Notice of Meeting

Health and Wellbeing Board

Date & time
Thursday, 10 September 2020
at **2.00 pm**

Place
Remote meeting

Contact
Amelia Christopher
Room 122, County Hall
Tel 020 8213 2838
amelia.christopher@surreycc.gov.uk

Please note that due to the COVID-19 situation this meeting will take place remotely.

Please be aware that a link to view a live recording of the meeting for members of the public will be available on the Health and Wellbeing Board page on the Surrey County Council website.

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Board Members

Siobhan Kennedy	Housing Advice Manager, Guildford Borough Council
Dr Andy Brooks	Chief Officer, Surrey Heath and East Berkshire Clinical Commissioning Group
Dr Charlotte Canniff (Deputy Chairman)	Clinical Chair, Surrey Heartlands Clinical Commissioning Group
Vacant	Executive Director for Children, Families and Learning, Surrey County Council
Jason Gaskell	CEO, Surrey Community Action
Dr Russell Hills	Clinical Chair, Surrey Downs Clinical Commissioning Group
David Munro	Surrey Police and Crime Commissioner
Mr Tim Oliver (Chairman)	Leader of Surrey County Council
Kate Scribbins	Chief Executive, Healthwatch Surrey
Vacant	Clinical Chair, East Surrey Clinical Commissioning Group
Simon White	Executive Director of Adult Social Care, Surrey County Council
Ruth Hutchinson	Director of Public Health, Surrey County Council
Dr Claire Fuller	Senior Responsible Officer, Surrey Heartlands
Fiona Edwards	Chief Executive, Surrey and Borders Partnership
Joanna Killian	Chief Executive, Surrey County Council
Helen Griffiths	Executive Dean of the Faculty of Health and Medical Sciences, University of Surrey
Sue Littlemore	Head of Partnerships and Higher Education, Enterprise M3

Mrs Sinead Mooney	Cabinet Member for Adults and Health, Surrey County Council
Mrs Mary Lewis	Cabinet Member for Children, Young People and Families, Surrey County Council
Vacant	Managing Director, North East Hampshire and Farnham Clinical Commissioning Group
Giles Mahoney	Director of Integrated Care Partnerships, Guildford and Waverley Clinical Commissioning Group
Rob Moran	Chief Executive, Elmbridge Borough Council
Rod Brown	Head of Housing and Community, Epsom and Ewell District Council
Borough Councillor Caroline Reeves	Leader of Guildford Borough Council
Borough Councillor John Ward	Leader of Waverley Borough Council
Frances Rutter	Principal and Chief Executive at North East Surrey College of Technology (NESCOT)
Robin Brennan	National Probation Service, South East and Eastern Division, Assistant Director and Head of Public Protection
Carl Hall	Community Rehabilitation Company, Kent, Surrey & Sussex, Assistant Chief Officer
Gavin Stephens	Chief Constable of Surrey Police
Ms Denise Turner-Stewart	Cabinet Member for Communities, Surrey County Council
Steve Flanagan	Representative, North West Surrey Integrated Care Partnership and Community Provider voice

TERMS OF REFERENCE

The Health and Wellbeing Board:

- oversees the production of the Joint Health & Wellbeing Strategy for Surrey;
- oversees the Joint Strategic Need Assessment; and
- encourages integrated working.

PART 1
IN PUBLIC

1 APOLOGIES FOR ABSENCE

To receive any apologies for absence and substitutions.

2 MINUTES OF PREVIOUS MEETING: 4 JUNE 2020 (Pages 1 - 12)

To agree the minutes of the previous meeting.

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

a Members' Questions

The deadline for Member's questions is 12pm four working days before the meeting *(4 September 2020).*

b Public Questions

The deadline for public questions is seven days before the meeting (*3 September 2020)*.

c Petitions

The deadline for petitions was 14 days before the meeting. No petitions have been received.

5 SURREY HEALTH AND WELLBEING BOARD MEMBERSHIP REVIEW (Pages 13 - 18)

Following agreement at the June Health and Wellbeing Board, a subgroup was formed to undertake a review of the membership over July. This report highlights the key proposed changes to membership and representation.

6 SURREY COVID-19 COMMUNITY IMPACT ASSESSMENT (Pages 19 - 50)

The Community Impact Assessment (CIA) explores how communities across Surrey have been affected by COVID-19, communities' priorities for recovery, and what support these communities might need in the event of another outbreak. The findings of the research show that COVID-19 has had a disproportionate impact on some communities within Surrey and identifies a risk that inequality between communities is likely to increase. The Board are asked to consider how the findings can be incorporated into the Health and Wellbeing Strategy and used to inform decisions around future service delivery and resource allocation.

7 SURREY SAFEGUARDING CHILDREN PARTNERSHIP: THEMATIC REVIEWS OF ADOLESCENT SUICIDE AND SERIOUS CASES (Pages 51 - 120)

The purpose of this report is to advise the Health and Wellbeing Board (HWB) of the findings arising from two important thematic reviews carried out over the last 12 months by the Surrey Safeguarding Children Partnership (SSCP). The report seeks to gain the support of the Board to achieve a robust multi-agency response in addressing the specific findings, enable development of practice and influence commissioning priorities.

8 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT (Pages 121 - 150)

This paper describes the status of projects in the Health and Wellbeing Strategy against previously agreed milestones as of July 2020. Given the summary nature of the June report this aims to provide more detail across all the priorities through highlighting progress being made whilst also continuing to recognise where there is a continued impact resulting from the COVID-19 pandemic. This varies between delays, continuing with a different focus, or continuing with a heightened focus or additional activity.

9 HEALTH AND WELLBEING COMMUNICATIONS PRIORITIES (Pages 151 - 154)

The Health and Wellbeing Board communications sub-group has produced a draft Communications Plan to support the work of the board over the next six to nine months.

The Plan, which outlines three priority areas of focus, is intended to ensure a coordinated approach across the system building on strong partnership working that has already developed. The Plan is intended to reflect the COVID-19 context and align with and complement programmes within the Health and Wellbeing Strategy.

10 SURREY LOCAL OUTBREAK ENGAGEMENT BOARD (Pages 155 - 164)

In response to the NHS Test and Trace Service, launched on 28 May 2020 which is designed to control the rate of reproduction of Covid-19 by reducing the spread of the infection; as part of their local arrangements councils are expected to have a member-led, typically by the Leader of the authority, COVID-19 Local Outbreak Engagement Board.

The Surrey Local Outbreak Engagement Board (LOEB) was formally constituted by County Council on 7 July 2020 as a formal sub-committee of the Surrey Health and Wellbeing Board and its Terms of Reference are included.

11 COVID-19 RECOVERY PLANNING - SURREY HEARTLANDS

The Health and Wellbeing Board is to receive a verbal update on COVID-19 recovery planning in relation to Surrey Heartlands Health and Care Partnership's Recovery Strategy.

12 DATE OF THE NEXT MEETING

The next meeting of the Health and Wellbeing Board will be on 3 December 2020.

Joanna Killian
Chief Executive
Surrey County Council

Published: Tuesday, 1 September 2020

QUESTIONS, PETITIONS AND PROCEDURAL MATTERS

The Health and Wellbeing Board will consider questions submitted by Members of the Council, members of the public who are electors of the Surrey County Council area and petitions containing 100 or more signatures relating to a matter within its terms of reference, in line with the procedures set out in Surrey County Council's Constitution.

Please note:

1. Members of the public can submit one written question to the meeting, giving at least 7 days notice. Questions should be within the committee's terms of reference and relate to general policy and not to detail. Questions are asked and answered in public and so cannot relate to "confidential" or "exempt" matters (for example, personal or financial details of an individual – for further advice please contact the committee manager listed on the front page of this agenda).
2. The number of public questions which can be asked at a meeting may not exceed six. Questions which are received after the first six will be held over to the following meeting or dealt with in writing at the Chairman's discretion.
3. Questions will be taken in the order in which they are received.
4. Questions will be asked and answered without discussion. The Chairman or Board Members may decline to answer a question, provide a written reply or nominate another Member to answer the question.
5. Following the initial reply, one supplementary question may be asked by the questioner. The Chairman or Board Members may decline to answer a supplementary question.

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MINUTES of the meeting of the **HEALTH AND WELLBEING BOARD** held at 2.00 pm on 4 June 2020 via Microsoft Teams.

These minutes are subject to confirmation by the Committee at its meeting on Thursday, 10 September 2020.

Elected Members:
(Present = *)

* Siobhan Kennedy
Dr Andy Brooks
* Dr Charlotte Canniff (Deputy Chairman)
* Steve Flanagan
* Dave Hill
* Jason Gaskell
* Dr Russell Hills
* David Munro
* Mr Tim Oliver (Chairman)
* Kate Scribbins
Simon White
* Ruth Hutchinson
* Dr Claire Fuller
* Fiona Edwards
* Joanna Killian
Helen Griffiths
Sue Littlemore
* Mrs Sinead Mooney
* Mrs Mary Lewis
* Giles Mahoney
* Rob Moran
* Rod Brown
* Borough Councillor Caroline Reeves
* Borough Councillor John Ward
Frances Rutter
Carl Hall
* Robin Brennan
Gavin Stephens
* Ms Denise Turner-Stewart

Substitute Members:

Liz Uliasz - Deputy Director for Adult Social Care (SCC)
Nicola Airey - Executive Place Managing Director for Surrey Heath CCG
Dr Bernadette Egan - Senior Research Fellow/Deputy Director NIHR Research Design Service South-East, University of Surrey

In attendance

Hayley Connor - Director - Commissioning (SCC)

The Board welcomed Steve Flanagan, Chief Executive of Central Surrey Health (CSH), as the representative for the North West Surrey Integrated Care Partnership and Community Provider voice.

12/20 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Apologies were received from Gavin Stephens, Simon White - Liz Uliasz substituted, Dr Andy Brooks - Nicola Airey substituted, Helen Griffiths - Dr Bernadette Egan substituted.

13/20 MINUTES OF PREVIOUS MEETINGS: 5 MARCH 2020

The minutes were agreed as a true record of the meeting.

14/20 DECLARATIONS OF INTERESTS

There were none.

15/20 QUESTIONS AND PETITIONS

a MEMBERS' QUESTIONS [Item 4a]

None received.

b PUBLIC QUESTIONS [Item 4b]

None received.

c PETITIONS [Item 4c]

There were none.

16/20 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT

Witnesses:

Phillip Austen-Reed - Principal Lead - Health and Wellbeing (SCC)

Sponsors:

Rod Brown - Head of Housing and Community at Epsom and Ewell District Council (Priority 1)
Giles Mahoney - Director of Integrated Care Partnerships at Guildford and Waverley Clinical Commissioning Group (CCG) (Priority 2)
Rob Moran - Chief Executive of Elmbridge Borough Council (Priority 3)

Key points raised in the discussion:

1. The Chairman explained that due to the challenges posed by Covid-19, the report does not provide a detailed performance of the priorities but rather highlights the impacted areas. The pandemic has brought to the foreground the vulnerabilities faced by many, such as the forty-thousand shielded residents and the increased use of food banks. This had impacted the local priorities and so there was an opportunity to review the delivery of the Health and Wellbeing Strategy against to ensure its priorities remain appropriate and relevant whilst linking with the restoration and recovery work.
2. The Principal Lead - Health and Wellbeing outlined that the status of the projects within the three priorities in rated from red to green,

highlighting areas most impacted as a result of reduce to resource or need for greater partnership work.

3. Positively, over half of the projects were continuing and adapting under the current situation, such as:
    - The creation of a Homeless Multi-Agency Group to support Borough and District Councils in response to the Government directive to provide accommodation to the homeless:
        - In response, a Board member commented that Covid-19 had magnified the housing shortage issues. All eleven Borough and Districts Councils responded to the directive to accommodate all rough sleepers aiding delivery of the Homelessness Reduction Act 2017 and personal plans were being made for people moving on. District and Boroughs were having meetings with the Ministry of Housing, Communities and Local Government to identify the particular needs of each rough sleeper as well as the solutions and funding needed. Despite some boroughs and districts not having sites to move people on to after the temporary accommodation, the use of Bed and Breakfasts, hotels, the Government preventing evictions in the private sector and triage support from health colleagues on who to prioritise for certain types of accommodation ensured that the directive has been largely met to date.
        - Responding to a Board member query, it was discussed that there were tensions with commercial hotels putting rough sleepers in temporary accommodation and them wanting to return to business as usual particular in Guildford and Woking. Half of those rough sleepers had been moved out of those hotels in Guildford and assurance was provided that the tensions would be managed in conjunction with MHCLG. There had been a recent more flexible approach by hotels after discussions with MHCLG, who were looking at capital funding and asking councils to look into their procurement solutions, in which Surrey was aided by the LRF.
        - A Board member was reassured that the Government was working proactively with councils on the long term issues surrounding rough sleepers and would consider potential funding from the Office of the Police and Crime Commissioner to help on that matter.
    - The positive work regarding domestic abuse, there was a new Domestic Abuse Executive Group:
        - The Priority 1 sponsor noted that he had been involved in various activities in response to Covid-19, including helping to manage the emergency response and setting up a community hub. There were mixed messages concerning the increase in domestic abuse, but it was noted that survivors were waiting until pandemic is over before reporting so data was being modelled to meet that demand after lockdown.
        - An attendee noted that the Executive Director for Children, Families and Learning (SCC) was chairing the Domestic Abuse Executive Group. Across the voluntary and community sector, Boroughs and Districts, Surrey Police and the Office of the Police and Crime Commissioner there was an increase in users to refuge services as well as an increase in domestic violence within assessments of children and in adult social care. In line with modelling which showed an increase in

domestic violence that occurs after significant incidences such as the pandemic, the rise over the next year would need to be addressed in conjunction with refuge providers to add additional refuge capacity to Surrey.
    - The Chairman noted that Surrey had been asked to participate in a Channel 4 documentary in the next couple of weeks to showcase its work on tackling domestic abuse.
- A virtual wellbeing hub and virtual safe haven had been developed for mental wellbeing support and adaptation to the community mental health offer:
    - The Priority 2 sponsor commented that the emotional wellbeing of people and psychological impact of the pandemic were at the centre of the recovery work and the multi-agency approach was encouraging as all were taking responsibility for mental health.
- Additional support for local suicide prevention plans and new healthy schools approach:
    - A Board member queried the national publicity about suicide rates rising, asking about levels of suicide in Surrey. In response, it was noted that a county-wide Suicide Prevention Strategic Group had been set up. The Consultant in Public Health added that it was complicated to get timely information relating to suicides from the coroner. Surveillance was crucial and they were working with Surrey Police to set up an early warning system. A data feed was being received weekly on unexpected deaths at home such as suicide and drug overdoses. The earlier increase in those deaths that coincided with the Covid-19 peak had returned to previous levels.
    - It was noted that Surrey Police were involved in many cases of unexplained deaths, the Chief Constable had a daily log of significant incidences which has seen more unexplained deaths during the pandemic. Regarding attempted suicides, the Consultant in Public Health noted that they were looking at whether information from hospitals could be sourced relating to poisonings or trauma which would not show up in police data.

4. The Principal Lead - Health and Wellbeing noted that impacted areas would likely slow the achievement of outcomes in the short to medium term and collaboration was key as part of the recovery work. As part of this the Surrey Heartlands' Recovery Strategy – current thinking' Annex to the report was noted. The recovery work on the Community Impact Assessment and the Joint Strategic Needs Assessment (JSNA) - item 6 - included intelligence on target populations which was vital and his team will be liaising further with the three priority sponsors on the matter to inform how best to approach building in the learning from this.
5. The Priority 3 sponsor noted that people leading fulfilling lives had been affected adversely by the pandemic with many focus areas impacted, however it is likely that there would be significant links to the recovery plans that are evolving.
6. A Board member summarised Surrey Heartlands' 'Recovery Strategy - current thinking' presentation, noting that there were a number of pieces of restoration work including starting up those health services that had been stood down due to the pandemic. Challenges included the fact that Covid-19 was still live and Personal Protective Equipment (PPE) supply issues. There were large changes to front line delivery

such as the use of digital to deliver health care, capturing those changes was key to develop the current strategies. It was important to have a county-wide view across health and social care, incorporating target populations and standardising health inequalities.

7. The Deputy Chairman commented that the pandemic had accelerated positive work, previous barriers such as digital transformation had been removed and discharge processes were more efficient, greater Borough and District Council partnership work established during the pandemic must be maintained. These were areas that were included in the work programmes within the priorities under the Recovery Board for Surrey Heartlands.
8. The Deputy Chairman explained that the End of Life Care programme was ongoing with support from an executive health lead and Surrey County Council lead, looking at county-wide strategy to come back to the Board for sign-off.
9. The Chairman endorsed the current partnership work, including the excellent coordination work of the LRF. It was noted at the recent regional health call, that Surrey was an exemplar of partnership working between the health system and local government.
10. A Board member stressed that is was important to ensure that public patient service user feedback formed part of the partnership work. Many members of the public had embraced the quick changes and those who risked being left behind must be central to the developing recovery work. In response to a Board member query regarding the recovery work mandated at a national level versus local prioritisation, it was explained that the JSNA work gathered intelligence in Surrey to address local priorities and could be used to measure behaviour changes such as greater personal responsibility over health, as well as the RCG's Surrey CIA and local partnership work, whilst adhering to national directives.

RESOLVED:

1. Noted the changes in the Health and Wellbeing implementation plans with some areas impacted or changing focus.
2. Ensured that the strategy priorities and associated focus areas were considered by partners represented at the Health and Wellbeing Board, as plans were put in place locally to support recovery.
3. Considered any implications on the delivery of the strategy and how work could be maintained through recovery as a high priority, particularly where projects have been refocused relating to the pandemic.
4. Considered the need to further prioritise any areas of the strategy and considered whether additional projects not currently in the scope of the strategy were needed to meet specific needs resulting from the pandemic, based on the developing elements of the Community Impact Assessment.

Actions/further information to be provided:

1. The Public Health team will liaise further with the three priority sponsors over the plans to progress the priorities, focus areas and projects.
2. The county-wide strategy for the End of Life Care programme under Priority 1, will be brought back to the Board for sign-off in due course.

17/20 ADAPTATION OF APPROACH TO JSNA DURING COVID-19: INTELLIGENCE TO SUPPORT RECOVERY

Witnesses:

Dr Julie George - Consultant in Public Health (SCC)
Satyam Bhagwanani - Head of Analytics and Insight (SCC)

Key points raised in the discussion:

1. The Consultant in Public Health introduced the report noting that proposals for refreshing the Joint Strategic Needs Assessment (JSNA) and the Social Progress Index were received last by the Board in March. Due to Covid-19, the approach would need to change to deliver the early population health intelligence response to support recovery in order to inform the refresh of the Surrey Health and Wellbeing Strategy and the Board's priorities for the next six months.
2. The Head of Analytics and Insight outlined the work of the Community Impact Assessment which was split into the following areas:
   - Overarching Thematic Assessment - different types of impacts on communities, including physical health impacts to those who had contracted Covid-19 or died from it and wider indirect impacts such as mental health, housing and transport issues.
   - Vulnerability and Impact Assessment - the geographical analysis of impact to understand areas in Surrey most impacted directly as well as indirect effects such as a rise in unemployment and domestic violence.
   - Place-Based and Population Based Strength and Needs Assessments - engagement with people, focus groups, linking back to communities and target groups in the Health and Wellbeing Strategy. Fifteen priority groups had been shortlisted and were provided to the Recovery Coordinating Group (RCG) and feedback from Board was welcomed. The qualitative approach was being finalised to identify the right people and partners with expertise to liaise with.

Dave Hill left the meeting at 2.55 pm

5. The Consultant in Public Health commented that work was already progressing in some of the fifteen priority groups identified, many of which overlap with the priority areas or target populations in the current Health and Wellbeing Strategy.
6. She summarised the findings from the 'Covid-19: Review of disparities in risk and outcomes' report recently published by Public Health England, through graphs which were separated by ethnic groups for males and females on the inequality in mortality over the past five years and over the ongoing Covid-19 pandemic. There was a large difference in mortality due to Covid-19 in non-White ethnic groups such as Asian, Black Mixed and Other for both men and women - more pronounced in men.
7. A Board member welcomed the Board's focus on health inequality. He noted that he and the Consultant in Public Health represented the Surrey Heartlands Integrated Care System (ICS) at the NHSE/I Southeast BAME Population Mortality Improvement Board. He

reported on examples of good practice elsewhere in the Southeast. These included Slough, where over half of its population belonged to BAME groups, where a population health management approach was being taken and West Sussex who were working through their primary care networks.

8. A Board member highlighted that the grouping of children with Special Educational Needs and Disabilities (SEND) was too wide a priority group. There was evidence that young people with autism found it difficult to deal with Covid-19, which should be a focus given the high cases in Surrey. In response, a Board member noted the national work on autism and the gap exposed by Covid-19. Surrey were involved in that work through the Surrey and Borders Partnership NHS Foundation Trust Chief Medical Officer Dr Justin Wilson.
9. The Consultant in Public Health recognised that the identified population groups needed refinement and would evolve as the community impact work is refined. Additional groups also identified were those with substance misuse issues and elderly residents whether in care homes or receiving domiciliary care. She suggested that members provide feedback on the fifteen populations groups identifying any gaps or more refined group definitions.
10. A Board member explained that a third of her workforce were BAME and queried whether there were active discussions by public sector employers to address Covid-19 inequalities. In response, a Board member noted that Surrey Heartlands ICS had a well-developed action plan to address risks for the BAME workforce issue, including implementing a risk assessment with large providers across Surrey Heartlands but also General Practices, care homes and wider primary care sectors. Weekly coordination calls had been set up with representation from across different organisations to address BAME inequalities. Work was ongoing to establish a BAME Alliance, to oversee the workforce and the population health work and would have wide representation across public sectors.

RESOLVED:

1. Agreed the approach to population health intelligence to support recovery.
2. Confirmed that the Board agrees that it is a suitable approach to providing Joint Strategic Needs Assessment for the next six months.

Actions/further information to be provided:

Board members are encouraged to provide feedback on the fifteen population groups, identifying any gaps or group definitions requiring refinement.

18/20 COMMUNITY SAFETY AGREEMENT INTERIM PLAN

Dr Claire Fuller left at 3.12 pm

Witnesses:

Sarah Haywood - Policy and Commissioning Lead for Community Safety, Office of the Police and Crime Commissioner (OPCC)

Key points raised in the discussion:

1. A Board member stated that the Community Safety Agreement (CSA) was a statutory document and the interim plan set out how the diverse spectrum of needs and shared priorities within the county will be addressed.
2. The Chairman reminded the Board that as a two-tier authority, Surrey County Council must ensure collaboration with its Borough and District Councils and key partners.
3. A Board member noted the opportunity to reset strategies during Covid-19 and welcomed the more detailed CSA plan to be presented at September's Board.
4. In response to a Board member comment on ensuring a joined-up approach across Borough and District Councils, the crucial role of the local Community Safety Partnerships was highlighted.

Fiona Edwards left at 3.18 pm

5. Responding to a Board member comment concerning full engagement with all relevant partners in the county, the Policy and Commissioning Lead for Community Safety (OPCC) responded that she would liaise with the statutory partners and link the detailed plan to the new recovery plans and the RCG's Community Impact Assessment (CIA).

RESOLVED:

The Health and Wellbeing Board approved the suggested plans for an interim Community Safety Agreement.

Actions/further information to be provided:

The more detailed Community Safety Agreement plan will be brought to the September Board, ensuring that the statutory partners have full engagement and linkage with the county's recovery plans and Community Impact Assessment.

19/20 HEALTH AND WELLBEING BOARD REVIEW 2020 – PROPOSAL

Witnesses:

Phillip Austen-Reed - Principal Lead - Health and Wellbeing (SCC)

Key points raised in the discussion:

1. The Chairman introduced the report and explained that the Board's composition had changed as a result of the merger with the Community Safety Board and that Dr Charlotte Canniff (Deputy Chairman) was now the single clinical chair for the Surrey Heartlands Clinical Commissioning Group (CCG).
2. The Chairman commented that Surrey's Health and Wellbeing Board was an important bridge between local government and health and it was wider in its remit than most. He noted the need to review whether it has the right membership to remain inclusive as well as effective.

3. He explained that the proposal was to remove the scheduled private informal business meetings, standing them up if needed for training sessions or workshops. The Board will continue to meet quarterly and in public, starting at 2pm on Thursdays.
4. Moving into the recovery phase of Covid-19 it was important for the Board to offer oversight over the delivery of the county-wide Health and Wellbeing Strategy through the Local Recovery Structures which includes Frimley, Surrey Heartlands and the Local Resilience Forum.
5. The Deputy Chairman commented that the membership review was a good opportunity since the merger of the four Clinical Commissioning Groups (CCGs). The Frimley and Surrey Heartlands collaboration from a health representation side was important. Initially the Board focused on both organisational and place representation to ensure a breadth of knowledge across acute and community trusts, mental health and primary care providers.
6. The Board agreed with the Deputy Chairman's suggestion of a subgroup seminar to discuss the membership going forward. The Principal Lead - Health and Wellbeing and his team as well as the Board's Committee Manager would liaise with members on that seminar, seeking comments in order to bring a final membership list for approval to the next Board meeting.

RESOLVED:

1. Approved the suggested meeting schedule and the Forward Work Plan (Annex 2).
2. Discussed the proposed changes to membership.
3. Discussed the questions on the governance and leadership role of the Health and Wellbeing Board.
4. Noted the HWBB Information Pack (Annex 1) which provides an overview and discussion points regarding the Board's statutory responsibilities, implementation of the Health and Wellbeing Board Strategy and its system leadership.

Actions/further information to be provided:

An informal subgroup seminar will be set up to discuss the Board's future membership and a final review of the membership will be brought back to the next Board meeting in September.

20/20 DATE OF NEXT MEETING

The next public meeting of the Health and Wellbeing Board will be on 10 September 2020.

Any other business:

- Surrey Local Outbreak Engagement Board

The Chairman noted that as part of the national Test and Trace Service launched by the Government on 28 May 2020 to control the spread of Covid-19, each Upper Tier local authority were expected to develop Local Outbreak Control Plans by the end of June. As part of their local plans, councils are expected to have a member led, typically by the Leader of the authority, Local Outbreak Control Board, which will provide political oversight of local delivery

of the Test and Trace Service. It was proposed that in Surrey, the Local Outbreak Engagement Board would be a subgroup of the Health and Wellbeing Board, leading the engagement with local communities and be the public face of the local response in the event of an outbreak. The first meeting of the new Board would be held privately on 18 June to review the draft Terms of Reference and approve the initial plan. He noted that the new Board would look to address the challenge of ensuring the rapid collection of local data needed down to postcode level and reinforcing preventative measures such as social distancing, commenting that Surrey was a high-risk area due to its proximity to London.

The Interim Director of Public Health explained that as part of the Test and Trace Service, anyone who received a positive test would be contacted by the national team and there will be a process of contact-tracing. Each area was different so they were tasked with writing their own Local Outbreak Plan. Surrey's proximity to Heathrow and Gatwick Airports did affect the infection rate at the start of the pandemic. She added that communications and surveillance would be essential during the recovery phase. Within the Local Outbreak Engagement Board there would be a Health Protection Board with wide representation across the system.

A Board member highlighted that the Council was a Beacon Council delivering excellence in key areas such as governance and was sharing best practice such as how it was working with businesses across the county to ensure that the workforce felt confident about returning to work, collaborating with public transport operators. Ensuring fast localised data down to postcode level was key for targeted partnership activity through the Local Resilience Forum and powers to enforce the required changes in activity in communities were needed from the Government.

A Board member noted that Surrey Police had a crucial role to play in reinforcing lockdown restrictions and social distancing and agreed that communications would be fundamental to the recovery work.

The Chairman noted an incoming announcement from Government about more Mobile Testing Units (MTUs) and testing centres, with tests to be accessible from General Practices and pharmacies. It was discussed that the link to the Testing Cell within the LRF was key.

- Update on Healthwatch's role

The Chief Executive of Healthwatch Surrey explained that Healthwatch initially took a step back early in the pandemic to review how they could most contribute to situation whilst system partners were dealing with Covid-19 on the front line. Planned face-to-face public engagement and meetings with system partners were cancelled whilst the helpdesk remained open to follow-up urgent cases. Resources were redeployed to help the voluntary and community sector and it worked with system partners to get the national messages out to communities. After a few of weeks Healthwatch England confirmed that local Healthwatch had been asked by the Government and NHS to continue their work gathering feedback and using engagement experience to ensure seldom heard groups were not overlooked locally. Healthwatch Surrey increased its insight gathering to reach out to communities using both digital and physical channels. It was a challenge as they were not able to go into care homes and use Enter and View to gather

information, nor visit hospitals or health centres, so it joined virtual meetings of many voluntary and community groups in Surrey and distributed leaflets for people who use food banks to share their experiences.

The key themes in the latest e-bulletin 'Healthwatch Surrey Intelligence Report May 2020': were summarised: most people felt that they have had good information around Covid-19, with a few exceptions - people with sensory impairments had accessibility issues and people with health conditions felt confused about some of the messaging around shielding vulnerable individuals.

They received positive feedback about the new ways of working through technology removing need for physical trips, however those without digital access were left behind. It was concerning that some cancelled their regular check-ups and treatments due to the fear of Covid-19, confidence needed to be rebuilt and aided by communications.
There was mixed feedback concerning regular contact from GPs, ongoing consistent communications with patients about next steps and managing symptoms was vital.

Healthwatch Surrey had not heard much from those with mental health issues and she was happy to work with the Board to identify and address any gaps. In response the Deputy Chairman noted that she and the Priority 2 sponsor could take an action back to the Recovery Board about the ongoing communications to patients waiting for services.

A Board member noted that resident groups were supporting communities, helping those with mental health issues during the pandemic. In response, a Board member commented that he was leading the voluntary and community sector strand of the Recovery Cell to maintain support offered by community groups.

The Executive Place Managing Director for Surrey Heath CCG positively commented that during the pandemic there was an increase in people self-managing their own care, she provided reassurance that the health service remained available for people needing treatment. In response, the Chairman noted the importance of harnessing those positive changes in behaviour and the Deputy Chairman added that primary care could be very proactive due to the manageable patient level. The Priority 2 sponsor noted that national funding for a one-thousand home remote monitoring programme had been secured, initially focusing on dementia patients and those with long-term conditions.

Meeting ended at: 3.52 pm

Chairman

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Health and Wellbeing Board Paper

1. Reference Information

Paper tracking information	
Title:	Surrey Health and Wellbeing Board Membership Review
Author (Name, post title and telephone number):	Phillip Austen-Reed (phillip.austen-reed@surreycc.gov.uk; 07813538431) Victoria Berry, Policy and Programme Manager - Health and Social Care Integration (victoria.berry@surreycc.gov.uk; 07989 663656)
Sponsor:	Tim Oliver, Chairman
Paper date:	10 September 2020
Version:	V0.1
Related papers	N/A

2. Executive summary

Following agreement at the June Health and Wellbeing Board, a subgroup was formed to undertake a review of the membership over July. This report highlights the key proposed changes to membership and representation.

3. Recommendations

The Health and Wellbeing is asked to;

1. Agree the proposed representation and approve the changes to membership;
2. Discuss and agree new sponsor for priority 2; and,
3. As a result of the merger of the Community Safety Board with the Health and Wellbeing Board, subject to approval, agree the arrangement of an informal session for HWB members in the Autumn to better understand the local community safety agenda. This will be used to inform an updated HWB members briefing pack for all existing and new members as vacancies occur.

4. Reason for Recommendations

At the June Health and Wellbeing Board, it was agreed that a membership review would be beneficial to ensure that it remained inclusive and effective. This was in recognition that the Board's composition had changed as a result of the merger with the Community Safety Board and the appointment of a single clinical chair for the Surrey Heartlands Clinical Commissioning Group (CCG) which has also recently formed.

5. Detail

Whilst determining the changes to membership, the subgroup agreed and applied the following working principles:

1. *All core members have a responsibility for cascading Health and Wellbeing Board information to individual organisations.*
2. *The board will have appropriate and balanced representation from partners each with a clear role to ensure manageable numbers.*
3. *Associate Members of the Health and Wellbeing Board with specialist interest will attend as determined by the agenda.*

The proposed changes include:

Local Authority membership[1]

1. Change from two District & Borough leaders to one.
2. Change Chief Housing Officers representative (Guildford BC) representation to associate member who will continue to attend whenever agenda has housing related items.
3. Continue representation from District & Borough Chief Executive.

Community safety membership[2]

Continue membership as agreed as part of Community Safety Board / Health and Wellbeing Board merger:

1. Surrey Police, Chief Constable.
2. CRC, Assistant Chief Officer.
3. National Probation Service - South East and Eastern Division, Assistant Director and Head of Public Protection.
4. Cabinet Member for Communities.

Health membership[3]

1. The Clinical Chair and SRO will provide the statutory representation on the Board for Surrey Heartlands (following creation of one Surrey Heartlands CCG).
2. The Chief Officer for Frimley Collaborative to provide statutory representation for Surrey Heath CCG and North East Hampshire and Farnham CCG.
3. The Frimley ICS Lead to represent Frimley ICS on the Board.
4. Additional non-statutory representation to be based on suggestion that each ICP should be represented on the board but ideally with an appropriate additional role to represent different health providers (Mental Health, Acute, Primary Care, Community).

[1] Statutory Membership: *at least one councillor of the local authority, nominated in accordance with subsection (3)*
[2] Statutory Membership: *police, local authorities, fire and rescue authorities, probation service, health*
[3] Statutory membership: *a representative of each relevant clinical commissioning group*

Other key membership

1. Representation from LEPs and NESCOT to formally move to the newly formed Growth Board whilst acknowledging key links to Priority 3 - Fulfilling Potential.

Proposed named representation assuming changes:

	Name	Representing	Comment
1	Cllr Sinead Mooney	Cabinet Member for Adults & Health	
2	Cllr Mary Lewis	Cabinet Member for Children, Young People and Families	
3	Nominated representative from Leaders Group	D&B leaders	
4	Rob Moran	Surrey Chief Executives *(Priority 3 Sponsor)*	Chair of Chief Executives Group or nominated representative
5	Cllr Tim Oliver	Health and Wellbeing Board Chair and Leader of SCC	
6	Ruth Hutchinson	Director of Public Health	
7	Rod Brown	Prevention Board *(Priority 1 Sponsor)*	
8	*Vacant*	Executive Director for Children, Families and Learning	Joanna Killian in the interim
9	Simon White	Director of Adult Social Care	
10	Joanna Killian	SCC Chief Executive	
11	Cllr Denise Turner-Stewart	Cabinet Member for Communities	Agreed March 2020 as a result of the Community Safety Board merger
12	Gavin Stephens	Chief Constable, Surrey Police	Agreed March 2020 as a result of the Community Safety Board merger
13	Carl Hall	Assistant Chief Officer, CRC	Agreed March 2020 as a result of the Community Safety Board merger. Remain as core member until probation take over full delivery of offenders in 2021
14	Robin Brennan	Assistant Director and Head of Public Protection, National Probation Service - South East and Eastern Division	Agreed March 2020 as a result of the Community Safety Board merger
15	David Munro	Surrey Police and Crime Commissioner, OPCC	Alison Bolton as formal deputy and exec observer/guest

16	Dr Claire Fuller	Surrey Heartlands (SRO)	
17	Dr Andy Brooks	Surrey Heath CCG, NEHF CCG and Commissioning Collaborative	
18	Dr Charlotte Canniff	Surrey Heartlands CCG (Clinical Chair) and Primary Care	
19	Michael Wilson CBE	Crawley, East Surrey and Horsham (CRESH) ICP and Acute Hospitals/Acute Trust Providers	
20	Dr Russell Hills	Surrey Downs ICP and Primary Care	
21	Steve Flanagan	North West Surrey ICP and Community Provider	
22	Vicky Stobbart	Guildford & Waverley ICP	
23	Fiona Edwards	Frimley ICS and Mental Health Provider (SABP)	
24	Kate Scribbins	Healthwatch Surrey	
25	Jason Gaskell	Surrey Community Action	
26	Helen Griffiths	University of Surrey	

Membership changes as a result of recommendations detailed above

Name	Currently representing	Comment
Siobhan Kennedy	Housing	Associate Member- attendance determined by agenda
Sue Littlemore	LEPs	Consider move to Growth Board as formal substitute
Frances Rutter	NESCOT	Consider move to Growth Board
Cllr John Ward	D&B Leaders	Nominated D&B Leader representative tbc
Cllr Caroline Reeves	D&B Leaders	Nominated D&B Leader representative tbc
Giles Mahoney	Guildford & Waverley ICP	Formally resigned from the Board and as Priority 2 Sponsor

6. Challenges

The proposed changes to Health and Wellbeing Board membership means there is a need for a new Priority Two Sponsor. Discussions are ongoing to finalise future arrangements.

7. Timescale and delivery plan

Subject to approval, changes to representation and membership will be implemented immediately, with the new membership coming together for the first time formally at the December Health and Wellbeing Board.

8. Next steps

- Subject to agreement, the ToR will be updated to reflect changes to roles and representation.
- Review, update and share the previous HWB induction pack to reflect the developing strategy and incorporate community safety as a result of the merger of the Community Safety Board.

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Health and Wellbeing Board Paper

1. Reference Information

Paper tracking information	
Title:	Surrey COVID-19 Community Impact Assessment
Related Health and Wellbeing Priority:	Supporting COVID-19 response and recovery All 3 Priorities within the Health and Wellbeing Strategy
Author:	Satyam Bhagwanani, Head of Analytics and Insight, 07970 779 253 Dr Naheed Rana, Public Health Consultant - Intelligence and Insight
Sponsor:	Ruth Hutchinson, Director of Public Health
Paper date:	10 September 2020
Version:	0.6
Related papers	Annex 1 – Geographical Impact Assessment Report Annex 2 – Recovery Progress Index Findings and Scorecard examples Annex 3 – Community Rapid Needs Assessments - Summary Table

2. Executive summary

The Community Impact Assessment (CIA) explores how communities across Surrey have been affected by COVID-19, communities' priorities for recovery, and what support these communities might need in the event of another outbreak. The findings of the research show that COVID-19 has had a disproportionate impact on some communities within Surrey and identifies a risk that inequality between communities is likely to increase. The Board are asked to consider how the findings can be incorporated into the Health and Wellbeing Strategy and used to inform decisions around future service delivery and resource allocation.

3. Recommendations

It is recommended that the Board:

1. Acknowledges the issues highlighted in the Community Impact Assessment (CIA) and asks lead officers to incorporate them into the Health and Wellbeing Strategy.
2. Supports the use of the CIA findings to refine the target populations in the Health and Wellbeing Strategy and instigate actions within the delivery plans to tackle the impact of COVID-19 on at risk and vulnerable communities.
3. Provides individual and collective leadership to ensure CIA findings are incorporated into organisational strategies and inform decisions around future service delivery and resource allocation.

4. Supports the proposal for the CIA steering group to become the Joint Strategic Needs Assessment steering group when the CIA is complete.

4. Reason for Recommendations

The Community Impact Assessment (CIA) is a suite of intelligence products that explores how communities across Surrey have been affected by COVID-19, communities' priorities for recovery, and what support these communities might need in the event of another outbreak. The results are relevant to all priorities in the Health and Wellbeing Strategy.

Looking across the products that make up the CIA, the initial findings show that COVID-19 has had a disproportionate impact on certain groups within Surrey, including people from Black, Asian and minority ethnic (BAME) backgrounds, people experiencing domestic abuse, people with mental health conditions and those in residential care. Specific places within Surrey also appear to have been impacted more than others, including areas in Spelthorne, Tandridge and Waverley. Overall the research identifies a risk that inequality between communities is likely to increase. The Board is asked to consider these findings and reflect on whether the Health and Wellbeing priorities and target population groups need refining in the current context.

Alongside other intelligence products such as the Social Progress Index (SPI), the findings of the CIA will enable the board and its members to target resources and support towards those communities where there has been the greatest impact, and which are most susceptible to falling behind. This will allow the board to more effectively support communities during recovery and help tackle health inequalities in Surrey.

Hundreds of community members and people working in frontline services have taken part in the CIA through interviews, focus groups and surveys, and the findings are rooted in what they have told us. Incorporating the CIA findings into the Health and Wellbeing Strategy, and other organisational strategies and operations, is an opportunity for the board and its members to embed community development in their work, which is a key commitment in the Health and Wellbeing Strategy.

In June 2020 the board approved the CIA to provide Joint Strategic Needs Assessment (JSNA) for the following six months. Going forward, the CIA steering group is well placed to become the JSNA steering group to continue to steer the ongoing JSNA process to inform and support health and wellbeing priorities.

5. Detail

Background

In June 2020 the Health and Wellbeing Board agreed to the Community Impact Assessment (CIA) as an approach to delivering early intelligence about the impacts of COVID-19 among different communities in Surrey to support recovery, including

informing the Health and Wellbeing Strategy and providing Joint Strategic Needs Assessment for the following six months.

Following the Board's approval, Surrey County Council's Public Health and Insight, Analytics & Intelligence teams rapidly progressed the CIA, engaging with local and regional stakeholders across the system to design and conduct the research and to establish a steering group.

Steering group

A multi-agency steering group has been established to oversee the CIA. The membership includes senior operational leads from a range of stakeholders represented on the Health and Wellbeing Board, including Surrey County Council, District and Borough councils, NHS partners, Office of the Police and Crime Commissioner, Healthwatch, the Voluntary, Community and Faith Sector (VCFS) and an independent public representative. The group is chaired by Jason Gaskell, Chief Executive of Surrey Community Action.

The group's responsibilities include advising on how the work can best meet the needs of the organisations represented, raising awareness of the work, disseminating it through stakeholder/community networks and providing feedback from these networks, and providing an assurance role in avoiding duplication of work and highlighting and harnessing existing insight and intelligence from elsewhere.

Aims of the CIA

The Community Impact Assessment (CIA) explores health, social and economic impacts of COVID-19 among communities across Surrey, communities' priorities for recovery, and what support these communities might in the event of another outbreak. It aims to:

- Enable partners to provide targeted support to communities impacted by COVID-19; and
- Enable partners to act preventatively to mitigate future risk and impacts.

What is the Community Impact Assessment?

The CIA is made up of several intelligence products that focus on different communities or different types of impact from COVID-19. Most of the products are still being developed, so the findings presented in this paper will continue to be refined over the coming months.

Product	Description	Lead team	Expected completion date
Geographical impact assessment	Presents analysis of the impact of COVID-19 on local communities across health, economic and vulnerability dimensions. The analysis helps to identify which	SCC Insights, Analytics & Intelligence	30 June 2020 (complete)

	places in Surrey have been most affected by the pandemic and how.		
Recovery progress index (RPI)	The RPI is a surveillance tool for monitoring how well Surrey is recovering from the pandemic. It looks at a range of indicators across five themes; Economy, Place, Health, Society and Infrastructure and forms a subset of the SPI.	SCC Insights, Analytics & Intelligence	18 September 2020
Temperature check survey	Survey of approximately 1,600 households from across Surrey to understand their experiences of the pandemic and lockdown.	SCC Insights, Analytics & Intelligence	28 September 2020
Community rapid needs assessments	10 in-depth assessments of how vulnerable communities have been affected during COVID-19 and the needs and priorities of these communities. Data has been collected through interviews with community members, people working in local services and from existing data on health risks and outcomes. The assessments provide nuanced insights into communities' experiences and recommendations for strategy and action.	SCC Public Health team	2 Oct 2020
Place based ethnographic research	Detailed ethnographic research into individual experiences of COVID-19 in communities that have been most impacted economically and socially.	SCC Insights, Analytics & Intelligence	7 October 2020

The following sections summarise the aims, methods and findings to date of each product.

Geographical impact assessment

Aims

To identify which places in Surrey have been most affected by the pandemic and how.

Methods

The assessment looks across three dimensions of impact: Health, Economy, and Vulnerable Groups. For each dimension, data has been collected at the Middle Layer Super Output Area (MSOA) level and used to construct an index which combines several indicators to produce a dimension score. The indicators used are:

- Health – Covid deaths per 10,000 population, number of care home outbreaks
- Economy – % point change in claimant count between March and April 2020, estimated % of people furloughed
- Vulnerable Groups – Non-covid deaths per 10,000 population (proxy for bereavement), shielded people per 10,000 population, proportion of people receiving disability benefits, prevalence of mental ill health, pensioners who live alone, carers who provide 50 hours of unpaid care per week

MSOAs can then be compared across these dimensions to understand where the impacts have been felt the most based on the metrics that have been included.

Results/Implications for strategy and services

The analysis has identified the following key findings:

- There is no single type of impact that can summarise which areas have been most affected during the pandemic. Often areas that are more impacted along one dimension are less impacted along other dimensions.
- There does not appear to be a relationship between those places that have been impacted in terms of health and those places that have been impacted economically.
- There is some relationship between places with a high prevalence of vulnerable or impacted population groups with places that have been impacted in terms of both health and the economy.
- There are 21 MSOAs that have been impacted greater than the average across all three dimensions. These are in Spelthorne (5), Waverley (4), Mole Valley (3), Tandridge (3), Runnymede (2), Reigate & Banstead (2) and Elmbridge (2).
- Typical measures of deprivation do not necessarily correlate to the areas that have been most impacted, especially in terms of health impacts. This is different to what has been found at a national level so further analysis is underway to understand the reasons for this in Surrey.

The implication is that recovery efforts should be guided by a nuanced understanding of the local impacts on any given place, which can vary widely between and within districts and boroughs. It should also be recognised that the impacts will evolve as lockdown eases and the full economic effects are felt.

Full details on the methodology and findings are described in Annex 1.

Recovery progress index

Aims

To measure and track over time how well Surrey is recovering from the impacts of COVID-19 across a broad range of indicators covering Economy, Place, Health,

Society and Infrastructure. The RPI is a subset of the Social Progress Index which is being developed in parallel to support priority 3 of the Health and Wellbeing Strategy.

Methods

The index provides a score and rank for each indicator to enable a comparison between areas, and to identify the geographic and thematic areas where Surrey is recovering well and those where it is struggling. This will be presented in the form of a scorecard at the county and district/borough levels. Examples of the scorecards are shown in Annex 2.

Currently we have data for most indicators at the Surrey level, though we are still missing several data points at the district/borough level. We intend to present the draft RPI at the next Surrey Chief Executive's Group meeting to expedite the collection of the missing data.

Initial findings

- Overall Epsom and Ewell is ranked top for overall recovery progress in the county, followed by Woking. This is because of a combination of low COVID-19 infection and death rates, a lower rate of furloughed staff and a lower increase in Universal Credit claimants, and a more stable change in recorded crime. Tandridge is ranked bottom which has been driven by high increases in racially motivated crime and domestic abuse and an increase in youth related anti-social behaviour.

- Over a quarter of people are furloughed in parts of Surrey but this is lower than the South East average. The proportion of people taking up the Coronavirus Job Retention Scheme in Surrey ranges from 27% in Spelthorne to 21% in Reigate & Banstead. This is lower than 29% for the South East.

- The rate of people claiming Universal Credit and Job Seekers Allowance increased dramatically as a result of Covid-19. The Claimant Count for June 2020 increased by 309.1% in Surrey compared to June 2019. All of Surrey's borough and districts recorded higher increases than the South East (183.9%) and national (131.7%) increases.

- During the pandemic transport usage has fallen but traffic levels are beginning to rise again. Car usage has fallen dramatically, with drop in average traffic flow in April to just 29% of the previous month's figure. Figures are now rebounding however to 66% of the March figures. The number of bus services in operation dropped by 37% during April and May, and passenger numbers have fallen to 11% compared to the same period last year.

More detailed findings are described in Annex 2.

It is important to note that there is variation in scores and ranking between the dimensions, and, in general, areas will rank well in one or two dimensions and low in others.

Data will be collected at both the county and district/borough level on a quarterly basis and used to refresh the RPI. This will give us an indication of the pattern of recovery across Surrey and an indication of the key areas of focus in each place.

Temperature check survey

Aims

To understand how residents have adapted their everyday life to the changes the pandemic has brought, what support they have required and how easy or difficult this has been. The survey is also looking at how the crisis has affected residents' priorities, their perception of their community and their hopes and fears for the future.

The data from this research should help us consider how we might adapt our response to any future pandemic or a second peak in the current one. It will feed into decision making relating to the reset of our services as we move from the emergency to the recovery phase.

Methods

The survey has been sent out to 8,000 households in Surrey, with an expected response rate of approximately 20% (1,600 households). The sample of residents has been stratified to provide us with views from a range of demographics including age, gender, ethnicity and socio-economic characteristics. It will also provide an even geographical spread across Surrey's 11 districts and boroughs with a minimum 100 respondents from each of these local authority areas.

Initial findings

Some initial findings from the survey indicate that:

- 77% of respondents have concerns about contracting the virus over the next six months.
- 62% of respondents have concerns about social distancing within the community over the next six months.
- 41% of respondents have concerns about support available from local councils / NHS / voluntary organisations over the next six months.
- 44% of respondents say that COVID-19 has had a negative impact on access to health care / medicine / dental services. For 5% of respondents it has had a positive impact, for 28% of respondents it has had a mixed impact and for 23% of respondents it has had no impact.
- 23% of respondents say that COVID-19 has had a positive impact on their physical exercise levels. For 34% of respondents it has had a mixed impact, for 18% of respondents it has had a negative impact, and for 24% of respondents it has had no impact.
- 26% of respondents say that COVID-19 has increased their levels of stress and anxiety, 37% of respondents say that it has had a mixed impact of their

mental wellbeing and for 28% of respondents there has been no change. Only 8% feel happier or less stressed.

- 29% of respondents have drunk more alcohol than normal during lockdown, compared to 18% of respondents who have drunk less. 33% of respondents have smoked more during lockdown, compared to 21% of respondents who have smoked less.

These are interim findings and are yet to be weighted. As expected, the response is skewed towards older people and females, so the results are likely to move slightly more in line with what younger people and males have said.

The first draft of the summary report is due on 11 September and the full and final report will be available week commencing 28 September.

Community rapid needs assessments

Aims

To understand in detail how 10 vulnerable communities have been affected by COVID-19, the services and assets that have supported communities during the pandemic and communities' needs and priorities for recovery and future outbreaks.

Methods

The Public Health team is leading 10 rapid needs assessments (RNAs), each focussing on a community at risk of being disproportionately affected by the pandemic in Surrey (from the infection itself and/or through indirect health, social or economic harms). These communities are:

- Black, Asian and Minority Ethnic communities
- Care home residents and their families
- People with mental health problems
- People with long-term physical health conditions and disabilities
- Children and adults with special educational needs and disabilities
- People with drug or alcohol problems
- People experiencing homelessness
- The Gypsy Roma Traveller community
- People experiencing domestic abuse
- Young people out of work

Each RNA involved interviewing community members and stakeholders across the system, including service commissioners, managers and frontline workers, to explore communities' experiences during COVID-19 and priorities for the future. Where possible, assessments also used data to quantify the health outcomes communities experienced during COVID-19 compared to previous years.

Initial findings

Community members and stakeholders gave very positive feedback about the opportunity to engage with the Council and feeling listened to. This suggests the project has strengthened connections with communities, partners and stakeholders.

The key themes and priorities emerging from the RNAs are shown in Annex 3. The RNAs are maturing, and initial findings show that COVID-19 has had a disproportionate impact on certain groups within Surrey, including people from Black, Asian and minority ethnic (BAME) backgrounds, people experiencing domestic abuse, people with mental health conditions and those in residential care.

Black, Asian and Minority Ethnic communities

Amongst the key finding, community members from BAME backgrounds felt that there was a lack of clear communication of guidelines at the beginning of the lockdown, which led to confusion about accessing care and support. This was made worse as the lockdown disrupted some of the community networks which were key in further supporting certain vulnerable groups. Some ethnic groups, particularly Chinese families, were subjected to hate crime and racism as a result of the pandemic. Some also experienced lack of access to finical support as they did not meet the eligibility criteria set by the government. Community members often found practicing effective social distancing a challenge, as many families live in overcrowded housing. The pandemic highlighted the lack of visibility and meaningful engagement with BAME community groups/ representative organisations in Surrey and the need for a closer partnership working to build trust with these communities.

People experiencing domestic abuse

Fifteen stakeholders and professionals were interviewed to gain understanding of the issues experienced relating to Domestic Abuse (DA) throughout the pandemic. Lockdown has exacerbated pre-existing abuse, and the closure of schools has likely further exposed children to the abuse being perpetrated in the household, which has increased the duties of victims and decreased opportunities to obtain support. Financial stresses may impact on the family also exacerbating any pre-existing control of the victim's finances. There is a deep concern about the long-term physical and mental impact of lockdown for victims of DA and their dependents. The mental health of children returning to school is a priority with the possibility of a "wave" of disclosures in the school environment upon reopening. There will be an impact on resources available to cope with any further increase in demand for services.
It is important to consider that the voice of victims and survivors has not been included in the current report, as it was deemed unsafe for Surrey County Council to engage with them given their very recent traumatic experience. Perspective of victims and survivor will be incorporated in Autumn 2020.

People experiencing mental health problems

The Mental Health of people was impacted in different ways during lockdown. However, the key drivers for worsening mental health were social isolation (due to lockdown), particularly on working-age adults living alone and those in poor health,

loss of coping mechanisms such as ability to connect with friends and family and taking daily outdoor exercise, fear of becoming infected, conflicting information, lack of knowledge about how and when to seek help, access to care (patients as well as carers) and working in frontline jobs. The latter was associated with both fear of infection and PPE access. Given the socioeconomic gradient in loss of income and jobs, the mental health burden and the long-term health impacts of job losses will also be unequally distributed across the community. The impact of lockdown has also widened some of the mental health inequalities in relation to accessing services. This is particularly the case for the individuals who do not have access to digital equipment (e.g. older adults), are unbale to receive support remotely or simply do not meet the threshold criteria for treatment.

Across the spectrum of the RNAs, there were cross-cutting themes emerging, further emphasising support and resource needed for mental health, carers and vulnerable groups.

Implications for incorporating into the delivery of the H&WB strategy

The initial findings of the RNAs align closely with priorities highlighted within the H&WB strategy; adding depth to specific areas of immediate targeted action. These include a focus on the following:

Priority One - Helping people in Surrey to lead a healthy life

- A programme to improve access to substance misuse and mental health services for those with serious mental illness
- A whole system approach to eliminate rough sleeping
- Specialist housing to enable independent living
- Early intervention and approaches to support young people
- Support to enable people to recover effectively from domestic abuse
- Rehabilitation programmes, including couples affected by situational violence
- Improving support for carers

Priority Two – Supporting the mental health and emotional wellbeing of people in Surrey

- Develop preventative mental health in-reach offer with schools
- Map and develop preventative mental health support access for Older People
- Support wellbeing at work
- Domestic abuse support/prevention offer around wellbeing of mothers throughout and after their pregnancy
- Social Isolation

Priority Three - Supporting people to fulfil their potential

- Strengthened infrastructure to best support children missing education due to social, emotional and mental health needs
- Analysis of current mentoring schemes offered to children and young people across Surrey to identify gaps and opportunities
- Supporting adults to succeed professionally and/or through volunteering

Combined with the Urgent actions to address inequalities in NHS provision and outcomes outlined in the Phase 3 Implementation Guidance published by NHS England and Improvement (7 August 2020), we are equipped with a wealth of insight and intelligence to develop targeted strategies, with immediate actions and associated outcomes to tackle the amplified impact by COVID-19 on our at risk and vulnerable communities.

It is important to note analysis is still underway with final RNA reports due to be published in September 2020. The initial findings in this report should provide a steer and support for informed decision making.

Place based ethnographic research

The place-based research aims to provide a deeper understanding of individual experiences of COVID-19 and lockdown from people living in communities that have been disproportionally impacted economically and socially.

This will be developed through one to one research and engagement with 20 to 25 residents from across seven places in Surrey, involving a mixture of interviews, focus groups and informal conversations. The places have been chosen to cover a range of different types of localities, using the findings from the Geographical Impact Assessment, as well as soft intelligence.

The seven places chosen are ones with one or more of the following characteristics; a high increase in unemployment due to Covid, high levels of deprivation, urban commuter towns, rural areas and areas where the impact of COVID-19 appears to be lower. The areas chosen are Stanwell North & Stanwell Moor (Spelthorne), Horley Central (R&B), Sheerwater (Woking), Guildford Town Centre (Guildford), Smallfield & Felbridge (Tandridge), Hindhead, Beacon Hill & Frensham (Waverley) and Ashtead West (Mole Valley).

The placed based research is ongoing, and the findings are expected in early October.

6. Challenges

Delivery to deadline depends on the Surrey County Council teams involved in the work continuing to have capacity. If Surrey experiences a significant COVID-19 outbreak, the outbreak response will be the top priority which may result in the delivery of the CIA being delayed. However, the CIA will remain high priority as it will inform ongoing COVID-19 response and recovery.

A key challenge once the CIA is published will be ensuring the findings inform meaningful change to strategy and service delivery. The multi-agency steering group advises on ensuring the outputs meet the needs of intended users. We also have plans to disseminate the findings widely (see below).

There is a risk that stakeholders and communities will have expectations that cannot be met due to resource constraints or other factors. Expectations have been managed throughout the research when communicating with stakeholders and will

continue to be managed through communicating the findings, recommendations and next steps in an appropriate and realistic way.

7. Timescale and delivery plan

Each product has a different timeline, but all are on track for publication on Surrey-I by 23 October 2020.

Interim findings will be communicated to stakeholders where appropriate with the aim of communicating early messages in a timely way, testing messages with stakeholders and receiving feedback to help develop the final products.

8. How is this being communicated?

We are working with Surrey County Council Communication and Engagement Team to develop a communications strategy for specific individual products and the overall Community Impact Assessment.

The steering group members have responsibility for disseminating the findings through their networks, facilitating engagement with stakeholders or communities, and relaying feedback from these networks.

We will present the findings widely – including to the Recovery Coordination Group, Surrey Heartlands System Board, other system-wide strategic and operational groups, and other organisations/groups with an interest in the findings.

The final reports will be shared with individuals and organisations that took part in the research.

9. Next steps

- Finalise each of the products that make up the CIA – ongoing
- Work with Surrey County Council Communications team to develop a communications strategy – including comms for individual products and for the overall CIA – completed by 25 September 2020
- Publish reports of each product and an overarching CIA summary on Surrey-I (public domain) – completed by 23 October 2020
- Disseminate the findings among stakeholders – ongoing
- Bring a paper on next steps for JSNA, and outcomes from the CIA, to the health and wellbeing board in 3-6 months

List of Annexes:

- Annex 1 – Geographical Impact Assessment Report
- Annex 2 – Recovery Progress Index Findings and Scorecard examples
- Annex 3 – Community Rapid Needs Assessments - Summary Table

Surrey Covid-19 Geographical Impact Assessment Report

This report summarises the findings of the first iteration of the Geographical Impact Assessment. The aim of the analysis is to identify specific places within Surrey that have been disproportionality impacted by Covid-19 as of June 2020. The analysis will be updated as recovery continues and more data becomes available.

We have analysed three different types of impact from Covid-19 (health impacts, economic impacts and vulnerable population group impacts) and have shown how these impacts vary across Surrey and how they relate to each other. To gain a deeper understanding of these impacts the next step is to conduct the place based ethnographic research by undertaking primary research in some of the areas highlighted by this analysis.

Findings

The analysis has identified the following key findings:

- There is no single type of impact that can summarise which areas have been most affected during the pandemic. Often areas that are more impacted along one dimension are less impacted along other dimensions.

- There does not appear to be a relationship between those places that have been impacted in terms of health and those places that have been impacted economically.

- There is some relationship between places with a high prevalence of vulnerable or impacted population groups with places that have been impacted in terms of both health and the economy.

- Most of the areas that show high combined impacts are found in the North, South East and South West of the county, with the highest numbers in Spelthorne, Waverley, Mole Valley and Tandridge.

- Typical measures of deprivation do not necessarily correlate to the areas that have been most impacted, especially in terms of health impacts, though further analysis is required to validate this.

The implication is that recovery efforts should be guided by a nuanced understanding of the local impacts on any given place and we should not assume that the usual areas of deprivation are the right places to target.

Dimensions of Impact

We have analysed three dimensions of impact from Covid-19. For each dimension, we have collected data at the Middle Super Output Area (MSOA) level and constructed a Surrey wide index which combines several indicators to produce an overall dimension score.

Health impacts: This dimension looks at where there have been direct health impacts as a result of Covid-19, including where there have been deaths directly attributed to the virus and outbreaks within care homes.

Economic impacts: This dimension looks at where there have been direct economic impacts as a result of lockdown, including where there have been increases in unemployment and where employees have been furloughed.

Population groups: This dimension considers where there is *likely* to have been disproportionate impact based on the prevalence of groups with pre-existing vulnerabilities, for example people with disabilities, people with mental health conditions, older people who live alone and carers. It also considers people who have been impacted by lockdown in another way, for example people shielding and friends and families who have been bereaved from non-Covid deaths.

Indicators used to calculate dimension scores

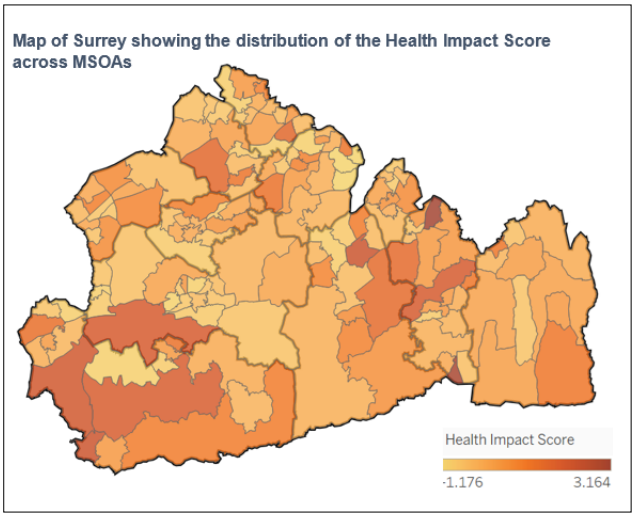
The table below summarises the indicators used within each dimension. The index creates a weighted average of the different indicators to create the dimension score.

Impact Dimension	Description	Indicators
Health	Variables that show a direct health impact of Covid-19	• Covid deaths per 10,000 population • Number of care home outbreaks
Economic	Variables that show a direct economic impact of lockdown	• % point change in claimant count between Mar – Apr 2020 • % of people furloughed
Population groups	Variables that highlight groups who are more likely to have been negatively impacted by lockdown	• Non-covid deaths per 10,000 population (proxy for bereaved families and friends) • Shielded people per 10,000 population • Proportion of people receiving disability benefits • Prevalence of mental ill health • Pensioners who live alone • Carers who provide 50 hours of unpaid care per week

Geographic variation in health impact

Health impact considers the numbers of deaths attributable to Covid-19 per 10,000 population and the number of care home outbreaks in each MSOA.

The map shows that the health impacts have been greater in some communities including parts of Waverley, Mole Valley and Reigate & Banstead. This is likely due to the high number of over 80s and care homes in these areas.



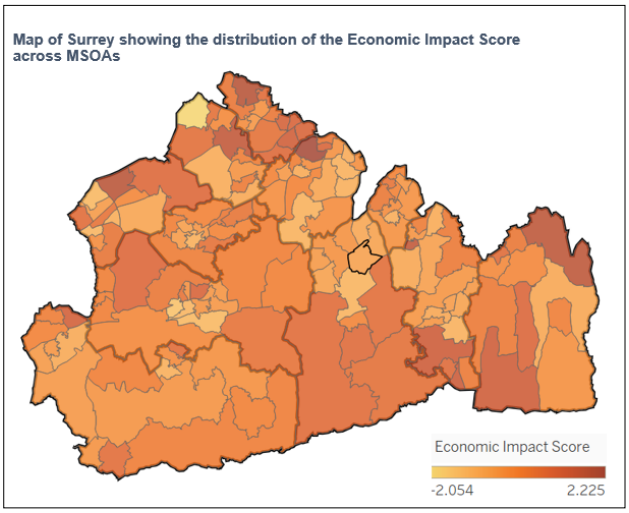
The top 5 most impacted MSOAs in the health dimension are:

- Banstead (Reigate & Banstead)
- Horley Central (Reigate & Banstead)
- Leatherhead South & Ashtead South (Mole Valley)
- Haslemere West (Waverley)
- Hindhead, Beacon Hill & Frensham (Waverley)

Geographic variation in economic impact

Economic impact considers the percentage point change in claimant count between March 2020 and April 2020, and the % of employees furloughed in each MSOA.

The map shows that the economic impacts are spread across the county. However, there appear to be hotspots in the North and South East of the county. This may be due to the proximity of these areas to Heathrow and Gatwick, and the high number of people working in the aviation sector.



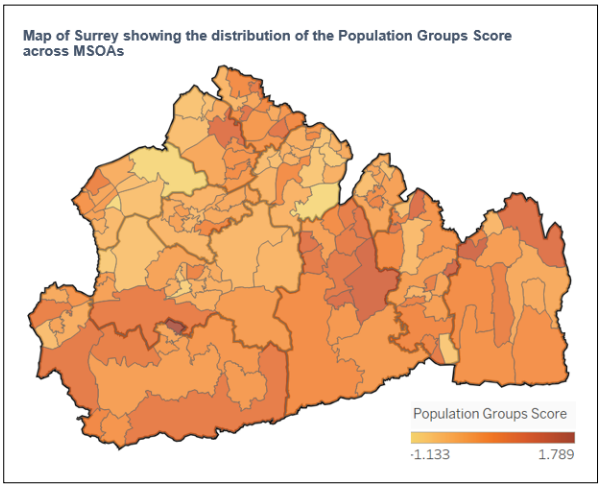
The top 5 most impacted MSOAs in the economic dimension are:

- Walton North & Molesey Heath (Elmbridge)
- Stanwell North & Stanwell Moor (Spelthorne)
- Bagshot (Surrey Heath)
- Warlingham East & Tatsfield (Tandridge)
- Tattenham South (Reigate & Banstead)

6

Geographic variation in vulnerable population groups

This dimension considers the prevalence of population groups with pre-existing vulnerabilities and/or who are more likely to have been impacted during lockdown, including bereaved families and friends, those who are shielding, people with disabilities, people with a mental health diagnosis, older people living alone and carers.



The map shows that the groups are spread across the county, with slightly higher prevalence in the South and East.

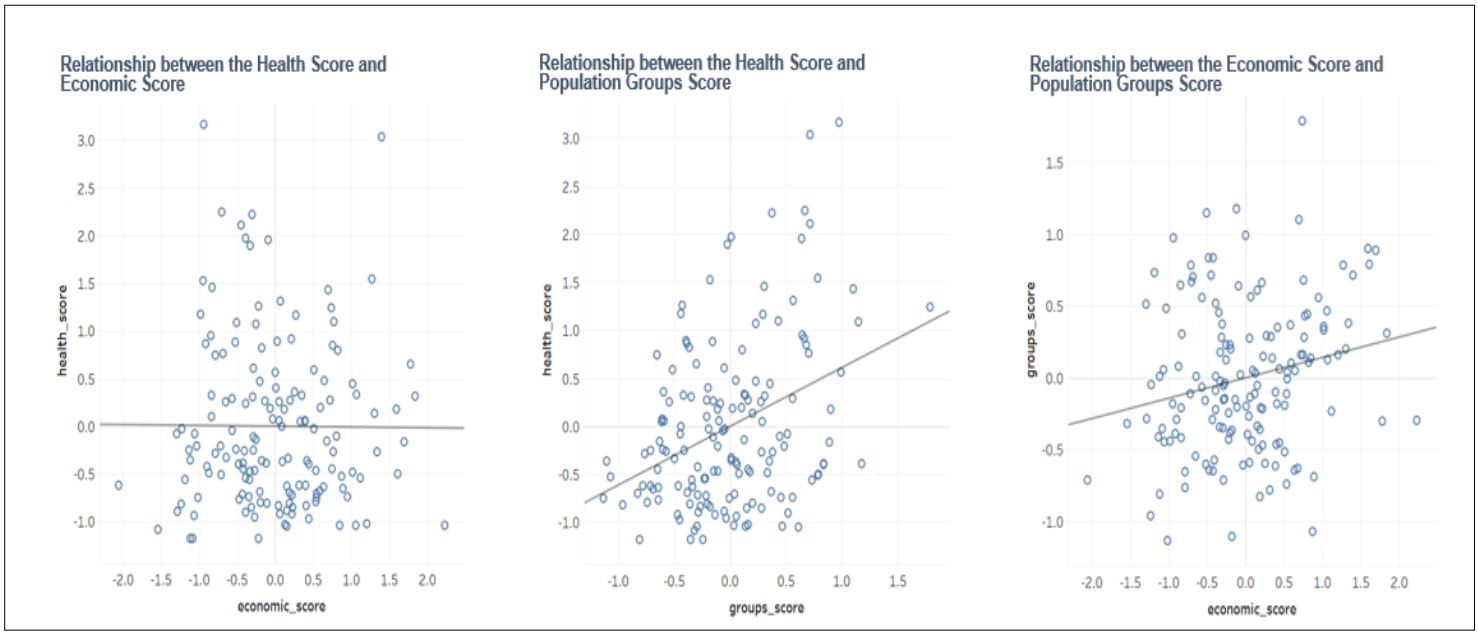
The top 5 most impacted MSOAs in the population groups dimension are:

- Farncombe (Waverley)
- Caterham West (Tandridge)
- Merstham (Reigate & Banstead)
- Box Hill & Brockham (Mole Valley)
- Dorking South (Mole Valley)

How do the dimensions of impact relate to each other?

To fully understand the impact of the Covid-19 crisis in Surrey we need to consider how the three dimensions relate to one another. If the areas that are most impacted in one way are also most impacted in others, it would make sense to focus our recovery efforts on these places.

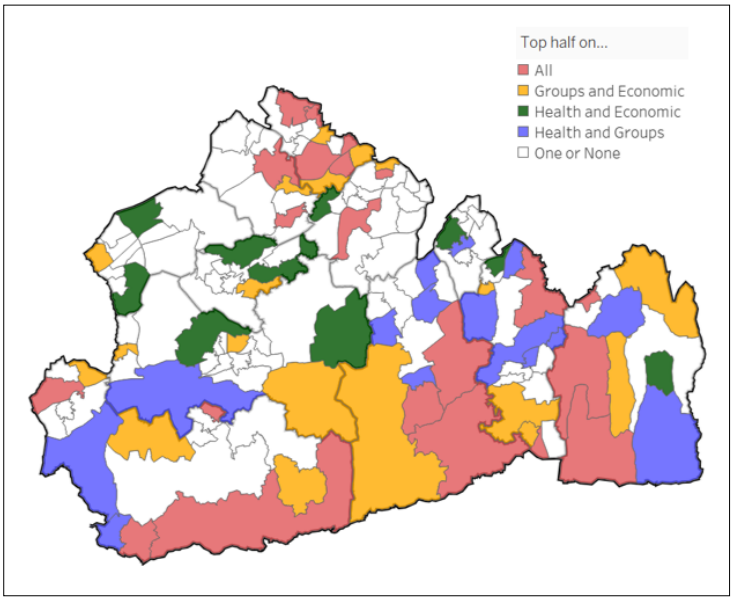
The analysis shows a mixed picture. There is no relationship between the Economic and Health dimensions, though both show a weak relationship with the Population Groups dimension. This illustrates that different parts of Surrey have been impacted by the crisis in different ways.



Geographic variation in combined impact

Some areas have been impacted in multiple ways. To show these cases of impact across multiple dimensions, we have identified MSOAs that are ranked in the top half (more impacted than average) along each dimension. We have then categorised areas by the number of dimensions on which they are more impacted than average.

The map shows that the combined impacts are spread across the county, but areas in the North, South West and South East have most commonly been impacted across the board.



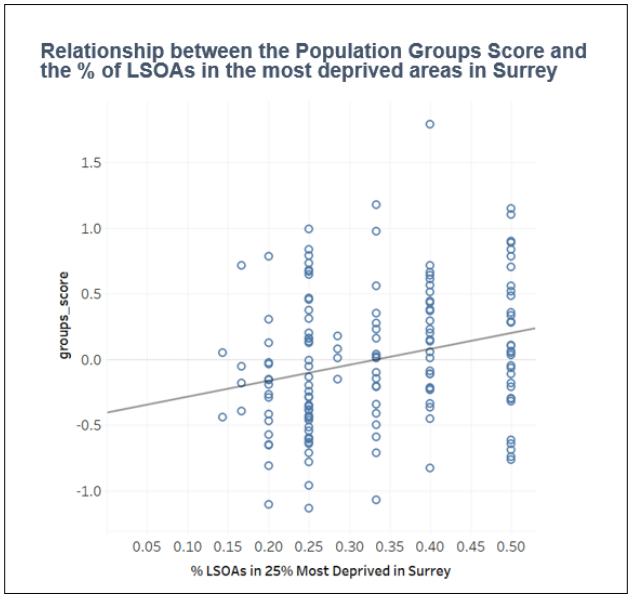
In total there are 21 MSOAs that fall into the top half across all three dimensions. These are in:

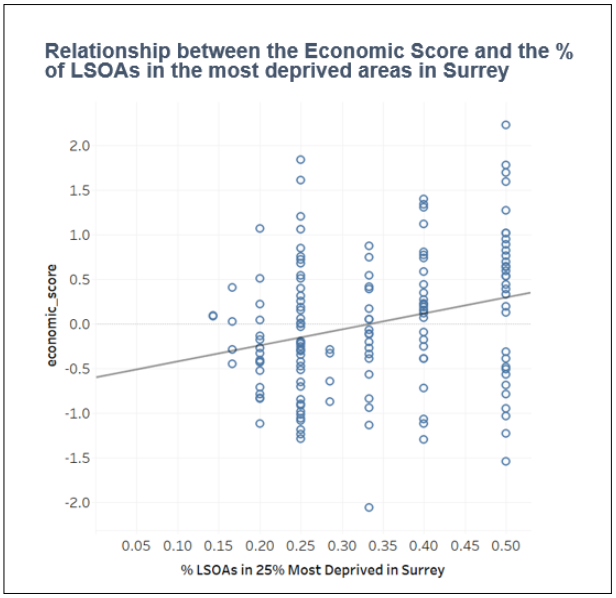
Spelthorne – 5
Waverley – 4
Mole Valley – 3
Tandridge – 3
Runnymede – 2
Reigate & Banstead – 2
Elmbridge - 2

How do the dimensions of impact relate to deprivation?

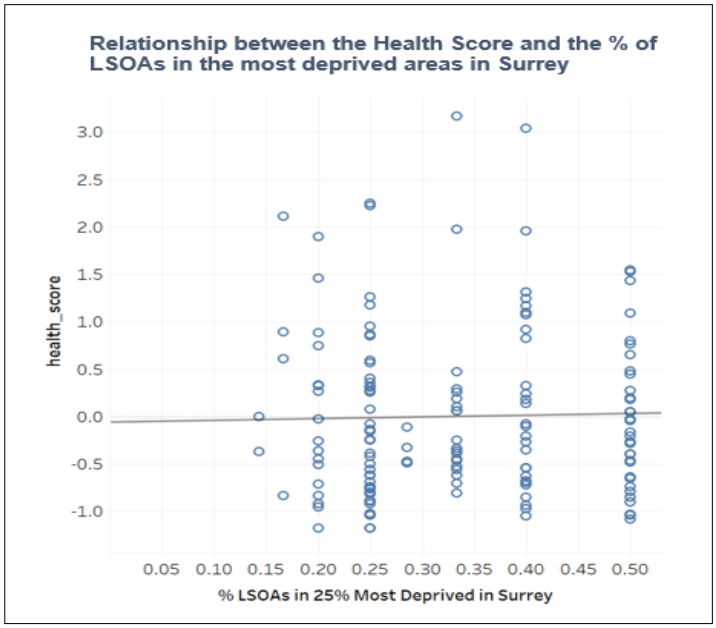
One consideration is how the three dimensions of impact relate to other indices, for example the Index of Multiple Deprivation (IMD).

The graphs below compare the Population Group and Economic dimension scores with a measure based on the 2019 IMD which captures the proportion of LSOAs within each MSOA that are in the 25% most deprived in Surrey. They show that there is only a weak relationship between the dimension scores and the IMD measure of deprivation. This suggests that the areas that have been most impacted are not necessarily the most deprived.





Similarly, we can look at the relationship between the Health dimension score and the same IMD measure:



The graph suggests that there is no relationship between these two variables, implying that those areas which are more susceptible to Covid-19 on health grounds are not generally the most deprived areas. This is different to what Public Health England have found at a national level.

It should be noted that these findings are limited to the specific indicators that are used to construct the indices. Moreover, analysis at the MSOA level might obscure very real relationships at lower levels.

Further analysis is required to understand what *has* driven health impacts in Surrey and to explore the strengths of areas that have been less impacted than others, which will validate and refine these findings and help us to understand differences between Surrey and the national context.

Next Steps

Using the findings from this analysis, the next step is to select a handful of places within Surrey and carry out further research to gain a more detailed and contextual understanding of the impacts. We have chosen places using the data presented in this analysis, soft intelligence from colleagues working in communities, and by thinking about different types of places within Surrey. Seven places will be investigated, which are:

Type of Place	Suggested Place(s)
High increase in unemployment due to Covid (JSA and UC) / High proportion of people working in affected sectors	Stanwell North & Stanwell Moor (Spelthorne) Horley Central (R&B)
Lower socioeconomic / relatively deprived area	Sheerwater (Woking)
Commuter town	Guildford Town Centre (Guildford)
Rural area	Smallfield & Felbridge (Tandridge) Hindhead, Beacon Hill & Frensham (Waverley)
Area with lower economic impact (as a comparison)	Ashtead West (Mole Valley)

Initial Findings from the RPI

Based on the indicators that are included in the current index, Epsom and Ewell is ranked first (1 is best, 11 is worst) for overall recovery progress in the county, followed by Woking, with Tandridge ranked 11th and Surrey Heath 10th. It is important to note, however, that there is variation in scores and ranking between the dimensions, and, in general, areas will rank well in one or two dimensions and low in others.

Epsom and Ewell currently ranks highest for recovery because of a combination of low Covid-19 infection and death rates (1.93 and 0.54 per 1,000 of the population respectively), a lower increase in Universal Credit and Job Seekers Allowance claimants (a 246.2% increase on the same quarter the previous year, which although still very high, is the lowest increase in the county), and the lowest fall in house sales (still a significant 80% reduction in sales, it is lower than the average drop of 85%). In comparison, Tandridge ranks 11th overall because of low scores across most indicators in the Place domain.

In terms of Place, Tandridge has consistently high increases in racially motivated crime and domestic abuse and an increase in youth related anti-social behaviour. These specific incident categories have been included in the index because of their association with behaviours specific to the pandemic and lockdown. For example, research by Women's Aid found that the nature and severity of domestic abuse escalated during lockdown for most victims, and that lockdown made it harder to seek specialist help. Likewise, the increase in anti-social behaviour is related to Covid-19 because of increased tensions or reduced tolerance during lockdown.

Over a quarter of employments eligible for furlough took up the Coronavirus Job Retention Scheme in July in Surrey. The proportion of people taking up the scheme ranges from 32% in Spelthorne to 27% in Elmbridge, Epsom and Ewell, Guildford, and Reigate and Banstead. The South East rate is 29%, and nationally it is 30%. Runnymede, Spelthorne, Surrey Heath and Tandridge are all above the South East rate.

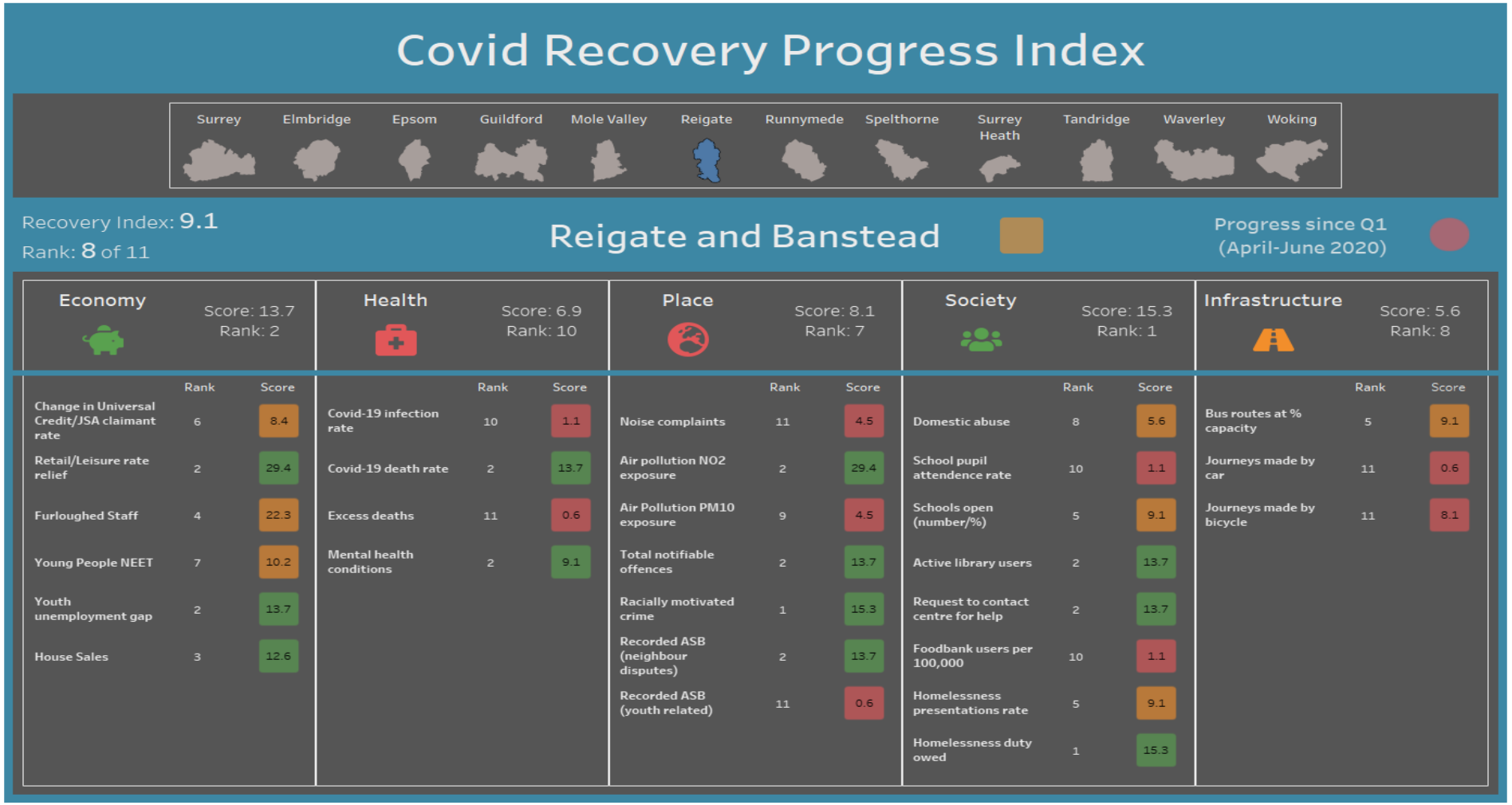
Area	Employments furloughed	Eligible employments	Take-up rate
Surrey	157,200	559,000	28%
Elmbridge	16,600	61,700	27%
Epsom and Ewell	10,100	38,000	27%
Guildford	18,200	68,000	27%
Mole Valley	11,000	39,400	28%
Reigate and Banstead	19,000	71,700	27%
Runnymede	12,800	40,800	31%
Spelthorne	15,900	49,700	32%
Surrey Heath	12,800	44,500	29%
Tandridge	11,200	39,200	29%
Waverley	15,200	54,800	28%
Woking	14,400	51,400	28%
South East	1,216,600	4,250,700	29%
England	7,600,900	25,577,800	30%

The rate of people claiming Universal Credit and Job Seekers Allowance increased dramatically as a result of Covid-19. The Claimant Count for the period April to June 2020 increased by 277.8% in Surrey compared to the same period in 2019. All of Surrey's

borough and districts recorded higher increases than the South East (170.4%) and national (120.9%) increases.
During the pandemic transport usage has fallen but traffic levels are beginning to rise again. Car usage has fallen dramatically, with drop in average traffic flow in April to just 29% of the previous month's figure. Figures are now rebounding however to 66% of the March figures. The number of bus services in operation dropped by 37% during April and May, and passenger numbers have fallen to 11% compared to the same period last year.

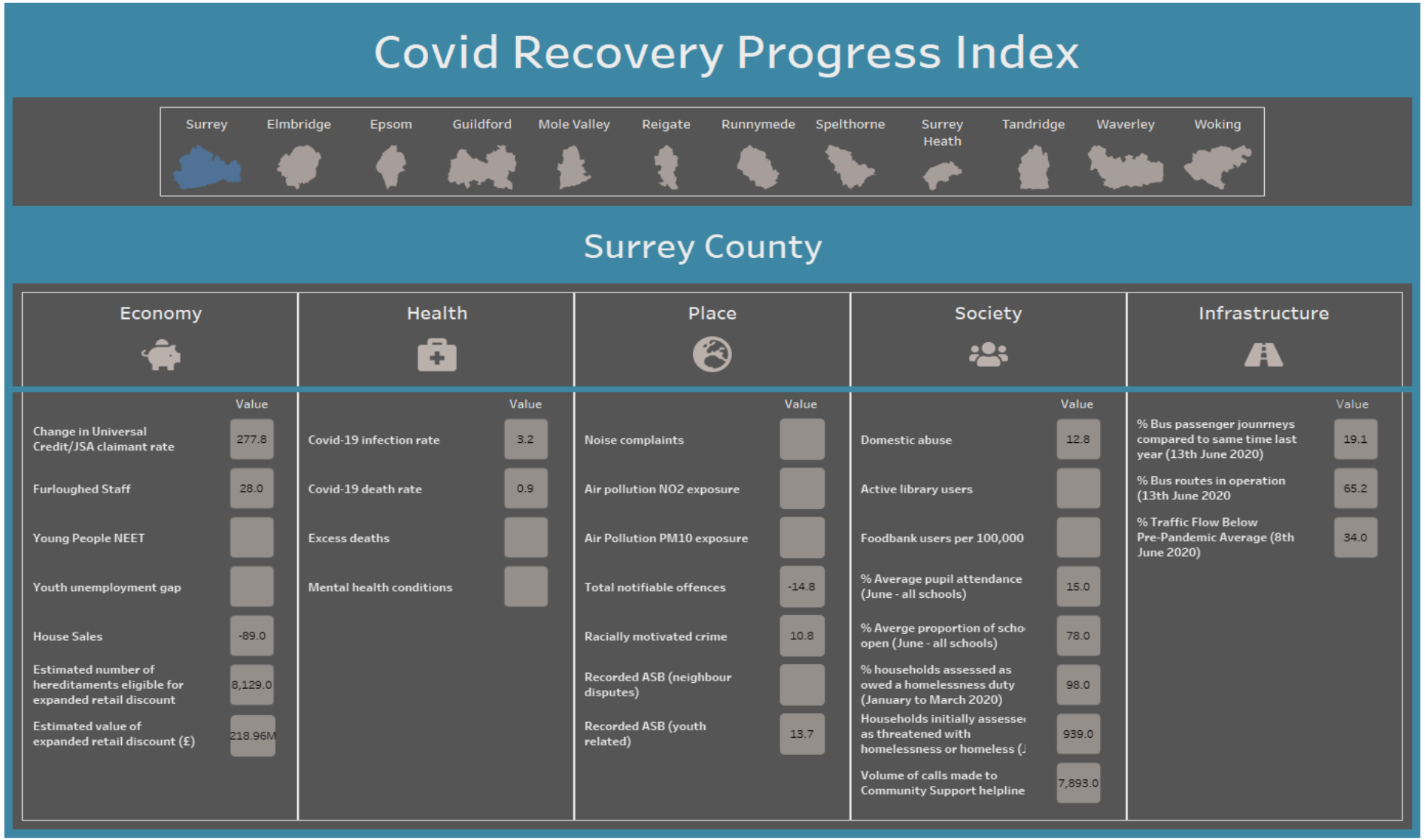
Incidents of domestic abuse were notably higher in March to May 2020 compared to the same months the previous two years. The volume of incidents across the entire county was 12.8% higher in the period than the same time the previous year. Lockdown in the UK began on the 23rd March.
Elmbridge and Tandridge recorded the largest increases (31.7% and 24.5% respectively) in Surrey in March to May 2020 compared to the same period in 2019. Waverley and Woking both recorded small reductions (8.6% and 1.8% respectively).

Example of a District / Borough Level Scorecard (Reigate & Banstead) *



*This example includes mock data as we are still missing data at the D&B level for some indicators: Rate relief: Retail, Hospitality and Leisure Discount, Air pollution- NO2 exposure, Air pollution- PM10 concentration, Homelessness

County Level Scorecard



Community Rapid Needs Assessments - Summary Table

Theme/ Focus	Key Findings and Priorities
Black, Asian, and minority ethnic (BAME) Communities	A total of ten interviews (eight) and focus (two) were conducted with key informants and one focus group was held with BAME community members. These interviews and focus groups provided an opportunity to gain a better insight into the factors that may be influencing the impact of COVID-19 on BAME communities at local level and strategies for addressing inequalities. **Common themes** • Most stakeholders believed that COVID-19 did not create health inequalities, but rather the pandemic exposed longstanding inequalities affecting BAME groups in the UK. • Lack of clear communication of the guidelines at the beginning of the lockdown, which led to confusion about accessing care and support. • Disruption of community networks which were key in supporting certain groups (e.g. older individuals whose first language wasn't English) • Some ethnic groups, particularly the Chinese families, were subjected to hate crime and racism as a result of the pandemic. Some experienced lack of access to financial support as they did not meet the eligibility criteria set by the government. • Practicing effective social distancing is often a challenge, as BAME families are more likely to live in overcrowded housing. • Although good progress has been made by organisations to complete risk assessment, there are some concerns by BAME staff about the use of data and its impact on their future job prospect. • Historic racism and cultural practices lead to BAME groups less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE). • Stakeholders felt that the disproportionate impact of COVID-19 on BAME groups has created an opportunity for a sustainable change to mitigate further impact. **Priorities Highlighted by Stakeholders** • Investment in BAME charity and voluntary, community and faith sector (VCFS) organisations to enable a meaningful engagement with BAME communities and to build trust. • Appropriate training for mangers to carry out the risk assessment for BAME staff and ensure effective mitigation measures are in place to reduce the risk of COVID-19 infection. • Improving access to testing and PPE to protect the frontline workers. • Proactive prevention with a focus on BAME maternity services (see NHS letter) and those with pre-existing physical (such as obesity, CVD, diabetes) and mental health conditions. • Improving ethnicity data collection and recording. • Fund and develop culturally appropriate communication materials to share the latest guidelines and health protection messages through trusted channels (e.g. community and faith leaders).

	• Empower BAME communities to reduce delay and stigma in accessing care. • Tangible actions by institutions to tackle racism and discrimination and provide equal opportunity for career progression at workplace. • Partnership working to reduce the health inequalities by reducing the impact of the wider determinants of health and discrimination.
Gypsy, Roma and Traveller (GRT) Community	Anecdotally GRT communities have responded well to COVID-19 guidance and sites have implemented government guidance. However, there is a lack of appropriate communications material, over reliance of digital media and not adapted for low levels literacy. The GRT Health Outreach team are well trusted, and often first point of contact for community members. There has been good use virtual working for services, particularly health. Telephone contact has worked well. There are concerns over mental health issues within the communities. Financial challenges highlighted as many community members generally self-employed. Challenges accessing water and cleaning facilities for some families. A GRT communities strategy group established to build on the work of the RNA and to provide a more multi-disciplinary approach to supporting GRT communities. **Priorities Highlighted by Stakeholders** • Strengthen engagement and further co-ordinated support for the local agencies and organisations working with GRT communities. • Cultural awareness training and a commitment to improving outcomes for GRT communities Closer working with organisations like FFT *Note: DHSC/MHCLG/VCS had a Roundtable for Gypsies and Travellers on the Test and Trace Programme on 6th Aug 2020*
Shielded, Chronic Illness, Physical Disability (provisional – ongoing analysis).	Five Stakeholders and eleven Key Informants were interviewed to get an understanding of the issues experienced throughout the crisis. Views were provided from the NHS, organisations that supported the elderly, the voluntary sector, a local church and a foodbank. Interview also conducted with members of the community who have been shielding or have been looking after residents in a caring capacity. **Themes** • Misclassification of people leading to being missed from shielding list and support services • Lack of prioritisation of services for people with long term conditions • Difficulty in obtaining GP appointment and missed appointments due to fear • Fear driven predominantly by the media

	• Lack of digital access – improving access a priority for second wave e.g. the provision of devices and training • Not all online services are suitable for all situations e.g. bereavement • The loss of independence (due to changes in routine/fear/ process of shielding for such as long period of time) – the result of which may be that people will require care services earlier in life • Judgement of carers purchasing items in bulk in supermarkets viewed as hoarding • Positive impact of increased volunteers during Covid-19 - awareness of services was raised • Positive impact of remote working opening opportunities for the disabled to work • Ongoing difficulties are obtaining staff with specialised training **Priorities** • Early warning system for local outbreaks to make informed risk assessment daily. • Set up support systems for individuals and staff, ensure social contacts are maintained • Availability of PPE and training in its use with infection control training • Clear care plans, conduct risk assessments for providing services • Provide clear guidance and messaging, implement interventions when announced (not 2 weeks later) • Send out more positive news • Better care for people who don't have Covid-19 so health issues aren't missed and to redress a lack of monitoring during the lockdown period • Reference new disabilities that have arisen from covid and the impact covid has had on existing conditions including chronic fatigue including those who have 'long covid'. • Psychological support for people who were shielded, have a chronic illness or are Disabled
Domestic Abuse	Surrey estimates based on the mid 2018 population count place the number of Surrey Domestic Abuse (DA) victims between 14,205 – 48,288 individuals. Fifteen stakeholders and professionals were interviewed to gain understanding of the issues experienced throughout the pandemic. **Key findings** • Increased awareness of DA and support available to victims. Demand for services changed, with increased contacts to helplines, particularly from "third parties", and a higher-than-average number of DA-related incidents. • All outreach and refuge services suspended face-to-face support and moved to a remote working model, facing important challenges in continuing their work to support victims.

	• Agreement that the Surrey DA partnership put together an agile and effective response, which materialized in greater coordination among system partners • Short term funding was made available, but there is a worry that the peak of reporting from DA survivors might be yet to come - further resources needed • A new refuge was developed, which accommodated 7 families at a time of crisis. • Lockdown has exacerbated pre-existing abuse, and the closure of schools has likely further exposed children to the abuse being perpetrated in the household, increased the duties of victims and decreased opportunities to obtain support. • Financial stresses may impact on the family also exacerbating any pre-existing control of the victim's finances. • There is a concern about the long-term physical and mental impact of lockdown for victims of DA and their dependents. • Mental health of children returning to school and a possible "wave" of disclosures in the school environment upon reopening. Impact on resources available to cope with any further increase in demand for services **Priorities for preparedness** • Work should continue at pace to address the challenges identified pre-lockdown, to ensure resilience in the Surrey DA response system • New partnership dialogue arrangements should be cemented. Networks across the sector became stronger and partnership arrangements working better since beginning of lockdown. • Data should continue to be used as a monitoring and planning tool • Awareness raising exercises should continue so that the general public is equipped to reporting incidents on behalf of victims as necessary • Opportunities for silent/digital reporting should be increased, so that victims can call on services to help even when opportunities to talk are limited • Direct links between the police and outreach services should be consolidated, and possibly extended to other system partners • The covid19 outbreak and lockdown have demonstrated Surrey's ability to act as a partnership, an ability that should be maintained in the future • Daily Multi-Agency Risk Assessment Conferences (MARACs) are highly valued in the partnership and have made a difference for adult services • Funding and sustainability of the new refuge should be considered. Available evidence points to Surrey being the only locality to open a new refuge during lockdown at national level. • Further ways of ensuring contact with victims is maintained in case of new lockdowns should be investigated • Further work should be carried out with survivors who have left their homes or sought support during lockdown to understand their experience of lockdown, so that the information can be used strategically to elaborate a lockdown-specific response

	• Training for all agencies in dealing sensitively with new, remote procedures and awareness training of how perpetrators might exploit lockdown to their advantage • Training should be developed and made available to school staff to help them identify signs of exposure to domestic abuse in children's appearance and behaviour It is important to consider that the voice of victims and survivors has not been included in this report currently, as it was deemed unsafe for Surrey County Council to engage with them given their very recent traumatic experience. in Perspective of victims and survivor to be incorporated in autumn 2020.
Homelessness	People who experience homelessness are disproportionately affected by health conditions such as cardiovascular disease and have an average life expectancy of 44 and 42 (men and women) compared to 76 and 81 for the general population[1]. Preliminary data from the COVID-19 pandemic showed a correlation between the presence of comorbidities and worse outcomes of an infection with SARS-CoV-2. 6 interviews conducted with stakeholders with offer a range of services to the Homeless population in Surrey. **Highlights: Positives and Negatives** - The 'everyone in' initiative resulted in unprecedented levels of engagement and stability for clients experiencing homelessness - More effective outreach work as clients were in 'stable' locations due to government limitation on movement during lockdown - Issues around contacting some clients virtually because of data costs, loss of mobile phones etc. - Quick adaptability to virtual working for a number of services - Difficulty in assessing clients in the same way especially over the phone/ loss of the detail that in person assessments give - Concerns about lack of accommodation in Surrey and the negative impact that out of area placements can have on clients - Exacerbation of mental health issues and substance misuse caused by lockdown - 'entrenched homeless' are the most likely to have been affected by COVID-19 and the lockdown. **Priorities Highlighted by Stakeholders** • Need for 'in area' emergency accommodation ensure no loss of support networks for homeless clients. • Continued funding for homeless services – there are concerns there may be cuts to funding. • Opportunistic comms when contact is made with any homeless clients e.g. whilst delivering food parcels

[1] https://www.gov.uk/government/publications/health-matters-rough-sleeping/health-matters-rough-sleeping

	• Need to incorporate a mixed methods approach to services in the future i.e. virtual as well as face to face *Recovery, Priorities and Solutions - analysis underway*
Special Educational Needs and Disability (SEND).	A number of 'Key Informants' and Families who have a child or young person with special educational needs or a disability were interviewed. **Common Themes** • Some families found that their child or young person 'thrived' during lock down, reasons related to not having to have social contact with others, not having to manage in a classroom environment or appreciating being at home with family. • Parents and Carers spoke about the positive impact of not having to do the school run and feeling things were more relaxed. • Others found lockdown difficult due to feeling isolated or lonely, experiencing difficulty in managing behaviours at home, and not feeling they have the advice, help and support that they needed. **Negatives and Positives** • The NHS, Social Care and Education came together in Surrey to identify those who have an EHCP and provided support to those at greatest risk • Some Medium/Severe Learning Disabilities Schools remained open • Advice and Guidance made available virtually for both families and professionals • Those with complex and severe needs continued to be seen face to face • Some families struggled without access to school or health/social care professionals face to face • For some young people, not having access to their friends caused exacerbated feelings of loneliness and isolation • Parents, Carers, children and young people worried about long term impact from not attending school **Priorities** • Families need to be able to feel supported during lockdown. • Help and support is vital for parents. Families don't necessarily find reading and researching helpful and a face to face discussion for some is of vital importance. • Re-integration in September 2020 needs to be handled sensitively and carefully. • Emotional and mental health needs have increased since phase three commenced and there must be specific attention to helping people with coping skills and robust plans to make support available through this transition.
Mental Health	Over 20 interviews were conducted with stakeholders, key informants and elected members. A focus group with current service users was held.

	Common themes • MH services were experiencing lack of resources before the pandemic, particularly the dementia services and some of the care pathway being fragmented. Certain criteria thresholds for MH interventions were often too high, which meant a specific cohort of people who experienced MH problems were often left unsupported. • Key drivers for worsening MH were social isolation, loss of coping mechanisms, fear of becoming infected, conflicting information and working in frontline jobs. The latter was associated to both fear of infection and PPE access. • During the lockdown, rapid efforts were mobilised to offer digital/virtual consultations to current patients. Other positive aspects included the development of Technology Integrated Health Management (TIHM) project, distribution of digital devices to enable remote working/consultation, GP In-Reach into mental health wards, provision of care home mental health support package and prioritising the workforce to access psychological interventions. • Some service users welcomed having remote or virtual consultations, whereas others found it challenging due to the lack of digital devices and or privacy at home with other family members being present. **Priorities** • Effective communication to raise awareness about MH services and how/when they can be accessed. • Improving Access to Psychological Therapies (IAPT) services • A support offer particularly for people with dementia living on their own. • Build capacity in voluntary sector services to enhance community-based support. • Investment in 24/7 crisis lines, alternatives to admission and strengthening community services to help people to stay well and avoid escalations. • Putting in place local offers to support health and social care frontline staff, ensure they have access to PPE and testing. • More partnership working to tackle MH inequalities impacting the most vulnerable groups (e.g. older, BAME groups) and reducing MH stigma. • Addressing the determinants of poor mental health that are being affected by COVID-19, such as financial difficulties and debt, unemployment, bereavement, domestic violence and abuse, risky alcohol consumption, substance misuse, and gambling addiction. • Investment to reduce digital inequalities. • Improve care pathways by enhancing service integration. **Resilience- evidence of recovery,** • Work of the MH reference group, including the staff wellbeing offer • Development of the MH recovery plan as part of the emotional wellbeing workstream of the Recovery Board

Youth Unemployment	Since the onset of the outbreak all Surrey districts have seen a marked increase in claimants (figures more than tripled). Waverley has seen the largest percentage increase of 566.7% whilst Woking has seen the lowest at 344.4% In July 2020, 5,150 people aged 16-24 claimed unemployment related benefits in surrey. This was an increase of **3,805** claimants, or 383**%**, from March 2020. When comparing the period January-June of 2020 to the last 5 years there is a noticeable increase in the monthly average for this period. Some increase in the Claimant Count is due to people who have become unemployed, some increase will also be due to employed people who have become eligible for Universal Credit as part of the government response. *Further analysis underway*
Substance Misuse	Analysis underway
Residential Care	Analysis underway

Health and Wellbeing Board Paper

1. Reference Information

Paper tracking information	
Title:	Surrey Safeguarding Children Partnership: Thematic Reviews of Adolescent Suicide and Serious Cases
Related Health and Wellbeing Priority:	Supporting the mental health and emotional wellbeing of people in Surrey and Commissioning Priorities
Author:	Surrey Safeguarding Children Partnership (SSCP): Contact: Paul Bailey, Partnership Development Manager Telephone: 07929 183 945.
Sponsor[s]:	Simon Hart, Independent Chair of the SSCP (The SSCP Executive) Tim Oliver, Chairman
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Version:	1
Related papers	Annex 1 – Thematic Review - Deaths of Children and Young People through probable suicide 2014-2020 Annex 2 – Thematic Review - Serious Case Reviews (SCRs) 2016-2020 – Briefing Paper

2. Executive summary

The purpose of this report is to advise the Health and Wellbeing Board (HWB) of the findings arising from two important thematic reviews carried out over the last 12 months by the Surrey Safeguarding Children Partnership (SSCP). The report seeks to gain the support of the Board to achieve a robust multi-agency response in addressing the specific findings, enable development of practice and influence commissioning priorities.

3. Recommendations

The SSCP is concerned to ensure that local arrangements for commissioning and delivery of services and practice can be influence by the findings arising from these important thematic reports.

The Health and Wellbeing Board is being asked to:

- Reflect and comment on the findings from the Thematic reports on Adolescent Suicide (Deaths of Children and Young People through probable suicide 2014-2020) and Serious Cases (Serious Case Reviews (SCRs) 2016-2020 – Briefing Paper);
- Commit to working with the SSCP to ensure a robust multi-agency response to findings;

- Ensure that commissioning arrangements for future service provision take full account of the findings;
- Support the SSCP in reviewing practice development through training and multi-agency audits over the next 24 months.

4. Reason for Recommendations

These recommendations are important because they will ensure learning from the experience of the children and families who have been the subject of these reviews is shared and that as a safeguarding system we are able to demonstrate systemic improvements in the quality of our work with children and families as a result.

5. Detail

Thematic Review - Deaths of Children and Young People through probable suicide 2014-2020 (Annex 1) analyses the deaths of 12 children between 1 April 2014 and 31 March 2020. These met the case definition for the thematic review of probable suicide. This represents a 100% increase since the previous 6-year reporting period (1st April 2009 - 31st March 2014). 9 of the children and young people were male (75%) and 3 were female (25%). 5 (42%) were aged 10-14 years. The Review was commissioned because most cases involving suspected suicide would not be subject to a Serious Case Review (SCR). However SSCP took the view that every child's death is a tragedy with a need to work in partnership to consider the evidence surrounding each of these deaths. SSCP is committed to implement system wide improvements based on best practice to help prevent future child deaths.

The review included experts in adolescent vulnerability from Kingston University.

Thematic Review - Serious Case Reviews (SCRs) 2016-2020 – Briefing Paper (Annex 2) analysed and summarised the learning from 13 SCRs and other reviews of children who either died or were seriously harmed in Surrey. The themes from these reviews include Professional Curiosity, Disguised Compliance, Multiple referrals and re-referrals, understanding and assessing Parental Capacity, authoritative practice, being attentive to the lived experience of the child. This briefing is essential learning for the development of effective multi-agency safeguarding practice.

The Thematic Reviews on Adolescent Suicide and SCRs present us with a significant opportunity to learn from the experiences of children and families from a significant number of cases over a period of more than 5 years. It is important that we use what we have learned from these two thematic reviews to continue to drive system-wide improvements in the quality of safeguarding practice across all agencies in Surrey.

6. How is this being communicated?

Please see below under next steps.

7. Next steps

The SSCP has commissioned a range of quadrant-based webinars to be delivered in autumn 2020.

In addition, the SSCP is working on a Surrey-wide conference to share the learning from these two reviews.

The SSCP will also produce a range of 7-minute briefings to support system wide dissemination of the learning from these thematic reviews.

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Thematic Review

Deaths of Children and Young People through probable suicide 2014-2020

"The death of a child is the most difficult thing any family can go through. 'Child death review' is a term used to describe the formal processes that happen after a child dies. There are some elements that take place for every child death, and some that may not be needed depending on the circumstances. By law all child deaths should be reviewed to try to prevent future deaths where possible."

'When a child dies.' NHSE (2018).

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There can be no greater or more enduring loss to a family than that of a child. When the loss is potentially preventable, then the feeling of devastation must be even worse. However we currently find ourselves in a position where suicide is the biggest killer of young people in the UK aged between 16 and 24 years, and in England alone it is estimated that over 180 young people aged 10-19 years took their own lives. This number rises alarmingly to 536 over the age range 10-24 years with by far, the greater number of deaths being of young males (Office of National Statistics 2018, ONS).

This sharp increase in suicide needs to be seen alongside an increasing trend in self-harm, a known potential indicator of suicidal thoughts in young people, and at a time when Child and Adolescent Mental Health Services (CAMHS) are under enormous pressure.

As young people develop through adolescence and become more independent, their lives can be filled with many changes. The teenage years in particular can become a very stressful time. Changes may be physiological, affecting thoughts and feelings. Other strong influences may include, changes within families, such as separation of parents, siblings moving on, within friendships or problems in school including bullying and a pressure to succeed, be it exams or other aspects of their lives

Strong feelings of stress, confusion, fear, and doubt may affect rationale and decision making.

For some young people, normal developmental changes can be very unsettling when combined with other events. Sometimes these problems may seem just too difficult to overcome and for some, suicide may seem like a solution. Imagine the feelings of isolation and despair when young people reach this point.

However, it is also important to recognise the impact upon other people who share part of the lives of young people, troubled in this way. Aside from family members and friends, in many cases there will be countless others, whether staff in schools, other groups and associations where young people may have been active and involved. Others in support networks including voluntary and statutory services –all of whom will question whether or not they had missed signs or signals and opportunities to intervene.

In some situations, case review processes may be deployed to help address some of the many questions that may arise following an incident of probable suicide. However in many, perhaps even the majority of cases, these processes are not likely to lead to the developments in practice that may be needed. Evidence clearly suggests that many young people who take their own lives have lived in relatively stable environments with no suggestion whatever that abuse, or neglect would have been a factor in their lives.

Some of the cases covered by this thematic review are subject to formal serious case or practice learning reviews. In commissioning this report, the Surrey Safeguarding Children Partnership (SSCP) has been clear in its desire and determination to set a course to better understand the pressures and influences that lead young people to harbour suicidal thoughts, to create better awareness of signs and signals and to support parents, families, friends and practitioners including education providers, all of whom are deeply affected by these tragedies.

Specifically the report aims to:

- Help develop a greater understanding of (teenage) suicide and the motivations of young people who harbour such thoughts based on local experience aligned to existing national research findings,
- Set out both strategic and especially early learning potential, providing pointers to changes of approach and practice and increased ability to better recognise potentially volatile circumstances
- Build upon learning from the well-established child death partnership
- Challenge current capacity and access to support arrangements at a local and national level

This report has been commissioned because the SSCP feel strongly that we need to understand much more than we currently do, in relation to suicide and self-harm in young people. We appreciate that the issues are hugely complex, unpredictable and solutions may be difficult to achieve. However, we are clear that we need to re-double our efforts and keep at the forefront of our minds the feelings of absolute desolation on the part of any young person close to suicide, ensuing any young person who expresses thoughts of suicide should not feel isolated or left alone.

Simon Hart
Independent Chair and Scrutineer, Surrey safeguarding Children Partnership

1 Introduction

This report presents the findings of a thematic review commissioned by Surrey Safeguarding Children Partnership in response to a number of suspected suicides by children and young people during the period 2014-2020.

The aim of this thematic review from 1 April 2014 – 31 March 2020 is to identify patterns and themes in deaths by probable suicide amongst under 18-year olds in Surrey and to look at how we can work more effectively together to prevent further deaths. Every child's death is a tragedy and we need to work in partnership to look at the evidence surrounding each of these deaths and work together to implement system wide improvements based on best practice to prevent future child deaths.

The work was supported by the detailed information held by the Surrey Child Death Overview Panel (CDOP); a multi-agency panel with responsibility for comprehensively reviewing all child deaths in Surrey, in order to better understand how and why children die, identify modifiable factors and learning that could prevent a similar death in the future. Whilst each child death is reviewed individually by the panel, this thematic review provides the opportunity to look across all the deaths by probable suicide over a six-year period

'In many cases, suicide is an avoidable death, preventable by identification of risk, public health interventions and high-quality evidence-based care. A robust suicide prevention approach needs to take place at individual and population levels and so needs the input of frontline services, commissioners and policy makers.'[1]

According to the 'International comparisons of health and wellbeing in adolescence and early adulthood.' Research report 2019 by the Nuffield Trust.[2] 'The NHS *Long Term Plan*, which sets out the way care in this country should be delivered given the new NHS financial settlement, is striking for its emphasis on improving the health of children. Health outcomes for young children in the UK are now worse than those in many similar countries. The UK is performing in the middle of the group of similar high-income countries for several indicators, including cancer mortality, suicide death rates and health-related behaviours such as smoking, alcohol consumption and cannabis use.

2 Background

2.1 Risk factors

[1] https://mycouncil.surreycc.gov.uk/documents/s55064/Surrey%20Suicide%20Prevention%20Strategy%202019-2021%20-%20Final.pdf

[2] http://www.youngpeopleshealth.org.uk/wp-content/uploads/2019/02/NT-AYPH-adolescent-health-report_WEB-200219.pdf

‘Suicide in children and young people is usually the outcome of a complex interaction between biological, genetic, psychiatric, cultural, social and psychological factors.’[3]

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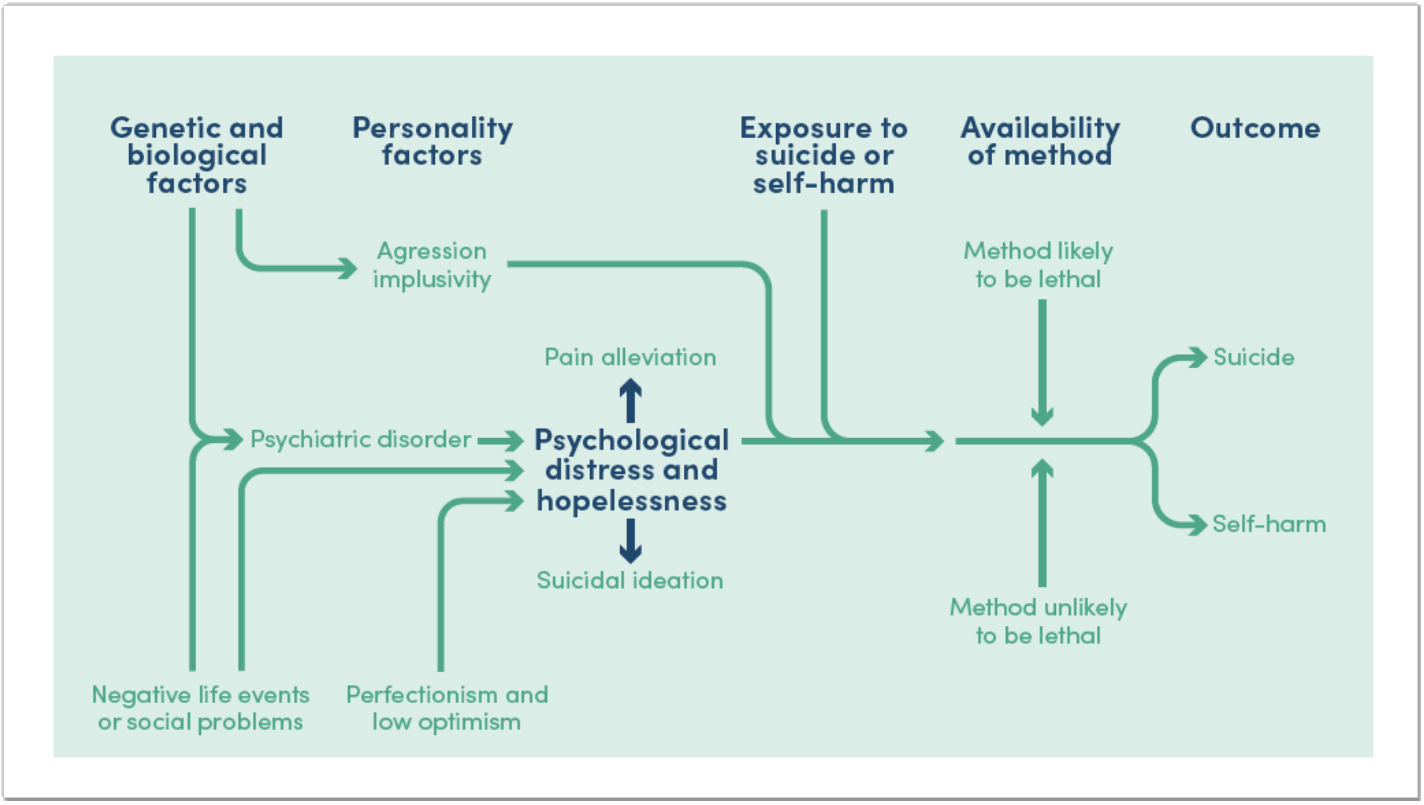
Figure1: Key risk factors for adolescent suicide and self-harm.



Source; Hawton, Saunders, O’Connor, 2012

[3] https://phw.nhs.wales/news/averting-tragedy-suicide-prevention-in-welsh-children-and-young-people/thematic-review-of-deaths-of-children-and-young-people-through-probable-suicide-2013-2017-main-report/

2.2 Current epidemiology in Surrey

Chart 1: Percentage of school pupils with social and mental health needs (School age)

School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (School age)

2018 — Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	193,657	2.39	2.38	2.40
South East region	–	30,591	2.42	2.40	2.45
Buckinghamshire	–	1,434	1.70	1.61	1.79
West Berkshire	–	438	1.70	1.55	1.87
Slough	–	554	1.83	1.68	1.98
Bracknell Forest	–	340	1.90	1.71	2.11
Wokingham	–	503	1.91	1.75	2.08
Milton Keynes	–	966	2.06	1.94	2.20
Hampshire	–	4,036	2.29	2.22	2.36
Kent	–	5,463	2.36	2.30	2.42
Surrey	–	3,720	2.40	2.33	2.48
West Sussex	–	2,772	2.47	2.38	2.56
East Sussex	–	1,685	2.52	2.40	2.64
Windsor and Maidenhead	–	577	2.67	2.46	2.89
Oxfordshire	–	2,512	2.68	2.58	2.78
Isle of Wight	–	472	2.82	2.58	3.09
Reading	–	659	2.99	2.78	3.23
Brighton and Hove	–	964	3.01	2.83	3.20
Portsmouth	–	788	3.04	2.83	3.25
Medway	–	1,482	3.25	3.09	3.41
Southampton	–	1,226	3.88	3.67	4.10

Source: Department for Education special educational needs statistics https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

In Surrey an estimated 2.4% (n- 3,720) school pupils of school age have social, emotional, mental health needs. This is similar to England (2.39%) and South East (2.42%).

Chart 2: Percentage of school pupils with social and mental health needs (Primary school age)

School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Primary school age)

2018 — Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	103,326	2.19	2.18	2.20
South East region	–	16,094	2.20	2.17	2.24
Bracknell Forest	–	167	1.55	1.33	1.80
Wokingham	–	250	1.63	1.44	1.85
Buckinghamshire	–	751	1.64	1.53	1.76
Slough	–	317	1.77	1.59	1.97
Milton Keynes	–	491	1.79	1.64	1.95
West Berkshire	–	259	1.87	1.66	2.11
Hampshire	–	2,161	2.05	1.96	2.13
Kent	–	2,715	2.14	2.06	2.22
Windsor and Maidenhead	–	234	2.20	1.93	2.49
Surrey	–	2,056	2.22	2.12	2.31
West Sussex	–	1,440	2.22	2.11	2.34
East Sussex	–	932	2.36	2.22	2.52
Reading	–	338	2.37	2.13	2.63
Oxfordshire	–	1,348	2.48	2.35	2.62
Brighton and Hove	–	483	2.50	2.29	2.73
Portsmouth	–	426	2.58	2.35	2.83
Isle of Wight	–	243	2.63	2.32	2.98
Medway	–	757	2.93	2.73	3.14
Southampton	–	726	3.53	3.29	3.79

Source: Department for Education special educational needs statistics https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

In Surrey an estimated 2.22% (n- 2,056) school pupils of primary school age have social, emotional, mental health needs. This is slightly higher than England (2.19%) and similar to the South East (2.20%).

Chart 3: Percentage of school pupils with social and mental health needs (Secondary school age)

School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Secondary school age)

2018 — Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	75,431	2.31	2.30	2.33
South East region	–	75,431	2.31	2.30	2.33
Buckinghamshire	–	514	1.38	1.26	1.50
Wokingham	–	168	1.57	1.35	1.82
West Berkshire	–	178	1.58	1.36	1.83
Slough	–	215	1.78	1.56	2.03
Milton Keynes	–	346	1.86	1.68	2.07
East Sussex	–	548	2.08	1.91	2.26
Hampshire	–	1,433	2.12	2.02	2.23
Kent	–	2,163	2.15	2.06	2.24
Surrey	–	1,419	2.38	2.26	2.51
West Sussex	–	1,130	2.47	2.33	2.62
Bracknell Forest	–	173	2.49	2.15	2.88
Oxfordshire	–	965	2.52	2.37	2.68
Portsmouth	–	253	2.85	2.52	3.22
Isle of Wight	–	220	3.07	2.70	3.50
Windsor and Maidenhead	–	330	3.12	2.81	3.47
Reading	–	236	3.16	2.78	3.58
Brighton and Hove	–	418	3.42	3.11	3.76
Medway	–	669	3.52	3.27	3.79
Southampton	–	419	4.01	3.65	4.41

Source: Department for Education special educational needs statistics https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

In Surrey an estimated 2.38% (n- 1,419) school pupils of secondary school age have social, emotional, mental health needs. This is slightly higher than England (2.38%) and the South East (2.31%).

Chart 4: Estimated number of children and young with mental disorders- aged 5- 17 year old.

Estimated number of children and young people with mental disorders – aged 5 to 17 New data 2017/18 Count - Count

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	-	-
South East region	–	-	-	-	-
Isle of Wight	–	-	2,285	2,145	2,442
Bracknell Forest	–	-	2,500	2,348	2,673
Reading	–	-	2,989	2,804	3,197
Windsor and Maidenhead	–	-	3,134	2,941	3,351
West Berkshire	–	-	3,272	3,073	3,498
Slough	–	-	3,484	3,268	3,728
Wokingham	–	-	3,487	3,273	3,729
Portsmouth	–	-	3,748	3,518	4,008
Southampton	–	-	4,107	3,854	4,393
Brighton and Hove	–	-	4,496	4,220	4,807
Medway	–	-	5,522	5,183	5,903
Milton Keynes	–	-	5,786	5,428	6,189
East Sussex	–	-	9,635	9,045	10,301
Buckinghamshire	–	-	11,023	10,348	11,786
Oxfordshire	–	-	12,632	11,858	13,506
West Sussex	–	-	15,343	14,403	16,405
Surrey	–	-	23,037	21,625	24,631
Hampshire	–	-	25,320	23,771	27,071
Kent	–	-	29,879	28,050	31,946

Source: NHS Digital

In Surrey it is estimated that 23,037 children and young people aged 5 to 17-years old have a mental disorder. This data cannot be compared to other areas as it is based on numbers and not % or by a rate per population.

Table 1: Hospital admissions for Surrey.

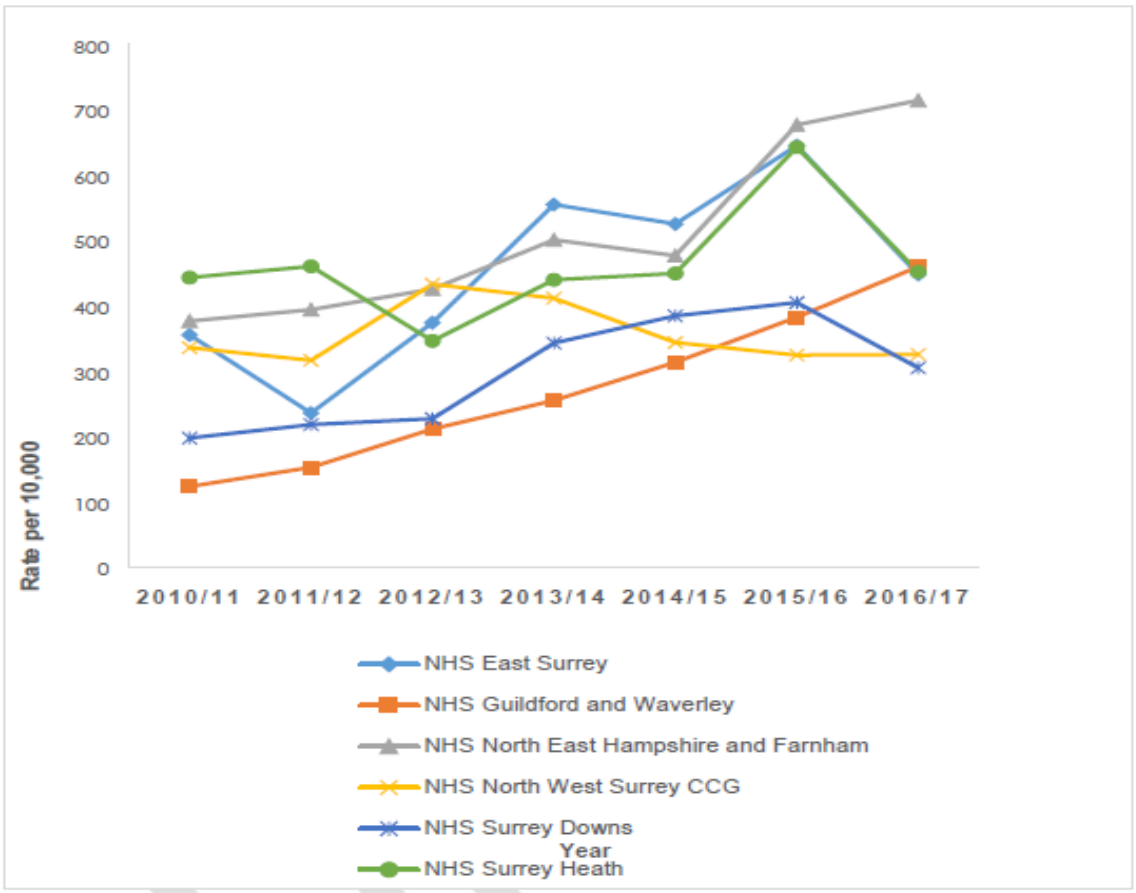
Indicator	Period	Surrey			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2018/19	↓	1,760	79.6	87.6*	96.1	184.9		45.1
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2018/19	→	1,825	138.3	142.4*	136.9	276.7		56.0
Hospital admissions for asthma (under 19 years) New data	2018/19	→	345	125.1	132.6*	178.4	485.9		50.3
Hospital admissions for mental health conditions New data	2018/19	→	225	85.9	88.9*	88.3	193.9		22.9
Hospital admissions as a result of self-harm (10-24 years) New data	2018/19	–	870	427.0	470.2*	444.0	1,072.7		91.1

1% of suicides in Surrey are among those who are under 25. Suicide in children and young people has a significant emotional and mental impact on other young people, families and the local community.

In Surrey, whilst we have access to data on self-harm resulting in a hospital attendance, not every incident of self-harm will require hospital treatment.

The rates of hospital admissions for self-harm per 10,000 population of 10-24-year olds in Surrey has increased over the last seven years. Data for 2018-19 showed that Surrey had a rate of 427.0 of the directly standardised rate per 100,000; compared to the national rate of 444.0 and the regional rate of 470.2

Figure 2: Hospital admissions as a result of self-harm in 10-24-year-olds 2010 – 2017 by CCG



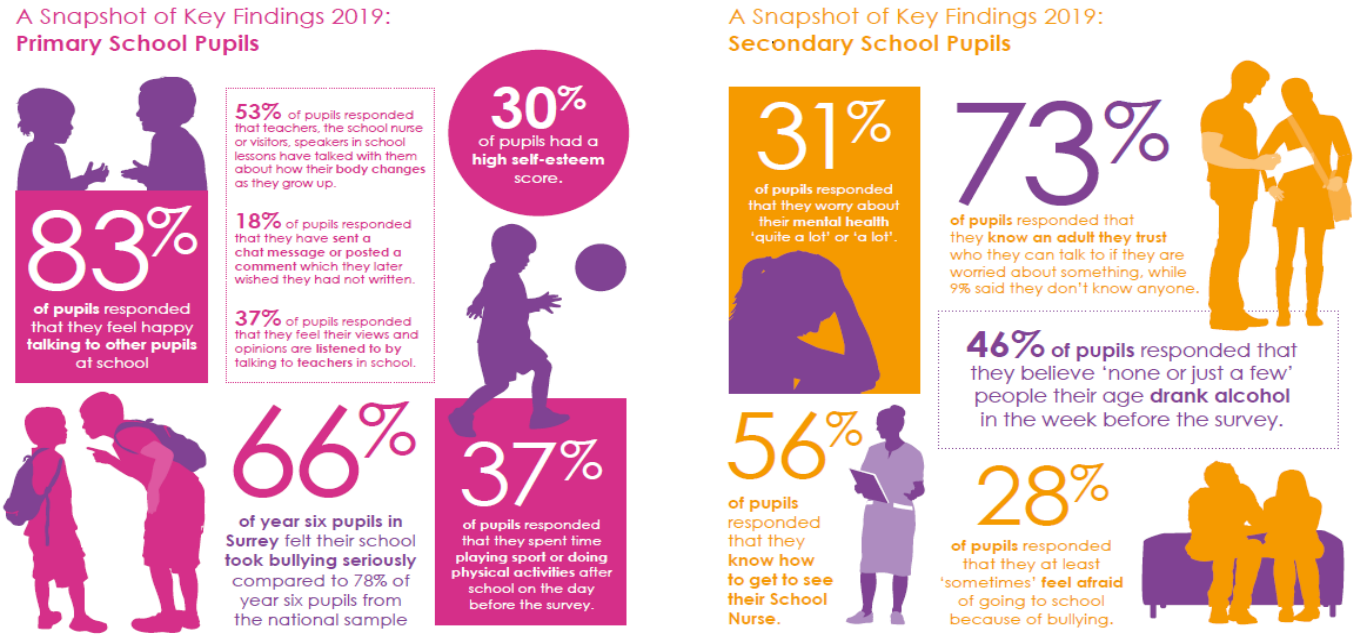
Source: (PHE Fingertips, 2018)

The increase in rates in those aged 10-17 years may reflect a genuine increase in self-harm rates, increased awareness and help-seeking combined with reduced stigma and/or improved management of self-harm in young people in line with NICE guidance (2004) which advises that individuals under the age of 16 presenting to hospital for self-harm should always be admitted for a comprehensive psycho-social assessment. There is evidence from the Adult Psychiatric Morbidity Survey 2014[4] that rates of self-harm have increased in the community, particularly in 16-24-year-old females, with one in nine (11.7%) reporting having ever self-harmed in 2007 and one in five (19.7%) in 2014.

According to ONS data for 2018, despite having a low number of deaths overall, rates of deaths by suicide among the under 25s have generally increased in recent years, particularly 10 to 24-year-old females where the rate has increased significantly since 2012 to its highest level with 3.3 deaths per 100,000 females in 2018.[5]

Health Related Behaviour Questionnaire (HRBQ) Data for Surrey. To gain insight into the health of children and young people in Surrey, Schools are able to take part in the Health-Related Behaviour Questionnaire which is carried out by the Schools and Student Health Education Unit (SHEU). This survey produces a detailed and anonymised profile of young people's lives at home, at school, and with their friends. This information is then used by services across the Local Authority to inform health needs assessment and health care planning, and by schools and educational establishments to promote needs-based practice, across the formal and informal curriculum. Below is a snapshot of key findings from the 2019 survey.

Figure 3: Snapshot of findings from Health-Related Behaviour Questionnaire (HRBQ) Data for Surrey.



[4] McManus, S., et al., Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. 2016, NHS Digital: Leeds

[5] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

A reduction in the death rate from suicide is a priority of Surrey's Joint Health and Wellbeing Strategy, signalling the commitment of partners across the NHS and Local Government to work together to save lives lost to suicide, through both whole population and targeted actions. The Surrey Strategy will harness that commitment to achieve the following aim: **To reduce suicide by 10% by 2021 through the coordinated actions of organisations**. This strategy will sit alongside the Emotional Wellbeing Mental Health Strategy for Children and Young People in Surrey 2019-22.

"Our ethos in Surrey is that every single suicide is a tragedy and is one too many. Our ultimate aspiration is, therefore, to eliminate suicide. We recognise the complexity of the factors that lead to someone taking their own life and although we may not be able to prevent every suicide, **we will make zero suicides in Surrey our ambition**. We believe this will facilitate a transformation of attitudes toward suicide locally, making it clear that suicide is not inevitable and that our organisations are jointly committed to the prevention of suicide locally." (Surrey Suicide Prevention Strategy 2019-2021)[6]

2.4 Adverse Childhood Experiences (ACEs)

A report by Young Minds highlights that 1 in 3 adult mental health conditions is related to adverse childhood experiences (Young Minds, 2016). These experiences include neglect, abuse, poverty, parental alcohol or substance misuse, parental poor physical or mental health, and parental suicide. Adverse childhood experiences increase the risk of suicide (Devaney, Northern Ireland).

3. Methods

3.1 Case definition

Children and young people's deaths for this review were defined as probable suicides (intentional self-harm and events of undetermined intent) aged 10 to 17 years normally resident in Surrey, between 1 April 2014 and 31 March 2020.

3.2 Data sources

Information on the children and young people was obtained from the Child Death Overview Panel database.

3.3 Research evidence review

A series of evidence searches were undertaken to review the literature around suicide in children and young people, with reference to issues identified by the Child

6 https://mycouncil.surreycc.gov.uk/documents/s55064/Surrey%20Suicide%20Prevention%20Strategy%202019-2021%20-%20Final.pdf

Death Review Partnership, who supported the thematic review. In particular, the evidence review sought to identify:

- Evidence of the risk factors for suicide in children and young people.
- Evidence of effective interventions to support the prevention of suicide in children and young people.

Following a series of scoping searches, a thorough review of the evidence was undertaken with a focus on high level evidence sources including NICE Guidelines, the Cochrane Database of Systematic Reviews and point of care tools (BMJ Best Practice, UpToDate and Clinical Key). This was followed by searching original research (primarily PsycINFO via Healthcare Databases Advanced Search, HDAS and the PsycARTICLES database).

Search results from HDAS were filtered based on their title and abstract. Articles that included results of systematic reviews, RCTs and larger studies were given more prominence.

Restrictions were applied and the search results were limited to studies of children (6-12 years) and adolescents (aged 13-17 years). The results were also limited to include English language articles only and research and reviews from the last 10 years.

Following the filtering process the search results were reviewed, prioritised and collated into themes. In total NICE Guidelines, Systematic reviews and original research articles where collated thematically.

The London, Kent, Surrey and Sussex Regional Searching Guidance (Jan 2020)[7] document informed the search process and approach taken, the search process although very thorough, cannot be described as fully comprehensive due to the limited timescale available.

3.4 Thematic review group

A thematic review group was convened. Members were drawn from academia, safeguarding, public health, the child death review team, education and specialist mental health services.

4 Findings

4.1 Children and young people included in this review

Between 1st April 2014 and 31st March 2020, 12 children and young people met the case definition for the thematic review of probable suicide. This represents a 100% increase since the previous 6-year reporting period (1st April 2009 - 31st March

[7] The London, Kent, Surrey and Sussex Regional Searching Guidance (Jan 2020) Regional Searching Protocol Working Group.

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2014). 9 of the children and young people were male (75%) and 3 females (25%). 5 (42%) were aged 10-14 years. The youngest was fourteen years old.

4.2 Summary of children and young people

Figure 4: Percentage analysis of themes of young people in the review

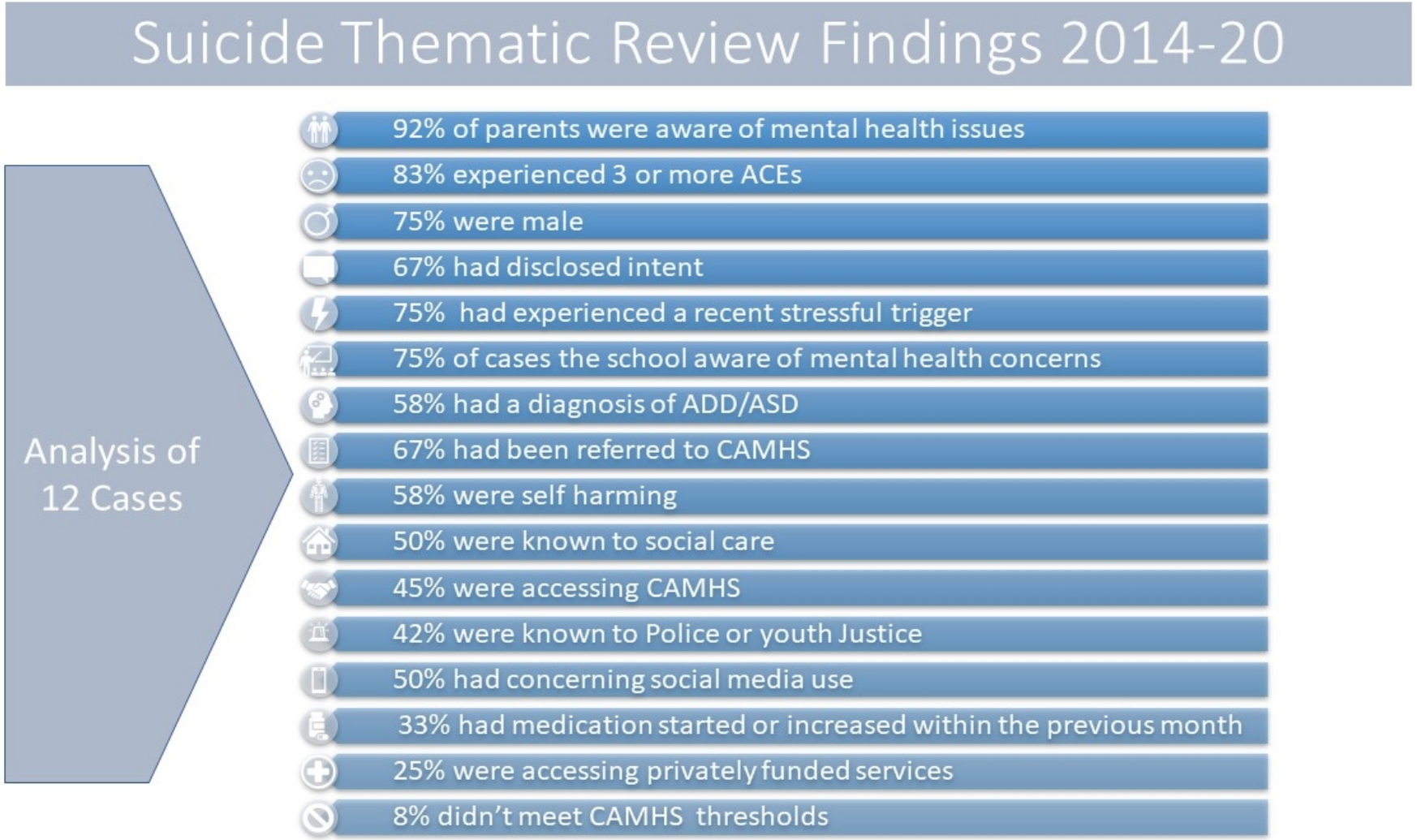


Chart 5: Age and number of children included in the review

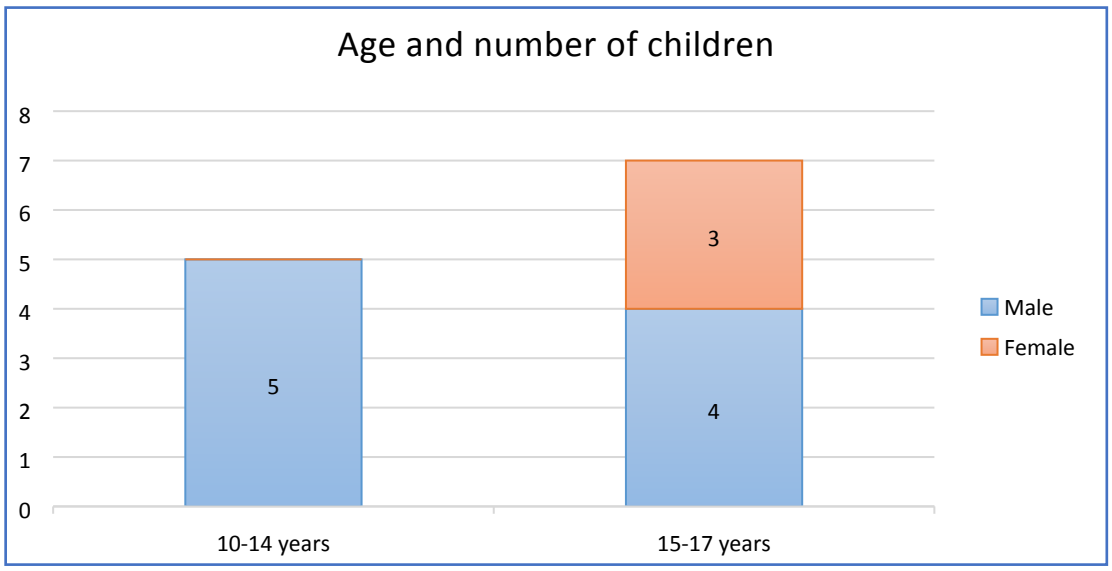
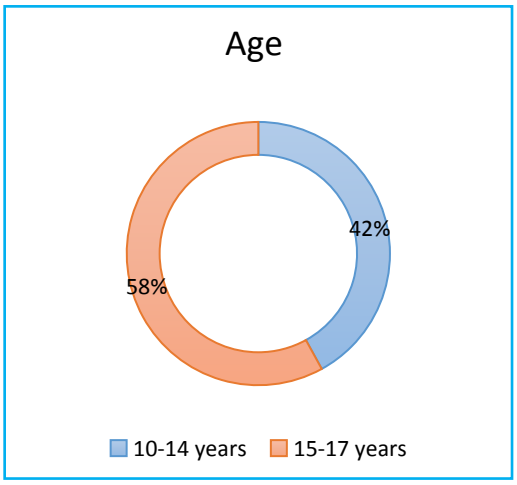


Chart 6 and 7 : Percentage age and gender of children involved in the review



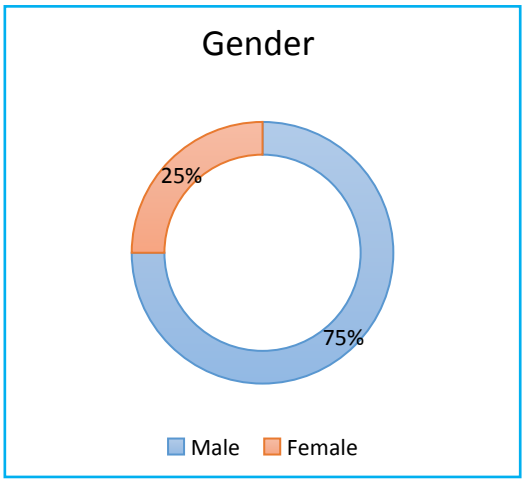


Chart 8: Percentage of children in the review by school year

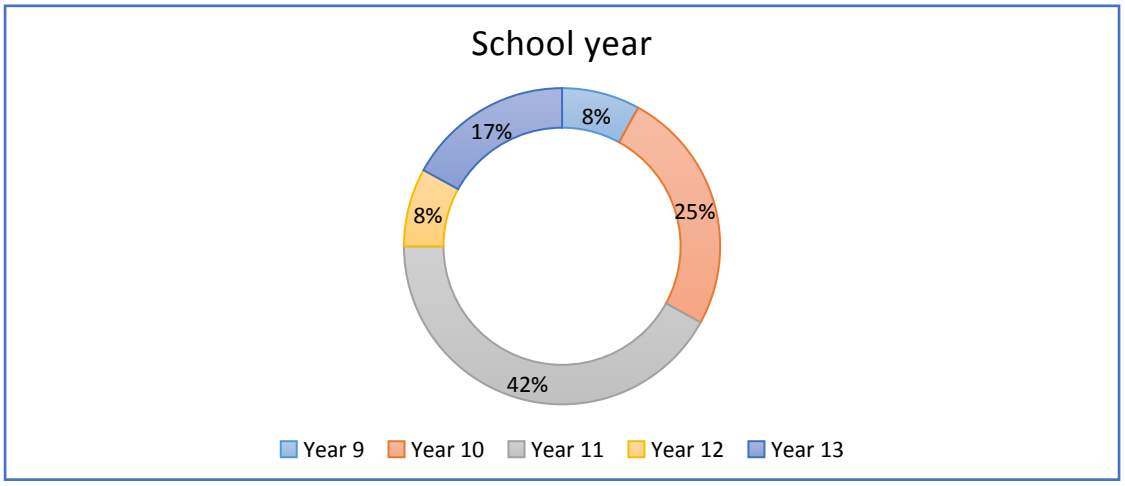


Chart 9: Percentage of children disclosing intent of suicide

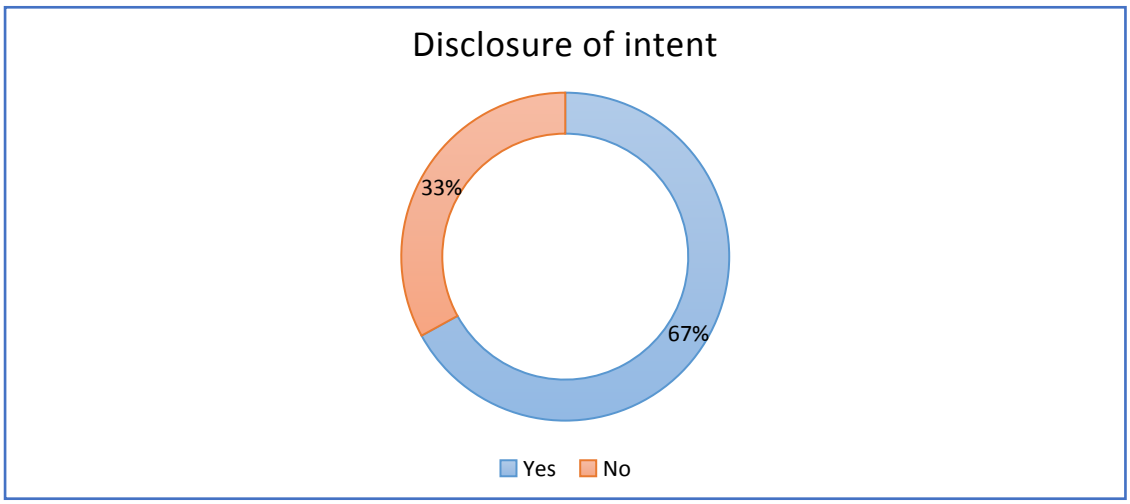


Chart 10: Percentage of previous reports of recorded self-harm incidents

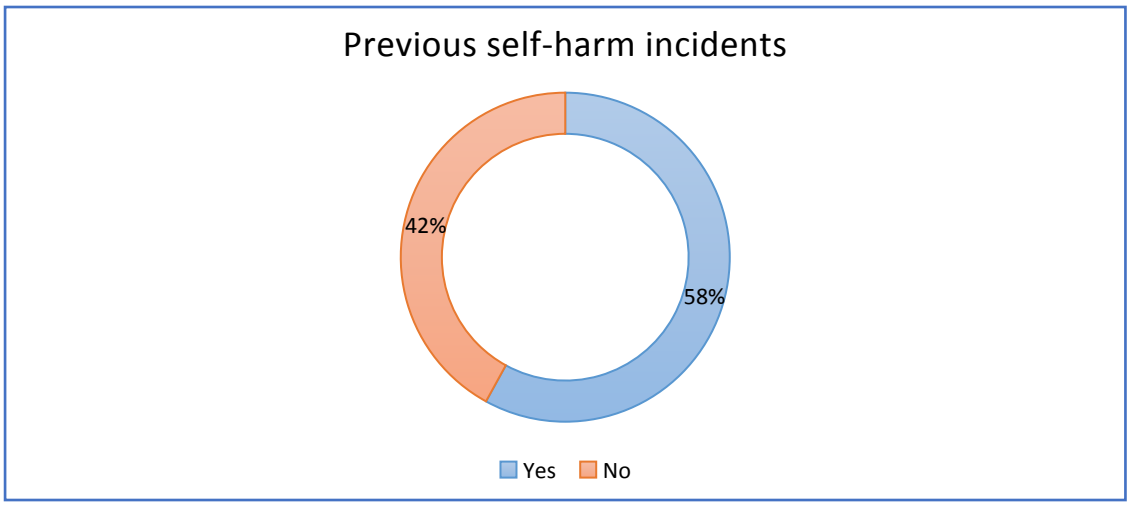


Chart 11: Percentage of children in the review with neuro-developmental concerns

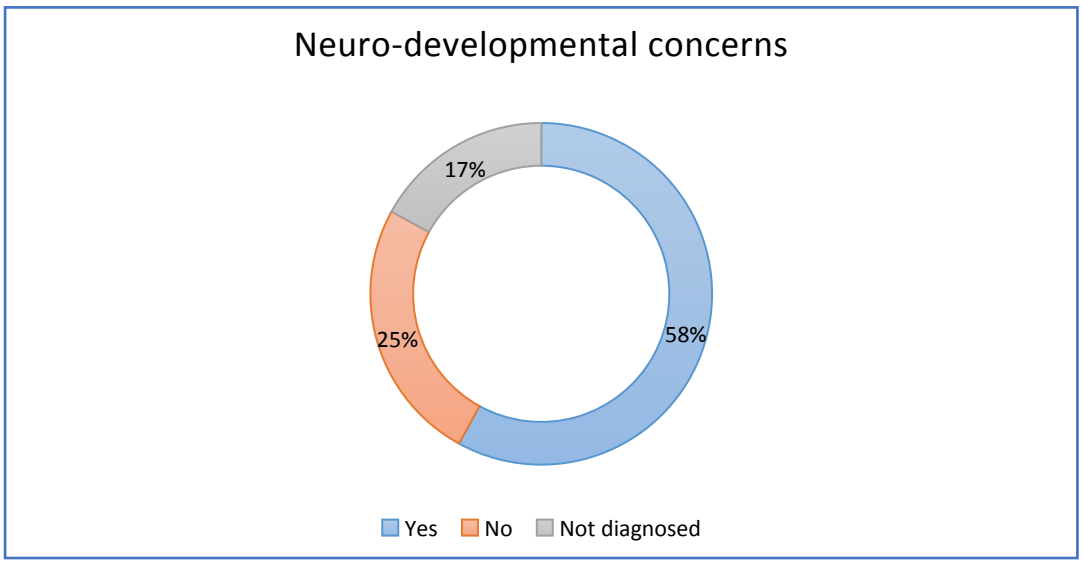
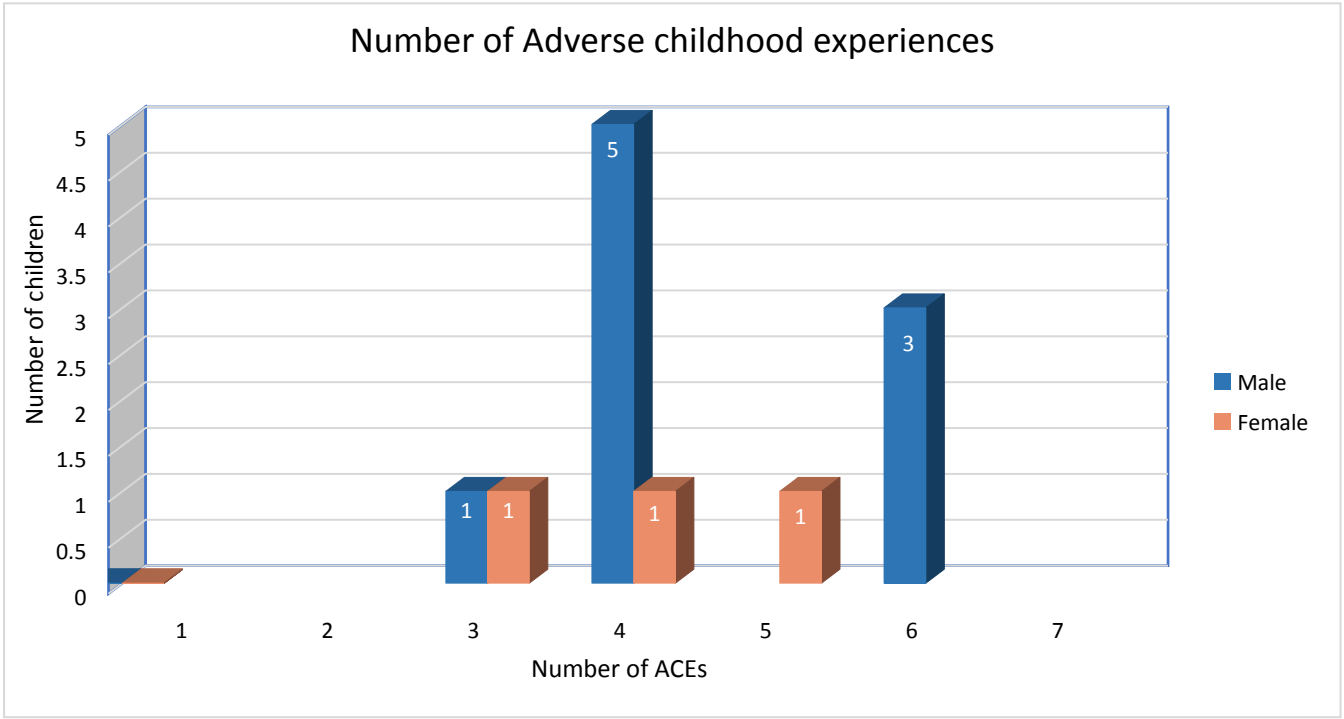


Chart 12: Number of ACEs experienced by children included in the review by gender.



5 Strengths and limitations

A major strength of this report was the multi-agency involvement and joint working through the thematic review group. In addition to this, the involvement of the Surrey Child Death Review (CDR) Team and the information held by the Surrey Child Death

Overview Panel (CDOP) allowed for an in-depth study of the common themes. In July 2018, a revised version of Working Together to Safeguard Children was published and an additional document for the child death review process entitled "Child Death Review Statutory and Operational Guidance" was published in October 2018. These two statutory documents lay out in detail the processes that must be followed when a child dies. The statutory guidance states that families should be involved in child death review processes and that parents should be assured that any information concerning their child's death which they believe might inform the meeting would be welcome. The high engagement of families in the CDR process in Surrey meant that the review had access to in-depth information including valuable parental input.

Whilst every death from suicide is a tragedy, the small numbers for this review mean that it will not be possible to have statistically robust data on the themes identified. Although we do know that several of the themes are backed up with supporting published evidence and mirror the national picture.

6. Issues identified in this review

Figure 5: Issues identified in this review:

6.1 Adverse Childhood Experiences (ACEs)

83% of the children in the review had experienced 4 or more ACEs. Dr Vincent Felitti, head of Kaiser Permanente's Department of Preventative Medicine, and Dr

Robert Anda, an epidemiologist from the CDC, surveyed over 17,000 patients for their experiences of childhood trauma.[8] Participants were asked about different types of childhood trauma which they referred to as ACEs. Key findings showed that:

- 60% of participants had experienced at least one ACE and 1 in 8 had experienced 4 or more ACEs.
- The higher the ACEs score, the higher the likelihood of developing long-term health problems like heart disease, stroke, cancer and Type 2 diabetes (a dose-dependence relationship).

Figure 6: Breakdown of adverse childhood experiences[9]

Wan et al 2019[10], in their study on associations of adverse childhood experiences (ACEs) and social support with self-injurious behaviour and suicidality in adolescents found that there is little investigation on the interaction effects of ACEs and social support on non-suicidal self-injury (NSSI), suicidal ideation and suicide attempt in community adolescent populations, or gender differences in these effects. A school-based health survey was conducted in three provinces in China between 2013 – 2014. A total of 14,820 students aged 10–20 years completed standard questionnaires, to record details of ACEs, social support, NSSI, suicidal ideation and suicide attempt. Wan et al concluded that ACEs and low social support are associated with increased risk of NSSI and suicidality in Chinese adolescents. Strategies to improve social support, particularly among female adolescents with a high number of ACEs, should be an integral component of targeted mental health interventions.

Mind, in their report in 2016 '*Beyond Adversity: Addressing the mental health needs of young people who face complexity and adversity in their lives.*'[11] recommended fast-tracking children for mental health support when they need it, even if they don't meet the usual thresholds for those services, improve training for doctors, teachers,

[8] Felitti, M. D., Anda, R. F., Nordenberg, M. D. et al (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study' *American Journal of Preventative Medicine.* 14.

[9] https://www.connectedforlife.co.uk/blog/2017/6/17/the-adverse-childhood-experiences-ace-study

[10] Wan Y, Chen R, Ma S, et al. Associations of adverse childhood experiences and social support with self-injurious behaviour and suicidality in adolescents. *Br J Psychiatry*. 2019;2014(3):146–152. doi:10.1192/bjp.2018.263

[11] https://youngminds.org.uk/media/1241/report_-_beyond_adversity.pdf

social workers, police officers and charities as well as establishing an expert group to improve understanding of adverse experiences in childhood and provide consistent treatment across the country.

It is important that adverse childhood experiences are not seen in a fatalistic or deterministic way; for example, some children and young people who have had adverse childhood experiences go on to thrive and have positive outcomes despite the trauma and abuse they have experienced. It is essential that practitioners and managers consider childhood adversity and ensure that support and resilience building is part of their work with children and families.

6.2 Autistic Spectrum Disorder

58% of the children in the review had a diagnosis of ASD/ ADD. These cases highlighted the importance of understanding the risk of self -harm and suicide in this group of young people. There can be the additional issues of fixation and rigidity of thought processes causing unpredictable and sudden self-harming behaviours.

When carrying out mental health risk assessments in this patient group, the increased vulnerability of this patient group needs to be taken into consideration. Raising awareness that ASD is a known risk factor for suicide would support and assist assessments with the Single Point of Access (SPA).

Mayers et al (2013) explored suicide ideation and attempts in children with Autism.[12] As part of the study, 791 children with autism (1–16 years), 35 non-autistic depressed children, and 186 typical children and risk factors in autism were determined. Percentage of children with autism for whom suicide ideation or attempts was rated as sometimes to very often a problem by mothers (14%) was 28 times greater than that for typical children (0.5%) but less than for depressed children (43%). For children with autism, four demographic variables (age 10 or older, Black or Hispanic, lower SES, and male) were significant risk factors of suicide ideation or attempts. The majority of children (71%) who had all four demographic risk factors had ideation or attempts. Co-morbid psychological problems most highly predictive of ideation or attempts were depression, behaviour problems, and being bullied. Almost half of children with these problems had suicide ideation or attempts. Mayers recommended that all children with autism should be screened for suicide ideation or attempts because ideation and attempts in autism are significantly higher than the norm and are present across the spectrum. They stated that this is especially important for children who have the demographic and co-morbid risk factors, many of which can be targeted for intervention to reduce and prevent suicide ideation and attempts.

[12] Suicide ideation and attempts in children with Autism. Mayes, Susan Dickerson; Gorman, Angela A.; Hillwig-Garcia, Jolene; Syed, Ehsan Research in Autism Spectrum Disorders; 2013; vol. 7 (no. 1); p. 109-119

6.3 Medication

33% of the young people had their medication changed or increased in the four weeks prior to their death. All depression medications and specifically selective serotonin reuptake inhibitors (SSRIs) carry a risk of increased suicide in children and young people. The risk is higher during the first month of starting antidepressants and particularly between 1-9 days (Jick et al., 2004). However, research evidence shows that antidepressants are negatively associated with suicide rates. Potential links between antidepressant use and suicide attempts require further investigation to understand the underlying mechanisms of this relationship (Valuck et al., 2012).

Miller et al (2014)[13] looked at antidepressant dose, age, and the risk of deliberate self-harm and concluded that children and young adults initiating therapy with antidepressants at high-therapeutic (rather than modal-therapeutic) doses seem to be at heightened risk of deliberate self-harm. Gibbons et al (2011)[14] examined strategies for quantifying the relationship between medications and suicidal behaviour. They concluded that in children, the results are less clear and further study is required to better delineate which children benefit from treatment and who may be at increased risk as a consequence of treatment.

6.4 Gender

75% of the young people in the review were male. This is in line with the results of the Manchester Suicide in Children and Young People study[15] where they found that the number of male suicides was higher than females, especially in the late teens and early 20s, with a male to female ratio of 2.6:1 in those aged 15-19, and 3.7:1 in those aged 20 and over.

6.5 Substance misuse - drugs and alcohol

25% of the young people in the review had been using drugs or alcohol. According to research, there is a link between risk taking including drug and alcohol use and suicide. Young people using substances such as alcohol and/or drugs are more likely to complete suicide. Studies have shown that personality difficulties are associated with substance misuse (Hawton et al., 1993). Previous research has highlighted that males with substance or alcohol abuse problems are at higher risk for completed suicide (Rowan, 2001). Adolescents with depression or antisocial behaviour and substance abuse are more likely to engage in suicidal behaviour.

[13] Miller M, Swanson SA, Azrael D, Pate V, Stürmer T. Antidepressant dose, age, and the risk of deliberate self-harm. *JAMA Intern Med*. 2014;174(6):899–909. doi:10.1001/jamainternmed.2014.1053

[14] Gibbons RD, Mann JJ. Strategies for quantifying the relationship between medications and suicidal behaviour: what has been learned?. Drug Saf. 2011;34(5):375–395. doi:10.2165/11589350-000000000-00000

[15] http://documents.manchester.ac.uk/display.aspx?DocID=37566

The use of substances plays a critical role to suicidal outcomes. Co-existing mental disorders such as depression, ADHD and conduct disorder intensify the relationship between suicide and substance abuse.

6.6 Management of self-harm

58% of the young people were self-harming. Many children and young people who self-harm feel guilty and afraid. There is often a fear of being labelled as attention seeking. The stigma around self-harm stops young people accessing support (Mental Health Foundation, 2012).

6.7 Schools and further education colleges

A number of the young people in the review were finding it hard to access school in a conventional manner.
There was evidence that deaths in school pupils caused considerable distress to the school community and access to bereavement support following a death by probable suicide was important.

6.8 Social care

50% of the young people were known to social care, this is in line with the findings of the Manchester Suicide study where 65% of the young people aged under 20 were known to social care.

6.9 Multi-disciplinary working within healthcare

A number of the children and young people had sporadic contact across a number of services. This included:

- where the young people attended ED after an episode of self-harm but did not enter any care pathway
- where the young people did not meet the threshold following a CAMHS referral or where the wait time was too long and so they accessed private services
- where the suicide risk of the child or young person was not recognised or documented appropriately by healthcare professionals including CAMHS

As such these opportunities for intervention were missed with little apparent oversight, communication or follow-up of loss of contact.

6.10 Multi-agency partnership working

For a number of children and young people schools sought support from CAMHS on a number of issues and felt that the support offered was not sufficient to support the teaching staff.

6.11 Social media sites and internet use

In 50% of the young people there was a concerning level of social media use identified by parents, along with researching of methods of suicide and self-harm online. In the Manchester study, 26% (74) had used the internet in a way that was related to suicide. 13% (37) searched the internet for information on suicide method and 10 died by a method they were known to have searched on. 4% (11) visited websites that may have encouraged suicide. 10% (29) had communicated suicidal ideas or intent online and 7% (21) had been victims of online bullying—10 in the 3 months prior to death.

Young people below 20 years who died from suicide were more likely to have researched suicide online and to have inappropriate content which may have acted as a primer to suicidal behaviour. It is suggested that mental health professionals are aware of online behaviours and interactions which play an important role in young people's lives. Online behaviours seem to present with increasing risks that often mental health professionals overlook. 90% of 11 to 16-year olds have a social media account (NSPCC, 2019). Guidelines need to be designed on how key workers should identify these risks and provide support to young people accessing destructive websites and social media platforms online which may exacerbate their current symptoms.

6.12 Media reporting

Some of the deaths of these children and young people were widely reported in the media. It is recognised that death by probable suicide in young people is more widely reported than similar deaths in other age groups[16]. Responsible reporting of suicide deaths can minimise any effects on vulnerable individuals and reduce further distress to family and friends[17].

6.13 Suicide cluster response plans

Published in 2015, the Public Health England document *'Identifying and responding to suicide clusters: A practice resource'*[18] advises that addressing suicide clusters is the responsibility of Multi-agency Suicide Prevention Groups, generally led by local authorities, which should build preparing for clusters into their local suicide prevention plans. These groups should include relevant organisations that might be affected, including mental health services, schools, colleges and universities**.** This group should work to develop a Suicide Cluster Response Plan. The aim of the plan

[16] Pirkis, J., et al., Reporting of suicide in the Australian media. Australian and New Zealand Journal of Psychiatry, 2002. 36(2): p. 190-197.

[17] Pirkis, J., et al., Media Guidelines on the Reporting of Suicide. Crisis, 2006. 27(2): p. 82-87.

[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/839621/PHE_Suicide_Cluster_Guide.pdf

is to support those affected by suicide and to prevent further suicides. Feedback from organisations facing suicide clusters has shown that a Suicide Cluster Response Plan should be in place before a cluster occurs; lack of such a plan can result in a haphazard response when a cluster is suspected. While use of the term Suicide Cluster Response Plan implies that a cluster has definitely been identified, in reality clusters are more likely to be suspected or there are concerns that one may occur because of the nature or circumstances of a specific suicide or suicides. The plan should be reviewed periodically to ensure it continues to reflect current agencies and partnerships.

Public Health England has a major role in suicide prevention and should usually be informed when local authorities are dealing with a suspected cluster. This should be done via the local Public Health England lead in the first instance. The CDOP should be linked to the Suicide Cluster Response Plan. There should be links between the Multi-agency Suicide Prevention Group and the Surrey Children's Safeguarding Partnership.

This review found no evidence of this taking place and no exploration of each death to determine if it was part of a cluster. The response plan is not documented in the Surrey Suicide Prevention Strategy 2019 - 2021.[19] Suicide clusters are of great concern, especially as they predominantly occur in young people and the fact that localities which have had clusters may be at heightened risk of further clusters. In groups particularly vulnerable to imitation (for example those in schools, further education colleges, universities or inpatient psychiatric wards), attention should be paid to possible contagion after even a single suicide. Clusters are not limited to geographical locations and any increase in suicides in young people, based on the PHE document should have triggered a cluster response plan.

6.14 Family engagement

The death of a child, of any age, brings heartbreak and devastation. For any parent to have a child die, whatever the age, whatever the cause is devastating. It seems to break the "normal" rules when a child dies before a parent.

Any bereavement can be immense, but with possible suicide, the grieving process may be more complex, intense and longer, although the actual experiences of grief may be similar to other bereavements.

After a possible suicide, it can be more difficult or impossible to understand why the child appeared to make that decision. The suddenness and nature of the death can be deeply upsetting or harrowing and hard to make sense of. Also, the sudden nature of the death means there is no opportunity to say goodbye. Some parents/ carers and siblings feel a social taboo in discussing suicide which can make it a difficult topic to talk about openly.

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19 https://mycouncil.surreycc.gov.uk/documents/s55064/Surrey%20Suicide%20Prevention%20Strategy%202019-2021%20-%20Final.pdf

There can be specific challenges for the whole family, and for children and young people when grieving after a possible suicide. Suicide brings particularly strong feelings which are often conflicting, including shock, anger, despair, guilt, shame, blame, relief, betrayal, isolation, confusion, exhaustion and low self-esteem. There may be a desperate 'need to know' in addition to all the other grief responses to sudden death. Thinking can become circular, endlessly trying to find answers to 'why?' and 'what if?' questions, searching to make sense of what has happened in a way that feels bearable. The loss of 'what might have been?' has an even more powerful impact when a death is by possible suicide because of the child's apparent decision to die. The greatest longing can be to go back and put right the terrible wrong of their death, to replay events and have a different ending. Questions can seem unanswerable.

Being given the opportunity to talk about your grief is an important part of getting through a bereavement. Surrey CDR Team proactively contact all families via the named nurse/child death review nurse to offer them bereavement support, the opportunity to contribute to the CDR process and allow their voice and the voice of their child to be heard.

Themes identified from parents and carers during this thematic review included:

Communication between CAMHS and parents of children accessing support

- *When their child was undergoing CBT counselling, parents report they were not told clearly or directly that their child continued to disclose suicidal thoughts during the sessions and as a result they were not aware of the seriousness of the risk for their child or the length of time that the child had been experiencing these thoughts. Words used by CAMHS professionals were 'low mood' rather than 'suicide'.*
- *Despite lots of input from CAMHS, parents felt very isolated and alone. Parents report poor communication between CAMHS and themselves.*
- *Parents felt they were kept on the periphery and were not aware of where and what the plan of care/crisis plan for their child was.*
- *Parents were unaware of who was the person in charge/key worker of their child's care. Who had oversight of all the support their child was receiving? What monitoring was going on to assess if child was progressing/deteriorating?*

Wait time to access support from CAHMS

- *Parents felt there are not enough resources in the NHS to cope with mental health problems in adolescents and children. Two families experienced a 6-month waiting list for CAMHS so accessed private support.*

- *Parents felt the time from initial referral to CAMHS to receiving a diagnosis was a prolonged period of time.*

Cancellation of CAMHS appointments

- *When appointments were cancelled due to exams timetable, parents felt that had they been aware and well informed of the risk for their child, they could have and would have actively requested another appointment as soon as possible.*

Multi-agency support

- *Parents felt that all professionals did their bit but would argue this was not done in a co-ordinated way.*
- *One family felt Education were not helpful in supporting their child/family with the behavioural difficulties presenting alongside mental health concerns.*
- *Social care did not offer further support to one family despite the child frequently going missing.*
- *Parents report support from Police was fantastic over the course of their child's mental illness. Police were the only service the parents could guarantee would respond when he called.*

Parental awareness of mental health and when to assess support

- *Parents would like all parents to know that they should not delay in seeking treatment for mental health concerns in their children.*
- *Parents felt that there should have been clearer warnings that suicide risks are increased when people start to improve and respond to treatment.*
- *Parents were not made aware of the increased risk of suicide if a child had ASD.*

Impact on parents/families when supporting a child with suicidal thoughts

- *Parents felt totally exhausted, overwhelmed at times and were desperate for help. Parents report they did not have the skills of a mental health worker and wanted practical help on how to best manage and help their child as they had exhausted all avenues and genuinely did not know what else to do.*
- *Parents felt Social Care were not helpful when they were approached for help during the breakdown in relationship between their child and themselves.*

Some of these issues are similar to those raised by parents nationally. In 2019, Jones et al[20] concluded that the high prevalence of parental unawareness and adolescent denial of suicidal thoughts found in their study suggests that many adolescents at risk for suicide may go undetected. These findings have important clinical implications for paediatric settings, including the need for a multi-informant approach to suicide screening and a personalized approach to assessment based on empirically derived risk factors for unawareness and denial.

Bereavement, grief and loss can cause many different symptoms and they affect parents/carers and siblings in different ways. Any death may be difficult to understand or make sense of, especially when it is sudden or unexpected. A death by possible suicide is likely to be even more difficult for families to face and to understand. There is no right or wrong way to feel. Bereavement can influence every aspect of well-being, from physical and mental health to feelings of connectedness and the ability to function at work or school.

Learning to live with the loss of someone close is one of the most painful experiences we can encounter. Society's response often makes it even harder. All too frequently, people report feeling isolated and being expected to 'get on with it' after a bereavement, even when they had been very close to the person who died or when their death has been unexpected.

The costs of bereavement are too great to ignore, both for individuals and society. Bereavement increases the risk of mortality and poor health. Providing support to bereaved parents, siblings and families can bring great benefits to individuals and to society as a whole. We also know from evidence that if you have experienced suicide by a close friend or family member that increases your own risk of suicide. Results from Hooven et al (2012) in their study 'Promoting CARE: Including parents in youth suicide prevention' revealed that the youth intervention and combined youth and parent intervention produced significantly greater reductions in suicide risk factors and increases in protective factors than IAU comparison group.[21]

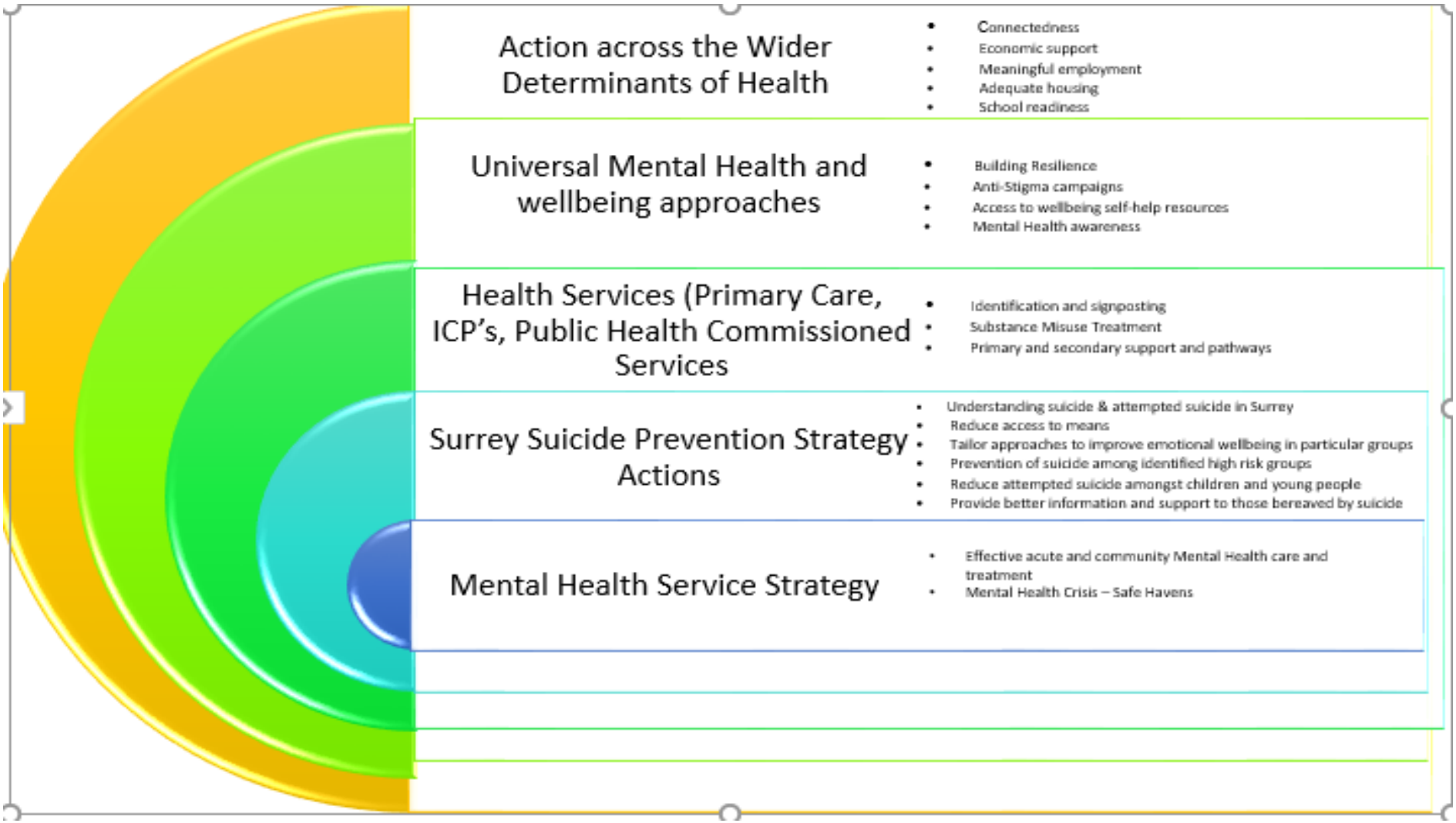
7 Opportunities for prevention

7.1 Existing activities which contribute to the prevention of suicide

[20] Jones JD, Boyd RC, Calkins ME, et al. Parent-Adolescent Agreement About Adolescents' Suicidal Thoughts. *Paediatrics*. 2019;143(2):e20181771. doi:10.1542/peds.2018-1771

[21] Hooven C, Walsh E, Pike KC, Herting JR. Promoting CARE: including parents in youth suicide prevention. Fam Community Health. 2012;35(3):225–235. doi:10.1097/FCH.0b013e318250bcf9

Figure 7: A comprehensive approach to Suicide Prevention in Surrey



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Various authors including the World Health Organisation 2018[22] have asserted that suicide is a global public health concern and The Institute for Mental Health indicated that the UK has recently seen a marked increase in rates of suicide and self -harm amongst young people. A recent published Lancet (2018) also asserted that suicide is the second-leading cause of death among young people and rates appear to be increasing.

A systemic review and meta-analysis in EClinical Medicine published in the Lancet (2018)[23] noted that, according to international best practice, most strategies recommend a comprehensive approach to suicide prevention covering universal approaches such as delivering awareness to groups or communities believed to be at higher risk of suicide; delivering to individuals displaying suicide-related behaviours and interventions ranging across settings to include clinical, educational, workplace and community settings and more recently the advocating of interventions to be delivered in digital as well as face to face settings.

Various authors have also asserted that suicides by people aged under 25 highlighted the importance of recognising the pattern of cumulative risk and 'final straw' stresses such as exams that contribute to suicide in children and young people.

British Transport Police were consulted as part of the thematic review and are undertaking ongoing work in reducing access to railways and preventing suicides. British Transport Police are working with Network Rail on a suicide prevention programme.

The suicide prevention programme includes the following initiatives:

- training railway employees to look out for and offer support to people who may be considering taking their own life on the railway – to date, 19,000 railway employees have received training to intervene in suicide attempts (and in 2018/19 rail employees, the Police and public intervened in more than 2,200 suicide attempts on the railway)
- working in partnership with Samaritans and other charities within the wider community to de-stigmatise suicide and promote help-seeking behaviour
- deploying mitigation measures, such as fencing to prevent access to the tracks at high-risk locations
- developing new and innovative ways to meet the suicide challenge on the rail network
- contributing our specialist knowledge of suicide prevention to national strategies and guidance so others can benefit from our experience
- Commissioning bespoke research into rail suicides

[22] WHO 2018 National Suicide Prevention Strategies Progress, examples and indicators

[23] Brodsky B S, Spruch-Feiner A, Stanley B 2018The Zero Suicide Model: Applying Evidence- Based Suicide prevention Practices to Clinical Care.

Our review of current best practices both national and international highlighted the following as key to suicide prevention which could apply to both adults and children.

These are:

1) **Brief Interventions**
   The safety plan intervention (SPI) is seen as a best practice brief intervention that incorporates evidence-based suicide risk reduction strategies such as lethal means reduction, brief problem solving and coping skills, increasing social support and identifying emergency contacts to use during a suicide crisis. It was noted that in conducting SPI, clinicians and patients collaborate to develop a six- step plan for staying safe. These include identifying warning signs, individual coping skills, people and places for distraction, people to contact for help, professionals to contact for help and steps for means safety.

2) **Crisis response planning** which involves individuals use of a small card to write out steps for step for self-identifying personal warning signs, coping strategies, enlisting social support and accessing professional services.

3) **School based awareness programmes** have shown promise in reducing suicidal ideations. These include gatekeeping training for teachers and staff, a youth mental health awareness programme and professional screening of students considered to be at risk. Whole school approaches to promoting emotional health and wellbeing and promoting resilience have been considered as best practice.

4) **Community-based approaches**:
   It was also noted that evidence has demonstrated that deaths by suicide can be reduced through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide.

5) **Implementing suicide safer places or environments** can also be effective where a range of initiatives enables people to talk about suicide and provide life-saving suicide prevention skills combined with signs or leaflets in appropriate targeted locations or settings and specific support groups or interventions for those at risk.

6) **Reducing access to the means of suicide** remains one of the most evidenced aspects of suicide prevention and this has included physical restrictions as well as improving opportunities for interventions.

7) **Working with local media to prevent suicides**:
   It was asserted that evidence has showed that inappropriate reporting of suicide may lead to imitative behaviour. Best practice has highlighted that local

media should adhere to the Samaritan's Guidance on responsible media reporting.

8) **Supporting those bereaved or affected by suicide**:
It was also acknowledged that those bereaved by suicide are at a high risk of depression, suicide attempt and even suicide. Best practice has highlighted that resources should be made available to support those bereaved, these could include help at hand cards / booklets via first responders, coroners, local funeral directors, voluntary sector organisations and within the community settings.

9) **Postvention** was also identified as key to suicide prevention:
This is the actions taken by organisations to provide support after someone has died by suicide. Effective support can help people grieve and recover therefore it is a critical element in preventing further suicides.

10) **Education in Primary Care** was also identified as good practice, as studies have shown that Primary care is often the first and last health care contact for people who die by suicide and 50% of GP's surveyed indicated that they have not undertaken any mental health training in the previous 5 years. (Preventing Suicide in Young people 2019)[24]

11) **Suicide is everybody's business:** It has been asserted that a whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. It was also noted that suicide prevention can be part of work addressing the wider determinants of health and wellbeing. An example given is the suicide safer communities framework which has been adopted in some areas in England where actions focuses on building communities that are committed to talking opening about suicide, promoting wellness and mental health and supporting those bereaved by suicide.

A report commissioned by HEE and published by the NCCMH[25] noted the Samaritans' slogan that 'suicide is everybody's business and therefore suggested that training programmes should be available and applicable across multiple settings such as within public services, employers and the wider general public. These principles could be applied to the work in preventing death by suicide in children and young people.

[24] Michail M, Upthegrove R 2019 Preventing Suicide in Young People
Institute for Mental Health, University of Birmingham
[25] NCCMH 2018 Self-harm and Suicide Prevention Competencies Framework; Children and Young People: Health Education England.

8 Recommendations and Action plan

Recommendations and opportunities not to be missed are summarised below. These were selected as there is a real chance that development of these opportunities could inform action to prevent deaths of children and young people through suicide.

- **Management of self-harm:** Full implementation of NICE guidance for the management of self-harm relating to children and young people.

- **Prevention of alcohol and substance misuse:** Ongoing action to restrict access of children and young people to alcohol, and full implementation of NICE guidance to prevent substance misuse, since alcohol and substance misuse pose a particular risk to children at risk of suicide.

- **Work across the County to mitigate ACEs:** Optimising provision and access and ensuring continued engagement with interventions for children who have experienced ACEs such as sexual abuse, sexual assault or domestic violence; and engagement with SSCP Partnership to raise awareness of the importance of protecting children from the effects of domestic violence and sexual abuse to prevent suicide and self-harm.

- **Timely support for children and young people in crisis, with support for completing effective referrals to be offered**: by CAMHS and support for other professionals and organisations working with those children and young people. Where suicide risk of the child or young person is recognised, risk assessments are updated in a timely manner by healthcare professionals including CAMHS.

- **Professionals must be clear that young people's need to be safeguarded overrides their right to confidentiality.**[26]

- **Implementing a Surrey Healthy Schools Approach:** All Surrey schools are engaging and taking a Surrey Healthy Schools approach, which includes the delivery of known evidence-based programmes and supports access to specialist mental health advice and pathways for sign-posting. The Surrey Healthy Schools Self-Evaluation Tool will signpost schools to appropriate support and guidance and will assist them in developing appropriate actions to aid physical and mental health and wellbeing.

- **All Surrey schools are engaging and accessing the Targeted Approaches to Mental Health in Schools**; initially undertaking the Emotional Wellbeing and Mental Health Training before accessing additional training, including training to support schools with their understanding of self-harm, in order to ensure that more targeted training is embedded in a whole school approach to prevention.

[26] https://learning.nspcc.org.uk/media/1541/gillick-competency-factsheet.pdf

- **Better knowledge and awareness for parents:** Exploration of evidence-based ways of increasing knowledge and awareness of self-harm and other risk factors for suicide; safety planning; help seeking, accessing services and tackling stigma along with tailored support so they can support their children.

- **Suicide cluster response plan:** The Surrey Suicide Prevention Partnership should ensure they have built in preparing for clusters into their local suicide prevention plans and this should be linked into the Surrey CDOP processes.

9 Summary

As a partnership **making zero suicides in Surrey is our ambition**. (Surrey Suicide Strategy 2019-2021).

There is no single reason why a child or young person takes their own life. An integrated approach to children's social and emotional wellbeing, using universal and targeted interventions, is recommended by NICE.

This review identified many existing activities that contribute to the prevention of suicide, as well as new opportunities that could inform action. Taking a whole system approach to preventing suicides in Surrey, where we make **'suicide everyone's business'** is essential.

An initial action plan has been developed to take forward the recommendations and is detailed in Appendix 1. The Surrey Safeguarding Children's Partnership (SSCP) will develop a more detailed overarching action plan. This overarching action plan will be monitored through the SSCP Case Review Panel, ensuring that a whole system approach is adopted to promote good practice and will support areas that need improvement in order to progress the Partnership's ambition.

Appendix 1

Thematic Review of Adolescent Suicide in Surrey Action Plan

What do we want to achieve	What will we do?	How will we know this is working? (How much? How well? What difference has this made?)	Governance oversight	Lead	Target date	Progress Blue/Green/ Amber/Red
SSCP to drive forward a whole system approach to promote and support effective local approaches to suicide reduction and to promote awareness of available support for young people, their friends, families, carers and professionals.	SSCP to develop an overarching action plan to promote good practice and support areas that need improvement, this will include: • Development of a toolkit to be used by children, young people, parents, carers, professionals that provides support in signposting to appropriate resources • SSCP to work alongside Commissioners to ensure services reflect need	Effectiveness of actions will be monitored through the SSCP Case Reviews Panel Evaluation of the effectiveness of the toolkit and its use will be assessed through feedback from children, young people, parents, carers, professionals Evidence through service delivery and improvements in service waiting times	SSCP	SSCP Case Review Panel	October 2020	

SSCP to share the learning and recommendations from the Thematic Review of Deaths of Children and Young People through probable suicide across all partner agencies	SSCP to provide briefings across Surrey on identified learning and recommendations from the Thematic Review of Deaths of Children and Young People through probable suicide	Evidence of briefings undertaken Recorded attendance at briefings Participant evaluation of briefings	SSCP	Surrey Children's Services Academy SSCP learning into Practice group	October 2020	
SSCP to be assured that all partner agencies (including, Children's Services, Health, Education, Police, Youth Services, Boroughs and Districts, Voluntary Sector and Faith Sector) take action in response to the recommendations highlighted in the Thematic Review of deaths of children and young people through probable suicide	SSCP to request all partner agencies to develop and submit relevant action plans in response to the recommendations highlighted in the Thematic Review of Deaths of Children and Young People through probable suicide SSCP will review submitted action plans to ensure actions identified are specific, measurable, achievable, relevant and timely.	SSCP will seek assurance by regularly reviewing evidence from all partner agencies that actions identified in individual action plans have been undertaken and learning has been embedded.	SSCP	SSCP Sub-groups	October 2020	

Authors:

Nicola Mundy, Child Wellbeing Professional and Lead for Learning from Child Deaths

Noreen Gurner-Smith, Surrey wide Safeguarding Manager with Lead for Child Death Review Services

Dr Maria Livanou, Lecturer in Forensic Psychology, Department of Psychology, Kingston University

Dr Mayvis Oddoye, Consultant Nurse – Safeguarding Children, FGM and Prevent Surrey and Borders Partnership NHS Foundation Trust.

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Dr Amanda Boodhoo (Chair) Surrey Wide Associate Director of Safeguarding

Nanu Chumber Stanley, Public Health Development Worker, Surrey County Council

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Thematic Review Group:

Elaine Andrews <elaine.andrews@surreycc.gov.uk>;

Laura Andrews laura.andrews@surreycc.gov.uk

Paul Bailey, Partnership Development Manager, Surrey Safeguarding Children Partnership, Surrey County Council

Lisa Bursill <Lisa.Bursill@surreycc.gov.uk>;

Dr Amanda Boodhoo (Chair) Surrey Wide Associate Director of Safeguarding

Nanu Chumber Stanley, Public Health Development Worker, Surrey County Council

Jane Donson, Senior Learning and Development Commissioning Officer, Surrey Children's Services Academy (SCSA)

Jane Dufton, Service Manager, School Relationships and Support, Surrey County Council

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Nicola, Eschbaecher, Surrey wide Named Nurse for Child Death Reviews

Noreen Gurner-Smith**,** Surrey wide Safeguarding Manager with Lead for Child Death Review Services

Laura Hoyles <laura.hoyles@surreycc.gov.uk>;

Dr Tara Jones, Surrey-wide designated GP for safeguarding (children and adults), Sessional GP and Clinical lead IRIS project, East Surrey CCG

Susannah Lea <Susannah.Lea@surreycc.gov.uk>;

Dr Maria Livanou, Lecturer in Forensic Psychology, Department of Psychology, Kingston University

Sarah Lyles, PSHE & Wellbeing Lead, Surrey County Council

Jo Moses <Jo.Moses@surreycc.gov.uk>;

Nicola Mundy, Child Wellbeing Professional and Lead for Learning from Child Deaths

Dr Mayvis Oddoye, Consultant Nurse – Safeguarding Children, FGM and Prevent Surrey and Borders Partnership NHS Foundation Trust.

Serious Case Reviews 2016-2020 Briefing Paper

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Contents

1 Introduction

Serious Case Reviews (Working Together 2015) and Local Child Safegarding Practice Reviews (Working Together 2018) are commissioned in cases where abuse is known or suspected and a child has died or been seriously harmed.[1] The purpose of a Serious Case Review (SCR) or a local child safeguarding practice review (LCSPR) is to ensure that the local safeguarding system is able to learn from these cases, identifying issues/potentially modifiable factors as well as learning from good practice and that demonstrable improvements are made in the quality of safeguarding practice. Learning reviews are not about apportioning blame or making hindsight judgements but are about improving the quality of practice.

This briefing report has analysed 13 case reviews[2] over the last 5 years in Surrey. This review has identified the features of the cases, the nature of harm experienced by the children who were the subject of each Serious Case Review or internal case review and the key themes. When reading the case reviews, we identified the very complex lives lived by these children and their families in our County and the challenges faced by agencies in supporting these children and keeping them safe from harm.

The purpose of this briefing report is to share the learning from local SCRs and other local reviews across all agencies in Surrey so that the quality of our practice with children and families improves. We have a responsibility to demonstrate that we are learning and taking action to improve practice from the experiences of children and families who have died or experienced serious harm whilst subject to our support and intervention. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents.

In this briefing report of Surrey SCRs we aim to

- understand the key issues, themes, challenges and highlight the implications for practice.
- draw upon the learning from both academic research and practice guidance.
- Ensure opportunities for improvement are shared with all agencies who work with children and their families in Surrey.
- include a series of reflective questions that can be used to guide and promote learning with individuals or groups of practitioners.

[1] Working Together 2015, defines serious harm as, "Seriously harmed" in the context of paragraph 18 below and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following: • a potentially life-threatening injury; • serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development., Chapter 4, paragraph 17, p. 76

[2] Sally and Simon SCR, (2016), HH, II, JJ SCR (2016), KK SCR (2016) and LL SCR (2016) , Child A SCR (2017), Family Cape SCR (2017),Child G SCR (2018), Child D SCR (2018), Child F Partnership review (2018), Family Blue SCR (2018), Child Z (Hampshire) SCR (2019), Rapid Review Report 2020

2 Identified child vulnerabilities and risks

The findings of the recently published DfE report, *Complexity and Challenge: a trienniel analysis of SCRs 2014-2017 (*March 2020) [3] found the following:

- The most prevalent parental characteristic reported in these SCRs was mental health problems, particularly in the mother (noted in 47% of SCRs) but also in the father or father figure.
- Parental alcohol or substance misuse were each noted in 36% of SCRs. In 37% of SCRs parental adverse childhood experiences were noted. Of particular note was the number of SCRs reporting parental criminal records (30% of SCRs, of which half reported [4]violent crime).
- Nearly half of SCRs involving children over 6 years of age reported mental health problems in the child; 24% reported alcohol misuse; and 29% drug misuse.
- Fourteen percent of children in these SCRs were reported to have a disability prior to the incident.
- In terms of practice nationally, they also found persistent and recurring themes relating to case management in the sample included: the recognition and identification of risk; the use of risk assessment and planning to provide a structured framework for intervening to protect children; and the provision of appropriate oversight to ensure that assessments and plans are purposeful and outcomes-focussed.[5]

Within Surrey the cases reviewed in this report included children subject to a range of safeguarding risks and the cases identified that there were a number of risks present including;

1. Chronic neglect
2. Domestic abuse including coercive control
3. Emotional abuse
4. Physical abuse
5. Sexual abuse
6. Adolescent Vulnerability and Safeguarding
7. Parental mental health
8. Parental substance misuse

Along with a range of practice issues including;

1. Listening to the voice and experience of children

[3] DfE report, *Complexity and Challenge: a triennial analysis of SCRs 2014-2017 (*March 2020)
[4] Ibid
[5] ibid

2. Asesment planning and intervention
3. Special guardianship orders
4. Effective multi-agency working
5. Information sharing
6. The need to 'Think-family'
7. Issues of escalation and professional disagreement including stepping down (de-escalating concerns)

2.1 Chronic neglect

National and local evidence shows that neglect is more likely to be identified in 0-4-year olds followed by the 10-14-year olds. Nationally, SCR findings in neglect cases typically include poor dental hygiene and untreated dental caries, incomplete vaccinations due to missed routine healthcare appointments, poor school attendance and developmental delays due to lack of stimulation.

According to the NSPCC there are four types of neglect[6]:

- **Physical neglect**
  A child's basic needs, such as food, clothing or shelter, are not met or they aren't properly supervised or kept safe.
- **Educational neglect**
  A parent doesn't ensure their child is given an education.
- **Emotional neglect**
  A child doesn't get the nurture and stimulation they need. This could be through ignoring, humiliating, intimidating or isolating them.
- **Medical neglect**
  A child isn't given proper health care. This includes dental care and refusing or ignoring medical recommendations.

2.1.1 Identifying neglect:

Within this briefing report different issues and missed opportunities around these types of neglect were identified, these included;

Appropriate investigations and assessments must be conducted when babies and infants have faltering weight. Findings will clarify the causal factors and inform the provision of support in order to improve weight gain and promote the well-being of babies and infants.

One review identified that it is challenging for professionals to evidence significant harm where there is neglectful parenting, and this may cause delay in the progress of legal proceedings. The review also highlighted that closer working between hospital professionals and social workers could assist in identifying significant harm earlier and improve safeguarding of children in these situations.

[6] https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/neglect/

In another review, it was identified that specialist services did not take into account the child's high level of distress, or work in a coordinated way with universal services to address identified risks associated with the reports of parental neglect and the impact this was having on the child. The review identified that too much reliance was placed on onward referrals, without checking that agencies were able to support or ensure compliance.

If cumulative long-term neglect is not recognised or addressed, babies, infants and children can experience significant harm. Evidence from case reviews showed that there was a history of professional concerns about the state of the home prior to the birth of the child. However, this understanding was not related to the lived experience of the child and did not form part of the professional intervention to safeguard children.

One case also raised the need for health practitioners, in this instance GPs, to raise concerns regarding the protection and care of children with children's social care.

2.1.2 Neglect and inter-agency working

Cases of chronic neglect highlights the need for effective inter-agency working. It is essential that attention is paid to all agencies who raise concerns regarding the quality of care and that these concerns are fully investigated. Research conducted by Hilary Tompsett et al in 2009 found that half of the GPs consulted expressed a preference for seeking early advice and support from a paediatrician or other health colleague, rather than children's social care. In addition, two thirds of GPs rated the health visitor as highly significant to refer to, where there was concern for a child. GPs on the whole would prefer a model of referral that allows more stages of consideration, discussion and consultation before 'raising concerns'.[7]

Failure to meet milestones can be a significant indicator of abuse. Common to these cases were **home observations.** Some agencies demonstrated greater awareness of home conditions on the emotional and physical well-being of the child than others. In common, were the challenges in understanding the impact of cumulative neglect before coming to a crisis point or an incident of significant harm. Learning from the reviews highlights the need to understand neglect in the context of historical concern and multi-agency interactions – without an holistic view of the risk supported by good information sharing negelct can be hard to identify. The neglect cases reviewed all reflected the uncertainty of whether there was neglect and evidence of health presentations where each incident was seen and treated in isolation. Of the neglect cases reviewed, the authors frequently mentioned delayed development as an indicator of abuse.

[7] Child KK SCR Report

Reflective Questions

What is your understanding of neglect? Do all agencies have access to the right multi-agency tools to help them recognise and respond to neglect?

How would you evidence your concerns regarding neglect? Do agency assessments/referrals accurately describe how poverty is impacting on the parent's capacity to parent, the voice of the child, what it feels like to be a child in that family and their daily lived experience?

What systems are in place to ensure parental failure to bring children to appointments are monitored and shared with safeguarding colleagues?

How well embedded is trauma informed supervision in all agencies that provide services to children and families where neglect is a feature?

2.2 Domestic Abuse, including coercive control

Research is clear that living with domestic abuse is always harmful to children. The Joint Targeted Area Thematic Review into domestic abuse found in cases of domestic abuse, that

> "focusing on the needs and experiences of children is critical. A failure to adequately focus on the experiences and needs of children means there is a high risk that the emotional and mental impact of domestic abuse will go unaddressed. Children and young people who have lived with domestic violence for several years frequently experience intense feelings of responsibility, guilt, anger and a sense of despair and powerlessness over their lives."[8]

A number of the reviews highlighted the complex nature of the children's lives. One case involved a family who had decided to electively home educate their children. It is evident that the father appeared controlling of the professional network and his hostility frustrated the interventions of a range of services across multiple Local Authorities. Professionals found the father to be aggressive and manipulative. In this case, the report notes that, "It is evident that the Local Authority involvement prior to and during the child protection planning was frustrated by the lack of engagement and by the father becoming increasingly hostile."[9]

The review recommended authoritative practice. "Authoritative practice means that professionals are aware of their professional power, use it judiciously and that they also interact with clients and other professionals with sensitivity, empathy, willingness to listen and negotiate and to engage in partnerships. They respect client

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Ofsted (2017) The multi-agency response to children living with domestic abuse Prevent, protect and repair September 2017, p. 14, paragraph 49, The Office for Standards in Education, Children's Services and Skills (Ofsted)

[9] ibid

autonomy and dignity while recognising their primary responsibility is the protection of children from harm and the promotion of their well-being."[10] (See also the section on authoritative practice below).

Seven reviews detailed domestic abuse including coercive control. This manifested as increasing push back on services, obstruction and or refusal to allow services access to children and vulnerable adults. In some cases, this enabled the abusive parent to shift the focus of the intervention toward them and their concerns and away from the needs and safety of the child. This also had an impact on practitioners' ability to challenge and steer the intervention from managing parental behaviours to focussing on professional concerns in relation to the child. Two cases identified incidents of physical assault on the child by the mother that may have been seen as an indicator of domestic abuse.

Common to all the observations of coercive control was the challenge of evidencing significant harm or abuse. Harm to children was often observed and considered but there was not always clear action in response. As a mirror to the aggression displayed by perpetrators using coercive control, there were cases of **disguised compliance**, in which both the aggression and coercive control served to deflect practitioners' attention from further investigations.

The reviews also highlight the ongoing impact on the emotional and mental well-being of children who are subject to or witness domestic abuse. Domestic abuse in the context of the reviews considered also highlights the issue of **'grooming'** of both professionals and other family members including the children. Of the 12 reviews, grooming of professionals and children to support the preferred narrative was explicit in three reviews.

A theme across the cases which involved coercive control was the impact on the emotional and mental well-being of the non-abusive partner. There was one case where the mother was charged and the father retained parenting capacity. Supervision orders were put in place which resulted in supervision being used as another point of control for the coercive partner. In this case there was insufficient attention given to the concerns of the mother over the behaviours of the father; which if investigated further, potentially could have resulted in referrals to MARAC. There was also evidence of a lack of understanding amongst professionals of how coercion can lead to retaliative violence.

2.3 Engaging challenging families

A Research in Practice Briefing, *Prompt Briefing, Engaging Resistant, Challenging and Complex Families*, the organisational barriers to effective engagement include

- A pre-occupation with thresholds
- 'Start stop' service delivery

[10] Essex Safeguarding Children Board (May 2011) *Authoritative Child Protection Practice: Quick reference guide*, May 2011 Adapted from Jane Gilgun

- Inactive case management and de-sensitisation of staff[11]

In one case, there was 'start stop' to service delivery and periods of inactive case management. In addition, this was a family with a history of moving between a range of local authorities across the United Kingdom.

When working with resistant families, avoidant or challenging families it is important that practitioners are respectfully persistent.

Practice guidance from *the London Child Protection Procedures* 5th Edition 2017 details the following,

When working with uncooperative parents, professionals in all agencies can improve the chances of a favourable outcome for the child/ren by:

- Keeping the relationship formal though warm, giving clear indications that the aim of the work is to achieve the best for their child/ren;
- Clearly stating their professional and/or legal authority;
- Continuously assessing the motivations and capacities of the parent/s to respond co-operatively in the interests of their child/ren;
- Confronting uncooperativeness when it arises, in the context of improving the chances of a favourable outcome for the child/ren;
- Engaging with regular supervision from their manager to ensure that progress with the family is being made and is appropriate;
- Seeking advice from experts (e.g. police, mental health specialists) to ensure progress with the family is appropriate;
- Helping the parent to work through their underlying feelings at the same time as supporting them to engage in the tasks of responsible child care;
- Being alert to underlying complete resistance (possibly masked by superficial compliance) despite every effort being made to understand and engage the parent/s;
- Being willing, in such cases, to take appropriate action to protect the child/ren (despite this action giving rise to a feeling of personal failure by the professional in their task of engaging the parent/s).[12]

Work with families who are aggressive and avoidant requires what, Professor Harry Ferguson describes as, the use of 'Good authority' (Ferguson 2011).

According to Ferguson, good authority requires three things:

- "a model/conceptual framework that clarifies its nature, role, ethical dimensions, appropriateness and methods of application
- An analysis of the relations of authority with the organization and their impact on how frontline staff feel about and exercise authority

[11] Fareena Shaheed, (2012) *Prompt Briefing, Engaging Resistant, Challenging and Complex Families,* p. 5, Darlington

[12] London Child Protection Procedures,(2017) *Managing work with Families where there are obstacles and resistance* https://www.londoncp.co.uk/chapters/manag_fam_obst_resist.html access 17th March 2020

- An understanding of one's own personal relationship to authority."[13]

Ferguson goes on to present a model of what he calls 'authoritative negotiated child protection'. The model consists of the following 8 steps

1. Recognise authority and assume conflict and not cooperation
2. Encourage openness and honest expression of feelings
3. Identify what the resistance is really about and what is working well
4. Identify dangers to the children
5. Identify what is not negotiable
6. Identify what is negotiable
7. Formulate a child protection plan
8. Be clear about criteria for progress[14]

There is a need for clarity and urgency when working with hostile and aggressive parents or carers. Practitioners must quickly understand what is driving the hostility and aggression and formulate a child-centred, protective response. Effective management oversight and supervision is critical to enable this.

Ferguson's work highlights this, and it is important to quote him at length when he notes,

> What is clearly needed are supportive systems that are emotionally aware. This is particularly important if the complex dynamics of pathological communication or danger are to be brought to the surface and combated. Workers' sense of safety or danger must be seen as a key measure of child safety. Organisations, managers and case supervisors need to give attention to all the emotional dynamics and relations of authority… Workers' feelings need to be at the centre of this, not simply so that their concerns for their own well-being can be addressed, but because their emotional experience provides crucial data about what the children are feeling and experiencing. If workers don't feel authoritative and safe, the strong likelihood is that the child is not safe either.[15]

Authoritative practice is not authoritarian, coercive or oppressive to service users, but it is practice which includes

- a clear focus on the desired outcomes,
- sets clear expectations regarding behaviour from parents and other adults in the family network including how breaches should be responded to.

[13] Ferguson, Harry, (2011) *Child Protection Practice,* p. 171, Palgrave Macmillan
[14] Ibid, pp.174-178
[15] Ibid p. 179

- ensures that the child protection (CP) plan is not simply a list of concerns, but the plan clearly identifies risks, the parental responses that are needed to address these risks and the required outcomes for children to be safeguarded and their welfare promoted.
- Authoritative practice follows through when the needed response/required outcome does not happen
- ensures contingency planning occurs through a legal planning meeting in which the thresholds for court action are clearly identified and progressed in a timely way[16]

Authoritative practitioners ask, what are the bottom-line expectations in this case? What are the known, evidence-based risks and harm to the children (including how these are understood by the professional network)? What are the bottom-line expectations of good and safe parenting and what needs to change in the care-giving responses of parents? What are the contingency plans if these expectations are not met?

Reflective Questions

How do you manage feelings of fear, intimidation and agression?

If you are afraid, intimidated, etc. what must it feel like to be a child in that family and their daily lived experience?

Evidence from research and these reviews show that perpetrators groom and intimidate victims and networks around victims, how can we remain focused on the safety of children and vulnerable adults?

What support is needed when working with service users who are aggressive or charming/manipulative and avoidant?

How can management support and trauma informed supervision help you to stay focused on safety for the children as well as keeping yourself safe as a worker?

2.4 Child Sexual Abuse

Cases of child sexual abuse present a range of practice challenges for professionals and those working with children. These challenges include the fact that in cases where sexual abuse is a feature, most interventions are disclosure-led. However, research shows that children and young people who are experiencing sexual abuse are unlikely to disclose. This dilemma is referenced in the Children's Commissioner's 2015 report into familial child sexual abuse, where it is noted that

> "Victims of child sexual abuse in the family environment may tell teachers or other professionals directly, though it is more likely that their suspicions will be

[16] *Authoritative Child Protection Practice Quick reference guide* Essex Safeguarding Children Board 2011

raised by the behaviour or presentation of a child or young person. This is the 'grey area' where concerns reside, and professionals are called upon to act upon their judgement in the best interests of the child. Participants in site visits and oral evidence sessions highlighted the difficulty of initiating safeguarding processes in the absence of a direct disclosure from the young person."[17]

This raises the importance of professional curiosity, the skilled use of questioning and, where necessary, professional authority. In addition, keen attention to the voice and experience of the child is critical to ensure that the child's safety remains the focus and he/she does not become invisible to professionals.

In one case, a father had a history of being sexually abused as a child and a history of sexually abusing children. In this case, as in others, there was a need for robust risk assessments of parents with a history of offences and allegations of direct or indirect harm to children. This case also highlighted the fact that assessments need to be shared with key agencies in the network.

It is important that information about risk is shared and acted upon in order to safeguard children.

There is a need for timeliness of decision-making and specialist risk assessments, for example, in one case there was a delay of two months before a child was seen and assessed by professionals.

Reflective Questions

Effective practice requires us to think the unthinkable. If you were concerned about a child experiencing sexual abuse, how would you raise the issue?

What signs or indicators of sexual abuse do you need to be attuned to?

How would you respond to a disclosure?

How well embedded is trauma informed supervision in all agencies that provide services to children and families where child sexual abuse is a feature?

2.5 Parental mental health

The most prevalent parental characteristic reported in these SCRs was parental mental health difficulties, particularly for the mother (noted in 55% of SCRs) but also for the father or father figure.

Parental mental health problems occur more commonly in the SCR population than the general population, depression and anxiety were found to have a prevalence of 13.7% in adults using the GP patient survey (Public Health England, 2018b)[18]. However, mental health problems occur in similarly high frequencies in families requiring social care support; 52.8% of adult social care users suffer from depression

[17] Children's Commissioner for England (2015) *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action* p. 33

[18] Public Health England (2018b) *Mental Health and Wellbeing JSNA*. Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/0

or anxiety (Public Health England, 2018b), and parental mental health problems were a factor in 40% of completed children's social care assessments (Department for Education, 2017b)[19].

One review recommended that adult mental health services inform health visitors as well as social workers of parental mental health episodes and the consequent ability of a parent to care for her/his child/ren.

There was some learning suggesting that there were failures to link parental mental health issues with domestic abuse and the link between child(rens) presentations to health with physical violence/neglect. A situation exacerbated by not having access to family histories.

Reflective Questions

What systems are in place to enable women or men to disclose domestic abuse including coercive control, to identify the risks to children, and to refer and assess cases where there are children in the family?

What is your understanding of domestic abuse and the ongoing nature of coercive control and its impact on the parent and children?

Do multi-agency practitioners have access to the right tools to help them recognise and respond to domestic abuse?

How well embedded is trauma informed supervision in all agencies that provide services to children and families where domestic abuse is a feature?

2.6 Cumulative harm

Cumulative harm is where there is the co-existence of multiple forms of risk and harm including parental mental health problems, parental substance misuse, and domestic abuse. Within the triennial review of SCRs, *Pathways to Harm, Pathways to Protection* published in 2016, researchers noted,

> …It has become clear that these three issues of domestic abuse, parental mental ill-health, and alcohol or substance misuse are not the only parental risk factors that may contribute to cumulative risk of harm. Other parental risk factors often co-existed with these factors, and potentially interacted with them to create harmful environments for the children. These included issues such as adverse experiences in the parents' own childhoods; a history of particularly

[19] Department for Education (2017b) *Characteristics of children in need: 2016-17, England*. Available at: https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2016-to-2017.

violent crime; a pattern of multiple consecutive partners; and acrimonious separation.[20]

Practitioners need to be clear that when multiple risk factors exist there is a need for clarity in assessment and urgency in action and intervention. It is also important that practitioners are tuned into the lived experience of children and young people.

> When a child presents with indicators of possible maltreatment and vulnerability, or a parent or carer presents with recognised risks, professionals have an opportunity to explore that vulnerability and risk and take steps to intervene and protect the child. This requires a stance of professional curiosity and awareness of possible maltreatment and cumulative risk. Professionals must challenge parents and explore the issues while maintaining an objective and supportive manner.[21]

These reviews all hightlighted the need to understand and share information effectively. One of the features of cases was that a great deal of information was known about the potential risks that perpetrators posed to children. However, there was limited evidence that this information was used effectively to inform assessments and to effectively manage risks.

Pathways to Harm, Pathways to Protection addresses this issue at length,

> Effective intervention requires careful assessment of the child's vulnerability and ensuring the child's rights and feelings remain central. The child's circumstances and environment, the resilience of the child and family, and any inherent risks, all work together to inform actions by the multi-agency team. Effective safeguarding work depends on collaborative multi-agency working: no single professional retains all of the required knowledge or skills. Good communication is essential for collaboration. Serious case reviews, and, by extension, child welfare professionals, are often criticised for repeatedly identifying the same failings in communication and information sharing. Given the centrality of effective communication to safeguarding work, it is inevitable that this remains one of the key points of break-down. Such communication requires practitioner skills, effective facilitative systems, and a culture that promotes information sharing for the protection of children. This must fit into a wider information-handling process whereby information is critically appraised and used to guide decision making and planning.[22]

According to statutory guidance, *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children 2018,* high quality assessments:

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[20] Peter Sidebotham, Marian Brandon, et al, (2016) *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014*, © University of East Anglia & University of Warwick May 2016 and DfE
[21] Ibid p.139
[22] Ibid, p. 162

- are child-centred. Where there is a conflict of interest, decisions should be made in the child's best interests: be rooted in child development: be age-appropriate; and be informed by evidence
- are focused on action and outcomes for children
- are holistic in approach, addressing the child's needs within their family and any risks the child faces from within the wider community
- ensure equality of opportunity
- involve children, ensuring that their voice is heard and provide appropriate support to enable this where the child has specific communication needs
- involve families
- identify risks to the safety and welfare of children
- build on strengths as well as identifying difficulties
- are integrated in approach
- are multi-agency and multi-disciplinary
- are a continuing process, not an event
- lead to action, including the provision of services
- review services provided on an ongoing basis
- are transparent and open to challenge[23]

Reflective Questions

How can you stay focused in the face of multiple and complex family needs?

What helps practitioners to work effectively together when working with complex families?

What does effective 'Think-family' work look like in high-risk, high harm cases?

What support is needed when working with the complexity of the lives of children and their families?

How can management support and trauma informed supervision help practitioners to stay focused on safety for the children and the challenges faced when seeking to support them?

3 Learning Themes for Practice

A number of themes for practice were identified as part of this review.

- Professional Curiosity
- Disguised Compliance
- Multiple referrals and re-referrals
- Parental Capacity
- Lived experience of the child

[23] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* chapter 1, pp. 25-26, paragraph 51

3.1 Professional Curiosity.

Professional curiousity is a stance of respectful scepticism where a practitioner remains open and enquiring about the possibility of harm to children. In practice, this means not taking things at face value or making assumptions about what is seen or heard.

A report by the Care Quality Commission notes that

> "The risks to many children are not always obvious and require a continuous professional curiosity about the child and their circumstances. The emphasis must be on both identifying and supporting those in need of early help, as well as those at risk of 'hidden' harms."[24]

In all of the cases reviewed there was a degree to which risk was left unchallenged through lack of professional curiosity, acting as an inhibitor to understanding the full extent of risk faced by the child(ren). The reasons for this were varied but can be summarised as:

- Lack of managerial supervision and reflective practice
- Assumptions about the narrative given by the parents with a lack of **respectful challenge**
- Not responding effectively to coercive and aggressive behaviours
- Cultural bias
- Lack of capacity in the system

The impact of practitioners not consistently being curious and challenging narratives was that at times indicators of abuse, particularly neglect and domestic abuse, were not recognised, recorded or escalated. There were missed opportunities to safeguard children and involve other services which could have provided a more holistic overview of the child(ren)'s history.

In relation to neglect, there was a lack of challenge and curiosity of parental narratives and/or with domestic abuse and neglect / lack of curiosity in relation to coercive control where interventions particularly from health and mental health focused on physical presentations rather than emotional health and well-being. Professionals seemed to become habituated to presentations of neglect.

Professional curiosity is much more likely to flourish when practitioners:

- are supported by good quality training to help them develop
- have access to good management, support and supervision
- 'walk in the shoes' (have empathy) of the child and/or adult to consider the situation from their lived experience

[24] CQC Report (2016) Not Seen, Not Heard: At review of the arrangements for child safeguarding and health care for looked after children in England, p. 5

- remain diligent in working with the family and developing the professional relationships to understand what has happened and its impact on all family members
- always try to see all parties separately.[25]

Reflective Questions

What behaviours or practices promote professional curiosity?

What behaviours or practices limit or inhibit professional curiosity?

How can you consciously tune into what you see, hear, smell and sense in families?

3.2 Disguised Compliance

Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement (Reder et al, 1993).[26]

To improve practice in relation to disguised compliance, the following is recommended

Recognising disguised compliance

- Local safeguarding agencies should ensure practitioners are trained in recognising and responding to disguised compliance.
- Practitioners need to remain aware that disguised compliance could be occurring.

Establish facts and gather evidence

- Practitioners should display professional curiosity when working with families and not accept information from parents and carers at face value without investigating further.
- Practitioners need to establish the facts and gather evidence about what is actually happening or has been achieved.
- Practitioners should focus on the child's lived experience rather than the parents' and carers' actions.[27]

Reflective Questions

What does authoritative practice look and feel like for your agency and in your role?

[25] Adapted from https://www.manchestersafeguardingpartnership.co.uk/resource/professional-curiosity-resources-practitioners/
[26] Cited in NSPCC (November 2019) *Learning from case reviews briefings Disguised compliance*, NSPCC
[27] ibid

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How can you be authoritative without being authoritarian – that is whilst respecting the rights of service users?

What helps to keep workers focused on the needs of the child and not distracted by the needs or behaviours of parents/carers?

3.3 Multiple referrals and re-referrals.

The reviews provide a significant amount of learning about **referrals.** One of the most common themes emerging was multiple and repeat referrals to either children social services or Children And Adolescent Mental Health Services (CAMHS) which resulted in no further action as referrals were assessed as not meeting the threshold despite the referrals coming from more than one agency. Overall, there is a general feeling that this was more prevalent in cases of neglect and domestic abuse.

The impact of a child not meeting thresholds for targetted or specialist support early in the life of the child meant that opportunities were missed to safeguard the child or put in support and services to reduce the risk of harm or abuse. A common thread was the ongoing concern of other professionals.

Conversly, there were missed opportunities to refer where a child would have met the threshold that were not taken – this appears to be mainly in response to personal disclosures either by an adult or a child that would have warranted further investigation, such as disclosure of physical violence.

3.4 Assessments and Planning

The right support at the right time; common themes identified across the reviews include:

- Premature or **poor planning and risk management in step down arrangements** across services
- Poor communication
- Drift and delay in the completion of assessments
- Poor quality assessments including lack of clear outcomes and poor decision making
- Not sharing assessment outcomes with key partners
- Missing critical input from key partners in planning meetings
- Lack of clear risk rating and risk mangagement around assessments
- Poor follow up of assessments
- Assessment being made without face to face contact
- Over-optimistic assessments
- Assessments too heavily reliant on parental narratives
- Poor communication of assessments.
- Lack of child and family history

3.5 Escalation of professional dissent:

Among health and universal services there was some evidence of child protection procedures not being fully followed. This included missed opportunities to refer to children's social care or escalate to the paediatrician in hospital. More common was the **lack of understanding of escalation and dispute resolution procedures** for dissent in decision making over the risk of harm to a child.

There are clear policies for escalating a concern over the professional judgement of risk to a child from another agency – but these seem not to be well understood or followed in at least three cases. In one case, there was evidence of over reliance on expert opinion rather than on professionals with longer term contact with the family. In Child Protection conferences there was evidence that professional opinion was not equally weighted. Professional differences are to be expected and are not unhealthy. Openly embracing and resolving them is an opportunity to strengthen safeguarding.

Reflective Questions

How do you evidence your concerns regarding a child/ren?

Do agency assessments/referrals accurately describe how your concerns are impacting on the parent's capacity to parent, the voice of the child, what it feels like to be a child in that family and their lived experience?

What further action do you take if a referral is not accepted and your concerns remain?

3.6 Parental Capacity

Across the reviews, there were a number of opportunities to reflect on parental capacity and the impact of various parental vulnerabilities from mental health, physical health, and substance misuse to learning difficulties.

There were missed opportunities to listen to professionals with concerns who had longer term contact with the families that would have in a broader context led to a more robust assessment of need and risk. There were also missed opportuhnities to listen to disclosures of one spouse on the other.

Assumptions relating to parental capacity were made based on unchallenged narratives of events or single presentations. This allowed for the explanation of events to be directed by the parent/carer

In all of the neglect and domestic abuse cases considered, one or both parents were involved in the abuse of the child. In the context of child sexual exploitation cases, child vulnerability or abuse did not originate from the family or at home but an external community or social risk. Although the CSE cases have some commonality with the themes of the neglect and domestic abuse cases, in the small number reviewed there seems to have been extensive interventions across agencies, often joined up albeit

with different applications and assessments of risk. The challenges in these cases appear on the surface to be more around the **efficacy of strategies** put in place to manage the risk and the lack of specialist resource accessible both in and out of county. Multiple placements appear to have an ongoing impact on stability for both the child, their personal relationships and education. Movement in placements were often cited in the two reviews as due to the inability or suitability of placement to manage behaviours – behaviours which were oversexualised, self harming or otherwise risky were little understood and required expert assessment to diagnose.

In common with all cases, a subtext to the reviews is the impact of abuse and neglect both current and historical to the parent on the ongoing emotional and mental health of the family. In the two CSE cases there was little evidence that the impact of early trauma on behaviour was understood. In the neglect and domestic violence cases there was evidence that violence in the family had been a factor in both historical and in current work.

Reflective Questions

Do agency assessments/referrals accurately describe the concerns that are impacting on the parent's capacity to parent, the voice of the child, what it feels like to be a child in that family and their lived experience?

How can management support, and trauma informed supervision help practitioners to avoid parental behaviours overshadowing the children's needs and stay focused on safety for the children?

3.7 Lived experience of the child

The voice and lived experience of the child was another common element of all the reviews and most clearly captured by the consultation with children/young people and their families during the review process. Each case identified a missed opportunity to understand the experience of the child(ren) from either their own or a siblings perspective.

In some cases this resulted in actions taken in the best interests of the child that did not fully consider the potential and actual trauma that these actions caused. In other cases it lead to delay in understanding the abuse or negect experienced by the child(ren). Also, this led to disclosures by the child to professionals not prompting referral or other appropriate actions. This is a critical learning for our safeguarding system.

Reflective Questions

How can you ensure that seeing and hearing children is an essential part of your practice with children and families?

How can you reflect the voice of the child in your work with children and families?

What are the barriers to hearing and responding to the voice of the child and how can these be overcome?

4 Adolescent Vulnerability

4.1 History and Family Functioning

The cases in this review highlight the need to take into consideration history and family functioning. The safeguarding adage: the best indicator of present and future harm is past harm.

It is essential that all practitioners working with vulnerable adolescents are fully aware of the history including understanding family functioning and the potential impact of adverse childhood experiences and family trauma.

It is also important that practitioners and agencies have an understanding and evidence-based assessment of the impact of cumulative harm. Neglect and abuse experienced in early childhood can result in vulnerabilities and increased risks that young people experience in adolescence. This issue highlights the need for effective early intervention.

4.2 Child Special Educational Needs

Children with special educational needs and disabilities are overrepresented in the population of children on child protection plans and in children who are at risk of various forms of child exploitation including criminal and sexual exploitation. Practitioners must be alert to the increased risks to children with special educational needs, including learning difficulties and social and emotional disorders such as autistic spectrum disorder and the impact of these additional needs on children's safety and well-being.

4.3 Missing Episodes and Placement Instability

There was evidence in reviews that missing episodes resulted in exposure to additional risk including sexual and criminal exploitation.

The findings of the Ofsted Inspection in relation to CSE and Missing Children found,

> "The response to children who go missing or who are at risk of sexual exploitation is improving, supported by new, stronger operational arrangements with partners. Return home conversations are also improving and are starting to be used to inform plans to reduce risks to children.
>
> Return home conversations are much improved since the recent commencement of new arrangements. Refreshed guidance and the

appointment of a coordinator for missing children and child sexual exploitation support this progress.[28]

Ofsted Inspectors also found that

> The strategic approach to child sexual exploitation has improved, with some evidence of better partnership working at district borough level. Performance on return home conversations has been poor, and there is only very recent evidence of improvement following recently introduced revised arrangements.[29]

Return home interviews (RHI) practice is still not always being consistently applied. There is evidence from this review that the return home interview (RHI) process needs to be strengthened.

4.4 Adolescent Safeguarding including Issues of Agency (freedom and choice) and Safety (mitigating and managing risks)

Adolescent safeguarding is complex, especially in cases of sexual exploitation and abuse. Complicating factors include the adolescent sociological drives for increasing independence and the need to be with peers, as well as adolescent neurological development in relation to risk taking behaviours (see Hanson and Holmes 2014[30]). This cases in this review highlighted the need to effectively balance issues of agency and choice with the need to safeguard children.

This dynamic is recognised in the work of Carlene Firmin (2018), which notes, that "Choices are made but social conditions have compromised the freedom and/or capacity of a young person to make a safe choice.[31]

There is a need for agencies and professionals to form a view around risk, welfare, choice and consent –this is a key issue arising from our SCR thematic report and the issue of authoritative practice.

Good practice in this review included:

- Attempting to ensure an effective transition between placement by securing continuity of key workers
- Ensuring there was a psychological assessment and the offer of therapeutic support
- Attempts to investigate and disrupt the activity of perpetrators including issuing a Child Abduction Order

The learning from this review includes practice related to

- Risk Management Meetings (RMM) – how effective are the multi-agency risk management meetings in diverting young people who are at risk of CSE and

[28] 2018 SIF, paragraph 37
[29] 2018 SIF paragraph 91
[30] Elly Hanson and Dez Holmes, (2014) *That Difficult Age: Developing a more effective response to risks in adolescence*
[31] Carlene Firmin (2018) *Abuse Between Young People: a contextual account* , p. 159, Routledge

CCE. Members of the Panel heard that Children's Services have since been reorganised; this includes the establishment of targeted youth support teams and safeguarding adolescence teams which have been set up to support vulnerable adolescents. It was noted that there is , increased joint work with the Police who are co-located in these teams. This also includes working with Community Safety in developing the strategic response to CSE and CCE. The Partnership should seek assurance regarding the effectiveness of Risk Management Meetings in supporting children who are at risk of CSE and CCE.

- Absence of a consistent meaningful relationship between social worker and young person
- The Effectiveness of Inter-Agency Working, particularly the effectiveness of information sharing between the Metropolitan Police and Surrey Police.
- The Independent role of the Independent Reviewing Officer (IRO) in preventing drift and delay and ensuring that children are safeguarded from experiencing significant harm. The Safeguarding Partnership should seek assurance from Children's Social Care that the IRO footprint is seen and there is evidence that this is working to reduce risk and safeguard children especially in cases where CSE and CCE is a factor
- Placing vulnerable children in educational provision that is known to be weak. It is acknowledged that this was a failing at the time of the incident. However, the Director responsible for Corporate Parenting has made this issue an area of conspicuous focus in order to ensure that looked after children are placed in appropriate educational provision.
- This case also highlights the need for effective multi-agency practice in relation to understanding adolescent sexuality, especially exploration of sexual harm in the context of unsafe relationships. This would include consideration of consent and issues of agency and choice with the context of adolescent vulnerability.

Other learning includes:

- The heightened risk of CSE for young people with SEND and learning disabilities
- Return home interviews (RHI) – on review of the case file whilst improvement has been noted in respect of offering a RHI, practice is still not always being consistently applied. The Partnership should seek assurance regarding the consistency and quality of return home interviews.
- Risk Management Meetings (RMM) – how effective are the multi-agency risk management meetings in diverting young people who are at risk of CSE and CCE
- The need to promote sex and relationship education, including understanding consent and what constitutes health relationships

- The need to ensure that foster carers are supported to provide care to highly vulnerable children who are at high risk of CSE in order to support permanency
- Absence of a consistent meaningful relationship between social worker and young person
- The Effectiveness of Inter-Agency Working, particularly the effectiveness of information sharing between the Metropolitan Police and Surrey Police.
- The Independent role of the Independent Reviewing Officer (IRO) in preventing drift and delay and ensuring that children are safeguarded from experiencing significant harm.
- Placing vulnerable children in educational provision that is known to be weak.
- Understanding the impact of cumulative harm.
- This case also highlights the need for effective multi-agency practice in relation to understanding adolescent sexuality.

5 Conclusion

Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened, but also why things happened as they did, can help to improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge. It is in this way that we can make good judgments about what might need to change at a local or national level.

Recommendations from reviews must be focused on improving outcomes for children. It is the responsibility of all agencies to ensure that relevant recommendations are fully implemented and used to make improvements to the quality of their practice in relation to safeguarding children.

The overall purpose of the serious case review/child safeguarding practice review arrangements is to ensure that practice is improved more generally through changes to the system as a whole. It is only through this kind of extended analysis that we will understand whether or not a systemic change is required, either at a local or national level. Without it, we risk making unnecessary systemic changes or not addressing the root causes of problems.

Health and Wellbeing Board Paper

1. Reference information

Paper tracking information	
Title:	Health and Wellbeing Strategy Highlight Report
Author:	Phillip Austen-Reed (phillip.austen-reed@surreycc.gov.uk; 07813538431)
Priority Sponsor(s):	• Rod Brown, Head of Communities and Housing, Epsom and Ewell District Council (Priority 1 Sponsor) • Giles Mahoney, Director of Integrated Care Partnerships, Guildford and Waverley CCG (Priority 2 Sponsor) • Rob Moran, Chief Executive, Elmbridge Borough Council (Priority 3 Sponsor)
Paper date:	10 September 2020
Related papers	• Appendix 1: HWBS Priorities milestones status (as at July 2020) • Appendix 2: 'Transitioning from Recovery': 'Place' • Appendix 3: Growth Board terms of reference

2. Executive summary

This paper describes the status of projects in the Health and Wellbeing Strategy against previously agreed milestones as of July 2020. Given the summary nature of the June report this aims to provide more detail across all the priorities through highlighting progress being made whilst also continuing to recognise where there is a continued impact resulting from the COVID-19 pandemic. This varies between delays, continuing with a different focus, or continuing with a heightened focus or additional activity.

The proposed links with the work of the recovery coordination group are included together with the next steps. Within some focus areas we the adaptation that is happening in response to the current pandemic is already becoming evident however it is recognised that the outputs of the rapid needs assessments also coming to the September board meeting will need to be factored into further planning within each priority over the next quarter.

3. Recommendations

We recommend that the Health and Wellbeing Board:

1. Approve the continued programmes of work within each of the Priority focus areas and that they be reviewed by the priority boards / coordinating groups to incorporate as necessary the outcomes of the Rapid Needs Assessments.

2. Discuss and agree new sponsor for priority 2.
3. Agree to a refresh of the published Health & Wellbeing Board (HWB) strategy to reflect the merger with the Community Safety Board within the strategy. This will include the addition of a third focus area under Priority Three to imbed community safety and meet the expectations as set out in the merger paper from March 2020.
4. Agree that HWB adopt the longer term oversight of relevant work identified within the current (Place – see appendix 2) and future RCG papers detailing the handover of "place" work and ask the Prevention and Wider Determinants board to review and if necessary amend the existing priority one implementation plan.

4. Current status of implementation plan activity

The following section highlights examples of work happening within each of the priorities, focusing on where progress is being made or particular issues are being faced.

More recently it is evident that some programmes have begun to adapt what they are doing to address the changing needs of the population given the impact of COVID-19. It is recognised that this will need to develop further based on the outcomes of the rapid needs assessments that are also coming to the September Board meeting and the longer term recovery transitioning work that is further described in section 4.

Appendix 1 identifies the current status of projects against key milestones as of July 2020. Whilst many are able to progress, where they continue to be impacted and delayed, this has generally been due to the following:

- A lack of capacity to take work forward where staff have been redeployed or key partners are unavailable during COVID-19 pandemic
- A lead has not yet been identified to take the work forward (following the risks escalated at the Health and Wellbeing Board in March)
- Work has refocused on continuing essential service delivery to ensure people have access to adequate levels of support during the COVID-19 pandemic

As the following highlights however, whilst milestones may have been impacted, there is a great deal of activity taking place within each of the priorities.

Priority 1: Helping People to live healthy lives

<u>Focus Area 1 Working to reduce obesity and excess weight rates and physical inactivity</u>

- The strategic leadership support for a whole-system approach to physical activity and the development and implementation of the Surrey Physical Activity Strategy 2020-29 is on schedule. The support for the workplace wellbeing frameworks for NHS, Local Authorities and Schools are underway with approved amendments and refreshes being made to the Sport England Evaluation Framework
- Evidence gathered during the pandemic shows that obese people are significantly more likely to become seriously ill and be admitted to intensive care with COVID-19 compared to those with a healthy BMI. This increases the urgency for immediate action to reduce the levels of obesity across the

County. Weight Management Programmes alone do not lead to sufficient long term weight loss and have little effect of prevalence levels which is why an evidence based whole-system approach (WSA) is being taken within the strategy. A logic model is being developed to work with stakeholders across the County to embed the WSA Framework. This has the aim of delivering sustainable, systemic change to ensure that those living and working in and those in greatest need in Surrey are provided with the right environment and the best opportunities to achieve and maintain a healthy weight. A progress report will be available at the Prevention and Wider Determinants of Health Board on 19 October 2020.

Focus Area 2 Supporting prevention and treatment of substance misuse, including alcohol

- The projects relating to supporting prevention and early identification of drugs and alcohol and the effective treatment and recovery of alcohol dependency including the review of the current provision are on schedule. The development of safer, stronger communities which include establishing processes to review and utilise shared data are underway or scheduled to start within the next quarter.
- The development of a consistent response from the wider system and the development of a Surrey workforce smoke free offer are underway with target completion in Spring 2021

Focus Area 3 Ensuring that everyone lives in good and appropriate housing

- An SRO Vacancy Brief for the Tackling Fuel Poverty Project is being drafted. Members of the Prevention and Wider Determinants of Health Board have agreed to undertake a system-wide campaign to fill this vacancy.
- The project which focuses on the Prevention of Homelessness and Rough Sleeping across SCC has been accelerated. A Prevention of Homelessness and Rough Sleeping Multiagency Group (MAG) was established which inter alia has assisted front-line agencies in Districts and Boroughs with the creation of Standard Operating Procedures including access to a crisis line for mental health emergencies, alcohol and substance dependency support and scenario planning as part of the Local Outbreak Plan. Temporary self-contained modular living-pods are being investigated for four areas as accommodation for homeless people who may require social isolation from September 2020 – March 2021.
- The Covid-19 pandemic has emphasised the need for flexible and accessible metal health and substance dependent services to be made available to people being housed by the Districts and Boroughs in the current and future emergency, temporary and move on accommodation. Priority 1 (Focus Area 3), Priority 2 and partner organisations are working in collaboration to develop effective solutions.
- The project to support people with Sever Multiple Disadvantage, Surrey Adults Matter (SAM) is closely allied to the Homelessness (MAG) and has also been accelerated in response to Covid 19. Work is in progress to record outcomes to inform future business and whole-system planning and commissioning.

Focus Area 4 Preventing domestic abuse (DA) and supporting and empowering victims

- In response to Covid 19 some of the eleven projects within this programme had to be accelerated and / or modified. By way of one example, additional emergency housing and support was urgently secured for people requiring refuge accommodation. Multi agency partnerships have been established to drive forward the needs of the residents. Mapping and scenario planning exercises have been undertaken as part of the recovery programme.
- With several projects being fast-tracked solid multiagency partnerships have been developed, and some of the original milestones and deadlines now need a refresh. This will be undertaken during September and October 2020. A full update of the Prevention of Domestic Abuse and Supporting and Empowering victims is scheduled at the Prevention and Wider Determinants of Health Board on 19 January 2021

Focus Area 5 Promoting prevention to decrease incidence of serious conditions and diseases

- During the pandemic referrals to the National Diabetic Prevention Services were reduced by approx. 90%. This had a knock-on effect to being able to improve the diabetes pathways across identification, prevention, treatment and management.
- NHS Health Checks (NHSHC) and blood pressure plus programmes have also been impacted due to their reliance on primary care. Discussions are underway to establish how these can be resumed safely.
- The project to promote bowel and cervical screening as a preventative health measure has moved forward to plan. An evidence-based review to explore barriers/attitudes to cervical screening has been completed. The design of a local survey to test national evidence and explore barriers/attitudes with residents has been developed.
- A successful bid with the Sussex and Surrey Cancer Alliance obtained funding to support North West Surrey with a project to improve screening rates in cervical screening. COVID-19 has unfortunately delayed the delivery timelines of the programme.
- A full update of Promoting Prevention to Decrease Incidence of Serious Conditions and Diseases is scheduled at the Prevention and Wider Determinant of Health Board on 19 October 2020

Focus Area 6 Improving environmental factors that impact people's health and wellbeing

- Guidance to support health and local planning in Surrey has been developed.
- A Planning and Health Forum to improve collaborative working across planning and health departments and maximise opportunities for health to influence Local Plans has been established

- An embedded Health Impact Assessment Approach is on target to deliver by 31 March 2021.
- The electrical vehicle charging policy is proceeding. The Greener Future Strategy is on target to deliver Strategic Priority 2: All council-owned vehicles, including SCC-owned bus fleet, to be zero carbon by 2030 or sooner and Strategic Priority 3: use its influence across its supply chain through procurement practices to drive significant carbon emission reductions in the operations of our staff, suppliers and partners.
- Whilst the support to the Districts and Boroughs to embed sustainability is in progress, additional work is required to meet agreed deadlines.
- The delivery of the Drive SMART Road strategy 2019 -2021 was delayed as school interventions were cancelled and engineering schemes were paused. Overall during the pandemic, the number of casualties reduced due to less traffic.

Focus Area 7 Living Independently and Dying Well

- A full update of the BAME Carers and system-wide Workforce Carers was presented to the Prevention and Wider Determinant of Health Board in July 2020. Two new carers strategies and a new carers service specification will be issued for consultation in October 2020.
- COVID-19 delayed the commissioning of the Technology Enabled Care offer and the At Scale / At Place programme. Revised timelines will be agreed for these projects and for the Better Care Fund evaluation scheme

- Throughout the pandemic the reablement service focussed on maintaining critical care within the community to prevent hospital admission and support hospital discharge. A refreshed reablement framework is being accelerated to recover time lost during the pandemic. The revised completion date is January 2021.
- Within the Improving End of Life Care Project, links will be made to the carers programmes and an update report shall be requested for the Prevention and Wider Determinants of Health Board in January 2021.
- The Head of Commissioning - Older Persons (North West Surrey & Surrey Heath) has been appointed as the SRO for Project 5, Adapting Homes to meet Health Needs and Promote Independence). An update on this project and its interconnectivity to other projects within the Focus Area is scheduled for the Prevention and Wider Determinants of Health Board on 22 April 2021.

Priority 2: Supporting people's emotional wellbeing and mental health

As expected, the pandemic has led to an increase in the demand for mental health services, including people who were previously known across the services. Modelling work is underway to plan for the next six months. The assumption is that providers will be around 20% busier, and other services will experience a significant rise in demand.

Surrey's approach to mental health through the Health and Wellbeing Strategy recently featured as a case study in the Centre for Mental Health's report "*Our place: local authorities and the public's mental health*" highlighting the key role local

authorities play in improving the mental health of their communities and reducing inequalities.

Work is continuing to identify joint health and care strategic commissioning opportunities around mental health through the 'Transforming Outcomes for People' programme.

Focus area 1: Access the right help and resources

- Work is continuing with the integration of mental health team into Primary Care Networks – providing support for GPs, virtual consultations and proactive outreach. As of June 2020, over 2100 people have been seen in Surrey Heartlands GPiMHS test sites, with service user experience rating very highly. Soft launches are continuing across the county, including North West Surrey earlier in July.
- The Surrey Virtual Wellbeing Hub was launched on 4th May, with a range of providers offering virtual support to individuals and carers. During the first 6 weeks it received 3000 visits and a business case is in development to inform the future of the model.
- Proactive contact has been brought in to follow up with shielded service users. Plans are in development to widen this contact and outreach to at risk groups (including BAME communities, people who are furloughed or recently unemployed, people treated for COVID-19 in critical care settings, and key workers). Building on the Virtual Wellbeing Hub and Recovery College offers; the voluntary, community and faith sector will be key to delivering this proactive demand reduction focused on local networks and support groups.
- Further workplace wellbeing initiatives are in place; IAPT are offering fast track support for key workers and volunteers. Psychological support is also available for BAME staff and to inform the risk assessment process.
- Whilst the data shows that overall rates of suicide have not increased during the pandemic, a wide range of work has been developed around suicide prevention. Mental Health First Aid training has been made available for volunteer call handlers supporting the Surrey community helpline. Workforce resources have also been collated onto the Healthy Surrey website and access to one-to-one support has been made available. In future, morning training will be provided to businesses, Citizen's Advice Bureau and other areas where those in vulnerable groups may have most contact.
- Work has progressed to allow GP in-reach into acute MH wards to upskill staff in physical health issues; a key challenge identified in Priority Two.

Focus area 2: Emotional wellbeing of mothers and families throughout and after their pregnancy maternity

- The draft First 1000 Days strategy has been completed and is currently out for engagement with families, professionals and wider stakeholders. Mental health is identified as a key outcome and programme planning will reflect the need to improve the mental health of parents during the first 1000 days.

- Multi-partner workstreams initiated to sit under the First 1000 Days programme to focus on system delivery of themes such as digital, supporting vulnerable families, developing peer support models.
- A virtual post-natal peer support programme has been designed and delivered during the coronavirus pandemic, with one aim being to support mental health. This has provided families with the opportunity to connect, to receive support from a counsellor and community nurse, and the opportunity to gain the knowledge and skills to care for themselves and their new-born. *'I really don't know how I would have coped without you two over the last few weeks – you've been a lifeline.'*
- As part of the COVID-19 response, communication to families has reflected mental health support for families, including the Surrey Wellbeing Partnership Facebook Page and the information leaflets for parents.
- Continued working with Best Beginnings to launch and embed the Baby Buddy app (an interactive pregnancy and parenting guide). This app provides mental health advice and videos for parents and has an evidence base demonstrating excellent uptake with BAME families.
- A partnership has been established with Best Beginnings to participate in research to support development of a weight management support tool for women.
- The process to purchase and roll out of a remote monitoring hypertension app for use by pregnant women has begun.

<u>Focus area 3: Preventing isolation and enabling support for those who do feel isolated</u>

- Surrey Heartlands was selected by NHSX, the digital arm of NHS England, as a pilot site for Facebook Portal devices. Care home residents and patients were able to keep in touch with friends and family with Facebook Portal video calling devices. 50 devices were provided free of charge and were used not only for older age adults but also those with learning disabilities.
- A Dementia Needs Assessment has been developed following mapping work and service user engagement. A Surrey Heartlands strategic plan is also in development.
- As a part of the project to support business links to reduce isolation, scoping work is underway with DWP, Citizens Advice Bureau and Financial Institutions to support people's emotional and financial health. Surrey Chambers of Commerce now has a Coronavirus information Hub containing details on mental health/self-care and links to for further support via Healthy Surrey. They are also providing webinars on the socioeconomic risks of COVID.
- As a part of the digital offer, Surrey Coalition of Disabled People Tech Angel service is providing technology and support to isolated and hard to reach communities. A mood tracking app has also been released by Surrey and Borders Partnership to support early intervention in psychosis.
- Local hubs and community groups are providing a range of services to support people to remain connected to their communities; including helping people with Autism with shopping, and connecting with others through video games to reduce anxiety.
- IAPT have developed a COVID bereavement module, and the development of the Surrey End of Life Care Strategy has resumed, following the pause during

the initial COVID response phase.

Priority 3: Supporting people to fulfil their potential

In March 2020, following the merger of the HWB and the Community Safety Board, the ambition was to develop a Community Safety Agreement (CSA) for Surrey for 2020 to 2024 with annual refreshes. However, the Covid-19 pandemic has seen several challenges impact this timeline. To meet the statutory requirement in the interim a section of the Healthy Surrey website was added to explain the current governance structure, how the partners work together and details the priorities for community safety, which reflects the current priorities of the HWB, the Police and Crime Commissioner and the seven[1] Community Safety Partnerships.

In light of the above and the publication of new data sets, the timing is appropriate to refresh the commitments set out in the current Surrey Community Safety Agreement and then fully imbed them into the Health and Wellbeing Strategy. It is proposed that the programmes of work identified in the CSA are imbedded across the strategy but particularly into Priority 3 as a new third focus area dedicated to community safety. This will also meet the expectations as set out in the March 2020 merger paper.

The above represents a significant development within priority three which was still becoming established prior to March 2020. Whilst much of these pre-existing programmes were paused in the initial response to COVID-19 the following areas are now again moving forwards:

Focus Area 1: Supporting Adults to succeed professionally and/or through volunteering

- Strategic mapping exercise is currently underway to identify provision against target groups to understand gaps, duplication and opportunities in order to develop an outcomes framework and recommendations for employment, skills and inclusion in Surrey. A significant recent development locally is the establishment of the Surrey Growth Board (Appendix 3 for terms of reference). It is anticipated that this new strategic board will enable a stronger emphasis on this focus area going forwards and work is planned to further explore how this can complement the work within this focus area and more generally across the HWB Strategy.

- Social Progress Index- at the beginning of March an event was hosted with a group of more than 30 colleagues from partners across the county to explore how we can develop an SPI for Surrey. The result was a list of over 300 possible indicators and the exercise was useful for challenging assumptions of what we know about how our communities are performing. This list was cross-referenced with a range of strategic priorities and outcomes frameworks from across our partnership to ensure alignment. Following this session, partners were invited to take part in an online consultation to input and help prioritise which indicators to include in the SPI. These results, along with analysis of various strategies, have been used to build a final list of indicators. During the Covid-19 pandemic the project was paused so the team could

focus on supporting the LRF response. In the past few months a Recovery Progress Index has also been developed which forms a sub-set of the wider SPI. The beta version of the SPI is now being finalised and a number of training sessions with Social Progress Imperative have taken place so analysts are trained to use the system.

Focus Area 2: Supporting children to develop skills for life

- There is significant work and oversight of this work already within established structures, for example "first 1000 days". As a result, the alignment with these structures is being explored to enable appropriate and effective links with the Health and Wellbeing Board and Strategy.

4. Links to Recovery

The multi-agency Recovery Coordinating Group (RCG) was established to plan for and coordinate recovery from the pandemic at a county wide level. The RCG developed a Recovery Strategy with the aim 'To restore the humanitarian, economic, environmental and infrastructure well-being, conditions and resilience of Surrey', and with the objectives to:

- Restore essential services that have been disrupted as a result of the Covid-19 pandemic and associated response measures (e.g. lockdown and social distancing)
- Ensure the effective transition to a 'steady state', with clear responsibilities identified for the continuation of services
- Capture lessons learned and refer on to the relevant body/authority.

The chair of the RCG has approached the HWB to request that the relevant elements of the longer term recovery work identified within the "place" subgroup of the RCG (see Appendix 2) be included within the ongoing Health and Wellbeing strategy governance for the purposes of ongoing oversight. The activity from this particular subgroup relates to priority one of the strategy meaning the areas highlighted in the paper should be reviewed at the next Prevention and Wider Determinants board to confirm the relevant activity is already included or will be included within the oversight they provide.

5. Key risks, issues and opportunities

- The proposed changes to Health and Wellbeing Board membership means there is a need for a new Priority Two Sponsor.

- Programme / project level indicator development sessions were previously planned with key stakeholders across all priorities to enable more detailed lower level reporting for review by priority governance structures which would complement the high level strategy outcomes. These were however postponed and rescheduled due to the COVID response and recovery taking priority. Engagement is now happening with all SROs across the different priorities to

identify appropriate existing project level indicators which will enable further progress reporting within each focus area.

- The activity described in the current and subsequent recovery handover documents presents an opportunity to ensure that where needed activity stood up during the COVID-19 response and recovery is sustained longer term where appropriate.

- Where programme milestones have been delayed or accelerated by COVID-19 these will be reviewed and amended for future reporting.

- Some SRO roles continue to be vacant within priority one however following discussion at March HWB the prevention and wider determinants board is actively seeking individuals to fill these last remaining vacant roles and has drafted SRO profiles for these.

6. Next steps

- All priorities will need to consider and incorporate outcome of rapid needs assessments through their appropriate governance structures and revise plans and milestones appropriately over the next three months.
- Integrate the new Community Safety Agreement within the health and wellbeing strategy through a task and finish group with representatives from the statutory partners. This is intended to stand alone as an appendix to the strategy but also be integrated within the three priorities of the HWB strategy.
- Subject to agreement arrange an informal HWB session to further understand the scope of community safety work following the merger of the two boards (as referenced in the HWB review paper).
- Review, update and share the previous HWB induction pack to reflect the developing strategy and incorporate merger of community safety (as referenced in the Surrey HWB Review paper).

List of Appendices:

- Appendix 1: HWBS Priorities milestones status (as at July 2020)
- Appendix 2: ‘Transitioning from Recovery’: ‘Place’
- Appendix 3: One Surrey Growth Board Terms of Reference

Appendix 1: Priorities, Focus Areas, Projects, Milestones RAG Rating

Completion delays possible	Start delayed
On track	Risk to project delivery

Priority 1: Helping People to Live Healthy Lives

Focus Area 1:

Working to reduce obesity, excess weight rates, and physical inactivity.

	Project	Milestone	RAG RATING Q1 2020
1	Project 1 - Develop a Whole Systems Approach to physical activity including improving green spaces, transport initiatives, and healthy planning	1. Secure strategic leadership support for a whole systems approach to physical activity. 2. Develop the Surrey Physical Activity Strategy 2020-29. 3. Support all NHS organisations, local authorities and schools (via completion of the Healthy Schools Evaluation Tool) to have a physical activity development plan (PDAP) - approved by their Board, Cabinet or Governing Body - as part of the Workplace Wellbeing Framework. 4. Implement the whole system approach (across the life course) through the Surrey Physical Activity Strategy 2020-29.	
2	SCC: Project 2 Implementing a Surrey obesity approach to encourage healthy weight	1. Set up a Surrey obesity approach 2. Building the Surrey obesity picture 3. Develop the Surrey draft obesity approach 4. Implementation 5. Evaluate, reflect and extend the obesity approach 6. Develop Surrey into a Healthy Food environment through a targeted approach 7. Implement Eat Out Eat Well in early years settings 8. Tackling maternal obesity 9. Working with partners to tackle childhood obesity 10. Implementation of the family healthy weight service	
3	SRO TBC: Project 3: Develop a Health Behaviour Framework	1. Scope the content and engagement for behaviour change framework 2. Develop an aligned behavioural insights capability 3. Develop a strategic commissioning framework across all healthy behaviour services to link across the life course.	
Overall Focus Area Rating			

Focus Area 2

Supporting prevention and treatment of substance misuse, including alcohol

No	Project	Milestone	RAG RATING Q1 2020
1	Support prevention and reduce substance misuse, including alcohol misuse and alcohol-related harm	1. Develop five-year Drug & Alcohol Strategy for Surrey (2020-2025) 2. Support prevention and early identification of drugs and alcohol 3. Support effective treatment and recovery for those with drug and alcohol dependency 4. Develop safer, stronger communities	
2	Implement targeted approaches for priority groups to stop smoking	1. Re-establish the Tobacco control and Alcohol Alliance 2. Surrey Tobacco Control Strategy Refresh 3. Ensuring priority groups are accessing stop smoking support 4. Developing a consistent response from the wider system 5. Develop a Surrey workforce smoke-free offer 6. Review and Development of next plan	
Overall Focus Area Rating			

Focus Area 3:

Ensuring that everyone lives in good and appropriate housing

	Project	Milestone	RAG RATING Q1 2020
1	Project 1 - Tackling fuel poverty in Surrey	1. Engaging communities 2. Partnership Governance 3. Develop data and understand existing impact 4. Develop and agree activity 5. Winter deaths review	
2	Reducing Rough Sleeping	1. Homeless Mapping 2. Improving health access 3. Homeless Friendly Surrey 4. Housing First	
3.	Project 3 - Supporting people with severe and multiple disadvantage (Surrey Adults Matter)	1. Data Sharing 2. Stakeholder Engagement 3. Induction 4. Referral Routes 5. Cohort Identification 6. Evaluation 7. Scope and set up Peer Network 8. Peer Mentor delivery 9. Peer Mentor training	

4	Project 4 - Supporting people who hoard in Surrey	1. Partnership Governance 2. Produce a multi-agency hoarding protocol for Surrey 3. Develop data and understand existing impact 4. Develop and agree activity	
5	Specialist housing	1. Developing Extra Care Housing 2. Developing Independent Living	
Overall Focus Area Rating			

Focus Area 4:

Preventing domestic abuse (DA) and supporting and empowering victims

	Project	Milestone	RAG RATING Q1 2020
1	Getting Started	1. Partnership endorsement, workstream leads agreed and Governance established	
2	Health Interventions	1. Prototype 1 (Health Interventions) Implementation & Evaluation	
3	Young Offenders and Domestic Abuse	1. Prototype 2 (Young Offenders & Domestic Abuse) Implementation & Evaluation	
4	Perpetrator Programmes	1. Prototype 3 (Perpetrator Programmes) Implementation & Evaluation	
5	Early Intervention	1. Prototype 4 (Early Intervention) Implementation & Evaluation	
6	Coercive Control	1. Prototype 5 (Coercive Control) Implementation & Evaluation	
7	Recovery & Coping	1. Prototype 6 (Recovery & Coping) Implementation & Evaluation	
8	Family Safeguarding Model	1. Prototype 7 (Family Safeguarding Model) Implementation & Evaluation	
9	Current DA Services	1. Shared understanding of current DA specialist services (including commissioned services) and recommendations to the partnership to build on existing good practice	
10	Whole System	1. Prototype 8 Implementation & Evaluation	
11	Final Service Model Re-design	1. Procurement of new DA Service	
Overall Focus Area Rating			

Focus Area 5:

Promoting prevention to decrease incidence of serious conditions and diseases

	Project	Milestone	RAG RATING Q1 2020
1	Establish a Surrey-wide CVD and Diabetes screening and testing programme	1. Identify High Priority Populations and Locations for Screening 2. Review access to screening programmes 3. Improve uptake of health checks in high priority groups 4. Review Quality Assurance Processes for Screening 5. Review Evaluation	
2	Improve the diabetes pathways across identification, prevention, treatment and management	1. Review and Update Diabetes Pathways 2. Establish a Surrey-wide diabetes testing programme 3. Develop the Diabetes UK (DUK) Champions Programme to target key communities	
3	Agree a Surrey-wide CVD prevention approach	1. Align Surrey CVD Programme with NHS Long Term Plan 2. Embed Lifestyle services across the system to prevent CVD 3. Optimise CVD Medication for CVD patients	
4	Promote bowel and cervical screening as a preventative health measure rather than purely for those at high risk	1. Understand the challenges to uptake and develop a surrey-wide response	
1	Targeted engagement with key geographies and groups to improve understanding and uptake of childhood immunisations	1. Scoping Coverage of immunisations and opportunities to address gaps	
Overall Focus Area Rating			

Focus Area 6:

Improving environmental factors that impact people's health and wellbeing

	Project	Milestone	RAG RATING Q1 2020
1	To promote healthy, inclusive and safe places through planning policies/decisions	1. Develop guidance to support health and local planning in Surrey 2. Establish a Planning and Health Forum to improve collaborative working across planning and health and maximise opportunities for health to influence Local Plans and draw on available funds, such as the Community Infrastructure Levy 3. Embed Health Impact Assessment approach 4. Engage in the Development Consent Order process for airport expansion application at Heathrow 5. Engage in the Development Consent Order process for the airport expansion application at Gatwick	
2	To promote healthy, inclusive and safe places through transport/highways policy, projects and operations	1. Implement actions within Surrey Transport Plan that contribute to improved health and wellbeing	
3	2. People who live and work in Surrey have an increased awareness of the health impact of poor air quality and take action to improve air quality	1. Deliver Schools Air Quality Programme (runs until July 2019) and Eco Schools 2. Surrey wide communications campaign to raise awareness of the importance of good air quality	
4	People who live and work in Surrey have an increased awareness and take actions to support environmental sustainability	1. Surrey's Greener Future Design Challenge/Call for Evidence 2. Implement the Surrey Single Use Plastics Strategy 3. Surrey wide communications campaign to raise awareness of the importance of environmental sustainability 4. Promotion of passenger transport services, including park & ride	
5	Public Sector across Surrey embed environmental sustainability within their organisations	1. Support local authorities across Surrey to embed sustainability 2. Support all NHS organisations across Surrey to have a Sustainable Development Management Plan approved by their Board	
6	Reduce death and injury on Surrey roads	1. Deliver the Drive SMART Road Safety Strategy 2019-2021	
7	Increase active travel across Surrey	1. Provide cycle training, pedestrian training and promotion of active travel to schools 2. Improving quality of walking, cycling, public transport and EV infrastructure in Surrey	
8	Project 8 - Connect people with the natural environment	1. Promote health benefits of Surrey's countryside and green space, building on Explore Surrey 2. Make rights of way more useful/suited for everyday journeys to work and school and encourage contact with the natural environment through the Rights of Way Improvement Plan (Countryside Access Team, SCC)	
9	Local residents and strategic partners understand the importance of seasonal health and wellbeing and undertake interventions to reduce the impact of hot/cold weather on health	1. Provide information and advice regarding seasonal health and wellbeing	
Overall Focus Area Rating			

Focus Area 7

Living Independently

	Project	Milestones	Rag Rating
1	Supporting Carers	1. Scoping and Mapping 2. Supporting Carers in the Workplace 3. Developing Carer – Supportive Communities 4. Carers through Surrey provides 5. Developing an offer to young carers	
2	Aligning the better Care Fund to the health and wellbeing Strategy	1. Better Care Fund Implementation 2. Future planning	
3	Developing a Reablement Framework for Surrey and Integrating Intermediate Care	1. Governance 2. Developing a Reablement 3. Framework 4. Developing a Surrey Integrated intermediate care service	
4	Improving End of Life Care in Surrey	1. Scoping and Mapping 2. Partnership Governance 3. Communications and Engagement 4. Out of Hours Crisis response 5. Developing Workforce 6. Develop and Agree activity 7. End of Life Training for all Carers	
5	Housing Adaptations	1. Scoping and Mapping 2. Improving Hospital Discharge 3. Clarifying the Financial and legal position	
Overall Focus Area Rating			

Priority 2: Supporting the Mental Health and Emotional Wellbeing of people in Surrey

Focus Area 1: Enabling children, young people, adults and elderly with mental health issues to access the right help and resources

No	Project	Milestone	RAG RATING Q1 2020
1	Children's Emotional Wellbeing and Mental Health Transformation	1. Development of Access workstream 2. Development of Early Intervention workstream 3. Development of Social, Emotional & Mental Health (SEMH) workstream 4. Development of Vulnerable Groups workstream 5. Vulnerable groups to be consulted on new service model 6. Development of Crisis workstream 7. Emotional Wellbeing work with schools	
2	Launching of Healthy Schools	1. Launch Healthy Schools programme	
3	Map and develop preventative mental health support access for Older People	1. Development of upstream, integrated models of care	
4	Scale up anti-stigma work, including rollout of the Time to Change training programme	1. Scale up Time to Change training programme	
5	Expand work to improve the links between physical and mental health	1. Using technology to support physical and mental health 2. Partnership physical and mental health links 3. Physical Health Check reporting for people with Severe Mental Issues 4. Co-Produce Plan to Retarget interventions to those with LD/Autism and Carers	
6	Supporting wellbeing at work through the development of a Wellbeing Charter for businesses	1. Promote mental health and wellbeing policies and workplace behaviours 2. Health and Wellbeing Board member organisations commit to Wellbeing Charter 3. Exploring support offer for unemployed people (Job Centre Plus, Supported Employment services, Community Connections) 4. Publish the First Steps booklets 5. Continue to scale up existing Every Mind Matters amongst Health and Wellbeing Board member organisations 6. Incorporate suicide prevention and emotional wellbeing initiatives into the healthy workplace programmes	
7	Develop new integrated models of care to support people at risk of	1. Crisis Work 2. Community Models of Care Transformation 3. NHS LTP UEC Standards 4. Reablement Mental Health Pilot	

	admission to secondary mental health services		
9	Mapping of Dementia services and develop partnership responses to system opportunities, to support people and carers to live independently for as long as possible	1. Scoping and mapping 2. Partnership governance 3. Develop and agree activity	
10	Develop system-wide aligned plans for people with mental health issues who need support in prisons or the criminal justice system	1. Mental Health in Prisons 2. Mental Health support for those within, or at risk of entering, criminal justice system	
11	Enable effective system-wide planning ensuring safe discharge into suitable accommodation for people upon hospital discharge	1. ASC discharge teams for MH to be established 2. Strategic commissioning approach to supported living for people with a mental health problem	
12	Suicide prevention work to be scaled up with existing partners, supporting our zero suicide ambition	1. Develop an information sharing protocol 2. Set up a suicide prevention database in partnership with Surrey Coroner 3. Develop an annual suicide report 4. Develop a system wide suicide risk log/areas of concern 5. Develop a process to learn from suicides and suicide-related incidents 6. National and Surrey initiatives which target support messages to particular groups 7. Carer for people with mental health needs are enabled to care for a person who has experienced suicidal thoughts, or has previously attempted suicide 8. Monitor and respond to emerging methods of suicide 9. Gain a better understanding of self-harm 10. Establish an annual coordinated training plan for staff on mental health awareness and suicide prevention targeted to high risk groups 11. Promote the bitesize e-learning on suicide prevention in communities with the highest suicide rates	
Overall focus area rating			

Focus Area 2: Supporting the emotional wellbeing of mothers and families throughout and after their pregnancy

No	Project	Milestone	RAG RATING Q1 2020
1	Develop offer around the emotional wellbeing of mothers through First 1000 Days planning lens	1. Development of First 1000 days strategy 2. Implementation of the First 1000 days strategy	
2	Develop a pregnancy Healthy Behaviours Framework	1. Scoping the strategy framework and stakeholders specifically around pregnancy	
3	Further development of wraparound care and support through Perinatal services	1. Perinatal service development 2. Perinatal service links with Public Health team offer	
4	Support the new, targeted provision delivered through Family Centres (such as the universal Family Centre offer in development in East Surrey)	1. Explore opportunities within Family Centres Transformation programme to support emotional wellbeing and mental health. 2. Develop further emotional wellbeing support programmes through community groups	
5	Domestic Abuse support/prevention offer around wellbeing of mothers throughout and after their pregnancy	1. Link in to Domestic Abuse Transformation Programme 2. Wider victims of crime offer	
6	Alcohol and Substance Misuse prevention offer in place prior to pregnancy	1. Care coordination and Public Health contract linkages	
7	Evaluation and implementation of family support tools (such as Dadpad, and Baby Buddy)	1. Development of family support tools and apps	
Overall focus area rating			

Focus Area 3: Preventing isolation and enabling support for those who do feel isolated

No	Project	Milestone	RAG RATING Q1 2020
1	Further develop an accessible community transport offer that supports people's social connections.	1. Community transport 2. Rethinking Transport Pilots 3. Engaging Communities	
2	Develop youth social isolation approach, including bullying	1. Rollout of Healthy Schools programme	

	prevention and social media offer, with schools		
3	Support for Surrey Dementia Action Alliance in establishing Dementia Friendly communities, as already seen in Oxted, Woking, and Hindhead	1. Engaging communities 2. Establishing further Dementia Friendly communities	
4	Establish business links to prevent isolation (such as Walking Friends) and unlock the potential of underutilised community space	1. Mental Health business links 2. Accessing green spaces	
5	Develop a wraparound, holistic bereavement support offer	1. Bereavement support and information 2. Postvention support	
6	Ensuring meaningful work and volunteering opportunities for those at risk of mental ill health and social isolation	1. Volunteering, apprenticeships and supported employment 2. Community engagement 3. Intergenerational activities	
Overall focus area rating			

Priority 3: Supporting people to fulfil their potential

Focus Area 1: *Supporting Adults to succeed professionally and/or through volunteering*

No	Project	Milestone	RAG RATING Q1 2020
1	Health and Economic interaction- *employment, skills and inclusion*	A significant recent development locally is the establishment of the Surrey Growth Board which provides the opportunity to refresh and place a stronger emphasis on the relationship with health and economic interaction. In addition, COVID-19 has significantly impacted employment and Focus Area 1 will be reviewed in light of the current environment to ensure alignment with recovery. 1. Priority groups and objectives identified 2. Data collection and analysis 3. Employment and skills framework developed and tested with key stakeholders 4. Strategic mapping of existing initiatives across the system against the framework 5. Opportunity and gap analysis 6. Options appraisal, benefit analysis and business case 7. Pilot	
2	Social Progress Index	1. Stakeholder engagement event and online consultation 2. Draft list of indicators 3. Refine indicators and cross reference against strategic priorities 4. Final list of indicators 5. Training sessions with Social Progress Imperative for analysts 6. Convert code in Stata to Python and R versions 7. Demo of RPI with HWBB 8. Build beta version of SPI (moved this down) 9. Demo with key partners 10. Officially launch	

Focus Area 2: *Supporting children to develop skills for life*

No	Project	Milestone	RAG RATING Q1 2020
1	*Alignment with existing architecture*	There is significant work and oversight of this work already within established structures. As a result, the alignment with these structures is being explored to enable appropriate and effective links with the Health and Wellbeing Board and Strategy.	

Appendix 2: Surrey Recovery Coordinating Group (RCG) – Covid-19 'Transitioning from Recovery': 'Place'

Background

Following the declaration of a major incident by the Local Resilience Forum to manage the response to Covid-19 in Surrey, the multi-agency Recovery Coordinating Group (RCG) was established to plan for and coordinate recovery from the pandemic at a county wide level. The RCG developed a Recovery Strategy with the aim 'To restore the humanitarian, economic, environmental and infrastructure well-being, conditions and resilience of Surrey', with the objectives to:

- Restore essential services that have been disrupted as a result of the Covid-19 pandemic and associated response measures (e.g. lockdown and social distancing)
- Ensure the effective transition to a 'steady state', with clear responsibilities identified for the continuation of services
- Capture lessons learned and refer on to the relevant body/authority.

A number of sub-groups under the themes of humanitarian, economic, environmental and infrastructure were established, and associated action plans developed and implemented.

Introduction

In line with the objectives of the Recovery Strategy, the action plans developed by the sub-groups identified short term 'restart and restore' actions across public, private and third sector organisations, as well as medium and longer term actions to support the Surrey community on its journey to recovery from the pandemic.

The RCG met weekly from April 2020 to August 2020 to oversee the 'restart and restore' actions, as well as looking at where actions could sit in the longer term. This document sets out some of the new practices developed during the pandemic and the medium and longer term actions that have been identified to support the recovery of Surrey. The responsibility for these actions will transition to existing agencies and partnerships to take forward as part of their business as usual activity, within their existing financial framework and governance arrangements. As well as identifying delivery partners for the actions, the document also identifies an overseeing body/strategic link, who will be asked to take on a governance role to ensure the proposed actions are fully considered and implemented and communicated as appropriate.

Going forward the RCG will move to a monitoring role, liaising with the delivery and oversight bodies accountable for delivery of the actions, whilst monitoring the Recovery Progress Index and the strategic risk register to ensure that Surrey continues to recover positively from the pandemic.

Place

To plan for a revisioning focussed on building in climate change to our lifestyles with better air quality, nurturing the environment and embracing the gains arising from working from home, less and more sustainable travel, technological connectivity and a better balance in lifestyles, access to housing, physical place and socialisation in line with the Surrey 2030 Community Vision and our Climate Change Strategy. Particular emphasis on Local Planning and encompassing the new normal and changed community expectations.

Some of the new practices/opportunities to be considered include:

- Considering the impact of changes on the demand and supply of physical infrastructure and accommodation.
- Implications for more sustainable access to quality residential accommodation for all.
- Impact on the world of business and work, demand for home working, travel, office and retail floorspace.
- Local Plans that meet the new aspirations for the future development of place.
- Addressing shortcomings in having enough community resilience accommodation for future emergencies.
- Ensuring the sense of community experienced continues in our places.
- Optimising the community and health and well-being benefits of well designed places and infrastructure that are integrated with natural infrastructure rather than conflicting.
- Understanding the skills and jobs that will be created as a result of achieving the "new normal".
- An opportunity to consider and plan for making town centres far more pedestrian and cycle friendly to secure air quality, climate change and public health benefits
- Public and community transport running to time without having to compete for road space derived in recent weeks, demonstrating benefit of priority public transport network.
- The opportunity to fundamentally review the local bus offer eg applying a different offer in rural areas, for example, considering Demand Responsive Transport (DRT).
- The opportunity to develop and encourage active travel building upon Government and NHS England's promotion of taking daily exercise each day to see how we can build walking and cycling better into the planning process and the reshaping of town centres.
- Maintaining the increased levels of exercise; walking, running and (non-sport) leisure cycling through interventions to keep local streets safe and quiet.
- Significant demand for greenspace, particularly in more built-up areas, with increased pressures on local parks and commons.

Specific actions identified by the RCG for consideration for the medium/longer term are set out below. Financial implications of these actions will be included in the Financial Strategies of relevant organisations. Appropriate comms support around the actions can be provided via the MIG.

Issue/Action	**Delivery partners**	**Overseeing Body / Strategic link**
Support home working – Positive planning and supporting investment in digital, IT systems and home working environments, whilst also addressing digital poverty. Focus infrastructure funds on broadband, 5G and other digital infrastructure and smart technology.	EM3, Coast to Capital (C2C) and county councils	One Surrey Growth Board
Bus provision based on user demand and social distancing measure. Comms in line with Government guidance	Bus operators in consultation with Strategic Transport Group, incl the travel needs of residents & businesses	SCC

Train provision based on user demand and social distancing measure. Comms in line with Government guidance	Train Operating Companies and Department for Transport (DfT), in consultation with councils	One Surrey Growth Board
More space for pedestrians - Implementation of agreed measures and changes through works programme	Highways with support from D&Bs	SCC
More cycle facilities - Implementation of agreed measures and changes and the acceleration of the completion of the local cycling and walking implementation plans (LCWIPS). Secure funding and implement a network of permanent cycle infrastructure schemes based on LCWIPS, whilst boosting the cycle training offer	Highways with support from D&Bs	SCC Prevention & Wider Determinants Board - Health and Wellbeing Board: HWBS Priority 1 – FA 6 – Healthy Environment
Return to school – reshape transport plans as schools reopen	SCC Children, Families and Learning (CFL) to lead supported by SCC Highways and Transportation (H&T), with operator liaison	SCC Prevention & Wider Determinants Board - Health and Wellbeing Board: HWBS Priority 1 – FA 6 – Healthy Environment
Support climate change agenda - Define a network of permanent bus priority schemes and pinch point interventions to support council and operator fleet and other investment. Secure funding and implement a network of permanent bus priority schemes and pinch point interventions to support council and operator fleet, information and other investment	SCC H&T in consultation with bus companies	SCC
Government Funding - Press Government to urgently review the conditions and deadlines attached to the many different funding streams. Also press to allow direct funding where it will have the most impact in addressing the immediate impact as well as the recovery from, and legacy of, COVID19	SCC H&T in consultation with LEPs and neighbouring councils	LEPS
Community Transport (CT) - Dial-a-ride demand likely to increase, but Centres for the Community staying shut. Ongoing need to support self-isolating with medicine & food collection / delivery. CT able to meet requirements of ad hoc school routes and NHS requirements, but may need to furlough staff should ASC services not return. Could result in job losses. CT operators ability to retain workforce and flexibility will depend on CT's ability to continue to diversify, alongside resumption of all school and adult centre	SCC H&T, CFL, Adult Social Care (ASC), Public Health (PH)	Health and Wellbeing Board

Aviation and jobs - Impact of COVID-19 on local jobs related to reduction in economic activity at Heathrow and Gatwick Airports. Mitigating the impact though working with LEPs and other partners. Key to this will be an understanding of the supply chains for businesses that are located close to the airports and their reliance upon it and the transport	SCC, D&Bs	One Surrey Growth Board Surrey Future
Decarbonation and revitalisation of town centres. Supporting the new and anticipated human, economic, travel and environmental needs of Surrey through transport	SCC, D&Bs	Surrey Future Prevention & Wider Determinants Board - Health and Wellbeing Board: HWBS Priority 1 – FA 6 – Healthy Environment
Climate change, including biodiversity, natural capital and carbon reduction. Plan for a "climate smart" recovery	SPOA/D&Bs Local Plans - in consultation. SCC Climate Change Strategy. Surrey Nature Partnership (SyNP). Surrey Climate Change Commission. Incl. Natural Capital Investment Plan and Nature Recovery Network and Strategy	Prevention & Wider Determinants Board - Health and Wellbeing Board: HWBS Priority 1 – FA 6 – Healthy Environment
Access to affordable quality housing. Planning for a restructured housing market and shift in values/costs. Including Biodiversity Net Gain in achieving	SPOA/D&Bs plus SyNP	D&Bs
Improved air quality. Almost entirely dependent on travel changes – staggered commuting, modal shift through investment in improved cycle and walking facilities.		Prevention & Wider Determinants Board - Health and Wellbeing Board: HWBS Priority 1 – FA 6 – Healthy Environment
Less congestion/easier travel/better connectivity. Travel changes – staggered commuting, modal shift through investment in improved cycle and walking facilities.	SCC/Rethinking Surrey Transport	Surrey Future
Improved 5G digital connectivity. To facilitate working from home (WFH), social resilience and a stronger digital economy		One Surrey Growth Board Surrey Future
Infrastructure and construction capacity. Investment in additional and upgraded infrastructure and public facilities	Surrey Place Ambition and D&B Local Plans/Infrastructure Plans	Surrey Future
Improved open spaces and leisure/recreation facilities	D&B Local Plans/developers/sports assoc/Sport England. Health and Well-being Strategy Priority 1	Prevention & Wider Determinants Board - Health and Wellbeing Board: HWBS Priority 1 –

		FA 1 – Excess weight and physical inactivity
Physical community resilience. Address the lack of shared community facilities available for future emergencies – centralised depots etc	SCC	LRF
Town Centres as geographical community hubs. Public realm improvements, need for physical floorspace in town centres/surplus office and retail floorspace. Reduced personal travel/car use	SCC, D&B Local Plans/Surrey Urban Strategy	One Surrey Growth Board Surrey Future
Identify sustainable placement (for homeless housed during COVID) in suitable accommodation. Ensure ongoing multi-agency support for health needs and recovery including: - Further mobilise primary care to support homeless - Manage discharge from hospitals and mental health care - Improved prison release process - Use learning from Surrey Adults Matter programme to inform engagement of all partners	Surrey Homeless Multi-Agency Group / Surrey Adults Matter	Prevention & Wider Determinants Board - Health and Wellbeing Board: HWBS Priority 1 – FA 3 – Housing

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Appendix 3: ONE SURREY GROWTH BOARD – TERMS OF REFERENCE

The One Surrey Growth Board is a significant alliance which brings together key stakeholders who have a vital role in safeguarding and supporting improvements to Surrey's economy, homes, infrastructure and quality of life. The One Surrey Growth Board is Surrey's strategic partnership which represents issues of key importance to the economy and 'whole-place'. It aligns directly to the Health and Wellbeing / Community Safety Partnership which operates as the 'People' body. The terms of reference for the Board are:

1. To develop formal agreement between Surrey's key stakeholders on the delivery of a long-term 'One Surrey Plan for Growth'.

2. To oversee the development and maintenance of the 'One Surrey Plan for Growth', taking an outward facing view and providing guidance and advice to wider sub-regional partnerships on the delivery of key infrastructure priorities needed to support the Plan.

3. To identify and recognise wider cross-boundary, sub-regional areas of economic Importance, particularly in relation to developing a symbiotic relationship with London. To work with all strategic partners to ensure effective promotion of shared issues and opportunities alongside the coordination of decisions and appropriate housing and infrastructure delivery.

4. To ensure alignment of the 'One Surrey Plan for Growth' with the 'People' plans for Surrey in order to safeguard and improve the quality of life and economic prosperity of Surrey residents with a focus on addressing issues of inequality and inclusion through access to educational and personal development opportunities.

5. Act as the voice of Surrey to Government, the emerging Sub National Transport bodies, Homes England, Highways England, Network Rail, TfL, Energy and Utility providers to ensure Surrey's infrastructure needs (including Digital Connectivity) are heard and recognised in future investment priorities and funding.

6. To put in place appropriate 'Delivery Engines' to achieve the ambitions of the board and the delivery of the One Surrey Plan, guiding, overseeing and monitoring their work.

7. To develop innovative joint financial models and to seek external funding opportunities to fund the development and delivery of key projects.

8. To monitor the development and delivery of all economic and whole-place projects.

9. To maintain particular focus on the regeneration of Surrey's Town Centres and development and delivery of key housing sites as part of the role as custodians of the 'One Surrey' place.

10. To integrate strategy and delivery with the Health and Well Being Board / Community Safety Partnership and the NHS in order to ensure future health provision is aligned with spatial and economic growth.

11. To develop a Strategic Growth Narrative for Surrey and explore a Growth Deal with Government to secure long term infrastructure funding and planning freedom and flexibilities.

12. The membership of the Board shall comprise 18 representatives proposed as follows:

8

Membership

	Organisation	Representative
1.	Surrey County Council Leader	Cllr Tim Oliver
2.	Former Chancellor and Surrey MP	Philip Hammond
3.	Member of Parliament for East Surrey	Claire Coutinho MP
4.	Surrey County Council Portfolio Holder	Cllr Colin Kemp
5.	Surrey County Council CX	Joanna Killian
6.	District / Borough Leader (Runnymede Borough Council)	Cllr Nick Prescot
7.	District / Borough CX (Elmbridge Borough Council)	Rob Moran
8.	Greater London Authority Deputy Mayor for Planning, Regeneration and Skills	Jules Pipe
9.	Health representative (CCG)	Claire Fuller
10.	Chair of Coast to Capital LEP	Tim Wates
11.	Chief Executive of EM3 LEP	Kathy Slack
12.	VC University of Surrey	Max Lu
13.	Principal of Royal Holloway University	Paul Layzell
14.	FE Representative- NESCOT	Frances Rutter
15.	Business Representative (1)	TBC
16.	Business Representative (2)	TBC
17.	Homes England Representative	TBC
18.	TfL / Network Rail Representative	TBC
19.	*Observer*	Lord Andrew Mawson

Health and Wellbeing Board Paper

1. Reference Information

Paper tracking information	
Title:	Health and Wellbeing Communications Priorities
Related Health and Wellbeing Priority:	All
Author:	Andrea Newman, Director of Communications and Engagement (SCC), andrea.newman@surreycc.gov.uk
Sponsor:	Tim Oliver, Chairman
Paper date:	10 September 2020
Version:	1
Related papers	Annex 1 - Communications Plan

2. Executive summary

The Health and Wellbeing Board communications sub-group has produced a draft Communications Plan (Annex 1) to support the work of the board over the next six to nine months.

The Plan, which outlines three priority areas of focus, is intended to ensure a coordinated approach across the system building on strong partnership working that has already developed.

The Plan is intended to reflect the COVID-19 context and align with and complement programmes within the Health and Wellbeing Strategy.

3. Recommendations

The Health and Wellbeing Board is asked to support the proposed communications plan and endorse the approach within their respective organisations.

4. Reason for Recommendations

A coordinated approach to communications across the system will help achieve the greatest impact for residents.

The plan builds on strong partnership working during the winter of 2019/20 which helped ensure consistent communications activity and avoided duplication of effort.

This way of working has progressed rapidly during the COVID-19 outbreak enabling a cohesive approach to supporting the county-wide response effort.

5. Detail

The Health and Wellbeing Board communications sub-group, which is formed of communications representatives from the board's member organisations, meets regularly to support the work of the board.

At the group's meeting on 14 July, it discussed the need for a set of communications priorities to guide the work of the group and help ensure activity is aligned across partners.

The group identified three key priority areas of focus which reflect the COVID-19 context and complement programmes of work within the Health and Wellbeing Strategy.

A draft "plan on a page" was developed and sent to members of the group for further comment. The tactics, channels, opportunities and audiences identified in the plan are not intended to be exhaustive and will be developed and kept under review.

6. Challenges

The changing broader landscape, particularly developments relating to the COVID-19 pandemic, poses a challenge to the plan which will need to reflect the situation at any given time and will be kept under review.

7. Timescale and delivery plan

The plan is intended to guide the work of the Health and Wellbeing Board communications sub-group over the next six to months to spring 2021.

Delivery tactics and evaluation measures will form part of campaign plans for various elements of the wider communications plan.

8. How is this being communicated?

The draft plan has been discussed at a meeting of the Health and Wellbeing Board communications sub-group and has been communicated to all members of the group.

9. Next steps

- The Health and Wellbeing Board communications sub-group will take forward the activity outlined in the plan.

SURREY HEALTH AND WELLBEING BOARD

COMMUNICATIONS PLAN

Healthy Surrey

HELPING SURREY RESIDENTS LEAD HEALTHIER LIVES

TRANSFORMING HEALTH AND SOCIAL CARE FOR RESIDENTS

*We will support the drive to transform residents' care using the latest technology so that people can **stay independent** in their communities for as long as possible and receive care that is tailored to their individual needs.*

Areas of focus:

- Building on the shifts to **digital ways of working** seen during the pandemic to improve how people access, and receive, health and social care support.
- Supporting the drive to harness advances in technology so that services better meet people's needs, leading to wider benefits such as **reduced road congestion and pollution.**
- Promoting **a shared story and understanding** of how joining up health and social care is benefiting residents.

ADDRESSING THE CONSEQUENCES AND "HIDDEN HARMS" OF COVID-19

*We will support continuing efforts to **address the risks** that the pandemic is presenting or exacerbating for vulnerable people.*

Areas of focus:

- Working with partners to raise awareness of **domestic abuse support,** building on work already underway.
- Supporting residents and the workforce with their **mental health and emotional wellbeing.**
- Helping to connect people with support to deal with **isolation and loneliness.**
- Supporting **suicide prevention** work.

PROMOTING TESTING, SELF-CARE AND ACTING EARLY TO PROTECT YOUR HEALTH

*We will encourage people to use **testing, screening and immunisation services** to reduce health risks during the winter months. Promoting self-care and healthy lifestyles will help prevent problems escalating.*

Areas of focus:

- Supporting the national **Test and Trace** campaign to encourage take up locally.
- Continuing to encourage people to follow **infection control measures.**
- Communicating the national **flu jab** campaign and making it locally relevant and meaningful.
- Supporting wider **winter health messages** including signposting to NHS 111.
- Supporting work to increase uptake of **childhood immunisations.**
- Promoting **cancer screening** services.
- Supporting residents to lead **healthy lifestyles.**

COVID-19
Communications will need to be considered in the context of the pandemic for the foreseeable future. Messages and channels will need to reflect the situation at that time and be kept under review.

TACTICS AND CHANNELS

As comms teams we will…

- *make sure our work is aligned with and complements programmes within the Health and Wellbeing Strategy,*
- *agree comms leads for each strand of work,*
- *consider all tactics and channels at our disposal including public awareness campaigns, social media targeting, the Next Door social networking service, text messaging via GPs, digital toolkits for partners to share as well as traditional offline channels to ensure older, more vulnerable residents are reached,*
- *mobilise a tactical sub-group to coordinate winter comms work across agencies,*
- *make sure our work is aligned with the Local Outbreak Plan, the communications plan for Test and Trace and wider recovery work,*
- *share updates with partners through the Multi-Agency Information Group (MIG), set up under the auspices of the Surrey Local Resilience Forum.*

OPPORTUNITIES / MILESTONES

- NHS winter campaign including flu jabs and push towards NHS 111 First.
- Childhood immunisation campaign.
- Public Health England “Better Health” campaign focusing on healthy weight, and due to be expanded to cover drinking, smoking and mental health.
- World Suicide Prevention Day (September).
- “Release the Pressure” mental health campaign (October).
- Mental Health Awareness Day (October).
- Stoptober (October).
- Get Online Week (19-25 October).
- Alcohol Awareness Week (November).
- National Safeguarding Adults Week (November).
- National Grief Awareness Week (December).
- Cancer awareness dates tbc.
- Mencap’s Treat Me Well campaign.

SUCCESS

- Behaviours and attitudes influenced so that more people use testing, screening and other preventative services.
- Behaviours influenced towards use of NHS 111; increased resilience across the system to deal with demand for services during winter months.
- People who are experiencing difficulties such as with their mental health access services which can help them.

KEY AUDIENCES

- Black, Asian and minority ethnic (BAME) communities.
- People who are, or have been, shielding.
- Hard to reach communities.
- Further key audiences to be informed by the findings of the Community Impact Assessment.
- Those cohorts eligible for free flu jab.

TO ACHIEVE THIS WE NEED:

A shared understanding across organisations of the priorities for improved health and wellbeing.

Buy-in from organisations to the communications approach.

Ownership of work strands to drive projects forward.

Ideas for stories and content.

Access to case studies and spokespeople to help us tell stories.

Regular and timely updates on plans.

Health and Wellbeing Board Paper

1. Reference Information

Paper tracking information	
Title:	Surrey Local Outbreak Engagement Board
Related Health and Wellbeing Priority:	N/A
Author:	Gail Hughes, Public Health Lead (SCC), gail.hughes@surreycc.gov.uk Andrea Newman, Director - Communications and Engagement (SCC), andrea.newman@surreycc.gov.uk Julie George, Consultant in Public Health (SCC) Amelia Christopher, Committee Manager (SCC), amelia.christopher@surreycc.gov.uk
Sponsor:	Tim Oliver, Chairman Ruth Hutchinson, Director of Public Health
Paper date:	10 September 2020
Version:	1
Related papers	Appendix 1 - LOEB Terms of Reference

2. Executive summary

The NHS Test and Trace Service, launched on 28 May 2020, is designed to control the rate of reproduction of Covid-19 by reducing the spread of the infection.
This is a national programme, but each Upper Tier local authority are expected to develop a Local Outbreak Control plan by 30 June 2020. Local Outbreak Control Plans are designed to clarify how local government works with the national Test and Trace service, so that the whole local system works to contain the virus.

As part of their local arrangements councils are expected to have a member-led, typically by the Leader of the authority, COVID-19 Local Outbreak Engagement Board. These arrangements are expected to provide political oversight of local delivery of the Test and Trace Service, will lead the engagement with local communities and be the public face of the local response in the event of an outbreak.

The Surrey Local Outbreak Engagement Board (LOEB) was formally constituted by County Council on 7 July 2020 as a formal sub-committee of the Surrey Health and Wellbeing Board. The newly formed Surrey COVID-19 Health Protection Operational Group (HPOG) is responsible for the operational development and delivery of the

Local Outbreak Control Plan and will report to the Local Outbreak Engagement Board.

3. Recommendations

- The Board is asked to note the Terms of Reference for the Surrey Local Outbreak Engagement Board.

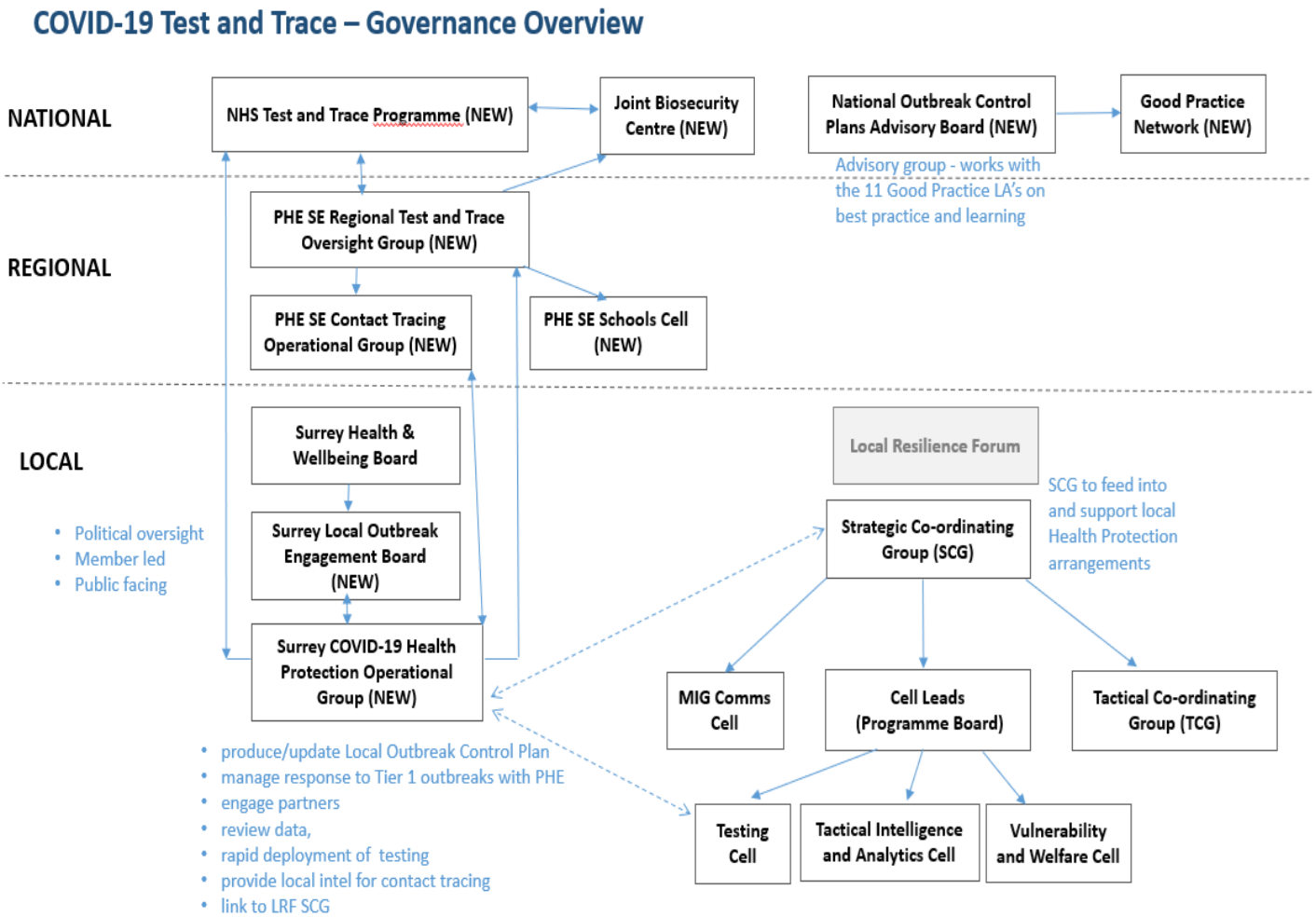
4. Reason for Recommendations

The Health and Wellbeing Board has oversight over the Local Outbreak Engagement Board as it was formally constituted as a sub-committee by County Council which approved the terms of reference on 7 July 2020.

5. Detail

Governance Overview

The Governance Overview below shows how the Health and Wellbeing Board; and Surrey Local Outbreak Engagement Board sits within the national, regional and local levels.



In line with section 3 of the Surrey Local Outbreak Board's Terms of Reference, please see the LOEB's Role and Responsibilities below:

- Sign-off of the general direction of travel for Surrey's COVID-19 Local Outbreak Control Plan and ongoing development of the plan;
- Senior level oversight of outbreak responses in Surrey, outlined in Surrey's COVID-19 Local Outbreak Control Plan and implemented primarily via the local COVID-19 Health Protection Operational Group (HPOG);
- Oversight of resource allocation relating to the delivery of Test and Trace in Surrey;
- Direction and leadership for community engagement for outbreak response;
- Approving the public-facing communications for outbreak response; and
- Approving recommendations from the Surrey COVID-19 Health Protection Operational Group.

A summary of regular updates received by the LOEB are highlighted below:

i. Local Outbreak Control Plan and Legal Context

Surrey's Local Outbreak Control (LOC) Plan was published on 30 June 2020. The full LOC Plan and Summary Plan are available to view on the council website: https://www.surreycc.gov.uk/people-and-community/emergency-planning-and-communitysafety/coronavirus/coronavirus-testing

This is an iterative document which will be updated to reflect ongoing changes:

- To national guidance, learning from outbreaks and incidents in Surrey or other areas
- To operational processes for supporting specific settings during outbreaks

The LOEB also receives an update from the Director of Law and Governance (SCC) who summarises the legal context in relation to the current legislation available in terms of a localised lockdown, the Health Protection (Coronavirus, Restrictions) (Leicester) Regulations 2020 which came into effect on 4 July 2020; created as an urgent order under the Public Health (Control of Disease) Act 1984.

ii. Communications Plan

An NHS Test and Trace Communications Plan for Surrey has been produced to support the Local Outbreak Control Plan from the 1 July as well as the Messaging Grid.

The Plan and Messaging Grid are contained within item 7 Local Outbreak Control Communication Plan Update included in the agenda of the Surrey Local Outbreak

Engagement Board that met on 16 July 2020 and can be accessed using the following link: https://mycouncil.surreycc.gov.uk/ieListDocuments.aspx?CId=820&MId=7727&Ver=4

The primary objective of the plan is to communicate Test and Trace advice and guidance to maximise awareness and compliance and so help contain and reduce the spread of COVID-19.

The communications plan will explain how we will:
- Amplify the national Test & Trace campaign through local channels with tailored messages for key audiences
- Provide a clear understanding of Local Outbreak Plans among key stakeholders
- Establish a rapid response process in the event of Local Outbreaks

It encompasses both online and digital tactics as well as how traditional methods will be used to ensure the widest reach across Surrey.

iii. National Update

As one of eleven Beacon Councils promoting best practice and good governance, the LOEB receives a national update from the Board's Chairman of the who sits on the National Outbreak Control Plans Advisory Board (NOCPAB) and the Chief Executive of Surrey County Council who sits on the Good Practice Network (GPN).

Updates are provided on areas such as data sharing, learning processes, changes to local powers to enable localised lockdowns and actions put in place in relation to localised outbreaks i.e. in Leicester and Blackburn with Darwen.

iv. Intelligence Update

A key element of successful outbreak management is access to timely and accurate intelligence to inform health protection action. The LOEB receives a regular update on intelligence as Section 8 (Data Integration) of the Surrey Local Outbreak Control Plan describes existing intelligence resources and plans to develop further resources to support other elements of the Plan.

The Public Health Intelligence & Insight team has already achieved the following:

- Established a regular dataflow from Public Health England (PHE), governed by a signed data-sharing agreement;
- Developed Beta test and trace dashboards for the outbreak control team to review and trained staff on their use;
- Set up systems and processes for the daily review of surveillance so that the outbreak control team can take health protection action when the surveillance and other sources of intelligence indicates this is needed.

The latest Surrey COVID-19 weekly intelligence summary can be found using the link below:

https://www.surreycc.gov.uk/people-and-community/emergency-planning-and-community-safety/coronavirus/testing/figures-and-statistics

This provides the numbers of COVID-19 cases in Surrey broken down by borough and district as well as a comparison with national cases; and information on the R number (the average number of infections (secondary) produced by a single infected person).

There are no set numbers of cases that define an area as being at a particular level of concern. To give advice to key partners, two main areas need to be considered beyond simple numbers:

1. Whether cases are linked to each other. Cases in a small area who have contracted COVID-19 from different sources requires a different response to cases in the same area who have contracted the virus from the same setting. There are strict definitions about what is an 'outbreak'. Local authorities work closely with Public Health England to establish if cases are linked or separate.
2. Whether the case numbers are significantly and consistently greater than expected. This involves interpretation of a daily 'exceedance report' from Public Health England, which takes into account the size of local populations, recent trends, the level of statistical confidence in fluctuations in case numbers, and the situation outside Surrey.

Surrey's Local Outbreak Control Plan has more information about the measures in place to identify and contain COVID-19 outbreaks and protect the public's health; the Plan is regularly reviewed and updated.

6. Next steps

The next meeting of the Surrey Local Outbreak Engagement Board will take place on 25 September 2020 and is scheduled to meet every other month in public.

The agendas, minutes and meeting information can be found by accessing the following link:

https://mycouncil.surreycc.gov.uk/ieListMeetings.aspx?CId=820&Year=0

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Surrey Local Outbreak Engagement Board
Terms of Reference - FINAL
Approved by the Council on 7 July 2020

1. Context

1.1 The NHS Test and Trace service is part of the Government's COVID-19 recovery strategy. It is aimed at controlling the COVID-19 rate of reproduction (R), reducing the spread of infection and saving lives. In doing so its aim is to help to return life to as normal as possible, for as many people as possible, in a way that is safe, protects our health and care systems and releases our economy.

1.2 This strategy requires local authorities to work with partners to build on existing health protection plans to put in place measures to identify and contain outbreaks and protect the public's health.

1.3 The strategy requires a public-facing board led by council members to communicate openly with the public. This will be through the Surrey Local Outbreak Engagement Board (LOEB).

1.4 This Board is a sub-committee of the Surrey Health and Wellbeing Board.

2. Purpose

2.1 The Board will oversee the local delivery of the primary objectives of the government strategy to reduce the spread of infection and save lives.

3. Role and Responsibilities

3.1 The Surrey Local Outbreak Engagement Board will be responsible for:

3.1.1 Sign-off of the general direction of travel for Surrey's COVID-19 Local Outbreak Control Plan and ongoing development of the plan;

3.1.2 Senior level oversight of outbreak responses in Surrey, outlined in Surrey's COVID-19 Local Outbreak Control Plan and implemented primarily via the local COVID-19 Health Protection Operational Group (HPOG);

3.1.3 Oversight of resource allocation relating to the delivery of Test and Trace in Surrey;

3.1.4 Direction and leadership for community engagement for outbreak response;

3.1.5 Approving the public-facing communications for outbreak response; and

3.1.6 Approving recommendations from the Surrey COVID-19 Health Protection Operational Group.

4. Principles

4.1 The same principles followed by the Surrey Health and Wellbeing Board describes how Board members will work together. Board members will:

4.1.1 Prioritise resources and make decisions in the best interests of the Surrey population based upon evidence and data;

4.1.2 Embrace the opportunity for the collective leadership of place, recognising and balancing the needs and opportunities presented by Surrey's geography;

4.1.3 Work in an open and transparent way ensuring there are no surprises for other partners – 'nothing about me without me';

4.1.4 Use consensus as the primary driver for decision making;

4.1.5 Hold each other (and the organisations and partnerships represented by Board members) to account for delivering on commitments made and agreed actions;

4.1.6 Seek to align local and system level success wherever possible; and

4.1.7 Champion an inclusive approach to engaging residents in the work of this Board.

5. Chairman

5.1 The Leader of the County Council will be the Chairman of the Surrey Local Outbreak Engagement Board.

5.2 A Vice-Chairman will be nominated at the first public meeting.

6. Membership

6.1 The Board membership will be as follows:

- The Leader of Surrey County Council
- Chief Executive of Surrey County Council
- Director of Public Health of Surrey County Council
- Cabinet Member for Adults and Health of Surrey County Council
- Cabinet Member for Children, Young People & Families of Surrey County Council
- Chief Executive of Mole Valley District Council
- Strategic Director, Waverley Borough Council
- The Leader of Reigate & Banstead Borough Council
- The Leader of Elmbridge Borough Council
- Clinical Chair of Surrey Heartlands Clinical Commissioning Group (CCG)
- Chair of the Royal Surrey NHS Foundation Trust
- Lead Primary Care Network (PCN) Clinical Director, representing the collective voice of PCNs across Surrey Heartlands
- Chief Constable of Surrey Police
- Surrey Police and Crime Commissioner
- Independent Chair, Frimley Health & Care Integrated Care System
- Chief Executive of Surrey Chambers of Commerce

6.2 Board members are able to nominate a deputy (as agreed by the Chairman) who can attend and vote in their absence but must have delegated authority to make decisions.

7. Quorum

7.1 There will be at least four representatives, one of whom will be the Chairman or Vice-Chairman.

8. Decision-making

8.1 The decisions will be made by consensus. Decision making authority is vested in individual members of the Board. Members will ensure that any decisions taken are with appropriate authority from their organisation.

8.2 Any member can make a proposition or propose an amendment to a proposed resolution if backed by a seconder. Votes will be taken if consensus is not reached. Voting will be by a show of hands.

9. Board Support

9.1 Surrey County Council Democratic Services are responsible for the distribution of the agenda and reports, recording minutes, maintaining the actions tracker and the organisation of the meetings.

9.2 The Surrey County Council Public Health team are responsible for the Board forward plan, developing the agenda and support for Board members to fulfil their role.

10. Meeting Frequency

10.1 The first informal meeting of the Board was held on 18 June 2020, the Board will then meet from the week beginning 13 July 2020.

10.3 Meetings will be held every two months in public. In line with statutory requirements, notice and agendas for public meetings will be published 5 clear working days before the meeting. The frequency of the meetings will be kept under review.

10.3 The Board may convene additional informal meetings if required to further develop its role and partnership arrangements.

10.4 Meetings will be held virtually and, when feasible at venues across Surrey as agreed by the Board.

10.5 Conflicts of interest must be declared by any member of the Board.

11. Review of Terms of Reference

11.1 These terms of reference will be formally reviewed by the Board by mutual agreement of its members. Reviews will be undertaken to reflect any significant changes in circumstances as they arise. These terms of reference, together with any amendments, will be signed off by the Board members.

11.2 County Council approved the terms of reference on 7 July 2020, formally constituting the Local Outbreak Engagement Board as a sub-committee of the Health and Wellbeing Board. The Health and Wellbeing Board will note the terms of reference at its next meeting.

12. Governance