Notice of Meeting

Adults and Health Select Committee

Date & time	Place	Contact	Chief Executive
Thursday, 9 November 2017 at 10.00 am	Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN	Andy Baird, Democratic Services Officer Room 122, County Hall Tel 020 8241 7609 andrew.baird@surreycc.gov.uk	Julie Fisher **We're on Twitter: @SCCdemocracy**

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Andy Baird, Democratic Services Officer on 020 8241 7609.

Elected Members

Mr Ben Carasco, Mr Bill Chapman, Mr Nick Darby, Mr Graham Ellwood, Mrs Angela Goodwin, Mr Ken Gulati (Chairman), Mr Saj Hussain, Mr David Mansfield, Mrs Sinead Mooney (Vice-Chairman), Mr Mark Nuti, Mr John O'Reilly and Mrs Victoria Young

Co-Opted Members

Borough Councillor Darryl Ratiram (Surrey Heath Borough Council), Borough Councillor Mrs Rachel Turner (Tadworth and Walton) and Borough Councillor David Wright (Tillingbourne)

TERMS OF REFERENCE

The Committee is responsible for the following areas:
Policy development, scrutiny and performance, finance & risk monitoring for adults' health and social care services:

- Services for people with:
  - Mental health needs, including those with problems with memory, language or other mental functions
  - Learning disabilities
  - Physical impairments
  - Long-term health conditions, such as HIV or AIDS
  - Sensory impairments

    - Multiple impairments and complex needs
- Elderly, frail and dementia care
- Services for Carers
- Social care services for prisoners
- Safeguarding
- Care Act 2014 implementation
- Review and scrutiny of all health services commissioned or delivered within Surrey
- Public Health
- Statutory Health Scrutiny
- Review delivery of the Health and Wellbeing Strategy
- Health and Wellbeing Board

AGENDA

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

2 MINUTES OF THE PREVIOUS MEETING: 4 SEPTEMBER 2017

(Pages 1 - 18)

To agree the minutes of the previous meeting as a true and accurate record of proceedings.

3 DECLARATIONS OF INTEREST

All Members present are required to declare, at this point in the meeting or as soon as possible thereafter:

I. Any disclosable pecuniary interests and / or

II. Other interests arising under the Code of Conduct in respect of any item(s) of business being considered at this meeting

NOTES:

- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest
- As well as an interest of the Member, this includes any interest, of which the Member is aware, that relates to the Member's spouse or civil partner (or any person with whom the Member is living as a spouse or civil partner)
- Members with a significant personal interest may participate in the discussion and vote on that matter unless that interest could be reasonably regarded as prejudicial.

4 QUESTIONS AND PETITIONS

To receive any questions or petitions.

Notes:

1. The deadline for Member's questions is 12.00pm four working days before the meeting *(3 November 2017).*
2. The deadline for public questions is seven days before the meeting *(2 November 2017).*
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 RELOCATION OF MENTAL HEALTH WARDS FROM EPSOM TO CHERTSEY

(Pages 19 - 34)

Purpose of the report:

To update the Committee on their Recommendations following the relocation of Delius and Elgar wards (Epsom) to the Abraham Cowley Unit

(Chertsey).

6 DEVELOPING MENTAL HEALTH IN PATIENT SERVICES IN SURREY (Pages 35 - 38)

Purpose of report:

To provide an update to the Adults & Health Select Committee on the progress of plans to improve mental health hospital facilities.

7 SUICIDE PREVENTION FRAMEWORK (Pages 39 - 60)

Purpose of report:

To provide assurance on the quality of the multi-agency Surrey Suicide Prevention Plan in response to the recommendation of the House of Commons Health Select Committee inquiry into suicide prevention**.**

8 UPDATE ON THE SOUTH EAST COAST AMBULANCE SERVICE (SECAMB) REGIONAL HEALTH SCRUTINY SUB-GROUP (Pages 61 - 68)

Purpose of report:

To provide an update on scrutiny that has been undertaken into the performance of South East Coast Ambulance Service (SECAmb) as conducted by a Regional HOSC Sub-Group.. Given the recent publication of the Care Quality Commission's (CQC) findings following an inspection of SECAmb coupled with the release of Professor Lewis' report into bullying and harassment at the Trust it is timely for the Select Committee to receive an update on the work of the Sub-Group.

9 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 69 - 72)

The Board is asked to review and approve the Forward Work Programme and Recommendations Tracker and provide comment as required.

10 DATE OF THE NEXT MEETING

The next public meeting of the committee will be held *on* Thursday 25 January in the Ashcombe Suite at County Hall.

Julie Fisher
Acting Chief Executive
Published: Wednesday, 1 November 2017

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MINUTES of the meeting of the **ADULTS AND HEALTH SELECT COMMITTEE** held at 10.00 am on 4 September 2017 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting on Thursday, 9 November 2017.

(* present)
Elected Members:

*	Mr Ben Carasco
*	Mr Bill Chapman
*	Mr Nick Darby
	Mr Graham Ellwood
	Mrs Angela Goodwin
*	Mr Ken Gulati
	Mr Saj Hussain
*	Mr David Mansfield
	Mrs Sinead Mooney
*	Mr Mark Nuti
*	Mr John O'Reilly
*	Mrs Fiona White
*	Mrs Victoria Young

Co-opted Members:

*	Borough Councillor Darryl Ratiram
*	Borough Councillor Mrs Rachel Turner
*	Borough Councillor David Wright

Substitute Members:

*	Mrs Fiona White

8/17 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Angela Goodwin, Graham Ellwood and Sinead Mooney. Angela Goodwin was substituted by Fiona White.

9/17 MINUTES OF THE PREVIOUS MEETING: 14 JULY 2017 [Item 2]

The minutes of the previous meeting were approved as a true and accurate record of proceedings.

10/17 DECLARATIONS OF INTEREST [Item 3]

David Mansfield informed the Committee that he worked for Central and North West London NHS Foundation Trust in a non-clinical role. He withdrew from the room.

11/17 QUESTIONS AND PETITIONS [Item 4]

There were five questions submitted to the Committee for response. The questions and their response are attached to the minutes as **Annex 1**.

There were four supplementary questions asked.

1) We are now being told that patients at the Blanche Heriot Unit with genital skin conditions and genital pain fall outside of the integrated Surrey contract for sexual health & HIV services and that these services will continue to be provided by Ashford & St Peter's Hospitals NHS Trust. These patients, which I understand to be around 3,000 in number, have always been treated by the Blanche Heriot Unit as part of its specialist genitourinary medicine service and funded, since responsibility and funding for commissioning GUM transferred with Public Health to local authorities in 2013, by Surrey County Council. Will Surrey County Council transfer funds, presumably from the integrated sexual health & HIV services contract, to enable the North West Surrey Clinical Commissioning Group to fund these services at St Peter's Hospital going forward?

   asked by Sheila Boon

2) Michael Devine noted his disappointment at the answer, and expressed the view that there appeared to be a lack of detailed capacity planning for the transfer of services from the BHU and surrounding clinics to the Buryfields clinic. He asked whether an environmental impact analysis and capacity planning for expected attendances had been undertaken, and whether the commissioners were prepared to share this information including number of daily attendances expected, number of consulting rooms, seating capacity of waiting area and the maximum occupancy insurance limit?

   asked by Michael Devine

3) One of the great strengths of the Blanche Heriot Unit is its very experienced clinical team who provide responsive, thorough and valuable support to GPs allowing direct interaction with a leading specialist. GPs are very concerned about the break-up of this team and the loss of expertise. What steps are the Council and NHS England, as the co-commissioner of the sexual health & HIV services contract, taking to ensure that GPs will continue to have direct access to such expertise and be able to refer patients direct to a specialist level 3 service?

   asked by Nigel Glynn

4) The question author queried how services would be funded in future, questioning whether Surrey County Council would transfer the

required funding to North West Surrey Clinical Commissioning Group by reallocating current funding currently assigned to the Blanche Heriot Unit?

asked by Steven Fryett

12/17 RESPONSES FROM THE CABINET TO ISSUES REFERRED BY THE SELECT COMMITTEE [Item 5]

There were no responses issued from Cabinet.

13/17 REFERRAL BY HEALTHWATCH [Item 6]

It was decided, with the approval of the Adults and Health Select Committee, to consider items 7 and 8 together.

14/17 SURREY INTEGRATED SEXUAL HEALTH SERVICES [Item 7]

Witnesses:

Members

Helyn Clack, Cabinet Member for Health

Speakers

Matthew Parris, Deputy Chief Executive Healthwatch
Stephen Fash, Resident and representative of the Blanche Heriot Group
Cliff Bush, Co-Chair - Surrey Coalition of Disabled People

Commissioners

Helen Atkinson, Strategic Director for Adult Social Care and Public Health
Ruth Hutchinson, Deputy Director - Public Health
Lisa Andrews, Senior Public Health Lead

Steve Emerton, Delivery Director South East, NHS England
Fiona Mackison, Service Specialist, Specialised Commissioning, NHS England

Providers

Stephen Tucker, Deputy Service Director, Central and North West London NHS Foundation Trust
Simon Edwards, Clinical Director, Sexual Health and HIV Services, Central and North West London NHS Foundation Trust

Ashford and St Peter's Hospital

Tom Smerdon, Director of Operations, Ashford and St Peter's Hospitals NHS Foundation Trust

Declarations of Interest:

David Mansfield informed the Committee that he worked for Central and North West London NHS Foundation Trust in a non-clinical role. He withdrew from

the room.

Key points raised during the discussion:

1. The Committee heard representation from the Deputy Director of Healthwatch, Surrey. It was noted that representatives of Healthwatch had attended several feedback events regarding the change in service offered by Central and North West London (CNWL) NHS Foundation Trust. They expressed the opinion that there was a lack of explanation of the services being offered by the new provider. Healthwatch also felt that there was inadequate consultation work with regard to the changes undertaken by the commissioners and providers. Healthwatch noted that, since the referral has been made, there has been more evidence of consultation made available. Healthwatch questioned whether the communication and consultation undertaken was wide enough and whether patients with chronic disabilities would still be able to adequately access services.

2. The Committee heard representation from a member of the Blanche Heriot Unit Group (BHUG). He expressed the opinion that patient support needs were significant for the services. He stressed that the Blanche Heriot Unit (BHU) serviced a large population in North West Surrey and that there was a higher than average demand for the services. It was also noted that the unit was used as a training resource for staff working with sexual health issues. The representative of the BHUG suggested that BHU patients were not sufficiently involved in consultation during the re-commissioning of services. He noted that the commissioners decision to reduce the overall spend of the provision for sexual health services was a primary reason for the former provider being unwilling to bid to provide the service and that this limited competition. There were also concerns raised regarding CNWL‘s ability to provide the service, noting that the provider was running at a budget deficit and that they could become overstretched and unable to provide services effectively in Surrey.

3. Representatives questioned the quality of CNWL’s current offer of Sexual Health Services, noting that there were some concerns regarding the emphasis on phone and email contact, rather than face to face services currently offered. The phone services were also deemed by “Mystery Shoppers” commissioned by the BHUG to be slow and unresponsive. Concerns were also raised regarding how the new service was proposed to be delivered, noting that the BHU was significantly larger than the Level 3 Genito-Urinary Medicine (GUM), HIV and Contraception services proposed in Buryfields, Guildford, and that this could cause capacity issues. The BHUG proposed that the service extend the contract for a further six months to the previous provider, in addition to the current six months that have been added, to allow for a more effective transfer of services.

4. The Co-Chair of the Surrey Coalition of Disabled People noted that he considered the levels of consultation to be inadequate, highlighting that the Surrey Coalition of Disabled People were not aware of the consultation regarding the recommissioning for a significant period of

time. It was also suggested that the Surrey Coalition of Disabled People were not provided with an impact assessment by Surrey County Council regarding the impact on patients. The Co-Chair commented that the commissioner had not undertaken sufficient consultation with those with hearing or visual impairments, young people, or those with mental health issues. It was also noted that the Buryfields, Guildford and Earnsdale, Redhill proposed sites were difficult to access for those with disabilities and chronic needs.

5. The Cabinet Member for Health explained to the Committee that Surrey County Council faced significant financial pressures, highlighting the need to make cost reductions of £104 million in the financial year 2017/18 as determined in the Medium Term Financial Plan. It was also noted that government grants had been lower than expected, and that the the ring-fenced Public Health funding was coming to an end. The Cabinet Member recognised the need for cost reductions, the quality of service would be closely monitored by Surrey County Council (Public Health) and NHS England.

6. The Cabinet Member for Health noted that the recommissioning of sexual health services was a positive development and that the service welcomed the saving options that it provided. The Cabinet Member stressed that the new model of a “hub and spoke” method of delivery was cost effective and could effectively deliver the services required across the entire county; stressing that the re-commissioning of services should be taken in the county context, rather than only considering the BHU.

7. Officers noted that the recommissioning of sexual health services and the budget in Public Health had been brought to the Committee’s predecessor for scrutiny.

8. Officers highlighted that they had observed national guidance, other service’s methods of delivering treatment for sexual health issues and implemented instances of best practice.

9. The service noted that they were conducting follow-up engagement with service users, and that the Equalities and Impact Assessment for the changes was part of the Cabinet papers in September 2016, and available to the public on the Surrey County Council web site.

10. Officers noted that the current service provision at ASPH (Ashford St Peters Hospital NHS Trust) were being retained for a period of six months until October 1st 2017 in order that current service users are adequately provided for, particularly being mindful of those with chronic conditions, and ensure that the service is able to cater for patients during the transition.

11. It was stressed by officers that any additional extension of the contract to the current provider for a further six months, to the six months currently in place, would result in the service making double payments to two providers. This was highlighted by officers as being an

unnecessary use of public funding, stressing that both the commissioners and providers considered that they were prepared for the safe transfer of services.

12. The new model of service delivery, particularly in the case of its HIV services, was in line with the King's Fund guidance. However, the new provider noted that there was a need for better co-ordination of care.

13. The new provider explained to the Committee that the main site for service delivery would be in Guildford, but that there would also be support available via email and telephone. It was also noted that, in cases of chronic illness, that medication could be delivered to patient's homes in the case that they were unable to reach their area of service delivery.

14. The new provider would be offering online booking in conjunction with use of a mobile app and the telephone to book appointments for sexual health services, which was targeted at young people who require these services. Members stressed that young people must be considered during the recommissioning of services, highlighting the requirement for accessibility for young people.

15. Officers explained that there had been, as part of the recommissioning process, a sexual needs assessment which included focus groups undertaken to consult with patients on the changes to the recommissioned services. It was also noted that paper and online surveys had been distributed to services users to gather their feedback, including an anonymous survey. There was an opportunity highlighted to provide feedback at a workshop event in early 2016. It was stressed that there would be continued discussion and engagement with patients and staff regarding how to manage the changes with providers and patients.

16. The representative from NHS England explained that they had worked closely with Surrey County Council. It was noted that national service specifications were used for the NHS England element of the recommissioning of sexual health services.

17. Members questioned how many service user responses had been received when gathering feedback. It was noted by officers that there had been 300 responses to the initial survey and that there were a number of meeting sessions which were well attended. Members noted with concern that the total number of service users across Surrey was significantly higher and that consultation should reach a wider audience.

18. The Committee queried what the focus and purpose of further consultation with patient groups would be in future. Officers noted that the process would ensure that patient groups were involved in the forward planning process and mobilisation process.

19. Officers noted that the CNWL NHS Trust was one of the largest providers of sexual health services in England and that they had recently received a result of Outstanding in the 19 June 2015 Care Quality Commission (CQC) inspection of sexual health services.

20. Members requested that the new providers improve dialogue with service users in response to the concern that there was a low level of consultation. Officers and providers stressed that this improved dialogue with patients was in place and that the provider had evidenced changes to their proposed offer in response to user feedback.

21. Officers noted that the performance of the provider would be monitored by Surrey County Council and NHS England. It was also noted that Public Health in Surrey was monitoring outcomes of a performance comparison with comparable local authorities. The provider responded to concerns raised by Members and stressed that they would provide the Committee with the provider's performance compared to national performance indicators.

22. The provider noted that Sexual Health and HIV services would be delivered within requirements set by Surrey County Council and NHS England.

23. The Committee noted that it would like explore the consultation undertaken by the service with regard to the recommissioning of sexual health services and determine whether there was scope for improvement in future.

24. The Committee suggested that the mobilisation of services should be monitored, with a follow up report suggested to be presented to the Committee in spring 2018.

Recommendations:

The Committee notes the concerns of patients, and thanks people for their evidence. It recommends:

1. That the performance of the sexual health and HIV service contracts are reviewed in 9 months' time.

2. That the Committee establish a task group to review the implementation phase, consultation process and lessons to be learned from the commissioning of sexual health and HIV services, with a view to informing future commissioning of services.

15/17 SUSSEX AND EAST SURREY SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP CLINICALLY EFFECTIVE COMMISSIONING [Item 8]

Witnesses:

Samantha Stanbridge, Director of Commissioning, East Surrey CCG

Declarations of Interest:

None

Key points raised during the discussion:

David Mansfield left the meeting at 11.36am

1. Witnesses explained that the Commissioning plan was intended to set common criteria across Sussex and East Surrey for treatments, including clinical procedures and the prescription of drugs.

2. Witnesses noted that the East Surrey commissioning was reviewed alongside other Surrey CCGs to ensure there were a common Surrey-wide criteria for treatments. There was not expected to be any changes to these as a result of the work being undertaken regarding the Sussex and East Surrey Sustainability and Transformation Partnership (STP). It was highlighted that Sussex would be subject to significant change in line with the desire to ensure greater consistency in treatment across Surrey.

3. Members queried to what extent the commissioning plan would reduce waste and release resources. Witnesses commented that East Surrey CCG was performing well in this area, and expressed the view that there were not significant efficiencies to be identified in this area.

4. Witnesses stressed that the STP needed to maintain a uniform approach to commissioning. It was highlighted that there could not be differing thresholds for Sussex and East Surrey and that Sussex CCGs would need to establish the extent of this through a gap analysis.

Resolved:

1. That the Committee notes the Clinically Effective Commissioning plan proposed by the Surrey and East Sussex STP.

16/17 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 9]

The Committee noted the recommendations tracker and forward works programme. It also noted the membership of the proposed Task and Finish groups.

The Surrey Heartlands Task and Finish Group was agreed with the following membership:

- Ken Gulati
- Bill Chapman
- Sinead Mooney
- John O'Reilly

The South East Coast Ambulance Task and Finish Group was agreed with the following membership:

- Sinead Mooney
- David Mansfield

17/17 DATE OF THE NEXT MEETING [Item 10]

The Committee noted that its next meeting would be held on 9 November 2017 at County Hall.

Meeting ended at: 12.11 pm

Chairman

Public questions to Adult and Health Select Committee – 4 September 2017

1. We are now being told that patients at the Blanche Heriot Unit with genital skin conditions and genital pain fall outside of the integrated Surrey contract for sexual health & HIV services and that these services will continue to be provided by Ashford & St Peter's Hospitals NHS Trust. These patients, which I understand to be around 3,000 in number, have always been treated by the Blanche Heriot Unit as part of its specialist genitourinary medicine service and funded, since responsibility and funding for commissioning GUM transferred with Public Health to local authorities in 2013, by Surrey County Council. Will Surrey County Council transfer funds, presumably from the integrated sexual health & HIV services contract, to enable the North West Surrey Clinical Commissioning Group to fund these services at St Peter's Hospital going forward?

Submitted by Sheila Boon

Response

The Adults and Health Select Committee has asked commissioners to respond to the concerns and have received the following response from SCC:

"During the mobilisation process it has become clear that there are a number of other services, in addition to GUM and HIV treatment and care, delivered by BHU, specifically pelvic pain and genital dermatology. These will continue to be provided by the Hospital Trust. Ashford and St Peter's recognises its duty in continuing to provide the best care for patients needing these services and is working with both Surrey Council and its principal commissioners, North West Surrey CCG, to ensure these services continue to be provided in line with best practice, national clinical guidance and commissioning responsibilities."

2. There was a dearth of activity data in the Invitation to Tender Document for the Integrated Sexual Health Services and HIV Treatment and Care Services for Surrey. I have seen the reported GUMCAD figures from January 2014 – September 2016. These show an average monthly attendance at Blanche Heriot of 1,551 which equates to 18,612 per annum. The figures for Buryfields Clinic, Guildford show an average monthly attendance of 1,274, which equates to 15,288 per annum. The GUM Clinic at Frimley Park Hospital had a monthly attendance of 1,068, equating to 12,816 per annum. The Frimley Park Clinic closed in June 2017.

Please can you address the following question? I am extremely concerned that Buryfields has the capacity necessary to provide a suitable, safe service to the additional number of patients listed above;

How many of these patients have transferred to Buryfields Clinic and what verifiable evidence does Central & North West London NHS Trust, who now operate the Buryfields clinic, have to demonstrate that Buryfields can accommodate a further 18,000 attendances a year from the Blanche Heriot Unit as well as the other 12,000 from Frimley?

Submitted by Michael Devine

Response

The Adults and Health Select Committee has asked commissioners to respond to the concerns and have received the following response from SCC:

"The new model of care is reducing the need for face to face consultations where appropriate. It is important to note that GUMCAD also includes activity delivered to non-Surrey residents. The current BHU service is not a singular service. In simple terms there would appear to be three distinct cohort of patients:

Sexual health – covered by the tender with CNWL
HIV – covered by the tender with CNWL
Multiple issues covering vulval pain, oncology, dermatology, multi-speciality services - not covered by the tender with CNWL and will continue to be provided at Ashford and St Peter's.

Not all the services covered by the tenders with CNWL will simply be transferred to Buryfields. The new provider will be delivering the service from three clinical hubs, clinical outreach services in four locations, an outreach programme and a programme of self-testing.

Frimley Park Hospital saw residents from both Surrey and Hampshire as well as Berkshire residents. Hampshire residents and some Surrey residents are accessing GUM provision from Aldershot Centre for Health as per the open access requirements for sexual health services.

Public Health also commission additional sexual health services within GP and pharmacy settings. These include long acting reversible contraception (coils and implants), emergency contraception (for under 25's) and chlamydia and gonorrhoea testing and treatment for 15-24 year olds.

For the reasons given above, we expect any increase in attendances to be significantly less than suggested, and that we believe Buryfields will be able to accommodate the increase."

3. The Council's decision to cut the budget for sexual health services by over a third and award the contract to a Central London service provider with no knowledge of the geography or public transport arrangements in Surrey will result in the closure of the long established hospital-based level 3 clinic at St Peter's, Chertsey. This will leave only the Buryfields Clinic in the outskirts of Guildford as a level 3 facility serving the whole of West Surrey with a late concession that some, as yet, undefined low level satellite clinics will be held. Within the Blanche Heriot Unit catchment area there are a significant number of patients with complex sexual health problems and problems pertaining to young people who may struggle, or be unwilling, to travel to Guildford. How does the Council propose to meet its obligations under the Equality Act 2010 to ensure that under 18yr olds, disabled and frail patients, and those on a low income, continue to have access to the care they need without having to travel across the county of Surrey?

Submitted by Nygel Glynn

Response

The Adults and Health Select Committee has asked commissioners to respond to the concerns and have received the following response from SCC:

"As part of the TUPE transfer the new provider has taken on the management of local staff from Virgin Care and Frimley Health in phases one and two of the transfer. The team are implementing the new model with these staff that have a wealth of local knowledge. The new provider also delivers physical health services in Surrey prisons.
The new provider will be delivering the service from three clinical hubs, clinical outreach services in four locations (two in the North West of Surrey), a clinical outreach programme and a programme of self-testing.

Services available through Clinical Outreach

The services delivered for residents in community settings are not the same as the services available from the CNWL Hub and Spoke Clinics. However, the development of modern clinical testing technology and electronic communication means we can now offer an extensive range of

services and support, without the need for people to attend a clinical site (although those with more complex needs may need to attend a clinic).

'Clinic in a Box', is the phrase we use for the sexual health resources that are placed in a mobile container (often a suitcase on wheels) which are transported sexual health resources into community settings). These resources mean that the following services and support can be available:

- Health Promotion, including advice information and support around reducing risk, unplanned pregnancy and self-care
- Onward referral for issues related to mental health, smoking, drugs and alcohol
- Full STI and HIV testing
- Chlamydia and Gonorrhoea testing targeted and tailored for under-25s
- Condoms and lube, including the Condom Distribution scheme for young people
- Rapid pathways to the CNWL HUB clinics for GUM and contraception including LARC (long acting reversible contraception - coils and implants)
- Targeted support to reduce teenage conceptions, including pregnancy testing
- Support, advice and referral relating to:
    - Safeguarding
    - Child sexual exploitation
    - Harmful Traditional Practices, including: Female Genital Mutilation, Forced Marriage and Honour based violence
    - Domestic Abuse
    - Gangs and associated sexual health violence/exploitation
- Education sessions, advice, information and support for professionals in general practice, pharmacies, Young People's Services, school nursing, Family Nurse Partnership team, Youth Centres, Looked After Children, youth offending, schools and colleges.
- Comments cards, quarterly surveys and focus groups to gather patient feedback

The service can be contacted:
- In person at the three main Hub Clinics (see contact details below)
- Telephone 01483 783340 (staffed Monday to Friday 9am until 5pm)
- Website at www.sexualhealth.cnwl.nhs.uk
- E mail sexualhealth.cnwl@nhs.net
- From October residents will be able to book appointments online

All three clinical hubs (Redhill, Guildford and Woking) are accessible to wheelchair users:
- Woking has onsite parking including disabled parking. The service is located on the ground floor with ramp access to the building.

- Earnsdale (Redhill). The service is on the ground floor with a lift providing access from the lower ground floor to wheelchair users. Assistance from staff will be required to access and use the lift. A disabled car parking space is available by the lower ground entrance. Additional disabled car parking spaces are located nearby.
- Buryfields (Guildford). There is ramp access into the building and a lift to the 2nd floor where the service is located. Disabled on street car parking is available outside of the building.

Hearing loops will soon be installed in all clinical hubs.

In addition to this, virtual and telephone appointments will be available as well as continuation of home delivery for HIV drugs. Transition clinics will be held on the ASPH site to make sure that more complex HIV patients' needs can be planned for with individual patients over the next few months.

Public Health also commission additional sexual health services within GP and pharmacy settings. These include long acting reversible contraception (coils and implants), emergency contraception (for under 25's) and chlamydia and gonorrhoea testing and treatment for 15-24 year olds."

4. Is the Committee aware of the All-Party Parliamentary Group on HIV/AIDS report 'The HIV puzzle - Piecing together HIV care since the Health and Social Care Act'? This was published in December 2016, after the contract was awarded to CNWL but before the due implementation date. The report refers to the significant upheaval to HIV and sexual health services since the Health & Social Care Act 2012 was implemented and the fragmentation of the service as evidenced by the following quotes:

   "The result of tendering of the GU and HIV services has been disastrous for the patients. Our Trust did not wish to bid for the service as there was no money in it."

   "There are no GU or HIV physicians now at the Hospital in the event that a patient is admitted. There is no agreement for their "ex HIV Physicians" to see such patients despite pleading from these physicians for such an agreement in advance of leaving the Trust."

   What steps are the commissioners taking to ensure that St Peter's Hospital continues to have direct cover from a GU/HIV physician when HIV patients require acute admission?

Submitted by Steven Fryett

Response

The Adults and Health Select Committee has asked commissioners to respond to the concerns and have received the following response from NHS England:

“CNWL, the new provider of the integrated sexual health and HIV service will provide telephone advice from a consultant specialising in HIV to assist with any clinical queries from acute hospitals in Surrey.

It is clear that clinical practice and support for patients with HIV admitted to acute hospitals in Surrey has varied from trust to trust. NHS England is working with CNWL to develop a pilot project to understand the level of specialised HIV inpatient support for clinicians that is required across all acute trusts in Surrey. This pilot will inform future commissioning plans.”

5. The Family Planning Association Report, ‘Unprotected Nation’ (2015) calculates that every £1 considered a "saving" in sexual and reproductive health could actually cost £86 due to the cost of unintended pregnancies and extra sexually transmitted infections.

   What steps are Surrey County Council as the commissioner of sexual and reproductive services taking to monitor the impact, in terms of increased teenage pregnancies and increased incidence of sexually transmitted infections, of the decision of CNWL to close over 30 contraception and sexual health screening clinics, reducing the number of locations from 17 to just 3 for the whole of the County?

Submitted by Jennifer Fash

Response

The Adults and Health Select Committee has asked commissioners to respond to the concerns and have received the following response from SCC:

“Young people are a priority group within the new service specification. Public Health at Surrey County Council has responsibility for reducing unintended teenage conceptions which is monitored via the public health outcomes framework. The new provider will be subject to quarterly monitoring against detailed KPIs in the contract.

Public Health lead a Surrey wide Sexual Health Operational Group. This network includes representatives from school nursing, the youth service and the family nurse partnership who are most in contact with more at risk

young people. The network also helps us to ensure that relationship and sex education messages are consistent and that best practice guidance is followed county wide.

Work continues with the CCGs who are the commissioners of termination services on contraception pathway. The new provider will be delivering the service from three clinical hubs, clinical outreach services in four locations, a clinical outreach programme and a programme of self-testing.

Services available through Clinical Outreach

The services delivered for residents in community settings are not the same as the services available from the CNWL Hub and Spoke Clinics. However, the development of modern clinical testing technology and electronic communication means we can now offer an extensive range of services and support, without the need for people to attend a clinical site (although those with more complex needs may need to attend a clinic).

'Clinic in a Box', is the phrase we use for the sexual health resources that are placed in a mobile container (often a suitcase on wheels) which are transported sexual health resources into community settings). These resources mean that the following services and support can be available:

- Health Promotion, including advice information and support around reducing risk, unplanned pregnancy and self-care
- Onward referral for issues related to mental health, smoking, drugs and alcohol
- Full STI and HIV testing
- Chlamydia and Gonorrhoea testing targeted and tailored for under-25s
- Condoms and lube, including the Condom Distribution scheme for young people
- Rapid pathways to the CNWL HUB clinics for GUM and Contraception treatment and care and support and LARC
- Targeted support to reduce teenage conceptions, including pregnancy testing
- Support, advice and referral relating to:
    - Safeguarding
    - Child sexual exploitation
    - Harmful Traditional Practices; including Female Genital Mutilation, Forced Marriage and Honour based violence
    - Domestic Abuse
    - Gangs and associated sexual health violence/exploitation
- Education sessions, advice, information and support for Professionals in General Practice, Pharmacies, Young People's Services, School Nursing, Family Nurse Partnership Team, Youth Centres, Looked After Children, Youth Offending, Schools and Colleges.

- Comments cards, quarterly surveys and focus groups to gather patient feedback

The service can be contacted:

- In person at the three main Hub Clinics (see contact details below)
- Telephone 01483 783340 (staffed Monday to Friday 9am until 5pm)
- Website at www.sexualhealth.cnwl.nhs.uk
- E mail sexualhealth.cnwl@nhs.net
- From October residents will be able to book appointments online

Public Health also commission additional sexual health services within GP and pharmacy settings. These include long acting reversible contraception (coils and implants) and emergency contraception (for under 25's)."

Ken Gulati
Chairman – Adult and Health Select Committee

NHS
Surrey and Borders Partnership
NHS Foundation Trust

Adults and Health Select Committee

9 November 2017

Relocation of Mental Health Wards from Epsom to Chertsey

Purpose of report:

To update the Committee on their Recommendations following the relocation of Delius and Elgar wards (Epsom) to the Abraham Cowley Unit (Chertsey).

Introduction:

1. This report provides an update to the Adults and Health Select Committee in line with the recommendations made by the Wellbeing and Health Scrutiny Board at its meeting on the 17 February 2017.

2. These recommendations resulted from the Committee's scrutiny of plans to relocate Delius and Elgar Mental Health Wards from the Langley Wing at Epsom General Hospital site to the Abraham Cowley Unit (ACU), St Peter's Hospital site, in February 2017.

Background:

3. In November 2016 Surrey and Borders Partnership NHS Foundation Trust (SaBP) took the decision that it was necessary to consolidate Delius and Elgar wards with inpatient services at ACU. Delius and Elgar wards, at the Mid Surrey Assessment and Treatment Centre (Langley Wing) on the Epsom Hospital site, served adults of working age living in mid Surrey.

4. Delius and Elgar wards, which each provided care and treatment for male and female adults of working age, transferred in February 2017 into Anderson and Clare wards at ACU. Anderson ward is a female-only ward with 13 beds and Clare ward is a male-only

ward with up to 20 beds. This provided four more beds than was previously available between the Delius and Elgar wards.

5. This decision was taken for the following reasons:

   5.1 The environment at Delius and Elgar wards no longer enabled us to provide the type of surroundings we wanted people to experience.
   5.2 Some work which had recently been undertaken there to implement environmental security and practice changes with the aim of reducing the risk of people going absent or missing from the wards did not have a positive impact on people's experience.
   5.3 An external report and internal infection control audits identified environmental issues with kitchen areas, flooring and bathrooms.
   5.4 The size and configurations of the wards, meant that therapy and diversional activities were facilitated for both wards within Elgar ward which could restrict people's ability to attend.
   5.5 The Care Quality Commission (CQC) raised some comments regarding SaBP's ability to be fully compliant with Maintaining Single Sex Accommodation guidance on these wards during the CQC inspection in March 2016.
   5.6 The relocation also enabled staff to work more collaboratively across the wards under clinical leadership based on a single site.
   5.7 SaBP are more able to create an environment that promotes dignity and respect at the ACU than at Elgar and Delius Wards. Whilst there are no single ensuite bedrooms at the ACU, people on the wards have easy and safe access to a full range of therapy activities and recreational spaces including a therapy kitchen, gym, skills workshop, craft room, café and pleasant outdoor space.

Recommendations from the Well Being and Health Scrutiny Board

6. The Wellbeing and Health Scrutiny Board were invited to review plans for relocation in November 2016. Members of the Board visited Elgar and Delius wards as well as the ACU. Board members also held a meeting with members of the Trust and stakeholders including people who use services to consider the proposals.

7. The report compiled by Members of the Wellbeing and Health Scrutiny Board was submitted for the Board to discuss at its meeting in March 2017.

8. The Board made seven recommendations as a result:

   Recommendation 1: That the Trust reviews the process by which it plans future ward relocations in order to improve its change management practices.

   Recommendation 2: That the Trust set out timescales for consultation and anticipated impact on current services and that the Board receive an update during consultation.

   Recommendation 3: That the Trust produce a travel plan to demonstrate how people and their families will be supported to access the Abraham Cowley Unit.

Recommendation 4: That the Trust provide additional resource to support people who use the wards to access Skype and other communication tools, where appropriate.

Recommendation 5: That the Trust monitor family and patient feedback following the move and provide a summary of key themes for the Board in six months-time.

Recommendation 6: That the Trust report the impact on Missing Person rates to the board in six months' time.

Recommendation 7: That the Trust and commissioner clarify the position on funding for the safe haven in Epsom.

A copy of the response to these recommendations is provided in Annex 1 to this report.

9. The Wellbeing and Health Scrutiny Board asked for a report back in six months' in relation in particular to recommendations 5 and 6. This update is provided in this report.

Update

10. **Recommendation 5 - That the Trust monitors family and patient feedback following the move and provide a summary of key themes for the Board in six months' time**

Information from 'Your Views Matter' surveys has been reviewed, a survey which invite people to feedback their experiences of SaBP's services. 'Your Views Matter' asks a number of questions. For the purpose of this report SaBP has looked specifically at whether people would recommend services to their Friends and Family (FFT) and what their wider views are of SaBP's services (Inpatient Survey).

The time leading up to the move **(August 2016 to January 2017)** has also been reviewed along with the period following the move **(February 2017 to August 2017).** When looking at this data it is important to bear in mind that whilst Delius and Elgar were both mixed wards providing care to both males and females, Clare ward is now male only and Anderson ward is female only.

An extract of this data is provided in Annex 2 and a summary of key themes is provided below.

Summary of Key Themes

- More people said they would recommend Delius ward (78.57%) to their Friends and Family than either Anderson (female only - 57.69%) or Clare (male only - 66.67%) wards.
- More people would recommend Clare ward and Anderson ward than Elgar ward (57.14%).
- Delius ward scored the highest for people's overall satisfaction at 67.86%, with Clare ward (57.16) and Anderson ward (53.84%) with Elgar being the ward people were least satisfied with (42.87%)
- People reported feeling safest on Delius (57.14%) and Clare (57.16%) wards

- People reported feeling least safe on Elgar ward (28.57%)

11. **Recommendation 6 - That the Trust report the impact on Missing Person rates to the board in six months' time**

    Annex 3 contains data on people who are Absent Without Leave (AWOL) and Missing Persons (MISPER) data provided by Surrey Police. A summary of key findings is provided below:

    - The number of people recorded as AWOL from inpatient settings has steadily decreased over the last 18 months following a peak of 17 in June 2017.
    - When comparing the two periods for which the data is available, the number of people recorded as missing by Surrey Police shows the following:
        - The Total Number of MISPER reports per bed per month has reduced from 0.164 to 0.153.
        - In Q1 (2016) and Q1 (2017), the number of MISPERs per bed at ACU and Farnham Road Hospital are both significantly lower than the rates at Langley Wing (Delius and Elgar wards, Epsom)
    - If the total number of MISPER reports per bed per month figure (0.164 to 0.153) was converted to a potential reduction in MISPER reports it would suggest that the hospital consolidation has led to a 5% reduction in MISPER reports. This would be 13 fewer people going missing and 13 fewer instances of distressed families and police deployments and, most importantly, a reduction in potential harm to vulnerable people.

Given this analysis, whilst there has been an ongoing focus to reduce MISPER across hospital services for many years, it is reasonable to assume that the move from Epsom has contributed to this improvement.

12. **Further Updates on Other Recommendations**

    Below is an outline of work undertaken to address recommendations made by the Wellbeing & Health Scrutiny Board beyond those areas where an update was specifically requested:

    Recommendation 3: The Trust produces a travel plan to demonstrate how people and their families will be supported to access the Abraham Cowley Unit.

    It was evident that for many people the move to Chertsey would involve additional travel time and that public transport would be complicated. The Scrutiny Board was provided with a copy of the travel plan which was developed alongside case studies for how SaBP could assist people in planning their travel at its meeting in March 2017. SaBP is continuously evaluating the type of support it can provide based on people's individual circumstances.

    Since the move SaBP has occasionally received feedback that some people are not being supported with their travel. Any feedback of this nature is followed up and anyone who is experiencing problems is encouraged to let SaBP know by contacting

either the Patient Advice and Liaison Service (PALs) team or the Associate Director for Hospital services so that we can help them.

Some of the ways in which SaBP has helped people are:

- As part of the Home Treatment Team assessment and preparation for admission SaBP will speak with family carers and the person being admitted about whether they have any problems with travel for visits and home leave.
- There are continued discussions with people about the Healthcare Travel Costs Scheme where appropriate
- Where home leave is being planned, the person's Care Coordinator, in discussion with the multi-disciplinary team, are available to support this and agree an individual travel plan. This may mean using public transport, the support of family and friends or a taxi can be organised for them.
- If family carers are visiting hospital using their own means of transport we do consider using carers' breaks/carers' assessments and Self-Directed Support packages where this may be of help.

Recommendation 4: The Trust provide additional resources to support people who use the wards to access Skype and other communication tools, where appropriate.

All wards now have guest Wi-FI access for people who wish to use their own smartphones. For those who do not have this a bookable laptop Is available for people to access via the acute therapy team.

Recommendations:

13. The Adults and Health Select Committee is asked to note the update following the consolidation of Delius and Elgar wards at the ACU, Chertsey.

Next steps:

None

Report contact:
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Contact details: 01372 216292 lorna.payne@sabp.nhs.uk

Sources/background papers:

Report to the Well Being and Health Scrutiny Board, March 2017 including Trust responses

Annexes:
Annex 1 – Response to Wellbeing & Health Scrutiny Board Recommendations
Annex 2 – Your Views Matter Survey Results
Annex 3 – Data: People Who are 'Absent Without Leave' and Missing Person

Glossary of Terms:

ACU – Abraham Cowley Unit
AWOL – Absent Without Leave
CCG – Clinical Commissioning Group
CQC – Care Quality Commission
FFT – Friends and Family
MISPER – Missing Persons
PALS – Patient Advice and Liaison Service
SaBP – Surrey & Borders Partnership Foundation Trust

Response to Wellbeing & Health Scrutiny Board Recommendations

Surrey and Borders Partnership

We would like to thank the Wellbeing and Health Scrutiny Board for the time its members have spent with us to consider our relocation of services and for your recommendations following your review.

We have considered these and are happy to provide our responses which we hope will aid the Board in its ongoing consideration of our services.

- That the Trust review the process by which it plans future ward relocations, in order to improve its change management practices

We understand that some of our stakeholders feel that our relocation of Delius and Elgar wards from Epsom to Chertsey was undertaken more quickly than was necessary and some people would have liked.

We have listened carefully to this feedback and reviewed our reasons for implementing the change. We do feel that in taking our decision to make this change that it was very important to achieve the improvements in the quality of people's experiences as quickly and as safely as possible.

We always try to work with people who use our services, carers and families and wider stakeholders as early as possible in our proposals for changes to the ways in which we deliver our services. We are committed to continuing to do this and will keep working with our stakeholders to help us get this right.

- That the Trust set out timescales for consultation and anticipated impact on current services, and that the Board receive an update during consultation;

We are working very hard, with our colleagues in our Clinical Commissioning Groups, to develop the proposals for the future of our hospital services for the people of North West, Mid and East Surrey. The consultation will be led by our CCGs and we are

supporting their current discussions on when they will be in a position to commence this.

We have agreed with our CCGs that an update to the Board will be provided as part of that consultation.

- That the Trust produce a travel plan to demonstrate how people and their families will be supported to access the Abraham Cowley Unit.

We have provided the Board with a copy of our travel plan and the posters and leaflets we have provided to inform people of how we can help them. To complement this we are developing some case studies for the Board. We hope these will provide a helpful illustration of how the plan can be applied in practice to support people and their families.

- That the Trust provide additional resource to support people who use the wards to access Skype and other communication tools, where appropriate.

We can confirm that we have provided additional resources to support people who use our wards at Abraham Cowley to support people's communication with their families and friends whilst staying on the wards.

- That the Trust monitor family and patient feedback following the move and provide a summary of key themes for the Board in six months' time.

- That the Trust report the impact on Missing Person rates to the Board in six months' time.

We will be very happy to provide an update for the Board in six months' time on both people's feedback of their experiences and the impact on our Missing Person's rate following the relocation of the wards.

- That the Trust and commissioner clarify the position on funding for the safe haven in

Epsom
We are delighted to be able to confirm that our Commissioners have confirmed the continuation of our funding for the Safe Haven in Epsom. We have not yet received confirmation from all our partners who provide the Safe Haven service with us, that our Commissioners have similarly been able to confirm their recurrent funding for the Safe Haven.

10th March 2017

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Your Views Matter Survey feedback

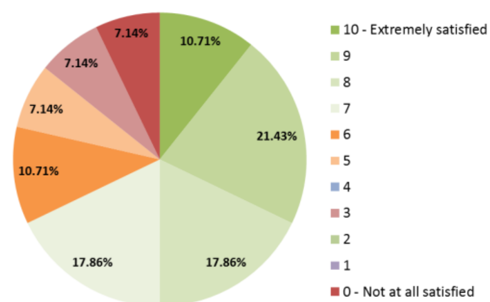
Friends and Family Test (FFT)

Area	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Langley Wing, Epsom General Hospital **Time leading up to move (August 2016 – January 2017)**									
24 7 Delius **(male & female ward)**	78.57%	10.71%	28	11	11	3	1	2	0
24 7 Elgar **(male & female ward)**	57.14%	28.57%	7	0	4	1	2	0	0
Abraham Cowley Unit, St Peter's Hospital **Post-move (February 2017 – August 2017)**									
24 7 Anderson (Female Ward)	57.69%	26.92%	26	4	11	3	1	6	1
24 7 Clare (Male Ward)	66.67%	33.33%	12	1	7	0	0	4	0

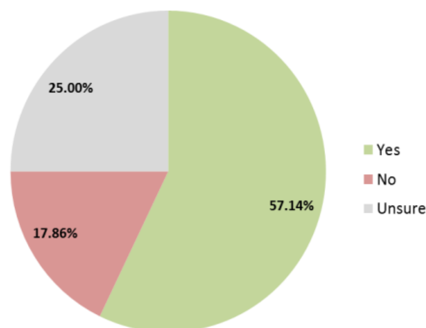
People's Feedback via Your Views Matter - Inpatient Survey

Delius Ward – time leading up to move (August 2016 to January 2017)

Overall Experience of the service



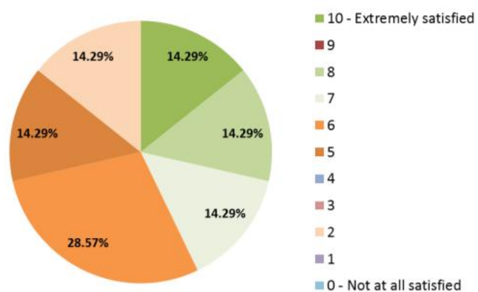
Do you feel safe in hospital?

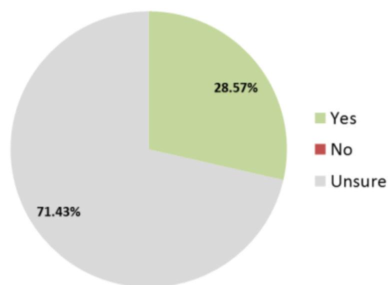


Elgar Ward – time leading up to move (August 2016 to January 2017)

Overall Experience of the service

Do you feel safe in hospital?

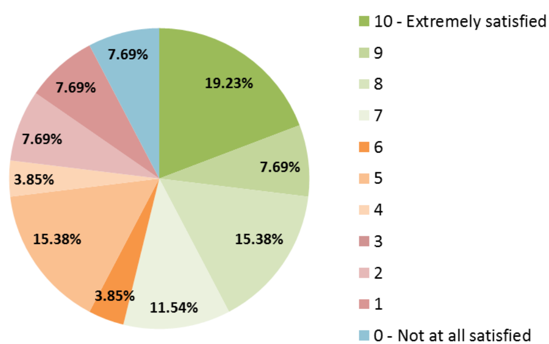


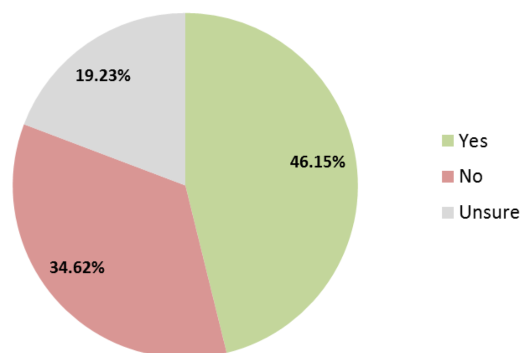


Anderson Ward – post move (February 2017 to August 2017)

Overall Experience of the service

Do you feel safe in hospital?

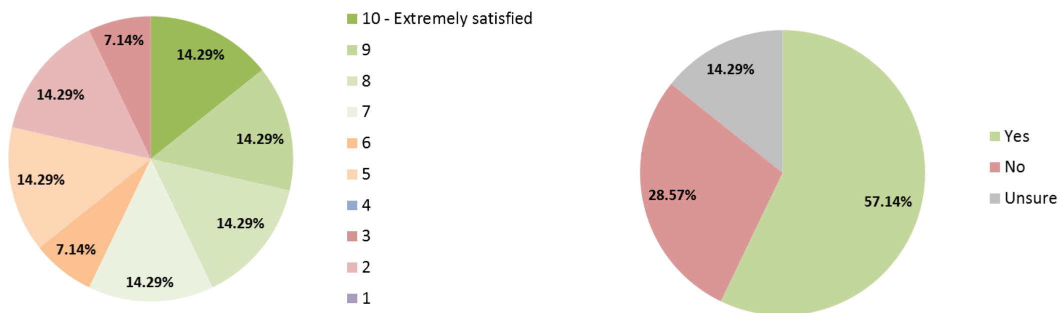




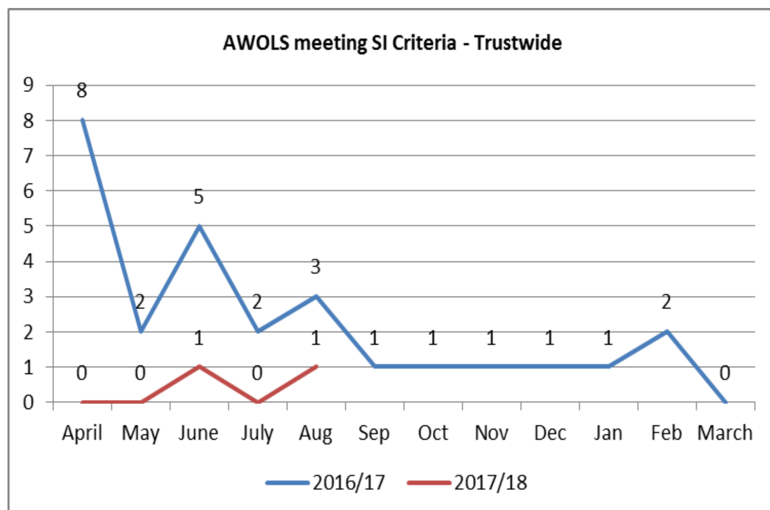
Clare Ward – post move (February 2017 to August 2017)

Overall Experience of the service

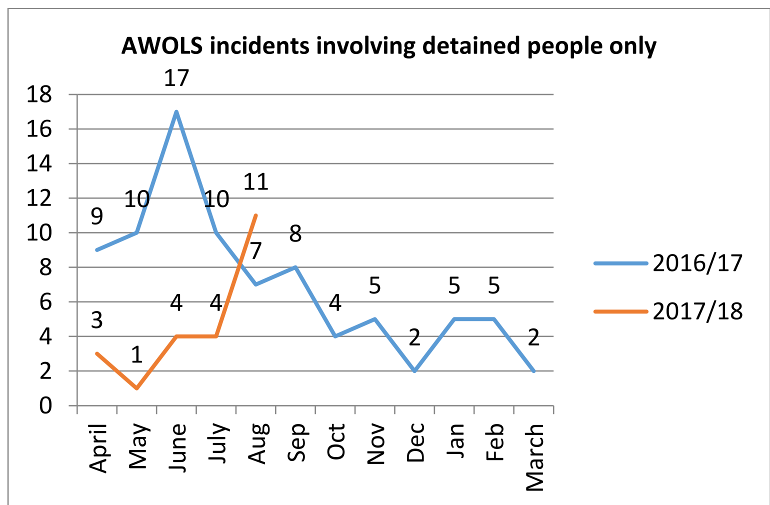
Do you feel safe in hospital?


7.14%
14.29%
14.29%
14.29%
14.29%
14.29%
7.14%
14.29%
14.29%
10 - Extremely satisfied
9
8
7
6
5
4
3
2
1
14.29%
28.57%
57.14%
Yes
No
Unsure

Annex 3 - Data - People who are “Absent without Leave” and Missing Persons



This chart shows the number of AWOL's reported meeting Serious Incident (SI) criteria. We have one AWOL meeting SI criteria this month, where an individual on section 3 of the Mental Health Act absconded from FRH using a key card from a member of staff.



This chart shows the AWOLS of individuals who are detained under the Mental Health Act but do not meet SI criteria (excluded failure to return from leave).

There were 11 incidents reported in August, and of those incidents only two people were involved. One individual was involved in three separate episodes of AWOL from Blake Ward.

Table to show differences in MISPER (Missing Person) Rates at SABP Hospital sites

		Apr-16	May	Jun	July	Aug	Sept	Oct	Nov	Q1	Q2	Q3	Total MISPER	TOTAL per bed	TPBPM
ACU		3	4	5	5	1	2	3	3	0.6	0.4	0.3	26	1.3	0.16
Langley		5	10	12	6	5	3	2	5	0.96	0.5	0.25	48	1.71	0.21
FRH		4	11	12	9	15	8	1	8	0.45	0.53	0.15	68	1.13	0.14
TOTAL		12	25	29	20	21	13	6	16				142	1.31	0.164
	Mar-17	**Apr**	**May**	**Jun**	**July**					**Q1**			**Total MISPER**	**TOTAL per bed**	**TPBPM**

ACU	2	8	7	17	17					0.65			51	1.041	0.21
FRH	7	3	4	10	4					0.31			28	0.52	0.10
TOTAL	9	11	11	27	21								79	0.77	0.153

The data above is provided by Surrey Police and presented to the Surrey Crisis Care Concordat Delivery Group. This shows people defined as MISPER ‘Missing People’ who are assessed to need police support to locate people missing from the wards. This is a wider definition than AWOLS (people absent from the ward who are detained under the Mental Health Act).

It may also include some people shown as MISPER from ACU who were actually reported by another part of the site (i.e. St Peters Hospital) and who were not inpatients at ACU at the time.

The number of beds available at each site vary considerably whilst the number of missing person reports recorded is an actual number; the quarterly figures therefore convert the number of reports into a number per bed per month.

Comparing 5 months of data for 2017 with 8 months of data in 2016 may mean that direct comparison is not possible. To aid comparison the final column shows the average number of MISPER reports per month per bed across the sites.

Guildford and Waverley Clinical Commissioning Group

Surrey and Borders Partnership NHS Foundation Trust

Adults and Health Select Committee

9 November 2017

Developing Mental Health inpatient Services in Surrey

Purpose of report: To provide an update to the Adults & Health Select Committee on the progress of plans to improve mental health hospital facilities.

Introduction:

1. In 2008/09 Surrey & Borders NHS Foundation Trust (SaBP) and its commissioners consulted publicly on re-providing mental health inpatient services on three sites. The outcome identified the three sites as Farnham Rd, Guildford; Abraham Cowley Unit, St Peter's Hospital, Chertsey and a site to be identified in Redhill in East Surrey. The first phase at Farnham Rd was completed at the end of 2015. Phase 2 (Chertsey) and Phase 3 (Redhill) have not commenced.
2. In 2015/16 SaBP established a group with representatives of people who use services and carers to review bed numbers that formed part of the public consultation in 2008/09, to consider whether they would still meet the needs of the population today and into the future. Health planning consultant, Mental Health Strategies, was commissioned to advise on the required bed numbers and the number of sites, taking into account recent developments within community services and the focus on recovery models and early intervention.
3. In 2016/17, a draft Strategic Outline Case was developed to consolidate phases 2 and 3 with detailed options appraisal including a shortlist of options for building a new facility. However, following discussions with commissioners, all of the shortlisted schemes were not considered to be financially viable. Since then, further design feasibility on alternative approaches has been considered based on a refreshed bed modelling study carried out in June 2017. The study demonstrated the need to respond to increased demand and demographic changes through additional beds beyond what is currently available and had been planned. This has resulted in a return to the three site option as it is more capable of delivering the quality and affordability required.
4. Do nothing is not an option as an improvement in the environment for people has to be achieved. The programme has therefore revisited options which would optimise the use of existing premises and sites through refurbishment and extension of existing buildings.

Drivers for Change

5. Quality and people's experience

5.1 **Farnham Road Hospital Guildford (Phase 1) -** A new building on our existing site has provided 60 beds consistent with modern care practices. A further ward in an older building on the same site has 20 beds but not of a modern standard.

5.2 **Abraham Cowley Unit, Chertsey** - Although the location, and general welfare facilities at Chertsey are both safe and convenient, ward layouts do not meet the privacy and dignity standards expected by the Care Quality Commission (CQC) as some beds are provided in dormitories, as opposed to single bedroom accommodation, and do not meet the single sex accommodation standards expected for mental health facilities that are the aspiration.

5.3 **The Meadows, Epsom** - Whilst this facility has single rooms, bathroom and toilet facilities are shared. The wards are small (eight beds) and whilst this does enable gender separation it is challenging from an efficiency point of view.

5.4 **Langley Green hospital, Crawley** - This facility is run by Sussex Partnership NHS Foundation Trust. It provides 13 beds (male and female) for people living in East Surrey. Sussex Partnership has indicated that, within the plan period they will require SaBP to vacate this ward and so it is proposed that the provision for East Surrey could be accommodated in the Phase three project.

6. Increasing demand and forecast bed requirements

6.1 SaBP's clinical strategy is underpinned by a philosophy of supporting people out of hospital and avoiding admission and nationally, Surrey has one of the lowest beds per population. However, SaBP routinely operates well in excess of 85% bed occupancy threshold considered optimum for running resilient inpatient services. This pressure manifests itself in delays and poor experiences for people (impacting on the wider system e.g. A&E and acute colleagues), an increasing need to fund additional beds in the private sector resulting in people being cared for out of area and consequent expenditure pressures.

6.2 SaBP renewed modelling for inpatient bed numbers with external consultants Mental Health Strategies to estimate the number of beds required to secure adequate provision for the population in the future. The outcome of this re-modelling is to estimate that the population needs 244 beds versus the 208 beds it currently operates. It should also be noted that:

- the 36 additional beds will probably require additional revenue funding of circa £4 million per annum and will cost £27 million to build;
- of the 208 beds SaBP currently operates, only 60 offering en-suite bedrooms and all remaining beds are provided in dormitories and/or with shared bathing facilities;
- 148 beds need to be re-provided. The cost of re-provision will be circa £75 million assuming that they will be a mix of refurbishment and extension rather than new build;

- the capital costs of providing 244 beds will be circa £100 million of which SaBP will be able to source circa £35 million from disposal of existing operational assets. The depreciation, interest and PDC impact of this £100 million capital expenditure will be another circa £3 million per annum.

The Way Forward

7. At the SABP Trust Board on 13th September 2017 a proposal was considered and agreed to achieve maximum benefit delivered in the swiftest time using existing capital resources.

8. As a result the Trust is now progressing plans to proceed with refurbishment and extension of the Abraham Cowley Unit on the St Peter's site in Chertsey which will provide 84 beds and satisfy part of the plan supported by the earlier consultation. This will be carried out in close collaboration with Ashford and St Peter's NHS Foundation Trust to optimise alignment with their urgent care development plans with a view to enhancing interface working across physical and mental health. The investment in this refurbishment and extension will be in the region of £35m funded through land sales.

9. Alongside this work will also begin on managing risks around decanting services through transitional work and drawing up plans for an improvement programme which will involve the development of up to 80 beds on a site in the east of the county. The lowest cost option is to refurbish and extend existing inpatient facilities at 'The Meadows' at the West Park Hospital site in Epsom. Alternative options are the other sites in Epsom and Redhill, but these would involve a new build potentially the leasing or purchase of land.

Conclusions:

10. Both developments are required to meet the quality and quantity of current and forecast mental health needs of Surrey's population. Whilst utilising capital resources will support the refurbishment of the Abraham Cowley Unit in Chertsey, there will be a gap in financial investment in this work that health commissioners will be considering to provide the number of beds required to support the revenue consequences and additional capital to complete the provision of 80 beds in the east of the County. These plans need to be supported by the Sustainability and Transformation Partnerships (STPs) and have been referenced in the Surrey Heartlands Plans.

Recommendations:

It is recommended that the Adults and Health Select Committee

i. notes progress and proposals to date to achieve improved hospital facilities for people who are mentally unwell.

ii. Receives a further update on the development of mental health patient in services at its meeting on 7 November 2018

Next steps:

None

Report contact:

Justin Wilson, Chief Medical Officer, Surrey and Borders Partnership NHS FT
Diane Woods, Associate Director Mental Health Commissioning, Guildford & Waverley CCG

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07912 774656; dianewoods@nhs.net

Sources/background papers:

Your Future Your Say consultation 2008/09
Surrey and Borders Partnership NHS FT: Board Item 98.17 24/7 Report 13.09.17

Glossary of Terms:

CQC – Care Quality Commission

SaBP – Surrey and Borders Partnership NHS Foundation Trust

Adults and Health Select Committee

9 November 2017

Surrey Suicide Prevention Plan

Purpose of report: To provide assurance on the quality of the multi-agency Surrey Suicide Prevention Plan in response to the recommendation of the House of Commons Health Select Committee inquiry into suicide prevention**.**

Executive Summary

The impact of suicide on family, friends, workplaces, schools and communities can be devastating; it carries a huge financial burden for the local economy and contributes to worsening inequalities.

The House of Commons Select Committee have therefore asked all Local Authorities to scrutinise local plans to reduce suicide.

The numbers of completed suicides in Surrey is significantly lower when compared to England and the South East Region. The suicide rate in Surrey 9.1 per 100,000 of the population compared to 10.1 in England and 10.2 in the South East region. However, there is still, on average 92 deaths from suicide every year which equates to one per cent of all deaths every year in Surrey.

Local authorities in England have found access to detailed data and intelligence on suicide challenging to collect in a timely fashion. A number of organisations are potentially involved in holding this information (police, ambulance services, mental health, A&E etc) and sharing sufficient detail is prohibited by national data protection legislation and organisational policies (**see Recommendation 1**).

In Surrey, where detailed audits of completed suicides have been undertaken, the intelligence gleaned about the risk factors for suicide reflects national reports and therefore contribute little additional understanding of the issue. However, a system facilitating timely access to data on the location and means of both suicides and attempted suicides would be useful in enabling Surrey's Suicide Prevention Group to respond more proactively to reduce suicide in Surrey (**Next Steps and Recommendation 2**).

There is no single risk factor and, no single solution to prevent suicide. In Surrey, therefore, joint, collaborative efforts utilising intelligence and evidence-based interventions are being employed to reduce suicide locally. The Surrey Suicide Prevention Group will develop an all age Suicide Prevention Strategy to make clear how all partners can support efforts to prevent suicide in Surrey (**Next Steps and Recommendation 2**).

This report recommends that the Adults and Health Select Committee:

a. raise concerns regarding national legislative constraints to proactive data sharing on suicides and attempted suicides to the House of Commons; and

b. review progress on delivery of next steps detailed in this report in 12 month time.

Introduction

Every suicide sends shockwaves through families and communities and can take years to recover from. On average, there are 13 completed suicides every day in England. At the beginning of 2017, the Government renewed their commitment to reducing suicide nationally by 10%.

The prevention of suicide requires the coordination of efforts at individual, population and service delivery levels, therefore, multi-agency action by health, social care, the criminal justice system and the voluntary sector is nationally advocated to reduce suicide locally and nationally.

In March 2017, the **House of Commons Health Committee** published their inquiry into suicide prevention. There were a number of considerations for local authorities, including a recommendation that **Health Overview and Scrutiny committees should be involved in ensuring effective implementation of local authorities' suicide prevention plans.** This paper will therefore provide an overview of efforts being advanced in Surrey by a range of organisations to reduce suicide and will outline the challenges to effective implementation of the national guidance described in Annex 2.

Suicide in Surrey

Number of completed suicides in Surrey

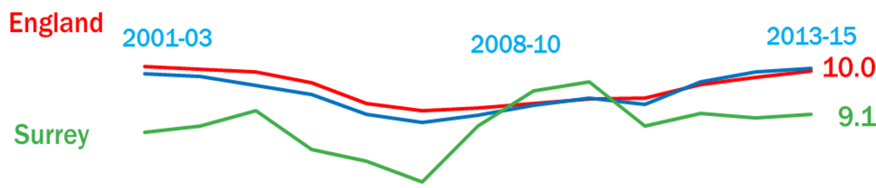
1. Every suicide is a tragic event affecting not only individuals but families and the local community. In Surrey, however, suicides are lower than the average across England as well as among local authorities in the South East Region.

2. The suicide rate is 9.1 per 100,000 of the population this is lower than England (10.1) and the South East region (10.2) (see figure 2). Suicide rate is twice as high among men compared to women in Surrey. Nationally, suicide rates among men are three times higher than women.

3. On average there are 92 deaths by suicide in Surrey every year with six of these among the under 25s (see figure 1). This equates to eight people a month or 2% of all deaths among people under the age of 75 in Surrey (see figure 3).

About 92 people die by suicide every year in Surrey

Figure 1: Suicides in Surrey



Following the credit crunch in 2008, the suicide rate in Surrey peaked to above the England and South East averages, but more recently has dipped below the national and South East figures

(rates are per 100,000 population)

Figure 2: Suicide trends 2001-2015

Suicide deaths as a percentage of all deaths in each age group

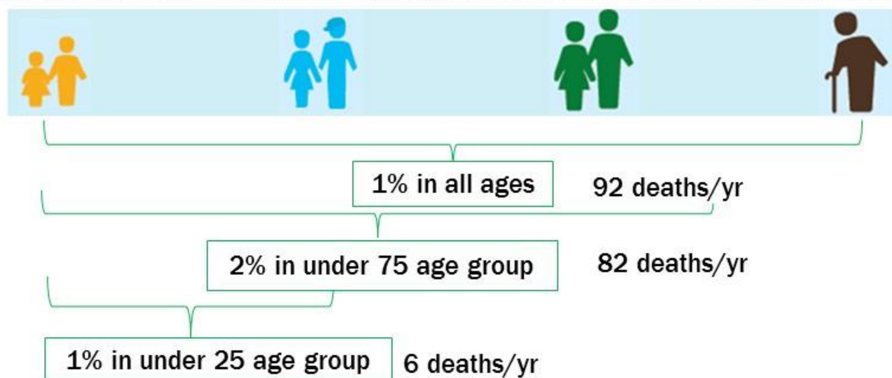


Figure 3: Suicide deaths as percentage of all deaths in each age group between 2013 and 2015

Risk factors for suicide in Surrey

4. Coroner's records on completed suicides are a source of more detailed information about the circumstances involved in a suicide. Previous audits undertaken by Surrey County Council Public Health team have confirmed that the risk factors for suicide in Surrey are in line with national evidence. These are:

   a. existing physical or mental health problems;
   b. being male;
   c. a history of substance misuse;
   d. previous suicide attempts and/or self-harm;
   e. poor economic circumstances; and
   f. living in an area of deprivation

In addition, national data suggests that people who have been bereaved by suicide are at an increased risk of suicide themselves.

Suicide Prevention in Surrey

5. It is clear from local and national experience and the evidence of effective interventions to address suicide (see Annex 2), that suicide prevention is not the sole responsibility of any one organisation and requires action by a range of agencies working both individually and together. Action to prevent suicide in Surrey therefore, takes place in a number of places by a number of organisations (see figure 4). This section will provide an overview of work happening in Surrey in each of the following areas:

    a. Surrey Suicide Prevention Plan
    b. Universal Emotional Wellbeing
    c. Health Services
    d. Mental Health Services
    e. Wider determinants of Health

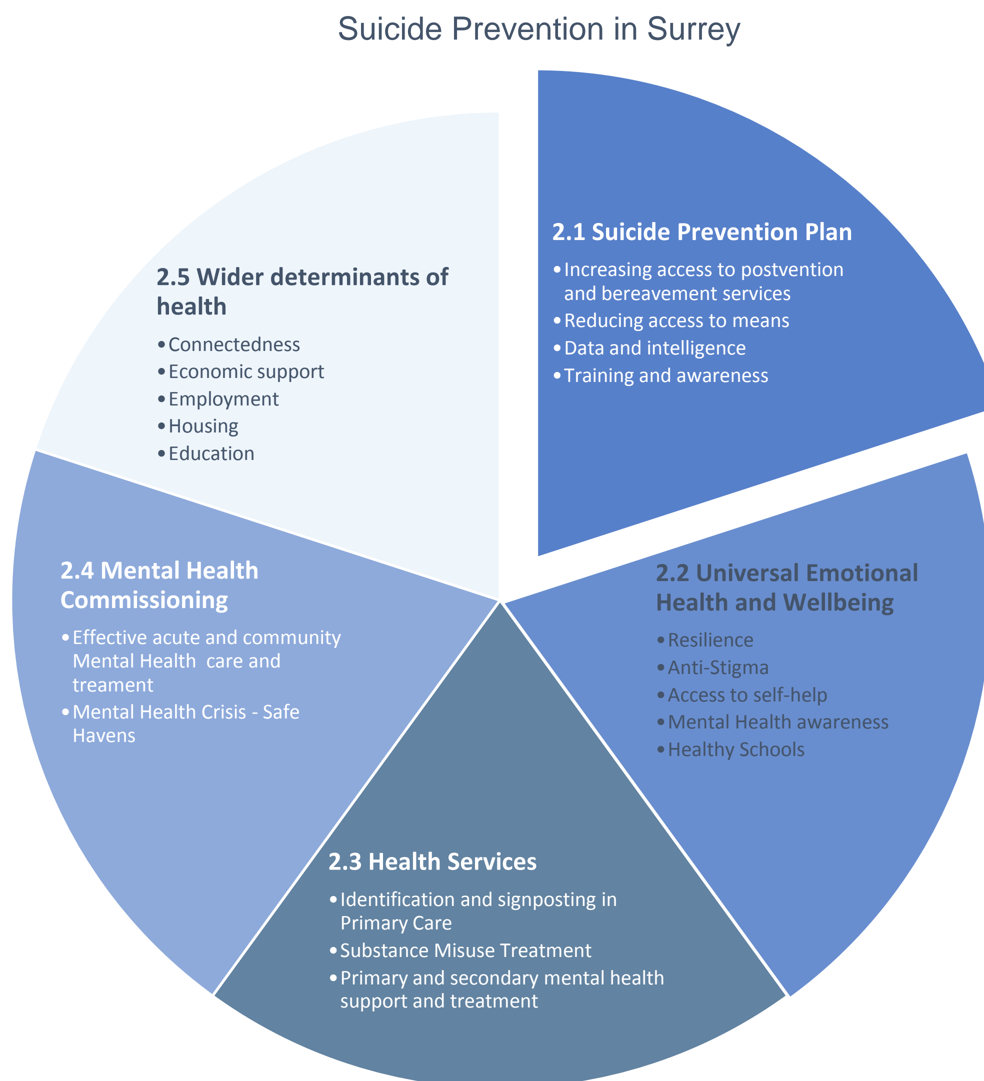


Figure 4: Suicide Prevention in Surrey

Surrey Suicide Prevention Plan

6. A Surrey- wide suicide prevention group was set up in 2008 to mobilise collective action to address suicide following a number of suicides at Deepcut Barracks and HMP High Down. Today, this group is coordinated by Public Health and has representation from a range of partners including community and acute mental health services, CCGs, the police and the voluntary sector (see attached **TOR in Appendix 1**). The role of the group is to provide intelligence and evidence to support and influence partners to engage in activity to prevent suicide and to deliver on the six multi-agency suicide prevention priorities outlined in the Suicide Prevention Plan:

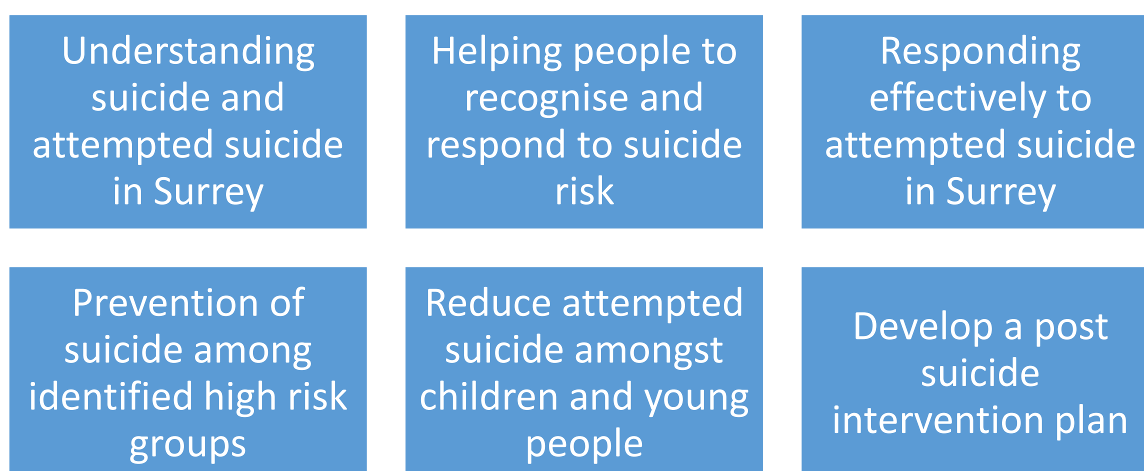


Figure 5: Surrey Suicide Prevention Priorities

7. The Suicide Prevention plan is a live document which uses evidence-based practice and local and national intelligence to identify priority areas for joint action. The priorities and key actions within the current Suicide Prevention plan and achievements to date are shown in Annex 1.

1.1 Governance of Suicide Prevention Plan

The Suicide Prevention Group oversees the development and implementation of the actions within the Suicide Prevention plan.

The group meets on a quarterly basis and reports progress to the Emotional Wellbeing and Mental Health Partnership Board.

There are a number of inter-dependencies with other partnership groups and / or organisations; members of the group are actively engaged in such partnership groups have the responsibility of linking to, sharing and gathering information to ensure that wider partners are engaged where appropriate (i.e. reporting to the Surrey Housing Alliance for actions and information specific to housing providers).

7.2 Development and Implementation of the plan

The Suicide Prevention Group regularly reviews and updates the suicide prevention plan to reflect up-to-date data, national guidance and any emerging local trends. Task to finish groups are engaged in more detailed planning against the key objectives. A Public Health Development Worker coordinates the delivery of the suicide prevention plan, gathering updates from partners on progress.

7.3 Monitoring and Evaluation of the plan

Monitoring progress - Progress against the suicide prevention plan is reviewed quarterly by the suicide prevention group.
Evaluating outcomes - The success of the suicide prevention group is reviewed annually through discussions with all involved to gather information on the outcomes achieved both individually within partner organisations and collectively through the partnership.

Evaluating impact – Impact is measured using three year rolling averages from nationally available suicide figures (PHOF) and benchmarking against other areas. Achievements can be found in Table 1.

Universal Emotional Health and Wellbeing

8. A number of initiatives and programmes are in place across Surrey to promote Emotional Health and Wellbeing, a protective factor for suicide. For example, Surrey has a Targeted Mental Health in Schools (TaMHS) approach which aims to skill up school staff in the support of pupils with emerging mental health and emotional needs and provide access to early advice and consultation from a mental health professional.

9. Surrey also has the Healthy Schools Programme, jointly funded by Public Health and Education, delivered by Babcock 4S, which supports the delivery of Personal, Social, Health and Economic Education (PSHE). The Healthy Schools Programme is part of a whole school approach to health and wellbeing and supports children and young people to be resilient and mentally healthy.

10. Public Health lead on universal and targeted work to improve emotional wellbeing among adults. This include resilience training and workshops with the public; mental health self-help resources and signposting to support services.

Health Services

11. In Surrey, a range of mental health and suicide prevention training is offered to primary care and all GP practices are provided with a directory of services to support early intervention and signposting. From 2018/19, the Department of Health is making funding available to CCGs for suicide prevention, the Suicide Prevention Group will work with CCGs to ensure this aligned to best practice and the local suicide prevention plan.

12. Surrey and Borders Partnership (SaBP) provide Public Health commissioned substance misuse treatment services in Surrey. Where suicide is a presenting risk then an assertive and coordinated approach is undertaken with Community Mental Health Recovery Services including interventions to prevent the risk of drug overdose.

<u>Mental Health Commissioning</u>

13. SaBP is the lead provider in Surrey for health and social care services for residents with mental ill-health, learning disabilities and substance misuse. Specifically related to

suicide prevention, SaBP align their work to The National Suicide Prevention Strategy and the Surrey Suicide Prevention Plan.

14. The Surrey Mental Health Crisis Care Concordat Delivery Group (MHCCCDG); a partnership of health, social care, Surrey police and non-statutory support, work together to prevent crises happening whenever possible through prevention and early intervention. The MHCCCDG partners pledge to meet the needs of vulnerable people in urgent situations and strive to make sure that all relevant public services offer high quality support to someone who appears to have a mental health problem to help move towards recovery. This includes the following actions for suicide prevention:

    - Commission, deliver and evaluate suicide prevention training to key front line professionals.
    - Gain an understanding of the learning from Serious Untoward Incident investigations for suspected suicides.

15. The voluntary sector also plays a key role in supporting the mental health of Surrey residents. Adult Social Care and the CCGs jointly commission community connections services. These services offer one-to-one, group and peer support, as well as activities to promote mental wellbeing and enable recovery for those who have experienced mental health problems.

16. The community connections services are a key part of the mental health pathway and are engaged with both the Mental Health crisis care concordat delivery group (MHCCCDG) and the suicide prevention group. They also deliver the four **safe havens** in Surrey alongside SABP. The safe havens are out of hour's services to support people who may be experiencing a mental health crisis or need help to prevent a crisis. Carers and family members can also access support through the safe haven.

Wider Determinants of Health

17. SCC and its partners have an important role in providing and commissioning services that protect individuals and communities from becoming at risk of suicide and improving and maintaining mental wellbeing. These include facilitating access to meaningful employment; debt advice services; community connectivity and the provision of affordable and supported housing. Membership of the Suicide Prevention Group reflects these areas of work and suicide prevention and mental health training is targeted to front line staff working with vulnerable individuals. Training supports staff to identify those vulnerable to suicide, raise awareness of mental ill health, promote mental wellbeing, reduce mental health stigma and signpost to appropriate services.

Challenges and Gaps

18. Whilst there has been traction across a number of areas within the Surrey Suicide Prevention Plan there are some areas of best practice that have been challenging to implement:

Data and Intelligence:

19. Due to data protection laws, the small numbers involved and the time taken to formally record a death as a completed suicide, Surrey Suicide Prevention Group does not have timely access to detailed information about the means, circumstances, location or demographics involved. More in-depth understanding about the specific factors involved in each suicide is held by the coroner. However, as detailed in section 1, completed

audits of coroner's reports is resource intensive and intelligence gleaned is in line with national findings.

20. A priority locally is therefore to establish a means to record and report data on location and means of suicide so that the suicide prevention group can respond accordingly.

Funding constraints

21. There is as lack of dedicated resources to coordinate and galvanise multi-agency engagement in collective suicide prevention intervention delivery and evaluation.

22. There is limited funding for the provision of suicide prevention training for all relevant front line staff across Surrey.

Support for those bereaved by suicide

23. There is limited support for families and significant others bereaved by suicide in Surrey.

Governance and accountability for suicide prevention

24. Work contributing to suicide prevention happens in a variety of places and there is currently no clear accountability/governance for all of this work. This should be addressed by the development of a Surrey Wide Suicide Prevention Strategy (see **Next Steps**)

25. The Suicide Prevention group has traditionally focused on adults, the involvement of Children and Young People's services would be required to develop a suicide prevention strategy across the life course.

Conclusions

The responsibility for reducing suicides is held by several different organisations including Mental Health Services, local authorities, CCGs and Surrey Police.

Surrey's current Suicide Prevention Plan includes evidence based priorities for multi-agency community-based actions to reduce suicide.

There is no dedicated resources to coordinate or implement suicide prevention efforts in Surrey.

SCC's Public Health and SaBP are committed to jointly developing a strategy for suicide prevention in Surrey to make clear recommendations to all partners on their role in reducing suicide risk.

Recommendations

It is recommended that the Adults and Health Select Committee:

i. responds to House of Commons Health Select Committee citing concerns regarding national legislative constraints to proactive data sharing to enable local identification of someone who could potentially be 'at risk' of suicide.

ii. reviews progress of the next steps in 12 months' time.

Next Steps

With the aforementioned recommendations considered it is anticipated that the following will be achieved over the next 12 months:

Governance and funding

- To request that the Health and wellbeing Board to:
    - Promote the involvement of all partners in the delivery of suicide prevention including committed resource to support this agenda;
    - identify a suicide prevention ambassador to champion suicide prevention within their organisation and lead the implementation of key recommendations within the Suicide Prevention Strategy.
- SaBP and Public Health in partnership with Surrey CCGs to lead the development of an all age Suicide Prevention Strategy for Surrey to ensure a whole systems and coordinated response to suicide.
- To request that CCG funding for Suicide Prevention be aligned to the Surrey Suicide Prevention Strategy and coordinated via the Surrey Suicide Prevention Group

Data and intelligence

- SCC to explore opportunities to implement 'real-time' reporting of location and means of suicide via the Multi Agency Safeguarding Hub (MASH) for attempted suicide and self-harm.
- SCC Coroner's office and the Suicide Prevention Group to work together to achieve improved and efficient data reporting including rapid summaries and data audits.

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Glossary of terms

ASIST - Applied Suicide Intervention Skills Training

Two-day interactive workshop in suicide first aid. ASIST teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety.

CAB – Citizen Advice Bureau

A network of 316 independent charities throughout the United Kingdom that give free, confidential information and **advice** to assist people with money, legal, consumer and other problems.

MHCCC- Mental Health Crisis Care Concordat (Delivery Group)

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. The MHCCC Delivery Group (MHCCCDG) monitors and reviews progress of a local multi-agency action plan for delivery of the recommendations and standards of the Crisis Care Concordat.

NICE – National Institute for Clinical Excellence

Provides national guidance and advice to improve health and social care.

NCISH - National Confidential Inquiry into Suicide and Homicide

UK's leading research programme in this field, the Inquiry produces a wide range of national reports, projects and papers – providing health professionals, policymakers, and service managers with the evidence and practical suggestions they need to effectively implement change

PSHE – Personal, Social, Health and Economic education

PSHE education is a school subject through which pupils develop the knowledge, skills and attributes they need to keep themselves healthy and safe, and prepare for life and work in modern Britain

SaBP – Surrey and Borders Partnership NHS Foundation Trust

Surrey and Borders Partnership NHS Foundation Trust is the leading provider of health and social care services for people of all ages with mental ill-health and learning disabilities in Surrey & North East Hampshire and drug & alcohol services in Surrey, Hounslow and Brighton

SPSG - Suicide Prevention Strategy Group

Suicide Prevention Group is a subgroup of the Mental Health Partnership Board. The Surrey prevention strategy group develops a plan which aims to reduce suicides and attempted suicides in Surrey.

TaMHs- Targeted Mental Health in Schools.

The TaMHS approach aims to skill up school staff in the support of pupils with emerging mental health and emotional needs and provide access to early advice and consultation from a mental health professional.

Sources/background papers:

1. All-Party Parliamentary Group on Suicide and Self Harm[i]. (2013) ll Party Parliamentary group on Suicide and Self Harm. (2013). *The future of local suicide prevention plans in England.*
2. NHS England Five Year Forward View for Mental Health, A report from the independent Mental Health Taskforce to the NHS in England. February 2016[ii]
3. House of Commons Health Committee (2017), suicide prevention inquiry publications.[iii]
4. House of Commons Health Committee. Suicide prevention Sixth Report of Session 2016–17 *Report, together with formal minutes relating to the report. 7 March 2017* [iv]
5. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives , January 2017[v]
6. NICE (NG58) Coexisting severe mental illness and substance misuse: community health and social care services [vi]
7. Public Health England (2016). *Local suicide prevention planning: A practice resource[vii].*
8. Public Health England (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions

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https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Suicide Prevention Plan 2014-2017

Priority	Main Actions	Partners included	Achievements
1) Understanding suicide and attempted suicide in Surrey	Undertake a suicide audit Annual analysis of available local and national data Monitoring of national/economic changes that may increase suicide Identification of areas where there has been a number of complete local suicides	Public Health, Coroner, police, NHS, Mental health services	A suicide audit of suicides taking place between 2012 and 2013 has been undertaken. There is a scrutiny panel (Public Health, CCG's and SABP) that reviews serious untoward incidences in acute mental health settings and SABP have an internal quarterly Suicide Prevention Information Network providing ongoing learning opportunities for organisations and their staff to learn from serious incidences. Public Health carried out a review of all national guidance documents which have been published in recent years. The purpose of this review was to identify areas that are appropriate to embed in the development of a local Suicide prevention strategy. National data on suicide and self-harm is regularly analysed and shared with the Suicide Prevention group. A multi-agency group was established in 2017 in response to a number of suicides at Woking Railway station/Line resulting in Woking being subject to the national rail escalation process. Members include Woking BC, British Transport Police, Surrey and Borders Partnership, Samaritans, CCG, Safe Haven and Community Connections. Some of the key actions include community suicide prevention training, setting up a mental health champion scheme, improving awareness of local services and identifying ways to communicate information about individuals that maybe distressed.
2) Helping people to recognise and respond to suicide risk	Development of a training programme for staff groups who work with people at risk	Public Health, Surrey and Borders Partnership Trust	Surrey CC Public Heath commissioned training – 250 health and social care attendees between 1st April 2015- 31st March 2017 A Suicide Prevention Conference, led by SABP, took place in July 2017 this was attended by over 100 local stakeholders, staff, carers and people who use services. The conference was well received and people made pledges on how they can make individual changes that may save lives. SABP have introduced Clinical Risk Management Training Compliance- eLearning training on clinical risk assessments tis available to staff. The objective of the training is to help drive the reduction in variation in our risk assessment and management approach. SABP Health Education for England grant funding as enabled a training programme to be developed

Priority	Main Actions	Partners included	Achievements
			in partnership with Public Health. Roll out will commence December 2017 for three target groups: Group 1: carers through recovery college Group 2: crisis care team. Delivered by Clinicians Group 3: SABP trust wide training. A Public Mental Health training plan has been developed for 2017/18 and will include suicide prevention sessions
3) Responding effectively to attempted suicide in Surrey	Improve pathways from A&E to appropriate support services for people who attempt suicide or self-harm.	Mental Health Services, NHS, A&E	All A&Es now have been provided with a directory of services (information includes community mental health services and support services). A third party referral scheme was established in September 2016 been set up between A&E and Samaritans (pilot scheme in St Peters hospital, Chertsey).This is for people who attend A&E expressing suicidal ideation, however after assessment are found to have no mental health need or don't meet the threshold for secondary mental health services. Work continues with psych-liaison service expansion to strength identification of those at risk who may present at A&E. There are a number of initiatives currently being embedded in partnership with SABP including 'core 24'. Core 24 is national funding awarded to Surrey with the aim to expand the provision of liaison mental health services in providing specialist, compassionate assessment, detection and treatment of mental ill health in general acute hospitals. This is overseen by the Mental Health Crisis Care Concordat Delivery Group.
4) Prevention of suicide among identified high risk groups	Suicide prevention and anti-stigma training and signposting for those who come into contact with vulnerable groups	Mental Health Service, NHS, Voluntary sector, Substance Misuse services; ASC	A directory of emergency contacts of local and national support services has been developed to signpost people to appropriate support. This is available on the Healthy Surrey website and has been widely distributed. Safe Havens have been developed across Surrey, delivered in partnership they aim to provide accessible alternative care and support pathways for people in mental health crisis and their carers that focus on preventing crises before they happen. The development of Safe Havens is overseen by the Mental Health Crisis Care Concordat Delivery Group. Additional bespoke suicide prevention training sessions have been provided for agencies who have been identified to be working with those at increased risk. Three sessions were delivered in 2017 to CAB staff, Carers and Housing providers. Domestic Abuse providers have attended the ASIST

Priority	Main Actions	Partners included	Achievements
			training. All prisons have a local plan that includes self-harm and suicide prevention[1]. Individuals who have absconded from hospital have been identified as increased risk from suicide, locally partners worked with the British Transport Police to develop a range of projects, including: Radio link between Farnham Road Hospital and local Radio Link system to identify individuals who have absconded from the hospital and alert relevant community contacts including BTP, CCTV headquarters in Guildford, local security staff. The aforementioned guidance review carried out by Public Health in July 2017 details those who have been identified as increased risk and provides example approaches for prevention. The review also included specific guidance on Lesbian, Gay, and Bisexual young people and Trans young people.
5) Reduce attempted suicide amongst children and young people	Delivery of emotional resilience via Healthy Schools programme. Development of a self-harm protocol for schools	Healthy Schools, CAMHs; NHS, CSF	The Healthy Schools programme includes emotional wellbeing, resilience and self-harm. The programme provides Training for school nurses and wider support for professionals working in schools to identify and support children with an emotional mental health and wellbeing need is offered through Emotional Wellbeing Service, through the community health provider. Any young person aged 10-18 can access the CYP Haven; a safe space where you can talk about worries and mental health in a confidential and friendly, supportive environment. This currently exists in the Guildford locality though any young person can receive support there.
6) Develop a post suicide intervention plan	Media monitoring Bereavement support and signposting Multi-agency high-frequency location plans to	Public Health, Ambulance services, Police and Voluntary Sector; Rail, planning, ASC.	Local guidance on media reporting of suicide, online content and social media has been developed. This was circulated to all members of the suicide prevention group. The national guidance has also been circulated to all the Surrey Media outlets. Poor press reporting of suicide is addressed via the Samaritans press office. A small working group has been established to improve support to people bereaved by suicide. This group consists of family members, CAB, Public Health and SOBS. When there has been a high profile online incident a statement with guidance has been issued to

[1] The Prisons have a Prison Service order 2700 "Management of prisoners at risk to self, to others and from others". In line with this order the Safer Custody lead in Surrey prisons ensures that suicide prevention is embedded across prisons in Surrey.

Priority	Main Actions	Partners included	Achievements
	reduce access to means and promote support		appropriate agencies. SABP have a local post suicide intervention plan

The national context and guidance on local plans

The national context

The **National Suicide Prevention Strategy** published in 2012 outlined two objectives: to reduce the suicide rate in the general population in England and better support for those bereaved or affected by suicide.

It called for a partnership approach to implement action in six areas:

1) Reduce the risk of suicide in key high risk groups: young and middle-aged men; people in the care of mental health services, people with a history of self-harm; people in contact with the criminal justice system and specific occupational groups such as doctors, nurses and agricultural workers.
2) Tailor approaches to improve mental health in specific groups.
3) Reduce access to the means of suicide.
4) Provide better information and support to those bereaved or affected by suicide.
5) Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
6) Support research, data collection and monitoring.

The **All-Party Parliamentary Group on Suicide and Self Harm** (2013) recommended local action to deliver the national strategy is implemented through the establishment of a multi-agency suicide prevention group, completion of a suicide audit and the development of a suicide prevention strategy or plan based on the national strategy and local data.

The **NHS England Five Year Forward View for Mental Health** sets an ambition to reduce suicides by 10% by 2021 and calls upon CCGs to support the development and delivery of local multi-agency suicide prevention plans. From 2018/19, 25m of funding over 3 years will be allocated to CCGs to support this.

The **House of Commons Health Committee** (2017) published a series of recommendations as a result of their inquiry into action on suicide prevention. In January 2017, the Government responded to these recommendations in the 3rd progress report of the cross-government strategy on suicide prevention which committed to strengthening action in the following areas:

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan by 2017, with agreed priorities and actions;
- Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services;
- Improving data at national and local level and how this data is used to help take action and target efforts more accurately;
- Improving responses to bereavement by suicide and support services; and
- Expanding the scope of the National Strategy to include self-harm prevention in its own right.

Progress on preventing suicide is measured through the **Public Health Outcomes Framework** and the **NHS Outcomes framework** which includes a number of indicators specific to suicide as well as a range of indicators likely to impact on suicide. An overview of how Surrey compares against England and the South East Region is provided in section 3.

National evidence and guidance on the development of local plans

Risk factors for suicide are broad and reducing them involves a wide range of agencies. The World Health Organisation presented a number of risk factors for suicide such as: barriers to accessing health care; access to means; inappropriate media reporting; stigma associated with help-seeking behaviour; trauma or abuse; social isolation; relationship conflict or loss; a previous suicide attempt; being diagnosed with a mental health condition; alcohol abuse; financial loss; chronic pain and a family history of suicide (World Health Organisation, 2014). The prevention of suicide, therefore, requires a multi-agency response involving the NHS; community and acute mental health providers; county; district and borough councils; the police; transport and the voluntary sector.

The evidence of effective interventions and national guidance provides the rationale for action to:

- support people with existing mental health illness; reduce access to methods of suicide;
- collect and share data on attempted and suspected suicides in a timely fashion;
- identify and respond to those vulnerable to suicides who are both within and outside of health services and
- to support those bereaved by suicide.

This evidence is summarised below:

Good practice for mental health providers and the NHS

The NHS and mental health services have an important role to play in identifying and responding to suicide risk. People with poor mental health and wellbeing present at many different services. Lower patient suicide is associated with specialised community teams; lower non-medical staff turnover; implementation of National Institute for Health and Care Excellence (NICE) guidance on depression; and implementation of recommendations made by the National Confidential Inquiry into Suicide and Homicide (NCISH) in particular 24 hour crisis care.

The Zero Suicide approach is a US model based on the concept that suicides in health and behavioural care settings are not inevitable. The approach is recommended by national guidelines and employs strong leadership, training and a data-focused quality improvement approach. A number of areas in England have adopted this approach and it includes activities such as personalised safety plans for service users with a history of self-harm, rapid post-suicide reviews and suicide prevention training.

Effective support for people with coexisting severe mental illness and substance misuse

A history of drugs and / or alcohol use are recorded in 54% of all suicides in people experiencing mental health problems (University of Manchester, 2016). NICE guidance (NG58) identifies that outcomes for people with psychosis and coexisting substance misuse is worse than for people without coexisting substance misuse, partly because the substances used may exacerbate the psychosis and partly because substances often interfere with pharmacological or psychological treatment. Public Health England (PHE) guidance (2017) “Better care for People with co-occurring mental health and alcohol/drug use conditions” supplements NG 58. The guidance provides support for local commissioning and delivery of evidence based pathways of care for people with co-occurring alcohol and/or drug misuse with mental health issues.

Community based approaches

National guidance "Local suicide prevention planning: A practice resource" (PHE, 2016) recommends awareness campaigns to improve mental health and to reduce stigma; signposting and fast-track into effective mental health treatment; and training for primary care doctors in recognising and treating depression.

Tackling high frequency locations

There are four main approaches to tackling suicide in locations where there has been a number of completed suicides:

1) restricting access to means (e.g. through installation of physical barriers);
2) encouraging help-seeking (by placement of signs and telephones);
3) increasing the likelihood of intervention by a third party (through surveillance and staff training) and
4) responsible media reporting of suicides.

There is an evidenced link between media reporting of suicide and imitative suicidal behaviour (PHE, 2016) and therefore local and national action to support the media to respond sensitively to suicide and suicidal behaviour can reduce suicide.

Bereavement support

There is a growing evidence base (PHE, 2016) that individuals and communities need support following suicides to reduce the risk of adverse impacts such as poor social and occupational functioning, depression and suicide. Access to bereavement support and information is cited as an important intervention.

Preventing and responding to self-harm

Whilst the vast majority of people who self-harm do not have suicidal ideation, there is a strong association between attempted suicide, self-harm and completed suicide. One study, concluded that 20-25% of suicides had presented at hospital admission for self-harm in the year previous to death (Foster, 1997).

It is therefore, important to ensure effective follow-up and care through the implementation of NICE standards and pathways for managing people who self-harm.

Economic support services

Suicide, particularly among men, is associated with a lower socio-economic position and unemployment. Almost a third of suicides in Surrey during 2012 and 2013 cited financial problems as a contributory factor. Therefore, working collaboratively with the voluntary sector such as Citizens Advice and the housing associations to train staff in suicide awareness and provide and promote financial support is recommended (PHE, 2016).

Understanding suicides

National guidance urges local suicide prevention groups to collect and analyse suicide data to understand who is at risk and changes in suicide over time to inform action and to monitor and review progress. A number of data sets are available nationally, and it is recommended that this is supplemented by local data from, for example, auditing coroner's suicide reports; sharing learning from Serious Untoward Incidents and monitoring attempted suicides and incidence of serious self-harm.

Appendix 1

Surrey suicide prevention strategy group 2014- 2017
TERMS OF REFERENCE

INTRODUCTION

Between January 2010- December 2011 there were 169 suicides in Surrey; an average of 84 suicides a year. Therefore reducing suicides in Surrey is important.

A new suicide prevention strategy needs to be developed to address this and will aim to reduce suicides and attempted suicides in Surrey. This will be overseen by a new Suicide Prevention Group which is a subgroup of the Emotional Wellbeing and Mental Health Partnership Board.

1. MEMBERSHIP AND PARTNERSHIP RESPONSIBILITY

Membership of the group:

Senior clinicians- CCG leads	Community connections
Commissioners	CAB
Surrey and Borders Partnership NHS Foundation Trust (SABP)	Acute Trusts
Surrey Police	SEC Ambulance trust
Surrey Prisons	Public Health
Surrey University	Virgin Care
Public Health England	First Steps
Virgin Care	IAPT
CAMHS	Safe Havens
Combat Stress	Substance misuse services
Adult social care	Diocese of Guildford
East Surrey Domestic Abuse Service (ESDAS)	Samaritans
Probation	Community connections
Network Rail representative	

Members are asked to attend four meetings a year. All members are asked to provide a brief quarterly update about suicide prevention activities in their organisations at the suicide prevention strategy group. If members are unable to attend and cannot send a representative to the meetings an update should be sent to nanu.chumber@surreycc.gov.uk and this will be included in the minutes of the meeting.

2. AIMS & OBJECTIVES

- Deliver the suicide prevention plan
- Oversee the development of the suicide prevention strategy

- Improve local data on suicide and attempted suicides
- Monitor and 'RAG' rate progress of the strategy every year
- Evaluate the action plan

3. ORGANISATION OF THE GROUP

The suicide prevention strategy group will be chaired by the Surrey County Council Public Health Team. Administrative support to the Group will be provided by Public Health Team. Meetings will be properly minuted and minutes circulated to all participants and nominated others. All members of the group should send agenda items to the public health team two weeks before the meeting.
Meetings will be held bi-monthly for the first four months. There after meeting will be every quarter.
Every quarter specific projects will be invited to present a project update to the group.

The group may delegate sub-groups for specific pieces of work or may delegate to other groups. Specific terms of reference will be established for any new groups and aims and objectives decided for any specific projects

The suicide prevention strategy group may invite representatives from other organisations to attend specific meetings

4. AGENDA ITEMS

The following items will be standing agenda items

- Suicide audit
- Attempted suicide data
- Any subgroups

Members are asked to email agenda items to the meeting coordinator a fortnight before the meeting.

5. ACCOUNTABILITY

- The SPSG will report to the EWMH Partnership Board every quarter
- The SPSG will write an annual progress report. This should be shared will all partners' senior management teams
- The SPSG may organise stakeholder events to consult about its work programme.
- The SPSG will seek regular feedback from service users to gain their views and evaluate the effectiveness of interventions

6. LINKS WITH EXISTING STRUCTURES

Where necessary the SPSG will develop links to other local organisations not listed in the membership.

7. Confidentiality

All members of the group must maintain confidentiality when sensitive data and information is shared.

Data and information from the suicide audit must not be shared until it has been signed off by the group.

8. ARBITRATION

In the event of serious disagreement between the group members the Partnership Board will intervene to resolve the issues.

Appendix 2:

Appropriate Language

1. Suicide numbers are low. Why is it a concern
    - One suicide is one too many
    - Every suicide is preventable
    - For every one suicide there are 6 people intimately affected
    - Suicide affects whole communities

2. Language/ Phases we don't use

Don't use	Use
Committed suicide or successful suicide	Completed suicide or death by suicide
Suicide hotspot or suicide cluster	There has been a number of completed suicides in a location
Unsuccessful suicide	Attempted suicide
Suicide craze	NA
Suicide tourist	NA
Cry for help or attention seeking	NA
Suicide victim	• If family member or significant other: *Bereaved by suicide* • If individual: *completed suicide*

3. Suicide methods:
    - We avoid going into too much detail about suicide methods.

4. Samaritans quick guidance:
   https://www.samaritans.org/sites/default/files/kcfinder/files/press/10%20things%20to%20remember%20when%20reporting%20suicide.pdf

Item 8

Adults and Health Select Committee

9 November 2017

Update on the South East Coast Ambulance Service (SECAmb) Regional Health Scrutiny Sub-Group.

Purpose of report:

To provide an update on scrutiny that has been undertaken into the performance of South East Coast Ambulance Service (SECAmb) as conducted by a Regional HOSC Sub-Group.. Given the recent publication of the Care Quality Commission's (CQC) findings following an inspection of SECAmb coupled with the release of Professor Lewis' report into bullying and harassment at the Trust it is timely for the Select Committee to receive an update on the work of the Sub-Group.

Introduction:

South East Coast Ambulance Service Foundation Trust (SECAmb)

1. South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provides ambulance services across a 3,600 mile area encompassing Kent, Surrey and Sussex. The operational area of the Trust is geographically diverse contrasting densely populated urban areas such as Brighton and Medway with large swathes of sparsely populated rural areas. To provide this service over such a wide and disparate area the Trust employs approximately 3,300 staff working across 110 sites. Within SECAmb's locality there are 22 Clinical Commissioning Groups (CCGs), 12 Acute Trusts and seven top tier local authorities. North West Surrey CCG commission the contract for SECAmb to operate across the entirety of this area.

2. SECAmb was inspected by the Care Quality Commission (CQC) the findings of which were published in September 2016 and rated the Trust as 'Inadequate' highlighting particular concerns around leadership and safety. As a result of this inspection NHS Improvement placed SECAmb in special measures. This report is published on the CQC's website and can be found at the following link: http://www.cqc.org.uk/sites/default/files/new_reports/AAAF5030.pdf

3. Interim leadership arrangements were in place at SECAmb between May 2016 and March 2017 when a new Chief Executive, Daren Mochrie, and Chairman, Richard Foster were installed at the Trust. This was closely followed by SECAmb relocating its central operations to a new purpose-built headquarters located in Crawley.

4. In April 2017, SECAmb commissioned a report from Professor Duncan Lewis to provide an independent assessment of concerns about a culture of bullying and harassment at the Trust. Professor Lewis concluded that bully and harassment were widespread and the results of his investigation were published in July 2017. The Professor Lewis report can be accessed at the following link: http://www.secamb.nhs.uk/about_us/news/2017/bullying__harassment_report.aspx

5. SECAmb was re-inspected by the CQC in May 2017 the findings of which were published on 5 October. Inspectors found the Trust to be 'Inadequate' once again citing leadership and safety as particular areas of concern. As part of the inspection report, SECAmb was given 17 'must-dos' by the CQC, i.e. 17 areas where specific action was required. It is anticipated that the Trust will remain in special measures following the outcomes of this inspection. The findings of the CQC's most recent inspection into SECAmb can be found at the following link: http://www.cqc.org.uk/sites/default/files/new_reports/AAAG5730.pdf

SECAmb Regional HOSC Sub-Group.

6. In response to the CQC's 2016 report into SECAmb, the South East Regional Health Overview & Scrutiny Committee (HOSC) Chairman's Sub-Group established a Task Group to conduct ongoing scrutiny of the Trust. The Terms of Reference for this Task Group were approved on 18 November 2016 and then reaffirmed after County Council elections in May following the transfer of Surrey County Council's (SCC) HOSC function to the Adults & Health Select Committee. The Terms of Reference for the SECAmb Regional HOSC Sub-Group require it to:

   a. monitor the development and progress of the NHS Improvement Plan for South-East Coast Ambulance (SECAmb) Trust;
   b. take into account the voice of local people (which may include consideration of feedback from local Healthwatch organisations) and seek to ensure that the needs of local people are integral to the improvements being designed and delivered by the Trust; and
   c. report back publicly to the relevant health scrutiny committees on a regular basis.

7. The Sub-Group includes representation from six of the seven top tier local authority areas which constitute SECAmb's area of operations: Brighton & Hove City Council, East Sussex County Council, Kent County Council, Medway Council, Surrey County Council and West Sussex County Council. The benefits of conducting collective scrutiny of the Trust's performance are defined within the Sub-Groups Terms of Reference as:

   a. reducing duplication through collaborative working
   b. scrutinising its delivery against the improvement plan
   c. contributing to the Quality Account for the Trust

8. This Council is represented on the Sub-Group by Ms Sinead Mooney and Mr David Mansfield who attend quarterly meetings along with Members from the five other local authorities to collectively scrutinise the Trust's performance and review delivery against its improvement plan. The Sub-Group has met four times since it was first established in November 2016.

9. The Sub-Group has requested updates and additional information on a wide array of areas relating to SECAmb's performance and service delivery. These range from implementation of the Trust's Quality and Improvement Plan arising from the outcome of successive CQC inspections to work force recruitment and retention as well as the surge management plans and insights into the role of health partners in enabling SECAmb to meet national targets on call response times. This update focuses on three key areas that the Sub-Group has focused on since it was established in 2016.

Scrutiny SECAmb's CQC Inspection Rating

10. Given the outcome of SECAmb's two most recent CQC inspections, scrutiny of the Trust's improvement plan has been a primary area of focus for the Sub-Group since it was established and an update has been provided on the implementation of SECAmb's Quality and Improvement Plan at the request of Members at each of the Sub-Group meetings to date. The CQC's inspection report published on 5 October 2017 determined that SECAmb had not made sufficient progress in implementing the Quality and Improvement Plan it had developed following the previous inspection. Specifically, the report identified 17 'must dos', 17 areas where action was required to improve performance. In addition, SECAmb was issued with two 'notice of proposals', areas of practice which require immediate action to address. These were in relation to medicines management and 999 call recording although it should be noted that the CQC has since withdrawn the notice of proposal issued on the former following an unannounced inspection in September 2017 which recorded good practice in relation to how the Trust handles and stores medicines.

11. At its most recent on 15 October 2017, the Sub-Group requested a presentation from the Chief Executive detailing the CQC's findings and outlining measures SECAmb was implementing to address concerns raised within the report. Following enquiries from Members regarding the notice of proposal on 999 call recording, the Sub-Group was informed that SECAmb's existing telephony platform occasionally caused static making recordings of some calls difficult to understand. The Trust had employed a member of staff to resolve these issues which has already significantly improved 999 call recording. A paper is also being brought forward to the Trust's governing body seeking approval to replace the existing telephony platform which will further improve 999 call recording. The new telephony platform is being financed through additional funding given to the Trust on account of it being in special measures. It is advised, however, that factors external to SECAmb make successfully recording 100% of calls unrealistic.

12. The Sub-Group also asked for information on efforts to address the 17 'must-do's' set by the CQC. Eleven task and finish group have been established and are chaired by a member of the executive leadership team to monitor comprehensive action plans in relation to these 'must dos'. The Chief Executive's presentation focused on an example of some of the 'must-do's', which included:

    - **Incident Reporting** – Ambulance services are required to record serious incidents as a means of learning lessons and improving patient safety. SECAmb records approximately 400 incidents a month with around one a week deemed to be a serious incident. The CQC highlighted concerns around SECAmb's incident reporting which produced a significant backlog in processing incident forms. Since the inspection this backlog has been reduced to 500 incidents and efforts to understand what caused this backlog has led to improvements in processing incidents. As part of this the Trust is working with partner agencies to understand how they handle incidents referred to them by SECAmb as this represents one of the main obstacles to progressing actions arising from these incidents. The Chief Executive stated that he wished to make SECAmb a 'learning organisation', minimising mistakes and learning from those that did occur.
    - **Safeguarding** – National guidance requires clinicians in emergency operations centres (EOCs) and emergency and urgent care (EUC) at ambulance trusts to have Level 3 safeguarding training. The CQC report found that that not all staff had completed this training. The Chief Executive informed the Sub-Groups that plans were in place for all staff to complete level 3 safeguarding training.
    - **Staffing in EOC** – Inspectors found that there were, at times, insufficient staffing relating to clinicians in the EOC including insufficient numbers of clinical supervisors

at the individual sites to ensure patient safety. Measures have been implemented to ensure staffing in the control centre was more multidisciplinary. The implementation of a new command and control system will also institute improved management of incidents by staff at the EOC. The national Ambulance Response Programme (ARP) is also being implemented at the Trust from 22 November which resets national targets for Ambulance responses and will facilitate more effective targeting of resources towards patient need.

- **Improved ACQI – Heart Attack** – A strategy would be implemented across the Trust in relation to improving clinical outcomes for particularly ill patients. This will be supported by a new health informatics system which will be in place by March 2018 and will provide more meaningful data that will help to drive performance. Members were informed that the Trust had 70 Critical Care Consultant Paramedics who were targeted to patients who had particular acuity through a critical care hub located within the control centre. A consultant paramedic specialising in responding to patients in cardiac arrest has also been employed by the Trust to drive forward a strategy on improving ACQIs for those experiencing a heart attack with the objective being to embed it within the organisation.

13. The Chief Executive of SECAmb stressed that the Trust had been in a particularly challenging position prior to the CQC inspection in May 2017 on account of juggling various priorities. This included relocating to new headquarters, implementing a new command and control system and attempting to introduce improvements from the previous inspection. This was compounded by uncertainty in the Trust's leadership structure which has now been resolved by the introduction of a permanent Chief Executive and Chairman. He emphasised that having more stability will enable the Trust to focus on embedding improvements identified by the CQC although he also stated that it was important to focus on the performance of the Trust as a whole to ensure that other areas don't deteriorate while responding to concerns raised by the CQC. As such, various work streams have been developed to take the organisation forward which are being wrapped around the 11 task and finish groups to ensure delivery.

14. Members are aware that performance reporting by SECAmb shows a continued decline in call response times against nationally targets although these were not available for scrutiny at the Sub-Groups meeting on 15 October. The Sub-Group will ensure close monitoring of performance against targets as set out in the ARP which SECAmb is adopting as of 22 November. The Chief Executive highlighted the impact that handover delays at A&E departments which mean that paramedics wait for extended periods of time at hospitals handing over patients instead of being available to respond to another call. Indeed within SECAmb's operational area there are hospitals in the top 10 nationally for handover delays. This is something that needs to be addressed by the system as a whole as something which can lead to significant improvements in ambulance response times. Members have asked to receive monthly handover delay statistics to identify hotspot areas to enable HOSCs to question local health partners on handover delays if required.

15. SECAmb has not yet been informed about whether it will remain in special measures but it is anticipated that NHS Improvement will follow the CQC's recommendation that the Trust stays in special measures.

Scrutiny of Efforts to Tackle Bullying and Harassment at SECamb

16. The SECAmb Regional HOSC Sub-Group has also had extensive discussions in relation to the findings of the Professor Lewis report which describes a culture of bullying and harassment at the Trust. The Chief Executive has acknowledged that

Professor Lewis' findings were disappointing but had decided to make the report publicly available to show that they did not wish to hide anything.

17. The Trust has already employed an additional member of staff with an Organisational Development background to lead improvements in culture across SECAmb and to drive out bullying and harassment. The Board would receive a further report at the end of the month regarding the strategy moving forward and continued efforts to strengthen staff engagement. A 200% increase in the response rate for the staff Friends and Family test and feedback from Trade Unions suggest that measure to improve staff engagement are already delivering results. The Chief Executive also recognises the importance of the senior management Team leading by example in building a culture of respect across the organisation.

Cardiac Survival to Discharge

18. The Sub-Group has identified concerns around SECAmb's cardiac survival to discharge rates which are significantly below the national average and has subsequently requested updates on measures being implemented by the Trust in order to improve these. Cardiac survival to discharge rate is the percentage of people who are taken to hospital by paramedics while in cardiac arrest and survive. Cardiac Survival to Discharge does not simply take into account whether a patient is alive when they arrive at hospital but includes the entirety of the care pathway to the point that they are discharged from hospital.

19. SECAmb has employed a consultant paramedic to ascertain how outcomes for those patients treated for cardiac arrest can be improved and has brought forward a number of recommendation on how the Trust can improve its performance in this area. This included public education on cardiac arrest to encourage 999 calls to be placed more swiftly, better information on resuscitation and promoting access to defibrillators. Work was also underway to ensure that calls are triaged correctly so that the appropriate resources can be despatched to the patient.

20. Data on Cardiac Survival to Discharge was being reviewed by the Board on a monthly basis to assess performance in this area. Members requested further detail on how SECAmb collected data regarding on Cardiac Survival to Discharge and were told that this relies on hospitals informing the Trust whether patients experiencing cardiac arrest brought in by paramedics had survived. Officers from SECAmb stated that dated collection was hampered by some hospitals who were not always forthcoming with this data

21. The current Cardiac Survival to Discharge rate for SECAmb in 2016/17 was 22.2% but the aspiration is to raise this to between 30-40%. This will, however, require a collective effort from public sector organisations across the South East. The Fire and Rescue Services could play a particularly important role in improving Cardiac Survival to Discharge Rates in the region as fire officers can often be first on the scene at specific incidents.

Conclusions:

22. The outcome of two CQC inspections and the publication of the Professor Lewis report demonstrate that some significant changes are required at SECAmb in order to achieve the standard of service delivery expected of it and recent figures showing continued decline in ambulance response times are a further cause for concern.

Scrutiny of the measures that SECAmb are now putting in place to address concerns outlined in the CQC's inspection report do, however, demonstrate that SECAmb recognises these concerns and, more importantly, how to address them. Measures introduced by the Trust have already delivered tangible improvements in performance such as in relation to medicines management and 999 call recording while the introduction of task and finish groups to monitor the progress of specific actions plans demonstrates a commitment to delivery on its Quality and Improvement Plan.

23. The Sub-Group also feels that a period of stability at SECAmb will enable Trust leaders to focus on enhancing its performance as installing a settled and consistent leadership team, completing the move to a new Headquarters and implementing a new command and control system have all now been completed. Members have also been encouraged by the introduction of specific workstreams which will enable SECAmb to take a holistic approach to improving performance rather than simply focusing on the areas outlined in the CQC's Report. The Sub-Group has found further encouragement in the Trust's 111 service which was rated 'Good' by the CQC at its most recent inspection.

24. There are factors beyond SECAmb's control which have a direct impact on its performance and capacity to respond to calls in accordance with Government targets. Specifically, delays in paramedics being able to hand patients over to hospital staff as well as a lack of clarity on care pathways for those who don't need to be taken to A&E. NHS Improvement has, however, gained pledges from partner agencies to review processes and procedures to ensure that they support SECAmb including in relation to handover delays at hospitals and the Sub-Group will monitor the progress of these pledges at future meetings.

Recommendations:

It is recommended that the Adults & Health Select Committee:

i. notes scrutiny that the Regional HOSC Sub-Group is undertaking of South East Coast Ambulance Service NHS Foundation Trust; and

ii. requests that it receives a further update from the SECAmb Regional HOSC Sub-Group in 12 months' time; and

iii. suggest aspects of SECAmb's performance and delivery that the Sub-Group should be scrutinising.

Next steps:

The Sub-Group is meeting again in January next year and will continue to review implementation of the Trust's Quality and Improvement Plan as well as performance against the new Ambulance Response Programme targets.

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Sources/background papers: none

Glossary of acronyms:

ACQI – Ambulatory Care Quality Indicator
ARP – Ambulance Response Programme
CCG – Clinical Commissioning Group
CQC – Care Quality Commission
EOC – Emergency Operations Centre
EUC – Emergency & Urgent Care
HOSC – Health Overview and Scrutiny Committee
SCC – Surrey County Council
SECAmb – South East Coast Ambulance Service Foundation Trust

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Adults and Health Select Committee – Forward Work Programme 2017/18

Select Committee	Topic	Date item expected to be scheduled	Involvement of other committees	Expected outcome
AHSC	Acute Mental Health Ward Relocation and future planning	9 November 2017	None	Assess the impact of the ward relocation in improving patient experience and safety, and plans for future acute ward provision in Surrey.
AHSC	Suicide Prevention Framework	9 November 2017	None	Review the suicide prevention framework, following a request from the House of Commons Health Select Committee. Explore what is being done to reduce suicides in the county (leading cause of death in 20-34 year olds in the UK).
AHSC	Update from SECAmb Regional HOSC Sub-Group	9 November	None	The Care Quality Commission's (CQC) undertook a formal inspection of South East Coast Ambulance Service (SECAmb) in May 2017, the report into this inspection was published on 5 October which rated SECAmb as 'Inadequate'. SECAmb is commissioned to provide ambulatory care across six top tier local authority areas and, as such, the Adults & Health Select Committee sends representatives to a regional sub-group which scrutinises the performance of SECAmb. Given the CQC rating, the Surrey representatives on the Sub-Group wish to report to the Committee on the work of the regional sub-group to provide assurances to both Members and residents that AHSC does retain oversight of SECAmb's performance.
AHSC	Home-based Care	25 January 2018	None.	Adult Social Care will be recommissioning home based care services in the autumn. The committee will review the plans to recommission, and investigate how the council is responding to the current pressures on providers created by market conditions.
AHSC	Accommodation with Care and	25 January 2018	None.	The Committee will review the next phase of the ASC accommodation with care and support project, following a

	Support (Extra Care)			Cabinet decision on the next phase in January 2018.
AHSC	Surrey Heartlands	Task group (see below)	None	The committee will need to consider how it reviews the Surrey Heartlands devolution proposal, and other strategic plans across the footrprint. As this is an area of considerable strategic change, it may wish to consider a plan of ongoing engagement with the topic.
AHSC	Learning Disabilities and Transition Task Group	November 2017 onwards	Children & Education Select Committee	The statutory responsibilities of the council to both children and adults with care and support needs are substantial. The number of young people with complex needs transferring into adult social care has been recognised as a significant demand pressure within the MTFP. This has also been identified by the Cabinet Members as an area requiring the support of the Council's scrutiny function.
AHSC	Guildford & Waverley CCG Adult Community Health Services Contract	7 November 2018	None	To review delivery on Guildford & Waverley CCG's Integrated Adult Community Health Services Contract following implementation.
Items in development				
AHSC	Demand management	In development	None	The committee will review the plans to manage demand in ASC, which accounts for approximately £4 million of ASC savings in the MTFP and has been identified as a red risk.
AHSC	Sustainability and Transformation Plan Progress	In development	None	The committee will need to maintain track on progress around the three STP footprints, and how this is impacting on the delivery and long term planning for social care and health. The committee will also need to consider how the three plans work together to mitigate risks of regional variation in health outcomes, and represent the best interests for Surrey

				residents.
AHSC	Access to primary care and GP services	In development	None	This has been identified an area of interest by committee members. The committee will need to consider how it approaches scrutinising the item, and will use the summer to scope it and report back to the Council Overview and Budget Scrutiny Committee
AHSC	Sexual Health Services	In development	None	At the Adults & Health Select Committee, Members agreed to form a Task Group to review the consultation and implementation phases of Surrey's new sexual health services contract.
AHSC	Blue Light Collaboration	In development	Communities Select Committee	To receive an update on the Blue Light Collaboration project.
AHSC	Adult Social Care Debt	In development	None	To receive an update on efforts to manage and reduce the amount of adult social care debt owed to Surrey County Council.

Committee groups

The SECAmb regional sub-group is formally constituted and its terms of reference cover regional scrutiny of SECAmb performance and improvement plans. The committee recommends that involvement in this group continues for the duration for 2017, as the CQC has recently re-inspected the Trust and expect to publish the results in September.

The Surrey Heartlands STP Task Group is in the process of being approved. Its terms of reference cover the Epsom estate, stroke review services and the devolution plans.

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