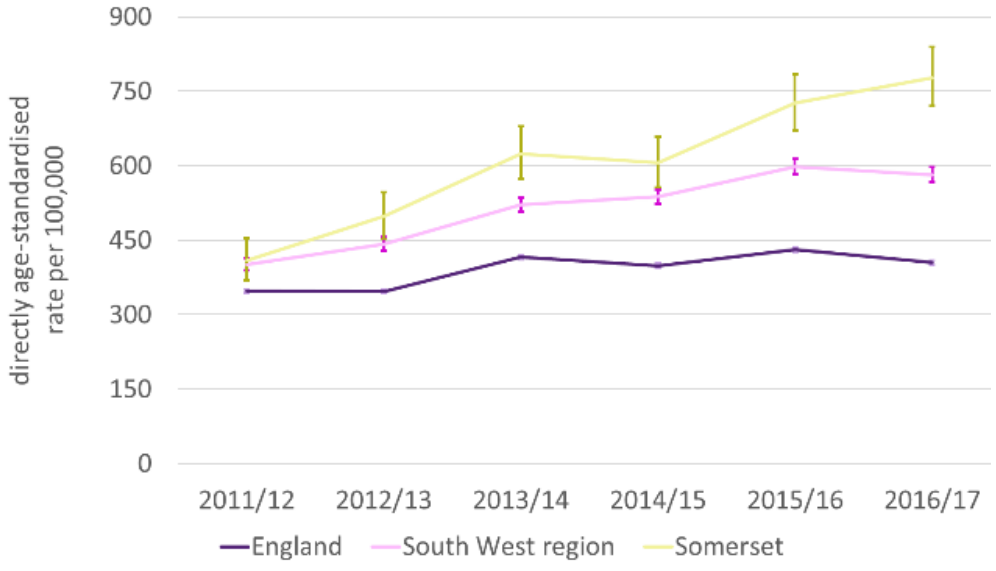


(Source - Public Health England, Public Health Outcomes Framework)

Young people's self-harm admissions

We can use the Public Health England Child Health Profile, for people aged 10-24, to investigate the patterns of admission broken down by age (but not sex) in a little more detail. The definition is similar, but includes all admissions, not just emergencies. As seen in Figure 2, Somerset's rates are consistently higher than the England and regional averages. Somerset has the fourth highest rate of hospital admissions for the 10-24 age group out of the 152 upper tier local authorities.

Figure 2: All hospital admissions for self-harm of young people (aged 10-24) trend over time, 2011/12 - 2016/17

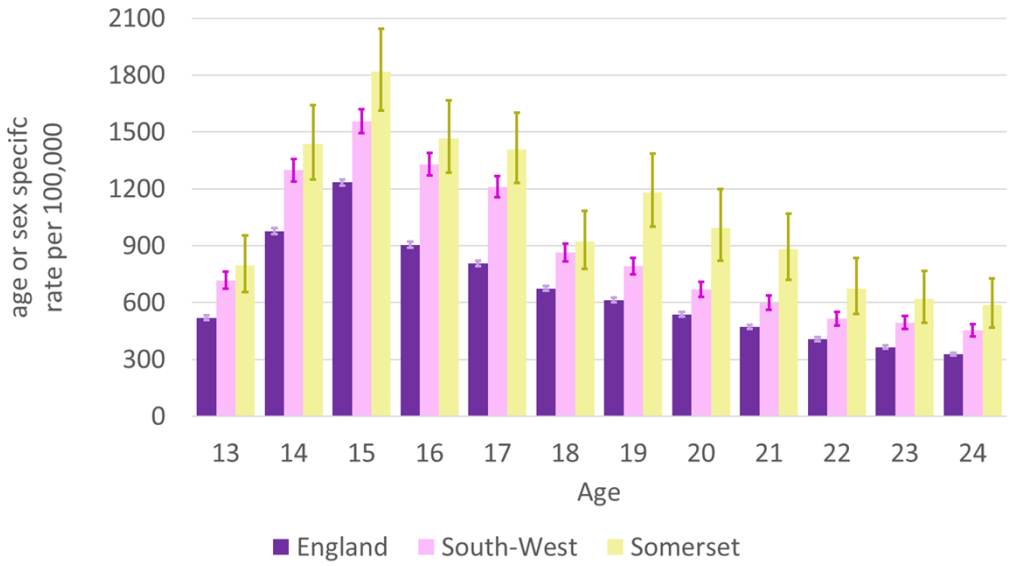


(Source - Public Health England, Child Health Profile)

So far we have only considered the total number of admissions, rather than the number of people admitted. A data source called “Hospital Episode Statistics” allows us to consider the number of people admitted. We have examined the period 2013/14 and 2017/18 for emergency admissions with a main cause of intentional self-harm.[8] The findings back up the picture we have so far.

Females are around twice as likely to be admitted than males, and young people aged 15-24 are the most likely age group to be admitted. Interestingly, the 45-54 and 55+ Somerset rates are similar to the rates for England and, statistically speaking, significantly lower than the south-west rates. Figure 3, showing the admissions broken down by both age and sex, demonstrates that the difference between the sexes is marked in the younger age groups (10–14 and 15–24). This difference is not seen to the same extent in the older age groups.

Figure 3: Individuals with an emergency self-harm admission per year by ten-year age-sex bands - 2013/14 - 2017/18



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Looking at single years of age (Figure 4) allows a more detailed look at the rates within the 15-24 age band. Emergency self-harm presentations by children under the age of 14 years are fortunately small and therefore have been suppressed for under the age of 13 years.

As can be seen in Figure 4 there is a distinct pattern of presentation for girls. Presentation for girls start to rise at around 13 years. The rates rise to a peak at age 15 and then decline year-on-year. This pattern of presentation is mirrored for England and the south west. However, the Somerset rates for girls and young women are significantly higher for each year of age than for peers across England. No similar pattern is seen for boys.

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Figure 4: People aged 15-24 with an emergency admission for self-harm per year by sex and single year of age - 2013/14 - 2017/18

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Re-admission ratios (repeat admissions to hospital)

Re-admission ratios allow us to measure repeat admissions and are simply the number of admissions divided by the number of people. A ratio of 1 would mean that everyone who was admitted at all was admitted only once; a ratio of 2 means that everyone was admitted twice in a year, and so on.

Table 1 looks at re-admission ratios amongst those people who have at least one re-admission in the same financial year. This shows that re-admissions for self-harm are lower in Somerset than both the national and regional ratios.

Table 1: Self-harm emergency re-admission ratios for self-harm amongst people with re-admissions

	England	South west	Somerset
Re-admissions ratio amongst people with 1+ re-admission per year	1.25	1.25	1.19

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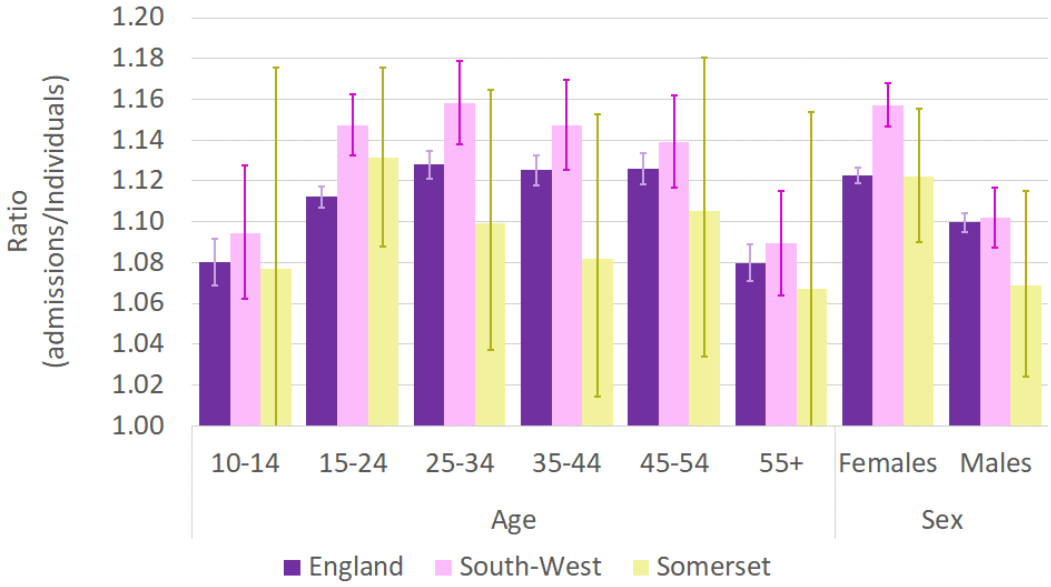
Figure 5 shows that in Somerset, for younger age groups (especially 15-24) more people are admitted to hospital each year for self-harm but on average fewer have a repeat admission in Somerset. This finding goes some way to helping us understand the overall rates of admission for self-harm. It now seems unlikely that the higher rates in Somerset are as a result of more people being admitted more often.

Figure 5: Self-harm emergency re-admission ratios per year by 10 year age bands and by sex, 2013/14 - 2017/18



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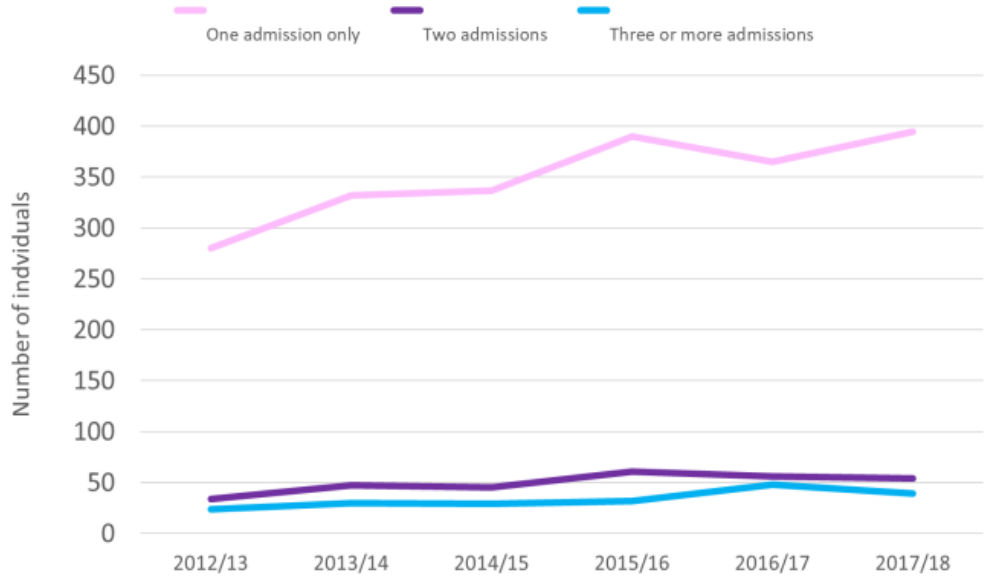
Specifically looking at the number of self-harm admissions for 10-24 year olds, Figure 6 shows a higher and increasing number of young people have one admission only; those with two or more admissions has stayed relatively low and constant over time. It would seem from this evidence that single admissions are driving increased rates in Somerset.

Figure 6: Number of self-harm admissions for young people aged 10 – 24



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Emergency admissions for self-harm - methods

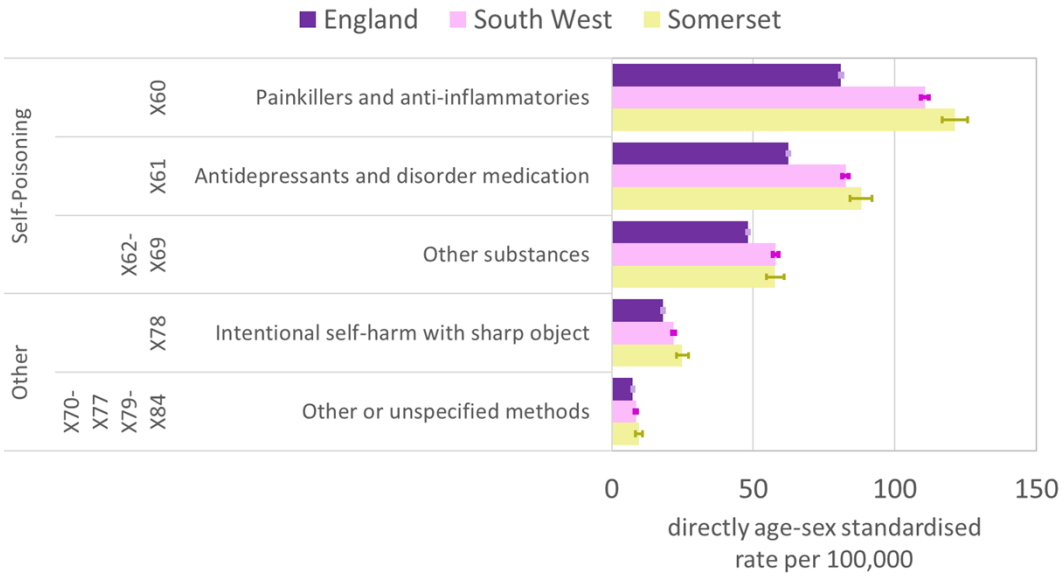
Turning our attention to the types of self-harm that warrant a hospital admission, it is important to understand the main codes used in hospitals that make up the national self-harm indicator.

The analysis of self-harm methods is based on admissions not individuals, because the same people may present with different methods of self-harm at different times. These methods are given different ICD10 (International Clarification of Disease) codes. This allows national and international comparisons to be made.

Figure 7 shows the emergency admissions to hospital by the recorded method of self-harm. Somerset admission rates are significantly higher than England for all methods. In Somerset there are annually about 1,350 emergency admissions against all of the codes for self-harm. The highest, approximately 1,200 emergency self-harm admissions (89% of all presentations in Somerset) are due to self-poisoning, sometimes referred to as overdose.

The ICD-10 codes are very detailed and medical , particularly in the case of some of the poisoning codes. Therefore, although not an official definition, code X60 (intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics) can be thought of as overdoses due to over the counter medications such as paracetamol, ibuprofen and aspirin. Similarly code X61 (intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified) can be thought of as anti-depressants and anti-disorder medication for conditions, such as Parkinson's and Epilepsy. The largest group of presentations for self-harm due to poisoning in Somerset, is coded as x60, those which are over the counter medicines such as paracetamol, aspirin and ibuprofen.

Figure 7: Emergency hospital admissions (all ages) for self-harm by method, 2013/14 - 2017/18



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Emergency admissions for self-harm by all methods are most common for females aged 15-24. In addition, Somerset has significantly higher rates for females in this age group when compared to England across all methods.

Admission due to overdose as a result of painkillers and anti-inflammatories, and admissions as a result of intentional harm with sharp objects, were higher for females aged 15-24. Rates for younger females aged 10-14 are also attributable to these methods. The rate for males aged 15-24 admitted due to overdose as a result of painkillers are also significantly higher than for England. However, the rate for girls of this age locally is still more than three and half times higher than for boys.

It should be noted that the guidance for paracetamol overdoses was changed in 2012 (this is a change to guidance, not coding of admissions, so we do not see a commensurate fall in another type of admission). Bateman et al. (2014) found that:

"There was a significant increase in the number of admissions following the implementation of this guidance estimating an increase from 31.1 per 1,000 to 49.0 per 1,000."[9]

Naryan et al.[10] found that

"Changes to the management guidelines for paracetamol poisoning in September 2012....have particularly increased paediatric hospital admissions for paracetamol poisoning."[11]

This change of guidance was applicable nationally and may account for some of the overall upwards trend for this method of self-harm, but it does not explain why Somerset has significantly higher admission rates than nationally.

Although the admission rates of self-harm with sharp objects are smaller, they should not be overlooked: these too are significantly higher in Somerset for 15-24 year olds and for females aged 10-14 than the south-west and England averages.

In Somerset, 40% of individuals with an emergency admission due to intentional self-harm with a sharp object also had one due to self-poisoning in the same year. However, only 4% of those with self-poisoning were also admitted for self-harm with a sharp object. This suggests that two in five people who cut themselves (seriously enough to be admitted) will also take an overdose, while someone with a self-poisoning admission is very unlikely (3 in 100) to also have an admission caused by self-harm with sharp objects[12].

Self-harm and social deprivation

We have already looked at patterns of self-harm admissions by age, gender and method. We can also look at patterns within Somerset by geographical spread and the social deprivation.

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation attempt to

measure a broad concept of multiple deprivation, made up of several distinct dimensions, or domains of deprivation.[13] We can investigate admissions for self-harm to see if there is an association with deprivation.

Figure 8 and Figure 9 show that emergency self-harm admissions are statistically significantly higher in more deprived communities. People living in the most deprived 20% of Somerset (quintile 1) are two and a half times more likely to be admitted for self-harm than people living in in the least deprived 20% (quintile 5).

Figure 8: Self-harm emergency admissions (all ages) by deprivation within Somerset, 2012/13 – 2017/18

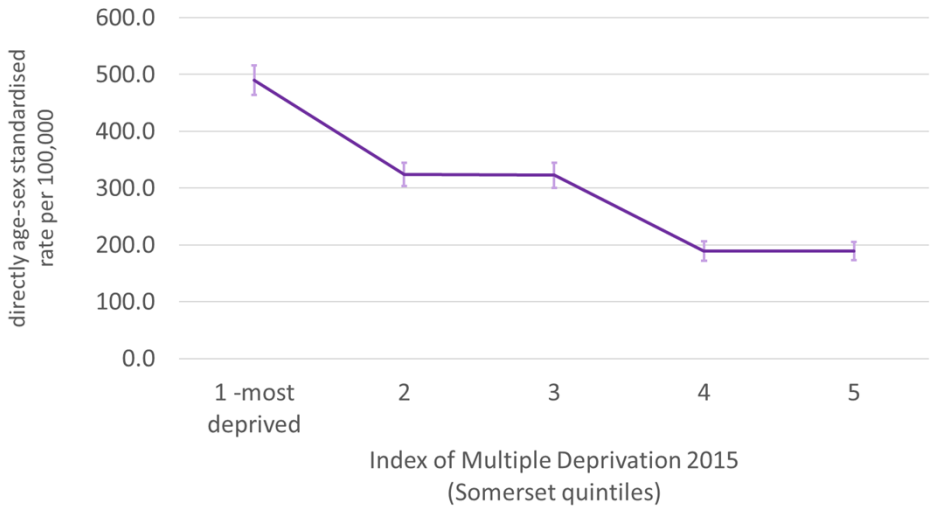

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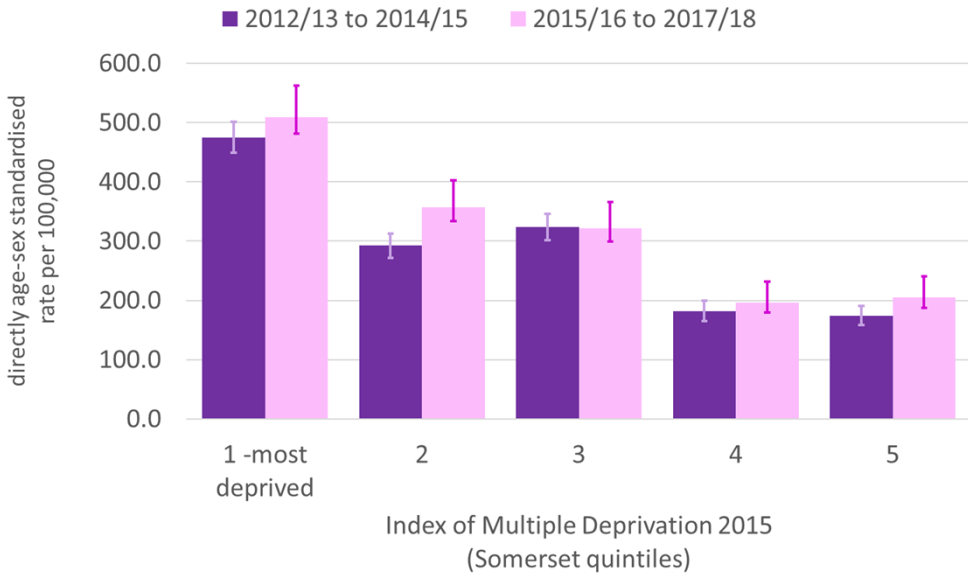
Figure 9: Self-harm emergency admissions all ages by deprivation within Somerset, 2012/13 – 2017/18



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13

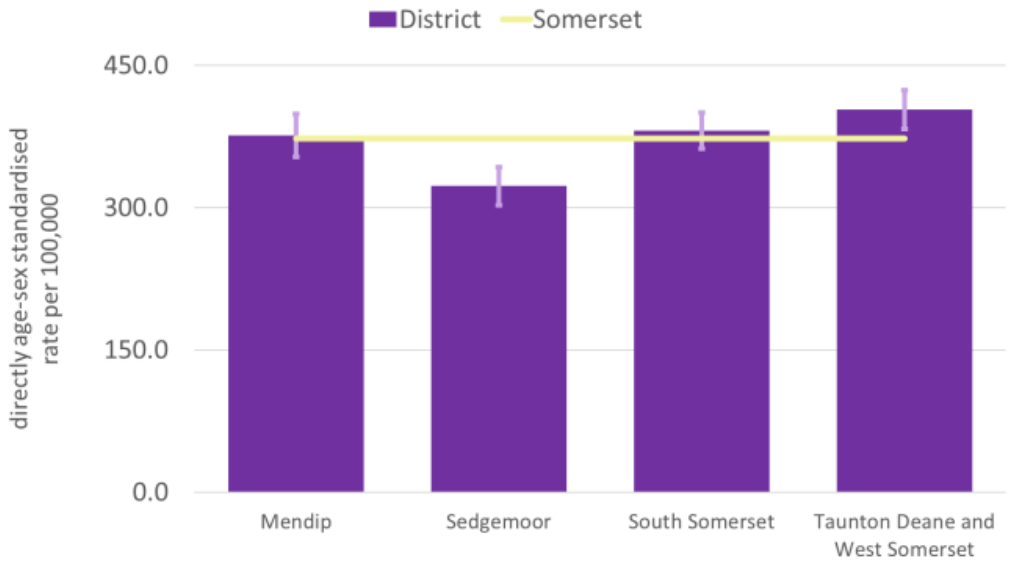
Figure 9 shows how rates for each of the deprivation quintiles have changed between the three-year pooled periods, 2012/13-2014/15 and 2015/16-2017/18. Whilst there is an upward trend between the two time points, for almost all the quintiles, this is only a statistically significant difference in quintile 2.

More detailed analysis[14] which examines the data by age and sex, finds two distinct patterns. There have been statistically significant increases amongst young people aged 15-24 of both sexes in the most deprived quintile and amongst females aged 10-14 and 15-24 in the second-most deprived quintile. However, there have also been statistically significant increases for young women aged 15-24 and 25-34 in the least deprived areas. Self-harm is currently predominantly higher in in more socially deprived areas but it is also increasing in the least deprived areas of the county.

Self-harm emergency admissions by district

We can also look at the differences in rates of hospital admissions between districts. (West Somerset has been combined with Taunton Deane due to small numbers). Figure 10 shows there are significantly lower rates of admissions from Sedgemoor when compared to the Somerset average (this is particularly seen for females aged 15-34); and significantly higher rates for Taunton Deane and West Somerset (the cumulative effect of slightly higher rates in all age-sex groups).

Figure 10: Individuals (all ages) with an emergency hospital admission for self-harm 2013/14 - 2017/18



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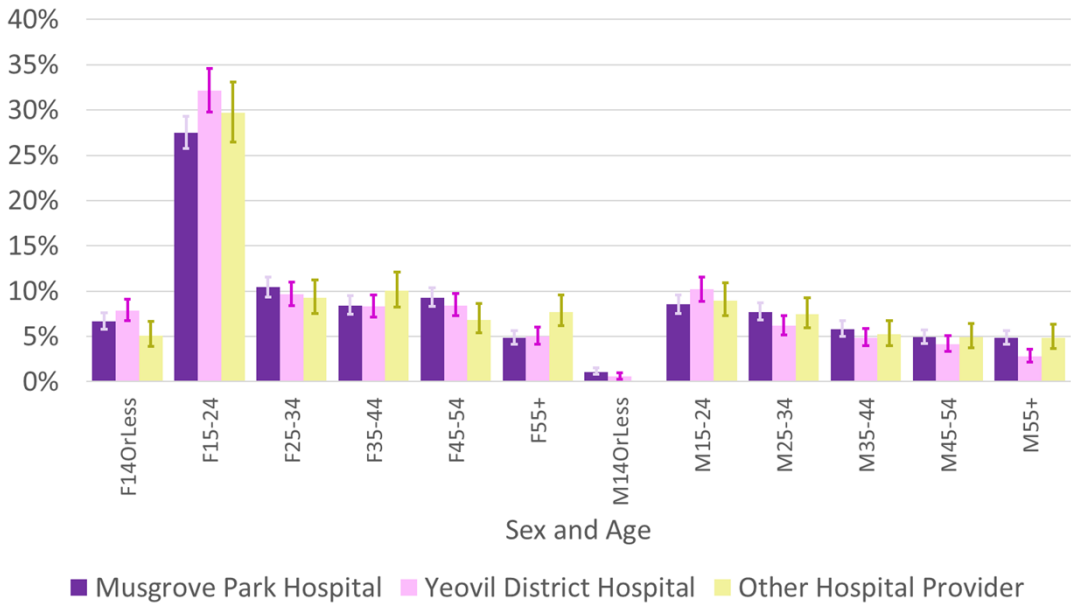
As can be seen in Figure 11, there is little difference in admission rates for self-harm to each of the local NHS hospital trusts, with the highest proportion of admissions to all hospitals being amongst females aged 15-24.

14

Figure 11: The proportion of emergency hospital admission of Somerset residents for self-harm by age-sex bands and NHS hospital trust 2013/14 - 2017/18



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Gaps in our understanding

This analysis uses information available to us to understand patterns of self-harm. However, we recognise that there are significant gaps in our knowledge, particularly because we cannot link the data held by different organisations. Some areas that we would like to understand further are:

- The overall prevalence of self-harm in the population
- Self-harm amongst vulnerable and protected groups
- The patterns and reasons behind self-harm behaviours
- Links with specialist services such as mental health, substance misuse and domestic abuse services
- Correlations with other diagnoses
- The links between self-harm and suicide
- Self-harm method and life-course approach.
- Discharge destination
- Multi-method presentations[15],[16]

15

What are people telling us about self-harm and mental health?

The discussion so far has been based on hospital presentations, which does not give us much information about other types of presentation or need. To get a deeper understanding we need to listen to the people who have experienced self-harm, to parents and to people working in related support services.

The experience of children and young people

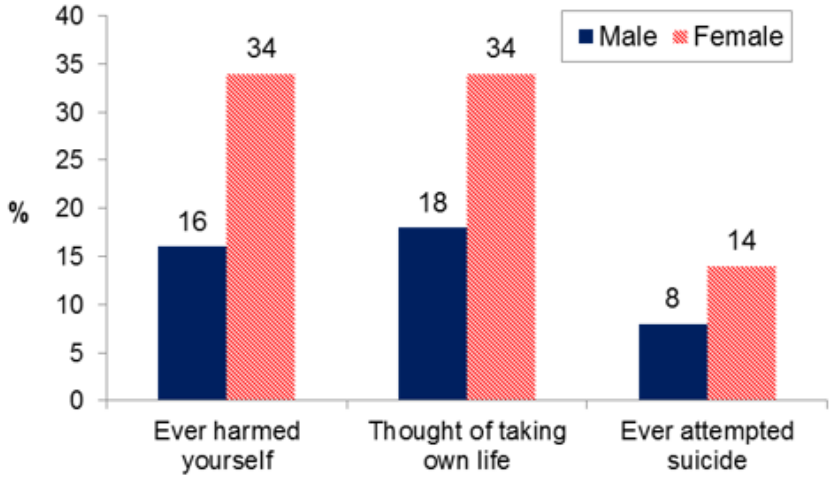
Self-harm is one of the questions included in the Somerset Children and Young People Survey[17] and is probably the best source of information we have about the overall prevalence of self-harming behaviour among Somerset young people. In spring 2018, this survey found that 28% of secondary school aged girls, and 19% of boys at least sometimes dealt with a worrying problem by hurting themselves (Figure 12).

These figures are similar to findings in the 2016 survey, where a rather differently phrased question gave figures of 34% for girls and 16% of boys having "ever harmed yourself" (Figure 13). Importantly, these figures are consistent with the view that self-harm is more widespread than is covered by emergency admissions alone.

Figure 12: Percentage of secondary pupils responding that, when they are struggling/ feel bad or stressed/have a problem that worries them, they at least "sometimes" deal with it by the means described above

	Boys		Girls	
1	Spending time on the computer/ gaming etc.	89	Relaxing (e.g. listening to music, being active etc.)	91
2	Relaxing (e.g. listening to music, being active etc.)	89	Crying	88
3	Speaking to/confronting the person who is causing you to worry	56	Speaking to/confronting the person who is causing you to worry	56
4	Lashing out in anger (verbally or physically)	55	Lashing out in anger (verbally or physically)	52
5	Crying	45	Spending time on the computer/ gaming etc.	52
6	Eating more	37	Eating less	49
7	Eating less	24	Eating more	47
8	Hurting themselves in some way	19	Hurting themselves in some way	28
9	Drinking alcohol	10	Drinking alcohol	15
10	Smoking	8	Smoking	10
11	Taking drugs	6	Taking drugs	6

Figure 13: Self-reported self-harm and suicidal thoughts for Somerset schoolchildren 2016



Source: SCYPS/SHEU

The experience of parents

Parents need access to information and resources to help them to understand and respond to the needs of their children. Seeing your child deeply unhappy or in acute emotional distress is extremely challenging. Fear and stigma associated with mental health problems, and with behaviours such as self-harm, make things even harder. And of course, parents feel a sense of guilt or failure, however misplaced this may be. As the "Cello" report says:

"Parents associate a young person self-harming with failed parenting and shame; many are frightened to let the issue "out of the home": over a third say they would not seek professional help."[18]

The experience of professionals

In compiling this report, we have talked to a range of professionals, four themes emerged from these discussions. These are outlined below.

Self-harm is a complex – and it has many forms

Whilst self-harm is usually taken to be cutting oneself and self-poisoning, it can also take other forms. The self-harm will inevitably be a symptom of other issues, worries and concerns. It's not an easy subject to talk about and not all professionals feel equipped to respond.

"National research in 2012 found 53% of GPs thought that self-harm had increased, with only 4% thinking it was in decline. Normally young people are less concerned than GPs, teachers and parents about issues, but self-harm is the one issue where everyone shares an equally high level of concern."[19]

Having a better understanding of the different needs behind self-harm and the patterns of presentation will be helpful in formulating an appropriate response. We can see, for example, even from this limited analysis that there is a peak of presentation for young women at around 15 years of age, the majority of which do not appear to re-present.

Self-harm as a response to increasing pressure on young people

Anecdotally, teachers, health professionals and others have said that there is increasing evidence of difficulties due to emotional distress and mental health problems among young people in Somerset. Professionals attribute this anecdotally to:

- overall, increased stress and pressure for children and young people from the internal and external expectations of a modern world
- the impact of social media (evidence suggests that social media contributes 25% to the shaping of young people's views on self-harm, albeit significantly less than the 45% from talking to friends)
- the need to perform well academically

The perception of increasing mental health problems may, of course, also reflect the greater willingness to discuss mental health problems and so be, counterintuitively, a "good thing".

If stress is indeed a causal factor, there are a range of steps which can be taken to support young people, schools and families to understand and manage stress better and to develop both individual and group resilience.

Furthermore, whilst raised as an issue of concern, it should also be noted that social media can also be source of support and social interaction, particularly in more rural sparsely populated areas. This was a finding from the qualitative research done by the Rural Youth Project to support the 2014-15 Joint Strategic Needs Assessment[20].

The complexity of "the system" - difficulty finding information and help

Parents, children and teachers have said repeatedly that they find it difficult to know where to turn for help in relation to emotional distress and mental health problems, and more broadly, how they support teenagers struggling with the normal challenges of adolescence and guiding them towards appropriate coping mechanisms when in distress. Dr Alex Murray told us that many GPs find a typical appointment slot far too short to deal with self-harm appropriately, and they need more information on where to refer young people who harm themselves, especially those who do not reach the threshold for CAMHS.

For self-harm specifically "nearly four in five young people say they don't know where to turn"[21]. This is something which, particularly in the digital age, we should certainly be able to do something about.

Access to support

CAMHS is both the main, formal provider of mental health services for children and young people and the best known. CAMHS are commissioned to provide specialist community and inpatient provision for 0-18 years olds with severe, complex and

persistent mental health conditions. They offer a number of different treatments by a range of professionals. Following an admission to hospital for self-harm, all children and young people receive a risk assessment which would help inform the most appropriate route of support.

Self-harm is for the most part perceived as a mental health problem and there is a general frustration about access to help. The expectation is quite widely held that this support should come from the Child and Adolescent Service (CAMHS).

CAMHS, however, are services for children and young people who require specialist treatment for a mental health problem and not all young people who are self-harming have a mental health problem. They are experiencing distress, they are hurting, they may be confused, fearful, angry and sad; but the fact that the majority of hospital presentations are single episodes tells us that we should not over-medicalise this issue, but understand it, and respond more effectively in other ways. Of course, intervention needs to be appropriate and timely and there are examples where appropriate support could reduce the demand at the higher levels.

Recognising that many young people utilise and are familiar with online services, Somerset has invested in Kooth, an online support and counselling service specifically for young people aged 11 to 18. This service is highlighted further in the next section of this report.

What have we learnt so far?

Self-harm is a complex issue and one which is of concern to young people, their families and their teachers. In writing this report, we have heard concerns that people admitted to hospital for self-harm may not have easy access to appropriate support. Parents, carers and young people have a clear need for easily accessible information and support around self-harm. There is also a view that services other than CAMHS are patchy in coverage, uncoordinated and often under-resourced.

From the emergency admissions data, it would appear that the higher rates of admissions for self-harm are largely driven by rates for young women aged between 10 and 24 and predominantly are as a result of paracetamol overdose. Most of the admissions are a single occurrence with no repeat admission within one year for self-harm.

Whilst young women appear to be significantly at risk of admissions for self-harm, and need a particular focus, we must not forget that this is an issue for all ages and for some boys and men.

It is clear from the survey of secondary school pupils 2018 that the emergency admission rates only provide part of the picture regarding the prevalence of self-harm. Self-harming behaviour is more widely experienced by Somerset young people and to a degree is a “hidden issue”.

Promoting and protecting the mental health of children and young people in Somerset

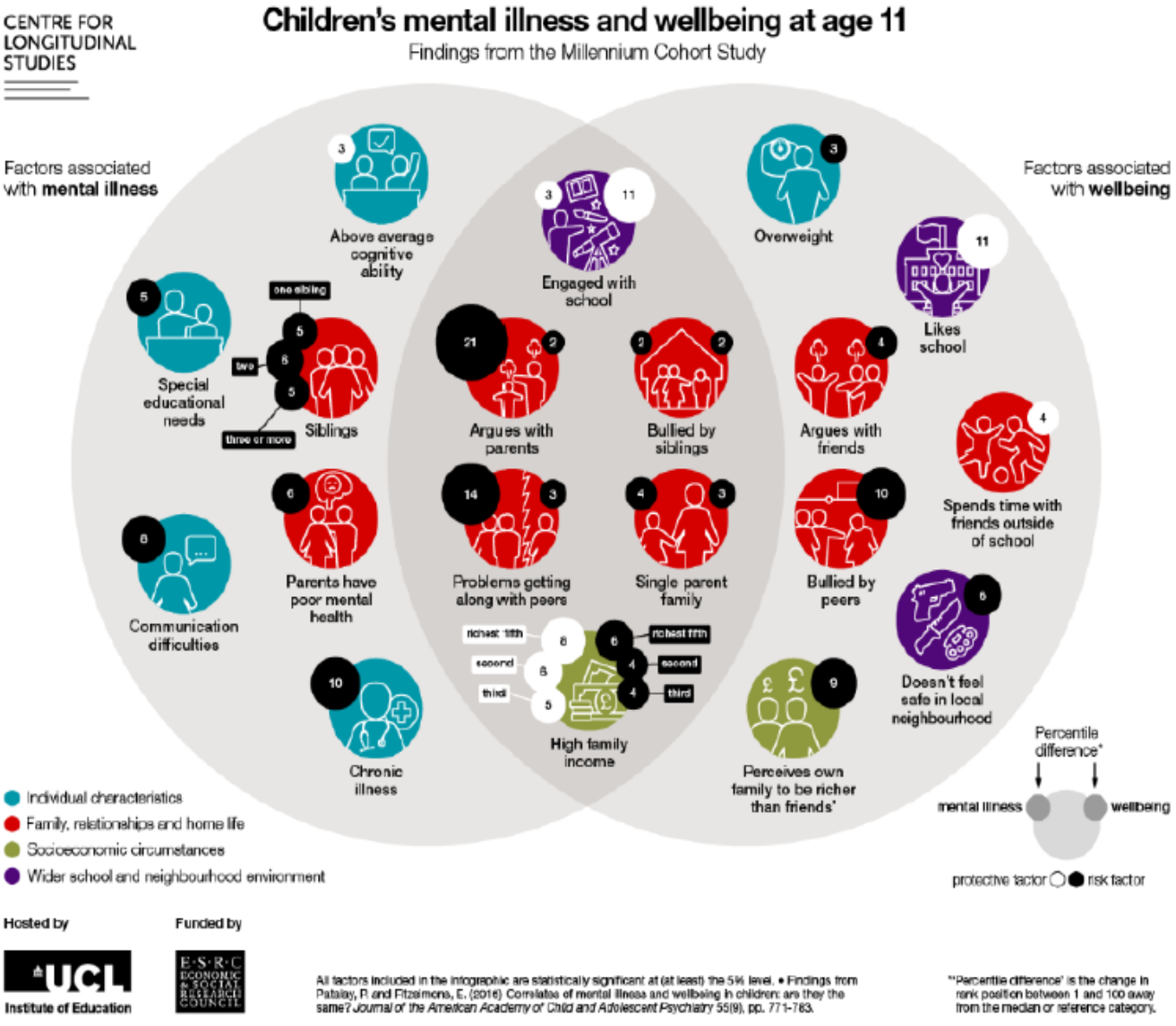
Mental health is central to all health and wellbeing. It is defined as the ability to cope with life's problems and make the most of life's opportunities. It is about feeling good and functioning well, as individuals and as communities. Good mental health is more than the absence of mental illness - it is the foundation for wellbeing. It is something you have to take care of, rather than take for granted. It is based on creating the right conditions for good mental health and wellbeing and on ensuring early interventions are in place when things start to go wrong. Improving mental health goes hand in hand with improving physical health for children and young people. Evidence and action to promote and protect positive mental health is clearly set out the in Positive Mental Health for Somerset Strategy (2014) and the national Prevention Concordat for Better Mental Health (2017).

Protective and risk factors

It is important to focus both on the factors that help promote mental health, as well as to reduce the risk factors that damage mental health. Good mental health allows children and young people to develop the resilience, referred to earlier in this report, to cope with whatever life throws at them and grow into well-rounded, healthy adults.

Figure 14 illustrates the interplay between intrinsic factors such as "enjoying school"; external factors such as being bullied; biological factors such as being overweight; development factors such special educational needs; social factors such friends and family; and socioeconomic factors such as poverty.

Figure 14: Protective and Risk Factors for Children



Prevention

Professor Sir Michael Rutter, renowned Child Psychiatrist, suggests we should think about resilience in the same way that we think about biology. If you want to protect people against infections, you don't put them in a cocoon and stop them ever having contact with bacteria and viruses - you expose them. But you expose them in ways that they can cope with, either through natural exposure or through vaccination. So the psychological equivalent is to say: what could we do to enable children to cope successfully with hazards? Because challenges, stress – that's part of growing up and you have to learn to cope, and the only way you learn is through exposure, but in small "safe" doses.

Evidence from a series of reports examining the prevalence of Adverse Childhood Experiences (ACEs)[22] in the Welsh adult population and their impact on health and wellbeing across the life course shows that there are key resilience assets that **every** child benefits from. These include experience of: *adult availability*, *a range of opportunities, being treated fairly, culturally engaged, having supportive friends and having good role models.*

Work undertaken in Somerset in partnership with primary, middle, secondary and special schools, as well as pupil referral units, has drawn from recent research[23], [24] resulting in the development of a Somerset Wellbeing Framework in collaboration with schools, parents (parent carer forum), the SHARE team (Somerset Partnership), Parent and Family Support Advisors and the Educational Psychology Service.

Somerset Wellbeing Framework

The framework has been developed to support schools to promote a whole-school approach to mental health and wellbeing, based on resilience and community building for staff, pupils and families. What this translates to is a conscious and fundamental shift in how schools respond to the children and young people in their setting with much greater emphasis, at a universal level, on building resilience.

Somerset County Council's Public Health Team has worked with schools to pull together the key findings from this work and to develop the framework as a whole-school approach. The key features of the framework are:

- Developing a sense of belonging and connectedness with the place you go to school; where you feel safe, valued and where you are enabled to develop a sense of purpose
- Building positive and caring relationships where children and young people have a voice, are heard and listened to by the adults around them and are given the opportunity to develop and practice emotional literacy
- Development of individual skills around self-care and a deeper understanding of how to promote/support wellbeing for yourself and others
- Access to the right information at the right time which is appropriately aimed at young people and includes ways to enhance wellbeing, prepare for times of stress and organisations that young people can contact
- Availability of suitable/relevant/expert services and resources when they are needed including staff with good levels of awareness and understanding around mental health, promoting resilience and managing young people's mental health behaviours including self-harm
- All of the above linked to wider community of the schools including parents and adults within children and young people's services

22

The main reason teachers say young people *stop* self-harming is that they learn to cope better with the emotions associated with it. There is an opportunity to educate about the emotional states that can lead to self-harm. Teaching emotional awareness and literacy creates a platform for raising the topic of self-harm in context.

The Somerset Wellbeing Framework includes targeted support with access to help for those that need more:

- Skilled staff and wellbeing leads
- Prompt identification of children and young people that need more
- Appropriate school-based intervention
- Links to local specialist provision
- Reviewing and monitoring mechanisms.[25]

'I feel positive about this work and difference it will make to the children and families in my school. It provides a great framework for improving what we do and there seems to be much more join up and clarity about where we can get additional support.'

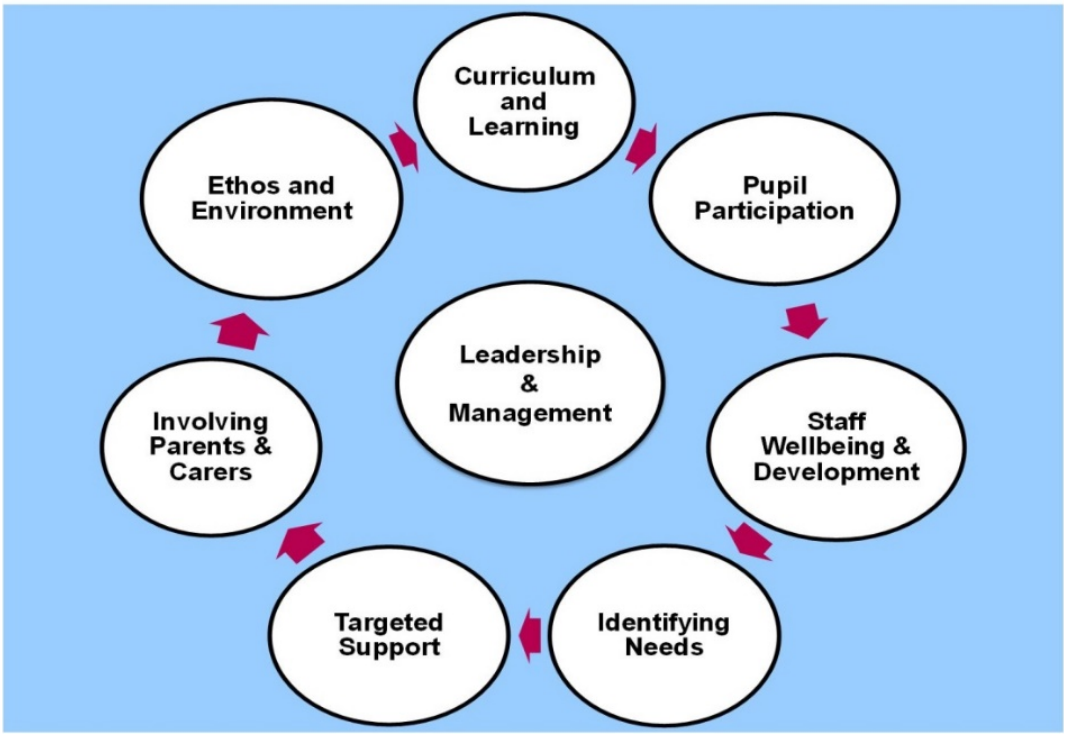
Head Teacher - Primary School

"Mental and emotional health has become a real issue in recent years and we know it is something we have to prioritise if we want the best out of young people. This framework will help us to gauge where we are and what more we can do."

Deputy Head – Secondary School

The framework uses the "eight principles" model developed by Public Health England (Figure 15) to achieve a holistic approach to wellbeing. The principles underpin an effective whole-school approach and provide the scaffolding needed to cover every aspect of school life.

Figure 15: Eight principles of a whole school approach



The latest research about promoting wellbeing suggests that there are some basic building blocks that have a real impact and - practiced from an early age - will provide a strong foundation for children and young people's emotional health. The pillars (Figure 16) are framed around three areas that coincide with the school year:

- developing a sense of belonging
- forming and sustaining positive relationships
- adopting healthy lifestyles

Schools, alongside families, are well placed to provide the support children and young people need to explore and develop these pillars. The importance of schools as a setting to promote and protect mental health has been identified nationally. Additional resources are being made available for schools through the NHS; these will focus on early intervention and whole school approaches for positive mental health.

Figure 16: Three Pillars of Wellbeing

Sources of support

Whilst prevention is extremely important, so is access to timely and appropriate help and support. As we have seen, children and young people's mental health is everybody's business – not just the business of specialist services.

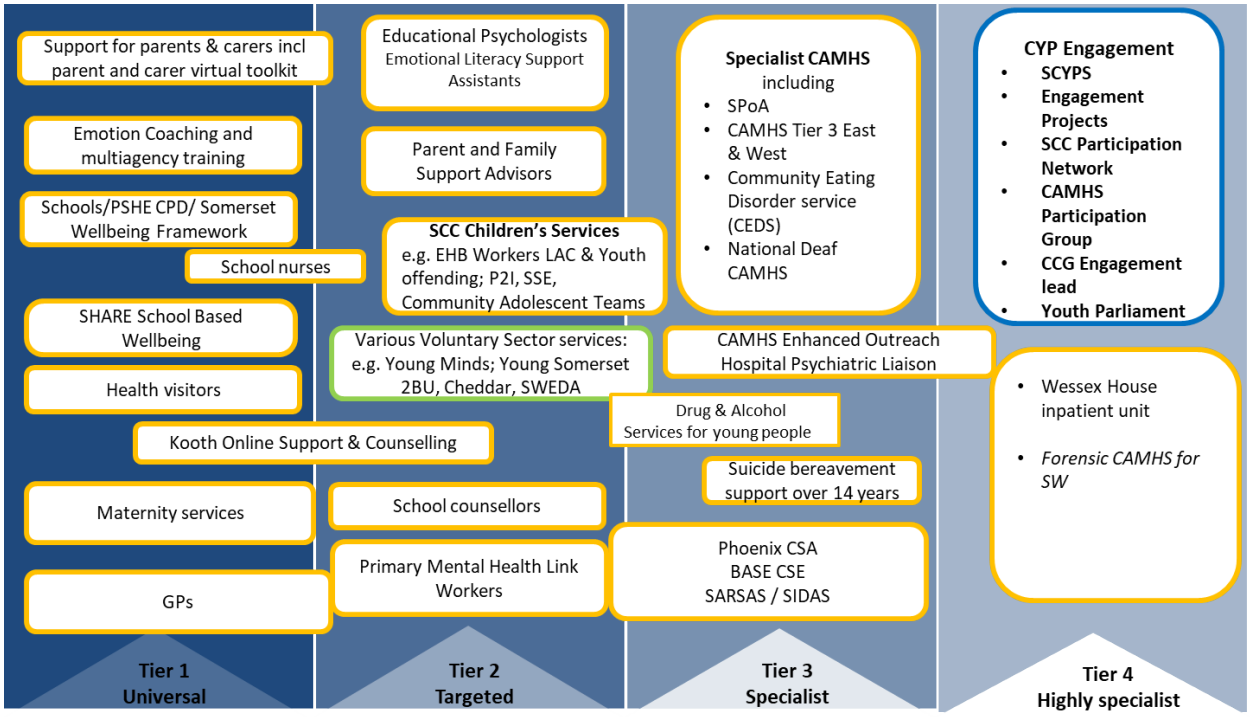
Help and support can be found in many forms and settings; in schools and communities, as well as health, social care and voluntary settings. Sometimes the most effective help and support comes informally from family and friends. Indeed, often only the most serious and recurrent self-harm is ever seen by health services.

> *"Having the time and opportunity for self-management may be enough for some people to make it through a difficult patch and of course, increasingly help and support is sought and available online."*
>
> *Dr Alex Murray, GP and CCG Clinical Lead for Mental Health*

The three most common ways of coping with problems/worries, amongst Somerset secondary school pupils, were "playing computer games" (boys), "playing music" (girls) and "talking to someone about it" (both).

Figure 17 below, describes a range of different support available in Somerset to meet different levels of need. This is by no means all that is available, but it serves to illustrate both the range of provision and something of the complexity which makes it difficult for young people, parents and teachers to work out where to go for help.

Figure 17: Emotional health and wellbeing support services for children and young people in Somerset

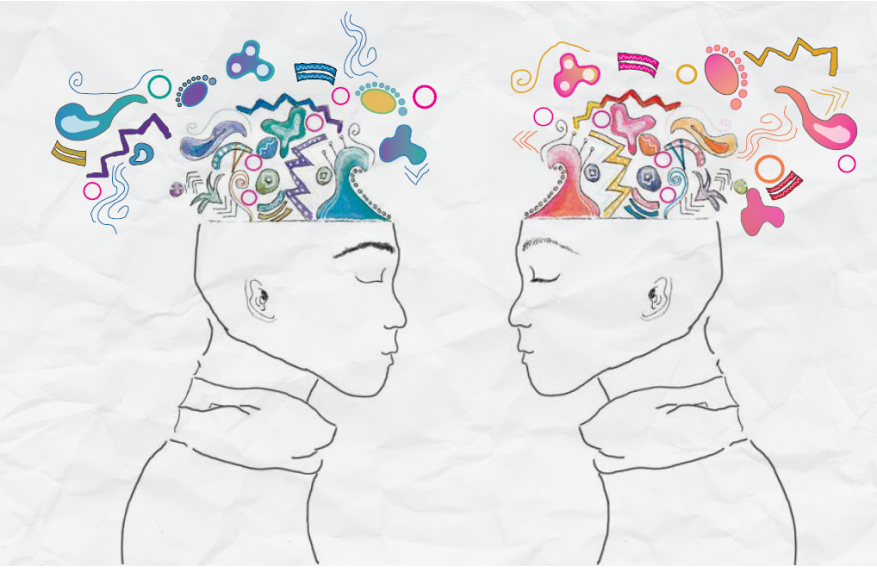


Some other important sources of help

Emotion Coaching

Emotion Coaching is a programme which teaches pupils and their teachers the principles of resilience and stress management. Year 8 students in schools who received Emotion Coaching are more likely to be able to say "no" to someone who is asking them to do something that they don't want to do (66% vs. 59%). Teachers who have engaged with the programme have reported more effective management of emotional and behavioural issues at school.

LifeHacks



Young people in Somerset have helped developed "Lifehacks[26]" to support themselves and each other.

Resources which have been produced include The Little Book of Mental Health LifeHack – Looking After Yourself which is packed with ideas and links to support people's own mental health and includes true stories from people who've tried them out.

There is also a Little Book of Mental Health LifeHacks to Support a Friend which is packed with ideas and links to support the mental health and again includes true stories from friends who've tried them out.

"We've been thinking about how to help ourselves manage our mental health and how to help our friends when they're struggling too. So we've come up with a set of LifeHacks to help you and your friends to keep mentally healthy!

Mental health is something you DO, not something you HAVE. We want to help you and your friends take action for positive mental health!"

Young person involved in

26

Online support

> *'I got all my support via the internet from other young people like me when I was self-harming. They didn't judge me and they understood it was a coping mechanism and not linked to me necessarily wanting to kill myself. There is such a panic about self-harm and other young people understand what it's really about.'*
>
> *A Somerset Young Person*

Social media has become a space in which we form and build relationships, shape self-identity, express ourselves and learn about the world around us. We must therefore strive to understand its impact on mental health. Social media is often cited as adding pressure on young people, but the internet can be a support as well. Social media platforms can promote a sense of community and facilitate the provision of emotional support.

"Kooth" is an online programme (https://kooth.com/) commissioned in Somerset to provide online support and counselling for young people aged 11 to 18. Kooth recognises that services have to "be where the young people are", especially in times of difficulty.

Facebook's suicide prevention tool launched in the UK in January 2016. If users believe a friend's post indicates self-harm or is suicidal in nature, as well as reaching out to them directly, users are able to anonymously report the post to Facebook. The post will be reviewed by Facebook's support team, and if appropriate, the author of the post will be offered a series of options via a private message screen, including access to support lines, resources or a prompt to reach out to their friends and family for help.

Harm Reduction

Unfortunately, for some young people "self-management" may actually mean harming themselves. The evidence suggests that this is typically cutting the body, rather than the overdoses identified as typical of emergency hospital admissions. Indeed, we know that some charities teach young people how to cut themselves safely – cleanly and hygienically – to reduce the physical danger. (Needle exchange is a similar type of harm-reduction initiative.) Self-harm can be a way for young people to cope with pressures at school or work, bullying, breakdown of relationships or sexual physical or emotional abuse.

> *'I "needed" to harm to punish myself for being what I believed to be a terrible person and to clear the fog in my head. As soon as I did, I'd feel in control, calm and as through a reset button had been pressed in my head.'*
>
> *MIND - Understanding self-harm 2013*

It is a difficult paradox that deliberately harming yourself is something that you do to try to help yourself with things that feel unmanageable. However, this underlying intention of taking care of yourself is exactly what can be harnessed to help people find a more constructive way forward. Although it takes time, courage and determination, there are ways to learn to manage difficult feelings differently and to be freed from the painful burden of self-harming urges.

Conclusion and Recommendations

This year, I have devoted my report to looking at emotional resilience and self-harm, particularly in relation to children and young people.

In Somerset we have seen an increase in presentations for self-harm in our hospitals and there is increasing concern from parents, schools and young people themselves about rising levels of self-harming behaviour.

This report has investigated emergency hospital admissions for self-harm and has found the increase in admissions is particularly driven by rising rates for girls and young women aged between 10 and 24. Rates were found to particularly peak at around the age of 15.

Rising emergency admission rates are, however, considered the tip of the iceberg. In a 2018 survey of Somerset secondary school pupils, 28% of females and 19% of males reported that they sometimes hurt themselves in some way when they feel stressed or worried.

The more important message is that the pattern of self-harm we are seeing in Somerset is telling us something about the emotional distress which young people are experiencing.

The information contained in this report still only presents part of the picture. There is far more to be done to understand the level of emotional resilience, particularly that of our children and young people. There is a need to develop a greater understanding of self-harming behaviour, and what support is needed to help young people, their parents, teachers and others to better promote positive emotional health and wellbeing and resilience.

Fundamentally, we need to reduce the stigma associated with self-harm, and improve access to the support available. We need to help young people to develop the skills they need to cope with more stressful and traumatic situations in a less harmful way.

Of concern is the fact that too often people simply do not know where to turn for help, or worse, feel that they won't get help until they get more ill or the situation reaches a crisis point. We cannot ignore the fact that many, including GPs, feel frustrated and concerned about lack of access to appropriate support for young people experiencing personal emotional distress.

The gains from promoting and protecting the emotional health and wellbeing of children and young people are known to be lifelong. The economic case for investing in prevention is clear. We need to understand that while prevention is about the provision of services, it is also about protecting children and young people from adverse experiences, about building resilience and about developing a culture of emotional literacy. If we are to reduce admission rates for self-harm and reduce the frequency and scale of self-harming behaviour in our young people, we will need to mobilise a whole system approach with all stakeholders and partners working together to bring about change.

Recommendations

This report is just the start of the conversation. The task of addressing the issue of self-harm and promoting positive mental health needs to be everyone's business and will require concerted and co-ordinated action. I have set out below some recommendations for action in Somerset.

Recommendation 1
We need to bring the issue of emotional resilience and self-harm into the open to help reduce the stigma associated with it. Talking openly about the issue will help people to access the right support when they need it.

Recommendation 2
There is a need to develop more accessible guidance and information about self-harm. This needs to be supported by increased knowledge, confidence and skills in responding to a situation of self-harm both for families, schools and health and care services.

Recommendation 3
All schools should adopt the Somerset Wellbeing Framework to support and promote positive emotional health and wellbeing and, where appropriate, could consider developing school based self-harm policies.

Recommendation 4
Health and care services need to ensure that the mental health of children and young people is given greater prominence, ensuring that prevention and early intervention is addressed as well as treatment.

Recommendation 5
The importance of developing stronger individuals, families and communities has to be at the heart of developing resilience. A joined-up approach to this would provide a far greater impact than organisations operating independently. A more proportional approach will be needed, focusing particularly on addressing the needs of individuals, families and communities living in more challenging circumstances.

Recommendation 6
Given increased national investment in mental health, Somerset Clinical Commissioning Group has a significant opportunity to invest in improving the emotional health and wellbeing. Working closely with local authorities and schools, investment in developing emotional resilience and early intervention is paramount.

Recommendation 7
There is a need for us to deepen our understanding of self-harm practices and understand more about the emotional resilience of children and young people in Somerset and what can be done to improve it.

Recommendation 8
Finally, and above all, we need to continue to listen to what children and young people are telling us about their experiences and to work with them in designing the solutions.

Acknowledgements
I would like to thank all those who have contributed to this report, those who have supplied data and those who have supplied advice and information both directly and indirectly. I hope this is the beginning of a much deeper and longer conversation in Somerset.

I would particularly like to thank the following people for their contributions:

Pip Tucker; Christina Gray; Jack Layton; Alison Bell; Kerry Allen and CAMHS team members; LifeHacks Young People's Group; Fiona Moir; Louise Finnis; Dr Alex Murray; Young Somerset and the multi-agency Self-Harm Steering Group; Jacqueline Burns

Appendix 1

Prevention Concordat for Better Mental Health

https://www.gov.uk/government/collections/prevention-concordat-for-better-mental-health

The Concordat advocates:

- Needs and assets assessment, with the effective use of data and intelligence (*such as http://www.somersetintelligence.org.uk/mental-health/*)

- Partnership and alignment
  Upstream prevention (stopping people developing issues in the first place) – to save the pressure on emergency services and the police

- Translating need into deliverable commitments
  Somerset's emerging Improving lives and Fit for my future strategies both cover mental health. When these strategies are complete we should use them to improve the services we provide.

- Define success outcomes
  Commissioning mental health services jointly or in alignment requires shared success and performance measures

- Leadership and Accountability
  The Somerset Health and Wellbeing Board is committed to promoting good mental health and prevention of mental ill-health, and stands ready to lead improvements.

Appendix 2

Positive Mental Health - Joint Strategy for Somerset 2014-19

This strategy advocates the following:

- Involve young people and their families in the co-design, co-production and co-delivery of services to support their health and wellbeing
- Make sure that everyone in the children and young people's workforce is well informed about emotional and mental health
- Invest in parenting programmes which are low cost, high value interventions which can be developed and delivered in a flexible and inclusive way
- Protect children, young people and families from risks such as exposure to bullying, violence, discrimination and from the effects of harmful drinking and substance misuse
- Invest in interventions for behaviour and for conduct disorder which have been identified as a "best buy for mental health" with potential savings from each case through early intervention estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems

Consideration needs to be given to how education on self-harm could be included in the curriculum via Personal, Health, Social and Education (PHSE) classes and other appropriate curriculum areas. As mentioned, consistent language that teachers, GPs and others can use when talking to young people about self-harm would be welcomed by them[27].

The report suggests there is an urgent need to develop new policies and procedures that clearly provide guidance and information regarding self-harm to all key stakeholders. This needs to be supported by an increase in knowledge around self-harm across all groups to ensure a more consistent and empathetic response is given and all groups provide better support to a young person who is self-harming.

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[1] https://cks.nice.org.uk/self-harm

[2] https://sites.manchester.ac.uk/ncish/ ; Preventing Suicide in England: a cross-government outcomes strategy to save lives, Department of Health and Social Care, September 2012; Suicides by children and young people in England - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, May 2016

[3] The Five Year Forward View for Mental Health; Dept. of Health and Social Care, Public Health England and NHS England, January 2017; Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing, Dept. of Health and NHS England, March 2015

[4] https://cellohealthplc.com/new-research-talking-self-harm-lifts-lid-on-hidden-despair/
[5] https://cellohealthplc.com/new-research-talking-self-harm-lifts-lid-on-hidden-despair/
[6] https://www.thelancet.com/action/showPdf?pii=S2215-0366%2817%2930478-9

[7] These are 'directly age-standardised' meaning that that differences in the population size and age structure are accounted for in the calculation. The definition is the number of finished first consultant episodes where the patient was admitted via an emergency method and where the main external cause recorded is given an appropriate code International Classification of Disease 10 (ICD-10) code:

- X60-X69 (intentional self-poisoning); X70-84 (intentional self-harm by other and unspecified means).

[8] Rates are calculated using Office for National Statistics (ONS) mid-year population estimates for relevant years and a simple line of best fit trend has been extended for the most recent year (2017) without published data using Microsoft Excel's Forecast function. Individuals are identified by unique identifier and either CCG of residence for Somerset or the ONS Government Offices for the Regions Code for the South-West. The England calculation simply include everyone in the dataset and represents activity in English hospitals; this does mean there may be small numbers of admissions of people from other countries and admissions where the residency was unknown. The calculation uses First Admissions Episodes rather than First Consultant Episodes. However, the number of admissions for self-harm where the patient was in the care of more than one consultant during their hospital stay is negligible.

[9] https://bpspubs.onlinelibrary.wiley.com/doi/pdf/10.1111/bcp.12362

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693484/

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693484/

[12] Please note that this does not account for any admission which might be caused by multiple self-harm methods, as only the main cause is considered. It also does not account for multiple admission across different years. It may also be affected by people's age and sex.

[13] English Indices of Deprivation 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015
[14] Analysis undertaken by Somerset Public Health
[15] https://www.bmj.com/content/342/bmj.d2218

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Somerset Health and Wellbeing Board

Report for information

An update on Positive Mental Health: A joint Strategy for Somerset

Lead Officer: Andrew Keefe & Louise Finnis
Author: Andrew Keefe and Louise Finnis
Contact Details: [Tel No] 01823 357262

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Trudi Grant	4/03/19
	Cabinet Member / Portfolio Holder (if applicable)	Christine Lawrence	4/03/19
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	12/03/19

Summary:	Positive Mental Health: A joint Strategy for Somerset, was published in 2013, and set the strategic direction of mental health support service for 2014-2019. The Health and Wellbeing Board has overseen delivery of the strategy over this time. *This report presents an update on the delivery of the Strategy, now that it is coming to an end, and calls for the refocusing of the strategy to ensure the continued relevance and impact of locally developed initiatives to promote positive mental health for the whole population of Somerset.*
Recommendations:	**That the Somerset Health and Wellbeing Board accepts the contents of the report and approves the recommendation of a refocused collaborative strategy. This strategy will include a new mental health model of delivery which puts greater emphasis on prevention and early intervention and to enable individuals to move within the new model as their needs change. The model will ensure current mental health services are safe and that it provides a platform to build parity with physical health services to deliver the Five Year Forward View for Mental Health.**
Reasons for recommendations:	*The existing strategy was published in 2013 and was effective for five years: it now needs to respond to the changing environment including both national and local drivers, resulting in the need for a refocused strategy.*

Links to Somerset Health and Wellbeing Strategy	*The strategy forms a key link to the new Improving Lives Strategy as a key golden thread to all priorities.*
Financial, Legal and HR Implications:	None
Equalities Implications:	None as this report is for information. Equalities implications will be considered within all future work
Risk Assessment:	None

1. Background

1.1. In 2013 the Strategy was brought to the Board ready for its launch in 2014.

1.2. The vision of the strategy was that…

"*People in Somerset are supported to maintain their mental health and wellbeing and are always able to access the right help, treatment and support when needed to maintain their independence and increasing their resilience, recovery and wellbeing".*

1.3. The document presented an analysis of the mental health needs assessment of the County and presented a range of approaches to address the identified deficits, including:

- Tackling stigma;
- Developing resilient people and communities;
- Targeting the emotional health and wellbeing of children, young people and families;
- Commissioning for quality and the best outcomes; and
- Promoting service delivery to ensure the right service was provided at the right time and in the right place.

2. Options Considered and reasons for rejecting them

2.1. Not applicable at this stage

3. Consultations undertaken

3.1. Not applicable at this stage

4. Implications

4.1. Not applicable at this stage

5. Background papers

5.1. None

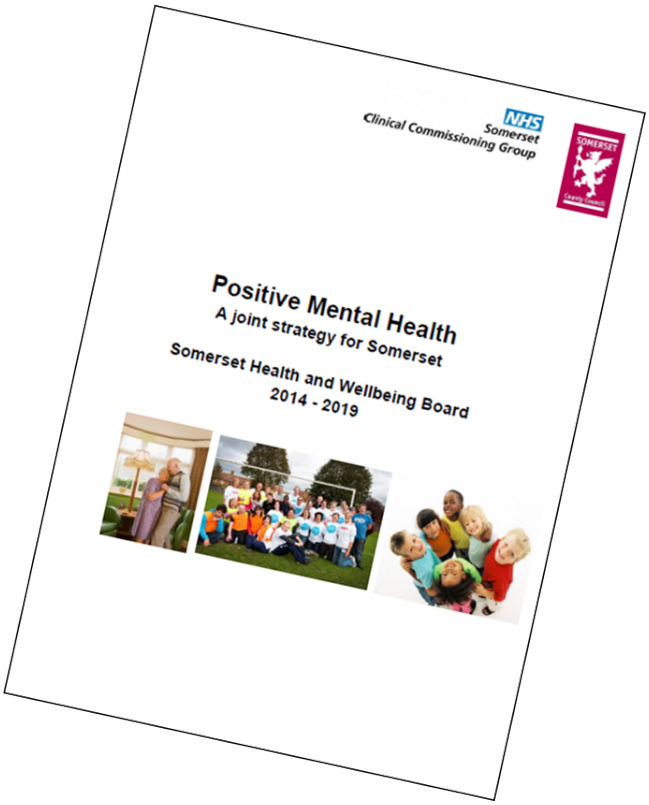
An update on Positive Mental Health: A joint Strategy for Somerset

1 Purpose

The purpose of this document is to provide an update to the Health and Wellbeing Board on the **Positive Mental Health: *A joint Strategy for Somerset***, 2014-2019.

2

Positive Mental Health: A joint Strategy for Somerset, was published in 2013, and set the strategic direction of mental health support service for 2014-2019. The Health and Wellbeing Board have overseen the delivery of this strategy, which was ahead of its time in many regards and has achieved a considerable amount since it was published.



The vision of the strategy was that…

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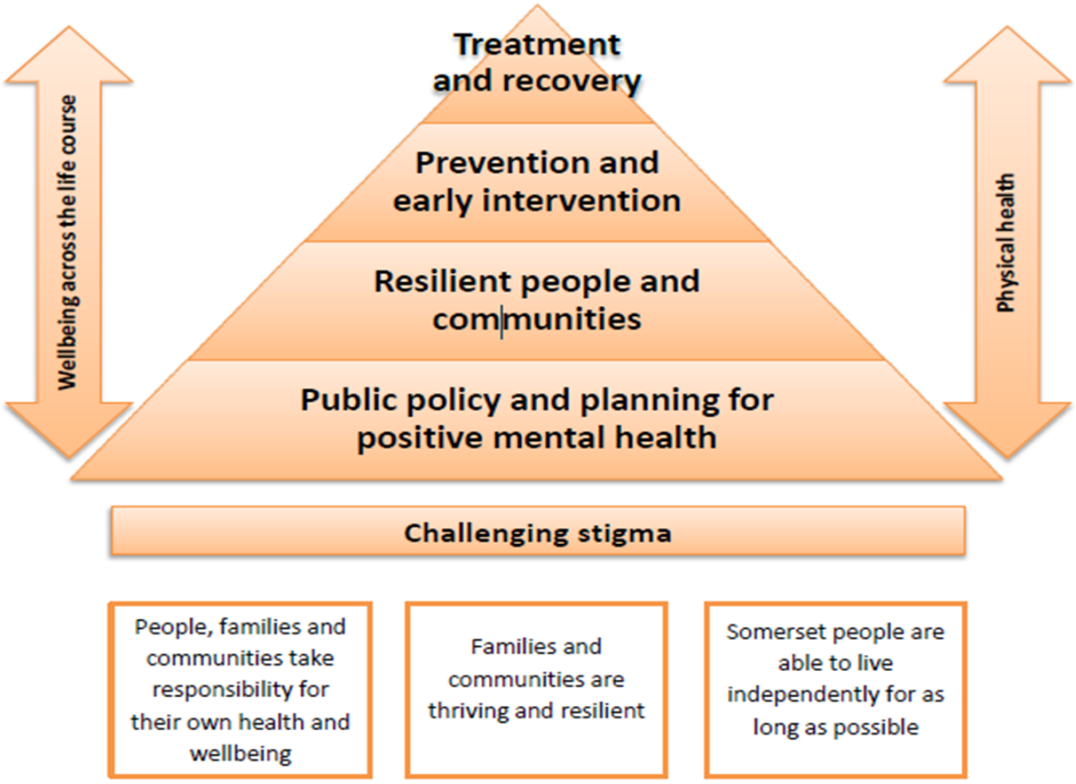
- Commissioning for quality and the best outcomes; and
- Promoting service delivery to ensure the right service was provided at the right time and in the right place.

The Strategy's whole system approach to mental health, (presented in the graphic below), was a tiered approach to support (the pyramid) supported by 'wrap around' enablers including: integration of physical health; all age approaches; challening stigma; individual resilience and independence in the context of families and communities.

All of these elements remain as relevant today as when they were first agreed.

Fig1: A whole system approach to population mental health in Somerset



Much progress has been made since the strategy was first published.

Mental health has a much higher profile in Somerset and society as a whole. This is reflected in Government policy and initiatives, including the following

- Parity of Esteem for mental health

- Five Year Forward View
- Five Year Forward View for Mental Health
- The Prevention Concordat for Better Mental Health
- Future in Mind
- The pending Adult Social Care Green Paper
- Green Paper for C & YP MH
- The Long Term Plan and its references to mental health support

Locally some highlights of progress include

- Stronger Communities agenda is promoting community assets that promote mental health including the use of greenspace.
- Tackling stigma agenda through initiatives such as Councillor Mental Health Campions, SCC Wellbeing at Work programme and Time To Change Community Champions and active events
- CAMHS Investment has seen the creation of a single point of access, more community and crisis support together with the setting up of specialist services such as Eating Disorders and regional Forensic CAMHS.
- CAMHS SHARE project was a new approach focusing on promoting emotional health and wellbeing in the school setting working closely with the Public Health Schools Wellbeing Framework. Over sixty schools have signed up to this approach.
- More children and young people are being seen by Liaison Psychiatric Nurses in both Yeovil and Musgrove District Hospitals
- The number of re-referrals into CAMHS within 12 months has decreased by -70%
- Increase in non-elective and emergency attendances at the County's two acute trusts for individuals with acute mental health needs
- IAPT service has been overhauled and includes self-referral and group work sessions as well as Talking Therapies. The number of referrals went up by 14.9% in 2018.
- Patients on a Care Programme Approach followed up with 7 days after discharge exceeds the national ambition of 95%

Going Forward…

In addition to national factors that require consideration, there are a number of locally identified drivers as to why mental health support locally requires a refocus in light of changes since the 2014-2019 strategy was published. These include the following.

- Changes introduced by the Care Act and gaps in the provision of social care locally resulted in the decision in that social care be brought back into SCC from Somerset Partnership.
- In line with the national picture, Somerset's services have seen an increase in demand and increasing complexity of people presenting with mental health needs. Current demand far outstrips capacity within existing service models. This relates to all ages and conditions.

- There is a need to put greater emphasis on mental health promotion and prevention of mental illness. As a County we need to create the right conditions for good mental health and wellbeing, and on ensuring early interventions are in place when things start to go wrong.
- There is a growing trend of increasing non elective and emergency attendances at the County's two acute trusts for individuals with acute mental health needs.
- There is a need for greater engagement with the people who access services and their carers.
- Somerset has historically under invested in mental health services when compared to other comparable localities. This includes both adult and children and young people services. Despite this underinvestment Somerset Partnership has generally been able to meet the required service performance standards and targets. This performance has however masked the reality of the strain placed on a number of services in the locality and quality and safety concerns are being identified. Also, the delay in the pending adult social care green paper has left underinvestment and a lack of earmarked funding for Mental Health within local government. Whilst the NHS has been given some ring fenced mental health funding to address parity of esteem issues this has not been the case for social care and prevention.
- There is a lack of quality accommodation and support for people with complex mental health and drug and alcohol needs.

The Board Workshop session on the 7th March is focusing on mental health; particularly on where we are now and where do we need to be. The recommendations from the workshop will be included in the presentation to the Board on the 21st March

Somerset Health and Wellbeing Board

21st March 2019
Report for information

Somerset Health & Care Integration

Lead Officer: Ian Triplow/Sustainability & Transformation Programme Director
Author: Ian Triplow / Sustainability & Transformation Programme Director – Somerset
Contact Details: 01935 385021

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Ian Triplow	27th Feb 2019
	Cabinet Member / Portfolio Holder (if applicable)	Pat Flaherty	27th Feb 2019
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	4th March 2019

Summary:	This paper updates on the progress of the Somerset Health and Care work that is being undertaken as a system including the focus on proposals that will be undertaking in 2019/20 that do not have a significant impact on the configuration and/or location of services. Proposals (previously categorised as "Group A") which require further work to determine they are likely to involve significant change and therefore public consultation will be updated to the Board in the next update as this work is still awaiting detailed proposals and formal review.
Recommendations:	**That the Somerset Health and Wellbeing Board receives an update on the proposals as part of the overarching strategy and vision work in line with the Somerset Fit for My Future engagement plans.**
Reasons for recommendations:	To provide the Health and Wellbeing Board with an opportunity to help shape emerging outcomes and decisions.
Links to Somerset Health and Wellbeing Strategy	The Health and Care Strategy supports the vision of the Somerset Health and Wellbeing Strategy, by encompassing its underlying principles and priorities in the development of the proposals (where applicable).
Financial, Legal and	

HR Implications:	No financial, legal and HR implications to note at this stage
Equalities Implications:	An equality impact assessment will be undertaken as options are developed prior to any formal consultation process.

1. Background

1.1. In January 2019 the Health and Wellbeing Board was updated on the Somerset Health and Care Strategy 'Fit for my Future' programme and the next steps from the document "Why do we need to change and what are our change ideas so far?". This classified the proposals into two key groups;

- Group A. Proposals potentially involving significant service change
- Group B. Proposals that can be taken forward without formal public consultation.

1.2. Group A proposals will be formally reviewed within the Fit for my Future programme by the end of March, and then updated to the Health and Wellbeing Board. Group B proposals have taken forward more quickly, through system-wide delivery groups (or through the formation of these).

1.3. Updates on Group B Proposals

Implement a neighbourhood health and wellbeing and team model

- A new neighbourhood board has been formed involving interested parties across health and care (including voluntary sector, primary care, community service, acute services and others)
- A clear system mandate has been provided from the leadership team for Somerset STP, and the neighbourhood board defined the vision and work plan at a workshop on the 27th Feb 2019. This includes testing different localised solutions within Somerset in 2019/20
- Neighbourhoods will work closely with the defined Primary Care Networks as defined within the NHS Long Term Plan

Developing a single, integrated system to access urgent and emergency care in Somerset

- The first phase of this programme of work, a Single Point of Access (SPOA)to urgent/emergency care via NHS 111 telephone was mobilised in Oct 2018 and the new IUC service was procured in Feb 2019. This includes a multidisciplinary health care professional access to GP out of hours (face to face or via the telephone), clinical validation of 999 calls, and direct booking with a GP Practice.
- The aim of Phase 2 (April 2019 to Dec 2020) is to expand and integrate other services within the pathway of IUC identified through an evaluation of current 'Right to Reserve' and activity/demand for related services

Review and transform outpatient services/access to a specialist opinion and review of diagnostic provision within Somerset to ensure it can address current and future need (elective and cancer)

- Short-term there will be an aim to maximise efficiency within the current

provision, provide additional clinics to support a reduction in non-admitted waits, move as much as possible to non-face to face and implement relevant speciality handbook recommendations. The focus for diagnostics also includes the use of telemedicine to help triage appropriate referrals (work plans being developed for delivering in 2019/20)

- The longer-term focus will be on the redesign of pathways to support as much provision as possible in the community, a focus on enhancing skills within primary care to deal with more activity, and more focus on self- management and returning to self- management.

Implement a business case for tackling tobacco dependence (smoking)

- Business case completed and under review in line with 2019/20 funding priorities, due for finalisation of cases to go to implementation by end of March 2019.

Commission a single non-surgical oncology service for Somerset

- Detailed work through medical teams and the proposed single service for Somerset, timelines and implications of change including internal staffing consultation processes.

Develop all components of mental health provision to address service gaps

- Short implementation of rapid improvement proposals developed an under review in line with business cases for 2019/20. Areas of focus include;
    - Developing the voluntary and community provision – building a Big Tent – to provide more early targeted support in the community and school settings
    - Extending and improving the support to children and young people in crisis - Increasing the hours of operation of the Enhanced Outreach Team (EOT)
    - Universal provision for people with lower level mental health needs – 3rd sector provision with specialist knowledge and expertise
    - Improving Access to Psychological Therapies (IAPT) – expanding the current provision
    - A Stepping Up service closing the gap between IAPT and secondary services for those with more complex needs in Primary care
    - Improve the quality and expand the capacity of Community Mental Health Services
    - Improve the quality and expand the capacity of the Home Treatment Team

Integrated children's service focussed on children and families health and wellbeing.

- A newly formed single Children's board for health and care has been formed (first meeting Feb 2019) and is developing a priority programme covering focus on supporting and empowering parents, teachers and health care staff alike to promote the emotional and physical health and wellbeing of our future generation and to avoid/prevent ill health and the need for hospital admission.

1.4. The Better Care Fund has long provided a vehicle to help enable joint ambitions and priorities and should be seen as such going forward. It is important that the HWBB takes note and challenges performance reporting whilst agreeing future priorities as well as a need to take stock on progress made towards integrated health and care. As a reminder the current schemes focus on four main metrics:

-Reduction in non-elective admissions
-Rate of permanent admissions to residential care per 100,000 population (65+)
-Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
-Delayed Transfers of Care (delayed days)

A dashboard is produced, monitoring these and the other key metrics and the Q3 submission is enclosed for reference and the performance report is also prepared for each HWBB. Whilst the future of the BCF remains unclear, it is a shared resource that can help facilitate joint ambitions if proactively managed and utilised by health, housing and care stakeholders.

2. Options Considered and reasons for rejecting them

2.1. Not applicable at this stage

3. Consultations undertaken

3.1. Not applicable at this stage

4. Implications

4.1. Not applicable at this stage

5. Background papers

5.1. None

Health and Wellbeing Board Work Programme – March 2019

Agenda item	Meeting Date	Details and Lead Officer
Health and Wellbeing Board Meeting (11am start)	**13 June 2019 (revised date)**	Dev session: Improving Lives
Healthwatch Report		Emily Taylor
Health and Care Integration		Maria Heard & Ian Triplow
End of Year Performance Report and Improving Lives Performance Framework		Amy Shepherd
Annual Report of the HWBB		Louise Woolway
Somerset Safeguarding Adults Board (SSAB)		Stephen Miles + Independent Chair (request for this item to be late on agenda)
JSNA 2019		Pip Tucker
Health and Wellbeing Board Meeting (11am start)	**11 July 2019**	Dev session: Stronger Communities and neighbourhood model
HWBB Constitution Revision		Trudi Grant, Louise Woolway and Julia Jones
Sexual Health Update		Alison Bell & Michelle Hawkes
Better Care Fund		Tim Baverstock, Stephen Chandler
Health and Wellbeing Board Meeting (11am start)	**26 September 2019**	Dev Session: Housing and health
Better Care Fund		Tim Baverstock, Stephen Chandler

Health and Wellbeing Board Work Programme – March 2019

Health and Wellbeing Board Meeting (11am start)	14 November 2019	
Better Care Fund		Tim Baverstock, Stephen Chandler