Notice of Meeting

Adults and Health Select Committee

Date & time
Wednesday, 20 October 2021 at 10.00 am

Place
Council Chamber, Woodhatch Place

Contact
Ben Cullimore, Scrutiny Officer

Tel 07977 275 279

ben.cullimore@surreycc.gov.uk

Chief Executive
Joanna Killian

We're on Twitter: @SCCdemocracy

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Ben Cullimore, Scrutiny Officer on 07977 275 279.

Elected Members
Nick Darby, Robert Evans, Chris Farr, Angela Goodwin (Vice-Chairman), Trefor Hogg, Rebecca Jennings-Evans, Frank Kelly, Riasat Khan (Vice-Chairman), David Lewis, Ernest Mallett MBE, Carla Morson, Bernie Muir (Chairman) and Buddhi Weerasinghe

Independent Representatives
Borough Councillor Neil Houston (Elmbridge Borough Council), Borough Councillor Vicki Macleod (Elmbridge Borough Council) and Borough Councillor Darryl Ratiram (Surrey Heath Borough Council)

TERMS OF REFERENCE

- Statutory health scrutiny
- Adult Social Care (including safeguarding)
- Health integration and devolution
- Review and scrutiny of all health services commissioned or delivered within Surrey
- Public Health
- Review delivery of the Health and Wellbeing Strategy
- Health and Wellbeing Board
- Future local delivery model and strategic commissioning

AGENDA

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Purpose of the item: To report any apologies for absence and substitutions.

2 MINUTES OF THE PREVIOUS MEETING: 3 MARCH 2021 (Pages 5 - 22)

Purpose of the item: To agree the minutes of the previous meeting of the Select Committee as a true and accurate record of proceedings.

3 DECLARATIONS OF INTEREST

Purpose of the item: 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

Purpose of the item: To receive any questions or petitions.

NOTES:

1. The deadline for Members' questions is 12:00pm four working days before the meeting *(14 October 2021).*
2. The deadline for public questions is seven days before the meeting *(13 October 2021).*
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 ENABLING YOU WITH TECHNOLOGY TRANSFORMATION PROGRAMME (Pages 23 - 30)

Purpose of the item: To update the Select Committee on the Enabling

You with Technology (Technology Enabled Care) Transformation Programme.

6 COVID-19 RECOVERY PROGRAMMES AND PREPARATION FOR WINTER PRESSURES

a SURREY HEARTLANDS HEALTH AND CARE COVID-19 RECOVERY PROGRAMME AND PREPARATION FOR WINTER PRESSURES (Pages 31 - 124)

Purpose of the item: To update the Select Committee on Surrey Heartlands' Recovery Programme and preparation for Winter Pressures (Surge Planning).

b FRIMLEY HEALTH AND CARE COVID-19 RECOVERY PROGRAMME AND PREPARATION FOR WINTER PRESSURES (Pages 125 - 176)

Purpose of the item: To update the Select Committee on Frimley Integrated Care System's Recovery Programme and preparation for Winter Pressures (Surge Planning).

7 UPDATE ON THE IMPLEMENTATION OF MENTAL HEALTH TASK GROUP RECOMMENDATIONS (Pages 177 - 206)

Purpose of the item: To provide the Select Committee with an update on progress in implementing the recommendations of the Mental Health Task Group, which was established to map the individual and carer's journey through adult mental health services in Surrey.

8 ESTABLISHMENT OF A HEALTH INEQUALITIES TASK GROUP (Pages 207 - 214)

Purpose of the item: To propose the establishment of a Health Inequalities Task Group based on the attached draft scoping document.

9 APPOINTMENT OF A NAMED STANDING OBSERVER AND SUBSTITUTE FOR THE HAMPSHIRE TOGETHER JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Pages 215 - 216)

Purpose of the item: To appoint a named standing observer and substitute for the Hampshire Together Joint Health Overview and Scrutiny Committee.

10 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 217 - 246)

Purpose of the item: For the Select Committee to review the attached recommendations tracker and forward work programme, making suggestions for additions or amendments as appropriate.

11 DATE OF THE NEXT MEETING

The next public meeting of the committee will be held on 16 December 2021.

12 PRIVATE BUDGET BRIEFING

A session on the 2022/23 draft budget will be taking place privately at 1:30pm, after the conclusion of the formal meeting.

Joanna Killian
Chief Executive
Published: Tuesday, 12 October 2021

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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Thank you for your co-operation

MINUTES of the meeting of the **ADULTS AND HEALTH SELECT COMMITTEE** held at 10.00 am on 3 March 2021 as a REMOTE MEETING.

These minutes are subject to confirmation by the Committee at its meeting on Wednesday, 14 July 2021.

Elected Members:

* Dr Bill Chapman (Vice-Chairman)
* Mrs Clare Curran
* Mr Nick Darby (Vice-Chairman)
* Mr Bob Gardner
* Mrs Angela Goodwin
* Mr Jeff Harris
* Mr Ernest Mallett MBE
  Mr David Mansfield
* Mrs Marsha Moseley
* Mrs Tina Mountain
* Mrs Bernie Muir (Chairman)
* Mrs Fiona White

Co-opted Members:

* Borough Councillor Neil Houston, Elmbridge Borough Council
* Borough Councillor Vicki Macleod, Elmbridge Borough Council
* Borough Councillor Darryl Ratiram, Surrey Heath Borough Council

In attendance

Karl Atreides, Chair, Independent Mental Health Network
Nick Markwick, Co-Chair, Surrey Coalition of Disabled People
Kate Scribbins, Chief Executive, Healthwatch Surrey
Patrick Wolter, Chief Executive Officer, Mary Frances Trust

11/21 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

None received.

12/21 MINUTES OF THE PREVIOUS MEETING: 19 JANUARY 2021 [Item 2]

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

13/21 DECLARATIONS OF INTEREST [Item 3]

None received.

14/21 QUESTIONS AND PETITIONS [Item 4]

Witnesses:
Ruth Hutchinson, Director of Public Health, Surrey County Council
Dr Sally Johnson, Clinical Lead for Covid Vaccinations, Surrey Heartlands
Sinead Mooney, Cabinet Member for Adult Social Care, Public Health and Domestic Abuse

1. A member of the public asked the following question in advance of the meeting: “How many of Surrey's care home residents have tested positive for COVID-19 since the Government lifted the last national lockdown on 2 December 2020?”

2. The following response was issued by Surrey County Council Public Health in advance of the meeting: “The Public Health England line listing of case data derived from our Power BI platform identifies 1,647 records of care home residents testing positive for COVID-19 since 2 December 2020 (up to 28 February 2021). Data included on the National Capacity Tracker estimates that the total number of care home residents in Surrey is approximately 9,799.

   Please note: due to data quality issues related to provider input, this data is subject to change.”

3. Having received this response, the questioner asked the following supplementary question at the meeting: what impact had the level of infections indicated in the response above had on COVID-related hospitalisations and deaths of care home residents during the same period, as well as on the rollout of the vaccine, since it was understood that vaccinations could not occur in care homes where there was an outbreak taking place?

4. It was agreed that a written response would be provided after the meeting.

5. The Clinical Lead for Covid Vaccinations stated that it was in fact possible to vaccinate residents and staff even when there was an outbreak in a care home. A risk assessment would have to be conducted, and vaccinations for people who had tested positive for the coronavirus would have to be delayed, but outbreaks in care homes had not hampered the vaccination programme significantly.

6. Members enquired whether the figure for Covid-19 cases in care homes was particularly high in Mole Valley and whether there were any other pockets across Surrey that had similarly high figures. The Select Committee requested to see comparative figures for each district and borough. The Director of Public Health agreed to include information on the prevalence of Covid-19 in care homes and the population as a whole in each district and borough in the written response.

7. The Co-Chair of the Surrey Coalition of Disabled People emphasised that domiciliary care should also be taken into account, not just care homes. The figures for domiciliary care were often ignored, yet domiciliary care clients and staff were impacted significantly by Covid-19. The Cabinet Member for Adult Social Care, Public Health and Domestic Abuse agreed to provide, where possible, data on the cases of hospitalisation or death of Adult Social Care clients in a domiciliary setting.

Actions/further information to be provided:

1. The Director of Public Health to provide a written response to the questioner’s supplementary question, including information on the

number of hospitalisations and deaths in care homes and domiciliary care settings for each district and borough.

15/21 COVID-19 VACCINATION PROGRAMMES [Item 5]

a SURREY HEARTLANDS COVID-19 VACCINATION PROGRAMME [Item 5a]

Witnesses:

Jane Chalmers, Covid Director, Surrey Heartlands
Ruth Hutchinson, Director of Public Health, Surrey County Council
Dr Sally Johnson, Clinical Lead for Covid Vaccinations, Surrey Heartlands
Giselle Rothwell, Associate Director of Communications and Engagement, Surrey Heartlands

Key points raised during the discussion:

1. The Covid Director provided an update on the data since the report had been published. The total number of vaccinations to date within the Surrey Heartlands area stood at approximately 330,000. Approximately 320,000 of these were first doses. About 27% of the Surrey Heartlands population had received at least the first dose of the vaccine. The roving model of vaccination used by the programme included administering vaccinations to homeless people and hard-to-reach groups. An important part of the programme now was understanding why some of the people who had been offered the vaccine had chosen not to take it up.

2. A Member asked what was being done to appeal to people who had been offered but declined the vaccination. The Director of Public Health emphasised that the programme was long-term. Whether people took up the vaccination when it was offered to them depended on the 'three Cs': confidence, convenience and complacency. The Director agreed to send a link to the Select Committee containing intelligence on vaccine hesitancy data. There was clear evidence on which population groups were less likely to take up the vaccine; these included black, Asian and minority ethnic (BAME), Gypsy, Roma and Traveller, and Pakistani and Bangladeshi communities, as well as people coming from certain economic backgrounds. As the vaccination cohorts were worked through and younger age groups came to be vaccinated, it was anticipated that patterns might also emerge of age groups that were less confident in taking the vaccine. Regarding the convenience of being vaccinated, it was important to understand the barriers to access and to work with affected groups to minimise barriers. This might involve making the vaccination experience accessible for people with disabilities, or ensuring vaccination sites were easy to reach by public transport. Regarding complacency, there was a need to understand complacency in some groups and develop solutions. Young people might be more likely to be complacent about taking up the vaccine. There was a comprehensive action plan and Equalities Impact Assessment (EIA) for the three Cs.

3. The Associate Director of Communications and Engagement added that a video had been produced in Urdu with the help of the imam at a mosque in Woking, and it was hoped that a trusted, local leader would help encourage people to come forward for the vaccine. A vaccination site had also been set up at this mosque. There was a Gypsy, Roma

and Traveller community service lead, who was working to develop a video of someone from within that community having their vaccine. Moreover, Surrey Heartlands was working with Surrey Care Association to dispel some common misconceptions and answer questions for care home staff. There were care homes that had vaccinated every member of staff, and those could be used as case studies to encourage other care home staff to take up the vaccination.

4. A Member expressed concern that once people had received the first dose of the vaccine, many mistakenly thought that they could not contract Covid-19 or transmit the virus. The need to maintain social distancing and abide by lockdown rules, even after vaccination, was not always mentioned verbally at the point of vaccination. The Clinical Lead for Covid Vaccinations replied that Surrey Heartlands was asking all of its staff to verbally emphasise at all vaccination appointments the need to continue to socially distance and wear a mask post-vaccination. Nevertheless, this would be restated to staff, to ensure it happened in every case. There was also a Public Health England leaflet that emphasised the need to continue to abide by restrictions post-vaccination.

5. A Member expressed concern that digital exclusion may lead to some people missing out on the vaccine, particularly elderly people or those who are not registered with a GP. The Clinical Lead for Covid Vaccinations stated that it could be difficult to contact people who were not registered with a GP. However, digital technology was not relied upon as the only method of contact for those who were registered with GPs; people were contacted about their appointment through landline phone calls and letters, and some GPs had even visited the houses of people they were particularly concerned about in order to ensure they could make an appointment to be vaccinated. Patients whose contact details were not in the system could be harder to contact, but it was key to remember that people did not have to have ever been registered with the NHS to be eligible for the vaccine. Anyone could phone the vaccination service or a GP and ask to be vaccinated, even if they were not registered. The Associate Director of Communications and Engagement added that the service was working with district and borough councils and local Covid champions to communicate information about the vaccine.

6. A Member asked how it was decided whether a person would receive the Oxford/AstraZeneca or Pfizer/BioNTech vaccine. The Covid Director responded that the supply of each vaccine to vaccination sites depended entirely on the national supply. Both vaccines were equally effective. The Clinical Lead for Covid Vaccinations added that a small number of people would not receive the Pfizer vaccine due to their medical history; this could include conditions such as severe anaphylaxis.

7. A Member asked for confirmation on whether the Epsom Downs Racecourse vaccination centre would close for the Epsom Derby in 2021 and whether it would reopen afterwards. The Covid Director stated that, while there would certainly be no closure of the vaccination centre in April 2021, it was possible that the centre might close temporarily in May 2021 for the Derby. If the centre was closed for the

Derby, this would be communicated to residents, alongside alternative vaccination plans for this period.

8. The Chair of the Independent Mental Health Network remarked that consumption of news media from traditional channels, such as television, was becoming less common, and many people now consumed news media through newer channels such as social media. He suggested that social media channels such as TikTok, which was popular amongst young people in particular, could be used to publicise and educate people on the vaccine. The Associate Director of Communications and Engagement agreed that using avenues such as TikTok should be looked into. Also, Surrey Heartlands had already made its own educational videos on the vaccine.

9. A Member asked whether Surrey Heartlands was in contact with the universities in Surrey about communicating the importance of the vaccine. Communicating with university students could be an effective way of reaching multi-generational households. The Associate Director of Communications and Engagement replied that Surrey Heartlands worked with the Multi-Agency Information Group (MIG) across all stakeholders including universities, and agreed that this could be a useful way to reach multi-generational households.

10. A Member expressed concern about a disconnect between the national and local vaccination systems, which could cause difficulty with booking appointments. The Covid Director stated that improvements had been made on this, although the system was not perfect.

11. A Member enquired what help was available regarding transport to vaccination sites for people who had mobility issues, were isolated or lived in a rural location. Was transport available and was it offered automatically, or could people contact someone and ask for assistance? The Associate Director of Communications and Engagement said that there was no formal national service for transport to vaccination appointments, but that the national booking service for vaccination appointments did offer the closest available appointment, meaning the distance of travel to the appointment should be minimal. The Clinical Lead for Covid Vaccinations added that the community transport service was transporting patients to appointments with the help of volunteers.

12. The Co-Chair of the Surrey Coalition of Disabled People asked how many people with protected characteristics had taken up the vaccine and requested more information on what the Equalities, Engagement and Inclusion Working Group had achieved since it had recently been set up and what actions from the stakeholder reference group for the EIA had been taken into account. The Associate Director of Communications and Engagement agreed to share the EIA and the initial findings of the Equalities, Engagement and Inclusion Working Group with the Select Committee.

13. The Co-Chair of the Surrey Coalition remarked that there were often no hearing loops installed at vaccination sites; these should have been installed earlier to ensure the sites were accessible from the

beginning. The Clinical Lead for Covid Vaccinations stated that a checklist of amendments that needed to be made at vaccination sites – including the installation of hearing loops – had now been put together. Staff had been working hard for some months and had not necessarily had the time to install hearing loops or other amendments so far.

14. The Co-Chair of the Surrey Coalition commented that, when a person had two or more carers, only one of the carers would qualify for the vaccine. Why was this? He expressed concern that unpaid carers might be overlooked. The Clinical Lead for Covid Vaccinations replied that there had been some challenges in defining 'carers' according to the national guidance. The definition now was the sole or primary carer of a clinically extremely vulnerable adult. She acknowledged that whether or not a person received the vaccine was ultimately down to the discretion of their GP, which could lead to inconsistencies. It was important to comply with the order of cohorts for vaccination, particularly in the early stages of the vaccination programme.

15. The Chief Executive of Healthwatch Surrey stated that the feedback Healthwatch Surrey had received about the vaccination programme was predominantly positive, particularly with regards to the experience at the vaccination centre itself. The clinical commissioning group (CCG) helpline had also been a useful place to refer residents.

16. A Member remarked that some people who had been amongst the first cohort to be vaccinated had not been able to book their second dose. How was the booking of second dose appointments being managed? The Clinical Lead for Covid Vaccinations responded that people who had received their first dose through the national booking system had been able to book their second appointment at the appointment for the first dose. All others who had received their vaccine at a local site would be contacted within the next few weeks and receive details of their second dose.

17. A Member asked who would contact residents about the second dose. The Clinical Lead for Covid Vaccinations stated that this depended on the vaccination site, but generally a text message would be sent by either the local vaccination site or the GP surgery, which worked closely together.

18. A Member mentioned recent evidence showing that the Covid-19 vaccinations were highly effective after just one dose. He suggested that this could be included in communications, to help persuade people to take up the vaccine. The Associate Director of Communications and Engagement agreed to raise this with NHS England, from whom they took their lead on messaging.

b FRIMLEY HEALTH AND CARE COVID-19 VACCINATION PROGRAMME [Item 5b]

Witnesses:

Sarah Bellars, Executive Director of Quality and Nursing, and Director of Infection, Prevention and Control, Frimley Collaborative
Paul Corcoran, Senior Quality Manager, Frimley Collaborative
Ruth Hutchinson, Director of Public Health, Surrey County Council

Key points raised during the discussion:

1. A Member noted that it had recently been announced in the media that the Pfizer/BioNTech vaccine could be stored at standard pharmacy freezer temperatures (originally, it had been thought that it had to be stored at extremely low temperatures). Would this discovery affect the rollout of the vaccine? The Executive Director of Quality and Nursing replied that the Frimley Collaborative received its direction from NHS England, and it had not received any direction regarding a change in the Pfizer/BioNTech storage temperature, so the vaccine continued to be stored at very low temperatures in accordance with official guidance.

2. A Member asked what the response of BAME communities had been to the vaccination programme. The Executive Director of Quality and Nursing stated that the Frimley Collaborative had been working on uptake and health inequalities from the start of the vaccination programme. It was important to adapt to different communities. The Frimley Collaborative had been successful in its work with BAME communities with regards to the vaccine so far.

3. A Member enquired how successful the programme had been in care homes in the Frimley area. The Executive Director of Quality and Nursing said that Frimley had been part of the national pilot in care homes and that all care home residents in the area had been offered the vaccine by the end of January 2021, well before the deadline of 15 February 2021.

4. A Member asked what Frimley's approach was to vaccinating people with learning disabilities and autism. The Executive Director of Quality and Nursing responded that steps had been taken such as simplifying settings for people with learning disabilities, utilising national tools such as easy-read materials and making the vaccination sites a comfortable, safe environment.

5. A Member requested more information on how hard-to-reach people were being reached for vaccination. The Executive Director of Quality and Nursing replied that a meeting had been held in a community hall to understand vaccine hesitancy amongst the Gypsy, Roma and Traveller community, and insights from that meeting had been taken on board. Also, vaccines for homeless people were being brought forward in terms of priority, in order to offer vaccinations to homeless people when they were more accessible during the period of cold weather. The Senior Quality Manager added that in the Surrey Heath area (at the Lakeside site), special clinic sessions with fewer attendees and more allocated time had been set up especially for clinically extremely vulnerable people who might be concerned about attending busy clinic sessions.

6. A Member stated that there had been some publicity encouraging people who were not registered with a GP to come forward for a vaccination; this message seemed to have fallen away recently. Should this message be reintroduced? The Executive Director of Quality and Nursing responded that unregistered patients such as homeless people or private patients could contact a GP surgery to ask

to receive the vaccine. She agreed to raise the possibility of reemphasising this point with NHS England.

Recommendations:

The Select Committee congratulates Surrey Heartlands and Frimley Health and Care on the successful rollout of their Covid-19 Vaccination Programmes and recommends that they:

1. Ensure that the need to continue following government guidelines on social distancing and mask wearing is both verbally communicated to all residents at their vaccination appointments and included in a prominent position in all leaflets;
2. Expand their communications messaging to as wide a variety of social media websites and applications as possible to help tackle vaccine disinformation;
3. Ensure that those residents without access to mobile phones and/or the internet receive all required vaccination information in a timely manner, and that steps are taken to identify and support those who are digitally excluded as quickly as possible.

Actions/further information to be provided:

1. The Director of Public Health is to share with the Select Committee a link to intelligence on vaccine hesitancy data that is in the public domain;
2. The Associate Director of Communications and Engagement for Surrey Heartlands is to the share with the Select Committee a copy of the Equality Impact Assessment;
3. The Director of Public Health is to share with the Select Committee the initial findings of the Equalities, Engagement and Inclusion Working Group;
4. The Associate Director of Communications and Engagement for Surrey Heartlands is to raise with NHS England the issue of including in communications messaging data on the success of the vaccination programme to date and evidence of the protection vaccines provide after the first dose;
5. The Executive Director of Quality and Nursing for the Frimley Collaborative is to raise with NHS England the possible reintroduction of messaging around residents not needing to be registered with a GP to receive a vaccine.

16/21 GENERAL PRACTICE INTEGRATED MENTAL HEALTH SERVICE OVERVIEW AND SERVICE MODEL [Item 6]

Witnesses:

Georgina Foulds, Associate Director for Primary and Community Transformation, Surrey and Borders Partnership
Rebecca Isherwood-Smith, Interim Mental Health Programme Lead, Surrey Heartlands
Dr David Kirkpatrick, Clinical/Managerial Lead (Integrating Primary and Mental Health Care), Surrey and Borders Partnership
Dr Maria Nyekiova, GP Partner and Mental Health Lead for COCO Primary Care Network
Paris Wilson, GP IMHS Service User

Key points raised during the discussion:

1. The Clinical/Managerial Lead introduced the report, emphasising the importance of configuring mental health services in a way that was not harmful itself to service users' mental health (for example, a high threshold for access to the service could cause deterioration of the mental health of someone who has just failed to meet the threshold). The introduction of the General Practice Integrated Mental Health Service (GPIMHS) aimed to help resolve this. The quality of service users' experience of accessing care was as important as the quality of the care that they were accessing. Social determinants of mental health could not be resolved by the mental health foundation trust alone; this must also involve the community. Surrey was fortunate to have a high standard of mental health services in general and strong links between partners, including the voluntary sector and primary care.

2. The Clinical/Managerial Lead continued to explain that it was important to have good mental health services in place in GP surgeries so that mental health issues could be recognised at the first point of contact and in order to ensure primary care staff felt supported with the skills to provide mental health support. GPIMHS would allow residents to go to a GP surgery and quickly have access to a mental health professional or Community Connector without having to reach a high threshold. GPIMHS was part of a vision for a 'no wrong door' system; in other words, the idea that residents would be able to access consistently high-quality mental health services by presenting initially anywhere in the system. The Clinical/Managerial Lead showed a case study, which illustrated the experience of a GPIMHS service user who was able to access help quickly and felt well-informed. Also, carers were an important part of mental health services, and were often not taken into account as much as they should be. Whether the service user had a carer or was a carer – including a young carer in particular – would always be taken into account as part of GPIMHS.

3. The GP Partner and Mental Health Lead for the COCO Primary Care Network (PCN) stated that prior to GPIMHS, many patients would experience a disconnect between the criteria for different services, meaning they would become stuck in a cycle and struggle to access the support they needed. GPIMHS, on the other hand, provided a useful bridge between primary care, secondary care and the community, and would hopefully resolve this disconnect. GPIMHS allowed for communication between multiple agencies – including, for example, substance abuse services and housing services – and could therefore be tailored to service users' individual needs. This may also allow for multiple mental health conditions to be recognised more easily. Since GPIMHS had been introduced, patients' care had improved significantly.

4. The GPIMHS Service User detailed her experience of the service. Having been discharged from the community mental health service in a London borough, she was subsequently disappointed in the comparatively inefficient mental health services she experienced after returning to Surrey. In Surrey, she tried to access the Community Mental Health Recovery Services (CMHRS) and Improving Access to Psychological Therapies (IAPT) services but did not meet the

threshold of criteria for these. She returned to her GP and asked to stop being referred to CMHRS, as it was proving unhelpful, at which point her GP told her about GPIMHS. Her GP referred her to GPIMHS who were significantly better than other mental health services she had experienced: GPIMHS staff were helpful and kind, she felt listened to and supported by psychiatrists, and she felt that they were comfortable with managing her psychiatric medication, whereas staff in other services had not seemed comfortable with this. GPIMHS focused not on her diagnoses, but rather on the actual symptoms that she was experiencing, which was helpful. Her only concern was that GPIMHS had not been publicised well enough – she had not heard of the service prior to her referral – and she wished she could have been referred there more quickly.

5. The Chief Executive Officer of the Mary Frances Trust agreed with the comments made so far and stated that referrals to Community Connections services had increased significantly in areas where GPIMHS operated. In the past, Community Connections would struggle to receive direct referrals from GPs, but GPIMHS had helped change this. GPIMHS had provided an important link between primary and secondary mental health services.

6. The Chair of the Independent Mental Health Network (IMHN) expressed concern that the CMHRS in Surrey did not work well and this could lead to deterioration in people's mental wellbeing.

7. The Chair of the IMHN asked who would run the carers' support groups mentioned in the report. The Clinical/Managerial Lead replied that this was part of the managing emotions pathway (MEP), which could involve self-referral.

8. The Chair of the IMHN asked whether the reablement pilot mentioned in the report was the same as the enabling independence programme. The Associate Director for Primary and Community Transformation explained that these were different, and the reablement pilot was a new programme. It had been delayed because of recruitment difficulties. The pilot would run for a year and would be integrated with GPIMHS. During this year, the progress of the pilot would be reviewed every six weeks. The pilot would be able to deliver some services that GPIMHS and MHICS (mental health integrated community services) could not deliver, such a conducting home visits.

9. The Chair of the IMHN enquired what the referral rate to the reablement pilot was for black, Asian and minority ethnic (BAME) people and people with long-term health conditions. The Clinical/Managerial Lead agreed to provide this information.

10. The Chair of the IMHN questioned why GPIMHS could not conduct face-to-face appointments during the Covid-19 lockdown, while other services such as safe havens and some GP appointments were offered face-to-face. The GP Partner responded that, if it was deemed necessary for the patient, GPIMHS appointments could be held face-to-face, but this required a large room with the windows open, and the wearing of face shields, in order to decrease the risk of coronavirus transmission. While GP appointments were typically only around

seven minutes long, GPIMHS appointments lasted from 30 minutes to an hour, meaning the risk of transmission was higher. The Clinical/Managerial Lead added that there was certainly value in face-to-face appointments, and it was important to give patients the choice between having some appointments face-to-face and others as telephone or video appointments. As Covid-19 restrictions were lifted, this would be communicated to PCNs.

11. The Chair of the IMHN suggested that, as well as telephone appointments, video appointments should continue to be offered to people with known mental health needs, even after the pandemic. The Associate Director for Primary and Community Transformation agreed to explore this.

12. A Member praised the report and the success of the GPIMHS programme. He asked whether there were funding issues, how likely it was that the service would receive sufficient funding, and how staffing issues could be addressed early to ensure that funding would not be refused due to staffing issues. The Associate Director for Primary and Community Transformation stated that funding issues had not yet been resolved. At present, the decision on the amount of funding to be provided to the transformation programme was being processed across NHS system partners. The service was doing everything it could to support sufficient funding for GPIMHS, and GPIMHS representatives would be meeting with NHS England soon in order to understand funding streams over the next few years. While this was not yet resolved, it was being worked on and the Select Committee's support in pushing for the funding was appreciated. The plans for the GPIMHS service had been approved and the service was preparing to mobilise expansion in the next one to two years; it was just the detail of the finances that remained to be resolved. Moreover, there was concern about staffing and recruitment to GPIMHS. The service had been fortunate in recruitment so far, and the innovative way of working was attractive to potential staff. While the Associate Director could not give complete assurance on recruitment in future, the service had done well with recruitment so far. It was also important to ensure that GPIMHS did not drain staff from core services.

13. The Select Committee expressed its eagerness to support GPIMHS. In addition to supporting the programme in the recommendations of this meeting, further ways that the Select Committee could offer its support would continue to be explored.

14. The Clinical/Managerial Lead explained that a potential challenge for GPIMHS that was currently being overshadowed by the Covid-19 pandemic was the stock of rooms and clinical spaces at primary care sites that could be used for face-to-face GPIMHS appointments. This would prove a key issue once the pandemic had subsided. A Member suggested that community or high-street spaces could be used for GPIMHS appointments if there was not sufficient space in GP surgeries. The GP Partner responded that the possibility of holding some appointments in community or high-street spaces could be explored, but when seeing some higher-risk patients, GPs may require access to an alarm bell for their own safety. There were lots of benefits

to hosting multiple services in the same building, but the services offered had simply outgrown the buildings.

15. A Member asked what support was offered to people in the 18-25 age group specifically. The Interim Mental Health Programme Lead responded that a young adult reference group had been created in order to incorporate young people's views into mental health work. These groups included a variety of stakeholders, such as carers and CAMHS (child and adolescent mental health services) staff. The work of the reference group had included workshops, surveys, focus groups and user voice participation groups. A key outcome of this work was the notion of providing transition packs to young people to prepare them for the transition from children's to adults' services. Another finding was the importance of training for clinicians on the use of language, particularly when interacting with people who had recently transferred from children's to adults' services. Moreover, the service was looking at creating a young adults' section on the Healthy Surrey website or somewhere similar, to make it easy for young adults to access tailored information in one place. The GPIMHS Service User, who had been involved in the young adult reference group, added that the group had discussed piloting young safe havens especially for young adults, as young adults sometimes felt that they could not access the more general safe havens that currently existed. The Select Committee requested more information about young safe havens and written copies of the introductions witnesses had provided to this item, if possible.

16. A Member asked whether the service was engaging with young adults on platforms such as TikTok, with creative and fun content for young people. The Interim Mental Health Programme Lead stated that the young adult reference group fed into work on this.

Recommendations:

The Select Committee:

1. Offers its support for the GPIMHS and MHICS approach and will explore ways to assist its continued development;
2. Acknowledges that in Surrey Heartlands conversations are happening about the acceleration of the GPIMHS rollout and encourages a rapid implementation of the service across the entirety of Surrey;
3. Requests a further update on the progress made regarding funding and workforce at a future meeting.

Actions/further information to be provided:

1. The Clinical/Managerial Lead (Integrating Primary and Mental Health Care) for Surrey and Borders Partnership is to share with the Select Committee the reablement pilot referral rates for BAME residents and people with long-term health conditions;
2. The Associate Director for Primary and Community Transformation for Surrey and Borders Partnership is to liaise with GPs on the possible continuation of offering video appointments for patients;
3. The Interim Mental Health Programme Lead for Surrey Heartlands is to provide the Select Committee with more information on the work being done regarding young safe havens;
4. Witnesses are to provide the Select Committee with written versions of the introductions they gave at the start of the item.

17/21 UPDATE ON THE IMPLEMENTATION OF MENTAL HEALTH TASK GROUP RECOMMENDATIONS [Item 7]

Witnesses:
Sinead Mooney, Cabinet Member for Adult Social Care, Public Health and Domestic Abuse
Stephen Murphy, Head of Mental Health Commissioning (Adult Services), Surrey Heartlands
Liz Uliasz, Assistant Director of Mental Health, Surrey County Council

Key points raised during the discussion:

1. The Chairman of the Select Committee informed those present that she had sent a letter to the Secretary of State for Health and Social Care on the work of the Mental Health Task Group and the possibility of further progress in this area. The letter is annexed to these minutes.

2. A Member asked how voluntary sector organisations were responding to the work that had arisen from the work of the Task Group, and whether they had seen any changes arising from it. The Assistant Director of Mental Health replied that the work of the Task Group had focused attention on what needed to be delivered and raised the profile of mental health. The Cabinet Member for Adult Social Care, Public Health and Domestic Abuse added that the Task Group's focus on the issue of commissioning of voluntary sector mental health services was important and had ensured a better approach.

3. The Chief Executive Officer of the Mary Frances Trust emphasised the usefulness of the Task Group's recommendations and stated that voluntary sector organisations were now being included more widely in work with NHS- or Council-run mental health organisations. However, there was still more work to be done, particularly around the commissioning of services; sometimes contracts and conditions were still not adequate from the point of view of voluntary sector organisations. Overall, though, a change had been made and voluntary sector organisations wished to see a continuation of this direction of travel. The Cabinet Member stated that it was important to note that longer-term contracts did not suit all providers; some providers preferred the flexibility of shorter-term contracts. In future, there would be a tailored approach to all contracts.

4. The Head of Mental Health Commissioning (Adult Services) emphasised the value of voluntary sector organisations, particularly with regards to patient experience. The possibility of a forum of providers was being considered.

5. A Member requested an update on the workforce resilience hub mentioned in the report. The Head of Mental Health Commissioning responded that the hub had originally been set up to in response to the Covid-19 pandemic, during which many health and social care staff had experienced extreme stress. The hub had started by primarily offering psychological therapies and had since been expanded to offer peer support. It was important to acknowledge that people often sought mental health support after the event and the service was mindful of the need to prepare for this. Also, the IAPT (improving

access to psychological therapies) service offered mental health support to as many people as needed it.

6. A Member enquired whether there would be mental health training for Members during the induction after the May 2021 local government election. The Cabinet Member acknowledged the importance of keeping the mental health agenda high-profile once new Members had joined the Council after the election, including ensuring Members had good knowledge on legislation and the political agenda with regards to mental health. She would research this and provide more information to the Select Committee.

7. The Cabinet Member mentioned the Mental Health Partnership Board, which had now had a few meetings and was in the process of agreeing its terms of reference. The Cabinet Member agreed to share the terms of reference with the Select Committee and to report back to the Select Committee on the progress made by the Board as part of the next update report on the Mental Health Task Group recommendations.

8. A Member asked whether the two wards that had been worked on at the Abraham Cowley Unit of St Peter's Hospital had now been completed. The Head of Mental Health Commissioning said that environmental improvement work on two wards had been completed, and work had begun on the third and final ward.

Recommendations:
The Select Committee:

1. Notes the significant work underway to implement the recommendations set out in the Mental Health Task Group;
2. Recognises the role of Priority 2 of the Health and Wellbeing Strategy, and the newly established Mental Health Partnership Board, in continuing to progress the mental health agenda, including the Mental Health Task Group recommendations;
3. Requests an update on the activity of the Mental Health Partnership Board in the next Mental Health Task Group recommendations update report.

Actions/further information to be provided:

1. The Cabinet Member for Adults, Public Health and Domestic Abuse is to update the Select Committee on the mental health awareness training offer for Members;
2. The Cabinet Member for Adults, Public Health and Domestic Abuse is to share with the Select Committee a copy of the terms of reference for the Mental Health Partnership Board, once agreed.

18/21 ADULT SOCIAL CARE DEBT [Item 8]

Witnesses:
Toni Carney, Head of Resources, Adult Social Care
Pamela Hassett, Lead Manager (Financial Assessment and Income Collection), Adult Social Care
Sinead Mooney, Cabinet Member for Adult Social Care, Public Health and Domestic Abuse

Key points raised during the discussion:

1. The Head of Resources gave an overview of the report. Income from collection of care charges from clients represented a significant section of the Adult Social Care (ASC) budget. There had been a reduction on income collected in this area this year compared to last year, which was largely due to the impact of the Covid-19 pandemic and the new discharge to assess model. It was important to note that the majority of people paid their care charges promptly. Direct Debit was the service's preferred method of collection, which was more popular with people whose charges were regular and consistent, and less popular with those whose charges fluctuated. The rate of Direct Debit use to pay care charges had remained static at 64%. The actual amount of debt overdue currently stood at circa £17m, but a large proportion of that amount was secured against property.

2. The Head of Resources continued to explain that the ASC income collection team had good working relationships with the Legal services, with whom they worked to recover debts. The Council had started using Money Claims Online, a service provided by HM Courts and Tribunals for claimants and defendants to make or respond to a money claim, and had had good results so far. This service would continue to be used for debts under £10,000. Also, the Council had employed Judge and Priestley Solicitors to work on 10 cases. The firm's specialist skills would help the Council with probate work, and the early indications were that the work with Judge and Priestley was going well.

3. A Member requested that officers report back on the work with Judge and Priestley Solicitors once this had progressed.

4. A Member asked what could be done to increase the proportion of people who paid by Direct Debit above the 64% figure. The Head of Resources stated that, when conducting a financial assessment with a resident at the beginning of the care charges process, the officer conducting the assessment would always mention the Direct Debit option to the resident. Often people did not actually sign up to a Direct Debit at that stage, as they did not yet know the charges they would pay, but it was mentioned then and continued to be mentioned at every stage in the process. There were understandable reasons why someone might not want to pay by Direct Debit; for instance, if someone's care charges fluctuated, they may not want to use Direct Debit, and for some people having to pay a Direct Debit every month could be a financial worry. Residents could now pay care charges over the telephone, and the Council was looking at this and other ways to encourage payment in instances when residents preferred not to use Direct Debit to pay care charges. At a later date, the Council would also conduct a campaign encouraging use of Direct Debit.

5. A Member asked what benefits would arise out of the replacement of SAP with a new enterprise resource planning (ERP) system. The Head of Resources replied that the service was hoping to achieve better age debt reporting through the new ERP system, which would be available from December 2021 onwards. It was also hoped that the new system would improve the understanding of age debt. The Member asked whether the new ERP system would allow for the

identification of patterns and pre-empting of problems in payment. The Head of Resources said that it was possible that this would be the case, but the real problem at the moment was age debt; clear analysis on age debt using the new ERP system would be useful. The Council would have to see what the new system could offer and then work using this.

6. A Member enquired whether the Council knew if the discharge to assess model, introduced during the Covid-19 pandemic, would be extended. The Head of Resources responded that a decision had not been made on this yet. It was hoped that the model would be extended, but as it stood it was due to end on 31 March 2021. However, the principles of discharge to assess would be extended and it might become the norm in future, as it ensured that adequate assessment on discharge from hospital was in place. The Council was working with NHS organisations to mitigate any negative impact of the cessation of discharge to assess funding.

7. The Head of Resources clarified that the 64% of clients who paid by Direct Debit roughly reflected the proportion of clients whose charges remained stable from payment to payment. Apart from this information, it had not been possible to analyse a profile of people who paid by Direct Debit, but it was hoped that the new ERP system would allow officers to do this.

Actions/further information to be provided:

1. The Head of Resources (Adult Social Care) is to provide the Select Committee with an update on the work being undertaken with Judge and Priestley Solicitors when it has progressed.

19/21 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 9]

The Select Committee noted the Recommendations Tracker and the Forward Work Programme.

The Chairman of the Select Committee requested that, as much as possible, the recommendations and actions were responded to within this Council term (before 6 May 2021).

20/21 DATE OF THE NEXT MEETING [Item 10]

The next meeting of the Adults and Health Select Committee would be held on 14 July 2021.

Meeting ended at: 1.04 pm

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Chairman

Response from Director of Public Health to supplementary public question asked at 3 March 2021 Adults and Health Select Committee meeting

Hospital admissions and deaths for the registered Surrey Heartlands Care Home population are shown in the table below. Please note that these number will include Surrey Heartlands patients that may be in care homes outside of the Surrey area.

Numbers Below Can Be Shared Outside Organisation	
Total Care Home Hospital Admissions (Dec - Feb)	3881
Care Home COVID Admissions (Dec - Feb)	341
Proportion of Care Home COVID Admissions	8.79%

Care Home COVID Hospital Deaths - SUS (Dec - Feb)	133
Overall Care Home Deaths - National Mortaltiy (Dec-Feb)	359

The figures listed are obtained from two data sources:

- The monthly hospital SUS data for inpatient admissions
- The national mortality dataset

Both datasets are matched to a list of care home patients based on the NHS number. The list of Care Home patients is obtained using a matching score of the patients address and postcode against that of the care home and only a score above 50% will be flagged as a care home patient. The data range is from Dec 2020 to Feb 2021 and has been captured on any activity that includes COVID-19 diagnosis. This may include admissions or deaths from other causes where COVID-19 was also diagnosed. All deaths recorded in the SUS data only represent the care home residents who died in hospital.

Care Quality Commission publishes data showing death notifications involving COVID-19 received from individual care homes. Data from the Care Quality Commission (CQC) shows that between 2nd December 2020 and 28th February 2021, there were 579 COVID-19 related deaths reported across 200 care homes in Surrey (of these 465 were COVID-19 confirmed and 114 were reported as COVID-19 suspected). These figures relate to deaths where the person's normal residence is a care home (regardless of whether the death occurred in hospital, in the care home or in another location). *It is important to note that many of the homes were completely closed during the December/January period and due to restrictions of visits by family and professionals deaths were reported by the Care Home managers and not necessarily confirmed as COVID-19 by GPs.*

The Care Quality Commission (CQC) has published data showing death notifications involving COVID-19 received from individual care homes between 10 April 2020 and 31 March 2021. This is accompanied by a CQC Insight report which draws from the data to make the key points and provides crucial context for understanding what this data says.

Vaccine deployment: "COVID-19 vaccination: a guide for social care staff" was published by Public Health England on 7th December 2020. Vaccine rollout commenced rapidly in Priority Group 1: *Residents in a care home for older adults and staff working in care homes for older adults*. On 14th January 2021, COVID-19 vaccine deployment programme commenced in priority Group 2: *All those 80 years of age and over and frontline health and social care workers*.

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ADULTS AND HEALTH SELECT COMMITTEE

20 OCTOBER 2021

ENABLING YOU WITH TECHNOLOGY TRANSFORMATION PROGRAMME

Purpose of report: To update the Adults and Health Select Committee on the Enabling You with Technology (Technology Enabled Care) Transformation Programme.

Introduction

1. Technology enabled care is a broad term that can include telecare, telehealth telemedicine, etc. and is the use of technology to assist people with activities of daily living, such as personal alarms, monitors, sensors, smart plugs, pulse oximeters, self-care apps, falls devices, etc.

2. The purpose of the "Enabling You with Technology" transformation programme is to design and deliver a technology enabled care offer for people with eligible social care needs and for self-funders to purchase, with the aim of supporting people to live independently in their own homes for as long as possible. Technology enabled care can enhance the care and support provided by carers and others, right-size the care package required and, in some cases, replace or reduce the need for personal care, thereby increasing independence.

3. The programme is in the early design phase, testing technology and approaches prior to rolling out a service county-wide. Therefore, it is not yet fully operational in any one locality, but the aim is to achieve a county-wide service by 2023/24.

Current technology enabled care landscape in Surrey

4. District and Borough Councils provide telecare services in Surrey; these are the traditional community alarms and pendant devices to enable people living at home to raise an alert when a person falls or needs urgent assistance. These are well established services and around 16,000 people benefit from the traditional telecare service. This generates an estimated gross income of £3.4 million for the District and Borough Councils, with any net income generally invested in other discretionary services to support people at home. The District and Borough Councils have a varied approach to telecare and to developing a wider technology enabled care offer; some are innovative and keen to trial different technologies, others are more traditional in the service they offer. There are different monitoring arrangements in place, with some monitoring taking place

locally and other monitoring services outsourced to providers outside of Surrey. There are also different pricing structures. A consistent Surrey-wide technology enabled care offer may be challenging to achieve as it is important that any new service does not disrupt existing services for Surrey residents.

5. Adult Social Care currently pays for the equipment, installation and monitoring of around 500 people who are assessed as having eligible needs under the Care Act, where it has been determined they would benefit from a community alarm or pendant alarm. In addition, a further 1,300 people have their monitoring costs disregarded from their available income when determining the amount of any contribution they should make to their Adult Social Care support. This means that Adult Social Care is supporting around 1,800 residents with their current telecare service. Though this is traditional in both the delivery and the outcomes achieved, it provides essential reassurance to people receiving the service.

Background to the Enabling You with Technology programme

6. Adult Social Care had been investigating models of technology enabled care used elsewhere for some time and determined that there was no single model or design of a technology enabled care service that was both prevalent and highly effective. Given the current landscape in Surrey with the District and Borough Councils being the main providers, in August 2020, we commissioned Public Digital Ltd, a digital transformation company to undertake a discovery phase focussed on research with a range of users: people in or recently discharged from Adult Social Care's reablement service, friends and family of people who had recent experience of Adult Social Care, reablement staff, care technology installers, and third sector providers. We also appointed an expert from the TSA, the technology enabled care Services Association (the trade body responsible for monitoring standards), to provide some consultancy advice during the discovery phase. The purpose of the discovery phase was to help Adult Social Care determine how we might develop a technology enabled care service that would focus on the needs of users and deliver transformational change based on evidence.

7. In the final report from Public Digital Ltd, they recommended nine key activities to improve the current use of technology enabled care. However, their overarching recommendation was to incrementally enhance the Surrey-wide offer through partnership with organisations across the county, including District and Borough Councils. They further recommended that Adult Social Care focus on the nine activities by working with a small number of partners to begin with to trial technology and processes, expanding over time. The key activities were:

    - Change Staffing Approach: embedding care technology more in staff roles, training and processes
    - Trial an accident response service: a service that can go out to help people in crisis
    - Set-up a kit dispensary service: take-home kit at the point of need for quick discharge in hospitals
    - Set-up a Community of Practice: to create the network and help the sum of the parts work better together

- Develop data dashboards: to understand what is happening
- Undertake simple monitoring and reporting: technology in the home to know how a person is doing
- Share simple information about service users: wider access to the 'softer' information about individuals
- Digital by Default processes: digitising internal processes to remove paper and duplication
- Provide a digital service that provides simple, clear information about what helps: fixing the confused and outdated web estate with some well-designed content and digital services

The overarching recommendation from Public Digital Ltd and the nine activities shaped the first phase of a pilot working with Mole Valley District Council.

Design Phase 1

8. Mole Valley District Council (MVDC) were chosen as our first District and Borough Council partner because they had been trialling new technology for some time and they were keen to do more to improve the technology enabled care on offer. They have their own Alarm Receiving Centre (ARC) in Leatherhead and they are experienced in monitoring residents both within and outside of Surrey, with around 15,000 current connections to their ARC. In addition to Mole Valley residents, they provide installation and monitoring services to residents in Reigate and Banstead Borough Council and Tandridge District Council. They also provide a monitoring service to Epsom and Ewell Borough Council and are TSA accredited.

9. The first design phase of the Enabling You with Technology programme was focussed on "design by doing", working in an agile way with MVDC to test out technology, share learning, working through challenges and opportunities together. The significant "new" technology was Cascade3d, an IoT (Internet of Things) data and analytics platform connected to sensors, smart plugs and other devices. The sensors monitor air temperature and movement. Monitoring is discreet; there are no cameras, though people do need to be able to consent to the service and we would not use the system without the necessary consents in place. The key point to note here, is that it is the data and analytics platform that has the potential to transform the way care and support is delivered by using the data to determine care needs, spot deterioration and need for intervention and provide reassurance that all is well.

10. Adult Social Care, through Surrey County Council Transformation programme funding, purchased 40 kits which we now own and can recycle. We also paid for the licences and monitoring for six months and Cascade3d provided a further six months licences free of charge. The future pricing model is under discussion and costs are commercially sensitive at this time. However, we will be able to provide

further details of the costs when we launch the self-funder model with MVDC early in the new year.

11. The first phase was very successful in terms of partnership working with MVDC. We focussed on the frailty pathway working with Adult Social Care's reablement service and with people recently discharged from hospital. Joint visits were undertaken by Adult Social Care staff and a Trusted Advisor from MVDC to assess the technology needed on an individual basis. This approach was key to learning the benefits of the technology. We offered technology to a wide range of people in order to understand how impactful the sensors and the data could be in supporting people in their own homes. Additionally, Adult Social Care and MVDC worked together with Cascade3d to design the dashboard that provides the alerts and monitoring data to respond appropriately.

12. The first phase started in January 2021 and we quickly expanded the use of the technology into the Adult Social Care locality team in Mole Valley, as Adult Social Care staff could see the benefits of using the technology to support people at home. During the first six months, we had 53 people using the technology (by recycling the kit), though some people have retained the technology for ongoing monitoring and support purposes as a preventative aid. The system can be used short term to help right-size the care and support a person needs and to provide reassurance to the person. The dashboard can also be made available to family carers and can help carers undertake their caring role whilst also achieving greater independence.

13. As stated previously, the benefits of this type of technology and the approach is the analysis of the data that is captured over time and how this can be used to support people in a proactive and preventative way. An example of this is where we were alerted through the data to the possibility that a person had a UTI (urinary tract infection) by noticing an increased frequency of visits to the bathroom outside the normal routine of the person. The concern was raised with the community nurse, who confirmed the UTI and was able to secure antibiotics for the individual and probably avoided a return to hospital for that person. In another case, an individual was discharged from hospital with a substantial 24-hour home care package recommended by clinicians, as the ward observed frequent visits to the toilet at night and he was deemed to be at risk of falls. Cascade3d was installed and his lifeline alarm was upgraded to a falls detector. The data from Cascade3d showed that he was very mobile during the day and had hourly visits to the bathroom at night. The frequent night-time visits to the bathroom were investigated and no medical issues found. Using the evidence from Cascade3d, we were able to safely reduce the support to two visits per day.

14. Not everyone will be comfortable with the idea of using technology or having sensors in their home and an important part of introducing technology to people is supporting people to understand how it works. In one case, on discharge from hospital a woman was discharged into a nursing home but wanted to return to her own home. Her son was advised that a discharge home would be unsafe without

24-hour support in place. The son initially moved in with his mother to provide support, but this arrangement was not sustainable, so remote monitoring sensors were installed. However, the son struggled with the technology. Surrey Coalition's Tech to Community Connect project was enlisted to help him view the dashboard and interpret information to provide assurance that his mother was safe. Giving access to the dashboard to family members enables family members/carers to be the first point of contact to provide support if they wish to do so. The feedback from family members and carers has been hugely positive, evidencing that the data provides significant reassurance to people and reduces anxiety.

15. Working with Surrey County Council's Communications Team, we have produced two short videos to share with people who have any concerns about the project and the technology we are using. These videos are available on the Council's website.

Design Phases 2 and 3

16. Design Phase 2 started in September and the focus in Phase 2 is to test the technology and the monitoring platform on a larger scale. We are rolling out the technology into the Reigate and Banstead and Tandridge areas, as both areas are covered by Mole Valley District Council. In Phase 2 we will be concentrating our efforts in supporting hospital discharges, specifically the discharge to assess pathway, whereby people are discharged from hospital before assessments are completed, so that people are assessed for ongoing support needs in their usual environment.

17. It is essential, in this phase, that we also understand the impact on the Adult Social Care workforce and MVDC of potentially monitoring a larger number of people at any one time. Further work is underway with MVDC and Cascade3d to refine the alerts, so that we are responding in appropriate circumstances and not overly involving ourselves in peoples' lives.

18. Phase 3 is in the early planning stage as we work towards trialling a mobile wellbeing and response service early in 2022 and a self-funder option. The initial proposal is to operate the mobile response service for 16 hours from 6am through to 10pm, 365 days per annum. Evidence from the Mole Valley ARC shows that most alerts are received during this period, suggesting that this would be the optimum time to trial a service. The trial is planned to run for a year to determine the benefits from the model and how we scale the service to a county-wide approach as well as understand the demand for the service from self-funders. The response service will be run by MVDC with wellbeing elements provided by working at pace with the relevant District and Borough Councils as well as our social care teams and other providers, connecting people to their community to support people to remain at home, looking to address issues such as social isolation, digital inclusion, etc. MVDC are in discussions with SECAmb about providing the training for the responders and further discussions are taking

place with SECAmb on the opportunity to work together, as we believe there will be system-wide benefits to operating a response service.

19. The model for a self-funder option would enable people to purchase the service to include the cost of the technology, the monitoring and response to alerts, and a subscription to the mobile response service. We know that some people move into residential care early due to feeling unsafe and socially isolated. If we can support people with an alternative option so that they can remain in their own homes for longer, the benefits for people are significant, including substantially reducing the costs to people who might self-fund their own care. Part of developing the self-funder model will also include looking at how residents could access this service online, the information they would need and will, in time, address the issues such as the outdated web estate.

20. Phase 3 will also involve the piloting of more technology enabled care solutions with our Learning Disability and Autism service and our Mental Health service. Working directly with our Learning Disability and Autism Service and with Surrey Choices, the project team have had some success with an initial pilot of HandiCalendar. This tool enables people to manage their activities of daily living independently but also enables carers and care workers to support individuals to achieve their goals. We are looking to expand the pilot now that day-time activities have resumed.

21. Adult Social Care's Transitions Team are piloting the use of Brain in the Hand, an app to assist people with activities such as travel training, managing anxiety, problem solving and decision making, and we are looking at a further pilot of a solution called AutonoMe to support the Preparation for Adulthood Transformation programme together with colleagues in Children's services.

22. Additionally, we have identified two new solutions we would like to pilot and are in discussions with the suppliers as to how we might design both pilots. The first of these solutions enables monitoring of individuals in a supported living environment and addresses the challenges of monitoring several people in a single property. The second solution is not currently deployed in an Adult Social Care service in the UK, but it could provide remote support for people open to Adult Social Care's Mental Health service. The app helps the individual monitor their mental health and wellbeing and provides tools to assist people with anxiety and other issues. The discussions for both pilots are in the early stages but more information can be provided when the commercial details are resolved. Trialling new technology in these services is different to the larger scale pilot with MVDC as our practitioners need to work directly with individuals.

23. An important part of piloting new technology is understanding the impact of using technology on the Adult Social Care workforce and whether we will need dedicated roles or some other model to enable technology to be a core feature of the service in the future. The next six months will help us assess the impact on our workforce and build this into any service remodelling that may take place.

24. An Equalities Impact Assessment (EIA) is underway, though communication and language barriers are addressed through our usual pathways, engaging with interpreters and advocates and partner organisations such as Sight for Surrey. The EIA will also specifically address how we can ensure that people who may be digitally excluded can be supported to use technology, and Surrey Coalition's Tech to Community Connect could be very beneficial in supporting this need.

Conclusions

25. In summary, the first phase of the frailty pilot proved the viability of technology enabled care, demonstrating benefits in the following areas:

- Supporting the assessment process and the rightsizing of care by providing evidence of improvement. This has resulted in an increase in care and support where a person has deteriorated but also proactive reductions in care when the data evidences a change in need
- Monitoring a person at risk of decline and allowing proactive interventions
- Providing reassurance to family members and carers in real time via the dashboard
- Providing reassurance to the person that they are being supported remotely in addition to face-to-face support they may receive
- Speeding up hospital discharge processes by adding an extra layer of assurance to all
- Keeping people in their own homes and delaying or avoiding the need for residential and nursing care, which can also have an impact on the cost of care for both Adult Social Care and the person

This phase of the pilot has enabled the identification of specific cohorts of people for whom technology enabled care is most beneficial, and these cohorts will be the main focus of the second phase as we move to test the benefits at scale.

Recommendations

The report is to be noted by all members of the Select Committee.

Next steps

- To progress Phase 2 of the transformation programme with the expansion of the pilots to Reigate and Banstead and Tandridge.

- To finalise plans for Phase 3 – the pilot of a mobile wellbeing and response service and development of a self-funder option.

Report contact

Toni Carney, Head of Resources and Caldicott Guardian, Adult Social Care (toni.carney@surreycc.gov.uk)

ADULTS AND HEALTH SELECT COMMITTEE

20 OCTOBER 2021

SURREY HEARTLANDS HEALTH AND CARE PARTNERSHIP COVID-19 RECOVERY PROGRAMME AND PREPARATION FOR WINTER PRESSURES

Purpose of report: To update the Select Committee on Surrey Heartlands' Recovery Programme and preparation for Winter Pressures (Surge Planning).

Introduction

1. The Covid-19 pandemic has been an enormous challenge and a period of significant change for health and care services. In Surrey Heartlands, our Recovery Programme aimed to meet the patient and citizen need arising from the pandemic. As the pandemic continued, the system adjusted to meet the needs of patients and citizens in a long-term sustainable way. We therefore reviewed the Recovery infrastructure and transitioned it into a long-term structure recognising the need for it to become 'business as usual'. This paper outlines the current position and transition.

2. We describe how the system has reviewed and learnt from the three waves of Covid-19 and how it intends to restore services plus maintain provision throughout the winter months. There is a clear focus on equity and a focused approach to **reducing health inequalities** and how we ensure we reach residents who most need our care.

3. The new infrastructure has embedded our learning and placed an infra-structure to Early Warn the system of any Covid-related impacts. This is also built within our Surge Planning, previously described as 'Winter Planning'. The paper describes the work that runs in parallel with other Covid-related work, such as the Mass Vaccination Programme, Testing and our Local People Plan; however, the Mass Vaccination Programme and Testing is not covered in this update.

Update following the writing of this paper

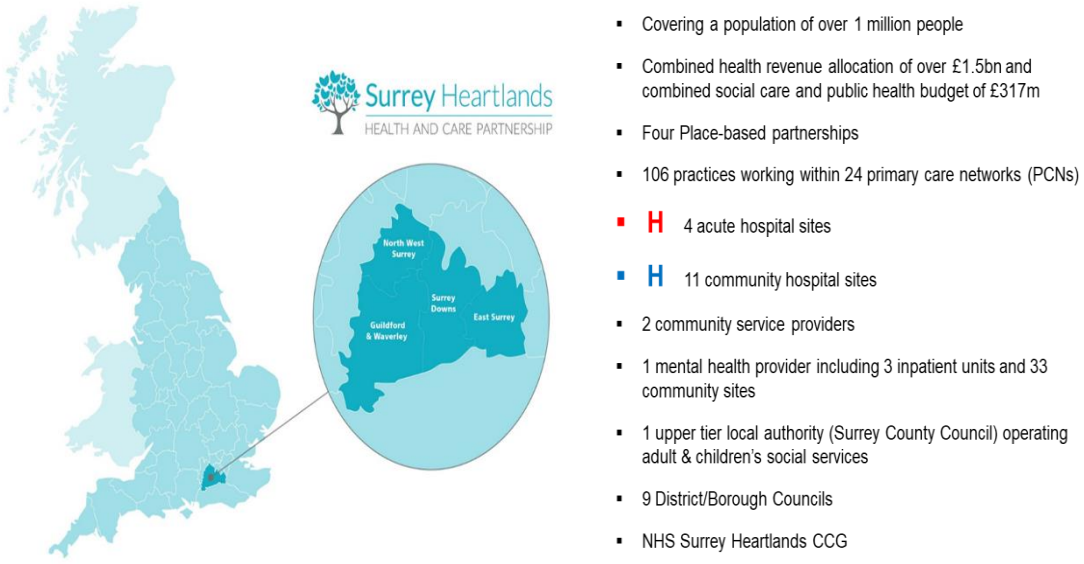
4. This paper was written at the beginning of October 2021 and represents the situation at that point in time. Due to the nature of the Covid-19 pandemic and

the progression of usual 'pressures' on health and care, the pressures on services can change rapidly. Rather than re-writing the paper to account for changes since the initial draft, a verbal update will be provided on the changes relevant to the Select Committee's discussion, bridging the gap between the time of writing and the meeting itself.

Introduction to Surrey Heartlands Integrated Care System

5. Surrey Heartlands Integrated Care System is a maturing partnership with the ambition to make a positive difference to local people and help join up health and social care. With 4 Integrated Care Partnerships (ICP), 4 acute Trusts, 2 community providers, 25 Primary Care Networks (PCN) working alongside the CCG, Surrey County Council (SCC), Surrey and Borders Partnership NHS Foundation Trust, and South East Coast Ambulance Service, we are an aspiring Anchor Network that has pledged to work together to make a lasting change, manage resources together, provide seamless care and enable employment opportunities that impact positively on the people we serve.

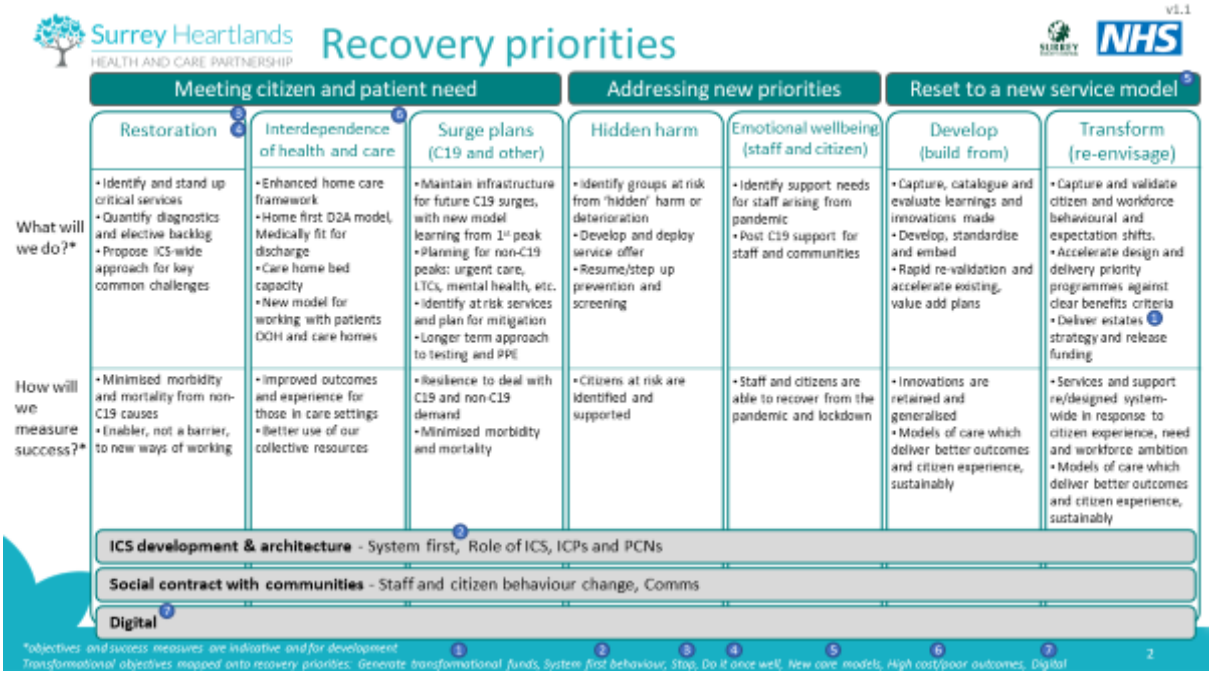
Fig 1 Surrey Heartlands Integrated Care System



Overview of the Recovery Programme and transition into Business As Usual

6. The Surrey Heartlands Recovery programme developed seven key Recovery Priorities based on a review of our strategic direction – including the Surrey Health and Wellbeing Strategy and our local response to the NHS Long Term Plan – in the light of Covid-19. They aimed to balance the immediate needs of restoring and maintaining services with the longer term need to learn the lessons of COVID and embed the positive work, which has happened through our response to the challenges it has presented.

✱Fig 2: Recovery priorities

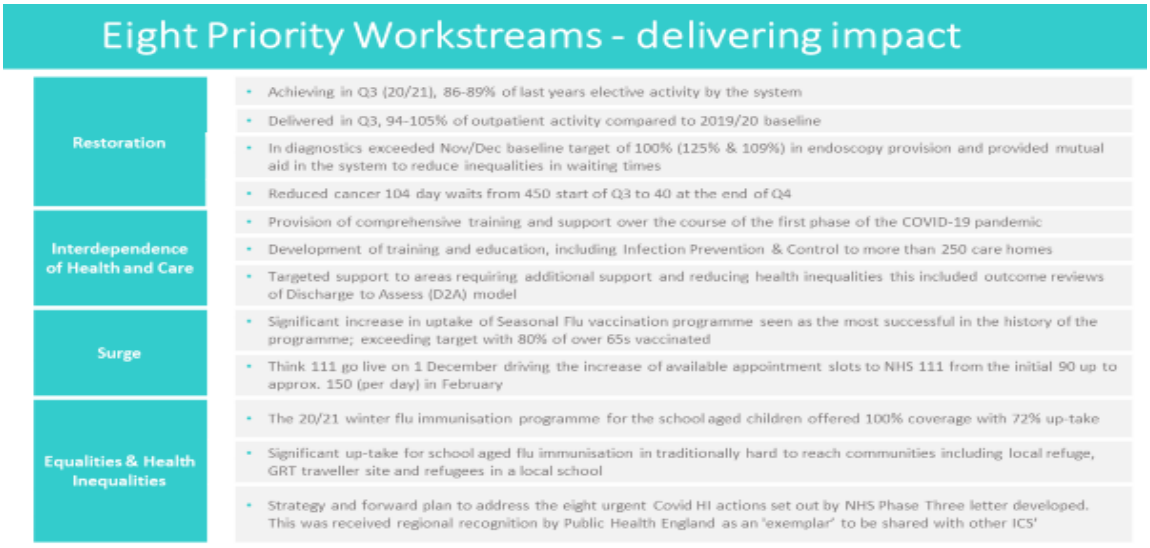


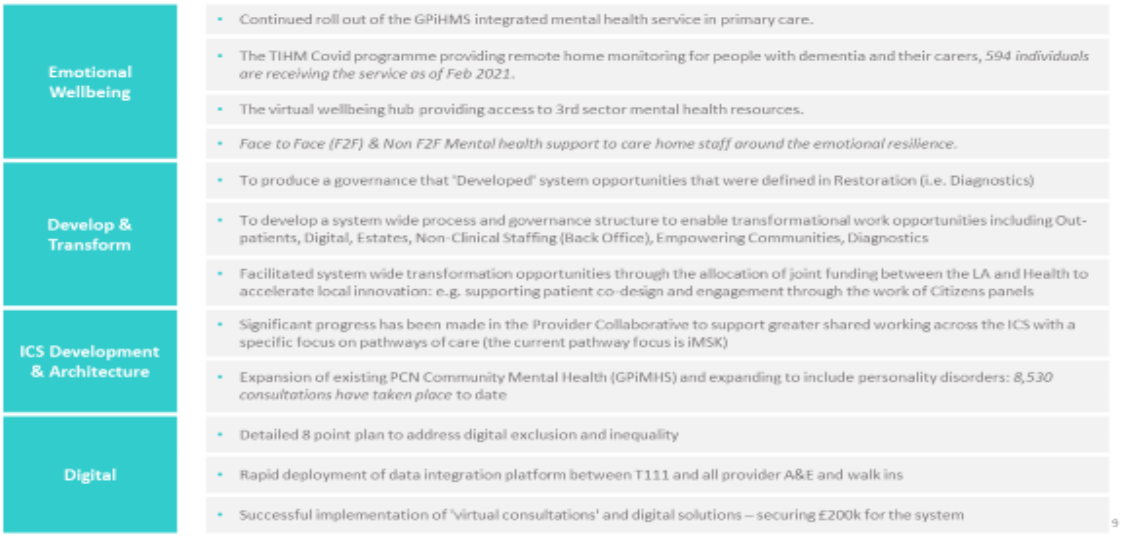
✱ NB: all graphs, tables and pictures are **repeated in Annex 1** to ensure that they are readable by those not reviewing papers electronically

7. The Recovery priorities were largely delivered through dedicated workstreams. However, where possible we overlayed the workstreams into existing structures in health and social care to create a strong link with 'Business as usual'.

8. Since the previous update the Priority workstreams have delivered significant benefit to the system and ensured the appropriate delivery of services within the constraints of the pandemic. The system when transferring to the now established long-term structure completed a stock-take; please see Fig 3 for areas of notable impact and performance.

Fig 3 Eight Priority Workstreams – delivery impact





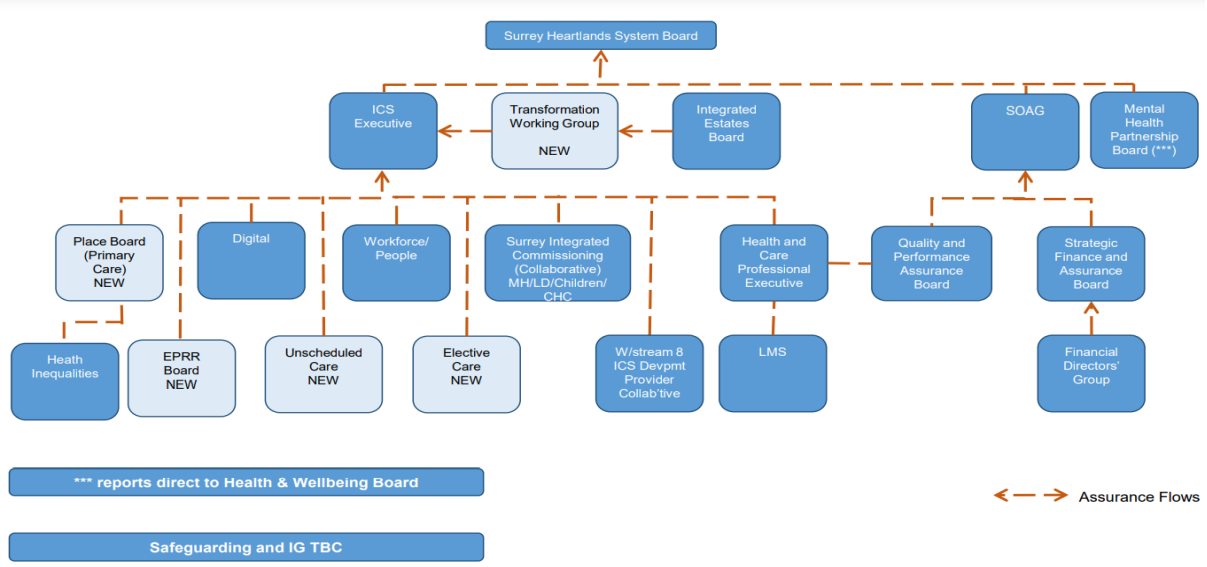
9. Additional to the stocktake to ensure that we have capture learning from both the first and second waves of Covid-19, we have also undergone a formal de-brief. The formal debrief of the ICS Incident Management Group (IMG) was held on 23 March 21 and a report was compiled and submitted to NHSE/I regional team. We also performed additional debriefing activities, such as an electronic questionnaire for CCG staff. The debrief identified positive responses to the way the system (ICS) communicated and engaged with its constituent partners and worked well across regional and geographical boundaries, for example mutual aid.

10. The learning from the Recovery Programme and the Covid-19 response has seen the development within the system from individual and organisational focus to instead partnerships with shared commitments and visions to improve the lives of our local population. The Operational Plan 2021-22 outlines in detail how we have learnt from the Recovery Programme and how we intend to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the Covid-19 pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes. Please follow the link for a copy of the plan: file (surreyheartlandsccg.nhs.uk)

11. The system as described in the Operational Plan 2021-22 has adjusted from a Recovery Programme to a long-term sustainable cross organisational structure, to meet the needs of patients and citizens in a sustainable way. The Recovery workstream infrastructure has transitioned into this structure, for instance the Restoration Priority workstream has transitioned into an Elective Care Board which now recognises the whole of the 'Elective Care Pathway'. A second example would be the Equality and Health Inequality Workstream which has combined with the 'Turning the Tide' Board and become a Board that considers both the issue of Equality and Health Inequalities for our citizens and patients

but also the workforce that supports this care. Please see Fig 4 for an outline of the new operational model and structure.

Fig 4 System (ICS) Governance Organogram



Restoration of services during the third wave:

12. In addition to the COVID patients who needed treatment, the pandemic has created other significant pressures on health services, in particular:

- Reduction in capacity due to a number of factors, including infection prevention and control requirements (e.g. fewer beds to maintain distance, enhanced cleaning between procedures) and workforce absence due to illness and self-isolation
- Increased backlog of patients waiting for diagnosis and treatment, due to the need to temporarily cease or reduce services
- Changes to patient behaviour. During lockdown many people reduced their contact with healthcare organisations. Changes to visitor policies also affected behaviour as patients were expected to attend appointments alone
- Effect on mental health and emotional wellbeing (see section below)

Elective Activity

13. Restoring planned services and access to unplanned services equitably has been a core principle of the NHS's recovery from the pandemic. Surrey Heartlands has worked closely with Regional NHS England and Improvement colleagues to agree appropriate yet achievable levels of activity that would start to impact on the long waits that had developed during the pandemic. All NHS organisations were asked to carry out more patient activity than took place in

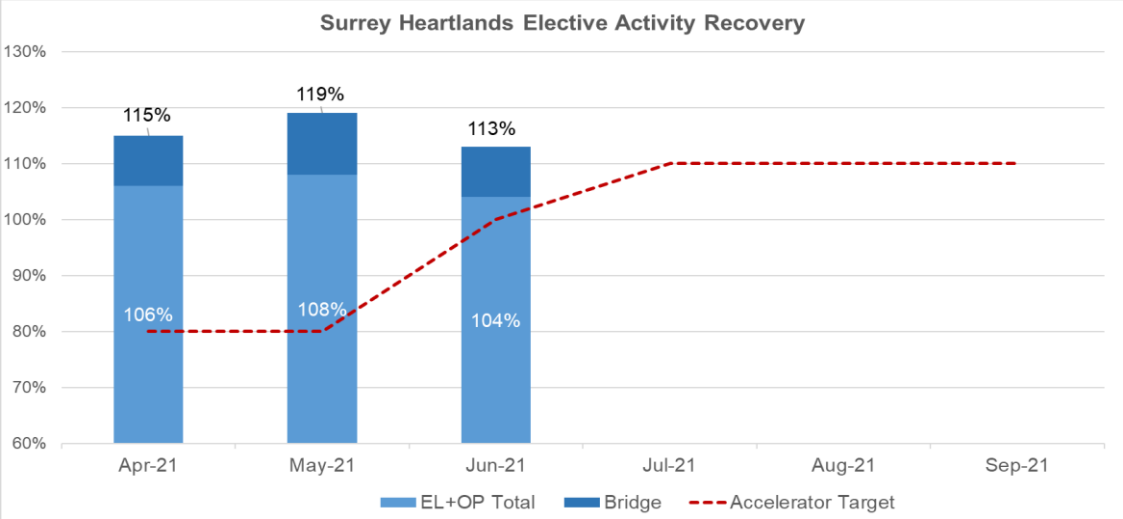
the period before the pandemic (19/20) to have the required impact. Focus has been on the following:

- Cohorts of our population that may not have accessed services as routinely during the pandemic. For example, we have a number of 'case findings' programmes related to specifical cancer pathways that have seen a reduced demand – lung and prostate in particular. In these programmes we invite an agreed cohort of our population to attend for a type of medical review and screening.

- Patients who have waited a long time for a diagnostic or surgical procedure. Specific focus has been on areas with especially long waits (due to high demand pre-pandemic), such as orthopaedics, eye services (ophthalmology) and ear, nose and throat. These specialties tend to have a higher levels of low priority surgery than other surgical specialties and therefore bore the brunt of the surgical cancellations from an early stage in the pandemic.

14. Activity data for Surrey Heartlands shows that in July 2021 the system delivered a higher level of activity than in the same month pre-pandemic (July 2019). This equated to 104% of the pre-pandemic level. Achieving a 4% increase in activity levels at a time when social distancing and infection control requirements had effectively reduced capacity is a significant achievement. It should also be noted that the NHS workforce have shown real dedication in delivering these high levels of activity at a time when many staff were also taking their much-deserved annual leave. In addition to this core activity, Surrey Heartlands has embedded a significant amount of the service transformation implemented during the pandemic. Many of these initiatives have seen activity delivered in different ways and patients cared for in their home environments wherever possible. If this activity is taken into consideration, Surrey Heartlands delivered closer to 13% above the July 2019 patient activity levels. This can be seen in the table below (additional transformational activity is referred to as 'Bridge').

Fig 5 2021 Elective Activity as a percentage of 2019 Elective Activity levels



Note: EL = elective spells and daycases, OP = outpatient attendances and procedures

15. By outperforming the pre-pandemic activity levels since April 2021, the system has made significant progress in reducing the volume of patients waiting long periods for diagnosis and treatment.

Long Waits – RTT, Cancer and Diagnostics

16. Seeing patients with long waits for diagnosis and treatment is a major priority for restoring services. We prioritised where longer waits are associated with higher clinical risk or poorer outcomes. All planned patients have been reviewed and allocated a clinical priority based on their part medical history and planned procedure. This review of all patients waiting has provided us with another filter with which to view and plan our patient care. Pre-pandemic patients were broadly seen in time order, whereas now we are able to combine time waited with clinical priority to ensure that we actively manage patient risk and treat the most vulnerable patients.

17. To help overcome patient reluctance, we proactively engaged with patients to encourage take up of assessment and treatment and contacted all planned care patients who have had their care disrupted. Consideration was given to patients who wished to wait for changes to lockdown rules and/or to receive one or both of their vaccinations. These patients have been enabled to wait safely by being given appropriate support whilst they wait.

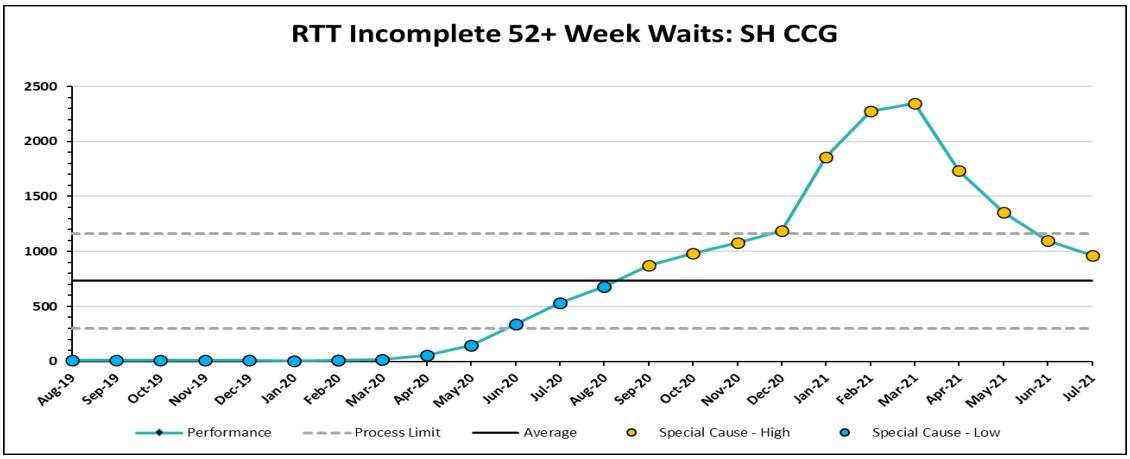
18. Surrey residents continue to have shorter waiting times than the majority of the country. The following figures are for Ashford & St Peters, Royal Surrey and Surrey & Sussex Hospitals combined to form the ICS position:

    - Patients seen who had waited more than 18 weeks for treatment have reduced from a peak of 28,000 in July 2020 to 17,000 in July 2021. Work

continues to reduce these further with the aim of returning to pre-Covid levels of approximately 8,500 patients waiting over 18 weeks.

- Surrey Heartlands CCG ranks first out of 106 CCGs in England as having the lowest number of patients waiting over 52 weeks.
- The volume of patients who have been waiting more than 52 weeks for treatment has reduced from a peak of 2,300 in March 2021 to 960 in July 2021. Pre-pandemic Surrey Heartlands had very few patients waiting over 52 weeks (average less than 10). It is our aim to recover to this position.
- Many systems have patients waiting over 104 weeks for planned care, but Surrey Heartlands is proud to have no patients waiting this length of time. The national expectation is that there should be no patients waiting over 104 by April 2022.

Fig 6: Number of patients waiting longer than 52 weeks for treatment

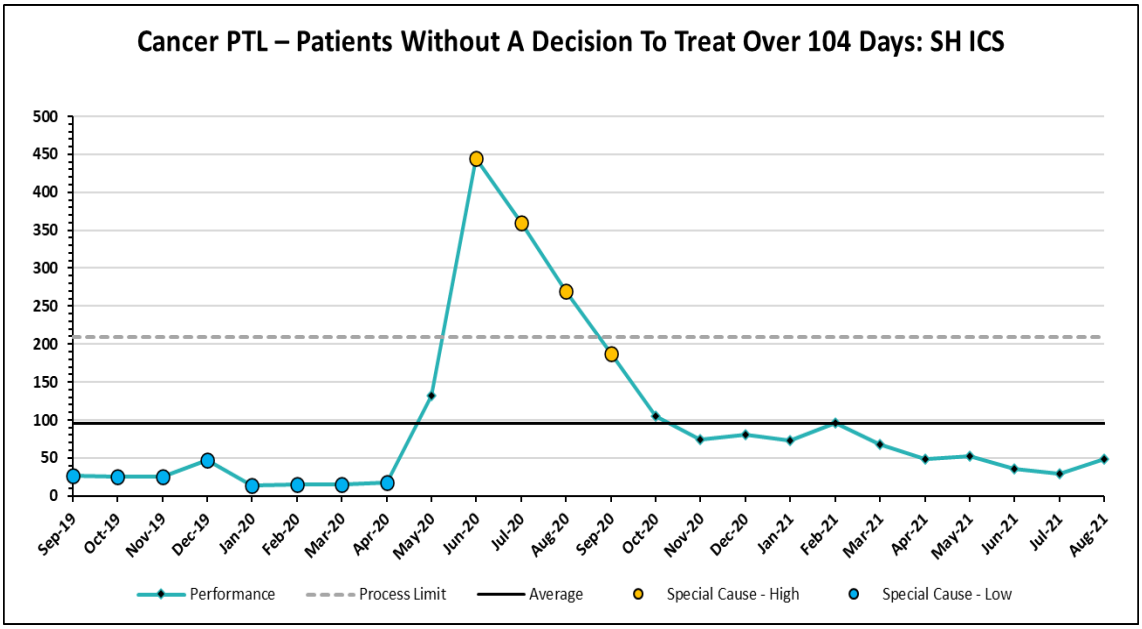


19. Patients on a cancer pathway are some of the highest clinical priorities. Cessation of diagnostics and treatments during the first wave led to a large increase in the number of patients waiting longer for treatment, with upper and lower gastro-intestinal and urology being challenges. Addressing this backlog of patients has been a top priority for Surrey Heartlands. Working with Surrey and Sussex Cancer Alliance, all our providers have placed significant effort into ensuring that patients are treated as soon as possible, with the result that the number of patients has fallen steadily since July. The following figures are for Ashford & St Peters, Royal Surrey and Surrey & Sussex Hospitals combined to form the ICS position:

- People on the cancer waiting list who have been waiting over 104 days for treatment has reduced from a peak of 445 in June 2020 to 48 in August 2021. Work continues to reduce these further with the aim of returning to pre-Covid levels of approximately 30.
- The majority of those waiting long periods largely have benign diagnoses, with some patients choosing to delay treatment or are on complex pathways.

- Surrey Heartlands ranks 4th out of 42 STPs (ICSs) for having among the lowest numbers of 104+ day cancer waits in England.

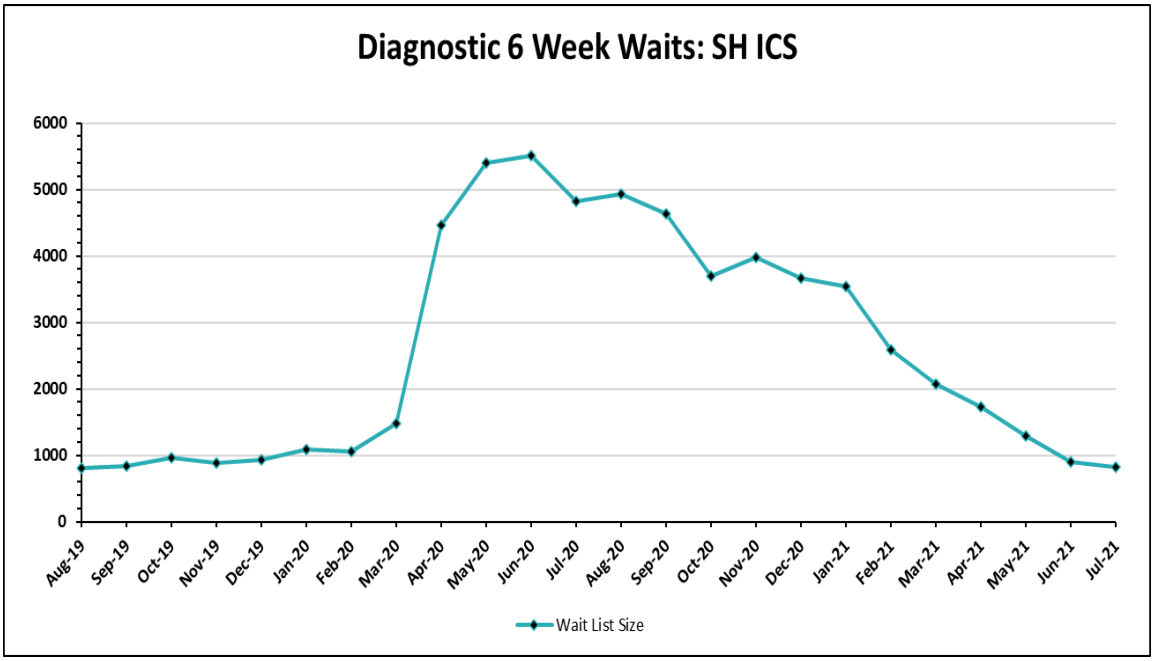
Fig 7: Cancer Patients waiting >104 days for treatment



20. Endoscopies were a key driver of long waits at the beginning of the pandemic, potentially for patients with suspected cancer. Endoscopies were also particularly affected by Covid-related infection prevention and control protocols, making the return to pre-Covid levels particularly challenging. However, the ICS has focused on solutions such as Faecal Immunochemical Test (FIT), plus creating capacity across the system. This has created significant improvement and reduced waits for these critical procedures. The following figures are for Ashford & St Peters, Royal Surrey and Surrey & Sussex Hospitals combined to form the ICS position:

- People on the diagnostics waiting list who have been waiting more than six weeks have reduced from a peak of approximately 5,500 in June 2020 to 820 in July 2021. This is now comparable to pre-Covid levels of around 880.
- People on the diagnostics waiting list who have been waiting more than 13 weeks have reduced from a peak of approximately 3,400 in June 2020 to 180 in July 2021. This is now comparable to pre-Covid levels of around 265.
- Surrey Heartlands CCG ranks 4th out of 106 CCGs as having among the lowest numbers of people waiting more than six weeks for diagnostics in England.

Fig 8 People waiting more than 6 weeks for diagnostics



21. The system has commenced development of activity and performance plans for the second half of 2021/22 (H2), which will include trajectories to further recover elective services and plan for winter pressures.

GP Appointments and Referrals

22. Digital solutions have been a key part of restoring primary care, although face-to-face appointments continue to be an important part of general practice, especially for patients or conditions which cannot easily be assessed remotely.

23. Data shows that although GP appointments dropped immediately after lockdown, they rapidly increased since May 2020 with an increasing proportion of appointments being conducted by video or telephone. We can now see how this additional activity has translated into increased GP referrals.

Fig 9 Primary Care Activity (Appointments and Online Consultations)

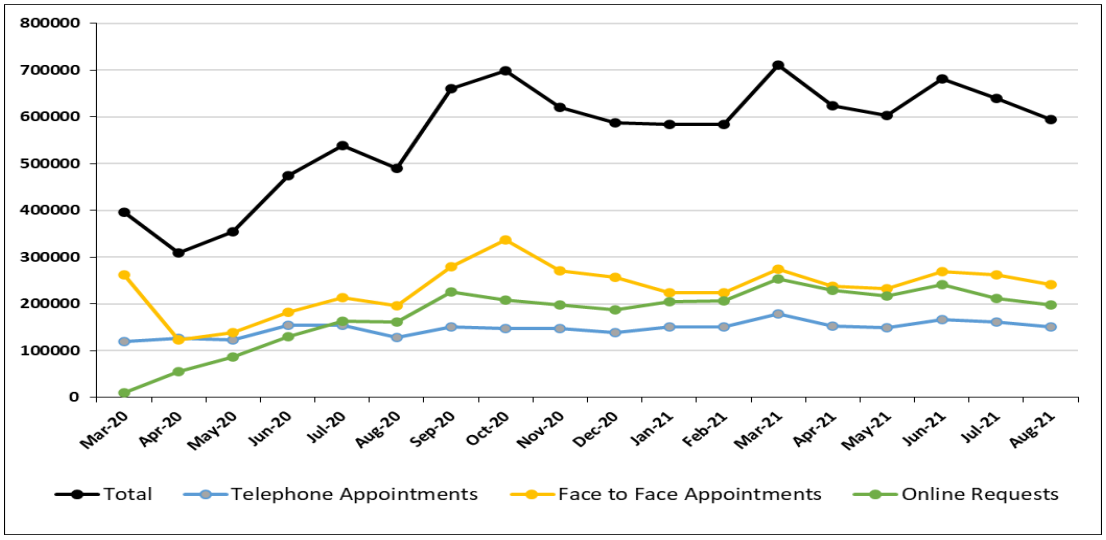
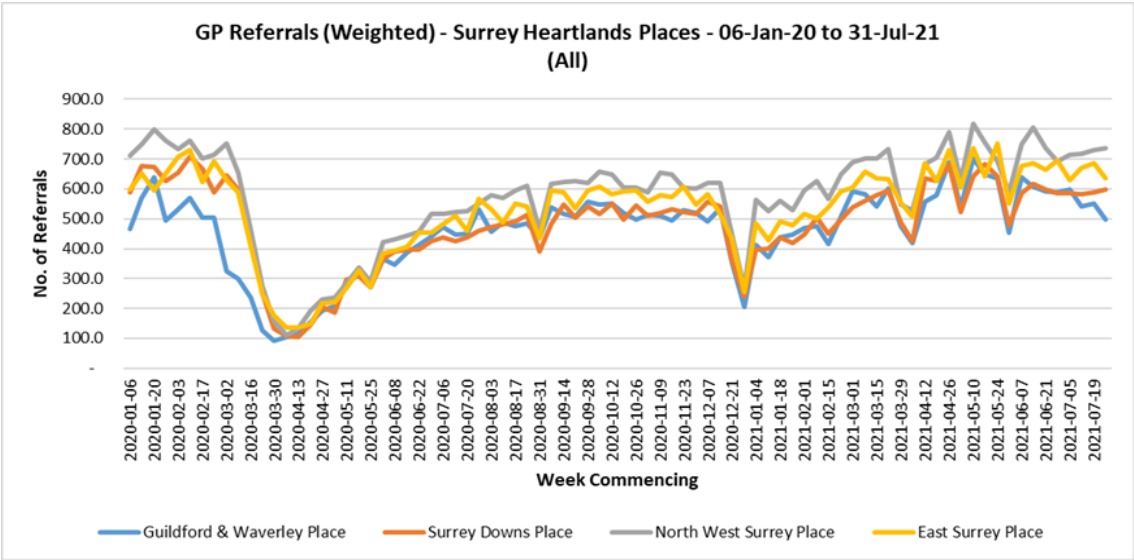


Fig 10 GP Referrals as ICS Total and by ICP



24. To ensure equitable care across the system, there has been detailed analytical work related to both Waiting Times and Referrals. Initial analysis of assessing the waiting lists did not highlight any observed differences in waiting times of patients by ethnicity, deprivation and/or gender. Initial analysis of assessing the referral data did not highlight any observed differences in referrals of patients pre-Covid to Covid, comparing BAME to Non-BAME. The data also confirmed previous finding on Virtual Consultations that points to ethnicity not being a confounding factor when accessing virtual care. We have also seen the maintenance of appropriate levels of referrals for people with Learning Disability plus Severe Mental Illness.

Preparation for Winter and Surge Planning

25. Using the learning over the past year, the System has prepared for Winter creating an agreed Surge Plan. Surge Plans consider not only the impact of Winter Pressures but also when there are potentially 'one-off events' such as Covid-19 resurgence, heatwaves, snow and sustained cold weather, and seasonal and pandemic influenza. It focuses on how the system should respond in a coordinated, planned and partnership way to manage and mitigate the risks these pose, often across organisational boundaries.

26. In summary, the plan utilises national, regional and local modelling from learnings in previous years demand, previous RSV (Respiratory Syncytial Virus) outbreaks and the Covid-19 pandemic to create a system approach to our planning, our capacity and our response at times of escalation. This is a shared approach with all key organisations agreeing the content and methodology. The organisations include:

    - Guildford & Waverley Integrated Care Partnership (ICP)
    - North West Surrey ICP
    - Surrey Downs ICP
    - East Surrey ICP
    - South East Coast Ambulance Service NHS Foundation Trust
    - Surrey and Borders Partnership NHS Foundation Trust
    - Practice Plus Group
    - NHS England South (South East)
    - Surrey County Council Adult Social Care

27. The Surge Plan includes clear escalation process for adult, paediatric and mental health services and considers in-depth:

    - Sustainable Corporate Governance
    - Integrated Care System Executive Governance
    - Sets out the risks and triggers for escalation and mutual aid
    - Sets out minimum expectations at each level of escalation
    - Clarifies roles and responsibilities
    - Sets consistent terminology/definitions
    - Defines communication processes, e.g. through agreed ICP and ICS System Call

28. The Plan also includes how the System prepares for such events, including Winter Pressures. This includes, but not exclusively, elements such as:

    - Sets out the demand and capacity modelling across:
        - Acute beds
        - Critical care beds (Oxygen, Continuous Positive Airway Pressure- CPAP and Ventilated)

    - Provision of Oxygen (O^2) across Trusts
    - Independent Hospital capacity availability and utilisation
    - PPE demand
    - Testing of acute patients
    - Apparent disproportionate effect on Black, Asian and Minority Ethnic (BAME) patients
    - ICP Community/out of hospital capacity – Hospice, community hospital, care homes
    - Workforce (Acute) – including disproportionate effect on BAME staff community
    - Excess Deaths – Mortuary capacity
- Tracking and surveillance of demand and capacity
- Identification of caps in capacity and supporting decision making
- Provision of a guide to Ethical Clinical Decision making

29. To ensure our focus in our preparation for Winter and Surge, Surrey Heartlands has developed a 10 Point Action Plan that reviews the key elements of our Urgent and Emergency Care response. This includes element such as our Community Engagement, Improvements in 111 and the steps taken to improve our transfer times and patient flow. The 10 Point Action Plan has analysed how the Region (South East England) plans to respond, how Surrey Heartland plans to respond and how each provider is planning in responding to this challenge. Please see Annex 3 for details.

30. Related to our preparedness for Winter and Surge is our ability to respond to a major incident. In co-ordinating any response to a major incident in the county, the NHS organisations, where needed in the response, including ambulance, acute, community and mental health Trusts, would work with other responders such as Police and Fire using the protocols set out in the Surrey Local Resilience Forum Emergency Response Plan. The plan has been well rehearsed and brings together partner organisations through tactical and strategic co-ordinating groups, as has been used for Covid-19 and most recently the fuel situation. Each organisation will have an incident management plan like Surrey Heartlands CCG and be supported by Incident Co-ordination Centres to manage the range of incidents and situations running at any one time. Where incidents create challenges for the response, partner organisations can request mutual aid from within the partnership or request assistance through national arrangements such as Military Aid to the Civil Authorities (MACA). Co-ordinating groups often have representation from the Department for Levelling Up, Housing and Communities Resilience Emergencies Division to share and receive messages from and to Government and, if necessary, to the Cabinet Office Briefing Room (COBR).

31. The Local Resilience Forum also includes representatives from the voluntary sector who also have a number of capabilities to offer, including support to the

ambulance service, 4x4 response and rest centre support, as well as search and rescue.

32. An Urgent and Emergency Care Early Warning System (EWS) has been developed which, in conjunction with the Covid Early Warning System, containing triggers and actions supported by the modelling. Triggers encompass all elements of the local health and social care system, Primary Care, Secondary Care, Community and Local Authority providers associated actions in times of surge detail those services that are required to alter or change configuration and planned levels of activity. The EWS will remain under constant review and subject to change as the peak seasonal demand unfolds. The Covid Early Warning System includes element such as Covid rates, Covid Vaccination rates, Covid Bed occupancy and Critical Care occupancy; this has allowed the system to consider the relationship between infection and vaccination rates but also its impact on bed capacity. Please see Annex 2 for an example Covid Early Warning System weekly report.

33. Through the third wave, numbers of Covid-19 patients in Intensive Therapy Units (ITUs) have remained at a manageable level. This is due to several factors, including lessons learned from the first and second wave, impact of vaccinations, the availability of treatments and non-invasive ventilation now that the disease is better understood. However, given the increased infection prevalence and the usual winter pressures expected, January is expected to be a particularly challenging period.

Impact of COVID and lockdown on mental health and emotional wellbeing

34. We are continuing to experience a surge in mental health and emotional wellbeing related demand due to the impact of pandemic, especially the periods of national lockdown, resulting social isolation and disruption in daily routine, e.g. school and employment.

35. Demand has remained high for some specialist mental health services. Refreshed data taken from the most recent NHS Benchmarking Report (July 2021) and local access information shows the current context in Surrey. Please note that the benchmarking data only covers NHS activity. Compared to the 2019/20 average, we have seen:

    - Changes in demand and access to services, with 57% more people referred to adult community services. Referrals to children's emotional wellbeing and mental health services remain above the national average and increased again in July. Caseloads are also above the national average and show a 28% increase in July 2021 compared to 2019/20. In response to the pressures across the Acute Paediatric wards and

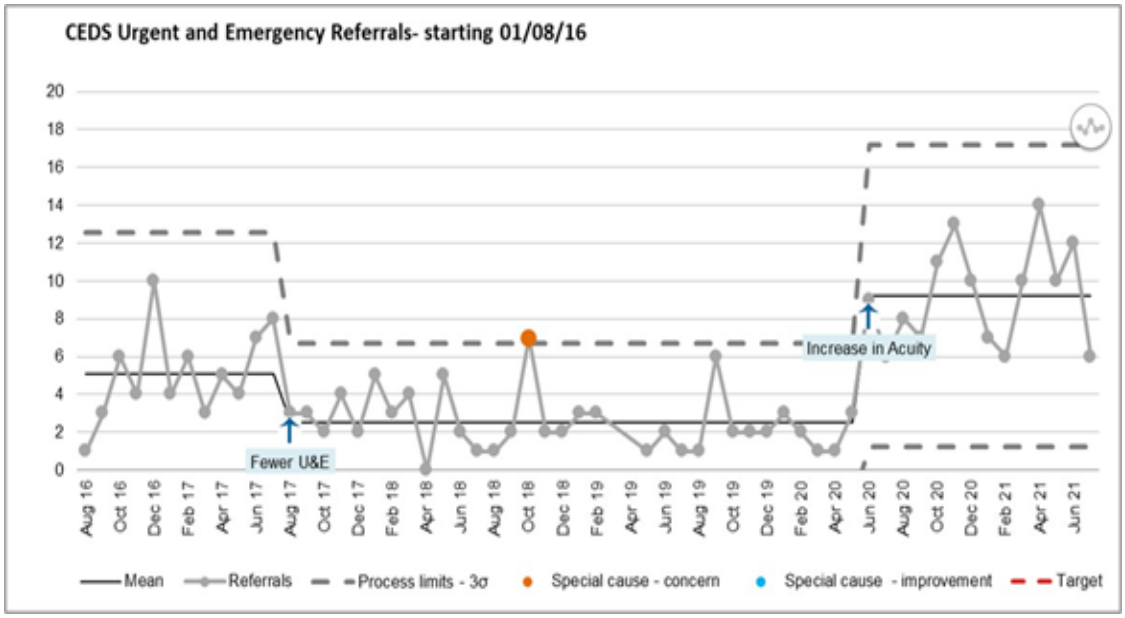
anticipated pressures due to RSV and winter, system leaders at ICS authorised the 'stepping up' of the CAMHS Crisis Pathway and support to Paediatric Wards.

- Changes in the level of complexity and acuity, with 30% more people referred to our Crisis Resolution Home Treatment Teams, an increase of 10% in Psychiatric Liaison teams' activity and acute bed occupancy rates of 93%, with a 28% increase in people detained under the Mental Health Act. Section 136 detentions (all age) have also increased by 15-20%. We have also seen unprecedented levels of people in crisis who were not previously known to services. Third sector and IAPT providers also report an increase in people with more complex needs accessing their services. We remain concerned about getting the best support possible for adults and children with autism and mental health needs presenting to services, and for adults and children with eating disorders.

- Changes in delivery, with in-person appointments doubling since January 2021 but a remaining focus on remote care delivery via telephone and video mediums. Sixty-three percent of adult community contacts and 79% of children's contracts were delivered virtually in June 2021.

- We have seen a significant increase on the demands for Children's Eating Disorder Services. The diagram below shows the peak volumes of urgent and emergency referrals for a sustained period.

Fig 11 Urgent and Emergency Referrals for Children's Eating Disorders from 01.08.2016



36. Integrated working is key to our current and ongoing response to mitigating demand and supporting earlier intervention. Service offers brought online or expanded include General Practice Integrated Mental Health Service

(GPIMHS), bereavement support, virtual safe havens, crisis pathway, fast track workforce wellbeing support, virtual wellbeing hub offering access to third sector interventions. The new Children's Emotional Wellbeing and Mental Health Service launched in April 2021 and is delivered through an alliance of NHS and third sector providers.

37. The Workforce Resilience Hub launched in January 2021 and the website has had 10,283 unique visitors. The landing page offers access to a range of self-help information and provides an access portal to additional support. 1,500 staff from across sectors have taken up either wellbeing workshops, direct 1:1 support, or team interventions. A number of staff have also been signposted to other services, e.g. their GP, IAPT or occupational health.

38. The pandemic has produced immense public support for the NHS and other essential workers, but it should be also be noted at times patients and the public have been understandably frustrated, but also less understandably abusive to staff. Each provider has established mechanisms to support staff and as a system we have created the Workforce Resilience Hub. Secondly each provider has developed 'conflict resolution' and 'customer care' training for its staff to aid in the de-escalation of potential abusive or tense situations.

Summary of Workforce Preparations

39. Surrey Heartlands Integrated Care System, with 4 Integrated Care Partnerships (ICP), 4 acute Trusts, 2 community providers, 25 Primary Care Networks (PCN) working alongside the CCG, Surrey County Council (SCC), Surrey and Borders Partnership NHS Foundation Trust and South East Coast Ambulance Service, makes it one of the largest employers in Surrey. We take pride in providing first-class careers and strive to ensure we have the right staff, with the right skills, who can provide high quality care to our population. Through our partnership and One Team approach, we will support our people to have successful and fulfilling careers in Surrey.

40. The past 20 months have been an extraordinary time for staff and the coming winter will be critical, as we seek to help staff recover, restore services and attract new talents to the services. Digital transformation has rapidly changed how staff work and patients access services. These changes will be built on for sustainable transformation over the longer term.

41. Workforce factors continue to pose limitations on the ability of services to meet current and future surge demands. Issues centre on the backlog of annual leave, simultaneous rollout of Covid-19 and flu vaccination programmes, general staff health and wellbeing, and the age profile of community care and primary care staff. These issues result in reduced capacity to respond to latent demand, which are further compounded by circulating Covid-19 infections,

unknown demand from Long Covid and increase patient acuity. To mitigate these risks, the system and individual providers have been proactive in their planning. For a detailed description please see pages 12-26 of the Operational Plan, link provided in Paragraph 10. For a summary of the key actions, please see below:

Fig 12 Key Workforce Risks and Mitigations

RISKS/ ISSUES	MITIGATIONS
Annual Leave – There is a risk that operational capacity may be impacted if a backlog of annual leave, and the potential sharp uptake of annual leave post lockdown, coupled with staff absence due to ongoing health and wellbeing concerns.	• Trusts have updated policies in relation to buying back / AL carry over • Annual leave monitoring and use of HRD Network and Surrey Heartlands People Board as escalation points • MOU in place to facilitate staff sharing across organisations.
Health & Wellbeing - Negative impact of Covid-19 pressures on staff wellbeing with potential for increasing levels of sickness absence if demand levels are sustained into the Autumn.	• All NHS providers have a Wellbeing Guardian function in place, along with the establishment of health and wellbeing groups. Health and wellbeing conversations are taking place both informally on a regular basis and formally on an annual basis, depending upon provider. • Moving forward with enhanced HWB and inclusive HWB programmes (includes HWB conversations and staff safety). • The Surrey Heartlands Resilience Hub provides access to health and wellbeing services. • Health and Wellbeing initiatives across the system include MHFA training, TRiM training, STRaW training, FTSU guardians, Staff Igloos at RSFT, Pods at SASH, and a new Wellbeing Centre at ASPH.
Recruitment and retention - Reduction in international recruitment rates due to several challenges (quarantine rules, agency delays, border controls, available mentors).	• Partners continue to manage recruitment of international staff internally, with escalation to the Resourcing Network and then Surrey Heartlands People Board where appropriate. • International Retention programme to commence in order to address issues related to turnover of internationally recruited staff • Vaccine Workforce Programme to commence in order to fill vacancies with individuals that have signed up to work for the vaccine programme. • Surrey Heartlands Recruitment campaign
Vaccination - Both the C19 and flu vaccination programmes are primarily delivered by out community and primary care providers, creating staffing and service delivery pressures during the recovery phase. There are also WF pressures at some of the Vaccination Sites as people return to their lives.	• Ongoing work with SJAB to support vaccination sites • Recruitment via Landmark into roles that can support CSH Surrey services • Ongoing communication between ICS and vaccination providers to ensure stability of services, with escalation where required
Community health – The increase in acuity and dependency of complex patients, both on inpatient wards and domiciliary caseloads, demand for long COVID services, and the age profile of our People in this area, create increasing pressures on our services.	• Workforce Development Funds to be used to develop the Out of Hospital workforce • Enhanced Health and Wellbeing programme to develop support for long COVID • Provision of support as per the Health & Wellbeing mitigations • Surrey Heartlands Recruitment campaign
Primary Care – Increased demand & workforce capacity gaps in particular in practice nursing, and difficulties in filling some professional ARRS roles to support.	• Surrey Heartlands Recruitment campaign • Commencing Primary Care digital staff bank. • Launching Return to practice Programmes for Occupational Therapists. • ARRS recruitment model will link with GPIMHS model. • Surrey Training Hub delivering action learning sets, coaching and mentoring to support development.

Building on changes made during our COVID response

Care sector

42. Covid-19 brought to the fore several existing issues with the way the health and care sectors have historically interacted. Much of the initial focus of the system was to embed a set of clear practical changes, including:

- Improved data collection in relation to Covid business continuity and capacity tracking via a new Capacity Tracker used by over 350 of our 370 care homes
- NHSmail update in care homes greatly increased, providing a secure means of transmitting personal records between partners and care home access to Microsoft Teams for virtual MTDs
- Enhanced healthcare support in care homes – 'Directed Enhanced Service' (DES) – providing a named clinical lead, weekly check-in calls to care homes and development of MDT care home rounds

43. General practice continues to deliver best practice support to care homes, including video consults, GP and paramedic visiting services, and weekly check-ins with community providers.

44. The focus in the system on a 'discharge to assess' model employed during the first phase of the pandemic has continued. This is under continued review and adjustment especially in the run into winter and potential Surge activity.

45. Learning the lessons from these temporary protocols, a revised discharge to assess model, Home First, has been implemented. This improves both citizen/patient experience and improves outcomes by ensuring that care is provided in the best setting, as well as releasing capacity in acute hospitals. Details of how this learning has been put into practice is described on slides 22-27 of Annex 3 that outlines our actions to improve patient flow.

Move to digital first in primary and secondary care

46. Before the pandemic, Surrey Heartlands had ambitious plans to reduce face-to-face out-patient appointments by 70% over five years. The move to virtual appointments during our Covid-19 response, whether online or telephone, has greatly accelerated the roll out of these plans as well as increasing acceptance among staff and patients of new ways of working.

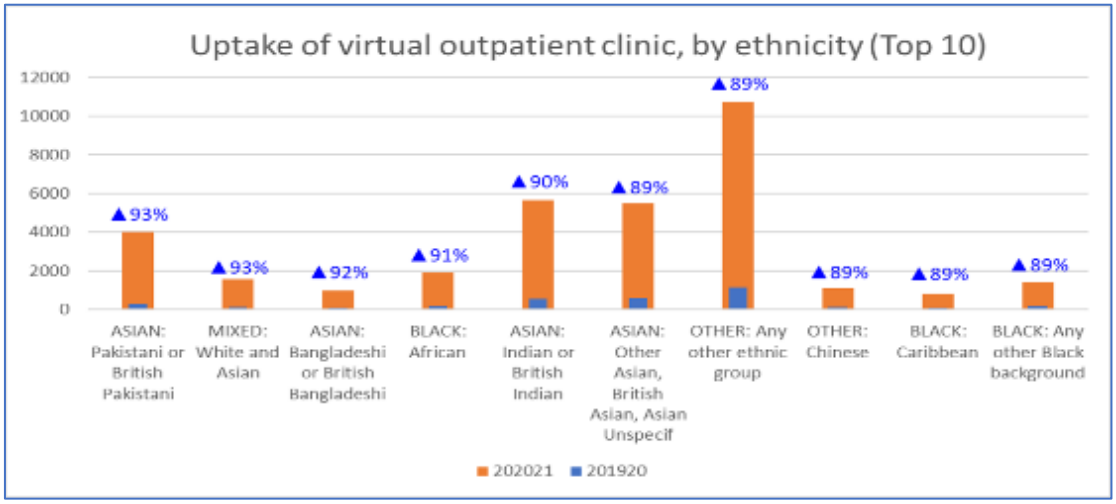
47. Before the pandemic, telephone and video consultations made up only a very small proportion of total consultations. During the pandemic we were able to quickly roll out and scale up services to ensure that patients had access to care wherever possible.

48. Although face-to-face appointments have resumed where needed, for example where particular patients or conditions cannot be assessed remotely, video and telephone consultations have now become a normal part of patient care, with acute trusts currently providing between 40% and 50% of consultations remotely. A full review into virtual consultations is required in order to facilitate effective patient care across multiple pathways and organisations.

49. Further digital tools such as Consultant Connect – providing GPs with access to specialist consultants – are enabling us to closed down more cases in general practice without referral to secondary care, resulting in quicker and more convenient care for patients and more efficient use of health resources.

50. To ensure equity of access we have clarified that patients' access to Virtual Consultations is comparable in all key BAME Communities (see below).

Fig 13 Uptake of virtual outpatient clinics, by ethnicity (Top 10)



51. To avoid misrepresentation of patients' experience, the data has also been triangulated with other quantitative and qualitative feedback, including a recent Covid Rapid Need Assessment by the Public Health team and a community-based survey to understand the mental health impact of Covid-19 on "People from BAME Groups and Barriers to Accessing Services and Support". This survey by was conducted jointly by the Surrey Minority Ethnic Forum (SMEF) and the Independent Mental Health Network (IMHN).

52. The move towards digital has also been an accompanying increase in our digital inclusion work. There is the potential for digital exclusion to exacerbate existing health inequalities, and in Surrey there is an overwhelming correlation between social exclusion and digital exclusion, linked to areas of greater deprivation and the communities that live in these areas. Steering groups in all four ICPs are now established and operational, meeting monthly to ensure Digital Inclusion is at the forefront of service provider consideration, and to share best practice moving forward.

53. Tech to Connect is a project to provide technology, support in using technology and virtual groups to reduce feelings of loneliness and isolation in people with care and support needs. Tech to Connect specifically addresses both those who do not have, or are unable to afford, a device and those who are unable to get out and about because of health needs, caring responsibilities, disabilities, or other significant barriers. A digital skills training platform, developed with the

Barclay's Digital Eagles, will be launch later this year offering focused modules covering the five key digital skills that define Digital Inclusion.

54. We also recognise that not everyone can or wants to engage digitally and we plan to carry out further research and engagement to understand barriers to digital. As part of this work, Digital Inclusion is now built into CCG Equality Impact Assessments to ensure Digital Inclusion is a consideration for service providers from the beginning.

55. As part of our move towards remote consultation, it has become clear than many patients prefer telephone to video, and we have adjusted our response accordingly. Our 'Think 111 First' programme, part of a national programme to ensure patients are seen in the most clinically appropriate setting, similarly uses telephone as a core entry point to NHS services.

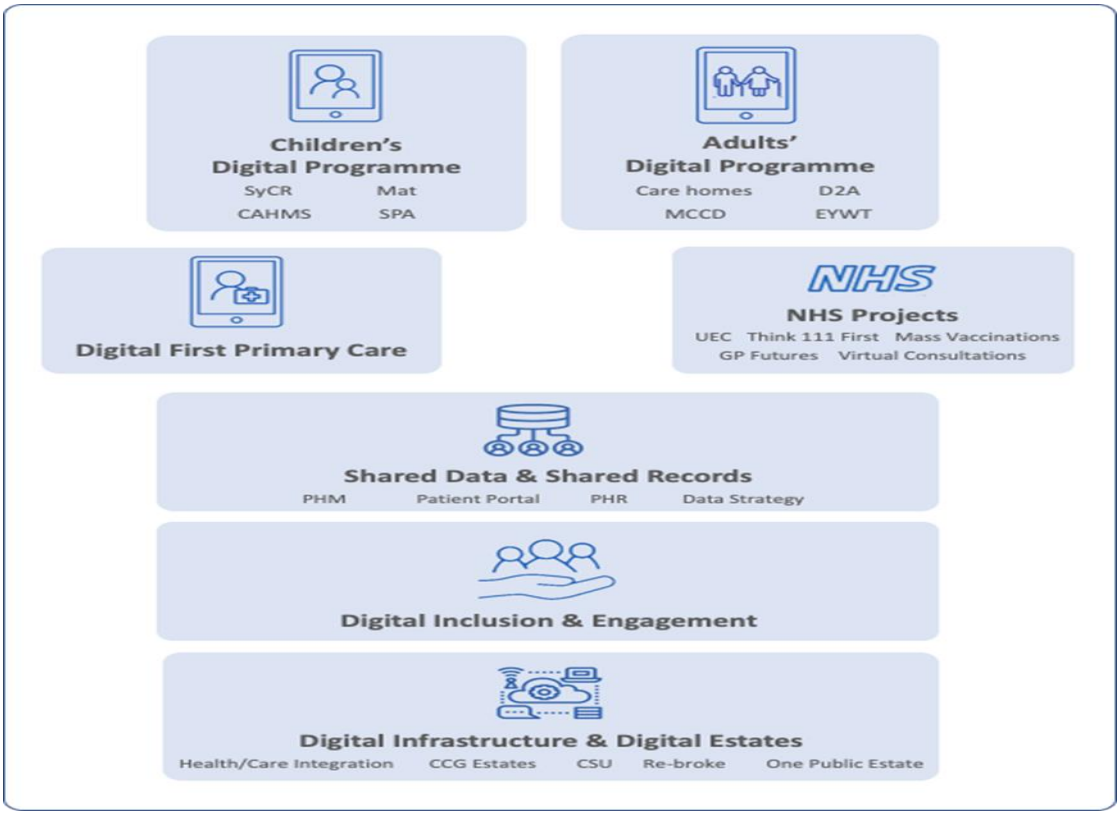
56. The Digital Champions programme (working closely with the Surrey Coalition's Tech Angels initiative), inviting volunteers to train and assist their local community with learning digital skills, will be launched in November 2021 along with a comprehensive online hub of support materials and a platform for volunteer registration as well as service provider nominations for residents requiring support with digital skills. We aim to recruit 400 Digital Champions by August 2022.

57. The 'success' of digital ways of working in this period has created a focus for the system to consider a long-term 'System Data Strategy' with the vision being to have a central data and analytics ecosystem comprising of shared data across a range of ICS partner organisations across Surrey (health, local authority, police, third sector) to achieve and enable the aims of an ICS these include:

    - Improve population health and health care
    - Tackle unequal outcomes
    - Enhance productivity and value for money
    - Support broader social and economic development

58. The digital programme is extensive and mature in Surrey and covers a wide range of activities as a key enabler for the system. The programme includes the creation of the Surrey Care Record allowing appropriately trained staff to review the appropriate patient level data to ensure quick and responsive care and minimise the need for patients to repeat their 'stories'.

Fig 14 Core ICs digital team programme focus areas



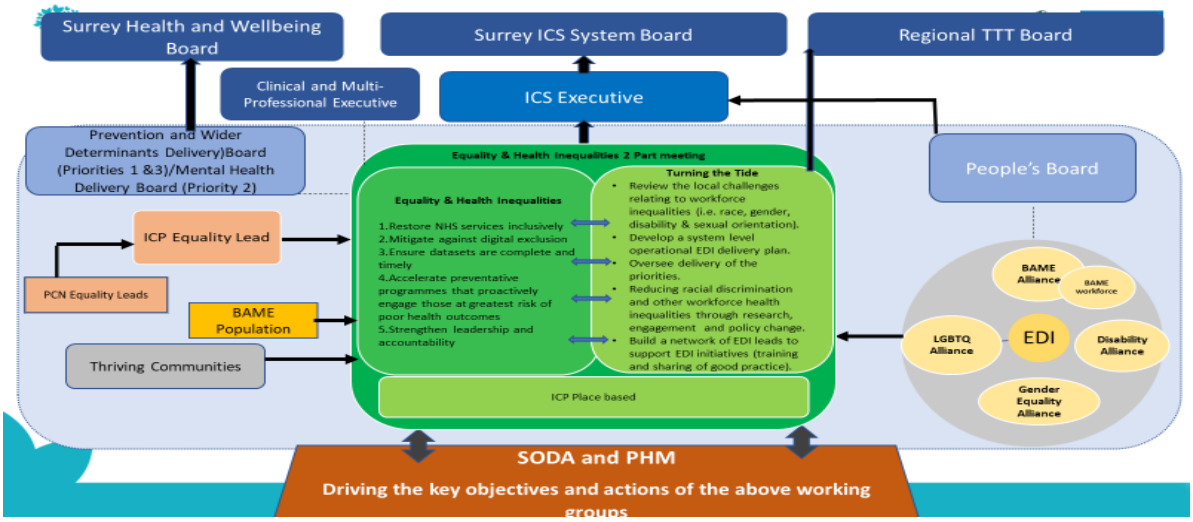
Our focus on Equality and Health Inequalities

59. In Surrey, as nationally, Covid-19 has further exposed some of the health and wider inequalities that persist in our population. The ICS has focused and continues to be planned in a way that inclusively supports those in greatest need through working with communities and across the NHS, Local Authorities and other partners. Therefore, when placing the Recovery Programme into a BAU structure, a specific emphasis was placed on the Equality and Health Inequalities which incorporated the work of the previous board but also the Turning the Tide Board. The role of the new Equality and Health Inequalities Board is to respond to the immediate disproportionate effects of Covid-19 on our populations but also to focus on our response to the NHS Operational Planning Guidance to the five priority areas for tackling health inequalities:

- Restore NHS services inclusively
- Mitigate against digital exclusion
- Ensure datasets are complete and timely
- Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- Strengthen leadership and accountability

60. The strengthen leadership and accountability priority area replicated many of the key areas of the Surrey Heartlands Turning the Tide Transformation and Oversight Board (TTT&OB) that had been established to turn the tide against racism and related inequalities that affect our BAME workforce and population. To reduce replication but also to ensure the focus, the two boards merged and have a joint workplan with shared targets and governance.

Fig 15 Equalities and Health Inequalities Governance



61. To ensure that the focus of the Equalities and Health Inequalities Board is based on the findings of the previous Community Impact Assessment and subsequent research and data, the ICS assembled an Insight and Analytic 'task and finish group' from Business Intelligence experts within the ICS, Public Health and NHSEI. The ICS also chose to commission additional capacity within the Business Intelligence department of the CCG.

62. From this, the group have developed the HI Dashboard, looking at 51 indicators which are soon to be expanded upon to consider elements related to waiting times, diagnostics and referral rates for BAME, Sex, Deprivation, LD and SMI.

63. The 'task and finish group' has focused on ensuring that there is Equity of Access within the system across Elective and Non-Elective Care. It has reviewed the data that has been gathered and then focused the work that indicates potential areas of concern. Areas of potential concern will potentially indicate where action needs to be taken and/or additional information is needed to validate/triangulate the data. This has also involved a qualitative as well as quantitative data gathering.

64. The Community Impact Assessment (CIA) had highlighted the key population groups who are most likely to be disproportionately impacted as result of the pandemic. These included people with long-term physical condition/physical or mental disability, BAME, young people out of work, those with existing mental

health conditions, people experiencing domestic abuse, GRT communities, children with special educational needs/disabilities (SEND), people with drug and alcohol problems, and those experiencing homelessness. The CIA also highlighted a number of cross cutting themes such as mental health (particularly on young adults) and digital exclusion.

65. Some of the key successes have been the implementation of the action plans (achieved through collaborative working between LA Public Health, Primary Care and the Third Sector) on the following priority areas: preventing cardiovascular disease amongst high-risk population (BP@home); targeted NHS Health Checks and community conversation delivered by SMEF); reducing digital exclusion; improving Covid-19 vaccination rate amongst communities with low uptake; and improving the annual health checks completion rate for people with serious mental illness (SMIs) and those with LD. We are also conducting three Participatory Community Research projects (supported by Health Education England with SMEF) focusing on cardiovascular disease, making the services more inclusive and improving maternity care of women from South Asian backgrounds.

66. Details of the work undertaken to meet the five key actions taken by Surrey Heartlands can be seen from page 229 onwards within the System Operational Plan 2021-22 that can be accessed through the link in Paragraph 10.

67. However, the key to this work has been our engagement with communities and the third sector. We have focused on:

- Work with VCSF organisations to engage with BAME communities through community events
- Develop culturally appropriate resources and services through participatory community approaches to enhance engagement and gain insight
- Rollout of targeted campaigns with hard-to-reach communities (flu immunisation, CVD and MH)
- Shared expertise, insight and resources across all partners in Integrated Care
- Work with national bodies to secure appropriate translated materials
- Ensure communications reach the digitally excluded
- Work with communities to improve health literacy

68. Some of this partnership working can be demonstrated in our targeted response to mass vaccination, with some examples listed below:

- Working on the production of a local video to support the Gypsy, Roma, Traveller community (filming took place 29/03): Gypsies, Roma, Travellers and Showmen unite to Give Covid the Jab | Travellers Times

- Implementing ‘I did it for …’ campaign – aimed at younger age groups/potential to use with staff – individuals photographed with a board on which they write ‘I did it for … *e.g. family member etc.’* for use on social media – recognising influence younger people also have on intergenerational families
- Planning a campaign to reach African/Caribbean communities (including staff) where we know uptake is particularly low, identifying local, trusted community leaders (recognising local trusted leaders often have more impact than working with national celebrities)
- Equalities checklist for each LVS and improved equality info (e.g. parking) on our website
- Developing resources to support Covid champions in the wider community/attending Covid champion meetings
- A series of Covid-19 vaccine conversations with different ethnic minority population groups in Surrey (organised by Surrey Ethnic Minority Forum) in different languages, delivered by medical doctors from the same communities to increase vaccine confidence

69. Long Covid and the system response to the potential health inequalities is similar to the national picture, i.e. it is still at the initial stages of understanding. To ensure services are closer to the patient, the system has created Long Covid clinics in each Place-based setting. Nationally, data is being reviewed, comparing patients in relation to referral source, ethnicity, sex, age and deprivation. However, it should be noted that the data is limited by the maturity of the ‘coding’ of Long Covid and the definition of the diagnosis itself. The ICS is in the process of replicating this analysis locally to potentially counterbalance any health inequalities raised.

Fig 15 The National Level Picture. Source: National Webinar: Long-Covid: Health Inequalities, 29 July

	ONS CIS	OpenSAFELY
Sex		
Female	58.0%	65.0%
Male	42.2%	35.0%
Other/unknown	0.0%	0.0%
Ethnicity		
White	93.4%	46.20%
Asian	3.0%	8.30%
Black	1%	2.80%
Mixed	1.9%	1.20%
Other	0.9%	1.10%
Unknown	0%	40.37%
Deprivation		
Deprived (IMD 1 and 2)	42.5%	44.2%
Non-deprived (IMD 3-5)	57.5%	55.1%
Unknown	0%	0.7%

Conclusions

70. The Covid-19 pandemic has been an enormous challenge and a period of significant change for health and care services. As the pandemic continued, the system adjusted to meet the needs of patients and citizens in a long-term sustainable way, transitioning from a structured 'Recovery' programme response to an embedded organisational system response placed into Business as Usual.

71. The system has engaged in 'stock-takes' and 'reviews' to learn from the three waves of Covid-19. This has informed our planning on how we restore services plus maintain provision throughout the winter months. There is a clear focus on equity and a focused approach to **reducing health inequalities** and how we ensure we reach residents who most need our care.

72. The new infrastructure has embedded our learning and placed an infra-structure to early warn the system of any Covid-related impacts. This is also built within our Surge Planning, previously described as 'Winter Planning'.

Recommendations

The Committee is asked to note the contents of this report and provide any comments on the transition of Recovery Programme into a Business as Usual infrastructure, plus its preparations for Winter and Surge Planning.

Next steps

Surrey Heartlands Health and Care Partnership will continue to deliver the equitable restoration of services in a long-term organisational structure, amending our approach for factors such as the potential continuation of the third wave into winter and any subsequent waves, vaccination roll out and any changes to the needs and priorities of our citizens and patients.

Report contact

Helen Coe, Surrey Heartlands Recovery Director (helen.coe@nhs.net)

Annexes

Annex 1 – The graphs, tables and pictures included in the main report, in a clearer format for those printing the report, plus some additional information as referred to above in the main report

Annex 2 – Example Covid Early Warning System weekly report

Annex 3 – Surrey Heartlands Urgent and Emergency Care 10-point action plan

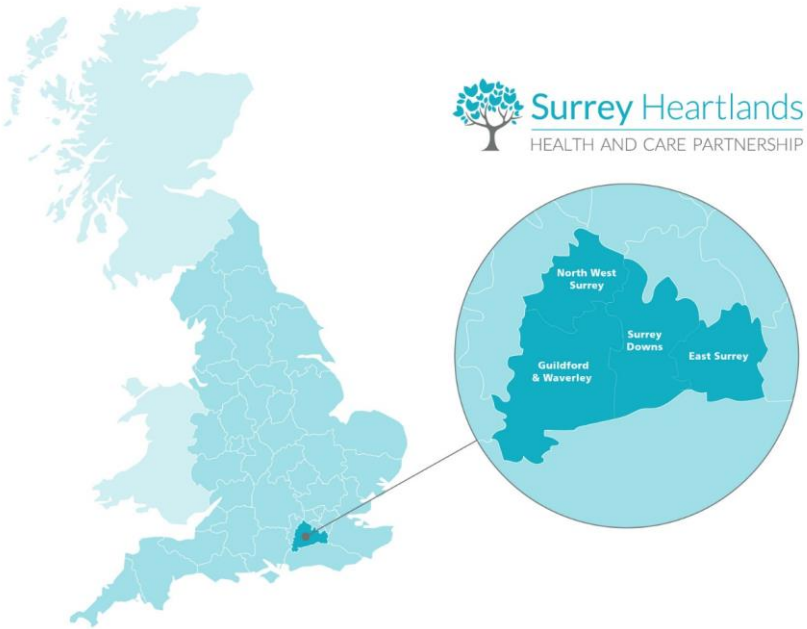
Appendix 1 – Graphs, tables and pictures

This appendix includes:

1. The graphs, tables and pictures included in the main report, to ensure that they are readable by those not reviewing papers electronically

The information provided in this appendix is presented in the order in which it is referenced in the main report.

Fig 1 Surrey Heartlands Integrated Care System



- Covering a population of over 1 million people
- Combined health revenue allocation of over £1.5bn and combined social care and public health budget of £317m
- Four Place-based partnerships
- 106 practices working within 24 primary care networks (PCNs)
- H 4 acute hospital sites
- H 11 community hospital sites
- 2 community service providers
- 1 mental health provider including 3 inpatient units and 33 community sites
- 1 upper tier local authority (Surrey County Council) operating adult & children's social services
- 9 District/Borough Councils
- NHS Surrey Heartlands CCG

Surrey Heartlands HEALTH AND CARE PARTNERSHIP

Fig 2. Recovery priorities

SURREY COUNTY COUNCIL NHS

	Meeting citizen and patient need			Addressing new priorities		Reset to a new service model (5)	
	Restoration (3) (4)	Interdependence of health and care (6)	Surge plans (C19 and other)	Hidden harm	Emotional wellbeing (staff and citizen)	Develop (build from)	Transform (re-envisage)
What will we do?*	• Identify and stand up critical services • Quantify diagnostics and elective backlog • Propose ICS-wide approach for key common challenges	• Enhanced home care framework • Home first D2A model, Medically fit for discharge • Care home bed capacity • New model for working with patients OOH and care homes	• Maintain infrastructure for future C19 surges, with new model learning from 1st peak • Planning for non-C19 peaks: urgent care, LTCs, mental health, etc. • Identify at risk services and plan for mitigation • Longer term approach to testing and PPE	• Identify groups at risk from 'hidden' harm or deterioration • Develop and deploy service offer • Resume/step up prevention and screening	• Identify support needs for staff arising from pandemic • Post C19 support for staff and communities	• Capture, catalogue and evaluate learnings and innovations made • Develop, standardise and embed • Rapid re-validation and accelerate existing, value add plans	• Capture and validate citizen and workforce behavioural and expectation shifts. • Accelerate design and delivery priority programmes against clear benefits criteria • Deliver estates (1) strategy and release funding
How will we measure success?*	• Minimised morbidity and mortality from non-C19 causes • Enabler, not a barrier, to new ways of working	• Improved outcomes and experience for those in care settings • Better use of our collective resources	• Resilience to deal with C19 and non-C19 demand • Minimised morbidity and mortality	• Citizens at risk are identified and supported	• Staff and citizens are able to recover from the pandemic and lockdown	• Innovations are retained and generalised • Models of care which deliver better outcomes and citizen experience, sustainably	• Services and support re/designed system-wide in response to citizen experience, need and workforce ambition • Models of care which deliver better outcomes and citizen experience, sustainably

(2) **ICS development & architecture** - System first, Role of ICS, ICPs and PCNs

Social contract with communities - Staff and citizen behaviour change, Comms

(7) **Digital**

*objectives and success measures are indicative and for development

Transformational objectives mapped onto recovery priorities: (1) Generate transformational funds, (2) System first behaviour, (3) Stop, (4) Do it once well, (5) New care models, (6) High cost/poor outcomes, (7) Digital

Eight recovery workstreams - delivering impact

Restoration	• Achieving in Q3 (20/21), 86-89% of last years elective activity by the system • Delivered in Q3, 94-105% of outpatient activity compared to 2019/20 baseline • In diagnostics exceeded Nov/Dec baseline target of 100% (125% & 109%) in endoscopy provision and provided mutual aid in the system to reduce inequalities in waiting times • Reduced cancer 104 day waits from 450 start of Q3 to 40 at the end of Q4
Interdependence of Health and Care	• Provision of comprehensive training and support over the course of the first phase of the COVID-19 pandemic • Development of training and education, including Infection Prevention & Control to more than 250 care homes • Targeted support to areas requiring additional support and reducing health inequalities this included outcome reviews of D2A model
Surge	• Significant increase in uptake of Seasonal Flu vaccination programme seen as the most successful in the history of the programme; exceeding target with 80% of over 65s vaccinated • Think 111 go live on 1 December driving the increase of available appointment slots to NHS 111 from the initial 90 up to approx. 150 (per day) in February
Equalities & Health Inequalities	• The 20/21 winter flu immunisation programme for the school aged children offered 100% coverage with 72% up-take • Significant up-take for school aged flu immunisation in traditionally hard to reach communities including local refuge, GRT traveller site and refugees in a local school • Strategy and forward plan to address the eight urgent Covid HI actions set out by NHS Phase Three letter developed. This was received regional recognition by Public Health England as an 'exemplar' to be shared with other ICS'

Eight recovery workstreams - delivering impact

Emotional Wellbeing	• Continued roll out of the GPiHMS integrated mental health service in primary care. • The TIHM Covid programme providing remote home monitoring for people with dementia and their carers, *594 individuals are receiving the service as of Feb 2021*. • The virtual wellbeing hub providing access to 3rd sector mental health resources. • *F2F & NF2F Mental health support to care home staff around the emotional resilience.*
Develop & Transform	• To produce a governance that 'Developed' system opportunities that were defined in Restoration (i.e. Diagnostics) • To develop a system wide process and governance structure to enable transformational work opportunities including Out-patients, Digital, Estates, Non-Clinical Staffing (Back Office), Empowering Communities, Diagnostics • Facilitated system wide transformation opportunities through the allocation of joint funding between the LA and Health to accelerate local innovation: e.g. supporting patient co-design and engagement through the work of Citizens panels
ICS Development & Architecture	• Significant progress has been made in the Provider Collaborative to support greater shared working across the ICS with a specific focus on pathways of care (the current pathway focus is iMSK) • Expansion of existing PCN Community Mental Health (GPiMHS) and expanding to include personality disorders: *8,530 consultations have taken place* to date
Digital	• Detailed 8 point plan to address digital exclusion and inequality • Rapid deployment of data integration platform between T111 and all provider A&E and walk ins • Successful implementation of 'virtual consultations' and digital solutions – securing £200k for the system

Fig 4 System (ICS) Governance Organogram

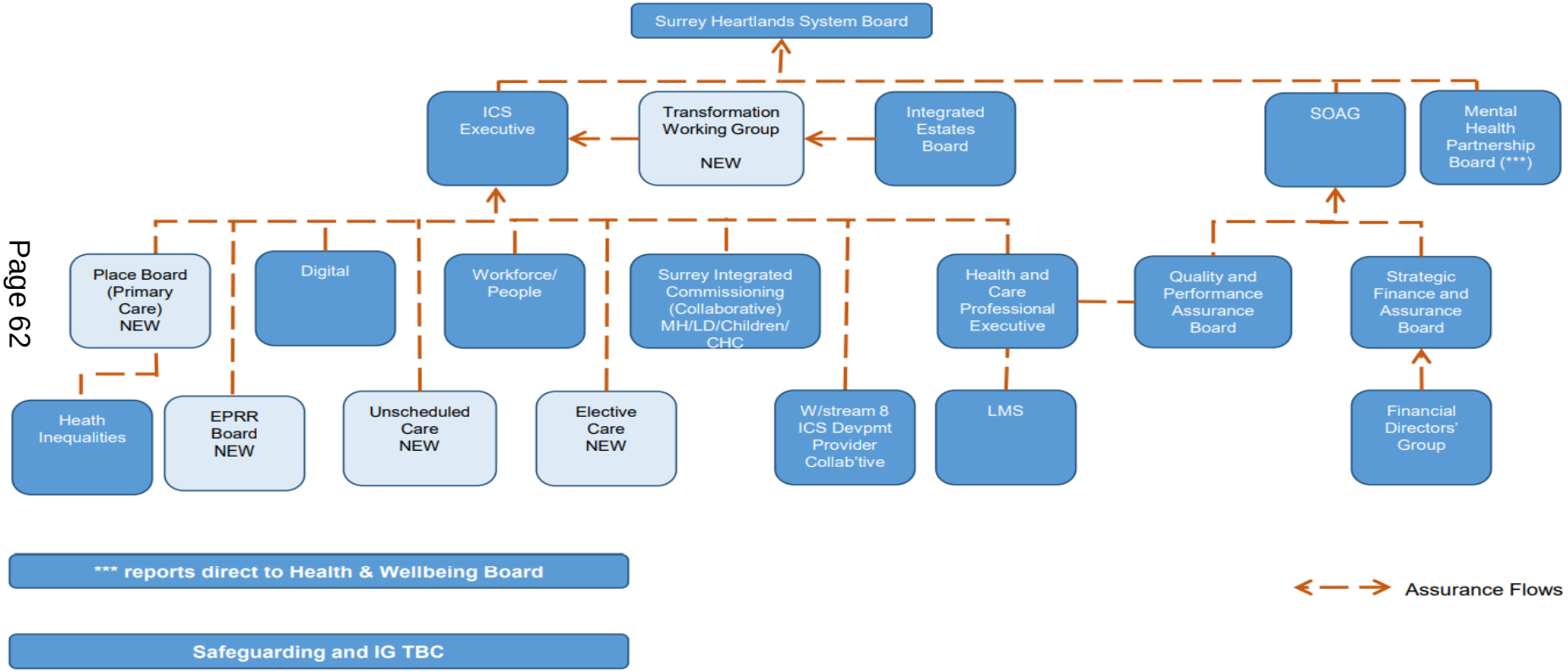
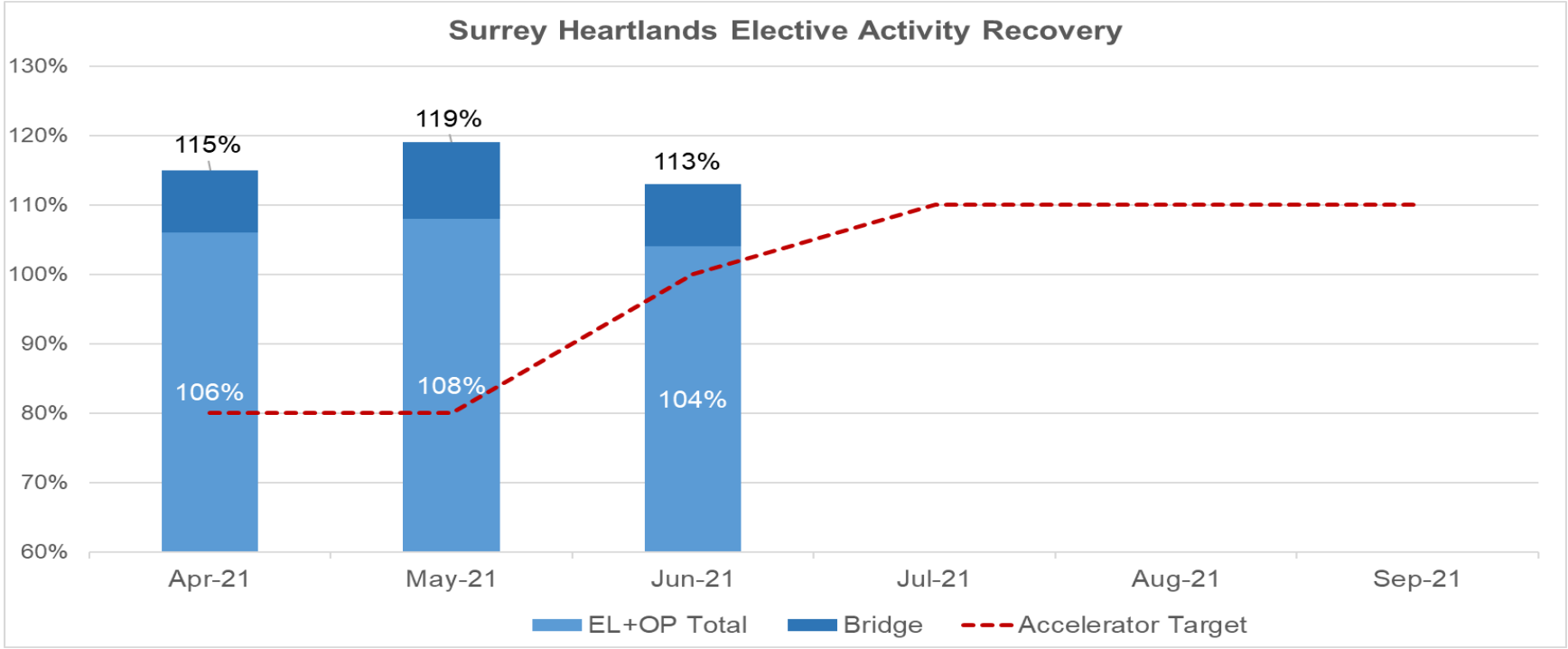


Fig 5 2021 Elective Activity as a percentage of 2019 Elective Activity levels



Note: EL = elective spells and daycases, OP = outpatient attendances and procedures *

Fig 6: Number of patients waiting longer than 52 weeks for treatment

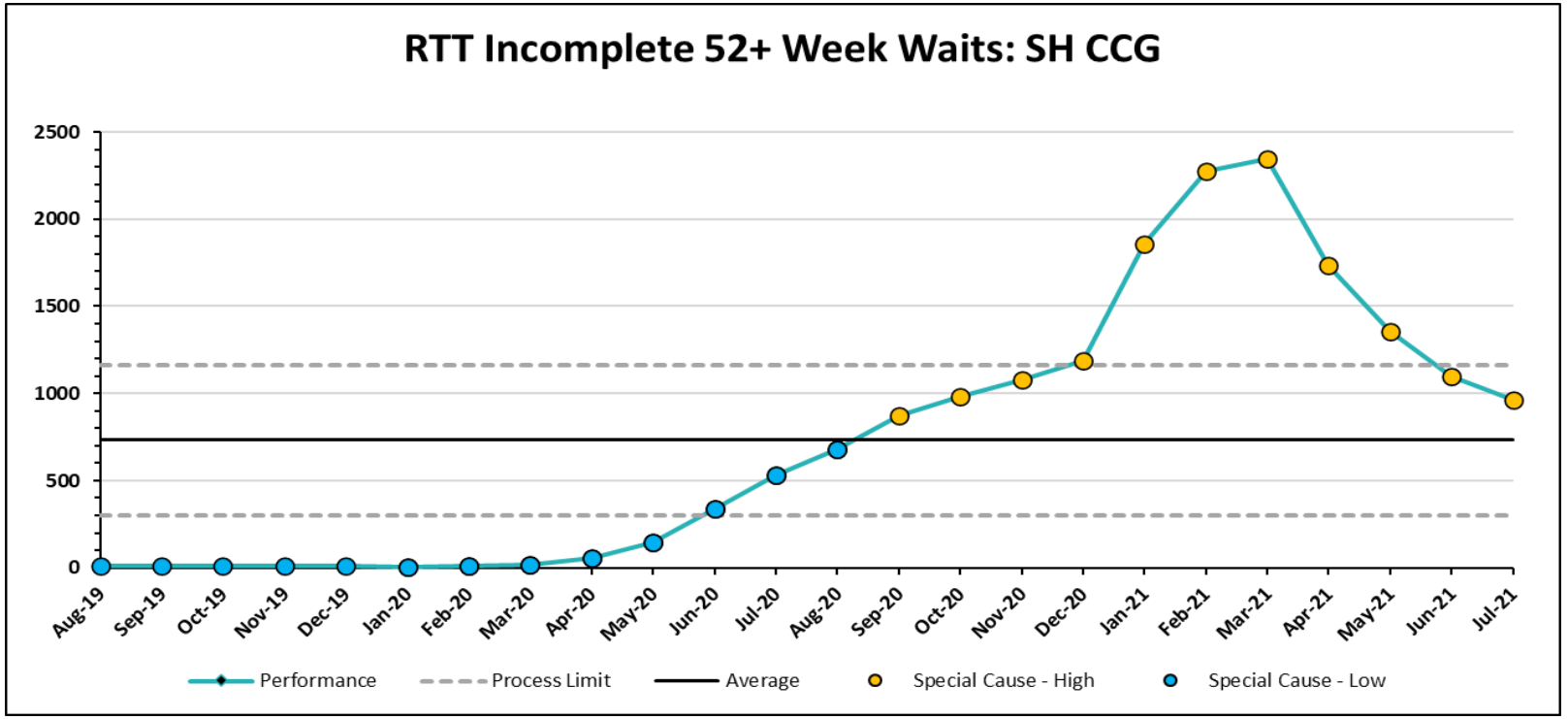


Fig 7: Cancer Patients waiting >104 days for treatment

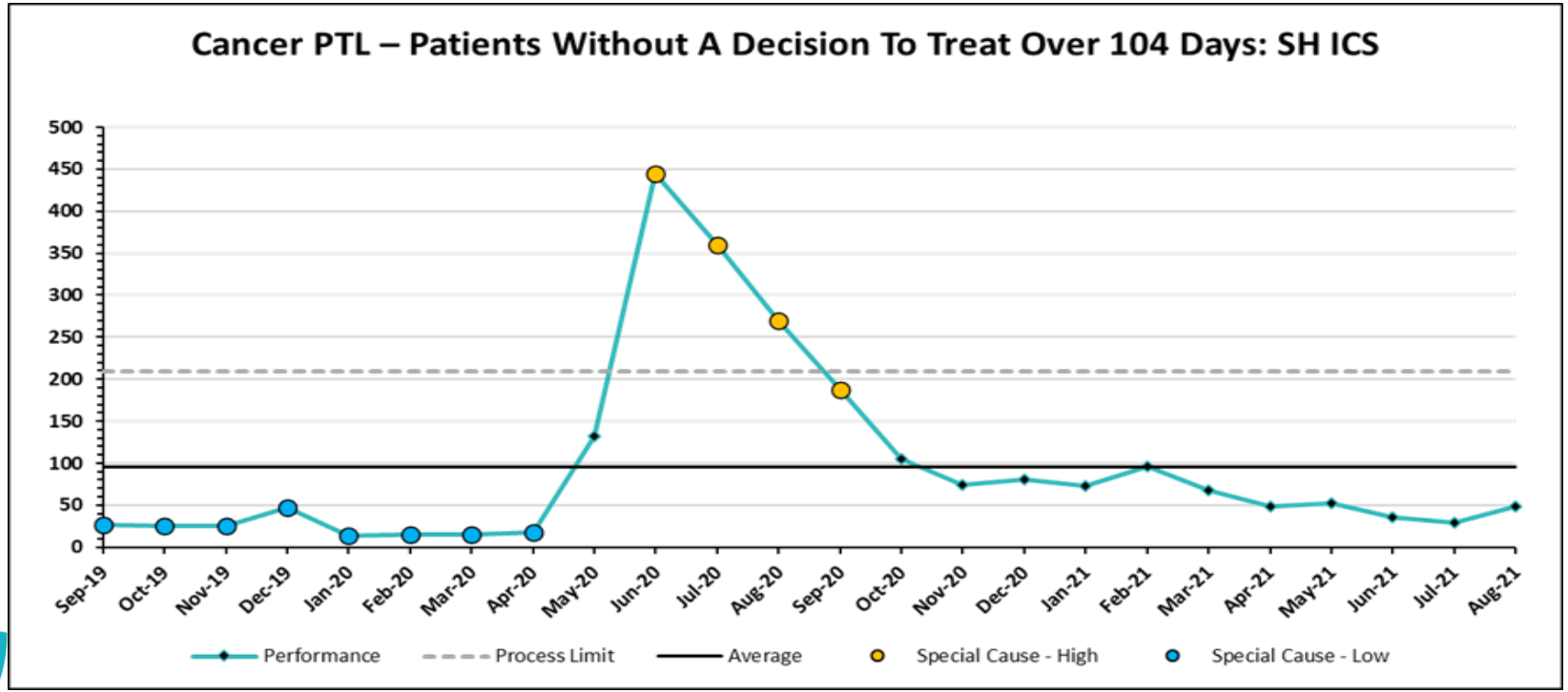


Fig 8 People waiting more than 6 weeks for diagnostics

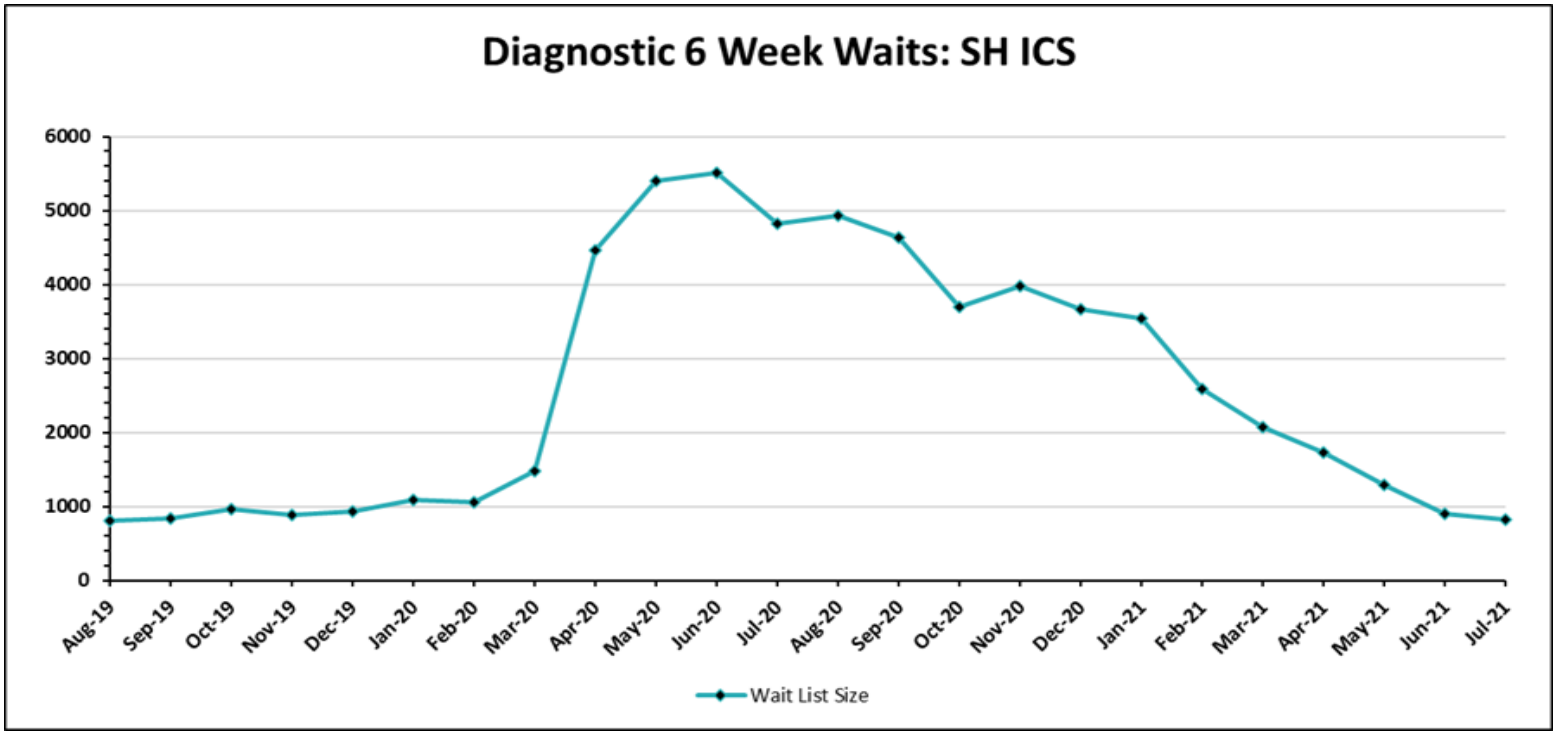


Fig 9 Primary Care Activity (Appointments and Online Consultations)

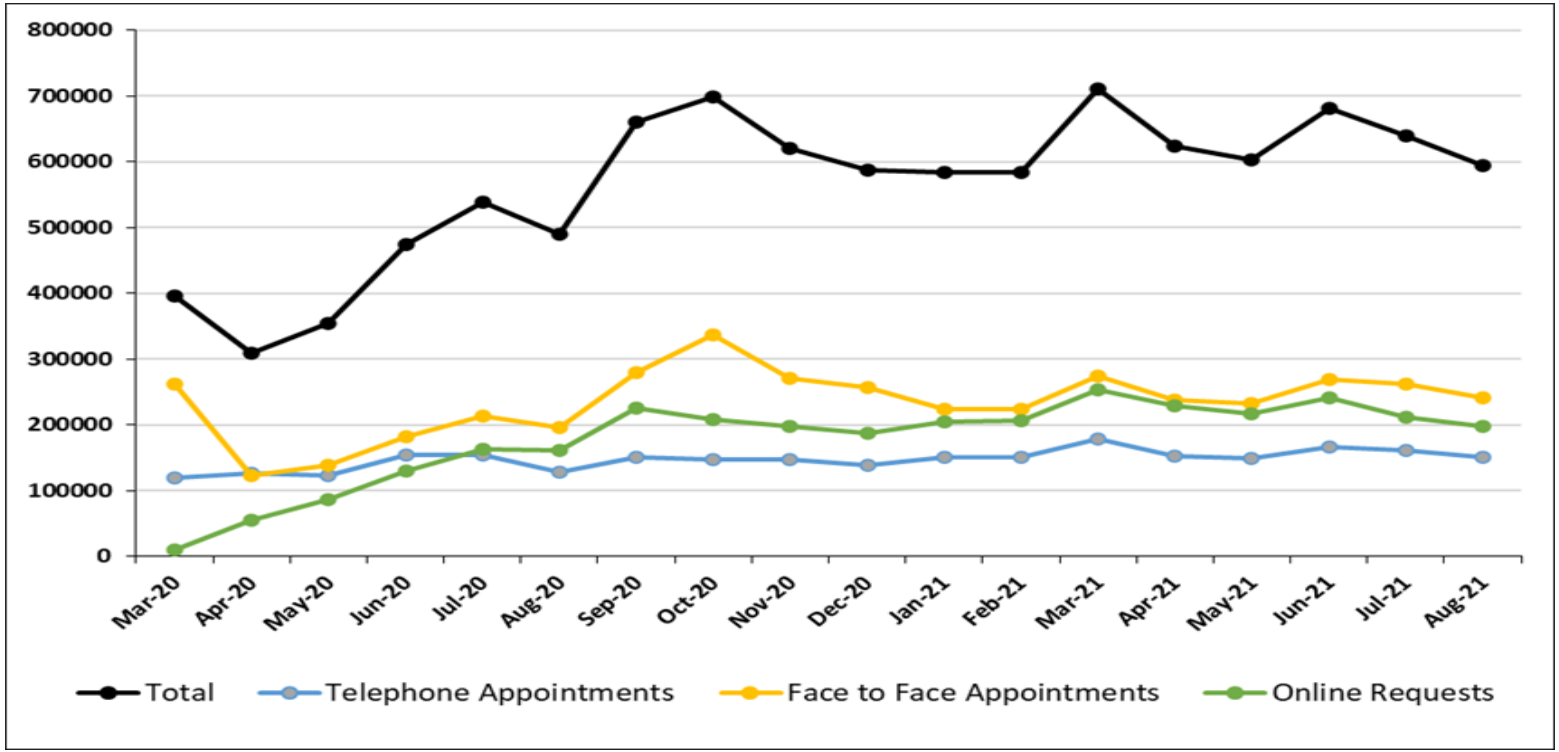
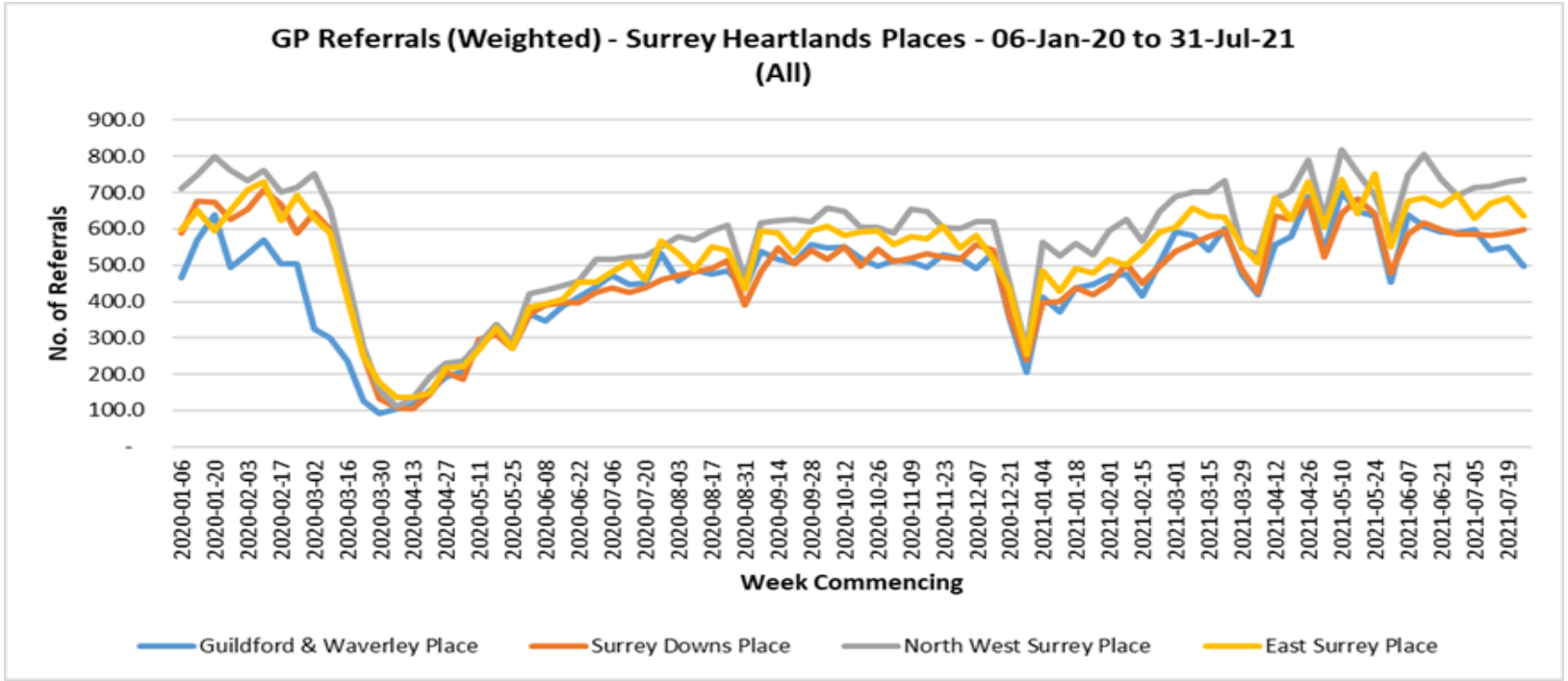


Fig 10 GP Referrals as ICS Total and by ICP



Data Source: e-Referrals as at Jun-21

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Fig 11 Urgent and Emergency Referrals for Children's Eating Disorders from 01.08.2016

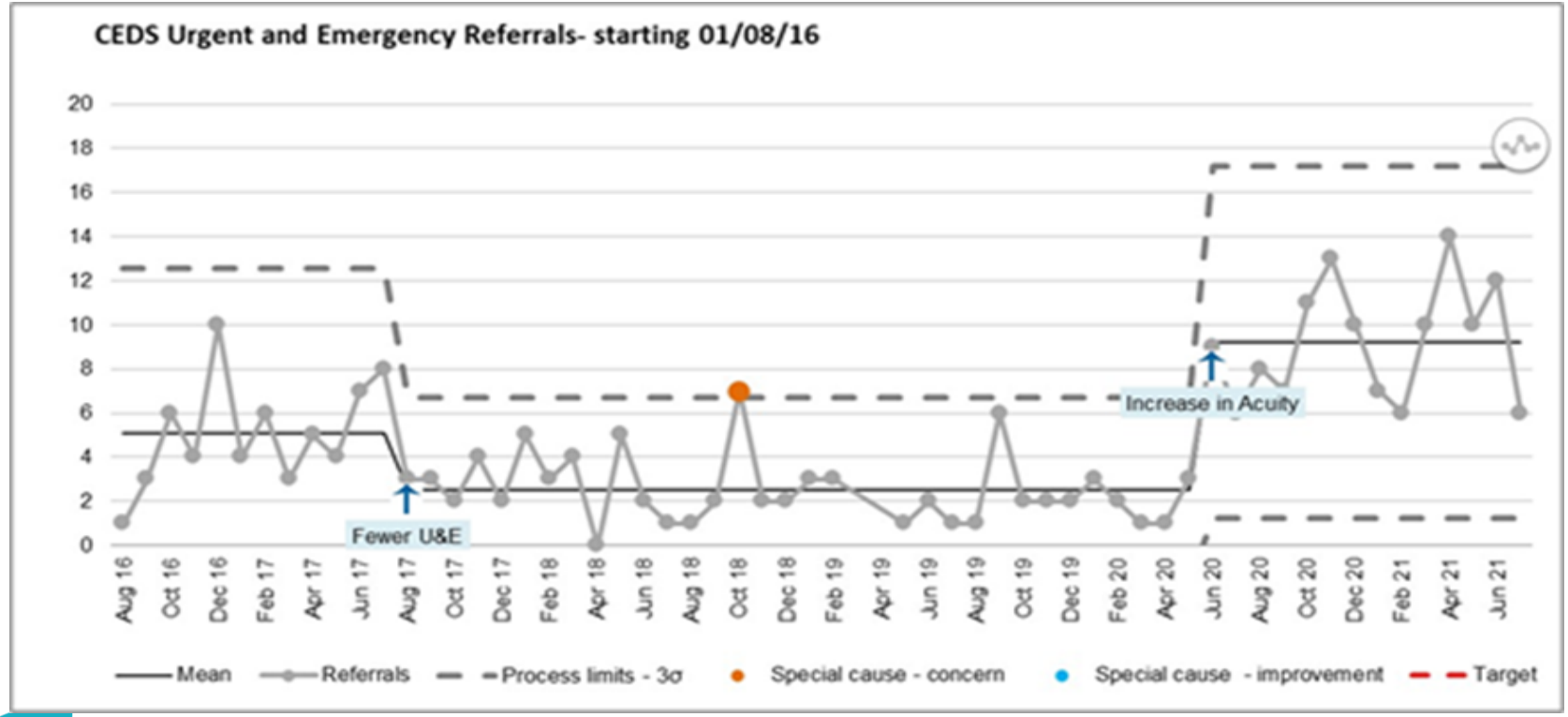

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Fig 12 Key Workforce Risks and Mitigations

RISKS/ ISSUES	MITIGATIONS
Annual Leave – There is a risk that operational capacity may be impacted if a backlog of annual leave, and the potential sharp uptake of annual leave post lockdown, coupled with staff absence due to ongoing health and wellbeing concerns.	• Trusts have updated policies in relation to buying back / AL carry over • Annual leave monitoring and use of HRD Network and Surrey Heartlands People Board as escalation points • MOU in place to facilitate staff sharing across organisations.
Health & Wellbeing - Negative impact of Covid-19 pressures on staff wellbeing with potential for increasing levels of sickness absence if demand levels are sustained into the Autumn.	• All NHS providers have a Wellbeing Guardian function in place, along with the establishment of health and wellbeing groups. Health and wellbeing conversations are taking place both informally on a regular basis and formally on an annual basis, depending upon provider. • Moving forward with enhanced HWB and inclusive HWB programmes (includes HWB conversations and staff safety). • The Surrey Heartlands Resilience Hub provides access to health and wellbeing services. • Health and Wellbeing initiatives across the system include MHFA training, TRiM training, STRaW training, FTSU guardians, Staff Igloos at RSFT, Pods at SASH, and a new Wellbeing Centre at ASPH.
Recruitment and retention - Reduction in international recruitment rates due to several challenges (quarantine rules, agency delays, border controls, available mentors).	• Partners continue to manage recruitment of international staff internally, with escalation to the Resourcing Network and then Surrey Heartlands People Board where appropriate. • International Retention programme to commence in order to address issues related to turnover of internationally recruited staff • Vaccine Workforce Programme to commence in order to fill vacancies with individuals that have signed up to work for the vaccine programme. • Surrey Heartlands Recruitment campaign
Vaccination - Both the C19 and flu vaccination programmes are primarily delivered by out community and primary care providers, creating staffing and service delivery pressures during the recovery phase. There are also WF pressures at some of the Vaccination Sites as people return to their lives.	• Ongoing work with SJAB to support vaccination sites • Recruitment via Landmark into roles that can support CSH Surrey services • Ongoing communication between ICS and vaccination providers to ensure stability of services, with escalation where required
Community health – The increase in acuity and dependency of complex patients, both on inpatient wards and domiciliary caseloads, demand for long COVID services, and the age profile of our People in this area, create increasing pressures on our services.	• Workforce Development Funds to be used to develop the Out of Hospital workforce • Enhanced Health and Wellbeing programme to develop support for long COVID • Provision of support as per the Health & Wellbeing mitigations • Surrey Heartlands Recruitment campaign
Primary Care – Increased demand & workforce capacity gaps in particular in practice nursing, and difficulties in filling some professional ARRS roles to support.	• Surrey Heartlands Recruitment campaign • Commencing Primary Care digital staff bank. • Launching Return to practice Programmes for Occupational Therapists. • ARRS recruitment model will link with GPIMHS model. • Surrey Training Hub delivering action learning sets, coaching and mentoring to support development.

Fig 13 Uptake of virtual outpatient clinics, by ethnicity (Top 10)

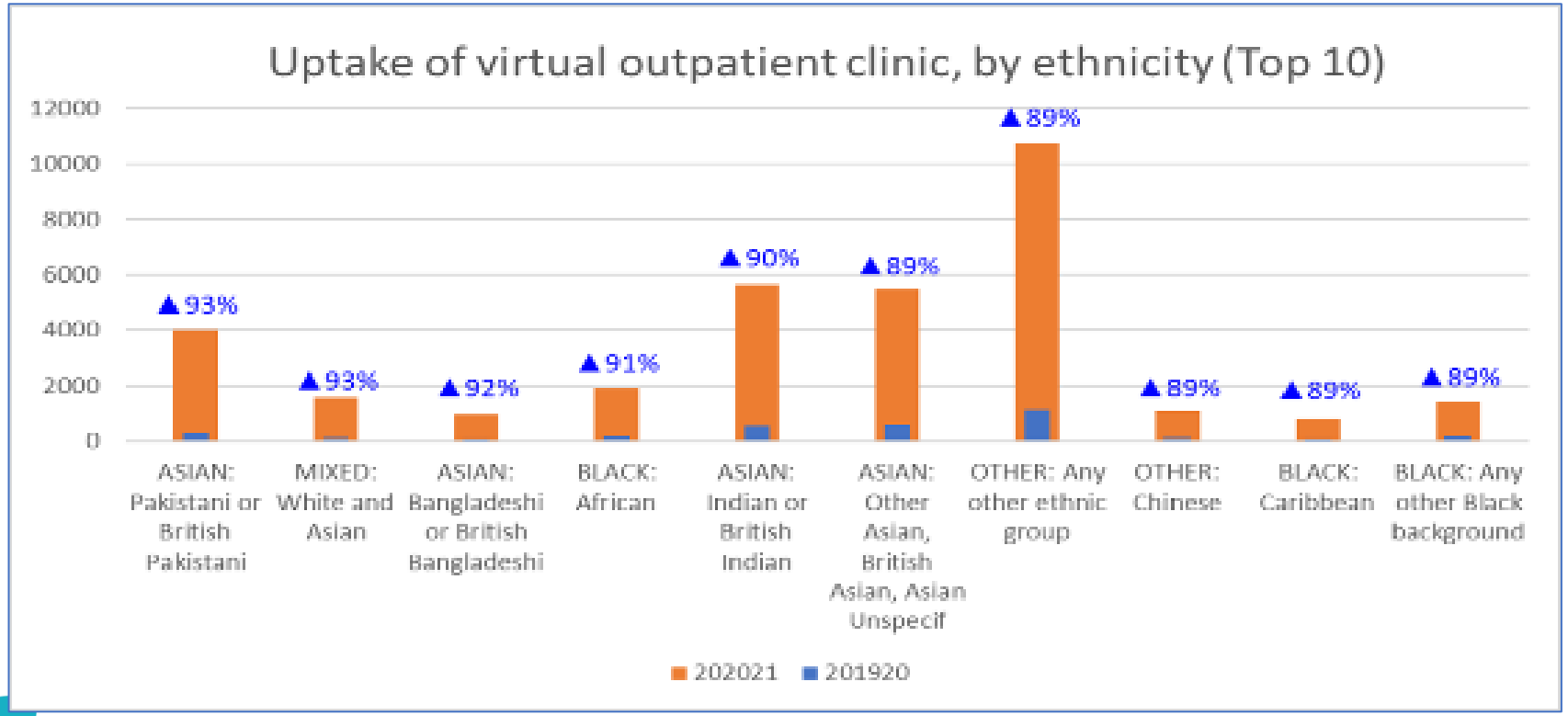


Fig 14 Core ICs digital team programme focus areas

Fig 10 Equalities and Health Inequalities Governance

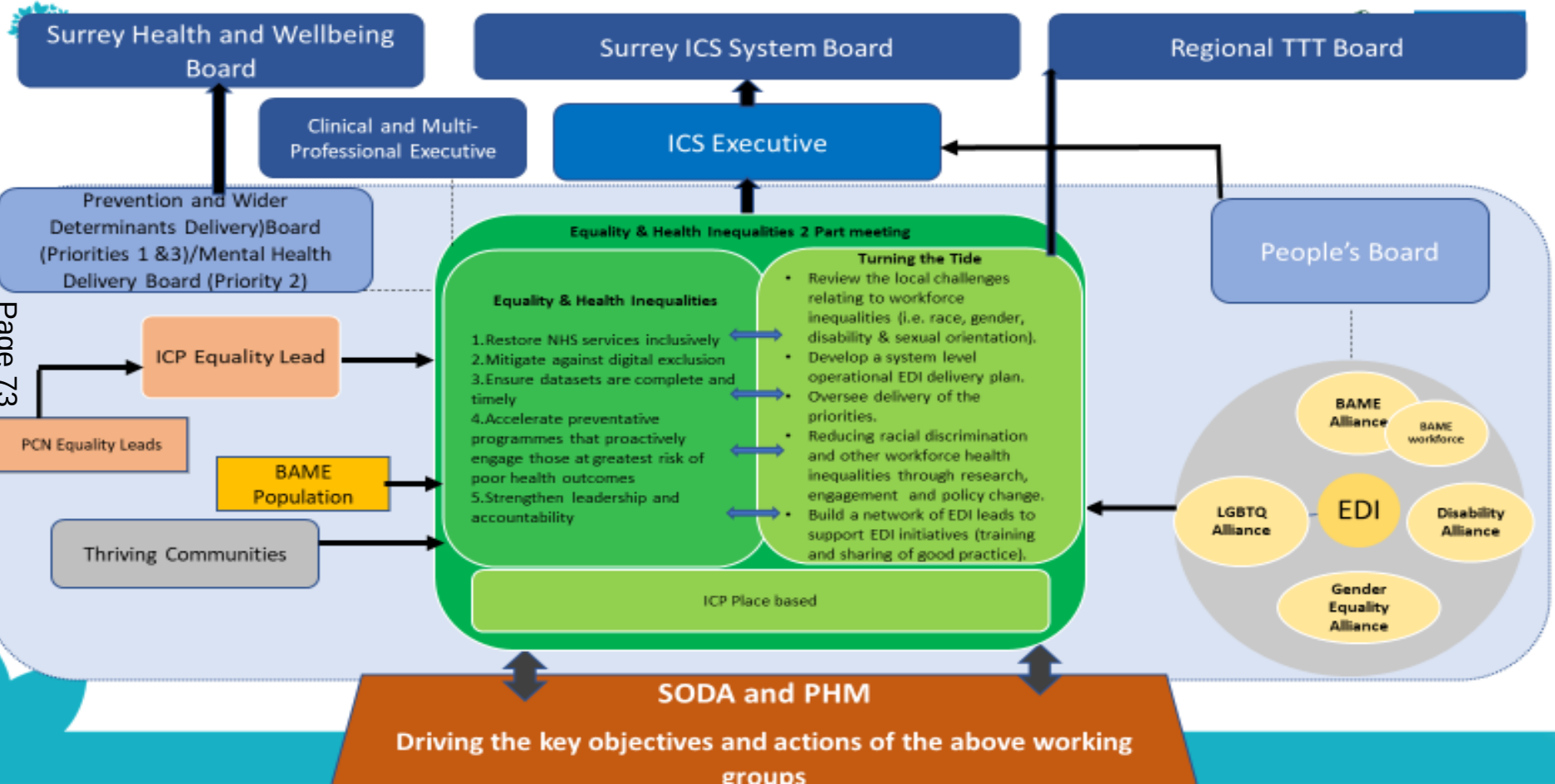


Fig 15 The National Level Picture. Source: National Webinar: Long-Covid: Health Inequalities 29th July

	ONS CIS	OpenSAFELY
Sex		
Female	58.0%	65.0%
Male	42.2%	35.0%
Other/unknown	0.0%	0.0%
Ethnicity		
White	93.4%	46.20%
Asian	3.0%	8.30%
Black	1%	2.80%
Mixed	1.9%	1.20%
Other	0.9%	1.10%
Unknown	0%	40.37%
Deprivation		
Deprived (IMD 1 and 2)	42.5%	44.2%
Non-deprived (IMD 3-5)	57.5%	55.1%
Unknown	0%	0.7%

Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY NHS

APPENDIX 2

COVID EARLY WARNING SYSTEM (EWS) SURVEILLANCE REPORT

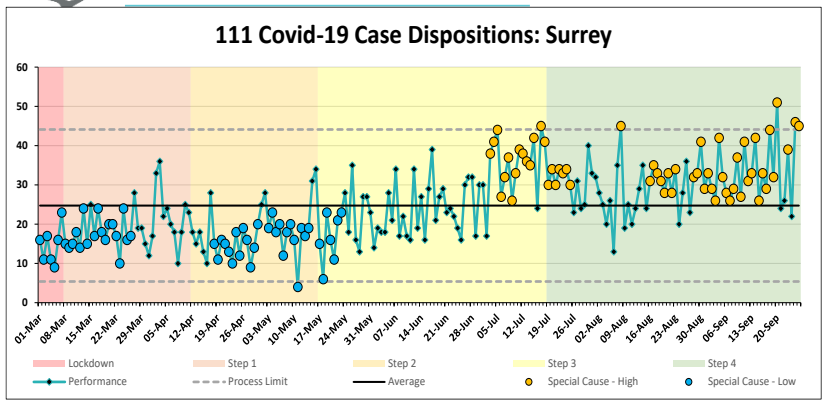
Monday 27 September 2021

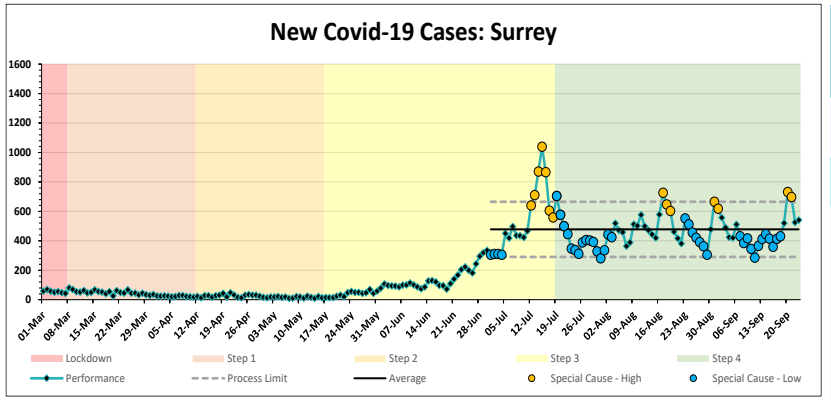
Surrey Heartlands ICS Performance & Assurance Directorate

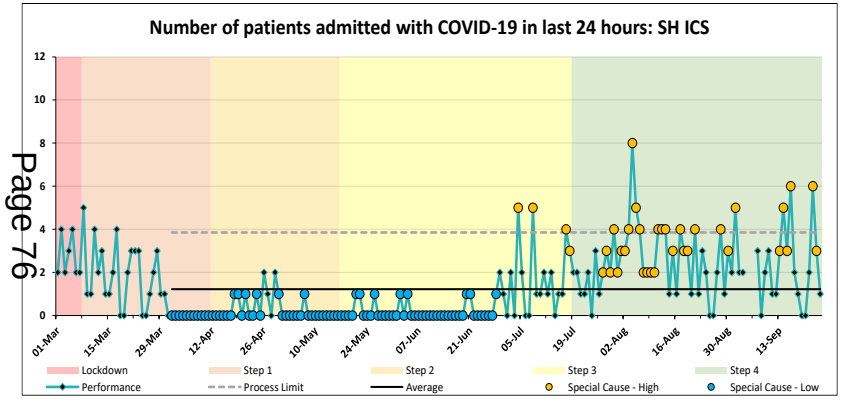
Assurance (shics.assurancesurreyheartlands@nhs.net)

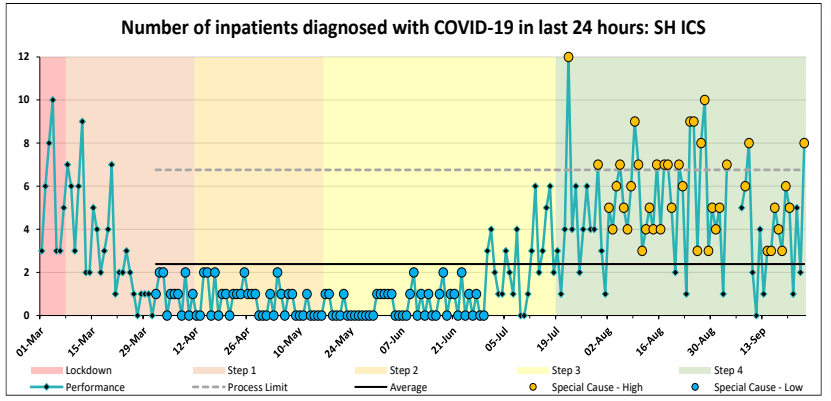
Performance (syheartlandsccg.performance@nhs.net)

Covid Early Warning Indicators (Surrey/ ICS) – 27-Sep

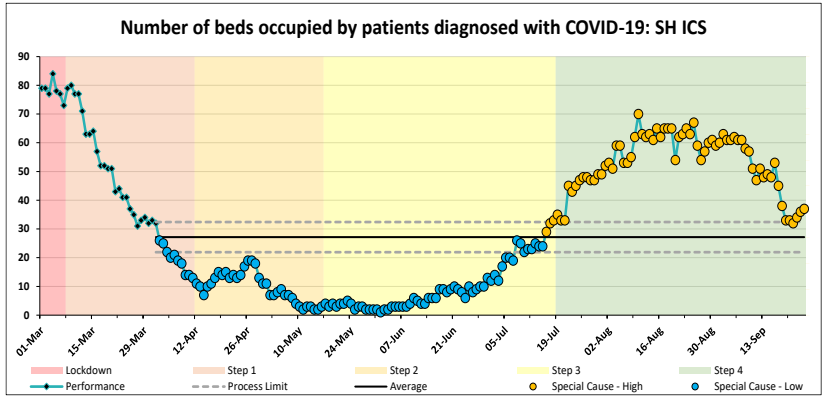








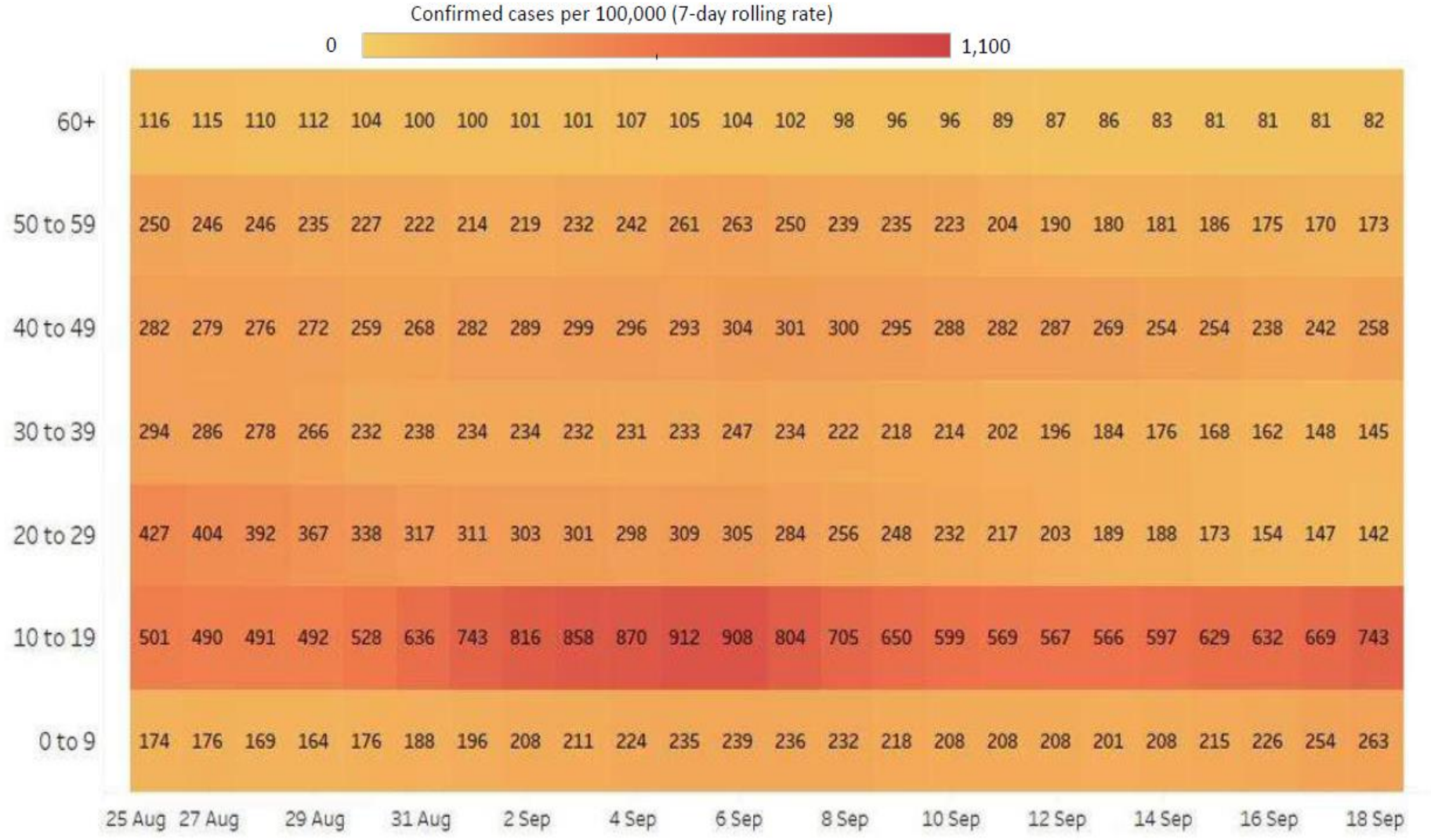
Area	COVID-19 Cases (Last 14 Days)		Rate per 100,000 Population	
England	313,198	-26,177	554	-46
Surrey	**6,088**	**+39**	**507**	**+3**
Elmbridge	855	+418	623	+84
Reigate & Banstead	912	+105	611	+70
Epsom & Ewell	490	+74	605	+144
Surrey Heath	473	-293	530	-28
Guildford	792	+313	527	-10
Tandridge	451	-303	509	-50
Spelthorne	465	+61	466	+5
Woking	432	-33	432	-93
Runnymede	398	-48	441	-30
Mole Valley	364	-170	416	-6
Waverley	456	-85	360	-182



Note: Step 1-4 refer to the easing of restrictions as part of the government's roadmap out of lockdown.

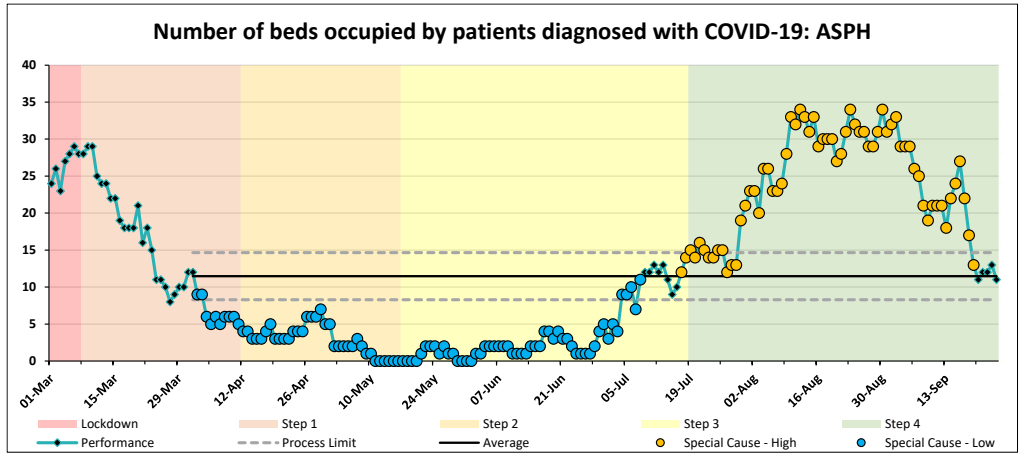
- Over the last two weeks (up to 21-Sep), new Covid cases in Surrey has slightly increased but remains below the England rate. However for three boroughs (Elmbridge, Reigate & Banstead, and Epsom & Ewell) the rate has increased above the national average.
- The case rate for the 20-29 age band has been consistently declining and is now at a similar level to other adult age bands. The case rate for the 10-19 age band has fluctuated over the reporting but remains significantly higher than all other age bands (21-Sep). This will be have been driven by children getting Covid tests in preparation for school.
- Cases of the variant of concern VOC 21APR 02, known as the Delta variant, have been identified in all parts of Surrey. The Delta variant is now understood to be the dominant coronavirus strain.
- Total beds (ASPH, RSFT and SASH) occupied with Covid patients are decreasing, and averaged ~35 over the week to 24-Sep, which is around 3% of the total bed base.

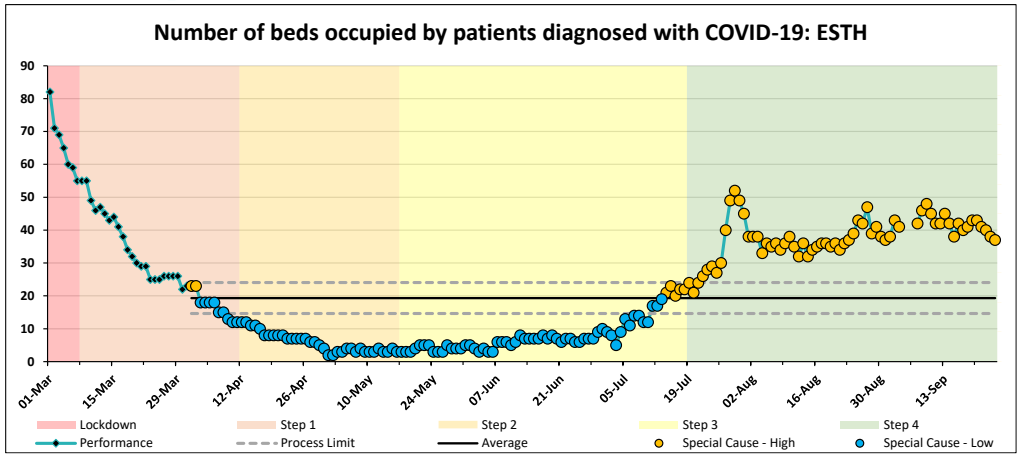
New Covid Cases by Age Band

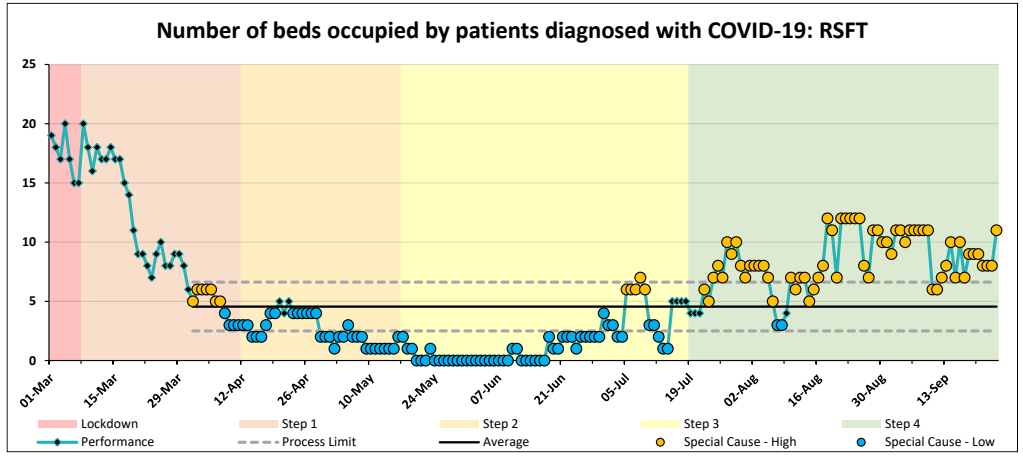


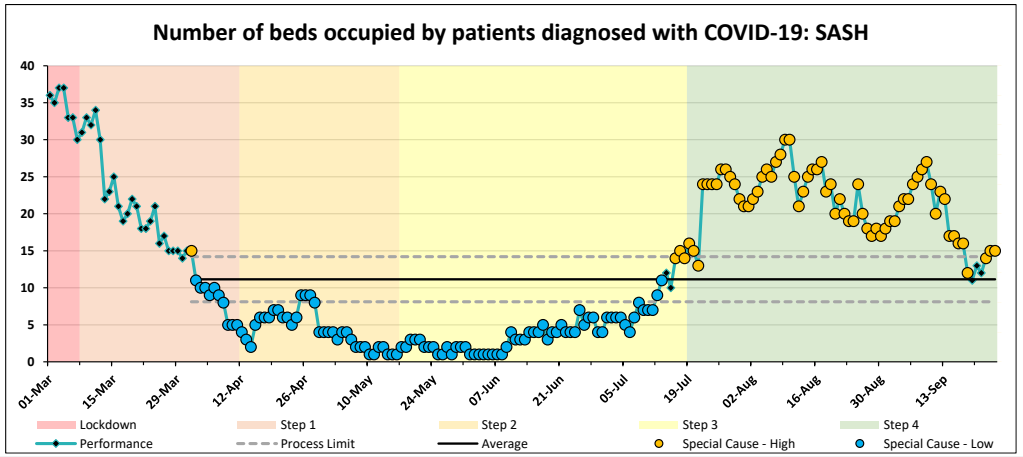
- The table shows the rolling 7 day new cases rate by age band over the period 25-Aug to 18-Sep.
- The case rate for the 20-29 age band has been consistently declining and is now at a similar level to the other adult age bands.
- The case rate for the 10-19 age band has fluctuated over the reporting period and remains significantly higher than all other age bands on 18-Sep. This will be driven by children getting Covid tests in preparation for school.

EWS Indicator 3c – Beds Occupied with Covid Patients





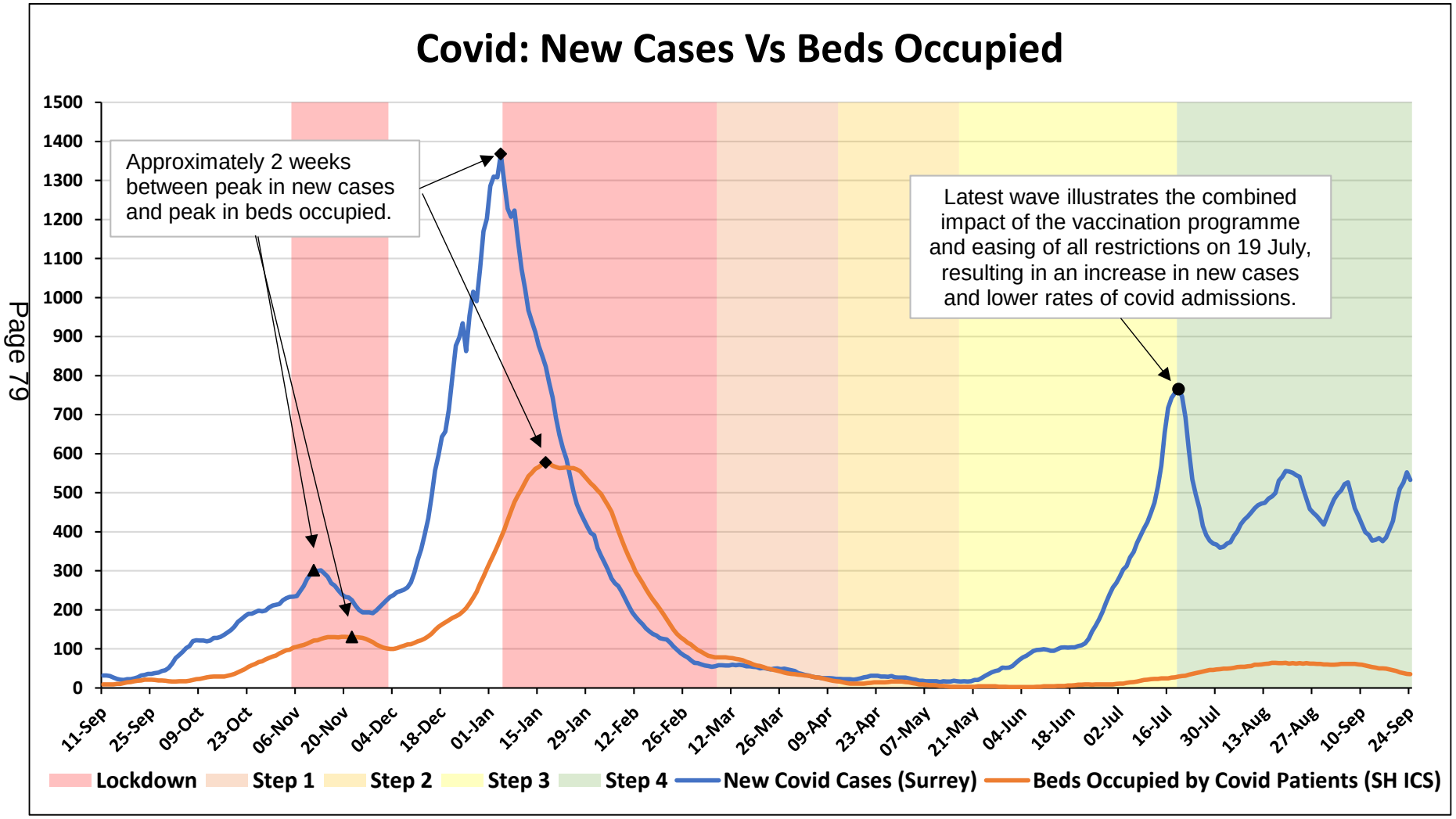




- Total beds (ASPH, RSFT and SASH) occupied with Covid patients averaged ~35 over the week to 24-Sep, which is around 3% of the total bed base.

Note: Step 1-4 refer to the easing of restrictions as part of the government's roadmap out of lockdown.

EWS Indicator Comparison – New Cases Vs Beds Occupied



The chart shows the rolling 7 day average for new Covid cases in Surrey and beds occupied with Covid patients across Surrey Heartlands ICS (ASPH + RSFT + SASH).

In Covid waves 2 and 3, the observed lag between the peaks in new cases and beds occupied was approximately two weeks.

In the latest wave, it is noticeable that trends have changed, illustrating the combined impact of the vaccination programme and the easing of all restrictions. Specifically:

- New cases peaked in mid July but started to increase again in August; this will have been influenced by the easing of restrictions on 19 July.
- Beds occupied with Covid patients increased steadily throughout July, peaking in mid August. Numbers and ratios of those admitted remain lower than in previous waves, with less than 15% of patients being admitted (compared with >40% in waves 2 and 3).

EWS Indicators: Overview

EWS Indicator	Type of Indicator	Scope	Data can be broken down by:	Caveats
1. 111 Covid symptomatic calls	LEADING	Surrey-wide	GP Practice, PCN, Borough, ICP, ICS	Data contains some out-of-area patients i.e not registered to an SH GP Practice.
~~2. Covid GP consultations~~	~~LEADING~~	~~ICS, excluding Dorking practices~~	~~GP Practice, PCN, ICP~~	This indicator has been stood down as not all practices are recording against the 5 possible Covid codes in EMIS.
3a. Patients admitted with Covid	LAG	Trust-wide for ASPH, RSFT, SASH, ESTH, FPH	Trust	Currently figures are so low that SPC analysis is overly-sensitive at identifying special cause variation.
3b. Inpatients diagnosed with Covid	LAG	Trust-wide for ASPH, RSFT, SASH, ESTH, FPH	Trust	Currently figures are so low that SPC analysis is overly-sensitive at identifying special cause variation.
3c. Beds occupied with Covid patients	LAG	Trust-wide for ASPH, RSFT, SASH, ESTH, FPH	Trust	Combined ICS picture can hide increasing pressure at one of the acute Trusts.
4a. New Covid Cases (positive tests)	LEADING	Surrey-wide	Borough	Latest few day's data can be incomplete i.e false 'low'.
4b. Rate per 100,000 population (last 14 days)	LEADING	Surrey-wide	Borough	Compared against England rate.

Surrey Heartlands Urgent and Emergency Care 10-point action plan

Appendix 3

Introduction

- This year has seen significant pressure put on Urgent and Emergency Care (UEC) services. As demand has returned to pre-pandemic levels, managing this activity whilst impacted by, for instance, staff isolation and Infection prevention and control measures has constrained the capacity within the system to manage this demand.
- There are further, complex, reasons for the current challenges within UEC which mean that it will take all parts of the system working together to ensure a strong recovery across urgent and emergency care services.
- The NHS has a plan on how the whole system will work together to ensure UEC services have resilience, by:

1. Supporting 999 and 111 services
2. Supporting primary care and community health services to help manage the demand for UEC services.
3. Supporting greater use of Urgent Treatment Centres (UTCs)
4. Increasing support for Children and Young People
5. Using communications to support the public to choose services wisely
6. Improving in-hospital flow and discharge (system wide)
7. Supporting adult and children's mental health needs
8. Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response
9. Reviewing staff COVID isolation rules
10. Ensuring a sustainable workforce

1a. Supporting NHS 111

System commitments: what's expected of us

Actions at regional level

111:

Participate in bi-lateral discussions with National colleagues to discuss:

- Service funding;
- Service demand and required resource;
- Performance; and
- Implementation of strategic developments.

Ensure continued implementation of NHS 111 First.

Implement Further, Faster (where applicable).

Consider regional networked call handling.

Actions at system/ICS level

111:

Demonstrate system leadership across UEC.

Ensure appropriate commissioning of UEC services and oversight of CAS services.

Facilitate discussions with local primary care, urgent care and secondary care services.

Continue to embed the principles set out through the NHS 111 First Programme.

Actions at provider level

111:

Ensure performance and quality of service.

Spend funding appropriately to maximise resource.

Plan for forthcoming winter.

Actions being taken to improve 111 service delivery

- We are working with Practice Plus Group (PPG) our Integrated Urgent Care (IUC) Provider to strengthen existing capacity across Health Advisor / Clinical advisors / Clinical Assessment Service Staffing through incentives for existing staff.
- Additional recruiters have been brought in to focus targeted recruitment campaigns on part-time/ short term / flexible workers
- Social media campaign and media video to promote working for PPG and 111 as well as retention initiative
- Investment into additional support tools and equipment to support for example home working.
- PPG are currently running a proof-of-concept operational change in the validation of Emergency Department (ED) dispositions to optimise clinical resource within 111 service provision and other services such as Patient Transport Services (PTS) and Same Day Emergency Care (SDEC) that sit across the system to support ED avoidance. ED referrals have reduced and of those that continue to be referred to ED, a higher percentage has had a clinical input and are deemed appropriate.
- We are achieving the national Think 111 first target of 70% of ED dispositions booked into an emergency department appointment slot, with acutes now offering 24hrs slot availability. In excess off 21,154 appointment slots booked since March 2021.
- Consider additional paediatric clinical support in the Clinical Assessment Service (CAS).

1b. Supporting 999 services

System commitments: what's expected of us

Actions at regional level

999

Ensure the £55m allocations are spent through ICSs.

Ensure that tackling ambulance handover delays is a system priority in order to reduce risk of harm to patients both in the community and delayed at hospital.

Actions at system/ICS level

999

Make sure there are robust steps in place to avoid handover delays and swift escalation and resolution of delays

Ensure alternative pathways (such as urgent community response, falls service, mental health crisis) are available to ambulance services to limit avoidable ED conveyance.

Ensure PTS is being most effectively deployed to support UEC and elective recovery.

Actions at provider level

999

Use the £55m allocations to drive improvement against trajectories.

Ensure C3/4 validation amends are implemented as needed.

Make sure capacity issues are escalated rapidly.

Acute providers to accept ambulance transfers rapidly (including to SDEC and specialities).

Actions being taken to improve 999 service delivery

- South East Coast Ambulance Service (SECAmb) have been under sustained pressure which the system is supporting through the actions outlined in the Urgent and Emergency Care 10 point plan. Demand remains exceptionally high, with SECAmb operating under REAP and SMP 4 actions. This is reflective nationally across the ambulance sector.
- SECAmb have stood up strategic commanders to ensure senior presence, support oversight 7 days per week in Emergency Operation Control (EOC)
- Provision of clinical and operational decision support for ambulance crews is in place with Paramedic Practitioner Hubs and Tactical Commanders on-duty 24/7.
- All available clinicians have been placed in patient facing roles. “Business as Usual” meetings have been suspended with all training cancelled (except university programmes for development to Paramedic qualification). SECAmb Leadership teams are working to support staff welfare and positive team working across the entire organisation.
- Cross border 999 impact is under review with predictive conversations being scheduled through with SCAS 999 during times of significant demand to ensure cross county awareness particularly in light of current operational challenges and knock-on impact within Hampshire footprint.
- All Emergency Departments across Surrey are proactively reducing handover delays to support SECAmb.
- Regional escalation calls remain in place on Friday morning with follow up calls continuing across weekends to provide oversight and support.

Actions being taken to improve 999 service delivery

- Central funding has now been allocated to support ambulance performance going into winter 2021/22. The total funding allocated to SECAmb is £4.3m (of £55m)

- SECAmb initiatives include:

  - Recruitment of a cohort of Emergency Medical Assistants (EMA) to reinforce call answer performance.

  - Expansion of capacity through additional crews on the road – considered via the use of Private Ambulance Providers (PAP) and the backfill of Operational Team Leaders and Operational Managers by admin staff (agency)

  - Strengthened additional clinical support in control rooms through recruitment of nurses and other generalists trained in PACCS to welfare call and close down call before physical response is required. This will increase the proportion of Hear and Treat and See and Treat which support less conveyance to ED's. Working with ICS teams, SECAmb will continue to utilise and develop Service Finder and the DOS to identify more appropriate pathways also gives a system wide benefit.

  - Increased Operational Team/Operational Manager hours to support extension of Hospital Ambulance Liaison Officer (HALO) cover at the most challenged acute trusts

  - Development of an approach to enhance the use of taxis to transport patients once initial virtual triage is undertaken that require transport support but do not require clinical attendance at scene. This Non-Emergency transport response will free the Ambulance Fleet up to deliver to C1 and C2 calls.

2a. Supporting Primary care to help manage the demand for UEC services

System commitments: what's expected of us

Actions at regional level

Workforce

Work *with systems and Primary Care Networks (PCNs) to* achieve full use of the Additional Roles Reimbursement Scheme funding in 2021/22 to recruit 15,500 FTE by end of 2021/22. 14 roles are included in the scheme, with paramedics and mental health practitioners added to the scheme in April 2021. Continue to work with the ambulance trusts to introduce rotational models for trainee First Contact Practitioner paramedics in PCNs.

Access

Work with ICSs to effectively plan and deliver support to PCNs and practices to develop effective PCN extended/enhanced access approaches which enable use of digital tools in general practice and PCNs.
Continue to support local implementation and uptake of community pharmacist consultation services, from all referral points, working with 111 and GPs.

Dental

Maintaining urgent dental care systems and current contracted activity. Utilising flexible commissioning and local schemes to target highest need with their populations.

Actions at system/ICS level

Workforce

Work with Primary Care Networks (PCNs) to achieve full use of the Additional Roles Reimbursement Scheme. Utilise the PCN Development funding and funding for training hubs to provide PCNs with the support required to recruit, train and retain the additional staff. Continue to work with PCNs to develop system-wide workforce plans.

Access

Use national DFPC funding to provide support to PCNs and practices to enable effective use of digital tools in general practice.
Ensure PCN plans FOR extended/enhanced access form part of a cohesive ICS approach.
Make plans to roll out PCN wide implementation and uptake of community pharmacist consultation services, from all referral points, working with 111 and GPs.

Actions at provider level

At Trust Level

Workforce

Continue to work with PCNs to developed rotational working models where it is appropriate to do so.

At PCN level:

Access

Use new network DES to develop additional capacity to support practices and PCNs across core and extended hours and make better links with IUC system.

At Practice level:

Access

Access support to enable effective use of digital tools in general practice to support improved access and improved practice workflows.
Implement referrals to community pharmacist consultation service for low acuity patients.

Workforce:

Primary Care Networks to use their full entitlement of Additional Roles Reimbursement Scheme (ARRS) funding to recruit additional staff into PCNs.
Continue to support GPs and additional staff through accessing support offers like #LookingAfterYouToo.

Actions being taken by Primary Care

- **Demand and capacity/ Operational Pressures Escalation Level (OPEL) framework for general practice**
  - Daily data upload from GP providers
  - Activity management framework supporting surge/pressures
  - OPEL framework based on demand and staff absences
  - Constant monitoring of modes of contact (ie. face to face versus virtual)
- **Additional capacity/access**
  - Accelerate delivery and referral to community pharmacy General Practice Community Pharmacist Consultation Service (GPCPCS)
  - Additional winter investment to support OPEL framework and capacity
  - Virtual consultations via external supplier
- **Workforce**
  - Additional Roles Reimbursement Scheme (ARRS) trajectory monitored, with support from CCG in recruitment/employment
  - Refocus on GP recruitment and retention
  - Scoping Surrey Heartlands receptionist accreditation scheme
- **Digital tools**
  - Remote monitoring tools for Long Term Conditions
  - Systems (AccuRx/Flories) – Quality and Outcomes Framework supported by additional digital data gathering
- **Wider system support**
  - All practices accessing 111 Slots
  - Hot hubs (with particular focus on paediatrics)

2b. Supporting community health services to help manage the demand for UEC services

System commitments: what's expected of us

Actions at regional level

Continue to support systems with the rollout of two-hour crisis response services.

Support systems and providers in working collaboratively with providers of NHS111 integrated urgent care services.

Where needed, support coordination and linking of 999 ambulance services with community health services.

Ensure systems and providers are working with directory of service (DoS) leads to add services to the DoS to ensure visibility and coverage of two-hour crisis response (UCR) services across the system.

Ensure any local communications campaigns align with national messaging and requirements around two-hour crisis response (UCR) and support the dissemination of national communications.

Actions at system/ICS level

Continue to support the rollout of two-hour crisis response services across the ICS in line with the NHSE/I Operational Planning and Contracting Guidance 2020/21.

Work with providers and DoS leads to profile (add) two-hour crisis response (UCR) services onto the DoS.

Work to understand potential demand for two-hour crisis response (UCR) services from key referral sources including NHS111 and 999 and link with wider UEC work around admission avoidance and care in the right place.

Along with 999 ambulance Trusts and community health service providers develop streamlined referral pathways to support ambulance hear and treat and see and treat.

Actions at provider level

Ensure delivery of two-hour crisis response (UCR) services in line with the NHSE/I Operational Planning and Contracting Guidance 2020/21.

Work with local DoS leads to profile (add) two-hour crisis response (UCR) services onto the DoS.

Work collaboratively with local NHS111, clinical assessment services (CAS) and 999 ambulance Trusts to agree streamlined and well governed referral pathways for clinicians (non-clinician referrals can be agreed locally). This may include validated cat3/4 999 calls.

Work collaboratively with local NHS111, CAS and 999 Ambulance Trusts to engage and support referring clinicians' knowledge and understanding of two-hour services to maximise referrals from these sources, through sharing of comms, CPD events and local feedback mechanisms to share learning.

Continue to monitor numbers of referrals from key sources and identify and address any gaps.

Actions being taken by community services

- All of our community providers have funding in place in the process of rolling out the urgent 2 hour community response service. Where we can this is being accelerated to be in place before the end of 21-22.
- Rapid community response to care homes is being stepped up to support keeping patients in their homes.
- The directory of service through 111 has been reviewed at place as part of the think 111 first programme. This ensures all community services are made available.
- Our urgent care services like our walk in centres and minor injury units along with Urgent Treatment Centres (UTCs) are all mapped on the Directory of Service (DOS) and have the ability for patients to be booked an appointment.
- We have mobilised the NHS Digital (NHSD) streaming and redirection tool to provide a digital triage offer at the front door of our EDs and UTC. To date 4515 unheralded patient's have used the tool and our ICP's are utilising this baseline data to consider opportunities to develop or improve alternative pathways where we can either internally stream or redirect to alternative services, with the aim of getting patient's to the right place first time and reducing pressure at the front door.

3. Supporting Greater Use Of Urgent Treatment Centres (UTC)

System commitments: what's expected of us

Actions at regional level

Ensure that systems are reviewing demand and capacity for lower acuity urgent and emergency care, and that the status of temporarily closed Type 3 and 4 services is reviewed to ensure capacity is aligned to local demand.

Work with their systems to explore UTCs or other enhanced triage services for lower acuity patients at the front door of ED, where this would address demand and capacity issues.

Actions at system/ICS level

Review capacity and demand across their portfolio of type 3 & 4 services, including those temporarily closed during Covid.

Ensure available capacity and capability of Urgent Treatment Centres is matched to demand, and that UTCs are commissioned and delivering against the agreed UTC standards.

Agree and develop new pathways for lower acuity patients as an alternative to ED, including booking from NHS 111.

Where outstanding, agree long term reconfigurations to adopt the UTC model.

Actions at provider level

Deliver the UTC model and support implementation of new pathways.

Where necessary, enhance current UTC capability and/or capacity to meet demands (e.g. extended hours, enhanced case mix.)

Where this would manage ED demand more effectively, review the need for enhanced triage and/or redirection at ED front door, with an emphasis on primary and community led-provision.

Action being taken to optimise use of urgent care provision

- Surrey Heartlands maintained all urgent care provision during wave one and two of COVID and in some parts of the system services have been increased to support reducing demand on the EDs
- Our UTCs are commissioned against the UTC standards.
- We have reviewed the DOS and ensured we have maximised the opportunity for directing patients from 111 in to UTC , Walk in Centres (WiC) and Minor Injury Units (MIU).
- UTC service has been extended to meet demand at Ashford & St Peters Hospital (ASPH) , other urgent care provision is exploring the potential to enhance the service but skilled workforce is a challenge.

4. Increasing support for children and young people

System commitments: what's expected of us

Actions at regional level

To oversee Regional surge planning/mitigations for RSV/seasonal demand in CYP services.

Actions at system/ICS level

To implement agreed surge planning and mitigations for RSV/seasonal demand in CYP services as appropriate.

Actions at provider level

To implement agreed surge planning and mitigations for RSV/seasonal demand in CYP services as appropriate.

Actions being taken to support young people and children.

- Proactive monitoring of surges in activity for all Children and Young Persons (CYP) regarding seasonal uplifts such as Respiratory Syncytial Virus (RSV)
- ICS Paediatric respiratory surge plan that identifies surge capacity, procurement of additional cots/equipment, improve process of early supported discharge, and agree mutual aid process.
- Paediatric transfer vehicle to support mutual aid to move lower acuity children to other sites across Kent, Medway, Surrey and Sussex (KMSS) to support paediatric units that are under surge and require capacity to treat our sickest children.
- Targeted comms to parents to support self care use of social media.
- Additional workforce in acutes to support surge beds.
- Paediatric specific Improved access appointments in primary care.
- Scoping use of clinical paediatric call back service for parents in the community.

5. Using communications to support the public to choose services wisely

System commitments: what's expected of us

Actions at regional level

Ensure signposting messaging is accurate and consistent across ICSs and providers in your region.

Amplify national campaigns and cascade regionally.

Ensure take-up of campaigns at provider level i.e. length of stay or flu campaigns.

Ensure local campaigns are consistent with national messaging.

Actions at system/ICS level

Work in partnership to co-ordinate consistent messaging across your ICS area.

Ensure messages/campaigns are shared, where appropriate, to your strategic partners such as local councils and voluntary sector.

Actions at provider level

Ensure promotion of length of stay campaign within your trust.

Work with ICS and regional colleagues to ensure understanding of other system pressures (i.e. NHS 111) before signposting patients to alternative services at busy times.

Actions being taken to support communications and citizen engagement

Leading system-wide communications

- As part of our system-led communications and engagement approach, we proactively reinforce national campaign messages across the ICS. Proactively sharing messages across our full suite of channels and platforms about where to seek help, and how to use services appropriately, forms a key part of this strategy.
- On a day-to-day basis, we reinforce national messaging through a range of different channels and tactics including social media (including paid advertising to target specific areas or demographics where needed), our CCG and ICS websites, the media (including putting a trained clinical spokesperson on radio to reiterate key messages), promotion of national campaign assets (including Help us Help you and Think 111 First messaging) and other forms of advertising, where needed.
- We also work closely with local partners including Surrey County Council, public health, district and boroughs and our providers to co-ordinate activity and campaigns, sharing assets to further amplify messages and maximise the use of all channels to reach and engage Surrey residents. This includes actively contributing to bi-weekly winter/ system planning meetings, meetings of the Surrey Health and Wellbeing Board communications Group and bi-weekly meetings with provider comms leads across Surrey Heartlands to ensure a coordinated approach.

Actions being taken to support communications and citizen engagement (continued)

Activating our Opel communications plan in response to sustained system pressure

- We work closely with the urgent care team to increase communications activity at times of sustained system pressure and we have well established protocols in place.
- This includes the activation of our Opel Communications Plan which triggers additional communication activity to increase the flow of messages and support the wider system during periods of significant pressure.
- The activation of this plan results in an increase in social media activity (linked to data insight where available – e.g. targeted messages to parents following an increase in paediatric ED attendances), specific and targeted information being shared through our networks, website updates and collaborative work with broader system partners to amplify key messages and enhance their reach to achieve greater impact.

Actions being taken to support communications and citizen engagement (continued)

Targeted campaigns

- In addition to the activity mentioned, the following campaigns are also in train to further amplify messages and help people understand how to access services appropriately.
- ***Help us, help you*** **campaign** – having secured match-funding from the regional team, we are developing a multi-channel campaign that is due to launch in November 2021.
- Working with a full service creative agency, the campaign will take a more creative approach to help educate people on which service to access when (based on their clinical needs). Campaign activity will include the development of an animation and other assets, targeted paid for social media advertising, outdoor advertising, radio and the creation of a micro-site that will sit under the ICS website. As part of the campaign, we will be working closely with Surrey County Council and other partners to amplify reach and we are also exploring plans to work with schools to incorporate a focus on behavioural change, educating young people on how to choose the right services in a fun and engaging way.
- As part of the broader '*Help us help you*' message, we are also supporting providers with the introduction of the streamer tool in A&E and messages linked to this. We are also working with national colleagues to further develop our communications plans as part of a national *'Further, faster'* pilot.
- Our campaign will complement the national *Help us, help you* message and we will also reinforce the **national NHS111 campaign** across the ICS, when this campaign launches in November.

Actions being taken to support communications and citizen engagement (continued)

Targeted campaigns

- The **'Face of support' mental health campaign**
- Following an increase in demand for mental health services, linked to the pandemic, we are also working as a system (with provider, Surrey County Council, district and boroughs, public health and the voluntary sector) to deliver a 'Face of support' campaign.
- Campaign activity includes the refresh of the Healthy Surrey website mental health pages, the development of a series of local assets for use on social media (including videos where staff talk about how to look after your own health and wellbeing and how to access support), paid for social media, outdoor advertising and a leaflet door drop to all households in Surrey (planned for November 2021 and also to include some wider system/ 111 messages).
- The campaign is already live on social media and further activity will launch to coincide with World Mental Health Day on 10 October 2021.
- Given the increase in the number of young people accessing support, there will also be a separate element of the campaign that will focus on young people – how they can stay resilient and look after their own emotional wellbeing, also with signposting to the new Surrey Mindworks service. Assets and materials will be an extension of the 'face of support' creative but will be developed to appeal to young people.

Actions being taken to support communications and citizen engagement (continued)

Targeted campaigns

- **Boost your immunity campaign**
- We are also actively promoting the national 'boost your immunity' campaign across the ICS, working with partners through a range of multi-agency groups.
- This includes working closely with Surrey County Council colleagues to target communications at specific cohorts (e.g. 12-15 year olds and other cohorts for Covid vaccinations/ boosters and cohorts that form part of the flu vaccination programme), using a range of different channels and tactics, supported by broader outreach work with communities, particularly in areas of lower uptake (e.g. pregnant women).
- Campaign activity is far reaching and includes social media (including paid for advertising), articles in publications, websites and the inclusion of messages in a door drop to all households in Surrey.

6a. Improving in hospital flow and discharge (SDEC)

System commitments: what's expected of us

Actions at regional level

Assure plans to implement direct referral from GP/111/999 to SDEC / secondary care.
Dedicated regional leadership to support SDEC/ Acute Frailty.
Assure provider plans to restore SDEC provision.
Escalate provider constraints to restoring SDEC minimum requirements to national team.
Assure capital spend for additional SDEC capacity, identifying gaps in estate provision against capital funding.
Identify providers requiring additional support with SDEC modelling.
Communicate new guidance and best practice to providers.

Actions at system/ICS level

Drive system culture and leadership plans to support Direct Referrals into secondary care/ SDEC.
Drive best practice sharing, peer reviews.
Own and monitor improvement programmes.
Drive conversations on capital spend for SDEC activity.
Drive provider plans to deliver SDEC/ AF to minimum standards.
Undertake system wide demand and capacity reviews for SDEC services ensuring these are aligned to ED demand.
Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Have plans in place to restore SDEC provision 12hrs, 7 days as a minimum. Promote direct referral provision from GP/111/999 and virtual ward.

Ensure Rapid Demand and Capacity Reviews match ED Demand, supporting patient flow.

Ensure sufficient estate to meet the increase in demand and constraints around IPC.

Avoid usage of SDEC as a bedded ward overnight.

Ensure acute Frailty SDEC Provision 70hrs + per week.

6b. Improving in hospital flow and discharge Commissioner Requested Services (CRS)

System commitments: what's expected of us

Actions at regional level

Assure system plans to measure:

- time to initial assessment for all patients presenting to A&E.
- the proportion of patients spending more than 12 hours in A&E from time of arrival.
- the proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed.

Assure system plans to incorporate daily reviews against the metrics, that meaningful conversations are taking place with referring specialties and that long waits are improving.

Actions at system/ICS level

Drive system culture and leadership plans to support CRS.

Drive best practice sharing, peer reviews and case studies.

Own improvement programmes with ongoing monitoring.

Drive provider plans to operationalise CRS metrics with specific focus on mobilisation and implementation plans.

Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Develop processes to implement time to initial assessment within 15 minutes of arrival.
Early senior review to support early discharge/ admission.
Review proportion of patients residing in ED for more than 12-hours.
All patients presenting to ED will have CRtP recorded.
Timely onward care once a decision has been made that the patient no longer requires treatment in ED and is ready to proceed to their next point of care, or discharged home – within 60-minutes.
Processes in place to review patients in ED longer than 60-minutes when declared CRtP with referring specialities.
Review 12+ hours waits - patients should not spend longer than 12 hours in ED from time of arrival.
Processes in place to treat the sickest patients quickly and departments do not become crowded by those patients who do not require admission into hospital.

6c. Improving in hospital flow and discharge (reducing Length of Stay - LoS)

System commitments: what's expected of us

Actions at regional level

Undertake data driven conversations, paying particular attention to key metrics to monitor progress.
Drive implementation of the National Operational Hospital Discharge policy
Maximise flow over seven days including increasing weekend discharges.
Drive clinical leadership and engagement to support discharges and reduce LoS .
Promote implementation of the RCP Ward Round/Board Round best practice.
Promote use of Criteria to admit improvement tools.
Continue to identify and work with Trusts of Focus.
Work with ECIST/Improvement colleagues where needed and promote Trust participation in the forthcoming Winter Alliance.

Actions at system/ICS level

Provide robust system leadership and undertake data driven conversations, paying particular attention to key metrics to monitor progress.
Drive implementation of the National Operational Discharge policy
Maximise flow over seven days including increasing weekend discharges
Promote clinical leadership and engagement to increase discharges and reduce LoS
Undertake system wide capacity/service provision gap analysis and apply integrated commissioning approach

Develop/strengthen governance arrangements to support collaboration.

Actions at provider level

Undertake data driven conversations, paying particular attention to key metrics to monitor progress
Drive implementation of the National Operational Hospital Discharge policy
Maximise flow over seven days including increasing weekend discharges
Utilise clinical leadership and engagement to increase discharges and reduce LoS
Promote implementation of the RCP Ward Round/Board Round best practice
Promote use of Criteria to admit improvement tools.
Work with ECIST/Improvement colleagues where needed and actively participate in the forthcoming Winter Alliance.
Building on Transfers of Care around Medicines (TCAM) work with AHSNs, providers should increase referrals into the community pharmacy discharge medicines service, to support safe and timely discharge of patients with complex medicines usage and to reduce emergency readmissions due to medication issues.

Actions being taken to improve hospital flow

- ICS have established a Urgent and Emergency care Board. This board oversee the delivery of the urgent care strategy and maintain oversight of our system response to surge. Its works in parallel to the System resilience and Emergency Preparedness. Resilience and Response (EPRR) board that oversees our preparedness and response to incidents.
- Improving flow through schemes like Think 111 first (further faster pilot) CRS, SDEC and reducing length of stay are overseen at an ICS level by the UEC board which the Local Accident and Emergency Delivery Board (LAEDB) at place report into.
- Acute providers all provide SDEC services across the 7 days. 200-260 patients per day utilise the Surrey Heartlands SDEC services.
- Through the Think 111 first programme and the ED streamer tool we are working with providers to identify patients that can bypass ED into SDEC services.
- Surrey Heartlands have been selected as on e of 7 sites to participant in the national "Further Faster" programme, this offers additional support (consultancy and funding) for areas that have an advanced position with regard to front end urgent care access, like developed Think 111 first programmes. Part of the Further Faster programme requires the meeting of the national SDEC commitments.

Actions being taken to improve hospital flow

- ICS UEC team are establishing a system resilience and surge hub to maintain operational and system oversight across the 7 days.
- The UEC team oversee performance against key metrics we collate through an information system called Alamac.
- Using the Alamac platform we identify triggers and are working towards ICS early warning system.
- We use this platform to also produce reports and it provides a live operational dashboard for all on call manager across the ICS to use.
- We hold daily ICS GOLD calls with providers to assessment the risks, agree the level of escalation as an ICS and agree actions.
- We have developed OPEL scoring matrix across providers to understand OPEL escalation level using same set of metric to compare providers level of surge,.
- We have a ICS surge plan we use to ensure we facilitate the right response and outline the roles and responsibilities.
- As an ICS we are developing our modelling and forecasting data with Alamac (Data provider) and providers to proactively manage surge. This include modelling for COVID, winter surge and paediatric demand.

Actions being taken to improve hospital flow

- All providers at place are finalising local winter surge plans
- ICS support this through bidding for additional funding from NHSE.
- Providers monitor length of stay and patients that are medically fit for discharge and all system partners meet daily to work through these patients to expedite discharges. This is extremely challenging with current workforce challenges across Health and Adult Social Care (ASC).
- Urgent Care (UC) and Mental Health (MH) regional leads are integral to development of winter planning.

7. Supporting adult and children's mental health needs

System commitments: what's expected of us

Actions at regional level

UEC and MH regional leads to ensure MH integral to winter planning.

Use ECDS dashboards to identify ICS with high/worsening mental health ED pressures, as well as where improvements have occurred.

Bring systems together to share learning.

Ensure all local areas have s.140 compliant MH service escalation in place as well as clear regional process.

Ensure MH funding allocated in line with MHIS; provide system support/challenge where spend not in line with expectations or LTP delivery off track (based on regular assurance returns).

Support use of discharge/LTP MH funding to enable multi-agency discharge planning / admission avoidance across providers CCGs and LAs and VCS, including through MADE events.

Promote and encourage access to staff wellbeing hubs and other initiatives.

Actions at system/ICS level

Promote 24/7 urgent MH helplines locally. Ensure all are profiled onto NHS 111 DoS as a minimum in short term (ahead of formal access to urgent MH care via 111 as per LTP).

Expand capacity and range of alternative spaces to A&E to meet urgent MH needs in the community.

Explore liaison at ED front door to support diversion where possible.

Allocate share of local capital funding for MH capacity pressures.

Ensure MH integration with ambulance response for see and treat to minimise conveyance toE.

Ensure NHS working alongside LA mental health services, including through place-based funding, s.75 arrangements, regular MADE events and use of discharge funding.

In particular, work with LAs on adult bed pressures – by commissioning and developing market of short/long term supported housing and AMHP provision as priorities.

Work with CYP LA services to avoid lengthy delays in ED or paeds wards for CYP with MH needs while awaiting LA input.

Put in place s.140 compliant bed escalation protocols.

Afford funding/operational freedom to provider collabs, embed light touch approach to contracting avoiding lengthy processes.

Actions at provider level

Invest in staff wellbeing initiatives.

Recover face to face care in CMHTs, particularly to prevent relapse for people with SMI to prevent relapse and high acuity presentations to crisis services.

Focus on reducing excessively long LoS in inpatient MH services using approaches such as setting estimated discharge dates, recording purpose of admission, red to green, D2A, 'perfect week'.

Ensure exec clinical/operational oversight of bed escalation and MH inpatient flow, with daily flow meetings, senior alerts for ED waits above 4/6hrs, long stayers in wards.

MH providers should work with the police to reduce avoidable use of s.136.

Acute providers should work with MH services to ensure dedicated MH assessment space available in or near acute hospital sites.

Provider Collaboratives to develop capability to directly sub-commission at place flexibly, including VCS and LA providers, with reduction in l contracting and procurement processes.

Actions being taken to support mental health

- Rolling out a mental health escalation protocol across all acute sites to manage mental health demand.
- Face to Face Care provided by Community Mental Health Teams (CMHT) for those patients with Severe Mental Health Illness (SMI)
- Enhance home treatment teams to increase resource to provide assessments and support in patients home.
- To continue remote monitoring of mental health patients in the community implemented through COVID. Providing in-reach through senior mental health nurses into patients homes.
- Enhance psychiatric liaison service to support holding patients in the community and following up patients at home after discharge.
- Enhance younger persons crisis support across all acutes.
- Young persons MH pathway workers to help with discharge and ongoing support.
- Extend the paediatric triage line for mental health support and advise.
- Extend financial support for packages of care outside of core services for young people. Includes children with ASD , LD and challenging behaviours.

8. Reviewing Infection Prevention and Control (IPC) Measures to ensure an proportionate response.

System commitments: what's expected of us

Actions at regional level

Actions will be formulated following the review of the IPC guidance.

Actions at system/ICS level

Actions will be formulated following the review of the IPC guidance.

Actions at provider level

Actions will be formulated following the review of the IPC guidance.

9. Reviewing Staff COVID Self Isolation Rules

System commitments: what's expected of us

Actions at regional level

Monitor the impact of staff absence due to isolation across Regional footprint supporting challenged organisations to take mitigating actions where appropriate.

Actions at system/ICS level

Monitor the impact of staff absence due to isolation across ICS footprint supporting challenged organisations to take mitigating actions where appropriate.

Actions at provider level

Ensure Compliance with updated Staff Isolation guidance.

Actions around managing COVID

- Each provider adheres to the IPC rules and have established COVID (Red) pathways (Amber) non COVID pathways and Green (Clean) elective pathways
- Each day providers have to review and adjust bed provision to meet demand of patients coming through these three pathways.
- As a system we are working to protect all three to maintain both urgent care demand but also elective and cancer demand.
- All provider monitor staff for COVID through Lateral flow testing. Attrition rated due to COVID infection or isolation are collated through specific COVID sit rep reporting

10. Ensuring a sustainable Urgent Emergency Care (UEC) workforce

System commitments: what's expected of us

Actions at regional level

Ensure sufficient Pillar 1 testing is available to support self-isolation.

Actions at system/ICS level

Work with the local Domiciliary and Care Home market to develop ICS led response to workforce shortages

Actions at provider level

Fully support and engage with staff on local and national HWB offers.

Plan recruitment across 111 services.

Repatriate workforce back to SDEC – looking at new way staffing models/ skill mix.

Planned Actions: Workforce

Workforce factors continue to pose limitations on the ability of services to meet current and future surge demands. Issues centre on the backlog of annual leave, simultaneous rollout of C19 and flu vaccination programmes, general staff health and wellbeing and the age profile of community care and primary care staff. These issues result in reduced capacity to respond to latent demand which are further compounded by circulating CoVid 19 (C19) infections, unknown demand from long COVID and increase patient acuity.

RISKS/ ISSUES	MITIGATIONS
Annual Leave – There is a risk that operational capacity may be impacted if a backlog of annual leave, and the potential sharp uptake of annual leave post lockdown, coupled with staff absence due to ongoing health and wellbeing concerns.	• Trusts have updated policies in relation to buying back / AL carry over • Annual leave monitoring and use of HR Director (HRD) Network and Surrey Heartlands People Board as escalation points • MOU in place to facilitate staff sharing across organisations.
Health & Wellbeing - Negative impact of Covid-19 pressures on staff wellbeing with potential for increasing levels of sickness absence if demand levels are sustained into the Autumn.	• All NHS providers have a Wellbeing Guardian function in place, along with the establishment of health and wellbeing groups. Health and wellbeing conversations are taking place both informally on a regular basis and formally on an annual basis, depending upon provider. • Moving forward with enhanced HWB and inclusive HWB programmes (includes HWB conversations and staff safety). • The Surrey Heartlands Resilience Hub provides access to health and wellbeing services. • Health and Wellbeing initiatives across the system include Mental Health First Aid (MHFA) training, Trauma Risk Management (TRiM) training, (Freedom to Speak Up (FTSU) guardians, Staff Igloos at RSFT, Pods at SASH, and a new Wellbeing Centre at ASPH.
Recruitment and retention - Reduction in international recruitment rates due to several challenges (quarantine rules, agency delays, border controls, available mentors).	• Partners continue to manage recruitment of international staff internally, with escalation to the Resourcing Network and then Surrey Heartlands People Board where appropriate. • International Retention programme to commence in order to address issues related to turnover of internationally recruited staff • Vaccine Workforce Programme to commence in order to fill vacancies with individuals that have signed up to work for the vaccine programme. • Surrey Heartlands Recruitment campaign
Vaccination - Both the C19 and flu vaccination programmes are primarily delivered by out community and primary care providers, creating staffing and service delivery pressures during the recovery phase. There are also WF pressures at some of the Vaccination Sites as people return to their lives.	• Ongoing work with SJAB to support vaccination sites • Recruitment via Landmark into roles that can support CSH Surrey services • Ongoing communication between ICS and vaccination providers to ensure stability of services, with escalation where required
Community health – The increase in acuity and dependency of complex patients, both on inpatient wards and domiciliary caseloads, demand for long COVID services, and the age profile of our People in this area, create increasing pressures on our services.	• Workforce Development Funds to be used to develop the Out of Hospital workforce • Enhanced Health and Wellbeing programme to develop support for long COVID • Provision of support as per the Health & Wellbeing mitigations • Surrey Heartlands Recruitment campaign
Primary Care – Increased demand & workforce capacity gaps in particular in practice nursing, and difficulties in filling some professional ARRS roles to support.	• Surrey Heartlands Recruitment campaign • Commencing Primary Care digital staff bank. • Launching Return to practice Programmes for Occupational Therapists. • ARRS recruitment model will link with GP Integrated Mental Health Service (GPIMHS) model. • Surrey Training Hub delivering action learning sets, coaching and mentoring to support development.

Surge Planning & Modelling

ICS Surge Planning

- The Surge plan for Surrey Heartlands is a live document which incorporates emerging guidance, modelling and learning from previous years of winter operations, Flu outbreaks and the first two waves of the CoVid19 pandemic such that it will continue to be a developmental plan and therefore this plan be updated to reflect the current situation in which we are operating.

- A UEC Early Warning System (EWS) has been developed which, in conjunction with the CoVid Early Warning System, contains triggers and actions supported by the modelling.

- Triggers encompass all elements of the local healthcare system, Primary Care, Secondary Care and Community providers associated actions in times of surge detail those services that are required to alter or change configuration and planned levels of activity.

- The EWS will remain under constant review and subject to change as the peak seasonal demand unfolds.

ICS Surge Planning

- In summary, the Plan:
  - Sets out the risks and triggers for escalation and mutual aid within prescribed and dictated responses,
  - Sets out minimum expectations at each level of escalation,
  - Clarifies roles and responsibilities,
  - Sets consistent terminology / definitions,
  - Defines communication processes e.g. through agreed ICP and ICS System Call Terms of Reference.

- The plan will continue to be updated and reflect the UEC Recovery 10 point action plan which identifies the way in which the whole system will work together to ensure UEC services and maintain resilience through 999 and 11 services, Primary Care and community, UTCs, Children and Young People, Communications, Patient flow in hospitals, Adult and Children's Mental Health, IPC, CoVid and Workforce

- The current winter plan has been submitted to NHSE/I for comment and assurance checks, future adaptations will be validated in this manner throughout the winter period as appropriate.

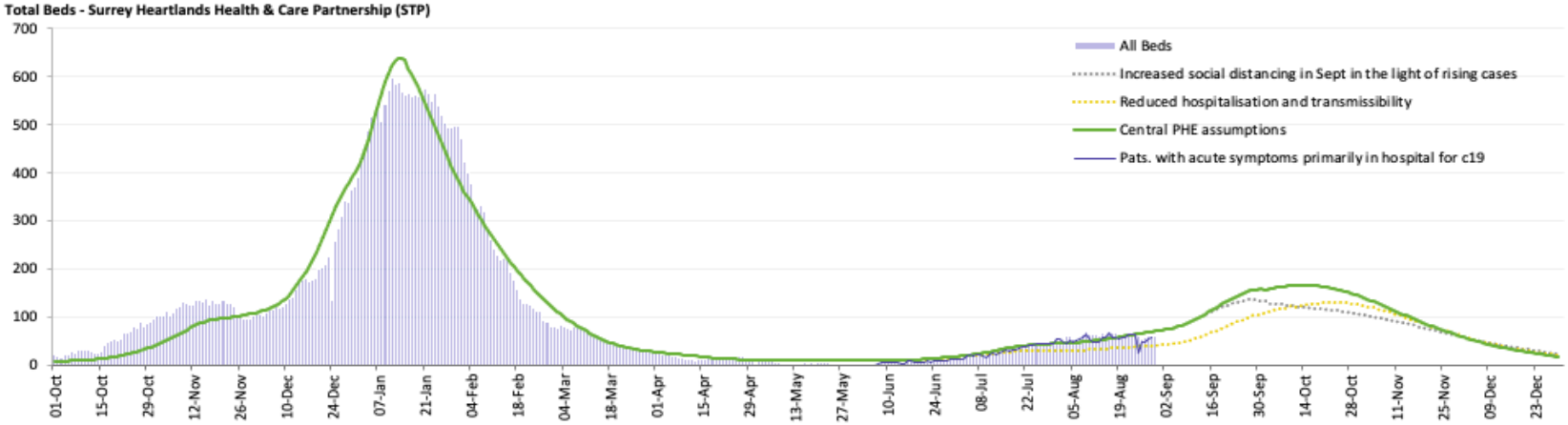
ICS CoVid Models

The modelling outputs are based on current understanding which is evolving rapidly around a number of pivotal modelling assumptions. They are therefore transitory in nature and there are inherent uncertainties in the modelling. They may be helpful for understanding the potential relativities in alternative scenarios but should not be relied upon as a source of projected absolute values for any output variables.

The scale and timing of further waves of CV19 demand on NHS services are driven on ***very uncertain modelling assumptions***, including:

- real world vaccine effectiveness against infection and severe disease leading to hospitalisation
- vaccine uptake in addition to rollout speed
- extent to which our local populations will continue to effectively practice the social distancing practices asked of them by the government to reduce transmission

ICS CoVid Model



- The modelling **does not take** account of a widespread new variant significantly decreasing the effectiveness of the vaccines.

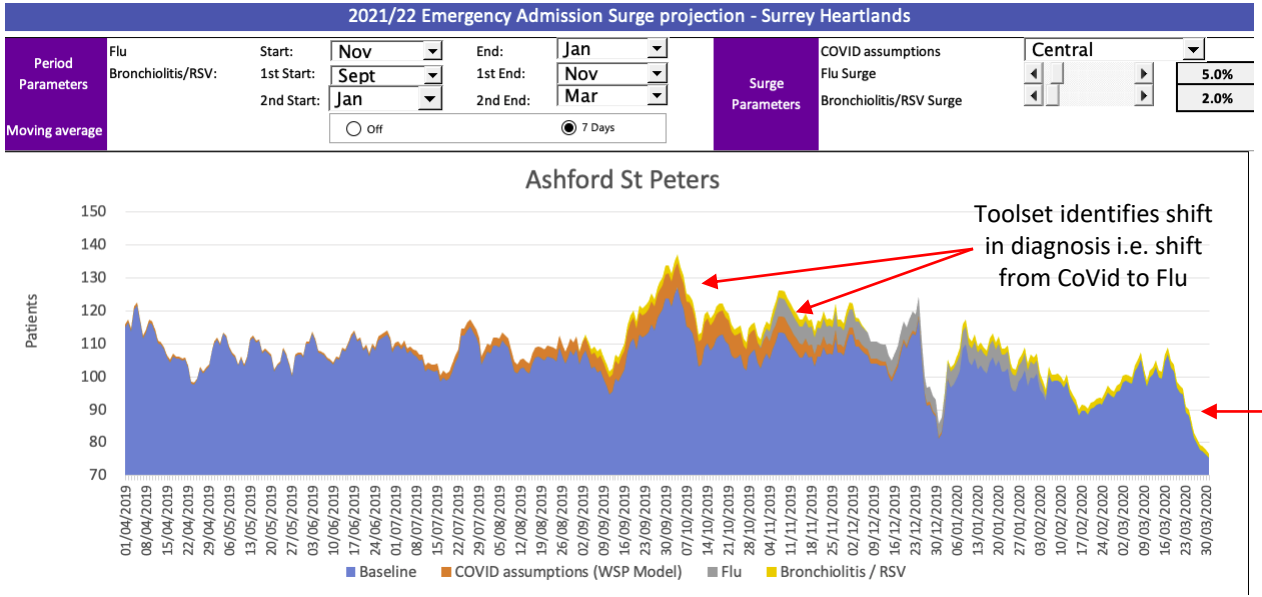
- Three reasonable scenarios have been produced based on the current understanding. It is highly probable the outputs of these scenarios will change in the coming weeks as we learn more.

- Long term scenarios are currently highly uncertain and should be used to inform colleagues of possibilities rather than used as the basis for planning numbers.

Trust Toolset - Summary

- The toolset has been developed to aid in operational decision making at each Trust, focussing on likely requirements for bed numbers,
- The toolset is built on a baseline from 2019/20 (as the last stable year statistically) the impact of CoVid plus a percentage uplift for Flu and RSV is then applied and can be altered reflecting actual % uplift for each group of patients admitted,
- Each Trust has their own, tailored model which has been constructed to reflect bed numbers, service offering and bed capacity and capabilities,
- In Covid waves 2 and 3, the observed lag between the peaks in new cases and beds occupied was approximately two weeks.
- Planning for additional uplift requires a significant lead time in order to work operationally, the addition or reduction of beds affects workforce, estates, processes and demand on external partners in all health settings

Trust Toolset - ASPH

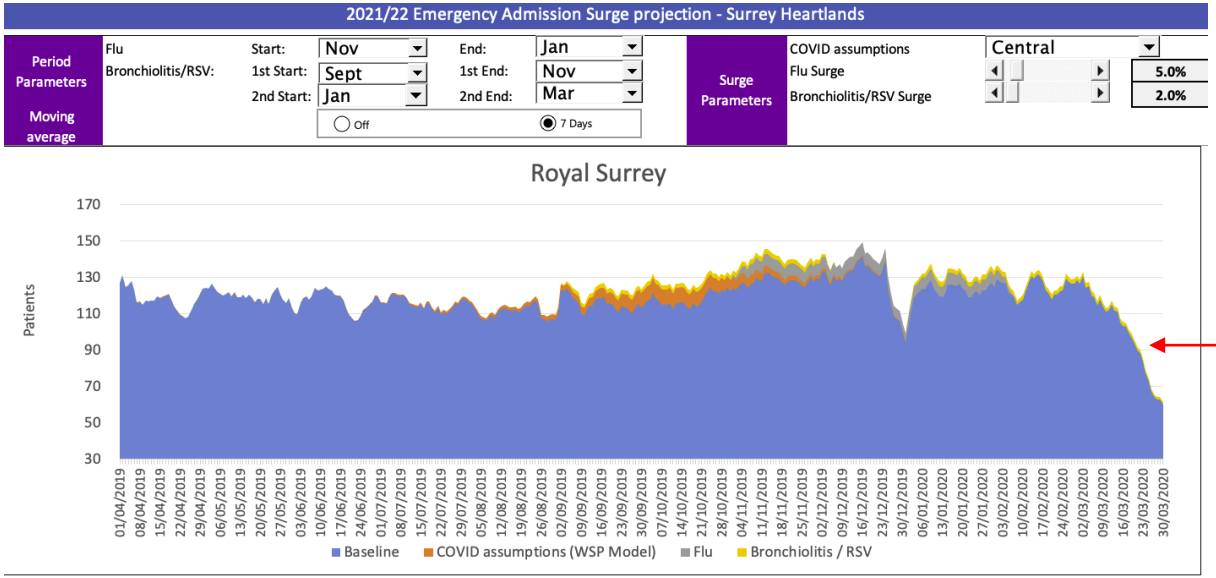


N.B Baseline is based on 2019/20 activity with surge uplift applied

1st CoVid wave affected bed occupancy mid / end March as elective activity ceased

ASPH baseline reflects a volatile baseline assumption which was heavily influenced by availability of beds and capability of the Emergency department – with regards to this years peak, a new build has been completed which increases flow and operational efficiency and smooth out the general requirement of admissions

Trust Toolset – Royal Surrey

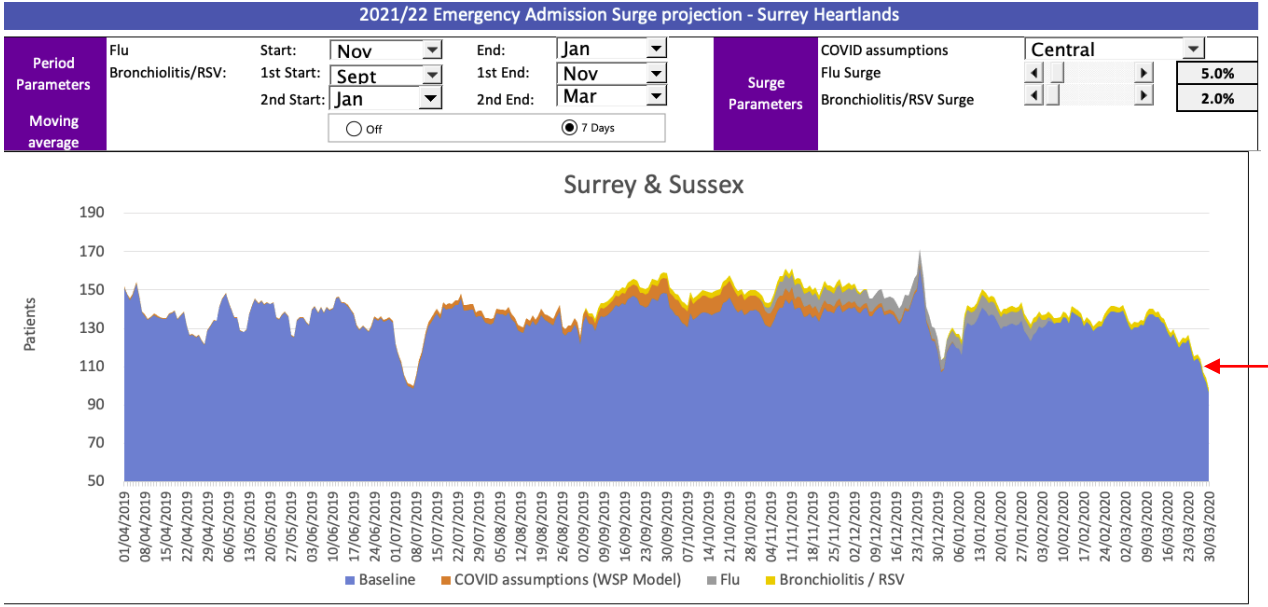


N.B Baseline is based on 2019/20 activity with surge uplift applied

1st CoVid wave affected bed occupancy mid / end March as elective activity ceased

- Less volatile profile than ASPH, but follows same trend
- Drop in occupancy more severe as high proportion of elective activity affected through cancellation. (Royal Surrey is also Cancer Tertiary centre)

Trust Toolset - SaSH



N.B Baseline is based on 2019/20 activity with surge uplift applied

1st CoVid wave affected bed occupancy mid / end March as elective activity ceased

- SASH elective activity less than other Trusts in the ICS, although same trend exists
- Independent providers utilised to enable maximum efficiency in bed utilisation

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ADULTS AND HEALTH SELECT COMMITTEE

20th October 2021

Frimley Health and Care Integrated Care System (ICS) COVID-19 Recovery Programme and preparation for Winter Pressures– Update

Purpose of report: To update the Select Committee on Frimley ICS' Recovery Programme and preparation for Winter Pressures (Surge Planning)

Introduction:

1. The Frimley ICS continues to experience sustained pressures across all health and care sectors, with some service backlogs, later presentation of disease, ongoing infection prevention and control and outbreak management measures, and a need to prepare for further demand surges due to the anticipated seasonal flu impact and other viral respiratory illnesses.
2. Throughout the pandemic we have been continuously reviewing and learning from each Covid-19 wave and this is informing how we will manage and balance the restoration of services plus maintain provision throughout the winter. In addition to identifying backlogs of work, we are using our data insights to identify unmet with a particular focus on reducing inequalities.
3. We acknowledge the need to continue to support the resilience of our own staff and their wellbeing. Workforce is an ongoing risk to recovery and winter capacity.
4. We have strengthened our governance and delivery structures in anticipation of the system pressures over the next 6 months and will continue to benefit from our foundation of strong partnership working.

Summary:

5. The attached presentation (appendix 1) covers:

   - the current context for recovery and surge planning
   - the principles and approach the system has used to develop its plan
   - the information and insights we have available including demand modelling assumptions
   - Communication of key winter messages to our communities

- risk and mitigation

Conclusions:

6. Effective collaboration within and across systems is at the heart of our recovery and winter plans which are set against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience, and outcomes.

7. Our plans are a mix of drawing on experience from previous winters, and throughout the pandemic and build in new ways of working better together based on new insights and innovations.

8. Our governance approach builds on our existing system and partner meeting structures with continued emphasis on patient safety, experience and equity in addition to demand and capacity management. Our approach to response and recovery includes various specific streams of work, with the Frimley ICS Partnership Board providing strategic direction and oversight.

Recommendations:

9. The Committee is asked to note the contents of this report.

Next steps:

10. Frimley ICS is currently mobilising the plans as described in appendix 1. The system will adjust and adapt to the changing context as we move into the winter months. We will ensure we continue to communicate and engage with patients and partners as part of this process, alongside a continued focus on the health and wellbeing of our staff alongside those of our residents.

Report contact

Fiona Slevin-Brown, Frimley ICS Executive Lead of Urgent and Emergency Care

Contact details

f.slevin-brown@nhs.net

Appendix 1 – Report detail

Frimley Health and Care

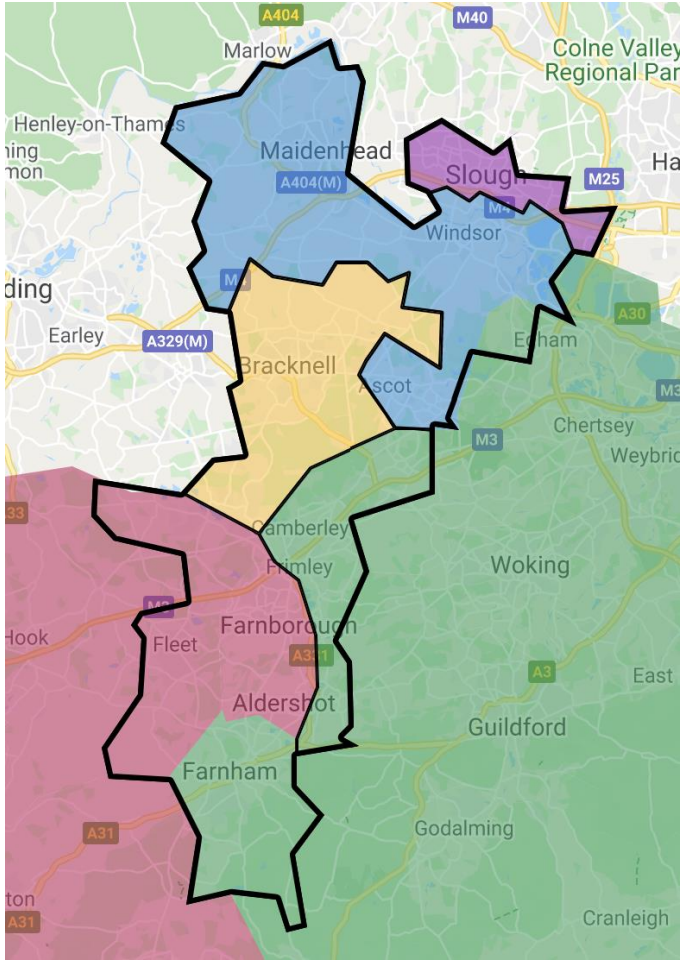
APPENDIX A

Recovery Programme and Preparation for Winter Pressures

Surrey Select Committee
20th October 2021

Contents

Frimley Health and Care



Emergency Preparedness Resilience & Response (EPRR)

Frimley CCG/ICS has a dedicated, fully trained & qualified, Emergency Preparedness, Resilience and Response Team in place:

- Director of EPRR/Systems Resilience
- EPRR Manager
- 2 x System Resilience and Emergency Planning Officers
- Incident Coordination Centre Manager and supporting team (x3)

Frimley CCG/ICS has a full suite of EPRR & Business Continuity plans as defined in the:

- Civil Contingencies Act 2004
- The Health and Care Act 2012
- EPRR Framework 2015
- The National NHS Core Standards

This year Frimley CCG/ICS is fully compliant with these standards (49) as part of the annual EPRR assurance process

Frimley Health and Care

Emergency Preparedness Resilience & Response (EPRR)

Frimley CCG/ICS has a detailed annual training and exercising schedule for:

- On Call staff
- The EPRR/Systems Resilience and Urgent & Emergency Care teams
- The Business Continuity Leads
- The Place Managing Directors including our Accountable Emergency Officer

On Call staff are fully trained to deal with a major incident, business continuity incident or critical incident in order for the CCG/ICS to have 24/7 resilient, response cover

This training links with the Skills for Justice National Occupational Standards in relation to Training and exercising also entails internal exercises and exercises with our multi-agency partners

Frimley interacts with three Local Health Resilience Partnerships (LHRPs) and three Local Resilience Fora. These cover Surrey, Hampshire/Isle of Wight and the Thames Valley

Working alongside our multi-agency partner is crucial to effective emergency preparedness and response.

Frimley Health and Care

Emergency Preparedness Resilience & Response (EPRR)

- We prepare for any catastrophic event and have been managing the National Level 4 Covid-19 Pandemic response since February 2020 to date
- We are continually planning for a concurrent event which we have already had with the death of the Duke of Edinburgh, as Windsor is in our area
- The EPRR team responded to this event for the 10 days duration of Royal funerals
- Working alongside our multi-agency partners they were able to understand the large amount of health assets that we have in Windsor and so these were able to be protected and patient care was not affected at any time. Minimal members of the public needed medical treatment
- We have a fully trained Incident Coordination Centre already in place to manage any other major incident/event that happens
- We are currently managing the fuel crisis linking in to our 3 multi-agency forums to represent Frimley CCG and our providers

Frimley ICS – Our Recovery Approach

Frimley Health and Care

- **Our Recovery principles:** continuing to test their relevance as we progress through recovery and continue to respond to the pandemic.
- **Setting our recovery journey:** acknowledging backlogs and suppressed demand, mitigating the ongoing impact on local communities and health inequalities with a need for a measured approach to recovery.
- **Baseline for impact:** Agree what other insights we need to support agreement on tactical priority actions for our local system with a strong health inequalities focus, but include experience, process, and outcome measures and trends.
- **Support our staff:** Ensuring accessible recovery interventions for all health and care staff, to support them with their resilience and in future delivery challenges
- **Sector-specific opportunities:** agree together what each sector is able to do now to achieve the right balance between ongoing emergency pressures/winter and actions to prepare us for next stages
- **Strategic ambitions/Turning the Tide:** aligned framing of the opportunities to address health inequalities
- **Finances/workforce:** balancing our ambition and building on transformational changes versus cost and capacity.
- **Governance**: strengthening to support cross system alignment and visibility beyond emergency response - referencing our Recovery Principles

The following slides detail the recovery principles which frame our ICS approach to restoration and recovery, our achievements so far, and our priority plans going forward

Recovery Principles

Frimley Health and Care

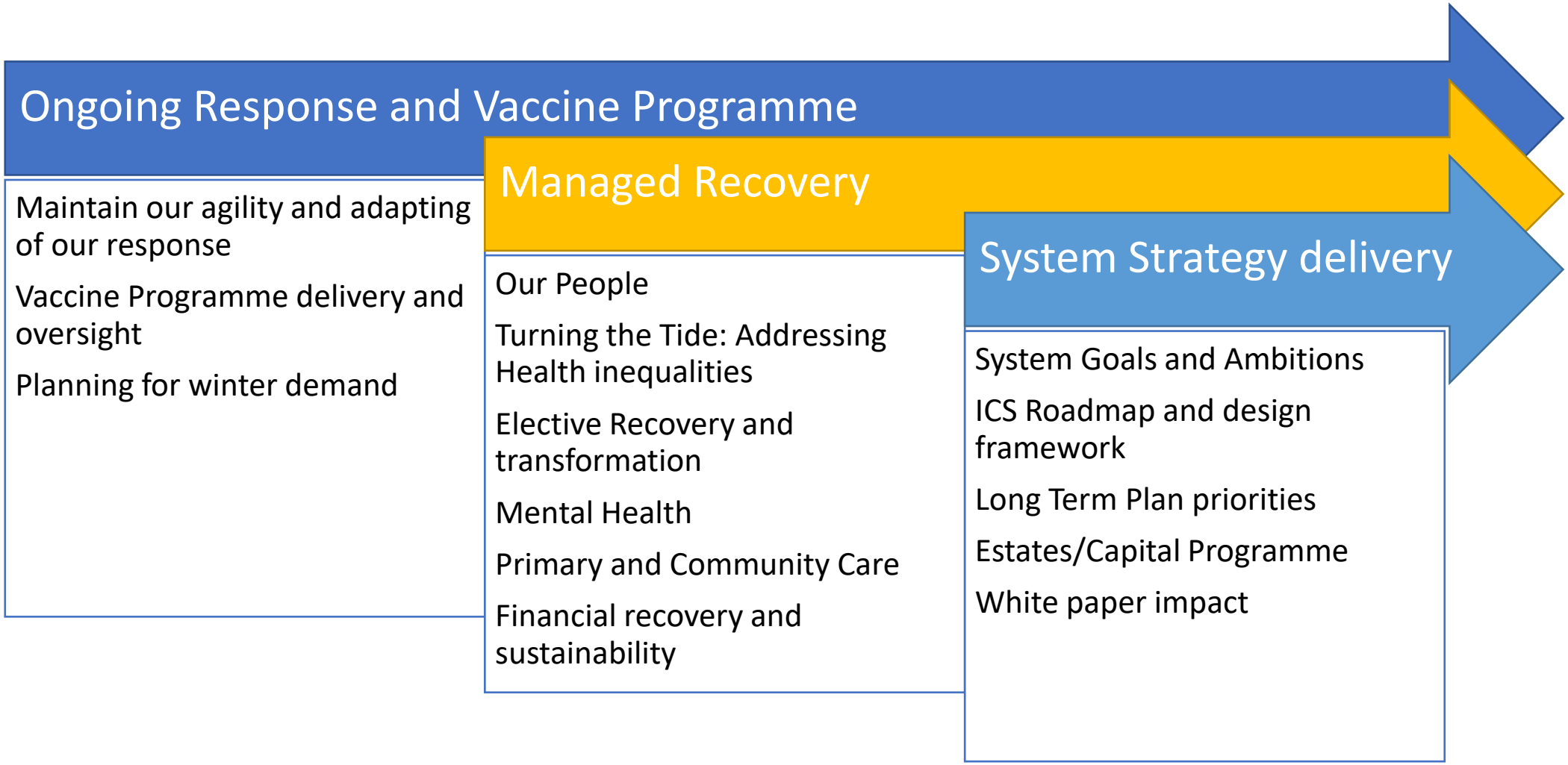
Population health approach	•We will take a population health approach to our recovery, using our data to ensure that our efforts and resources are directed to where the greatest improvement in population health outcomes will happen including deprived communities.
Share, learn and understand	•We will always seek to share, learn and understand to underpin our approach at ICS level, within Place and within partner organisations as well as with other systems, Local Resilience Fora, Regionally and Nationally.
Support for the whole sector	•We will support all organisations within the wider health and care sector with recovery, including care homes, care agencies and the voluntary and community sector.
Share early, stay connected	•We will always take the risk of sharing early to help ensure connection so that opportunities for involvement and more radical transformation are not missed.
Working as partners for the whole system	•We will work as partners by continuously checking in and debriefing, to ensure we can have a deep and broad sense of the consequences of our work on all parts of the system.
Respect and support individual partners	•We will respect the knowledge, expertise and responsibilities of all partners and support those shaping and delivering their own organisational recovery.

Recovery Principles (2)

Frimley Health and Care

Working efficiently around aligned goals	•We recognise that we do not need to do everything together but we are committed to avoiding duplication while ensuring that our recovery makes sense for the communities we serve.
Leading through uncertainty	•We will model managing ourselves and our teams to face into the painful challenge of living and working in a world where we need to be prepared for the risk of further surges and consequences that we cannot foresee.
Ambitious in our transformation, devolving to the front line	•We will be ambitious in keeping and developing radical transformations that benefit individuals, communities and our staff. Our Partnership will hold the authority for this collectively through the Partnership Board. As leaders we are committed, wherever possible, to devolving transformation and decision-making to within frontline teams and services.
Inclusive, asset-based and embracing diversity	•Through this approach we will develop a joint narrative which supports a reset relationship with our residents in Frimley, which is consciously inclusive and recognises and builds on the many assets they hold. Using straight forward language, we will embrace all sectors within our system, and the rich diversity within our communities and organisations.
Recovery flows through all our work	•Recovery in Frimley is not a programme but will flow through all our work. There will be phases to go through and we will seek to be rigorous about both immediate and long term work to enable us to work at pace on the right things.
Supporting our People	•We see people who work for us as critical partners in our recovery and these principles apply to our work with them focused in the programmes to support our People Ambition.

Concurrent Response and Recovery Context



The Frimley ICS Surge and Winter programme 2021/22

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Introduction:

The Frimley ICS Surge and Winter plan is a programme of work that builds upon surge planning from previous years, our experience of managing Covid during wave 2 and winter last year. It draws upon robust integration at strategic and operational levels on a daily basis, benefitting from continual review and refresh from senior leadership, informed by dynamic front line delivery of care.

Planning was initiated early in summer 2021 to formulate a response to growing surges in patient activity across the Frimley System. Our winter programme will compliment and support existing system wide surge and escalation protocols, aligned and informed by the regional South-East winter proposed operating model. 2021 has seen the Frimley System under consistent heightened pressures with all partners operating at levels equal to or greater than pressures seen during the last 2 winter periods.

This winter plan has been reviewed by system and Place leads underpinned by detailed activity planning and winter forecasts for both capacity and demand to inform this live document.

This document sets out the system level response/plans that are in place or will be in place imminently to mitigate known or potential pressures, to ensure the safety of patients and staff, and the continued delivery of services at acceptable levels.

The Final Frimley Surge and Winter plan will be reviewed at the Frimley ICS Urgent and Emergency Care board at the on 6th October 2021, and final sign off planned for the November board following feedback from NHS SE/I Region and continual review by system leaders, to take account of daily efforts to deliver high quality, safe care over winter.

The Frimley ICS Surge and Winter programme 2021/22

Surge and Winter Planning Considerations

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- **Impact of the pandemic** - Ongoing and sustained pressures across all health and care sectors, service backlogs, and late presentation of disease, ongoing infection prevention and control and outbreak management measures, and further demand surge preparedness. Noting expected prevalence of seasonal flu and other viral respiratory illnesses
- **Workforce** - Finite workforce availability and resilience across all sectors - vacancies, sickness absence, and chronic fatigue limiting ability to flex capacity
- **Conflicting and competing demands** – multiple priorities and demands on our staff and resources. Consideration of the context of policy and legislative changes for Health and Care
- **System Recovery and Progress** - continued focus on recovery – bedding in long term transformational change
- **Covid and Seasonal Flu Vaccination programme from Sept 2021 –** details to follow however this is likely to take significantly more coordination and oversight this year recognising the risk within unvaccinated communities
- **Population Health** – recognising health inequalities, mitigating the ongoing and future impact on local communities
- **Learning, sharing and building on good practice** – using the learning from the last 18 months in developing our plans for the coming months and retaining a flexible approach to our partnership response

The Frimley ICS Surge and Winter Programme 2021/22
Key Risks & Mitigation

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Key Risks

- Health Care work force and resilience
- Compliance with current government guidance
- Demand outstripping capacity leading to the need to step down elective or planed activity to redeploy staff and resources
- Impact of COVID infection rates and other infections on demand and pressures on services
- Risk of concurrent events or further stresses on the system
- Impact pressures have on our ability to recover services and the associated impact on our communities
- Impact of vaccination requirements on the Care Home sector and wider recruitment and retention across the Health Care sector
- Inability to further flex capacity without impacting on our recovery plans
- Patient / family choice to attend ED for "face to face" over virtual offers from other care pathways

Mitigation

- Utilising local analytics and the UK Health Security Agency intelligence to forecast disease prevalence and potential demand to inform organisational and system plans
- Detailed Surge /Winter plans by all sectors at a place and wider system level
- Delivery of the COVID and Flu vaccination program
- Ongoing public communications campaign aligned to LA and PH messaging
- Continued health and wellbeing support for staff
- System and organisational workforce plan delivery
- Continued close joint working and forward planning with partners including the third and voluntary sectors
- Ongoing focus on delivery of our strategic recovery and transformation plans
- System level mutual aid pathways between partners utilised

An ICS risk register is being maintained to capture and monitor all winter / surge related risks to be reviewed by the U&EC Board monthly

Surge and Winter Plan Approach sign off and timelines

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- We have used the normal CCG/ICS routes for coordinating the completion of the Plan – oversight and sign off via the UEC Board. Tactical oversight will be held by the System Response and Recovery Group.
- Our plans are built around the need for flex and adaption as required.
- Specific requirements and future submission timelines will take into account further guidance from NHSE/I.
- Plan development and delivery through the following and co-ordinated through ICS Partner Leadership:-

✓ Place Based - primary and community care plans

✓ Portfolio - workshops such as CYP, Mental Health and Discharge and Flow

✓ Individual organisational – SCAS for 111/PTS/999 & SECAMB 999 .

The process will be a dynamic approach in order to react to new ideas and escalation triggers through tactical daily monitoring.

- Reporting to NHSE/I SE Regional team in accordance with SE OPEL Framework and the Frimley System Surge and Escalation Protocol

Frimley Incident Coordination Centre and S-VOC

Frimley Health and Care

Frimley Incident Coordination Centre (ICC) acts as the single overarching response / coordination / oversight function on behalf of the ICS Partnership and the single interface with the NHSE/I SE Regional ICC /RVOC.

It acts on behalf of the ICS within the context of the statutory framework - liaising with the 3 Local Resilience Forum etc. – ensuring the resilience and response needs of the Frimley ICS partnership are clearly understood and escalated.

It ensures key risks and issues are collated, actioned or escalated with respective organisations or leads, and acts as a key interface with the ICS Leadership providing expert advice and support when required.

The ICC functions in support of the system including ensuring logs of all critical EPRR and other response related system decisions and information flows are appropriately tracked and filed.

The Frimley ICC will manage all information flows regarding the following. This list is not exhaustive:

- Covid-19 and the third and on-going wave
- Winter, including; Surge and Escalation and system wide OPEL statuses at level 4
- Declarations of Critical/Business Continuity Incidents
- Phase 3 of the Vaccination Programme including the annual “flu” jab
- The management of equipment/PPE issues
- Management of all mutual aid requests
- Ambulance Service REAP/OPEL Level declarations
- Any concurrent event

Frimley Health and Care

Preparation for Winter

Helping our Communities

- Clear messaging on how to prevent ill-health –reinforcing national infection control messages and clear signposting to self care resources and tools
- Coordinated communications to help with signposting to services e.g. “Know Where to Go”
- Updating and refreshing information on public facing websites, social media and literature
- Using every contact as an opportunity for a positive conversation

Follow and share on Social Media

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@NHSFrimleyCCG

@FrimleyHC
@Frimley_CCG

@NHSFrimleyCCG

Visit our websites:

www.frimleyhealthandcare.org.uk
www.frimleyccg.nhs.uk

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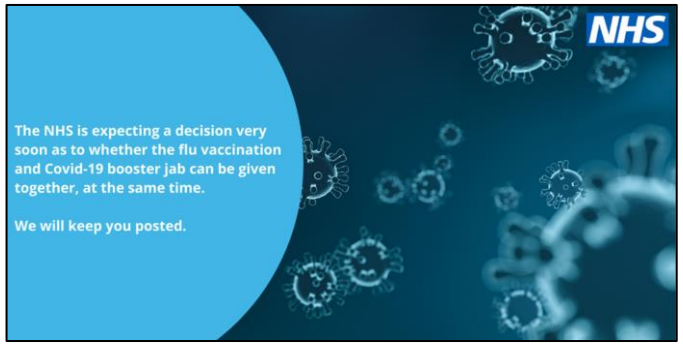
Preparation for Winter



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Using information and insights

Surge and Winter demand Forecasting – assumptions

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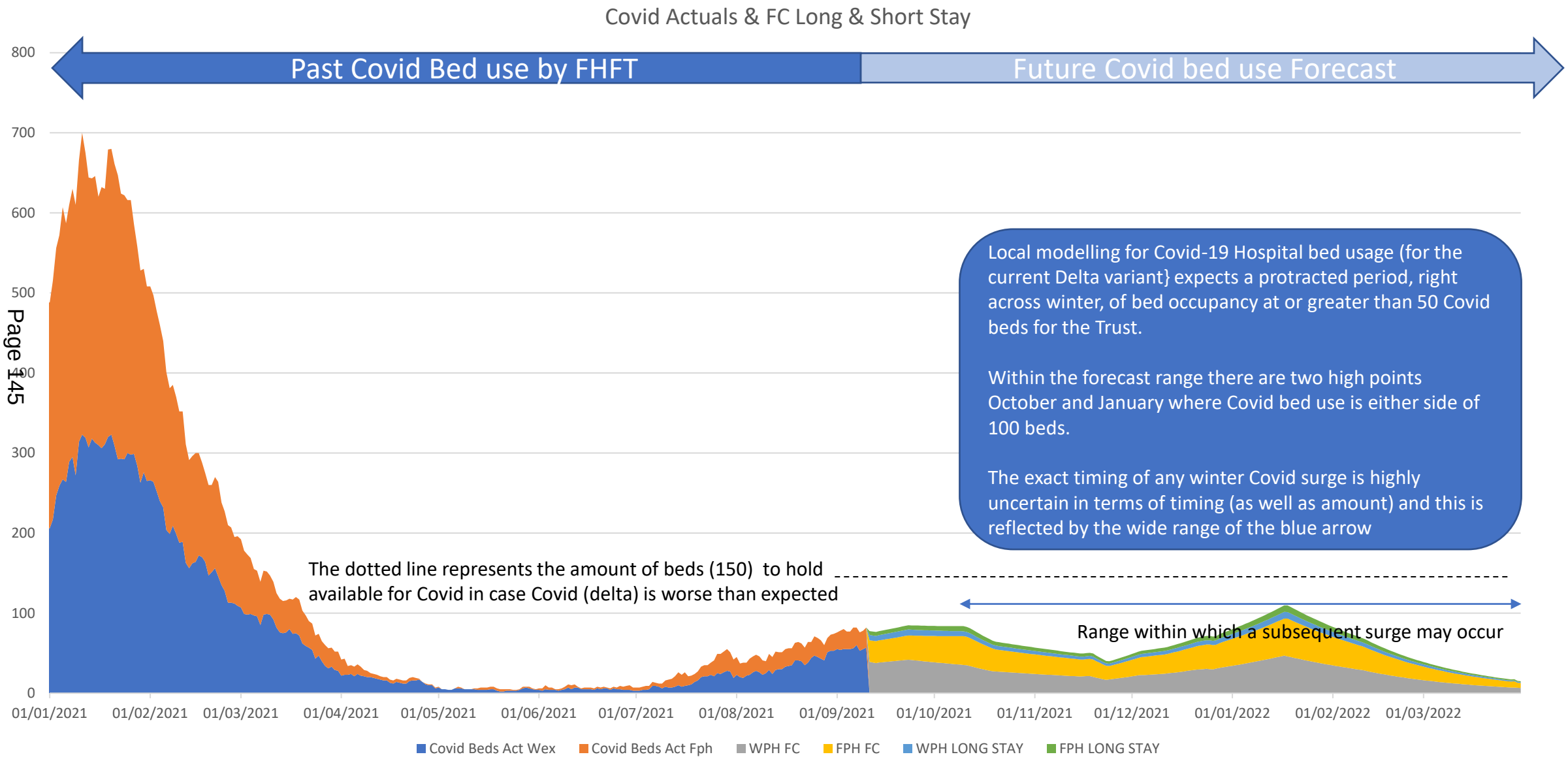
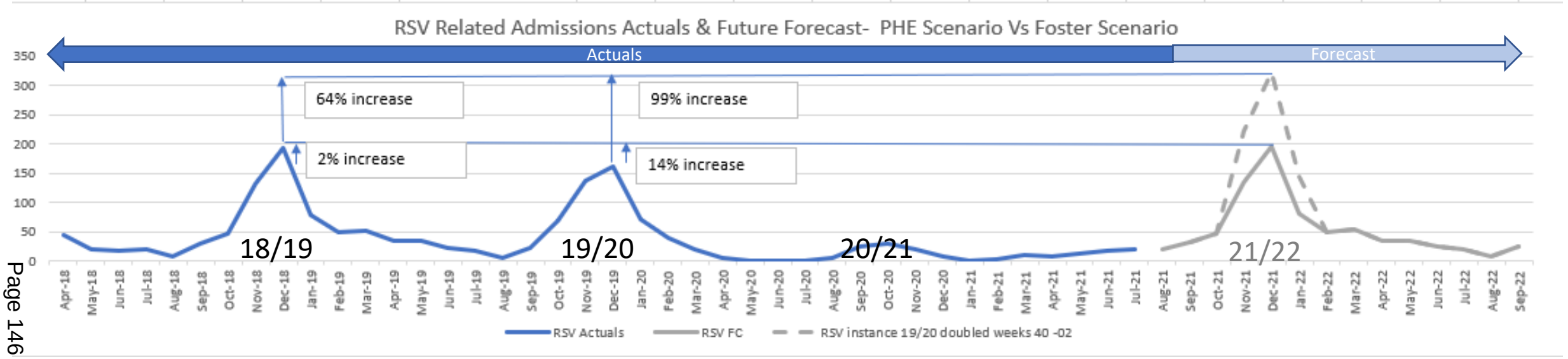
- Assuming ongoing surges of Covid – August/September/October – plus another later in the winter potentially
- Increased flu and viral presentations in Children & Young People and amongst the wider population from August
- Negative impact on staff wellbeing with potential for increasing levels of sickness absence if demand levels are sustained into the Autumn combined with circulating infections in local communities, and impact of increased annual leave post phase 4 of Government roadmap
- Ongoing impact of infection prevention control on productivity and capacity - further guidance due post Phase 4 announcement
- Ongoing and increasing pressures across sectors of acute mental health presentations – adults and children
- Unknown impact of Long Covid in the community
- Return of seasonal variations in demand such as the Post-Christmas spike in attendances and acuity (as usually seen pre-Covid) as a compounding factor
- Workforce continues to be a limiting factor in terms of increasing capacity however there are indications that there is workforce availability in some professions such as pharmacists
- Need to maintain focus on recovery particularly where we know there to be impact on specific communities and to consider the specific areas of interest at national and regional level
- For Long Covid we have estimated we will have a tier 3 cohort of some 1300-1600 in the community and have included post Covid readmissions in our Secondary Care bed occupancy forecast.

Covid Actuals & Forecast Occupancy (Long & Short Stay)

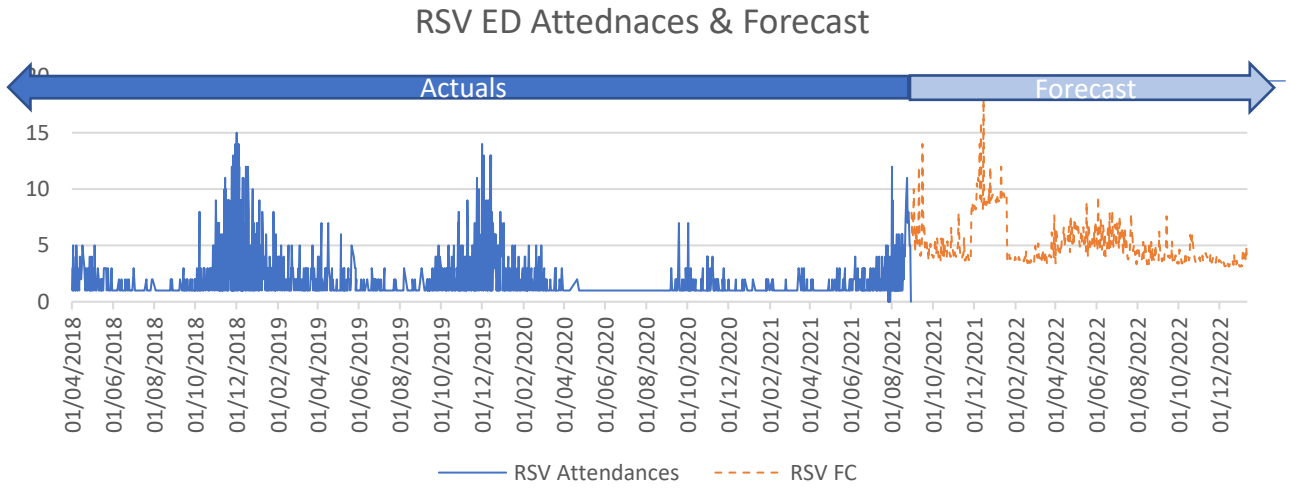


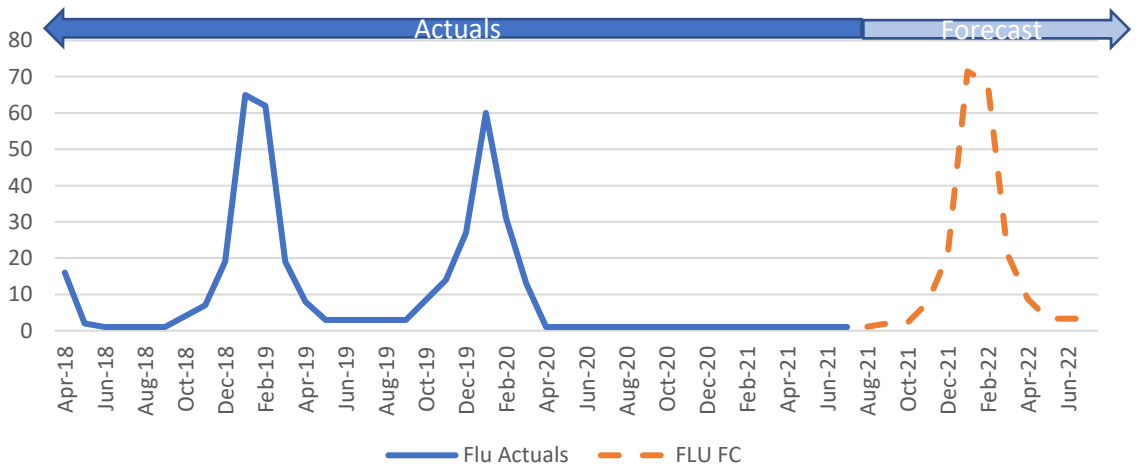
Flu & RSV Predictions

The RSV admissions prediction below (solid grey) suggests a higher RSV challenge this year than any of the three last years, with a worst case scenario (dotted grey). The prediction is based on a 2.3% higher than the worst of the last three RSV peaks, while the worst case a double of the 19/20 (normal) RSV admissions. Bottom left are the ED attendances predicted associated with the RSV demand.

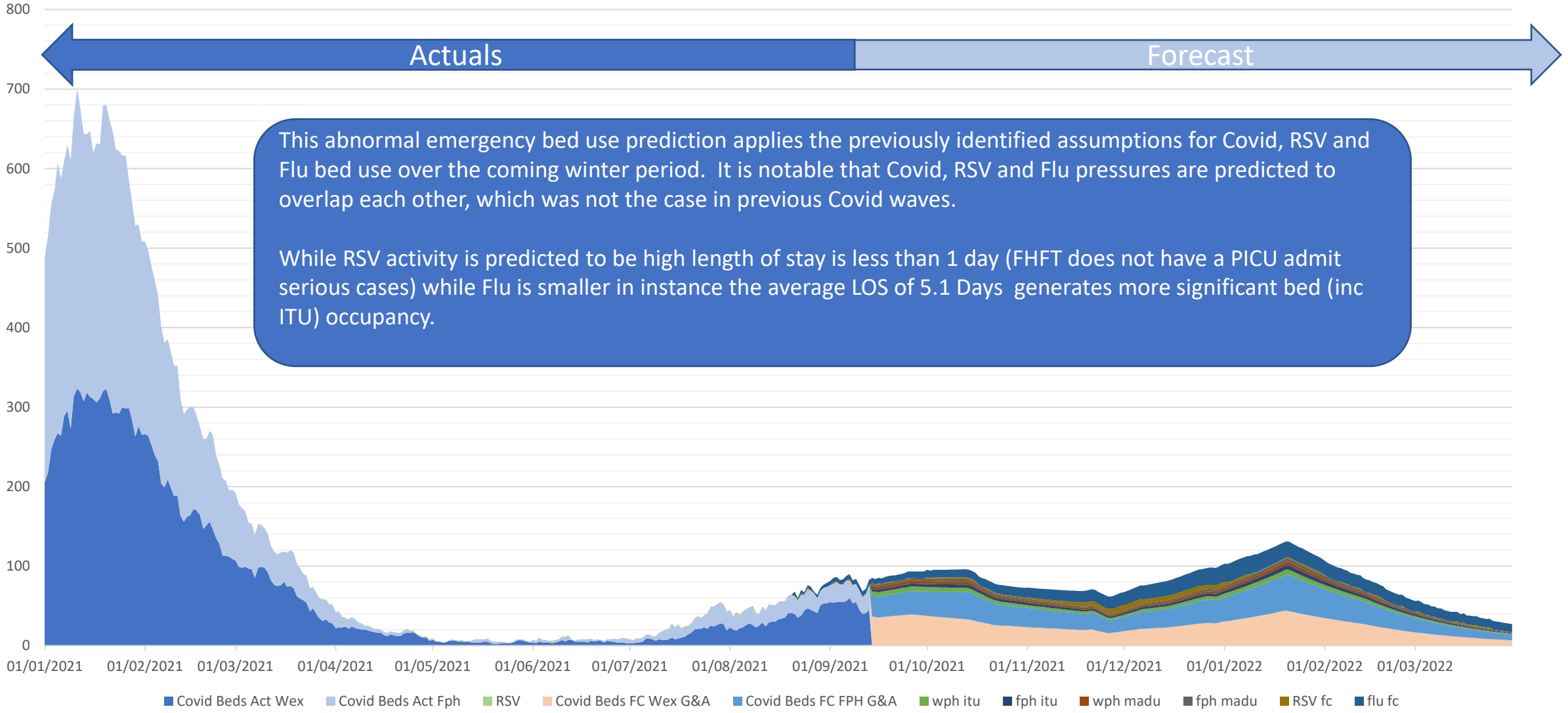


The below Flu prediction is based on an extrapolation from historic Flu activity cycles

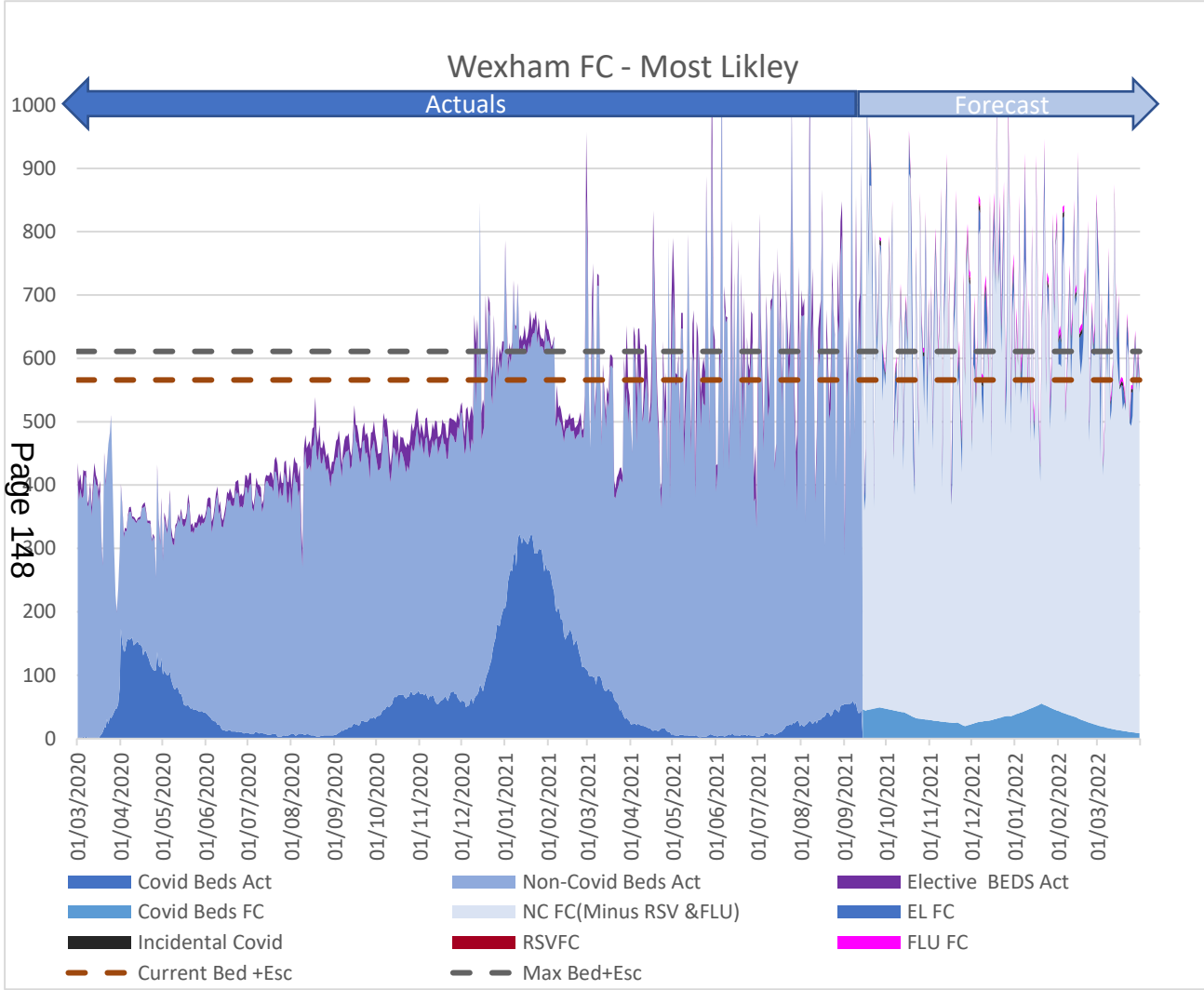


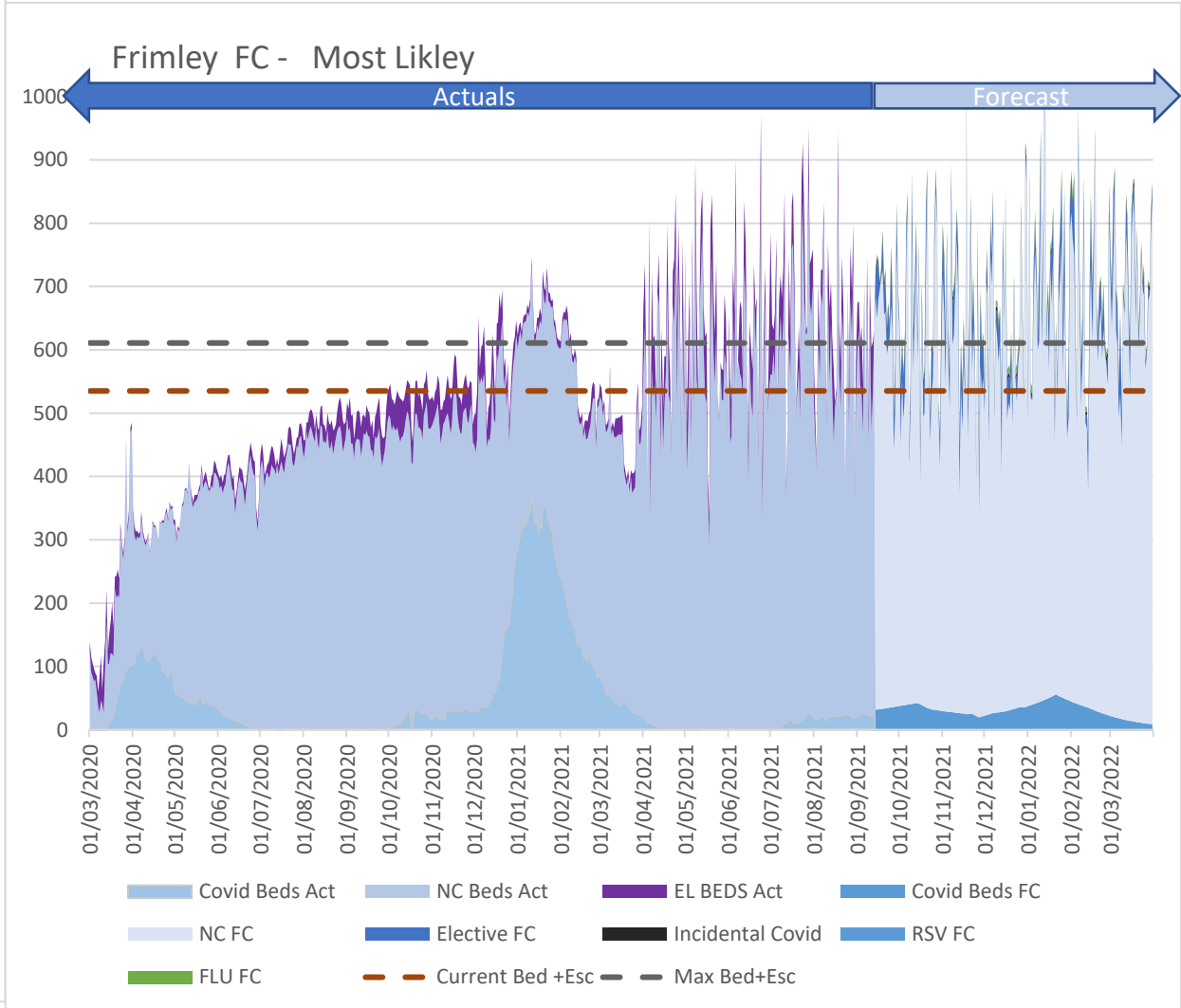


Covid, Flu & RSV Actuals & Prediction (bed Occupancy)



Covid All Beds Impact

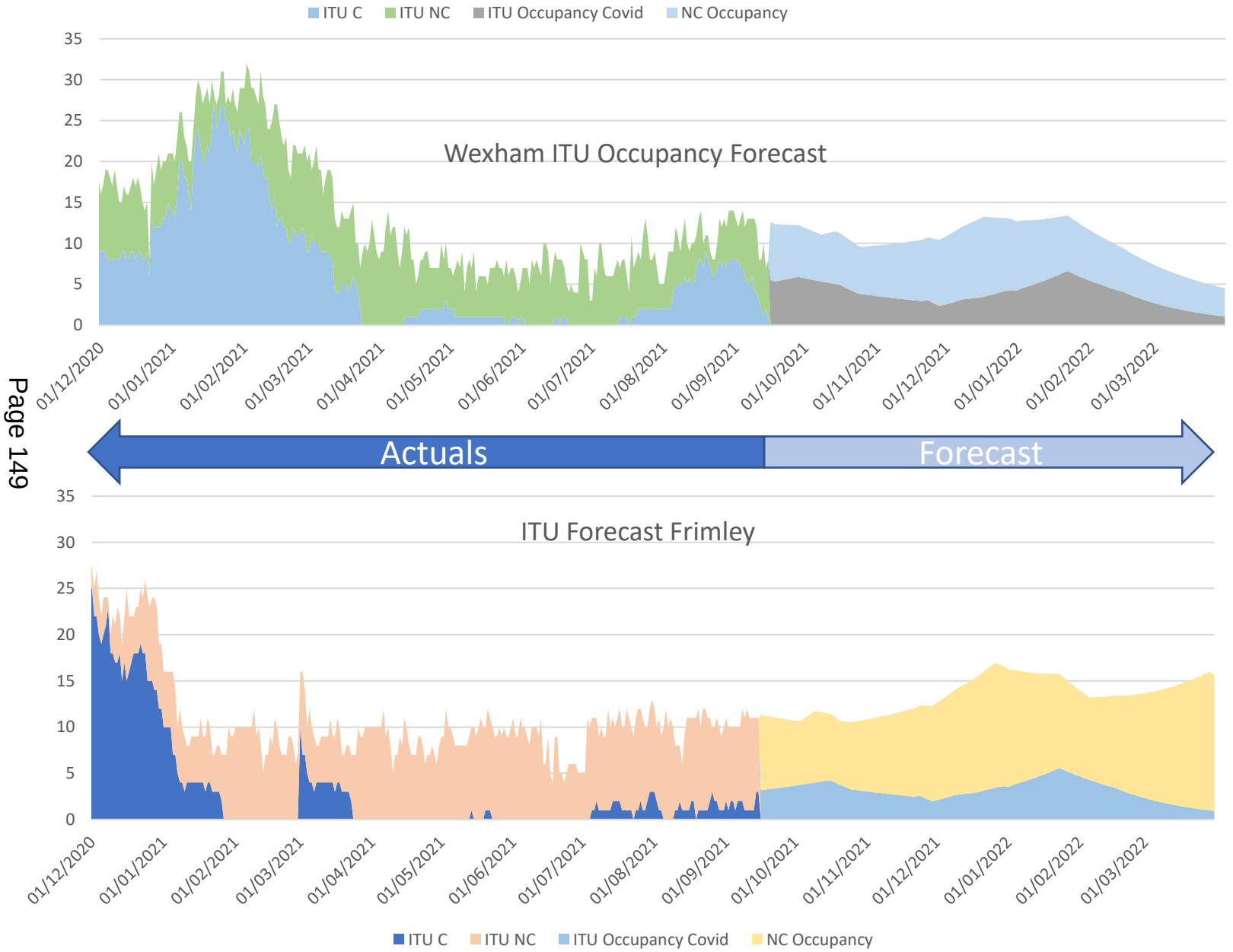




The above *acute* site level occupancy predictions layer Covid, abnormal emergency (RSV & FLU), BAU emergency and elective bed requirements, one upon the other and compare this to available beds (dotted lines representing core and escalated capacity). Covid and emergency demand are explained in previous slides, for BAU emergency this represents 19/20 volumes and case mix (with no reduction) and an uplift in activity in the 5 services predicted to be impacted by post covid: Respiratory, Cardiology Nephrology, Neurology & Gen Med. Elective forecast presumes delivery of 19/20 volumes and casemix of elective activity in H2.

The current predictions indicate that unless BAU emergency bed occupancy declines or Covid demand is averted there will be significant bed constraints this winter

ITU Actuals & Prediction (bed Occupancy)



ITU predictions based on ~15% of bed occupancy being ITU. This matches the Surge 2 assumption. Earlier models had presumed a lower rate but this has not been borne out by actuals.

It should be noted that for FHFT ITU assumptions are not comparable with other units. The MADA (respiratory units delivering single organ support (NIV etc) are not part of ITU. If a proxy were applied the combined value would be ~25%

Insights to support with Winter & Surge Planning

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Recovery Insights	In parallel with analysis to support with operational pressures, we have multiple workstreams exploring how we can proactively support patients keep well which will lead to better care and support long term sustainability. We have linked data from across health and care and public health to in order to achieve this. This includes a powerful data model that enables us to provide leaders with insights, front line professionals with critical information at point of care and the capability to evaluate in a timely manner to ensure interventions are making a positive difference.
Operational	We have a combination of live and real time data supporting us to understand operational pressure which informs modelling as well as supporting short-term decision making. Examples of this include a real-time feed of Covid-19 test results from Department of Health & Social Care, (currently receive daily from PHE), live feeds from A&E and daily feeds from primary care, OOH, community and mental health. This live patient level data enables to link activity to clinical and wider determinants and has been used to support key programmes such as Pulse Oximetry @Home.
Front Line	Building off the shared record infrastructure where we have circa 4k staff actively using the platform (includes Berkshire West), we have the capability to disseminate the cohorts identified through the insights work in an easily accessible way. By linking information, we have from across the ICS, we can better support front line professionals' triage and prioritise patients under their care. Examples of this include prioritising diabetics in need of review based on urgent care activity across the system. The shared care record infrastructure allows us to bring together all relevant professionals across our ICS around a specific cohort of residents with specific needs allowing for and integrated MDT approach and resource efficient use of workforce.
Proactive	A key driver for our ICS is to shift from reactive to proactive care. Our applied population health allows our teams to work with pre-Identified groups of residents. This allows us to proactively identify those who may need integrated MDT intervention. The ecosystem also allows our professionals to work together in one digital hub to case manage and monitor the identified cohort moving from siloed to integrated and away from a push referral model to a proactive pull model. We are also able to monitor the impact of interventions on inequalities and work with clinicians and leaders to identify unmet need in our ICS. An example is patients who have low level mental health issues who are interacting with multiple urgent care teams who could be better supported by primary care based mental health professionals.

Using Population Health modelling to predict and mitigate health inequalities

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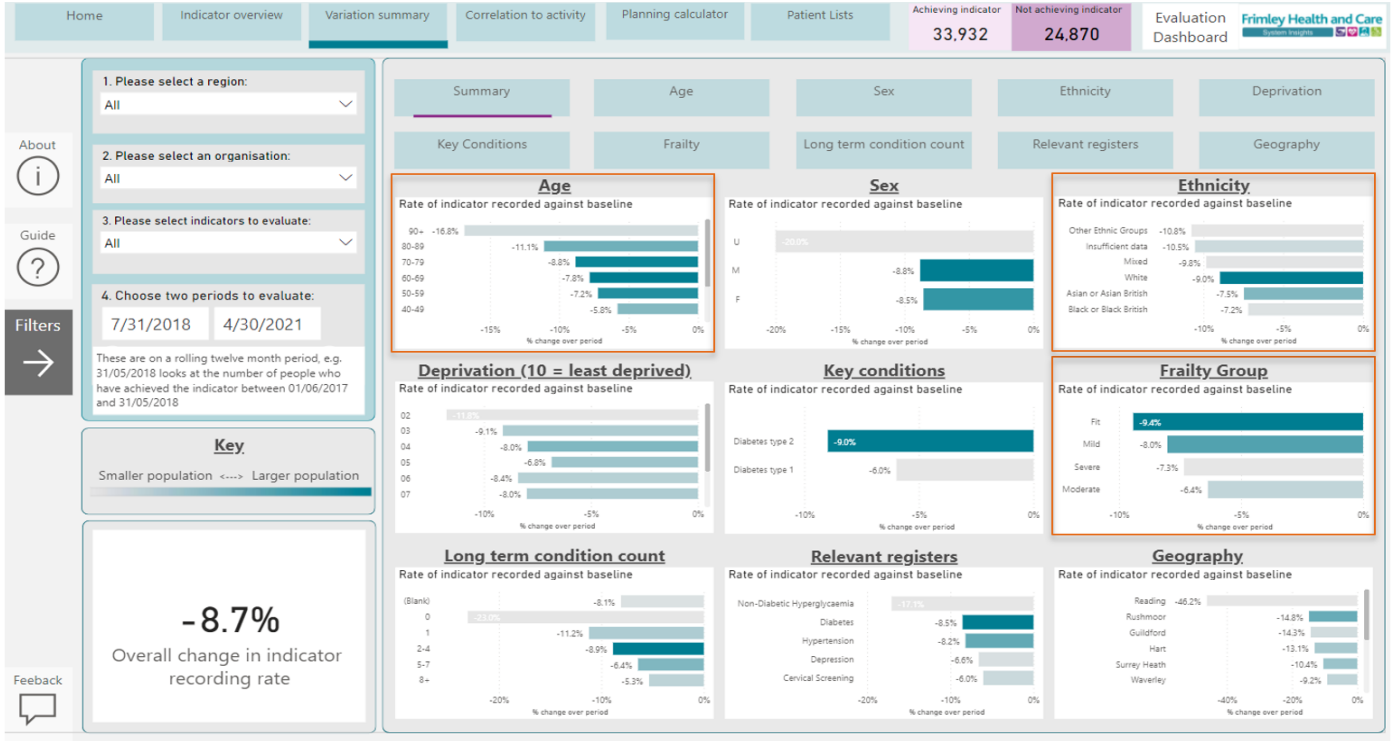
- We know that the onset of the Covid-19 pandemic has exacerbated previous health inequalities and generated new areas of variation in outcomes for our different populations
- Sometimes these inequalities can be expressed through population characteristics (i.e. specific groups or communities, ethnicities, age or gender) but can also be present in particular geographies or linked to wider determinants such as deprivation or housing status
- We can use the strength of our combined data architecture and analytical insights approach to both detect these inequalities and also predict them; allowing us to take a pro-active approach to mitigating them or preventing them arising
- Our System Analytics team has built a suite of reports and products which take data feeds from NHS, Local Government and Public Health data systems to create a near real time view of population health risk
- This has allowed the creation of a set of Covid Impact tools to help manage the operational pressures arising from the pandemic and also longer term population health management tools

Example: Diabetes care processes (ready for deployment)



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Our People

Planned Actions: Workforce

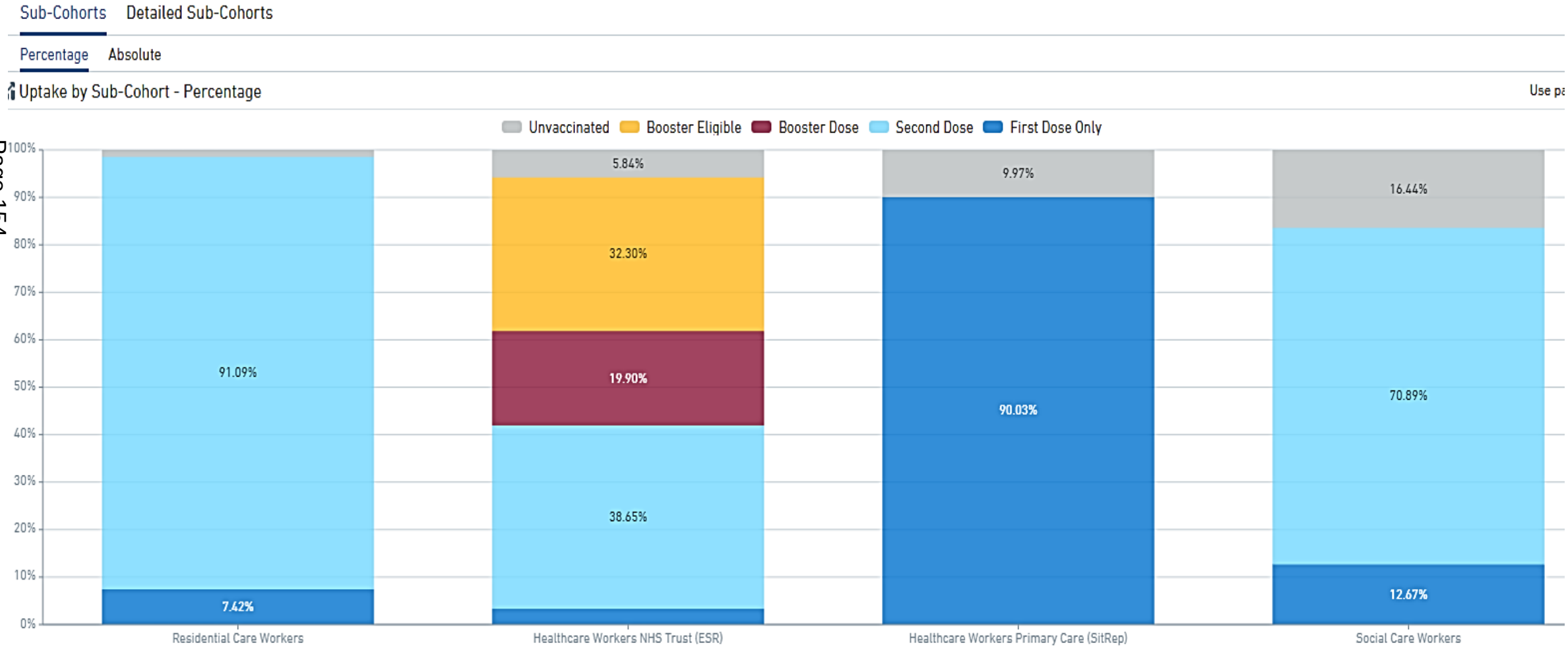
Workforce factors continue to pose limitations on the ability of services to meet current and future surge demands. Issues centre on the backlog of annual leave, simultaneous rollout of C19 and flu vaccination programmes, general staff health and wellbeing (specifically for staff critical to recovery plans) and the age profile of community care and primary care staff. These issues result in reduced capacity to respond to latent demand which are further compounded by circulating C19 infections, unknown demand from long COVID and increase patient acuity

RISKS/ ISSUES	MITIGATIONS
Annual Leave - The inability of our people to take annual leave in the face of demand has reduced staff wellbeing. Operational capacity concerns exist if the backlog of annual leave is coupled with a sharp uptake in annual leave post phase four of lockdown.	• Trusts have updated policies in relation to buying back / AL carry over • Annual leave monitoring and use of HR Ops group and People Board as escalation points • Frimley showing below regional and national averages • Workforce Bureau - supporting deployment of additional staff
Health & Wellbeing - Negative impact on staff wellbeing with potential for increasing levels of sickness absence if demand levels are sustained into the Autumn.	• Wellbeing warning system to provide data insights, refining a holistic wellbeing view that considers staffing pressures, EAP referrals, absence analysis. • Trusts have embedded health & wellbeing conversations as std practice to staff appraisals – monitored at Trust boards • Magnet4Europe programme examining how we can redesign workspace to support staff wellbeing • Two Wellbeing Hubs provide rapid access to health and wellbeing services and enhanced occupation health support. • Whole teams and team managers are provided with H&W support, development & training (Schwartz rounds & MHFA)
Recruitment and retention - Reduction in international recruitment rates due to several challenges (quarantine rules, agency delays, border controls, available mentors).	• FHFT continue to work with the Home Office and DHSC who are central to the successful recruitment of international staff. • IR – cohort targets have been increased to offset the reduction in recruitment in H1. • HCSW – successful vaccinator retention/ training plan and development of pathways for our Band 3 staff into roles/ areas of demand
High risk staff – certain groups of staff are critical to the recovery plans due to their specialism, underlying recruitment/ retention issues and wellbeing. These high risk staff must be well supported in these roles to ensure service continuity	• Identified and continual monitoring those (and emerging) high priority staffing roles (radiographers, sonographers, consultant radiologists, anaesthetists, theatre nursing). Continued adjustments to staffing plans to balance annual leave, sickness and demand. • Use of wellbeing warning system being considered (issues with the granularity of team Vs dept data) • Provision of support as per the Health & Wellbeing mitigations • Enhanced payment incentives being explored to improve temporary staffing fill within critical areas.
Vaccination - Both the C19 and flu vaccination programmes are primarily delivered via the Frimley Primary Care Networks, creating staffing and service delivery pressures during the recovery phase. There are also WF pressures in the Mass Vaccination Site leading to a reduction in vaccinators as people return to their lives, whilst providing support to the FHFT Booster & flu programmes.	• Reopening of recruitment pipeline for Band 5 vaccinators, target of 30 by Sept (8 recruited with a further 13 interviews scheduled) • NHS Professionals vaccinator applications • Additional peripatetic support provided by Medics
Community health – The increase in acuity, and dependency of complex patients both on inpatient wards and domiciliary caseloads, demand for long COVID services and the age profile of our People in this area create a increasing the pressures on our services.	• AHP programme – a review of intermediate care services in NEHF & Surrey Heath to determine whether workforce capacity is sufficiently resourced to meet the increased demand of complex patients being managed out of hospital • Annual leave utilisation monitoring • Provision of support as per the Health & Wellbeing mitigations
Primary Care – Increased demand & workforce capacity gaps in particular in practice nursing, and difficulties in filling some professional ARRS roles to support.	• A range of options are ready to be deployed that include social prescribing, health coaching and care coordination. • Consideration of winter scheme to support wider at scale recruitment of staff to ARRS Personalisation Team roles • Potential to draw on the existing pool of vaccination site volunteers and unqualified vaccinators as the Phase 3 vaccination programme ends

Health and Social Care Workers, Frimley ICS Vaccination Status at 6.10.21

Frimley Health and Care

There is no single entirely reliable data source for this cohort. We use the Foundry system to look at the best available data, but filtering by JCVI cohort groups HSCWs together with over 80s. Using a different set of filters on Foundry gives the following data, but with the following caveat: *The JCVI cohort filter is not applicable on this tab as the data sets presented here are aggregated. Be aware that when selecting more than one sub-cohort, the resulting combined figures (numerator and denominator) are the sum of both groups, so will be in excess of the true combined population.* This the best dataset we can give, though not perfect.



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Elective Recovery

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Elective Recovery

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Focus areas

- Managing patients in order of priority
- Infection control
- Increasing activity
- Improving efficiency
- Working differently
- Reducing inequalities
- Recovering cancer wait times

Key actions

- Collaboration across the ICS to implement new patient pathways and different ways of working
- Staff support package
- Increased use of virtual and video consultations
- Reducing unnecessary follow ups
- Increasing capacity through additional activity and the independent sector

Progress to date

- Good progress with most areas of activity back to pre-covid levels

Risks/issues

The ICS has identified risks to recovery and has a range of mitigations in place to reduce any potential impact

- Staff are tired
- Emergency and critical care activity may over-run elective capacity
- Delays in discharge reducing elective bed availably
- IPC requirements reducing efficiency
- Patients continuing to delay treatment
- Longer waits for first appointments with specialist
- Delays getting tests and results

Key Winter actions

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- Surge capacity is available for Critical Care including the extension of respiratory Level 2 (O+) capacity for Non-Invasive Ventilation. A surge plan has been developed and is in place.
- Staffing plans remain in place to support the escalation of capacity with ongoing 'refresher' training being provided to staff identified as likely to support critical care in the event of escalation.
- Surge planning is underway for the predicted RSV uplift and this plan will be integrated with the other surge plans such as those for winter / 'flu and Covid-19 in order to ensure that a coordinated response is in place particularly around estate, equipment and workforce.
- General and Acute bed capacity is managed and flexed in accordance with current demand and the **System Surge and Escalation framework** to release capacity appropriately to the areas most in demand. Escalation capacity has been identified, but is relatively limited, and workforce remains a significant constraining factor in the ability to open escalation capacity.
- Acute & Community Same Day Emergency and Urgent care pathways / units are in place across the major specialty areas. Pathways and provision are at present being reviewed in the light of the opportunities identified through Recovery and system analytics, learning from other system and feedback from local clinicians .
- Infection Control teams work closely with the site teams to maximise bed capacity whilst maintaining ward IPC and safety during business as usual and particularly in the event of outbreaks and surges in demand

Frimley Health and Care

Frimley
Integrated Care System
Primary Care

Surge/Winter Plan 2021-22

Frimley Primary Care: Existing and Predicted Challenges

Frimley Health and Care

- Primary care including general practice has a key role to play in the resilience of local health services over a period of increased demand on health care services. The sustainability of primary care services should be a high priority for the system due to the impact on other services should these general practice have increasing resilience issues.
- Over the last six months general practice has delivered more contacts than the same period pre-pandemic, resulting in good restoration of services and leading to greater innovation in order to maximise the capacity available to see patients.
- Responding to the challenges brought by the COVID pandemic continues to challenge our workforce, impacting on the ability to address the predicted surges over the winter period.
- Increased urgent demand on primary care impacts on the core offer around routine and preventative care, resulting in the risk that there could be a backlog in activity, where capacity is insufficient – as with secondary care services, there is a risk of a vicious cycle when routine and preventative care services are delayed.
- The increase in same day demand has accelerated the use of the digital offer in primary care over the last 12 months – consideration needs to be given to the patient experience, confidence in the care received over digital offers, and also the impact of the demand on our practice teams.
- There are predicted surges in demand but the timing is unpredictable, specifically respiratory conditions / RSV
- The impact on the well-being and capacity in our workforce following such a demanding 18 months will challenge the continuation of existing offers as an impact of only small changes on demand, and could impact on the additional capacity planned over this winter.
- Generally our population values general practice as a trusted source of care and support, however the increased level of anxiety and deferred need during the pandemic has led to a change in behaviours and how patients are using services. This has put pressure on services such as 111, emergency departments and general practice.

Frimley Primary Care: Planned Actions

Frimley Health and Care

Capacity:

- Work has been undertaken to ensure that extended and improved access capacity remains available, including flexibility to offer evening and weekend access. This is primarily supporting planned appointments, with additional services in place for urgent appointments via 111 and out of hours. The models are tailored to local provision and population needs.
- General practices have the support of the Frimley General Practice Prioritisation framework enacted through Place teams proactively identifying practices under pressure and/or practices asking for support. Surge planning with primary care will include enacting our prioritisation framework for general practice to support high risk activities only, switching off routine access for lower risk activities (some LCSs) and ensuring care is prioritised for those most in need.
- Funding to support additional capacity (50k appointments) in general practices during the autumn/winter has been commissioned, with flexibility to meet local priorities including reviewing the balance of face to face capacity with need. Focus will be on increasing the number of urgent/same day appointments being delivered for all patients to provide access to primary care.
- All PCNs have plans to secure capacity for the anticipated RSV surge.
- Workforce risk assessment and practice business continuity plans reviewed in practices.

Access:

- Triage is in place in practices via online and telephone consulting ensuring the most effective pathway for patients. All practices have implemented online consulting and have had support to ensure sustainability and improved access for patients.
- All practices offer online repeat prescription services (EPS) and PCNs are looking to adopt the Community Pharmacy Consultation Service (CPCS) to support patients in accessing appropriate care.

Frimley Primary Care: Planned Actions

Frimley Health and Care

Demand:

- Focused admission avoidance activities drawing on intelligence and inequalities: provide extended offers to ensure patients have access to the right primary care to address their needs. Using MDT approach to target and review patients proactively identified as most at risk of crisis and onward admission through PCNs enabling best use of additional roles.
- National communications would be helpful to supplement local approaches and support the local population in knowing where to go when they need access to services. National communications to supplement local approaches, including 'Frimley Healthier Together', information for patients and carers on 'how to stay well through winter' complementing the Covid/flu vaccination programme and collaborative communications with local authority colleagues.

Prevention:

- Vaccination programme delivery: ensure prevention programmes such as vaccinations and screening are maximised in our population resulting in continued health improvement.
- Focused admission avoidance activities drawing on intelligence and inequalities: provide extended offers to ensure patient have access to the right primary care to address their needs.
- Increased use of anticipatory care to target individuals and communities through PHM: work proactively to identify those patients who are most likely to need additional care over this period.

Frimley Primary Care: Vaccination programme delivery

Frimley Health and Care

- Vaccination has an increased priority to prevent illness and reduce the impact of surge demands on services.
- The Covid Vaccination Programme will continue to deliver vaccinations through the current requirements and adapt to the phase three requirements. Local Vaccination Services will continue to provide a vaccination offer with established plans to December 2021.
- Inequalities in uptake have centred around our most vulnerable communities including those resident in care homes and the BAME population with high risk or poor outcomes, ensuring positive messages around the benefits of vaccination to those who may be hesitant and reaching into our population to ensure access is as flexible as possible to achieve the highest levels of vaccination.

Ensure workforce are risk assessed and supported in receiving the vaccination/s, and where risks are identified and mitigations enacted in the best interest of the individual and patients. Individuals going into highly sensitive settings such as care homes will be required to be in line with government vaccination legislation to keep people safe.

- The uptake for seasonal flu vaccinations in 2021 is anticipated to be high. Robust plans are in place through the Primary Care Networks and Place teams to ensure good access and high levels of vaccination across all cohorts are achieved.
- Primary care networks are working through Local Vaccination Services to adapt their models to support the seasonal flu vaccination programme, through hybrid models including co-administration of the flu and Covid vaccinations in many areas.
- Community pharmacies will contribute to both the Covid and flu vaccination delivery in 2021, offering the flu as in previous years and adding to the capacity for any Covid booster campaign. Relationships through Primary care Networks and the Local Pharmaceutical Committee continue to develop with the adoption of CPCS and with a population focus on the deliver of the vaccinations.

Primary Care: Surrey Heath Additional Plans

Frimley Health and Care

Additional Arrangements/Plans	Comments / Expected outcomes	Date to be in place by
Practice resilience	Proactively identify and work with practices on resilience in relation to workforce, capacity & demand, and estates. Understand any areas where CCG can provide support.	Nov – Dec 21
Inequalities	The PCN are actively planning on commencing mobilisation of a project focussed on their local health inequalities with the aim of improving care to these areas of the population.	Nov - Jan 21
Paediatrics	Additional appointment capacity focused on febrile children under 5 years; supported through promotion of Frimley Healthier Together and access to specialist advice and guidance through a paediatric hotline supported by Health Visiting Team.	Sept - April 21
Rapid recruitment of additional roles	Increased rapid recruitment of ARRS roles – social prescribers, health and wellbeing coaches, Physicians associates, and care coordinators to support practices and patients with low-level mental health and other social and care support.	Sept – Nov 21

Frimley Health and Care

Mental Health

Covid Impact – Benchmarking

Frimley Health and Care

Services continue to experience a surge in mental health and emotional wellbeing related demand due to the impact of pandemic, especially the periods of national lockdown resulting in social isolation and disruption to daily routines such as school and employment. Demand has remained high for some specialist mental health services, notably all age crisis, all age eating disorders and acute inpatients. Providers continue to see an unprecedented number of people previously unknown to services presenting in crisis.

- **Bed availability -** nationally availability dropped 5% by April '20 , but by July 2021 was back to pre-covid position nationally. In the South East the availability of beds has been variable but are back to pre-covid position (14/100k). In Frimley, our providers have a low bed base and during covid they have increased availability through the independent sector.
- **Mean length of stay (LOS) -** has been variable over the course of the pandemic nationally and is currently at 35 days. For Frimley, Berkshire LOS has increased whereas SABP's has reduced against backdrop of 31 days across the South East in July '21.
- **Bed occupancy –** in 2019/20 the national median average was 91% with the South East at 94%. In 2021 this has increased nationally to 94% but reduced in the South East to 89%. Bed occupancy for Frimley providers remains high, above 93%.
- **Use of Mental Health Act -** Nationally and within the South East detention rates under the MHA were 45% pre-covid. By July 21 there has been an increase in detentions nationally and regionally with South East at 52%. Although below the national average, SABP admissions under the MHA in July '21 .
- **Child and Adolescent Mental Health Services (CAMHS):** The South East is a hotspot for service demand and high caseloads
  - CAMHS is the fastest growing specialty in mental health. Referrals doubled between 2012 and 2020. Referrals have fluctuated with lockdowns and school closures and they remain high in Frimley.
  - Frimley providers also hold high caseloads. Regionally caseloads are 30% higher with BHFT having the second highest and SABP at the top of second quartile.
  - The South East is the best performing region in terms of spreading digital services (at 24% against 19% nationally), with Berkshire and Surrey well above average

SABP – Surrey and Boarders Partnership Foundation Trust, BHFT – Berkshire Healthcare Foundation Trust

Mental Health Service Risks

Frimley Health and Care

Currently we are seeing a pressure on:

- **Acute Bed Pressures** continue to be experienced by both our Providers, BHFT and SaBP with a high demand for admissions and out of area placements in response to high occupancy in adult acute and older peoples beds. Covid cases have fallen to zero most weeks however, the pressures of ward closures as a result have reduced but the demand and acuity is still high.
- **Out of Area Placements (OAPs) -** inappropriate OAPs remain high across the system in response to demand and pressures / unavailability of acute beds. Revised trajectories have been agreed with NHSE which will result in Frimley CCG not reaching zero by year end. Changes to the classification of independent providers within area or where there is a continuity of clinical pathway has been implemented, with both main Providers establishing block contracts for beds locally. This has stemmed the increase in number of inappropriate OAP bed days. We are monitoring the situation closely.
- **CYP attendances and admissions** - there is a growing number of children and young people who are both attending and being admitted to our acute hospital sites. This is a particular challenge for Frimley Park Hospital which is impacting the acute's ability to maintain flow in and out.
- **Autism / ADHD** – growing appetite for patient choice in seeking independent provider ASD/ADHD assessments which in turn likely to add additional pressure to already under pressure service. Mental Health teams began work in understanding this impact as concern that there will be a disparity for people waiting with local NHS service. This is manly for adults but some evidence for CYP also.

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Mental Health Service Risks

Frimley Health and Care

- **Recruitment and retention -** there is both a short and long term pressure recruiting to the wide ranging Mental Health roles in community, primary and secondary care. A Workforce Summit is being planned in collaboration with Workforce Development group to include all system partners to address the issues we face in filling vacancies both new and existing and retaining staff. The shape of this summit is under development and is planned for November.
- **Referrals and demand for CAMHS** services continues to rise, with particular concern regarding CYP Eating Disorders and ARFID (Avoidant Restrictive Food Intake Disorder). Referrals into CPE/ SPA continue to be above the 20/21 average. Significant investment in Hampshire CAMHS (£11m) to increase capacity within the service – currently an additional 70 staff in post with recruitment ongoing. Surrey CAMHS has increased investment to tackle historic wait lists and in recognising the increase in referrals for CYP with eating disorders has developed a Safety Plan in consultation with Commissioners and wider System Partners. Berkshire BHFT are utilising additional investment monies to decrease wait times in CAMHS teams.
- **IAPT Access** remains below the required target and has not experienced the surge in referrals that was anticipated following the first waves of the pandemic. Non-recurrent funding provided in the spending review is being utilised to improve access and outcomes for specific patient groups, including older adults and people from ethnic minority communities. IAPT services are reporting that those patients who do engage are often requiring a higher number of sessions before being discharged, meaning overall activity levels remain high.

Mitigating Actions: Mental Health (Adults)

Frimley Health and Care

Integrated working is key to our current and on-going response to mitigating demand and supporting earlier intervention. Service offers brought online or expanded include Mental Health Integrated Community Service (MHICS), bereavement support, virtual safe havens, crisis pathway, fast track workforce wellbeing support, virtual wellbeing hub offering access to third sector interventions.

1. **Acute Bed Pressures** - enhanced bed management and bed flow optimisation, with weekly & daily system Exec partners meetings (Surrey & Berkshire) to expedite discharges & increase patient bed flow. Linked to a clear and visible OPEL methodology across Frimley Health.

2. **OAPS**:

- SaBP – OAPS generally reducing with additional capacity purchased in local Independent Sector Providers. Plan that anyone needing and adult Acute MH bed will receive support in Surrey by end 2021.
- BHFT instigated similar arrangement with private providers in Berkshire to increase bed capacity re-classified as non OAP. A total of x5 PICU and x8 adult acute beds.
- Focus on the urgent care part of the MH pathway is given daily priority by all Community MH services. Crisis Resolution Teams are working hard to keep patient at home and avoid admission thus preventing further OAPS. Data in SABP to show a daily meeting has reduced requests from people in their own homes by 50% since July.

3. Peer Support Workers / Assistant Psychologists to work alongside Psych Liaison to provide bridging support. We are scoping the possibility these with the addition of these being joint posts with our Acutes

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Mitigating Actions: Mental Health (Adults)

Frimley Health and Care

4. Crisis House/ Beds – we have tested a crisis bed (with the option to flex up to two) as an alternative to admission in the North of Frimley and plan to review the opportunity to expand this offer into the South.

5. Adult eating disorders services have seen similar pressures as the CYP services. We propose to hold a pot for funding that can be used to spot purchase additional packages of care / support to de-escalate crisis. NHSE has agreed to fund 7 beds at Priory Marlow non-recurrently for Surrey adults waiting for specialist eating disorder services.

6. Discharge fund – this will be continuing and focused on funding schemes that have worked over the winter including Discharge to Assess, deep cleans, funding placements without prejudice, purchase of block beds

7. 16-25 Safe Haven – recognising there are a number of young people who need to access a safe haven but are in the process of transitioning a 16-25 safe haven is being scoped up.

8. **Acute In-reach & extra support following a crisis line call** from third sector providers to provide additional support to people and help avoid a relapse or an escalation of a potential crisis.

Mitigating Actions: Mental Health (CYP)

Frimley Health and Care

1. Weekly discharge calls with system partners (Acute, CAMHS, Crisis, LA and CCG) to run through medically fit list to ensure plans are put in place to unblock DTOCs and expedite discharges. This also includes a risk review with system partners to understand the crisis offer, key risks and agree any additional mitigations required

2. Community Engagement campaign: There is a need for some clear proactive communications with local communities to support the prevention agenda and encourage people to seek early help. Particularly for parents and carers whose wellbeing will be under strain. Recruitment to a Community Engagement Worker who can work with communications and Place teams as well as link into communities, establish relationships and building a network of communication routes , understand health inequalities and barriers to accessing MH services and proactively informing communities of local services and encouraging take up of early help and intervention

3.Peer support workers to work alongside psychiatric liaison teams to offer pastoral support to people coming into ED and actively bridging to more appropriate community services at discharge

4.Advice and Guidance to Primary Care and Paediatricians – CAMHS psychiatry and crisis support for primary care and acute colleagues afternoon to late evening (1500 - 2300).

5.Therapeutic Respite / Step down provision – interim health and social care provision similar to Extended Hope Service in Surrey as both alternative to admission to and step down from acute where CYP is fit for discharge. This would be a time limited transition (max 7 days) to support both flow in the acute and prevent CYP from deteriorating further. To be confirmed subject to review of the suitability of the site available.

6.Contingency Fund Availability of grant funding that can be used to spot purchase short term support. Funding can be used to provide additional breaks for family carers, for equipment, accessing therapies or activities, or other innovative approaches which will help to sustain stability. This should be in addition to normal levels of support from health and social care. (have included the template developed for the LDA short term funding).

Learning Disabilities & Autism

Frimley Health and Care

People with learning disabilities have a life expectancy of around 14 years below the general population. The pandemic has had a devasting effect on people with learning disabilities and an article in the BMJ in June 2021 identified that people this cohort of people are highly vulnerable to Covid 19 and data from Public Health England showed that mortality rates in this group were up to three times higher than that of the general population. The article, written by recommended that they should be prioritised and protected.

Additional funding has been agreed to:

1. Help increase early uptake of Covid and Flu vaccines for people with Learning Disabilities and Autism across our 5 Places, through supporting in reach service so that people are able to receive their flu jab, covid jab and annual health check in their own home for those who are especially worried or particularly vulnerable.
2. Increase the prevalence rates of people with a learning disability by providing some additional capacity to each of the 5 places to support a focus on the GP/LA lists. Finally, we will use some of the funding for a targeted coms campaign for people with Learning disabilities, autistic people and their carers to ensure they have their health check and vaccinations.
3. Spot purchase specialist behavioural interventions for CYP with LD or autism
4. Enable additional provision of short breaks for CYP with LD or autism in collaboration with local authorities

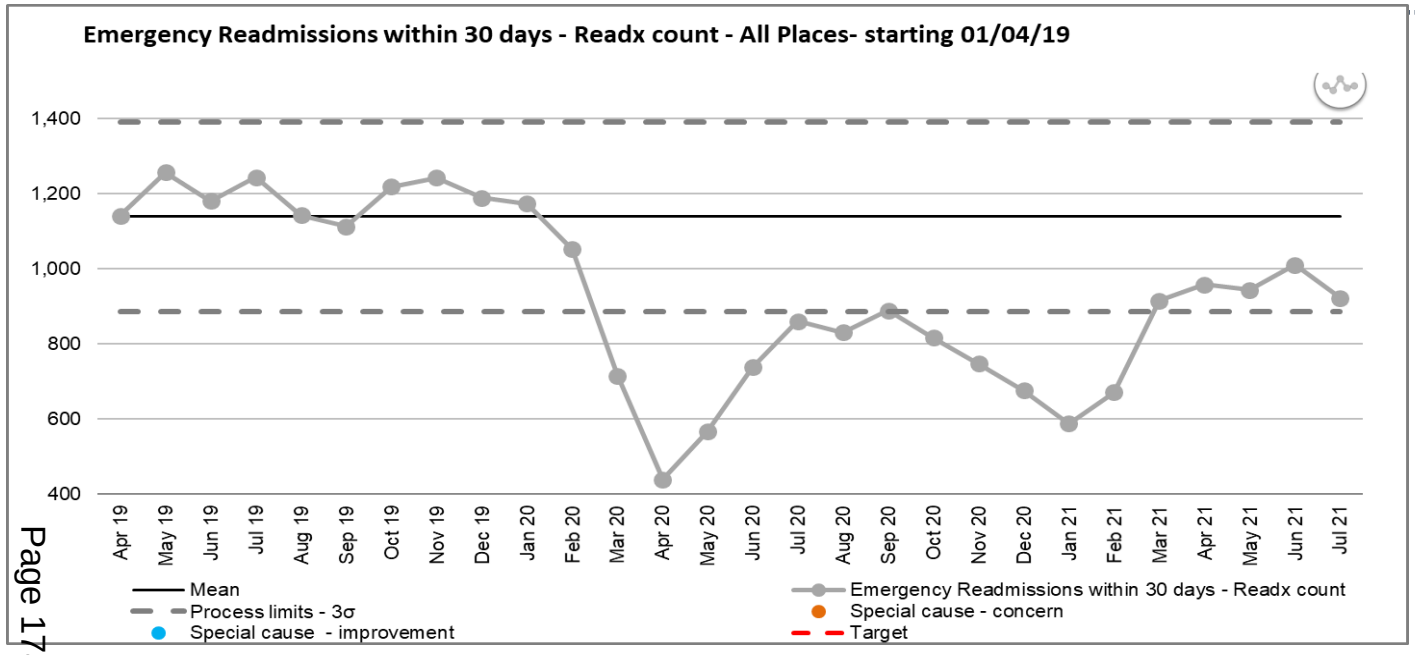
Frimley Health and Care

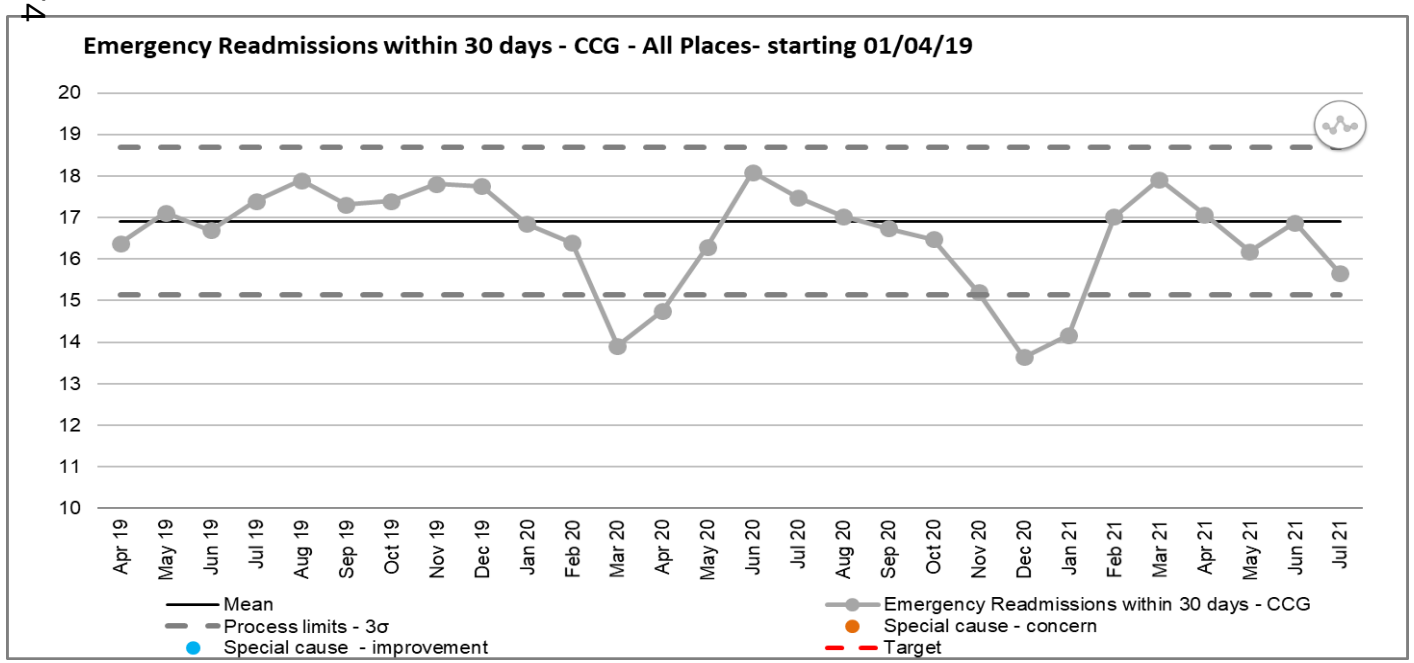
Further Information

Supporting Documentation
(available on request)

- Frimley ICS Winter Plan
- FHFT Winter Planning 2021-2022
- Discharge & Flow Surge & Super Surge Plan 2021-2022
- Frimley ICS Surge & Escalation Protocol 2021-2022
- Communications & Engagement Plan Winter Plan 2021-2022

Non-Elective Readmissions within 30 days: Frimley CCG patients





The top chart to the left shows the actual number of emergency readmissions within 30 days (i.e. readmitted as an emergency within 0-29 days of discharge) for Frimley CCG for the period April 2019 to July 2021. The month refers to the month of discharge for the index admission, and not for the readmission spell.

The bottom chart gives the readmission rate (the numbers of emergency readmissions divided by the number of discharges).

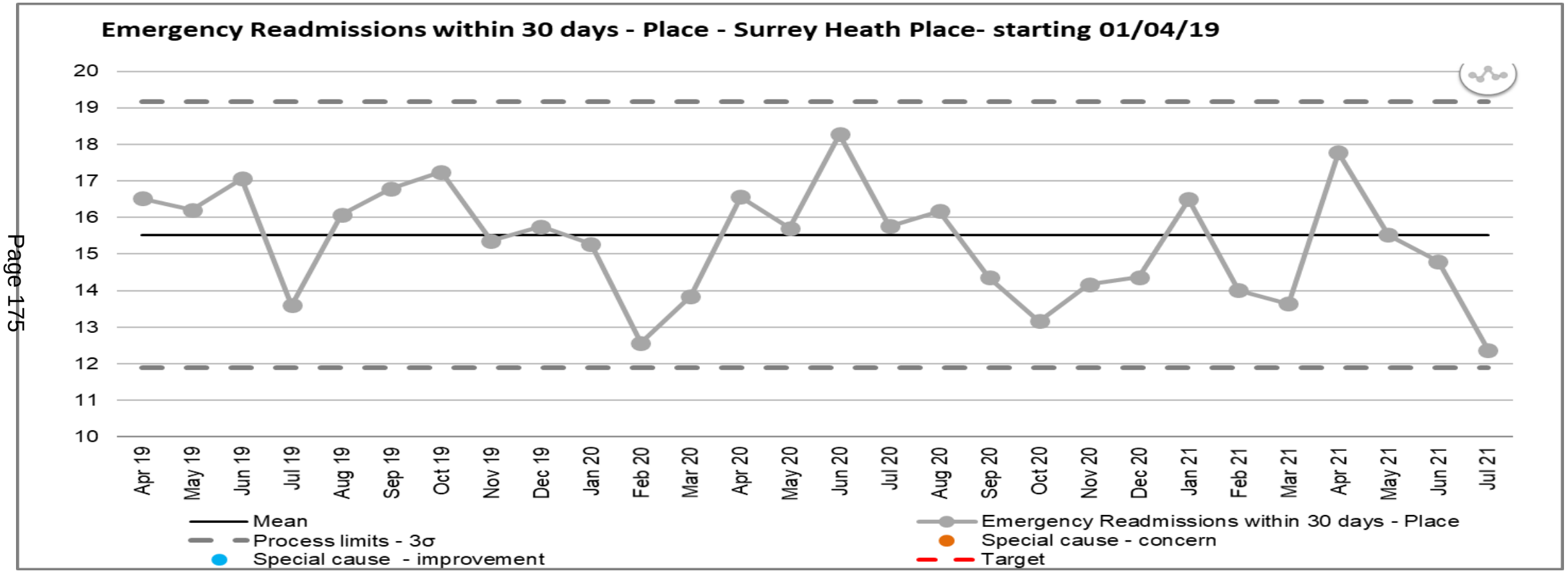
As can be seen, the readmission count dropped significantly throughout the COVID period, however this also reflects the reduction in the number of admissions / discharges that took place in that period.

When considered as a rate however, we can see that this has been fairly consistent across the period, with a slight reduction outside of 'normal' levels around the lockdowns in February / March 2020 and December 2020 / January 2021.

Non-Elective Readmissions within 30 days: Frimley CCG patients in Surrey Heath

Frimley Health and Care

Considering the readmission rates at Place level, we can see that there were few months with any significant variation from expected levels across the Places.



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ADULTS AND HEALTH SELECT COMMITTEE

20 OCTOBER 2021

UPDATE ON THE IMPLEMENTATION OF MENTAL HEALTH TASK GROUP RECOMMENDATIONS

Purpose of report: To provide the Adults and Health Select Committee with an update on progress in implementing the recommendations of the Mental Health Task Group, which was established to map the individual and carer's journey through adult mental health services in Surrey.

Introduction

1. On 8 March 2019, the Adults and Health Select Committee formally established the cross-party Mental Health Task Group, which would aim to map the individual and carer's journey through adult mental health services in Surrey. However, due to a combination of Select Committee restructuring and the Covid-19 pandemic, the Task Group's work was delayed until the spring of 2020.

2. Between 8 June 2020 and 1 September 2020, the Task Group conducted 13 separate evidence-gathering sessions with 40 witnesses from a wide variety of organisations.

3. The findings and recommendations of the Task Group were presented to Cabinet in October 2020 and were welcomed. This report provides a progress update on actions that have taken place to implement each of the Task Group's 20 recommendations.

Progress made on implementing the Task Group's recommendations

4. **Recommendation 1:** GPs, when referring patients, ensure that all relevant information is passed on so that patients avoid repeating their stories multiple times, and that GPs ensure they explain to patients, both those they are referring and those who are self-referring, how they can release their medical records to mental health services.

5. **Progress update:** There is now a live and operational Surrey Care Record which enables the safe sharing of data between mental health services and GPs and Surrey County Council. This is the core data sharing product for direct care and has now been in place for six months. The full patient record is shared between authorised health and social care professionals. Adult services and

SABP are both users of the platform and use will continue to widen over time. A link to a demonstration of the Surrey Care Record can be made available for the Select Committee and programme leads would be delighted to offer an introductory session to whomever would benefit from it.

We have also seen improvements in the interface between Primary & Secondary Mental Health care with the development and spread of the GP Integrated Mental Health Service (GPIMHS). GPIMHS has spearheaded the integration of adult mental health services across Primary Care Networks and specific GP practices, which greatly improves the flow of information between health and care professionals by the sharing of clinical information. The initial programme of work has been very successful, and the roll out continues across Surrey. The new model of care will facilitate wrap around care services and improve patient experience.

In Frimley, the same mental health data flows to Connected Care, which is the Frimley shared care record.

6. **Recommendation 2:** From 2021, GPs receive additional mental health top-up training on an annual basis, and that at least one GP per practice has undertaken more specialist mental health training.

7. **Progress update:** Surrey Heartlands CCG commissions the GP Advanced Diploma in Mental Health. The diploma has been recommissioned for 2021/22 and is being promoted to all Primary Care Networks (PCNs). As part of the GP Integrated Mental Health Service (GPIMHS) development, each PCN that has a GPIMHS service is required to have a GP complete the diploma.

8. **Recommendation 3:** From 2021, GPs receive regular training to ensure they understand how to use resources such as Surrey Information Point and Healthy Surrey, so that primary care partners are aware of what mental health services and third sector organisations are available in Surrey, and for these resources to be updated by Surrey County Council on a regular basis so that health partners can access all of the necessary information as easily and quickly as possible.

9. **Progress update:** The flow of new and relevant information throughout the health and social care system is becoming easier by use of technology, however there is risk of several forms of communication being used to share knowledge which becomes confusing and unwieldly. In Surrey, there is a focus on a core group of platforms to update professionals, most recently the platform of Teamsnet which is a repository of information for GPs which can be updated by various stakeholders. This reduces the volume of emails and newsletters received by GPs and facilitates a place where information can be accessed anytime and updated as required.

Via the Local Contracted Service (LCS) for the Severe Mental Illness (SMI) - Mental Health Enhanced Physical Health Checks & Suicide Prevention, primary care colleagues in Surrey Heartlands signed up to the LCS have access to a SMI physical health check and suicide prevention eLearning modules.

In addition, Surrey Public Health are working with an external agency reviewing the content of Healthy Surrey Mental Health section to most effectively and accessibly provide resources and information to residents. Cross-agency communication teams are also involved in this work.

10. **Recommendation 4:** Each primary care network in Surrey nominates a mental health champion to help strengthen partnership working across the primary care system.

11. **Progress update**: The GPIMHs model has a lead GP for the mental health development in each PCN. As the model roll outs across Surrey Heartlands these leads will increase and have full coverage across PCNs. As part of the new GP and standard NHS contract, there is an entitlement for each PCN to establish an additional Mental Health Practitioner role from 2021/22.

    We are recruiting to the Mental Health Alternative Roles Reimbursement Scheme. These workers will link closely with the GPIMHS programme to ensure a fully integrated approach. This scheme has been funded through the Spending Review allocation for mental health. Given the competing recruitment challenges in our geography, identifying sufficient skilled staff is presenting a challenge but we are working with PCN Clinical Directors to develop creative solutions.

12. **Recommendation 5:** A solution is found to the problems surrounding the sharing of data and IT infrastructure between the NHS, Surrey County Council and external providers to enable third sector organisations to fully and safely support those in their care, and that Surrey County Council and Surrey Heartlands liaise as a matter of urgency.

13. **Progress update:** As stated in Recommendation 1, progress with the Surrey Care Record is supporting the sharing of data between the NHS, Surrey County Council, and external providers. Work is continuing between health, social care, and the third sector to bring together resources and data on shared IT platforms; such as the Surrey Virtual Wellbeing portal which brings together a range of courses and online support delivered by third sector providers onto a simple portal.

    Further to this, one of the workstreams within the Mental Health Improvement Plan is focused on data. It intends to address the culture, behaviour and

systems to improve accurate collection and use of relevant mental health data sets. A series of workshops are being led by Public Digital to identify how we need our digital and data systems to improve to ensure the mental health system is easier to navigate and that people only have to tell their story once.

14. **Recommendation 6:** The GP-consultant text system is expanded to include questions relating to mental health concerns.

15. **Progress update:** A pilot project commenced in February 2021, which facilitates GPs receiving information from Mental Health Clinicians. The service is already in use between GPs and Medical Professionals. The service is available for GPs to access advice from Mental Health Services regarding patients who are experiencing delirium and confusion. The pilot project will be evaluated in due course with a view to being rolled out further if successful.

    GP Mental Health Leads across Surrey are in the process of developing a virtual Community of Practice, which will provide an opportunity for sharing and support amongst GP leads. The plan is for the Community of Practice to be built by identifying GPs who have undertaken the Diploma of Mental Health and then expanding to try to find one GP with an interest in mental health in each practice.

    Changes have been made to Footfall (the software used by the majority of GP Practices in Surrey on their websites) to include details of Mental Health Support for Adults and Children in the Wellbeing Centre. A mental health crisis is also now listed on Footfall as an example of an emergency where you are advised to dial 999.

16. **Recommendation 7:** Third sector organisations are given the ability to refer to Community Mental Health Recovery Services and Community Mental Health Teams to ensure that those with mental health issues are signposted to the services that are right for them and their needs.

17. **Progress update:** Third sector organisations can signpost clients to the Single Point of Access (SPA). If the SPA service assesses that the client would benefit from a referral to the Community Mental Health Recovery Services or Community Mental Health Teams, they will arrange for this to happen. Third sector organisations have staff embedded in the Single Point of Access as Community Connectors who are improving the management of referrals. Collaboration with the third sector has been significantly strengthened during the pandemic and work is currently underway to develop an alliance of providers, including the NHS and third sector. Collaboration with the third sector is also playing a significant part in delivering the Surrey Mental Health Improvement Plan. Work is being led by Public Health to review access points to mental health support and providers are working with the Academic Health

Science Network to innovate and develop a better solution to the access challenges of the past.

18. **Recommendation 8:** From 2021, meetings involving CCG leads and third sector organisations take place on at least an annual basis to help facilitate stronger partnership working and understanding, and that all stakeholders, including third sector organisations, are represented at all meetings and committees that impact the work of the third sector and external providers.

19. **Progress update:** Regular meetings between CCG leads and the third sector will continue as required. Third sector organisations and wider partners are currently represented throughout the Surrey mental health governance architecture, including the Mental Health Partnership Board and the Mental Health Delivery Board. Similarly, third sector organisations are involved in the fortnightly Mental Health COVID Emergency Response Group that reports into the Surrey Heartlands Incident Management infrastructure. Partnerships with the third sector are strong and there is a huge range of excellent examples of integrated working in our geography, such as the new Surrey Children's Emotional Wellbeing and Mental Health Alliance, Safe Havens, GP IMHS and Criminal Justice Liaison and Diversion Services. Third sector organisations are also playing a crucial role in delivering the Surrey Mental Health Improvement Plan and are leading in key areas such as developing the vision for early intervention and prevention.

20. **Recommendation 9:** All health providers and commissioners ensure that the use of remote meeting software remains an option for future meetings, appointments and therapy sessions to ensure that location and access issues are not a barrier to participation.

21. **Progress update:** It has been built into Surrey mental health planning that remote meeting software will remain an option for services in future to ensure accessibility for residents.

    Surrey has been leading the way in providing access to digital services according to recent NHS Benchmarking. Our aim is to ensure a blending of face-to-face and digital services are available to take account of service user/carer/family choice, needs and risks.

22. **Recommendation 10:** Surrey County Council conducts a review of the nature and length of contracts currently offered to third sector providers, and that all future contracts are for a minimum of five years.

23. **Progress update:** Since the previous update, the Adult Social Care Mental Health Commissioning Team is looking to further extend the Community Connections contracts; these are our main VCFS contracted providers for adult

mental health. If approved by the Surrey-wide Commissioning Committees-in-Common, the providers will enter their sixth year of service delivery from April 2022. Where it is within the gift of the Council, any new procurement/tender exercises in this field will be for a minimum of five years.

24. **Recommendation 11:** Surrey County Council lobbies central government for more funding for mental health to enable further initiatives to achieve early intervention, and that a review is undertaken of third sector funding.

25. **Progress update:** The importance of providing longer-term funding stability for the third sector is well understood. It can support working in greater partnership and can also create opportunities for VCFS partners to attract additional external funding. In mental health specifically, community connections (third sector) contracts have proved highly effective in securing additional external funding almost doubling their funding through other projects; this contract arrangement has now entered its fifth year from April 2021. Even when longer-term contracts or funding arrangements are agreed, contracts would contain provisions to protect the Council's interests should concerns about quality of service delivery arise.

    A Mental Health Partnership Board report recommended commissioning specialist health economists to analyse and better understand the funding and resourcing of emotional wellbeing and mental health services in Surrey, including the voluntary and community sector, with the purpose of creating an evidence base understanding of the sufficiency and effectiveness of mental health resourcing. This work is now being taken forward through the Improvement Plan.

26. **Recommendation 12:** Public Health undertakes an employer-focused mental health campaign in 2021 to help improve employer knowledge about mental health and ensure that Surrey employers are aware of how to access courses and training.

27. **Progress update:** The Surrey Wellbeing and Workforce Collaborative (SWWC) was formed in March 2021 and membership includes Surrey County Council, Public Health, Surrey and Borders Partnership, Woking Mind, Surrey Chambers of Commerce, and Oakleaf Enterprise. The purpose of the group is to take an evidence-based and collaborative approach to engage with and support wellbeing of those working in Surrey businesses/organisation. In June 2021 a virtual event was held, with over 80 people in attendance. There was positive feedback that the event provided a space where people could talk about real life business experience, overcome obstacles and learn from others. Work is now underway to broaden the reach.

The Collaborative is working to further engage businesses through sharing resources and virtual events. Resources to support the workplace for 2021/22 include devising a Wellbeing Champions programme and embedding Mental Health First Aid training.

28. **Recommendation 13:** From 2021, induction-level training in mental health awareness and suicide prevention is provided for all Surrey County Council members of staff and councillors, as well as all affiliated organisations.

29. **Progress update:** Surrey Public Health have organised for several Surrey County Council staff to attend a Train the Trainer course in Mental Health First Aid Training. This will allow the Council to deliver training for wider staff as a sustainable delivery method.

30. **Recommendation 14:** From 2021, frontline members of staff and decision makers from all public and health organisations in Surrey receive training so they use instructions and terminology with service users that are appropriate for those with mental health issues, learning disabilities and autism to ensure that those whose conditions are not immediately obvious are better served.

31. **Progress update:** Surrey Public Health team offer a suite of mental health training including:

    - COVID-19 related training
    - Suicide prevention training to help improve understanding and confidence to intervene with people at risk of suicide
    - Wellbeing workshops promote positive, emotional and mental wellbeing through six everyday actions
    - Connect 5 – Ways to work with Mental Wellbeing in everyday practise. This course will enable people to have conversations about mental health and offer information on local service. Connect 5 is aimed at everyone
    - SafeTALK – Half-day alertness training that prepares anyone 15 or older, regardless of prior experience or training, to become suicide-alert
    - Applied Suicide Intervention Skills Training (ASIST) is a two-day interactive workshop in suicide first aid

    This training is available to staff and decision-makers from all public and health organisations in Surrey. As referenced in Recommendation 13, several Surrey County Council staff attending the Train the Trainer course in First Aid for Mental Health will also allow a wider rollout of mental health training.

    Outside of the Public Health team, a range of training options and resources are available to support staff when working with people with mental health issues. For example, in East Surrey, Medical Director Des Holden has developed and released 'Don't Walk Past' – a serious game for supporting recognition and

sign-posting of mental health need in people admitted to hospital with a physical illness.

32. **Recommendation 15:** Surrey County Council and Surrey and Borders Partnership NHS Foundation Trust explore how they can work more closely together to ensure Surrey County Council social workers are involved as early as possible (including at the diagnosis stage) so that those with autism, Asperger's and/or learning disabilities – especially those with complex needs – are fully supported and potential mental health issues are identified.

33. **Progress update:** The Surrey County Council Adult Social Care mental health teams continue to work closely with Surrey and Borders Partnership colleagues to ensure that referrals are made in a timely way, and attend multi-disciplinary meetings with trust both in the community and in hospital settings.

    Surrey County Council ASC has purposefully linked elements of the All-Age Autism Strategy to addressing some of the issues and challenges identified in the Mental Health Taskforce Work that was endorsed by Select Committee – research suggests that 70% of autistic people have a mental health condition, and that 40% have two or more. Autistic people are up to four times more likely to have anxiety, and twice as likely to have depression. Research has shown that autistic people are more vulnerable to negative life experiences, which may also impact mental health. Therefore, within the Health and Social Care Support work stream, both the need to improve the timeliness of assessment and diagnostics of people with Autism and providing better education and training for Mental Health professionals in autism awareness have been identified as priorities. This is to improve the ability of Mental Health services staff to recognise and respond appropriately to autistic needs and the impact on mental health and wellbeing better.

    As part of the Council's Preparing for Adulthood Transformation Programme, the reach of the Transitions Service is being expanded to offer specialised Transitions Support to those young people with mental health needs who are Care Act eligible, who currently receive a relatively disjointed approach from across social care, education and health; leading to more young people than necessary being placed in institutionalised forms of care within acute inpatient units rather than being supported in their communities. This work is just commencing with colleagues from within Adult Social Care and Children's Services, identifying and agreeing numerous care pathways into adulthood from children's services. It is anticipated that this change programme will run at least over the following 12-18 months. Work is also underway to agree a pathway between the ASC Learning Disabilities and Autism team and ASC Forensics Team to ensure that individuals with complex forensic needs are supported by the right team.

The mapping of mental health care pathways from Children's Services into adulthood has been completed by Commissioners and we are now prioritising which services will most likely be those who will work with Adult Services to ensure Mental Health support is more seamless as young people approach their 18th year. This will include support by the Adult Social Care Transitions Service and Educational Support commissioned via SEND. It is anticipated this work will be implemented from early 2022, within the Preparing for Adulthood Transformation Programme.

34. **Recommendation 16:** The Surrey Heartlands mental health diploma is re-established and offered to all GPs in Surrey.

35. **Progress update:** The mental health diploma remains commissioned in Surrey Heartlands and is promoted across all practices.

36. **Recommendation 17:** Health commissioners obtain funding to undertake a modelling exercise and, if funding permits, a pilot study focusing on what patient outcomes could be achieved by extending opening hours for Safe Havens in Surrey and operating them throughout the night, to ensure that people experiencing a mental health crisis or emotional distress, and the police officers who are often relied on to support them, are no longer left without any option but to attend A&E to receive help.

37. **Progress update:** A 12-week trial of a 24/7 Safe Haven operating from the existing Woking Safe Haven site took place from February to May 2021. The pilot was carried out during a time when there were lockdown restrictions, which may have impacted on individuals seeking support and may not fully represent the need for a 24/7 service.

    An evaluation of the pilot was carried out looking at service user attendances, operational challenges and feedback from staff and service users. The combination of data and feedback highlights the Safe Haven as an established part of the local mental health pathway. Further analysis is needed to understand the impact on A&E and blue light services. Future considerations also include the need for closer working relationships to be undertaken with the Police and SECAmb by a dedicated manager to raise the awareness of Safe Haven as a recourse from emergency departments.

    While there was limited evidence of the need for a 24/7 model, discussions are now going to take place on the potential for an extended Safe Haven provision.

    Surrey and Borders Partnership are also exploring options around crisis bed provision, which could provide a meaningful alternative to admission, and plan to seek support to use discharge funding to establish this.

38. **Recommendation 18:** The General Practice Integrated Mental Health Service continues to be rolled out across Surrey and receives the funding needed to ensure its continued operation, and that a report on the progress made and future plans is presented to the Adults and Health Select Committee no later than October 2021.

39. **Progress update:** The General Practice Integrated Mental Health Service (GPIMHS) continues to be rolled out across Surrey and is strengthened with a dedicated focus on improving the pathway for people with Personality Disorder traits and their carers/families. Work is also progressing to test the next phase of maturing the system towards a single integrated, community-focused service model, with the Epsom pilot to eradicate barriers between primary and secondary care provision.

    Transformation funding for expanding and improving community mental health services has been committed to by both NHSE/I and the CCG to 2023/24. Running alongside GPIMHS expansion is the investment in Mental Health Practitioner roles to build mental health capacity and expertise across the PCNs, reimbursement to SABP (50%) and PCNs (50%) is under the Additional Roles Reimbursement Scheme (ARRS).

40. **Recommendation 19:** The production of the final business case for the improvements to the Abraham Cowley Unit is progressed urgently and implemented with the utmost speed and no further delays. It also requests that a report on the progress made and future plans is presented to the Adults and Health Select Committee no later than October 2021.

41. **Progress update:** Safety works to the Abraham Cowley Unit (ACU) were completed in April 2021 and included environmental changes to the layout of the toilets and bathrooms, improving safety and privacy and dignity; installing Safehinge Primera doors that provide an alarm in the event they are used as a ligature anchor point and have an anti-barricade mechanism; installing a passive monitoring system, enabling staff to monitor the health of patients without the need to disturb them during the night; replacing furniture to a new standard approved for use in mental health inpatient environments; and, finally, replacing all sanitary wear with specialist anti-ligature products.

    The total investment was in the region of £3m. The learning from the safety works at the ACU has been incorporated into the standard specification and working practices for the acute inpatient environments, including the deployment of digital technology in the form of Oxehealth. Planning is underway to incorporate this technology into other wards whilst minimising disruption to existing services.

The Outline Business Case for the redevelopment of the ACU has been approved by the Trust Board and submitted to NHS England for approval of the funding allocation under the Eliminating Dormitories scheme. Enabling projects, including the construction of a temporary older adult ward on land adjoining the St Peter's Hospital site, refurbishment works at our hospital in Guildford and the acquisition of a building in Chertsey for community services, are progressing well with planning permission and building contractors on board. The ACU will be vacated in April 2022 and all services moved within Surrey to enable demolition to commence immediately. A building contractor has been selected and building works will commence in summer 2022 and continue for two years. Services will move back into the new facility in mid-2024 as previously reported.

We have identified a site, subject to achieving planning permission, to operate temporary facilities for acute inpatient services from late 2022 near Leatherhead, which will increase SABP-operated bed capacity during the construction period.

The planning for the closure of the ACU includes provision to enhance the monitoring and oversight of the quality of the placements within the independent sector and links to the community pathways, including in-reach.

42. **Recommendation 20:** The Children, Families, Lifelong Learning and Culture Select Committee conducts a similarly broad and wide-ranging mental health journey task group concentrating on both children and those transitioning to adult mental health services.

43. **Progress update:** The Adults and Health and Children, Families, Lifelong Learning and Culture Select Committees continue to liaise regarding future scrutiny of children's mental health services and the transition to adult mental health services. The Select Committees have been jointly monitoring the commissioning of new Emotional Wellbeing and Mental Health (EWMH) services for children and proposed changes to the governance of Surrey's mental health system; the Children, Families, Lifelong Learning and Culture Select Committee, with representation from the Chairman and Vice-Chairmen of the Adults and Health Select Committee, is scheduled to scrutinise the performance of the new EWMH services at its public meeting on 18 October 2021; and conversations are taking place to enable continued joined-up scrutiny of mental health services going forward.

Mental Health Improvement Plan

44. In November 2020, Surrey County Council hosted a Mental Health Summit with the purpose of building consensus around what needed to be done to improve mental health services in Surrey.

45. Following the summit, in December 2020, the Surrey Heartlands Integrated Care System recommended the establishment of an independently chaired Mental Health Partnership Board (MHPB). The MHPB met in early 2021 and commissioned a Peer-led Review, with the objective of identifying the priority actions needed to drive the required improvements and developments across the mental health system.

46. The Review and its recommendations were presented to the MHPB in April 2021 and the MHPB produced a report and Improvement Programme.

47. The Mental Health Improvement Plan was ratified by the Health and Wellbeing Board on 2 June 2021. The Mental Health Delivery Board is now working on implementing the recommendations in the improvement plan.

48. From the 19 thematic improvement recommendations from the Independent Review, 10 Programme areas and 3 cross-cutting themes were identified:

    - Early intervention and Prevention Vision and Strategy
    - Improving access and preventing service gaps
    - How we work together
    - Resourcing
    - Training and awareness
    - Integrated system working
    - Data analytics
    - Comms and engagement
    - Mental Health system governance
    - Workforce planning and development

    Cross-cutting themes which are to be considered across all workstreams are:

    - Covid lessons
    - User, carer and community voice
    - Digital innovation

49. Activity has now started in each of the workstreams, and where relevant recommendations from the Mental Health Task Group are being taken forward with them and expanded upon. Please see Annex 1 for further information.

Recommendations

The Select Committee is asked to:

1. Note the significant work underway to implement the recommendations set out in the Mental Health Task Group report

2. Recognise the role of the Mental Health Improvement Plan and the Mental Health Partnership Board in continuing to progress the mental health agenda, including the Mental Health Task Group's recommendations

Next steps

The implementation of the Mental Health Task Group's recommendations will continue apace.

Report contacts

Professor Helen Rostill, Director for Mental Health Surrey Heartlands ICS and SRO for Mental Health Frimley ICS (helen.rostill@sabp.nhs.uk)

Liz Uliasz, Assistant Director of Mental Health, Surrey County Council (liz.uliasz@surreycc.gov.uk)

Kirsty Slack, Policy and Programme Manager (Health and Wellbeing), Surrey County Council (kirsty.slack@surreycc.gov.uk)

Annexes

Annex 1 – Mental Health Improvement Plan Update

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Update on the Mental Health Improvement Plan Programme Progress

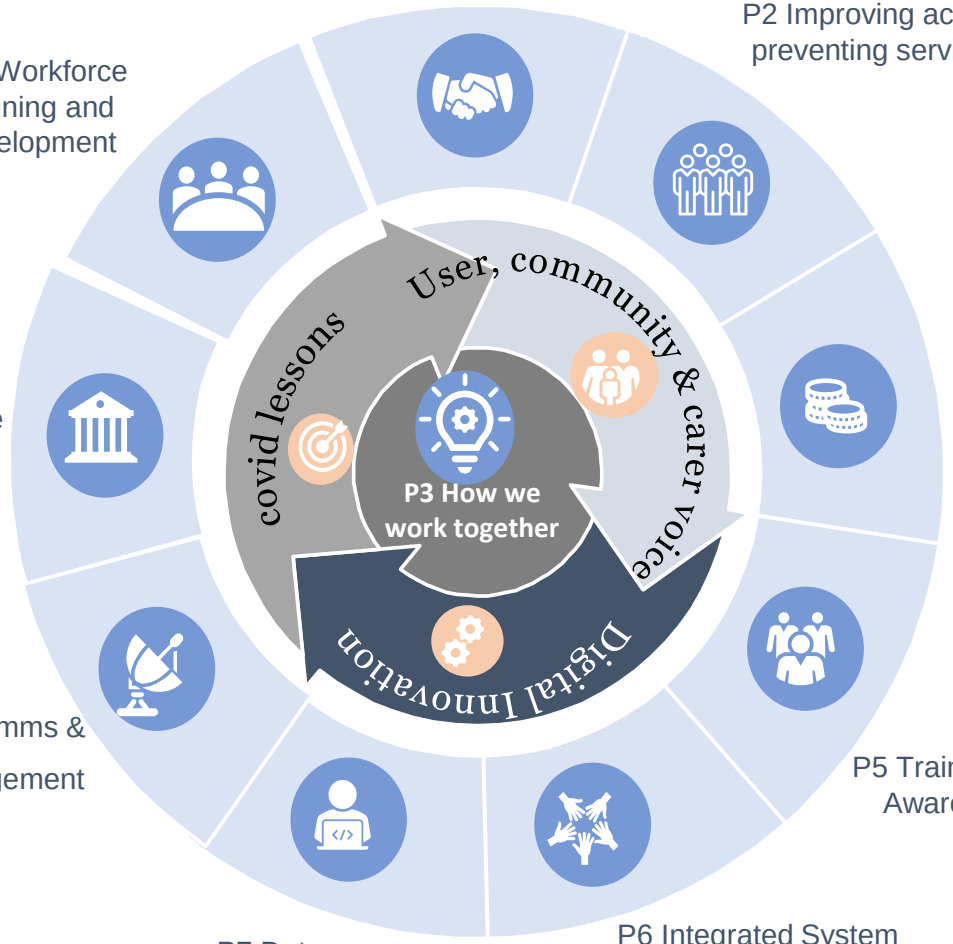
August 2021

Progress Update

The following set of slides provides an overview of progress to date in moving forward the Mental Health Improvement Plan. The slides include:

- Programme Structure
- High level summary of each programme area focus
- High level Progress on each programme
- Governance
- Programme Support
- Level 0 plan

Mental Health Partnership Board Improvement Plan Programme Structure



We have taken the 19 thematic improvement recommendations from the Independent Review and identified:

- 10 Programme areas

and

- 3 cutting themes

1 Covid Lessons

- Adapting services that either come from the pandemic (PTSD, bereavement, long covid, unemployment, BAME impact) or suppressed (people coming back Into services)
- New service delivery models

2 User, Carer and community voice

- Understanding barriers to engagement
- Working with service users, carers and communities, better understand what good looks like
- Simplify access, resources, self help and signposting

3 Digital Innovation

- Develop, test and spread our digital capability
- Invest in expansions of IAPT and wider services with strong digital offer, effective apps, remote monitoring

Programme Area focus

Programme	Focus	Proposed Sponsors
P1 Early Intervention and Prevention vision and strategy	• More preventative and early help approach • Shared co-ordinated vision	Claire Burgess, Sue Murphy, MH Convenor
P2 Improving access and preventing service gaps	• Resilience, early support and helping people understand and access it • No bounce backs and pass arounds of referrals • Address barriers to service access • Focussed work on scaling IAPT, GPIHMS and reviewing and improving S136, all age crisis and inpatient provision and support to schools	Tim Bates, Andy Erskine,
P3 How we work together	• Improve individual and organisational working relationships and address findings from relational diagnostics outputs- Linguistic Diagnostics being commissioned	Helen Rostill, Sue Murphy
P4 Resourcing	• Stand up Resourcing T&F group to focus on : 1) Demand and capacity modelling (outsourced)2) Funding review – with support from health economist (centre for mental Health) and 3) workforce review	Graham Wareham and Matthew Knight
P5 Training and Awareness	• Develop a training collaborative to have a more joined up approach to upskill workforce	Lucy Gates
P6 Integrated system working	• Improved place based join up of care, planning and resourcing • Embed and use Surrey Multi- Agency Information Sharing Protocol (MAISP) • Develop a system wide population based needs approach to planning	Lorna Payne, Liz Ulliasz, Patrick Wolter
P7 Data	• Stand up data group to shape mental health data systems and integrations • Address the culture, behaviour and systems to improve accurate collection and use of relevant MH data sets	Katherine Church, Toby Avery.
P8 Communications and Engagement	• Develop public comms and engagement strategy and campaign	Laura Downton, Marcel Berenblut
P9 Mental Health system governance	• Refresh and streamline Mental health system governance • Ensure user voice centre piece	Clare Burgess, Helen Rostill
P10 Workforce planning and delivery	• Build on system wide people plan to improve recruitment, retention and development of workforce • Develop more “grow your own” projects and further development of experts by experience and advocacy roles	Cheryl Newsome

P1: Early Intervention and Prevention Vision and Strategy

Progress to date

- ✓ Sponsors and project support identified, with MH Convener joining Surrey in October 2021
- ✓ Vision, which links to the whole programme, is underway. 38 response from people with lived experience, people without lived experience and carers. Paper has been drafted and shared with delivery board for feedback by 10th September.
- ✓ Engagement forums being mapped by the Independent Mental Health Network.
- ✓ Workshop being arranged for mid September to focus on operating model
- ✓ Public Health Mental Health Prevention Strategic Plan in place for implementation of prevention interventions at Place, community and individual level.
- ✓ Mental Health Development workers recruited
- ✓ Population Survey on perception of emotional and mental wellbeing for adults

Short Term Deliverables (1-3 months)

- Workstream meetings established and work scoped
- Agree the vision based on engagement with users, carers and stakeholders (to be agreed at MHPB on 29th October)
- Engagement forums mapped out
- Mapping of early intervention offers
- Develop overarching operating model
- Customer journey mapping
- Third sector alliance scope agreed and contact in place to undertake work

Medium (3-6) and longer term (6+) Deliverables

Medium:

- Validate operating model with users, carers and key stakeholders
- Define implementation plan (link to P2, P3, P4 and P6)
- Establish baseline and evaluation methodology

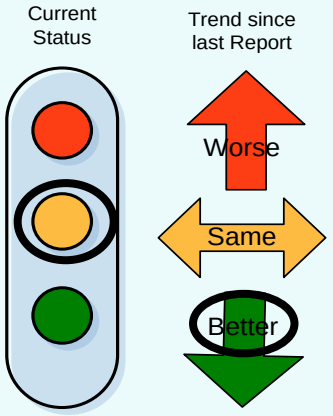
Longer term:

- Transition piece

Programme Sponsors

- Clare Burgess, Sue Murphy, Incoming MH Convener

MH Improvement Progress since last month



MH Improvement Priority ranking

- First

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P2: Improving access and preventing service gaps

Progress to date

- ✓ Sponsors and project support identified
- ✓ Recovery and connect service is live
- ✓ In-reach discharge service now live
- ✓ Existing Recovery Workstream 4 docked in
- ✓ GPimhs/MHICS roll out and ARRS recruitment well underway
- ✓ Co-design workshop taking place in September to develop principles for a single telephone access point
- ✓ Public Health scoping access points for mental health across the system underway
- ✓ 4 meetings have taken place between Public Health, SABP and third sector to agreed need for a common entry point
- ✓ Public health have done a series of rapid need assessments for vulnerable groups, including one on MH
- ✓ Ongoing meetings to consider mobilisation of mental health E-Hub
- ✓ Transitions young adults user group established and report circulated
- ✓ Mobilisation of new CYP EWMH services
- ✓ Surrey selected as vanguard for support around SMI and physical health checks
- ✓ Veteran's High Intensity Service (HIS) soft launch.
- ✓ SABP accredited Member of Veterans Health Care Alliance

Short Term Deliverables (1-3 months)

- Workstream meetings established and work scoped
- Continue planned roll out of mental health integration in primary care
- Co-design improved access point for emotional wellbeing and mental health referrals and develop implementation plan (link to P7)
- Map health inequalities and vulnerable groups
- Review recommendations and the delivery plan from the IMHN and SMEF report on COVID and BAME communities
- Set up steering group for NHSX vanguard pilot for physical health checks in mental health
- Focussed place-based model
- Prototype of the THRIVE framework
- Schools-based Cluster model mobilisation
- Establishment of CYP led Alliance Board Implementation of process review in the Access and Advice (SPA) function
- Full launch of Veteran's High Intensity Service

Medium (3-6) and longer term (6+) Deliverables

Medium:

- Implementation of improved access point for mental health referrals
- Engagement strategy/approach for vulnerable groups (link to P1)
- Further roll out of EI Cluster Model for schools
- Further roll out of next phase of MHST
- Re-launch of CYP Safe Havens
- Expansion of suicide prevention work through in reach into acutes for CYP
- Review of equity of access, fall outs and drop out across the patient pathway

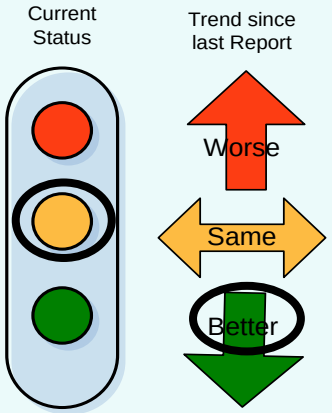
Longer term:

- Embed Pillar 4: Emergency Group Priority – Referral pathway primary and secondary care reviewing rejected referrals from MH SPA – mapping of referral flows and customer journey
- Embed Pillar 3: Emergency Group Priority - IAPT pathway for people with complex needs and further review of IAPT commissioning – discussion planned with CCG contracting team and Place Leads
- Evaluation of CYP EI and prevention services
- Apply for Veteran's Bronze Employer Recognition Scheme

Programme Sponsors

- Tim Bates, Andy Erskine

MH Improvement Progress since last month



MH Improvement Priority ranking

- First

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P3: How we work together

Progress to date

- ✓ Sponsors and project support identified
- ✓ Scoping discussion (x3) with Linguistic Language to gain deeper insights into what we need to change across the system to improve our culture and ways of working. Areas identified include.
- ✓ Workshop with Linguistic Landscapes on 13th August
- ✓ SABP currently finalising scope and procurement of work with Independent Mental Health Network, Surrey Minority Ethnic Forum and Healthwatch Surrey to undertake a transformation project on user-led design with SABP. Expected to start late August 2021
- ✓ CYP EWMH principles and ways of working established
- ✓ Development of an adult mental health alliance

Short Term Deliverables (1-3 months)

- Commission Linguistics Landscape work.
- Discovery work on user-led design with SABP.
- Establishment of Young persons EWMH Programme lead (service user led)

Medium (3-6) and longer term (6+) Deliverables

Medium:

- Receive report and recommendations to increase user-led design
- Generate common principles to improve ways of working and develop an approach and toolkit to support organisational and cross-organisational development
- Produce a roadmap setting out what needs to change/improve and how over the next 12 to 18 months
- Identify a series of engagement events to test out and agree the delivery plan and gain system buy-in for the change we want to see
- Develop an outcomes approach to measure success

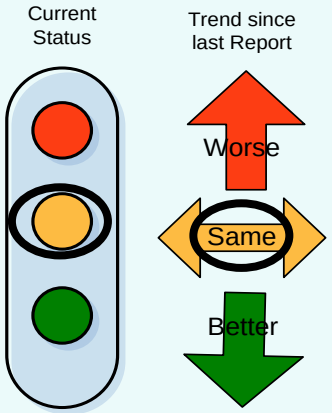
Longer term:

- Readminister the relational diagnostics

Programme Sponsors

- Helen Rostill, Sue Murphy

MH Improvement Progress since last month



MH Improvement Priority ranking

- First

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P4: Resourcing

Progress to date

- ✓ Sponsors and project support identified
- ✓ Contract with the Centre for Mental Health has been finalised and feasibility work formally started, led by Nick O'Shea.
- ✓ Specification to bring in a consultancy firm to support the wider demand and capacity piece went live 29th July and closes 19th August. Evaluation underway. Kick off for this work is mid September. This will build on learning and initial findings from the Centre for Mental Health and the work will incorporate SME.

Short Term Deliverables (1-3 months)

- Complete feasibility work with Centre for Mental Health.
- Agree contract with consultancy firm to support wider demand and capacity piece (by mid September).
- Begin demand and capacity work including - mapping exercise and reviewing/refining objectives.

Medium (3-6) and longer term (6+) Deliverables

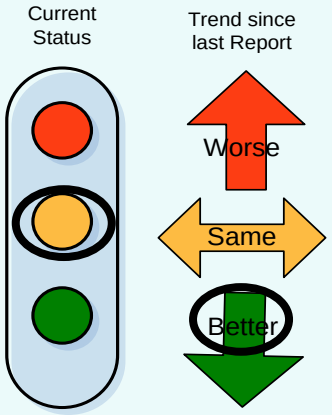
Medium:
- TBC with consultancy firm

Longer term:
- TBC

Programme Sponsors

- Graham Wareham, Matthew Knight

MH Improvement Progress since last month



MH Improvement Priority ranking

- Second

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P5: Training and Awareness

Progress to date

- ✓ Sponsors and project support identified
- ✓ Funding £116K from Education England has been identified to support the work
- ✓ CYPS Thrive framework and training underway across the system
- ✓ Trauma Informed Care training rolled out to Surrey Police
- ✓ GP Mental Health Diploma scheme in place
- ✓ Plethora of training available from Public Health including prevention '5 ways to wellbeing' through to suicide awareness training.
- ✓ Resistance Hub Training delivered
- ✓ Appreciative training inquiry completed for Children.
- ✓ Training review for CYP task and finish group, PID and governance in place.

Short Term Deliverables (1-3 months)

- Workstream meetings established and work scoped
- Plan how allocated funding will be spent
- Full system mapping of existing training for adults and CYP and develop a scope for training collaborative
- Parameters set and infrastructure support for new model of training for CYP
- Expansion of suicide training rolled out focussed on CYP
- Induction training for new EI staff in the CYP EWMH School Clusters

Medium (3-6) and longer term (6+) Deliverables

Medium:

- Map existing training and develop a scope for training collaborative
- THRIVE framework Leadership Action Learning training programme continues

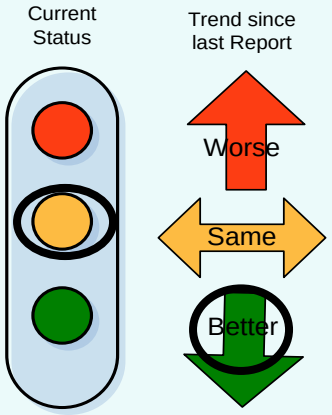
Longer term:

- TBC

Programme Sponsors

- Lucy Gate

MH Improvement Progress since last month



MH Improvement Priority ranking

- Second

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P6: Integrated System Working

Progress to date

- ✓ Sponsors and project support identified
- ✓ Gpimhs roll out underway and ARRS recruitment launched
- ✓ SABP Board meeting on 1st July agreed mobilisation plans and behaviours
- ✓ SABP senior operational and clinical leaders co-design workshop - planned 1st October
- ✓ SABP executive leads have been identified and places notified
- ✓ Epsom CMHRS integrated pilot underway
- ✓ Links made with each place to discuss the localisation of the Improvement Plan
- ✓ Establishment of EWMH services and adoption of system wide approach to Thrive
- ✓ Establishment of new CYP crisis helpline
- ✓ CYPS paediatric triage line to support DGH went live 2nd August.
- ✓ Enhanced model of psych liaison.

Short Term Deliverables (1-3 months)

- Workstream meetings established and work scoped
- SABP identify Executive leads who will each hold a Place portfolio and be the senior strategic link
- Co-design with PCN clinical directors and place to be planned for October/November
- Senior operational and clinical leadership team, with delegated authority to be set up at each place
- Co-design of SABPs operating model aligning to place
- Prototyping the place-based THRIVE models of delivery

Medium (3-6) and longer term (6+) Deliverables

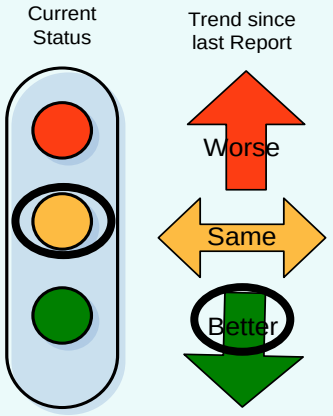
Medium:
- TBC

Longer term:
- Go-live of CMHRS linked to PCNs and model for aligning SABP services
- Full roll out of all CYP EWMH Pathways
- Establishment of Surrey CYP Tier 4 unit

Programme Sponsors

- Lorna Payne, Liz Uliasz, Patrick Wolter

MH Improvement Progress since last month



MH Improvement Priority ranking

- First

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P7: Data

Progress to date

- ✓ Sponsors and project support identified
- ✓ Initial meeting between digital leads planned with the aim of using mental health as a test case for developing a data operating model
- ✓ Katherine Church has agreed to use mental health as a test case for the data strategy and integrate the improvement work within the existing Surrey Heartlands Digital infrastructure
- ✓ Work with Public digital scoped and planning of first workshop underway.

Short Term Deliverables (1-3 months)

- Establish workstream TOR including meetings and membership, agree priority outcomes
- Run initial facilitated workshops (external provider Public Digital) to understand what a future operating model could look like by using some user journey maps
- Progress funding opportunity with NHSE/I/X to look at process and improvements on how we improve physical health checks for people with mental health
- Identify best practice across the ICS to share learning (for example Barnardo's, Forensic Liaison)
- Establish current state regarding Mental Health Access Standards (participation in field testing)
- Define fields for service specifications to include protective characteristics (to enable review of equity of access and flow through pathways)

Medium (3-6) and longer term (6+) Deliverables

Medium:

- Map 'as-is' against the Mental Health Improvement Plan and Surrey Heartlands data strategy project alongside regional and national policy to identify gaps and opportunities
- Engagement work across the system to articulate the why and seek buy in from those in digital and data roles – establish mechanism for sharing ideas
- Build on the (Children's) Emotional Wellbeing & Mental Health Service to scale up and adopt
- Horizon scan to determine who we can learn from nationally (schemes or individual organisations)
- Assess shared capabilities aligned to the user journey maps, identifying investment areas and roadmaps
- Commence work to ensure service specification templates and sign offs include as standard; data fields of protective characteristics and KPIs on review of equity of access and patient flow, identifying fall outs and drops outs

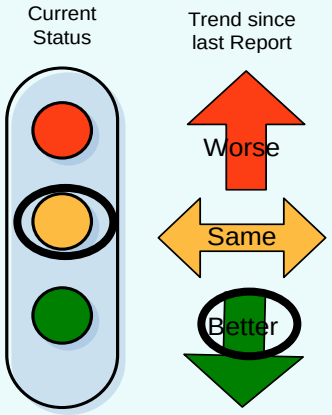
Longer term:

- Build a system operating model for mental health digital and data
- Developed a phased delivery of approach of improving infrastructure at a system level including early roadmaps
- System wide comms & engagement plan (linked to C&E workstream /PMO for whole MH Improvement Plan) to share plans
- Commence systematic equity audits across pathways

Programme Sponsors

- Toby Avery, Katherine Church

MH Improvement Progress since last month



MH Improvement Priority ranking

- Second

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P8: Communications and Engagement

Progress to date

- ✓ Sponsors and project support identified
- ✓ Comms group already established and re-purposed
- ✓ Funding allocated to undertake the work.
- ✓ Agreed comms sign-off protocol.
- ✓ Plans underway to roll out a systems public campaign - 4 page A5 door drop planned to go in the autumn to every home in Surrey, perhaps tied to 10 Oct World Mental Health Day.
- ✓ A special landing page for Healthy Surrey has been developed. Purpose is to show campaign branding (so you know you've landed in 'the right place') and to track traffic so we know campaign is working.
- ✓ The Mind Matters team have been involved in the development of social media assets, due to launch, without much fanfare, from SCC's social media account imminently.

Short Term Deliverables (1-3 months)

- Development of Healthy Surrey landing page.
- Roll out a systems public campaign.
- Development of social media assets involving images of service partners.
- Agree comms sign-off protocol.
- Launch and new branding of CYP EWMH Alliance

Medium (3-6) and longer term (6+) Deliverables

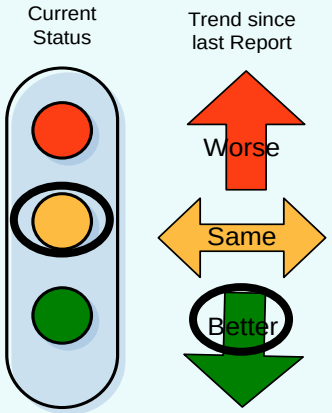
Medium:
- Production of video and podcast for Surrey Matters.

Longer term:
- TBC

Programme Sponsors

- Laura Downton, Marcel Berenblut

MH Improvement Progress since last month



MH Improvement Priority ranking

- Second

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P9: Mental Health System Governance

Progress to date

- ✓ Sponsors and project support identified
- ✓ Governance structure agreed
- ✓ Delivery group and Steering group up and running
- ✓ Expert by Experience and CYP sub-group of the Suicide Prevention Partnership established.
- ✓ Development of a Young peoples alliance board.
- ✓ Proposed route towards a VCSE alliance has been shared across the sector for comment.

Short Term Deliverables (1-3 months)

- Workstream meetings established and work scoped
- Review/refresh Improvement Plan governance
- Identify programme director and PMO resource from across the system.

Medium (3-6) and longer term (6+) Deliverables

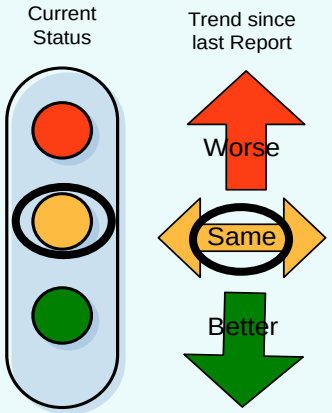
Medium:
- TBC

Longer term:
- Development of VSCE alliance and embedding in system level governance.

Programme Sponsors

- Helen Rostill, Clare Burgess

MH Improvement Progress since last month



MH Improvement Priority ranking

- Second

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

P10: Workforce Planning and Delivery

Progress to date

- ✓ Sponsors and project support identified
- ✓ Leads to be agreed and workplan require to scope work and actions
- ✓ Need to dock into existing Surrey Heartlands workforce planning and development infrastructure
- ✓ Surrey Workforce and Wellbeing Collaborative has been in place since March 21.
- ✓ "Good Mental Health is Good Business Sense" event held on 30th June.

Short Term Deliverables (1-3 months)

- Workstream meetings established and work scoped
- SABP workforce strategy and plan to be developed for the Children's EWMH Alliance, ensuring linkage to the broader third sector workforce strategy
- Review feedback from "Good Mental Health is Good Business Sense Event" to inform future events.
- Promote Surrey Workforce and Wellbeing Collaborative.

Medium (3-6) and longer term (6+) Deliverables

Medium:

- Development of training and resources for Surrey Businesses
- Development of case studies/vignettes of good practice to share
- Children's EWMH Alliance workforce strategy – implementation begins with initial focus on SABP.

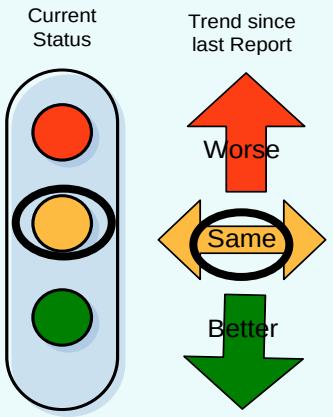
Longer term:

- Full implementation and monitoring of the Children's EWMH Alliance workforce strategy and plan.

Programme Sponsors

- Cheryl Newson

MH Improvement Progress since last month



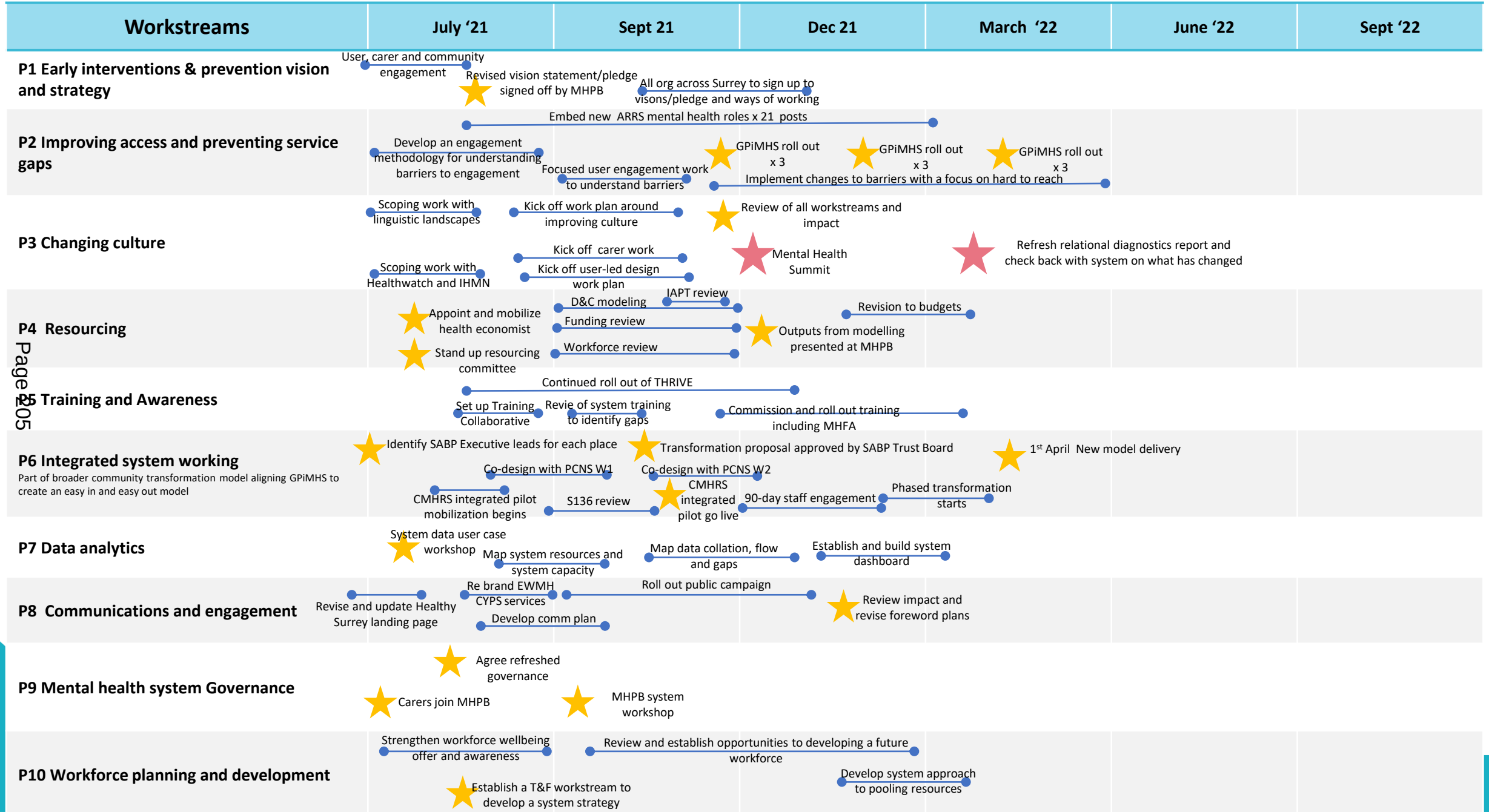
MH Improvement Priority ranking

- Second

Cross Cutting Themes	COVID-19 Lessons	User, Carer and Community Voice	Digital Innovation

Proposed Level 0 Project Plan on a Page *July 2021 – September 2022*

Key system check points | Milestone | Activity



Delivery Architecture

Mental Health Partnership Board

Mental Health Delivery Group
Chair: Helen Rostill/Tim Bates
Monthly

- Provides collective leadership to support Project Group, Delivery Group and workstreams
- Responsible for reporting on overall status and progress against targets
- Maintains oversight of the programme timelines and delivery and resolves escalation points
- Manage wider stakeholders of programme

There are a number of other boards which will be provided with update papers, these include:

- **Health and Wellbeing Board**
- **Health and Care Professionals Executive**
- **Children's Safeguarding Board**

Improvement Plan PMO Steering Group
Chair: Programme Director
Fortnightly

- Ensures proper interface and engagement between programme and workstreams
- Maintains the overarching programme plan and reporting, ensuring workstreams are progressing towards their targets
- Problem-solves or escalates any problems and risks identified
- Agrees key inputs, assumptions and outputs for analysis, modelling and forecasting

Workstream meetings *As determined by sponsor*

P1 Sponsors: Clare Burgess, Sue Murphy, MH Convener	**P2** Sponsors: Tim Bates, Andy Erskine	**P3** Sponsor: Helen Rostill	**P4** Sponsors: Graham Wareham, Matthew Knight	**P5** Sponsor: Lucy Gates (TBC)
P6 Sponsors: Lorna Payne, Liz Uliasz	**P7** Sponsors: Toby Avery, Katherine Church	**P8** Sponsors: Laura Downton?	**P9** Sponsors: Clare Burgess, Helen Rostill	**P10** Sponsor: Cheryl Newsome

- Responsible for the delivery of workstream objectives
- Responsible for regular review of the progress against plans to ensure targets remain achievable
- Enable ownership of plans and outcomes amongst relevant delivery teams
- Problem-solve and escalate issues and risks that are stopping progress

ADULTS AND HEALTH SELECT COMMITTEE

20 OCTOBER 2021

ESTABLISHMENT OF A HEALTH INEQUALITIES TASK GROUP

Purpose of report: To propose the establishment of a Health Inequalities Task Group based on the attached draft scoping document.

Summary

1. At its private induction meeting on 14 July 2021, the Adults and Health Select Committee conducted a forward planning session and identified the reduction of health inequalities as a key area of focus.

2. It was subsequently agreed that the Select Committee would explore the establishment of a task group to investigate health inequalities in Surrey and what is being done to tackle these issues.

3. On 8 September 2021, a first draft of the scoping document for the Health Inequalities Task Group was circulated via email to members of the Select Committee, who were asked to notify the Scrutiny Officer if they wanted to be a member of the Task Group.

4. The Scrutiny Officer was subsequently notified by the following Members that they wanted to be members of the Task Group:

    - Angela Goodwin
    - Trefor Hogg
    - Riasat Khan
    - Carla Morson
    - Bernie Muir (ex-officio)

5. The Task Group's aims, objectives and expected outcomes are outlined in the draft scoping document, which is attached to this report as **Annex 1**.

6. Further work on the scoping document will be undertaken by the Task Group at a planning session scheduled to take place on 25 October 2021.

7. Following the planning session, a final draft of the scoping document will be shared with the Select Committee via email, and this will include any

amendments made in response to feedback provided by Members at the Select Committee's public meeting on 20 October.

Recommendations

The Adults and Health Select Committee is asked to:

1. Review and comment on the draft scoping document of the Task Group.

2. Approve the membership of the Task Group.

Report contact

Ben Cullimore, Scrutiny Officer (ben.cullimore@surreycc.gov.uk)

Annexes

Annex 1 – Health Inequalities Task Group draft scoping document

Select Committee Task and Finish Group Scoping Document

The process for establishing a task and finish group is:

1. The Select Committee identifies a potential topic for a task and finish group
2. The Select Committee Chairman and the Scrutiny Officer complete the scoping template.
3. The Select Committee reviews the scoping document
4. The Select Committee agrees the membership of the task and finish group.

Review Topic

Health Inequalities in Surrey

Select Committee(s)

Adults and Health Select Committee

Relevant background

Health inequalities are defined by the King's Fund as being "avoidable, unfair and systematic differences in health between different groups of people" caused by a complex mix of societal, environmental and individual influences.

The reduction of health inequalities has been an important component of public service policy and delivery for over a decade, and yet nationally they have continued to increase. As outlined in Surrey County Council's Organisation Strategy, agreed by full Council on 8 December 2020, tackling health inequalities is one of the Council's four priority objectives, and over the next five years it aims to "drive work across the system to reduce widening health inequalities". Further to this, the Surrey Health and Wellbeing Strategy, first published in May 2019, seeks to "reduce health inequalities so no one is left behind", and, with this aim in mind, a refresh of its priorities, governance arrangements and metrics is currently underway.

The Covid-19 pandemic has highlighted and deepened the stark health inequalities across the UK. The risk of dying among those diagnosed with Covid-19 is higher in people living in more deprived areas than those in the least deprived, and this is an indicator of the inequalities that have existed for many years across all aspects of health, brought into focus by the global pandemic.

With this in mind, integrated working between the Council and Surrey Heartlands ICS has led to the establishment of the Equalities and Health Inequalities Board, the focus of which is to implement key urgent actions while linking with the long-term actions (i.e. wider determinants of health) identified and set out in the Health and Wellbeing Strategy.

At its private induction meeting on 14 July 2021, the Adults and Health Select Committee conducted a forward planning session and identified the reduction of health inequalities as a key area of focus. As a result, it was agreed that a task group would be formed to investigate health inequalities in Surrey and what is being done to tackle these issues.

Why this is a scrutiny item

Scrutiny can take an elevated view of health inequalities in the county by considering individual experiences of those experiencing health inequalities (as outlined in the Priority Populations identified in the Health and Wellbeing Strategy) and their interactions with different organisations, as well as interviewing Council officers and health and social care partners to review the strategies currently in place to deal with issues faced by Surrey's most vulnerable residents. Scrutiny can support both the Council and the wider health and social care system in Surrey to understand how they can address and tackle health inequalities faced by residents.

Considering these many interconnecting services collectively from the perspective of residents will foster an improved understanding of how public sector organisations can work together more effectively to improve outcomes. Scrutiny can also support the Council and its partners to identify any gaps in support as well as highlighting those services and initiatives that work well.

The structural complexity of health inequalities makes scrutiny an ideal space for its investigation. Scrutiny is uniquely able to investigate complicated cross-cutting issues and has the statutory powers to undertake this important piece of work.

What question is the task group aiming to answer?

<u>People with lived experience of health inequalities (Priority Populations identified in the Health and Wellbeing Strategy)</u>

1. What are the underlying issues driving local health inequalities and what can be done to tackle these?
2. What are the barriers to services being faced by people with lived experience of health inequalities?
3. What examples are there of Surrey residents experiencing health inequalities?
4. How are people with lived experience of health inequalities involved in the co-production of measures to tackle these issues?
5. If there was one thing you could change to help tackle health inequalities in Surrey, what would it be and why?

<u>Public Health/NHS officers and partners</u>

1. What is your organisation's strategy for tackling health inequalities?
2. What measures are in place to provide extra support and services to those in Surrey most likely to experience health inequalities (to redress the balance)?
3. What data is available on local health inequalities and what are the key issues arising from this?
4. How does the Council and its partners work with local communities and service users to learn from them about how to reduce health inequalities?
5. How does the Council and its partners ensure local people are involved in making decisions about the services and support they receive?
6. Do the Council and its partners face any barriers that prevent them from further reducing health inequalities? If so, why?
7. What work does the Council do to learn from other local authorities and improve how it tackles health inequalities?

Aim

For Members of the Task Group to develop an understanding of health inequalities in Surrey, scrutinise the progress being made on tackling these, and contribute to the development of future policy by both Surrey County Council and its health and social care partners

Objectives

- Develop an understanding of the lived experiences of those residents experiencing health inequalities and the barriers they face
- Develop an understanding of the data, strategies in place and work being undertaken by the Council and its partners to help tackle health inequalities
- Develop an understanding of good practice elsewhere and how this might be applied in Surrey
- Develop a set of recommendations to help assist the Council and its partners in continuing to tackle health inequalities across Surrey
- Communicate its findings to partners both locally and nationally

Scope (within/out of)

In scope

- Relevant work and strategies currently in place to help reduce health inequalities
- Health and Wellbeing Board and its implementation of the Health and Wellbeing Strategy
- Residents with lived experience of health inequalities
- Third sector organisations and charities
- Any organisations commissioned by the Council and/or the NHS to deliver services to tackle health inequalities
- Best practice exhibited by other local authorities and health and social care partners

Out of scope

- Non-Surrey County Council services
- Non-NHS services

Outcomes for Surrey/Benefits

- Contribute to the reduction of health inequalities being faced by Surrey residents
- Contribute to the Council's strategic priority to "drive work across the system to reduce widening health inequalities"
- Support both the Council and the wider health and social care system in Surrey to understand how they can address and tackle health inequalities faced by residents
- Create a shared understanding of barriers being faced by residents with lived experiences of health inequalities
- Take an elevated view of services and support available in Surrey by considering individual experiences of those with lived experience of health inequalities and their interactions with different agencies

Proposed work plan

It is important to clearly allocate who is responsible for the work, to ensure that Members and officers can plan the resources needed to support the Task Group.

Timescale	Tasks	Responsible
October 2021	Workshop with Public Health officers to better understand health inequalities in Surrey and what practical measures they, and other partners, are seeking to take to address the issues	Scrutiny Officer, Public Health, Task Group
October 2021	Planning workshop with Task Group Members to agree the scope, work plan and desired outcomes	Scrutiny Officer, Task Group
November 2021-January 2022	Witness sessions with representatives of groups experiencing health inequalities	Scrutiny Officer, Task Group
January 2022	Interim report to the Select Committee	Scrutiny Officer, Task Group Spokesman
February-April 2022	Witness sessions with Council and NHS officers to understand what practical measures they are seeking to take to address the issues Witness sessions with other local authorities, partners and academics seeking to tackle the issues to understand what best practice looks like elsewhere	Scrutiny Officer, Task Group
May 2022	Workshop with Task Group Members to identify potential recommendations	Scrutiny Officer, Task Group
May-June 2022	Compile report Test recommendations Report sign-off	Scrutiny Officer Scrutiny Officer Task Group
June 2022	Report back to the Select Committee/Cabinet	Task Group Spokesman

Potential witnesses

- Surrey County Council Director of Public Health
- Surrey County Council Health Inequalities Lead
- Cabinet Member for Adult Social Care
- Cabinet Member for Health
- Community/voluntary sector organisations
- Independent Mental Health Network
- Surrey County Council Assistant Director for Mental Health
- Healthwatch Surrey
- District and Borough Councils
- Gypsy, Roma and Traveller community representatives
- Black, Asian and Minority Ethnic community representatives
- Learning disabilities and autism charities
- Surrey County Council Assistant Director for Learning Disabilities, Autism and Transition
- Homeless charities
- Food bank representatives
- Domestic abuse charities
- Surrey County Council Domestic Abuse Team
- Surrey Heartlands
- Surrey and Borders Partnership
- Housing charities
- Citizens Advice Bureau
- Academics specialising in health inequalities

Useful documents

- Build Back Fairer: The Covid-19 Marmot Review: Build Back fairer - the COVID-19 Marmot review (health.org.uk)
- Health Equity in England: The Marmot Review 10 Years On: the-marmot-review-10-years-on-full-report.pdf (instituteofhealthequity.org)
- The King's Fund: What are health inequalities? What are health inequalities? | The King's Fund (kingsfund.org.uk)
- Centre for Governance and Scrutiny: Peeling the Onion – Learning, tips and tools from the Health Inequalities Scrutiny Programme: Peeling the onion (cfgs.org.uk)
- Surrey Joint Strategic Needs Assessment: Joint Strategic Needs Assessment – Surrey-i (surreyi.gov.uk)
- Surrey Joint Health and Wellbeing Strategy: Surrey Health and Wellbeing Strategy (healthysurrey.org.uk)
- Surrey County Council Organisation Strategy: Surrey County Council Our focus (surreycc.gov.uk)
- Surrey Covid-19 Community Impact Assessment: Surrey Covid-19 Recovery Community Impact Assessment (surreycc.gov.uk)

Potential barriers to success (Risks/Dependencies)

- Lack of willingness to engage by representatives of groups that have experience of, or are currently experiencing, health inequalities and barriers to services
- Lack of willingness to engage from agencies that are not statutorily required to provide evidence to the Select Committee

Equalities implications

The Task Group recognises that there are a number considerations around equalities when conducting its work, and there are a number of people with various needs that will be contributing to this process. It will be mindful of how it conducts its work in order to ensure people are provided the opportunity to contribute, and that any barriers to doing so are mitigated.

The Task Group will monitor with officers the equalities implications emerging from its recommendations and will work to identify mitigation measures for those with a potentially negative impact.

Task Group Members	Angela Goodwin Trefor Hogg Riasat Khan Carla Morson Bernie Muir (Ex-Officio)
Co-opted Members	N/A
Spokesman for the Task Group	Angela Goodwin
Scrutiny Officer	Ben Cullimore

ADULTS AND HEALTH SELECT COMMITTEE

20 OCTOBER 2021

APPOINTMENT OF A NAMED STANDING OBSERVER AND SUBSTITUTE FOR THE HAMPSHIRE TOGETHER JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Purpose of report: To appoint a named standing observer and substitute for the Hampshire Together Joint Health Overview and Scrutiny Committee.

Summary

1. In October 2019, Hampshire Hospitals NHS Foundation Trust (the Trust) received funding under the Department of Health and Social Care's Health Infrastructure Plan (HIP) to build a business case for capital investment to improve the services it offers to patients in north and central Hampshire. The Trust is part of Phase 2 of the HIP and has been given £5m seed funding to produce a Strategic Outline Case by 2022.

2. Options for the future service delivery model, including the potential for a new hospital site for acute services, have been shortlisted following initial public engagement, which took place between 1 June 2020 and 7 August 2020. The Trust, in conjunction with its Clinical Commissioning Group (CCG) partners, plans to begin consulting with the public on what these services might look like.

3. The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS commissioners to consult local authorities on proposed substantial variations to health services and notify its local authority partners when it has such proposals under consideration.

4. The Trust and CCGs have engaged with both Hampshire County Council and neighbouring local authorities regarding their plans. On Friday 9 October 2020, Trust and CCG representatives met with the then-Chairman and Vice-Chairmen of the Adults and Health Select Committee to discuss their proposals and arrangements for local authority scrutiny.

5. During the discussion, Members were presented with data relating to Trust hospital activity by local authority and hospital activity for north and central Hampshire patients between 2017/18 and 2019/20.

6. It was subsequently agreed that, if a Joint Health Overview and Scrutiny Committee (JHOSC) was formed, Surrey County Council would not join as a full member but would instead send a standing observer to JHOSC meetings so that it could be kept informed of developments and the impact these might have on Surrey residents and services.

7. On 3 December 2020, a JHOSC comprising representatives from Hampshire County Council and Southampton City Council was established by Hampshire County Council, and Surrey County Council was invited to attend future meetings as a standing observer.

Recommendations

The Adults and Health Select Committee is asked to appoint Trefor Hogg as standing observer for the Hampshire Together JHOSC, and to identify and appoint a named substitute.

Report contact

Ben Cullimore, Scrutiny Officer (ben.cullimore@surreycc.gov.uk)

Sources/background papers

Hampshire County Council Full Council agenda – 3 December 2020

Hampshire Hospitals NHS Foundation Trust Hospital Activity by Local Authority from 2017/18 to 2019/20

Health Infrastructure Plan: A New, Strategic Approach to Improving Our Hospitals and Health Infrastructure

Hospital Activity for North and Mid-Hampshire Patients from 2017/18 to 2019/20

Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

ADULTS AND HEALTH SELECT COMMITTEE

20 OCTOBER 2021

ACTIONS AND RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME

Purpose of report: The Select Committee is asked to review its actions and recommendations tracker and forward work programme

Recommendation

That the Select Committee reviews the attached actions and recommendations tracker and forward work programme, making suggestions for additions or amendments as appropriate.

Next steps

The Select Committee will review its actions and recommendations tracker and forward work programme at each of its meetings.

Report contact

Ben Cullimore, Scrutiny Officer

Contact details

020 8213 2782 / ben.cullimore@surreycc.gov.uk

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Adults and Health Select Committee
Forward Work Programme 2021 – 2022

Adults and Health Select Committee Chairman: Bernie Muir I Scrutiny Officer: Ben Cullimore I Democratic Services Assistant: Xanthe McNicol						
Date of Meeting	**Type of Scrutiny**	**Issue for Scrutiny**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Cabinet Member/Lead Officer**
16 December 2021	Performance and finance	**2022/23 Draft Budget**	For the Select Committee to scrutinise the draft 2022/23 budget, Medium-Term Financial Strategy and other relevant information, before it is finalised in January 2022.	To ensure the 2022/23 budget and MTFS deliver good value for residents and are compatible with the 2021-2026 organisational priorities.	Growing a sustainable economy so everyone can benefit	Sinead Mooney – Cabinet Member for Adults and Health
	Overview, policy development and review	**Adult Social Care Complaints Bi-Annual Review**	The Select Committee has identified complaints received by Adult Social Care as a key area for examination. Reports highlighting complaints activity will be provided to the Select Committee on a bi-annual basis.	The Select Committee is to review complaint activity in Adult Social Care.	Empowering communities, tackling health inequality	Sinead Mooney – Cabinet Member for Adults and Health Kathryn Pyper – Senior Programme Manage, Adult Social Care

14 January 2022	Overview, policy development and review	**Adult Social Care Transformation Programmes Bi-Annual Review**	The Select Committee is to review the progress made on the Adult Social Care Transformation Programmes on a bi-annual basis.	The Select Committee will review and scrutinise the ongoing Adult Social Care Transformation Programmes, making recommendations accordingly.	Empowering communities, tackling health inequality	Sinead Mooney – Cabinet Member for Adults and Health Simon White – Executive Director of Adult Social Care
	Overview, policy development and review	**Surrey Heartlands Digital Inclusion Programme**	Surrey Heartlands has introduced an ambitious programme of work to facilitate the move to digital first in primary and secondary care, as well as an increase in its digital inclusion work. The Select Committee has identified this as a key area of interest.	The Select Committee will review the progress of the Digital Inclusion programme of work, taking into consideration the associated impacts and risks for Surrey residents.	Tackling health inequality, empowering communities	Katherine Church – Chief Digital Officer, Surrey Heartlands ICS
3 March 2022	Overview, policy development and review	**General Practice Integrated Mental Health Service Implementation Review**	The Select Committee is to receive an update on the implementation of the General Practice Integrated Mental Health Service (GPIMHS) across Surrey, as well as information on the progress made regarding funding and workforce and plans for its future development.	The Select Committee will review the progress of the GPIMHS programme of work, making recommendations accordingly.	Tackling health inequality	Professor Helen Rostill – Director of Mental Health Services, Surrey Heartlands ICS

	Overview, policy development and review	**Adult Social Care Debt**	The Select Committee has identified the reduction of debt owed to the Council for the provision of adult social care services as a key priority. The Adult Social Care directorate has introduced new processes to improve how it handles and follows up on debt, which the Select Committee will review alongside information on the Council's current debt position.	The Select Committee will gain an understanding of how the Council manages debt owed to it by residents for the provision of adult social care services and gain an insight into whether new initiatives introduced to expedite debt recovery have been successful.	Tackling health inequality, empowering communities	Sinead Mooney – Cabinet Member for Adults and Health Toni Carney – Head of Resources, Adult Social Care
23 June 2022	Overview, policy development and review	**Adult Social Care Transformation Programmes Bi-Annual Review**	The Select Committee is to review the progress made on the Adult Social Care Transformation Programmes on a bi-annual basis.	The Select Committee will review and scrutinise the ongoing Adult Social Care Transformation Programmes, making recommendations accordingly.	Empowering communities, tackling health inequality	Sinead Mooney – Cabinet Member for Adults and Health Simon White – Executive Director of Adult Social Care

	Overview, policy development and review	**All-Age Autism Strategy Review**	The Select Committee is to receive a report outlining the progress made on the implementation of the new All-Age Autism Strategy.	The Select Committee will review and scrutinise the implementation of the new All-Age Autism Strategy, making recommendations accordingly.	Tackling health inequality	Sinead Mooney – Cabinet Member for Adults and Health Steve Hook – Assistant Director (Learning Disabilities, Autism and Transition), Adult Social Care Hayley Connor – Director of Children's Commissioning
	Overview, policy development and review	**Adult Social Care Complaints Bi-Annual Review**	The Select Committee has identified complaints received by Adult Social Care as a key area for examination. Reports highlighting complaints activity will be provided to the Select Committee on a bi-annual basis.	The Select Committee is to review complaint activity in Adult Social Care.	Empowering communities, tackling health inequality	Sinead Mooney – Cabinet Member for Adults and Health Kathryn Pyper – Senior Programme Manage, Adult Social Care
Items to be scheduled						
Date of Meeting	**Type of Scrutiny**	**Issue for Scrutiny**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Cabinet Member/Lead Officer**

Date TBC	Scrutiny	**Access to GPs**	The Select Committee is to receive a report on the current status of accessibility to GPs in Surrey, outlining what is working well (and why), potential barriers facing patients and what is being done to improve accessibility.	The Select Committee will review the current status of accessibility to GPs in Surrey and any potential barriers being faced by residents, making recommendations accordingly.	Tackling health inequality, empowering communities	Nikki Mallinder – Director of Primary Care, Surrey Heartlands ICS
	Scrutiny	**Access to Dentistry Services**	In February 2021, Healthwatch Surrey published a report that outlined some of the issues regarding dentistry services in the county. Due to the increase in the number of residents raising queries relating to the availability of appointments, communication and access, and payments and charges, the Select Committee has identified this as an area for future scrutiny.	The Select Committee will review the current status of accessibility to dentistry services in Surrey and any potential barriers being faced by residents, making recommendations accordingly.	Tackling health inequality	To be confirmed

	Scrutiny	**Reconfiguration of Urgent Care in Surrey Heartlands**	NHS England has developed clear guidance for commissioners responsible for the development of Urgent Care. This report will provide an update on the impact and risks associated with the reconfiguration of Urgent Care services in Surrey Heartlands and the preferred options for the proposed changes.	The Select Committee will scrutinise the programme's preferred options prior to their approval.	Tackling health inequality, empowering communities	Simon Angelides – Programme Director
Task and Finish Groups; Member Reference Groups						
Timescale of Task Group	**Issue for Task Group**		**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Membership**
October 2021 – June 2022	**Health Inequalities**		For Members of the Task Group to develop an understanding of health inequalities in Surrey, scrutinise the progress being made on tackling these, and contribute to the development of future policies.	The Task Group will seek to contribute to the reduction of health inequalities being faced by Surrey residents, contribute to the Council's strategic priority to "drive work across the system to reduce widening health inequalities", support both the Council and the wider health and social care system in Surrey to understand how they can	Tackling health inequality	Angela Goodwin (Chairman), Trefor Hogg, Riasat Khan, Carla Morson, Bernie Muir (ex-officio)

			address and tackle health inequalities faced by residents, create a shared understanding of barriers being faced by residents with lived experiences of health inequalities, and take an elevated view of services and support available in Surrey by considering individual experiences of those with lived experience of health inequalities and their interactions with different agencies.		
To be received in writing and informal briefing sessions					
Date of briefing session (if applicable)	**Issue for Briefing**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Cabinet Member/Lead Officer**
21 October 2021	**Health integration briefing session**	For Members of the Adults and Health and Children, Families, Lifelong Learning and Culture Select Committees to gain a greater understanding of the work being undertaken to better integrate health and social care in Surrey.	Select Committee Members will better understand the work being undertaken by the Council its partners to better integrate health and social care in Surrey, helping them to plan what	Tackling health inequality, empowering communities	Tim Oliver – Leader of the Council Sinead Mooney – Cabinet Member for Adults and Health Clare Curran – Cabinet Member for Children and Families

			areas could be scrutinised and how this might be undertaken.		Louise Inman – Health Integration Policy Lead
Joint Committees					
Dates	**Scrutiny Topic**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Membership**
Ongoing	**South West London and Surrey Joint Health Overview and Scrutiny Committee**	The South West London and Surrey Joint Health Overview and Scrutiny Committee is a joint standing committee formed with representation from the London Borough of Croydon, the Royal Borough of Kingston, the London Borough of Merton, the London Borough of Richmond, Surrey County Council, the London Borough of Sutton and the London Borough of Wandsworth.	The Joint Committee's purpose is to respond to changes in the provision of health and consultations which affect more than one London Borough in the South West London area and/or Surrey.	Tackling health inequality, empowering communities	Bernie Muir, Angela Goodwin, Riasat Khan (substitute)
Ongoing	**South West London and Surrey Joint Health Overview and Scrutiny Committee – Improving Healthcare Together 2020-2030 Sub-Committee**	In June 2017, Improving Healthcare Together 2020-2030 was launched to review the delivery of acute services at Epsom and St Helier University Hospitals	A sub-committee of the South West London and Surrey Joint Health Overview and Scrutiny	Tackling health inequality, empowering communities	Bernie Muir, Angela Goodwin (substitute)

		NHS Trust (ESTH). ESTH serves patients from across South West London and Surrey, so the Health Integration and Commissioning Select Committee (the predecessor to the Adults and Health Select Committee) joined colleagues from the London Borough of Merton and the London Borough of Sutton to review the Improving Healthcare Together Programme as it progresses.	Committee has been established to scrutinise the Improving Healthcare Together 2020-2030 Programme as it develops.		
Ongoing	**Hampshire Together Joint Health Overview and Scrutiny Committee**	On 3 December 2020, the Hampshire Together Joint Health Overview and Scrutiny Committee, comprising representatives from Hampshire County Council and Southampton City Council, was established to review the Hampshire Together programme of work, and Surrey County Council was invited to attend meetings as a standing observer.	The Joint Committee is to scrutinise the Hampshire Together programme of work and associated changes in the provision of health services.	Tackling health inequality, empowering communities	Trefor Hogg

Standing Items

- **Recommendations Tracker and Forward Work Programme:** Monitor Select Committee recommendations and requests, as well as its forward work programme.

ADULTS AND HEALTH SELECT COMMITTEE – ACTIONS AND RECOMMENDATIONS TRACKER

The recommendations tracker allows Committee Members to monitor responses, actions and outcomes against their recommendations or requests for further actions. The tracker is updated following each meeting. Once an action has been completed, it will be shaded green to indicate that it will be removed from the tracker at the next meeting.

KEY	No Progress Reported	Action In Progress	Action Completed

Date of meeting	Item	Recommendations/Actions	To	Response
14 July 2021	Induction session	Actions 1. Scrutiny Officer to circulate the Mental Health Task Group report to the Select Committee. 2. Deputy Director of Adult Social Care to provide guidance on hospital discharge for sharing with the Select Committee.	Scrutiny Officer Deputy Director of Adult Social Care	1. This has been completed. 2. The guidance has been circulated to the Select Committee.
3 March 2021	Adult Social Care Debt	Actions The Head of Resources (Adult Social Care) is to provide the Select Committee with an update on the work being undertaken	Head of Resources, Adult Social Care	The Head of Resources has been made aware of this. The update will be provided as part of the report that comes to the Select Committee on 3 March 2022.

		with Judge and Priestley Solicitors when it has progressed		
3 March 2021	Update on the Implementation of Mental Health Task Group Recommendations	<u>Recommendations</u> Requests an update on the activity of the Mental Health Partnership Board in the next Mental Health Task Group recommendations update report <u>Actions</u> 1. The Cabinet Member for Adults, Public Health and Domestic Abuse is to update the Select Committee on the mental health awareness training offer for Members	Surrey Heartlands, Surrey and Borders Partnership, Cabinet Member for Adult Social Care, Public Health and Domestic Abuse Member Services Manager	Item has been added to the Select Committee's forward plan and will be considered at its public meeting on 20 October 2021. 1. The following response has been received via Rachel Basham, Member Services Manager, and sent to the Select Committee: "I had a meeting with Christopher Barton (Wellbeing and Employee Experience Lead) last week and we looked at two aspects of mental health training for members. Firstly, ensuring that councillors are offered training and resources to support their own mental health. We agreed to create a wellbeing handbook for members (to be provided to them post induction) and ensure that all councillors receive

				a regular wellbeing e-mail with information about courses and resources they can access (such as the recent resilient training that has been offered to staff). We also discussed how to support members to increase their awareness of mental health issues that residents may be facing and Chris is going to speak to Public Health to see if we can extend the Mental Health First Aid Training staff offer to include members. As soon as we have more information on what this offer could look like, I can pass it onto you to share with Sinead and the rest of the committee." A further update was received from Sarah Quinn, Member Services Manager, in October 2021: "Mental Health Awareness training will be offered to all Members in early 2022. Two virtual sessions will be offered and a recording will be made for the Member Portal for anyone unable to attend "live". The training will introduce the concept of Mental Health First Aiders with a view to offering further training to any Members who are interested in taking on this specific role.

		2. The Cabinet Member for Adults, Public Health and Domestic Abuse is to share with the Select Committee a copy of the terms of reference for the Mental Health Partnership Board, once agreed	Cabinet Member for Adults, Public Health and Domestic Abuse	The Wellbeing Handbook was circulated to Members at the time of the post-election induction, and an updated version will be produced to reflect the fact that many Covid-19 restrictions are no longer in effect." This response has been circulated to the Select Committee. 2. The Cabinet Member has shared the terms of reference with the Select Committee.
3 March 2021	General Practice Integrated Mental Health Service Overview and Service Model	<u>Recommendations</u> The Select Committee requests a further update on the progress made regarding funding and workforce at a future meeting <u>Actions</u>	Surrey Heartlands, Surrey and Borders Partnership	Item has been added to the Select Committee's forward plan.

		1. The Clinical/Managerial Lead (Integrating Primary and Mental Health Care) for Surrey and Borders Partnership is to share with the Select Committee the reablement pilot referral rates for BAME residents and people with long-term health conditions	Clinical/Managerial Lead (Integrating Primary and Mental Health Care), Surrey and Borders Partnership	1. It was agreed that the Select Committee would be updated in summer 2021. The Clinical/Managerial Lead has been contacted for a response.
		2. The Associate Director for Primary and Community Transformation for Surrey and Borders Partnership is to liaise with GPs on the possible continuation of offering video appointments for patients	Associate Director for Primary and Community Transformation, Surrey and Borders Partnership	2. "The Integrated Primary Care Mental Health Service has been offering virtual appointments via telephone or Attend Anywhere video appointments during the pandemic. Whilst the team is keen to see more people in person when the restrictions ease, the team are committed to offering a choice of appointment type which will include video appointments."

		3. The Interim Mental Health Programme Lead for Surrey Heartlands is to provide the Select Committee with more information on the work being done regarding young safe havens 4. Witnesses are to provide the Select Committee with written versions of the introductions they gave at the start of the item	Interim Mental Health Programme Lead, Surrey Heartlands Surrey Heartlands, Surrey and Borders Partnership	3. The Young Adult Reference Group (YARG) have liaised with Catalyst, the Community Connection Provider for the Guildford Safe Haven, to discuss their proposal. We understand Catalyst are currently considering how this can be incorporated into the existing service. 4. Written versions of the introductions given at the start of the item have been circulated to the Select Committee.
3 March 2021	Covid-19 Vaccination Programmes	<u>Recommendations</u> The Select Committee congratulates Surrey Heartlands and Frimley Health and Care on the successful rollout of their Covid-19 Vaccination Programmes and recommends that they:	Surrey Heartlands ICS, Frimley Health and Care ICS	Officers at Surrey Heartlands have been contacted regarding this. Frimley Health and Care have provided a response, which has been circulated to the Select Committee.

		1. Ensure that the need to continue following government guidelines on social distancing and mask wearing is both verbally communicated to all residents at their vaccination appointments and included in a prominent position in all leaflets 2. Expand their communications messaging to as wide a variety of social media websites and applications as possible to help tackle vaccine disinformation 3. Ensure that those residents without access to mobile phones and/or the internet receive all required vaccination information in a timely manner, and that steps are taken to		

		identify and support those who are digitally excluded as quickly as possible Actions 1. The Director of Public Health is to share with the Select Committee a link to intelligence on vaccine hesitancy data that is in the public domain	Director of Public Health	1. The Director of Public Health has been contacted regarding this.
		2. The Associate Director of Communications and Engagement for Surrey Heartlands is to share with the Select Committee a copy of the Equality Impact Assessment	Associate Director of Communications and Engagement, Surrey Heartlands	2. The Equality Impact Assessment has been circulated to the Select Committee.
		3. The Director of Public Health is to share with the Select Committee the initial findings of the Equalities, Engagement and Inclusion Working Group	Director of Public Health	3. The Director of Public Health has been contacted regarding this.

		4. The Associate Director of Communications and Engagement for Surrey Heartlands is to raise with NHS England the issue of including in communications messaging data on the success of the vaccination programme to date and evidence of the protection vaccines provide after the first dose	Associate Director of Communications and Engagement, Surrey Heartlands	4. The Associate Director of Communications and Engagement has provided assurance that this point has been addressed with NHS England.
		5. The Executive Director of Quality and Nursing for the Frimley Collaborative is to raise with NHS England the possible reintroduction of messaging around residents not needing to be registered with a GP to receive a vaccine	Executive Director of Quality and Nursing, Frimley Collaborative	5. Frimley have provided assurance that the messaging on not needing to be registered with a GP is part of the national public information, and that the information is also included in the Frimley ICS frequently asked questions for the general public, at the following link: COVID-19 vaccination Frequently Asked Questions

				(FAQs) | Frimley Health and Care. Moreover, the Executive Director of Quality and Nursing has also asked Frimley's communications team to reinforce the message via social media.
3 March 2021	Questions and Petitions	Actions The Director of Public Health to provide a written response to the questioner's supplementary question, including information on the number of hospitalisations and deaths in care homes and domiciliary care settings for each district and borough	Director of Public Health	The Director's response has been circulated to the Select Committee.
19 January 2021	Surrey Heartlands Covid-19 Recovery Programme Update	Recommendations The Select Committee requests that future recovery reports include information on mental health and wellbeing support being offered to NHS staff and social care workers	Recovery Director, Surrey Heartlands	This information has been included in the Recovery Programme Update report to be presented to the Select Committee on 20 October 2021.
19 January 2021	Adult Social Care Transformation Update	Recommendations The Select Committee requests that Members of the	Deputy Director, Adult Social Care	The Deputy Director has been made aware of this and will pass on more

		Select Committee attend and observe staff motivational interview training <u>Actions</u> 1. Democratic Services officers to liaise with the Cabinet Member for Adults and Health about organising a briefing session on the Care Pathway programme of work 2. Deputy Director of Adult Social Care is to produce a briefing note on Liquid Logic	Scrutiny Officer, Democratic Services Assistant, Cabinet Member for Adults and Health Deputy Director, Adult Social Care	details once these are available. Members may receive a recording or other materials from the training sessions rather than actually attending, as this may be more appropriate with regards to staff attending the training. 1. Information on the Care Pathway programme of work will be included in the next Adult Social Care Transformation Programmes Review report. 2. "Liquid Logic (also referred to as LAS) is the adult social care recording system. All relevant adult social care staff have read and write access to LAS and receive training on case recording. LAS is a legal record and all information held on LAS is subject to the common law duty of confidentiality. Social care staff record all interactions with people open to us on LAS, including assessments, reviews, support plans and case notes."

		3. Chief Executive of Healthwatch Surrey is to provide the Select Committee with more information on the work being done with Action for Carers and Adult Social Care on how discharges from hospital have been experienced by carers	Chief Executive, Healthwatch Surrey	3. A report will be circulated to the Select Committee once this information is available.
19 January 2021	Development of New All-Age Autism Strategy	Recommendations 1. The Select Committee recommends that officers simplify the Autism Delivery Governance Structure to ensure that governance and oversight is as streamlined as possible	Assistant Director of Learning Disabilities, Autism and Transition	1. "Following the Select Committee recommendations, the governance structure for the All-Age Autism Strategy has been simplified from the previous draft. However, it is important to acknowledge that this is an ambitious five-year plan that aims to be wide-ranging and so does necessarily need to have links with a broad range of decision-making forums."

		2. The Select Committee recommends that, as part of the Strategy, training is developed to ensure that all officers use autism-appropriate language <u>Actions:</u> Assistant Director of Learning Disabilities, Autism and Transition is to provide the Select Committee with a summary of the services	Assistant Director of Learning Disabilities, Autism and Transition Assistant Director of Learning Disabilities, Autism and Transition	2. "Within the Strategy there are six key 'pillars' or work streams to deliver the strategy: • Awareness and understanding of Autism • Information and navigation • Education and Preparation for Adulthood • Health & Social Care Support • Housing and independent living • Employment Across all pillars there is an element of training and awareness-raising integral to that workstream. However, workstreams 1 and 2 include the development of a training plan for Autism awareness across social care as well as health, housing, etc. and workstream 2 focuses on the use of appropriate language." The Assistant Director's summary has been sent to the Select Committee.

		relating to horticulture and animal husbandry that Surrey County Council commissions and offers to children and adults with autism.		
17 December 2020	Scrutiny of 2021/22 Draft Budget and Medium-Term Financial Strategy to 2025/26	Actions Democratic Services officers to look into the possibility of organising for Members to visit Learning Disabilities and Autism services (whether remotely or in person)	Scrutiny Officer, Democratic Services Assistant	The Cabinet Member for Adults and Health has been contacted about this, and in-person visits will be scheduled for a suitable time due to the effects of the Covid-19 pandemic.
17 December 2020	ASC Complaints April – September 2020	Actions The Senior Programme Manager to ensure the Listening to Your Views leaflet is made available as a core leaflet in care homes and community hubs	Senior Programme Manager, ASC	"Printed copies of the new Adult Social Care complaints leaflet 'Listening to your views' have been provided to Adult Social Care teams, including our in-house care homes. The leaflet has also been widely distributed as a PDF document to Adult Social Care teams and the key community hubs, so it can be easily shared with anyone who requests a copy electronically. The leaflet is available as an easy read version and has been included in our publications library in a web accessible format Publications for

				Adult Social Care - Surrey County Council (surreycc.gov.uk)."
17 December 2020	Healthwatch Surrey – What Are We Hearing About Adult Social Care?	Actions The Cabinet Member for Adults and Health is to keep the Select Committee updated on the progress made regarding the possible introduction of a care navigators system	Cabinet Member for Adults and Health	An update has been circulated to the Select Committee as of October 2021.
15 October 2020	Update on ASC Mental Health Transformation Programme	Actions The Assistant Director of Mental Health to share suitable pre-prepared text and JPEG images with the Select Committee for sharing on social media.	Assistant Director of Mental Health, ASC	The Assistant Director has been contacted regarding this.
14 July 2020	Learning Disabilities and Autism Service Update	The Select Committee: 1. Recommends that future annual health assessments are more focused on unearthing mental health issues, which can have physical manifestations 2. Recommends that greater emphasis is	Assistant Director of Learning Disabilities, Autism and Transition Assistant Director of Learning	1. Response has been circulated to the Select Committee. 2. Response has been circulated to the Select Committee.

		placed on the transition period and that the steps taken to address this are outlined in a follow-up report	Disabilities, Autism and Transition	

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