Notice of Meeting

Adults and Health Select Committee

Date & time
Friday, 14 January 2022 at 10.00 am

Place
REMOTE & INFORMAL MEETING

Contact
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Chief Executive
Joanna Killian

We're on Twitter:
@SCCdemocracy

Please note: that due to the COVID-19 situation the Chairman has decided that this meeting will take place remotely and will therefore be an informal meeting of the Select Committee.

Please be aware that a link to view a live recording of the meeting will be available on the Select Committee's webcasting library page on the Surrey County Council website. This page can be accessed by following the link below:
https://surreycc.publici.tv/core/portal/webcasts

If you would like a copy of this agenda or the attached papers in another format, eg large print or braille, or another language please either call 07977 275 279, or email ben.cullimore@surreycc.gov.uk.

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: 16 DECEMBER 2021 (Pages 5 - 18)

Purpose of the item: To review the minutes of the previous meeting. The minutes will be formally agreed as a true and accurate record of proceedings at the next public meeting of the Select Committee.

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 *(Monday, 10 January).*
2. The deadline for public questions is seven days before the meeting *(Friday, 7 January).*
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 ADULT SOCIAL CARE TRANSFORMATION PROGRAMMES BI-ANNUAL REVIEW (Pages 19 - 46)

Purpose of the item: To provide a progress update on the programmes

which make up the ASC transformation programme and to share the ambition for 2022/23.

6 JOINT HEALTH AND SOCIAL CARE DEMENTIA STRATEGY FOR SURREY (2022-2027) (Pages 47 - 78)

Purpose of the report: This report presents the Joint Health and Social Care Dementia Strategy for Surrey (2022-2027) for the Select Committee's views and input during the consultation period, which runs until 21 January 2022.

7 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 79 - 100)

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.

8 DATE OF THE NEXT MEETING

The next public meeting of the Select Committee will be held on 3 March 2022 at 10.00am.

Joanna Killian
Chief Executive
Published: Thursday, 6 January 2022

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MINUTES of the meeting of the **ADULTS AND HEALTH SELECT COMMITTEE** held at 10.00 am on 16 December 2021 as a REMOTE & INFORMAL MEETING.

These minutes are subject to confirmation by the Committee at its meeting on Friday, 14 January 2022.

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)
* Buddhi Weerasinghe

(*=present at the meeting)

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

Substitute Members:

* Jonathan Hulley

32/21 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Rebecca Jennings-Evans. Jonathan Hulley attended as a substitute for Rebecca Jennings-Evans.

33/21 MINUTES OF THE PREVIOUS MEETING: 20 OCTOBER 2021 [Item 2]

The minutes to be agreed at the next public meeting on 14 January 2022.

34/21 DECLARATIONS OF INTEREST [Item 3]

Trefor Hogg declared a personal interest as a community representative for Frimley Clinical Commissioning Group.

35/21 QUESTIONS AND PETITIONS [Item 4]

None received.

36/21 SCRUTINY OF 2022/23 DRAFT BUDGET AND MEDIUM-TERM FINANCIAL STRATEGY 2026/27 [Item 5]

Witnesses:

- Sinead Mooney, Cabinet Member for Adults and Health
- Simon White, Executive Director for Adult Social Care
- Ruth Hutchinson, Director of Public Health
- Wil House, Strategic Finance Business Partner (Adult Social Care and Public Health)
- Anna D'Alessandro, Director of Finance (Corporate and Commercial)
- Rachel Wigley, Director of Finance (Insight and Performance)
- Adam Whittaker, Senior Strategy and Policy Lead
- Immy Markwick, Mental Health Lead (Independent Mental Health Network)

Key points raised during the discussion:

1. The Director of Public Health provided an update to the Select Committee regarding the current situation of the COVID-19 pandemic. Surrey had some of the highest rates of positive COVID-19 cases in the country, which was different to the trends seen in 2020 where higher rates were found in the north of England. The Director shared a slide (Annex 1) which showed a ranking of seven day case rates for lower-tier local authorities in England from 5 December 2021 to 11 December 2021. Three out of the top 20 of the lower-tier local authorities with the highest seven day rates were found in Surrey, with Reigate and Banstead recording the highest rates in the whole country. The Director highlighted that the number of confirmed Omicron cases within the county were only the tip of the iceberg, as they were

likely to be a significantly higher in reality. The Director noted that this was a rapidly changing situation.

2. The Cabinet Member for Adults and Health introduced the report and the context which underpinned it. The Cabinet Member welcomed the government's decision to reform Adult Social Care (ASC) and its focus on the front-line social care workforce and prevention agenda. Both demand and cost in ASC exceeded the funding provided by central government which had led to higher thresholds to access services. The proposed increases in national insurance would drive up cost for providers and would add to challenges with recruitment and retention. The Cabinet Member noted that arrangements were being made for her to shadow a care home and a care provider in the community once it was safe to do so, and the findings of these visits would be shared with the Select Committee in due course. The invitation was extended to Members of the Select Committee.

3. The Director of Finance (Corporate and Commercial) noted that the Council was expecting the provisional Local Government Finance Settlement from central government today (16 December 2021). Following a briefing with Cabinet Members, information on the settlement would be shared with all Members. It would take longer to understand how the settlement could change the budgetary gap. The draft budget was established in line with the Community Vision 2030 and the Council's priority objectives. The 2022/23 draft budget presented a net gap of £19.5 million. It had been assumed that the Council would receive circa £16 million from the settlement and this had been factored into the draft budget. The Council presented a circa £50 million efficiency programme, which included £19.4 million efficiencies in the Adult Social Care Directorate and £0.3 million in the Public Service Reform and Public Health Directorate. There was no planned use of any reserves for 2021/22 at this point in time, which suggested a reserves balance of £196.7 million at the end of the financial year.

4. Regarding the consultation and engagement process with residents, the Senior Strategy and Policy Lead informed the Select Committee that it was strongly felt by residents that funding for services which supported vulnerable residents should be protected. Where the rationale for increasing council tax and/or use of the ASC precept was to protect funding for those services, residents were more likely to support such a rise. The closing date for the consultation on the draft 2022/23 budget was 28 December 2021. This process would help to identify potential

areas of support and resistance within the draft budget before going to Cabinet on 25 January 2022.

5. The Director of Finance (Insight and Performance) explained the rationale behind the Twin-Track approach. Any changes as a result of the Local Government Finance Settlement would come back to the Select Committee in early 2022 if possible, to allow for scrutiny of such proposals. Work undertaken had followed guiding principles which included being enabled by data and insight and maintaining a focus on outcomes.

6. The Executive Director of Adult Social Care introduced the ASC draft budget for 2022/23. A strength-based approach was adopted to promote people's independence and well-being and reduce dependence and a life-long reliance on care services. This aimed to shift support away from institutional models of care, unless such models were the only option to appropriately support people who have the most complex needs. The intention was to support residents to remain in their own home or supported accommodation where possible. The numbers of residents who were receiving care had fallen during the pandemic, whilst the average cost of care had increased sharply. The full year cost of care packages delivered in 2021/22 was likely to be circa £18 million above the current budget, which had been built into next year's (2022/23) budget as a pressure. The hospital discharge programme had resulted in increased unit costs for ASC. The impact of ASC's transformation programme was demonstrated by the fact that since 2017/18, the Council's spend on ASC had increased by 8% compared to 14.5% in the South East.

7. The Director of Public Health explained that there were strict criteria for the use of the Public Health (PH) Grant (£38.6 million for the Council), a reasonable proportion of which was allocated to other departments which spent the money according to the grant requirements. The Treasury was yet to announce whether the council would receive extra allocation regarding the COVID Outbreak Management Fund, or if funding received to date could be carried forward into 2022/23.

8. The Chairman asked how confident the officers were that the red- and amber-rated efficiencies would be achieved and what impact such efficiencies might have on service users. The Executive Director of Adult Social Care responded that at this stage in the process, it would be expected that a large proportion of the proposed efficiencies would be rated amber or

red. These efficiencies were considered challenging in a variety of ways, but if they were not considered challenging then the Service would already be doing them. The Cabinet Member for Adults and Health explained that a robust monitoring mechanism sits behind these challenging efficiencies which provided a level of confidence. The Strategic Finance Business Partner (ASC and PH) added that there were no savings which were solely rated red.

9. The Chairman enquired about the sustainability and risks of the Learning Disabilities and Autism (LD&A) efficiencies. The Executive Director of Adult Social Care explained that expenditure on LD&A had risen, and would continue to do so, due in large to those transitioning from Children's Services into ASC every year. The Chairman asked about the rationale behind the assumptions related to LD&A efficiencies, particularly those related to day care, as well as the suspected demand in this area in 2022/23. The Executive Director of Adult Social Care explained that the proposed efficiencies in this area were focused around changing the model of day care services and a maximisation of independence. The approach had shifted to making services accessible to those with LD&A and supporting those currently in institutional models of day care to enjoy universally accessible activities. The Executive Director of Adult Social Care noted the importance of responding to the needs of families this would affect. The Chairman asked about the lessons learnt from the first lockdown and the financial steps that ASC would take to support families with LD&A needs if restrictions tightened further or another lockdown was introduced. The Cabinet Member for Adults and Health shared that during lockdown and COVID restrictions, the Council was able to offer providers with a great deal of support, particularly financially. Conversations had taken place with providers, such as Surrey Care Association, to understand what more the Council could do to support them should that situation arise.

10. A Member asked how confident officers were that the forecasts were accurate and what assurances could be provided to the Select Committee. The Strategic Finance Business Partner (ASC and PH) explained that it was a rapidly changing situation, however the draft budget proposed, a sizeable increase in ASC's budget of £18.6 million between 2021/22 and 2022/23. A robust monthly monitoring process enabled the Council to be clear on how expenditure on ASC services compared to the budget

proposals. The Member asked whether the potential financial impact of the Omicron variant had been factored into the reserves for 2022/23. The Director of Public Health explained that the risk of a new variant had remained on the corporate risk register and that through using COVID reserves, PH could flex their services as appropriate.

11. A Member asked what contingency plans had been established to reshape services if the county was faced with adverse outcomes from the Omicron variant and any future variants. The Executive Director of Adult Social Care responded that with all future options, a best-case and worst-case scenario were accounted for. The Director of Public Health explained that this would be when the Local Outbreak Management Plan would be utilised which provided a framework of how to respond to changes in the pandemic. The Director of Finance (Corporate and Commercial) stated that from the 2021/22 financial year, the Council had circa £11 million of reserves and contingencies which could be added to the 2022/23 budget, any unspent money from 2021/22 was assumed it could be carried over. The Spending Review had not announced any new COVID related grants.

12. A Member enquired about the dilemma surrounding the amount the Council was able to pay for services from providers and the cost at which providers could provide such services for, as well as inflationary increases and national insurance increases. The Executive Director of Adult Social Care explained that once the settlement had been received, the Council could review the general level of inflation offered to the sector and it was hoped this could be a generous offer. The intent was to reduce variation of the cost for services, which would create savings and could be achieved without damaging the provider's underlying business model. The Cabinet Member for Adults and Health added that this was one of the single biggest challenges the directorate was facing in this draft budget and it was a key priority.

13. The Mental Health Lead for the Independent Mental Health Network asked for reassurance that mental health would be a focus of forthcoming budgets to ensure that ASC capacity could meet the increased demand on the Service as a result of mental health issues. The Executive Director of Adult Social Care acknowledged the impact that the pandemic has had on residents' mental health and the increased demand this had put

on ASC services. The current system-wide approach to mental health was recognised as not working well in its current state. There was a desire to improve practice related to hospital discharges after an admission under the Mental Health Act and to provide solutions which promoted the individual's long-term wellbeing. The Strategic Finance Business Partner (ASC and PH) stated that the assumption of a continuation of the high level of demand for mental health services was built into the draft budget for 2022/23. The Mental Health Lead enquired about the impact on the voluntary, community and faith sector from the draft budget 2022/23. The Executive Director of Adult Social Care highlighted the crucial support provided by third-sector organisations and reassured Members that there was a commitment to maintaining funding for this sector. The Cabinet Member for Adults and Health endorsed the commitment to working with third-sector organisations and informed with Members about the recently held Mental Health Summit. The Director of Public Health highlighted the importance of financial investment and system-wide prevention work, this was shown through the Health and Wellbeing Strategy Refresh.

14. A Member asked for clarity regarding the closure of some care homes and the impacts this could present for residents, as well as the difficulties surrounding recruitment of staff. The Cabinet Member for Adults and Health acknowledged the important partnership work which had kept care homes open throughout the pandemic. The Member questioned why the Council was not utilising its reserves in order to make fewer cuts in such exceptional circumstances and increased demand. The Director of Finance (Corporate and Commercial) explained that the Council had large reserves due to the scale of the services it provided and to mitigate financial challenges of unexpected events. Financial resilience had been achieved in the last three years through lots of hard work. There had been increased investment in transformation programmes through use of reserves. The Strategic Finance Business Partner (ASC and PH) brought attention to the Capital Programme which had a significant amount of investment earmarked for ASC.

15. A Member asked what funding had been put in place to ensure residents were aware and engaged with the LD&A changing model of care, referencing feedback from a resident. The Executive Director of Adult Social Care explained that any large service changes must include consultation with residents. There had not yet been a general communication strategy, but the

feedback was noted. Another Member shared their concerns regarding a lack of communication with policy changes. The Executive Director stated that this would be taken away and a colleague would write to the Member in due course.

16. Regarding what cost implications were anticipated for the ASC budget as a result of winter pressures and the affect the Omicron variant could have on hospital discharges, the Executive Director of Adult Social Care stated that there would be cost implications if we entered into another crisis due to the Omicron variant. The Service was yet to reach a stage where it could not respond to the circumstances. However, there were problems with NHS community services, which needed to be addressed if individuals were to be discharged with greater needs.

17. A Member asked whether the strength-based approach had worked to deliver efficiencies. The Executive Director of Adult Social Care explained that, prior to the pandemic, this approach had delivered efficiencies over a number of years satisfactorily. If the Service remained in a perpetual crisis, then social workers would be dominated by responding to the crisis and residents in the community could fail to receive the appropriate response they required.

18. The Chairman enquired about how the efficiencies identified would help to tackle health inequalities and the impact on residents. The Director of Public Health explained that the efficiencies outlined in PH for the 2022/23 draft budget were relatively small and that they should not have any material impact on health inequalities. All of the PH spend was based on services that aimed to reduce health inequalities. The Strategic Finance Business Partner (ASC and PH) added that there were no significant changes to services provided as a result of planned efficiencies and other funding opportunities were being explored.

Recommendation:

The Select Committee agrees that, subsequent to this meeting, the Adults and Health Select Committee will agree wording for inclusion in the report to Cabinet regarding the draft budget and Medium-Term Financial Strategy, which is to be prepared jointly by the Council's four select committees.

Actions/requests for further information:

The Cabinet Member for Adults and Health to feed back to the Select Committee her views and findings of the care home shadowing work she will be undertaking.

37/21 ADULT SOCIAL CARE COMPLAINTS APRIL - SEPTEMBER 2021 [Item 6]

Witnesses:

- Sinead Mooney, Cabinet Member for Adults and Health
- Simon White, Executive Director of Adult Social Care
- Kathryn Pyper, Senior Programme Manager (Adult Social Care)
- Kate Scribbins, Chief Executive Officer (Healthwatch Surrey)
- Nick Markwick, Co-Chair (Surrey Coalition of Disabled People)

Key points raised during the discussion:

1. The Senior Programme Manager introduced the report and stated the importance of complaints within ASC and the learning opportunities they provided. Complaints received had increased from this time last year (2020), due to the impact of the pandemic. The Ombudsman investigated six complaints during quarters one and two, and of those, upheld three complaints. On a national scale, the Ombudsman tended to find fault more often with local authorities and providers. A monthly summary was produced for members of the ASC leadership team which covered complaints in their area and the learning that was emerging. Compliments were a useful insight into what was working well, themes of compliments would be featured in future reports. There was no formal process for recording issues of concern at this stage, but they would always be addressed by officers and recorded in case notes. Work was underway to launch a Quality of Practice Dashboard in ASC, the first phase to be launched in January 2021.

2. The Chairman asked about the timeline of achieving changes regarding learning from complaints and how such changes had been monitored. The Senior Programme Manager explained that in terms of learning that had emerged from a complaint, there would be an action plan in place which would be monitored to ensure the actions had been implemented. There was no response to address general themes of complaints, rather they were addressed on an individual basis. A lot of

improvement work was ongoing and occurred as business-asusual pieces of work. The Chairman questioned how robust the customer relations management technology was within the Service. The Senior Programme Manager shared that there was a new corporate system introduced a couple of years ago which was fairly robust, and it was within this system that actions and learnings were recorded.

3. The Chief Executive Officer (CEO) of Healthwatch Surrey highlighted the importance of the complaints process being well publicised and accessible to all, as well as the learning opportunities from issues of concern. The Senior Programme Manager explained that the 'listening to your views' leaflet had been refreshed and offered to community hubs, and replenishment of the stock could be offered. Best practice issued by the Care Quality Commission required residential homes to have a complaints procedure and complaints literature available to residents and families. The CEO asked how ASC assures itself that it is hearing complaints regarding all aspects of the Service, especially those in residential care, and from service users from all demographics. The Senior Programme Manager stated that at the moment, complaints were looked at in terms of the Service's main client groups, rather than in terms of protected characteristics. Work could be undertaken to review complaints received in this financial year using the categories of protected characteristics. The Chairman sought reassurance that there was a process in place to ensure complaints were heard from those who could be too afraid to make a formal complaint due to dependence on the staff. The Senior Programme Manager responded that complaints could be made anonymously to reduce fear when making a complaint. The Executive Director of Adult Social Care added that those who could be too afraid to complain were at the heart of safeguarding practices.

4. A Member asked how residents were informed about improvements following complaints that had been received. The Senior Programme Manager explained that when responding to the complainant in writing, it would always be explained what actions would be taken following their complaint. It would be assumed that the resident was satisfied with the response unless they said otherwise or went to the Ombudsman.

5. A Member asked about the classification regarding complaints on the area of 'PLD, Autism & Transition'. The Senior Programme Manager explained that this category included

complaints from all of those areas, but they could be separated in future reports. The Vice-Chairman asked whether an example of a summary of complaints provided to members of the ASC leadership team could be shared with the Select Committee Members. The Senior Programme Manager stated that an example could be shared with all personal details redacted due to General Data Protection Regulation. The Vice-Chairman enquired about whether the Members could sign up to the monthly ASC E-Brief. The Senior Programme Manager stated that this was an update just sent to ASC staff, however, there could be discussions about extending the audience.

6. A Member asked whether there were any plans to formalise the various forms of monitoring into one system. The Senior Programme Manager explained that all the practice information was being pulled together into the Quality of Practice Dashboard, which would include complaints and compliments. Through the Digital Front Door work, further methods of formalising this would be explored.

7. The Co-Chair of the Surrey Coalition of Disabled People asked whether there was a formal method of monitoring complaints made by staff themselves. The Senior Programme Manager explained that staff were always consulted when changes were made within the Service and there was a hope that staff would feel comfortable enough to raise concerns generally, but there was no formal process of recording such complaints. The Chairman asked whether there were any plans to introduce this. The Senior Programme Manager explained that staff were regularly involved in discussions and focus groups to ensure their views were heard, but there were no plans to introduce a formal process.

8. The Chairman asked about the training provided to staff to gather information that could represent issues of concern and how staff channelled complaints. The Senior Programme Manager explained that a monthly training course was held for members of staff and it was well attended. The Chairman queried whether this was the case for agency staff as well. The Senior Programme Manager thought this would be part of the standard induction but would need to check. Staff could also drop into lunchtime learning sessions which occur each month. The Chairman asked whether attendance to training sessions for staff was recorded. The Senior Programme Manager explained that there would be a report available regarding who had attended each training session and the expectation was that

senior managers were responsible for monitoring attendance of their team. Attendance was not recorded for lunchtime learning sessions as they were purely voluntary.

9. The Chairman asked how complaints are shared with any relevant stakeholders. The Senior Programme Manager explained that the Council would lead on the complaints and would liaise with partner agencies to receive their input and for them to complete their part of the investigation. The Council would then respond on behalf of partner agencies which were involved.

Recommendation:

The Select Committee recommends that a way of formally monitoring “issues of concern” is developed to ensure complaints and comments made by residents and staff that do not go through formal complaints process are logged, monitored and learnt from, and that the Council works closely with Healthwatch Surrey to ensure that as wide a range of feedback as possible is collected as part of this process.

Actions/requests for further information:

i. Senior Programme Manager to ensure complaints literature is replenished in all settings across Surrey.
ii. Senior Programme Manager to provide the Select Committee with an example of an E-Brief.
iii. Senior Programme Manager to provide the Select Committee with an example of a summary of complaints provided to the leadership team.
iv. Senior Programme Manager to ensure that future Adult Social Care Complaints reports to the Select Committee include:
    a. Detailed summaries of complaints where learning was identified and implemented (as referenced in Paragraph 29),
    b. Key messages relating to complaints received by providers and how they are being addressed (as referenced in Paragraph 31),
    c. Breakdown of complaints received from residents from all demographics across Surrey,
    d. A breakdown of complaints received regarding the Learning Disabilities, Autism and Transition

service and the specific areas to which these complaints are related.

38/21 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 7]

Key points raised during the discussion:

None.

Recommendation:

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

39/21 DATE OF THE NEXT MEETING [Item 8]

The next meeting of the Select Committee will be held on 14 January 2022.

Meeting ended at: 1.41 pm

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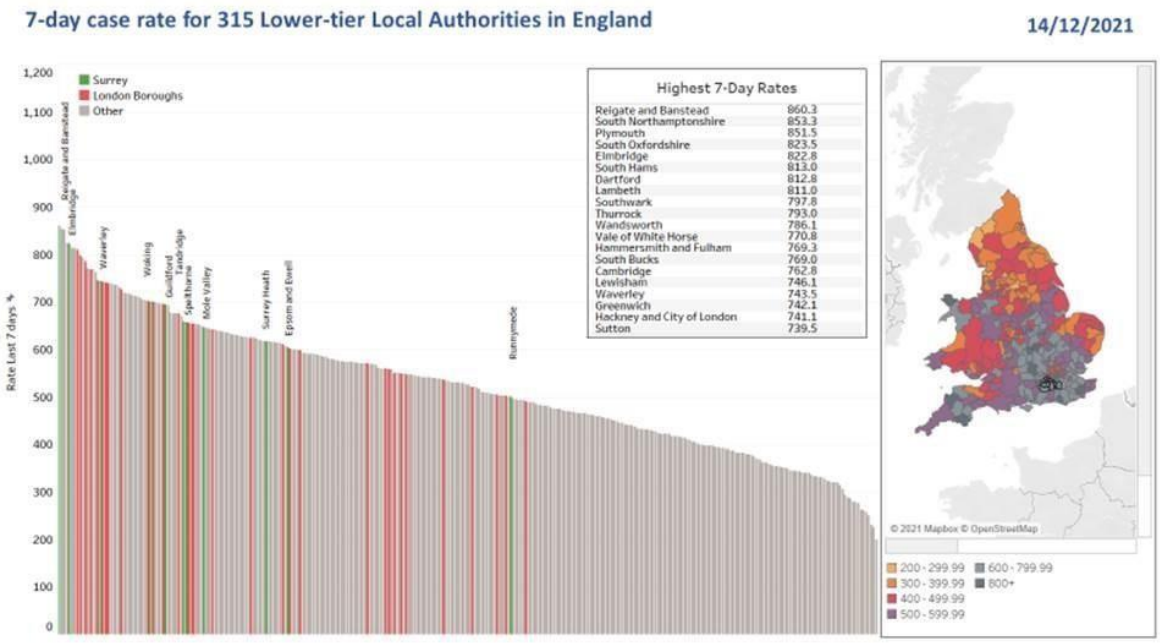
Chairman

Annex 1


7-day case rate for 315 Lower-tier Local Authorities in England
14/12/2021
Surrey
London Boroughs
Other
Rate Last 7 days
Highest 7-Day Rates
Reigate and Banstead 860.3
South Northamptonshire 853.3
Plymouth 851.5
South Oxfordshire 823.5
Elmbridge 822.8
South Hams 813.0
Dartford 812.8
Lambeth 811.0
Southwark 797.8
Thurrock 793.0
Wandsworth 786.1
Vale of White Horse 770.8
Hammersmith and Fulham 769.3
South Bucks 769.0
Cambridge 762.8
Lewisham 746.1
Waverley 743.5
Greenwich 742.1
Hackney and City of London 741.1
Sutton 739.5
Runnymede
© 2021 Mapbox © OpenStreetMap
200 - 299.99
300 - 399.99
400 - 499.99
500 - 599.99
600 - 799.99
800+

ADULTS & HEALTH SELECT COMMITTEE

14 JANUARY 2022

ASC TRANSFORMATION PROGRAMMES BI-ANNUAL REVIEW

Purpose of report: To provide a progress update on the programmes which make up the ASC transformation programme and to share the ambition for 2022/23.

Background

1. The ASC transformation programmes were set up in April 2018 as part of the Council's transformation agenda and built upon changes already underway in the Directorate. They were shaped by the findings of the Local Government Association (LGA) peer review undertaken in summer 2018 and supported by the Social Care Institute for Excellence (SCIE) as our improvement partner.

2. These are long-term strategic change programmes. As change has been successfully delivered and embedded each programme has moved into the next phase of transformation.

Strategic direction

3. Adult Social Care's vision is 'to promote people's independence and wellbeing'. This vision sets an aspiration for a modern service and the ASC transformation programmes are driving the changes needed to realise this. It is a complex, long-term change programme with many interdependencies. The focus of each programme moving forward is as follows:

   - **Accommodation with care and support** will increase the availability and range of accommodation so residents remain independent for longer, with 725 units of affordable Extra Care Housing by 2030 and 500 units of Supported Independent Living by 2025.
   - **Care pathway** will reshape our front door with short term reablement interventions and a robust community and prevention offer, supported across the directorate by a well-structured and skilled workforce
   - **Enabling you with Technology** will design and deliver a universal digital health and care monitoring offer to support people with eligible social care needs that can also be purchased by self-funding Surrey residents.
   - **Evaluate in-house service**s will assess the future of the Council's in-house residential care homes for older people and for adults with a learning disability, as well as reviewing care provision to our extra care services.
   - **Learning disability and autism** will continue to transform services through strengths-based reviews, the strategic shift to independent living, modernising day services and transforming care offer with an OT service, reablement and health facilitation.

- **Market management** will develop a market management and a residential and nursing strategy, will deliver a market management system together with a redesigned brokerage function.
- **Mental health** will embed a high-level operating model and structure, continue working with partners to improve hospital pathways and is leading a S117 joint review programme with health partners to ensure compliance with statutory duties under the Mental Health Act and better outcomes for individuals.

Efficiencies 2021/22

4. The ASC transformation programmes are designed to deliver £8.7m (of the total £11.9m) of Adult Social Care efficiency savings in 2021/22 as part of the Council's Medium-Term Financial Strategy (MTFS). The table below illustrates how just over £5m of the £8.7 efficiencies are forecast to be achieved, representing an underachievement of £3.6m. Whilst the transformation programmes are successfully delivering against their delivery plans, the pandemic has meant changes in the cost of new packages in 2021/22 which has made delivering savings more challenging. The Adults Leadership Team (ALT) have agreed a series of actions to improve the position and are working hard to deliver them.

Efficiency	Transformation Programme	2021/22 Savings Target £	Savings Achieved (P7) £	Total Savings Forecast in 2021/22 £	Over (+), Under (-) Target £
Transform care pathways	Care Pathways	£3,017,898	£0	£0	-£3,017,898
Decommission traditional day & introduce new transport policy	LD & Autism	£2,564,522	£525,551	£2,650,945	£86,423
Strategic shift from residential care to independent living	Accommodation with Care & Support	£1,451,554	£227,741	£455,668	-£995,886
Improved purchasing of Older People nursing / residential care beds	Market management	£1,082,864	£182,000	£250,000	-£832,864
Improved purchasing of Home-Based Care packages	Market management	£362,158	£0	£927,731	£565,573
Mental Health transformation	Mental Health	£208,560	£0	£738,635	£530,075
Total ASC transformation efficiencies		**£8,687,555**	**£935,292**	**£5,022,979**	**-£3,664,576**

5. No efficiencies are expected to be achieved against the £3.1m target for transforming care pathways as the cost of new packages in 2021/22 is running significantly higher than pre-pandemic 2019/20 levels that efficiency targets were based on. The cost of new packages has increased substantially due in particular to the impacts of the pandemic including increased levels of need and the hospital Discharge to Assess system. Accommodation with Care & Support strategic shift savings are forecast to underachieve by £1m, as both the % saving per transfer from residential to supported living services and the number of transfers is behind the budgeted profile, noting that it has inevitably been harder to support people to move to alternative accommodation during the pandemic.

6. Market management savings are forecast to underachieve by £0.3m. The total cost of new Older People residential placements is higher than the pre-pandemic baseline

resulting in £0.8m forecast deficit. This is offset by a forecast £0.5m surplus for Home Based Care efficiencies. An overachievement of £0.5m is forecast for Mental Health transformation. However, it is important to note that this overachievement is due to growth in NHS funding for Section 117 aftercare clients rather than cost efficiencies (an overspend is forecast in 2021/22 for Mental Health's care package gross expenditure excluding income).

Investment bids for 2022/23 to 2026/27

7. For 2022/23, the ASC transformation programmes have submitted bids for the investment from the Council's Transformation Support Unit (TSU) as set out in the table below. This investment will ensure the Directorate has the change capacity it needs to continue its transformation journey and to deliver the £13.7m of Adult Social Care efficiency savings in the Council's 2022/23 MTFS.

8. Column A shows the bid submitted for each ASC transformation programme in 2022/23. Column B is the efficiency saving allocated to each ASC transformation programme in the MTFS for 2022/23, whilst column C shows the longer-term efficiency savings. This demonstrates a good return on investment for the Council.

ASC Programme	A Investment Bid 2022/23	B MTFS Benefit 2022/23	C MTFS Benefit 2022/23 to 2026/27
Accommodation with Care & Support	£1,116,788	£737,000	£3,528,000
Learning Disability & Autism	£811,419	£3,571,000	£8,836,000
Care Pathways	£635,877	£1,572,000	£2,829,000
Enabling You with Technology	£290,500	£750,000	£2,950,000
Market Management	£157,104	£4,218,000	£11,072,000
Evaluate In-House Services	£194,659	£1,591,000	£10,862,000
Mental Health	£115,000	£1,357,000	£1,743,000
Total	**£3,321,347**	**£13,796,000**	**£41,820,000**

Progress and forward focus

9. The key deliverables for each of the ASC transformation programmes are set out in the following pages, together with a summary of progress to date and the milestones for 2022/23.

10. A number of case studies to bring the programmes to life are included as follows:

- Appendix 1 - Accommodation with Care & Support – Extra Care Housing and Supported Independent Living
- Appendix 2 - Care Pathways - Adult Social Care Webchat
- Appendix 3 – Care Pathways – Communities and Prevention
- Appendix 4 – Enabling You With Technology – Home Sensors

11. A member of the ALT is the Accountable Executive for each programme and progress is reviewed each month by ALT and the Council's Transformation Assurance Board. Each transformation programme has robust governance in place

with a programme board and reporting to Adults & Health Select Committee, Commissioning Committees in Common and Cabinet as appropriate.

Accommodation with Care & Support

Key Deliverables

• 725 units of affordable Extra Care Housing by 2030
• Care and support strategy for Extra Care Housing
• 500 units of Supported Independent Living by 2025
  ○ Circa 110 units of Supported Independent Living for individuals with Learning Disabilities and/or Autism using SCC assets
  ○ Circa 90 units of Supported Independent Living for individuals with Learning Disabilities and/or Autism with the market deregistering existing provision. (Deregistering is where an existing residential care homes changes into supported living. The home is no longer directly registered with the Care Quality Commission (CQC) but the support provider which delivers the support is registered with the CQC giving more flexibility to personalise the support for each individual).
  ○ Circa 120 units of Supported Independent Living for individuals with Learning Disabilities and/or Autism through market development
  ○ Circa 90 units of Supported Independent Living for individuals with Learning Disabilities and/or Autism through partnership working district and borough councils
• Implement the Supported Independent Living Dynamic Purchasing System
• Implement the Supported Independent Living Programme for individuals with Mental Health needs
• Develop a communications and engagement strategy for the Accommodation with Care and Support Programme
• Develop strong and effective partnerships with our District and Borough Councils to make best use of existing stock

Progress to date
Strong progress has been made across the whole Strategy with tangible deliverables achieved in the past year. We have effective governance in place with corporate buy in from both senior officers and Cabinet Members and strong partnership working with Land & Property, Legal Services etc. This has supported delivery and ensuring that the programmes are held to account. We have acquired multilateral political support for the delivery of our strategic ambition across the spectrum including local ward members and district and borough councillors. The programme teams are well established and is performing to a high standard. **Extra Care Housing** • In final discussions on Contract Award for Extra Care Housing at the Pond Meadow site in Guildford, and subject to final agreement on the Contract Award we would expect the construction phase to commence at some point in 2022. • In discussions with Guildford Borough Council on our nominations/allocations agreement for the future scheme. • Readying the publication of the Invitations to Tenders for a further four schemes.

- Identified sufficient capacity in Surrey County Council owned assets to achieve our target of 725 units of affordable Extra Care Housing by 2030.
- Preparing the business cases in the Spring of 2022 for the delivery of the full programme.
- Prepared our Design Brief Specification for Extra Care Housing with input from operational colleagues including occupational therapists.
- Developing our Countywide Care and Support Commissioning Strategy for Extra Care Housing.
- Published promotional material for the Extra Care Housing Strategy. Affordable Extra Care Housing in Surrey (accessible version) - YouTube

Supported Independent Living

The Supported Independent Living Programme is a five-year transformation programme and 2022/23 will by year three. It has particularly strong dependencies with the Learning Disability & Autism transformation programme. The Supported Independent Living Programme is facilitating the provision of supported independent living across Surrey, whilst the Learning Disability & Autism programme is working to facilitate these moves.

- Identified three sites for Supported Independent Living.
- Preparing the business cases for the delivery of the three sites in the Spring of 2022.
- Developed the Care Savings model for Supported Independent Living.
- Created an additional 101 units of Supported Independent Living through the deregistration of existing care homes.
- Plan to create a further 22 units of Supported Independent Living in 2022/23 through deregistrations.
- Prepared our Design Brief for Supported Independent Living with input from operational colleagues including occupational therapists.
- Finalising a new Pricing Structure for Supported Independent Living.
- Prepared a new service specification for Supported Independent Living.
- Preparing the Invitation to Tender for the new Supported Independent Living Dynamic Purchasing System in 2022.
- Completed market engagement to support the delivery of the strategy.
- Engaged carers and users on the new Supported Independent Living Strategy.
- Published promotional material for the Supported Independent Living Strategy. Supported Independent Living in Surrey - accessible version - YouTube
- Fully resourced our operational Move on Team who have supported individuals into their new accommodation.

Mental Health

- Developed the new model for Supported Independent Living for individuals with mental health needs.
- Cabinet agreed implementation of the new Accommodation with Care and Support Programme for people with mental health needs to Cabinet in the Autumn of 2021.
- Hosted a key stakeholder workshop on the strategy.
- Recruited to project officer resource to support the delivery of the strategy.

- Scoped the new programme structure.
- Mapped out District and Borough Housing data in relation to mental health.

Key milestones for 2022/23

- Contract Delivery for Extra Care Housing at Pond Meadow - Q1
- Complete the procurement on the four schemes for Extra Care Housing - Q4
- Implement delivery model for the remaining Extra Care Housing schemes following Cabinet approval - Q1
- Agree the Surrey wide Care and Support Commissioning Strategy for Extra Care Housing - Q2
- Implement delivery model for the Supported Independent Living schemes following Cabinet approval - Q1
- Complete all planned Supported Independent Living deregistrations for financial year - Q4
- Implement the Accommodation with Care and Support Strategy for people with mental health needs following Cabinet approval - Q1

Care Pathways

Key Deliverables
ASC Digital Front Door • View the Adult Social Care front door through a digital lens identifying possibilities for digital improvement. • Implement changes to the Adult Social Care digital front door following agreed recommendations from comprehensive user insight research • Explore the customer facing technology and digital systems and opportunities to enhance them including scoping and implementing an IT tools & systems for a new customer experience journey • Establish a self-service model to support the funding reforms that will see greater numbers of residents coming to ASC from 2023. **Motivational Interviewing** • Train all frontline staff in motivational interviewing to help embed strengths-based practice. Motivational interviewing is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. **Reablement** • Remodel Adult Social Care's integration with Reablement to adopt a Reablement first approach ensuring all residents go through Reablement first prior to accessing assessments to reduce spending on long term packages of care. • Improve the customer and partnership experience at the reablement front door. • Design and implement a stronger partnership model between reablement service with health and community partners across Surrey to give residents an equal and consistent offer of care • Transform the reablement service operating model following the evaluation of benefits from embedding a digital system and a commissioned collaborative reablement service for further financial efficiencies **Communities and Prevention** • Supporting people with additional needs to access and maintain employment. • Peer-led approach to tackling health inequality. • Maximising Social Value as a new funding stream. • Collaborating with and mobilising the Voluntary Community & Faith Sector.
Progress to date
ASC Digital Front Door has been in the discovery phase establishing what activities need to be completed in 2nd half 2021-22 and beyond. • Quick wins are also being piloted including webchat for ASC and Online Financial Assessments and use of Notify.gov for SMS messages. • Extensive user research undertaken with residents and interest groups.

- Survey and focus groups have been held with SCC staff to focus next steps on internal and external professionals.
- The discovery activity will confirm the next steps – including discussions at ALT and sessions with IT&D's Digital Design Team – to ensure that the objectives are met and opportunities for Transformation are identified.

Establishment Review - The first phase of this work reduced the vacancy factor to achieve a properly funded establishment by releasing vacant posts to ensure ASC is operating within the funded staffing budget. The second phase looked at the size and shape of locality teams in context of demand, workload and staffing levels to achieve greater consistency. This project will be completed and transition to business as usual from 1 April 2022.

Motivational Interviewing – Mental Health teams have completed their motivational interview training to help embed strengths-based practice. The training is now being rolled out across locality teams and the LD&A teams. This training will continue into 22/23. Motivational interviewing is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence.

Reablement

- Reablement team leaders moved to a seven-day service to support the existing operational seven-day service – this change enabled reablement to take referrals seven-days a week, to be more preventative and avoid admissions over weekends.
- Management reorganisation – implementation of a new management structure to reflect, manage and drive forward a digital and integrated reablement service, live as of 1 April 2021.
- Workforce development – introduction of Occupational Therapists into the service to embed a therapy approach across reablement; train and upskill the workforce in strengths-based practice and moving and handling.
- Commissioning of Collaborative Reablement – service specification developed for the new collaborative service; evaluation and moderation of submitted bids; 6 chosen suppliers awarded contracts; suppliers onboarding sessions for a contract start of 1 October 2021.
- Specialist Reablement (LD&A and Mental Health Services) – design and develop an offer to different client groups also contributing to a reablement first approach. Service criteria defined and agreed. LD&A launched in August 2021 and Mental Health to launch early November 2021.
- Beginning to scope out Integrated Reablement Services, first by reviewing the front door.

Communities and Prevention

- Supporting people with additional needs to access and maintain employment - Undertaken user research to understand the barriers to accessing and maintaining employment. Explored these barriers with potential employers and employment support organisations to propose feasible solutions. Established a cross-sector partnership network committed to addressing these issues. Bid for £500k funding to deliver sustainable solutions.
- Peer-led approach to tackling health inequality - Identified the priority challenges underpinning the health inequality. Secured funding to develop an accessible and sustainable training programme addressing these priority challenges. Commissioned a training collaboration including a health trainer and people with lived experience who will work together to co-design and co-produce the peer health and wellbeing training programme. Run two pilot peer health and wellbeing champions training cohorts – one with people with learning

disabilities and one with people with autism. Developed a suite of sustainable training materials. Developed a train the trainer programme suitable for people with learning disabilities and/or autism as well as professionals to continue to train more health champions in the future.

- Maximising Social Value as a new funding stream - Run a test and learn site exploring how businesses could match their social value offer with the VCFS needs in Surrey. Established a learning model with Unit 4 to secure for ASC and our partners the £500k social value committed in their tender. Explore with ASC frontline teams and partners what social value is required.
- Collaborating with and mobilising the VCFS - Drawn together the outcomes in the 2030 Vision, SCC organisational strategy, health and wellbeing strategy and Better Care Fund framework to create a concise outcomes framework. Co-designed with VCFS partners how they could use the outcomes framework to frame their existing activity and support collaborative conversations. Worked with Local Joint Commissioning Groups to use the outcomes framework to articulate local activity needed and funding intentions. Used the outcomes framework to inform a transparent grants programme to mobilise supporting VCFS activity.

Key milestones for 2022/23

- **ASC Digital Front Door** - Conclude the implementation of tools and systems to support the digital front door - Q4
- **Motivational Interviewing** - Complete roll out to front-line ASC staff - Q2
- **Reablement** - Implement integrated reablement model, review CRS and new Electronic Call Monitoring (ECM) system - Q4
- **Communities and Prevention** - Test at-scale delivery proposal for a) increasing employment amongst those with additional needs, b) peer health and wellbeing champions for people with Learning Disabilities or Autism, and communities which experience health inequality and c) maximising use of social value in ASC - Q4

Enabling You With Technology

Key Deliverables
• **ASC and self-funder technology enabled care offer (including remote monitoring and reporting)** - Designing a universal digital health and care monitoring offer, using a Trusted Advisor model, to support people with eligible social care needs that can also be purchased by self-funding Surrey residents. Using motion and temperature sensors amongst others, it monitors trends and provide alerts to carers and a monitoring centre that enable practitioners to right size care and support and trigger reminders such as a need to hydrate and increase movement. **Phase 1** started in Mole Valley in January 2021 and ended in July 2021, testing the viability of the service. **Phase 2** commenced in August in MV then was extended to Reigate and Banstead and Tandridge in September to test the scalability having identified the cohorts where it works best, with a particular emphasis on Discharge to Assess. **Phase 3** will be the development of a self-funder offer to include a mobile wellbeing and response service and is planned for January 2022. Discussions also taking place with Epsom and Ewell to join the pilot from January 2022. • **Rapid hospital discharge service** - Rapid hospital discharge enabled by an efficient kit dispensary service- alarm device and key safe. This commenced in December 2020 and is ongoing. • **Learning Disability & Autism (LD&A) solutions** - Investigate digital solutions to support people with a diagnosis to be more independent. Handicalendar pilot went live in May 2021, testing an app that supports people to be organised. Another solution, Just Roaming is also being explored for use in supported living or sheltered accommodation and expected to 'Go Live' in January, subject to approval. • **Mental Health TEC offer** - Explore technology solutions to support mental wellbeing. • **Wellbeing Response Service** - Pilot a comprehensive Well-being and Falls Response Service model to provide a wraparound service that responds to falls 16-hours 365 days of the year within 45 minutes, provides wellbeing calls and links people to local community services as required and offers a falls prevention service. Planned for January 2022.
Progress to date
• **ASC and self-funder remote monitoring and reporting offer and Rapid hospital discharge service** - Phase 1 of the Frailty pilot, a 6-month trial to prove the viability of remote monitoring and reporting sensors and a kit dispensary service, has been completed. This was delivered in partnership with Mole Valley Life to test a new preventative and proactive offer for people in the Mole Valley Reablement Service. This was quickly extended to the Mole Valley Locality Team in March, due to high demand, for people on a Discharge to Assess pathway. We have since been trialling a kit dispensary service and remote monitoring technology with these cohorts. This initial phase targeted a wide range of users to explore where the technology was most beneficial. Several significant benefits to using the technology were identified as a result, including:

- Supporting the assessment process to help right-size packages of care (people are often discharged by clinicians with excessive support and families are reluctant to agree a reduction in support)
- Monitoring a person at risk and allowing us to intervene proactively.
- Providing reassurance to an anxious person/family.
- Working alongside reablement goals to evidence achievement

The pilot has been hailed by staff and individuals using the service as beneficial with some high-cost packages reduced and individuals and their families feeling reassured as they are able to assume more independence. For example, in one case the individual was able to remain in his home where residential care had been initially considered, he was subsequently given 9-hour care on discharge but with TEC this was reduced to 1.5 hours a day which has enabled his independence and reduced the anxiety having a carer for half a day was causing. In another case a gentleman with medical challenges, that moved in with his mother in her 90s, has been able to return to his home after TEC was installed and he was supported to use it so he can check on his mother's safety.

- **Learning Disability & Autism (LD&A) solutions** - 9 people are currently using the HandiCalendar app as part of a 1-year LD & A pilot, delivered in partnership with Surrey Choices. The calendar app enables their independence by embedding organisational skills and allowing family members and carers to remotely monitor how individuals are getting on with their tasks. This has been slow to take off due to the pandemic, with day centre visits reduced. In the next few months there is a drive to grow the numbers to 30.

Key milestones for 2022/23

- Phase 2 Frailty Pilot ends - Q4
- Phase 3 Self-funders pilot 6-month evaluation - Q2
- Website development - TBC
- Phase 4 - Pilot remote monitoring and reporting offer in Epsom and Ewell - TBC
- Wellbeing & Response Service pilot ends – Q4
- Just Roaming- LD&A 1-year pilot- 6-month review – Q2

Evaluate In-House Services

Key Deliverables
• **Evaluate the future of in-house residential care homes for older people** - A public consultation was launched on 11 October 2021. Feedback will be considered by Cabinet in early 2022 and subsequent decisions implemented. • **Evaluate the future of in-house residential care services for adults with a learning disability** - Planning for a public consultation on the future of residential care and supported living services to be undertaken in 2022. Feedback will be considered by Cabinet and subsequent decisions implemented. • **Review of care provision to current extra care services** - Review of services provided by the council to residents currently living in 'extra care' settings owned and operated by partner agencies. Feedback will be considered by Cabinet and subsequent decisions implemented.
Progress to date
• Groups were established and began planning for transformational change in 2020/2021. Work did not progress as planned due to the COVID-19 pandemic. The pandemic has significantly impacted on initial programme timeframes as council and partner resources were focussed on supporting Surrey residents through the pandemic. The planned public consultation regarding in-house residential care homes for older people was rescheduled to a time when it was felt that care home residents could be supported by families and relatives. Consultations regarding other services will take place in 2022. • Planning has continued in the background and all three areas of the programme have progressed to timelines that have been reviewed and realigned to meet the changing requirements of the COVID-19 pathway. • Financial investment to date has and, if agreed, will continue to enable the Service to operate in accordance with regulatory requirements and enable experienced staff to plan, oversee and respond to questions that arise from public consultations. • Investment provided through the Transformation Programme for the in-house older people's care homes is critical to the success of the whole programme. Funding has enabled Service Delivery to absorb the additional requirements of managing the learning disability and extra care workstreams. • In September 2021, Service Delivery supported 173 residents living in care homes for older people, 86 adults with learning disabilities, 44 living in residential care settings and 42 in supported living. The Reablement service also provided approximately 4,000 individuals with care in their own homes. • Service Delivery employs more than 1,000 staff, over half of whom could be subject to redundancy or TUPE arrangements dependent on decisions made by Cabinet and the Adult Leadership Team in 2022. In this scenario, the Council would seek to redeploy as many staff as possible.

- Additional resources will be required to ensure all residents and their families and staff are communicated with and supported in a timely way during planned public consultations and in implementing the outcomes of Cabinet decisions.
- Should a decision be taken by Cabinet to make changes to any of the existing services, the support currently funded through the Transformation Programme will be instrumental in enabling outcomes to be successfully delivered.

Key milestones for 2022/23

- OP Services Residential Care Homes - Cabinet decision in Q4 21/22
- Services for Adults with a Learning Disability
  - Arundel - Cabinet decision in Q1 22/23
  - Langdown and Rodney House - Move from residential care to supported living - new arrangements in place Q2/3 21/22
- Extra Care Services – detail project plan developed Q4 21/22

Learning Disability & Autism

Key Deliverables
Strengths-based reviews • Continue reviewing activity to ensure an 80% review target is reached in 2021/22 (from a baseline of 60.2% in March 2021) and all overdue reviews are completed in line with Care Act duties and individuals have strengths-based support plans. • Communities and providers will be better equipped and supported to deliver care and support in an individualised way that meets outcomes to support and maintain independence – partnership and collaborative working will ensure longer term benefits. **Strategic shift to independent living** • Continue moving people on from residential to more independent or supported accommodation, making sure efficiencies are achieved and people live as independently as possible. • Specific targeted work will support people to move back into Surrey from residential placements out of county to more independent living, closer to their families. **Modernising Day Services** • Continue modernising the day services to provide opportunities within a community setting with a vocational focus for people with LD&A • Alternative day opportunities and how people travel to these will also be modernised **Transforming care & modernising services** • Transforming Care project will work to support the reduction of people with LD&A occupying inpatient beds this number currently sits around 25 cases • Development of a new OT service will enable specialist OT provision for those with Learning Disability & Autism. • Embed and the specialist reablement offer to help equip people to gain skills for independent living. • Health Facilitation to ensure people with LD&A get access to universal healthcare, building integrated working to bring further improvements and better working with health partners, better integrated services, new models of working with health and efficiencies targeted work.
Progress to date
LD&A is a 5-year transformation programme (2022/23 will be year 4) that will ensure that the Learning Disabilities & Autism services are modernised, to embed strengths-based practice, right size existing packages of care, review all overdue packages of care and support people to move out of residential care, into more independent or supported living. The programme has been successful in its first full year reaching and exceeding its 55% reviewing targets for the last financial year with only 28% of reviews completed in July 2020 rising to 60.2% in March 2021, this contributed £832,209 of efficiencies.

Work to move individuals from residential to independent living was slowed by the covid 19 pandemic. However, the moving on team has successfully worked with 19 individuals on new independent/supported living opportunities to date. Despite the pandemic challenge the team has undertaken a lot of work in the background to prioritise and plan for potential moves which are scheduled for autumn/winter 2021. Over the next 5 years there is a target to move 500 people from residential to supported or independent living and a sustained team will be needed for the duration of this work to support the operational team to deliver the ambitious targets. Work has also been started to identify those placed out of county who may wish or benefit from moving back to Surrey to live closer to family and become more independent. Our baseline in September 2020 was 64.5% adults with a learning disability category with an independent living status, with the figure currently sitting at 73.2%.

Work with Surrey Choices on a journey to modernising day service is underway, with improvements and efficiencies being established by right sizing of care packages, providing more appropriate day opportunities and improved travel options. This workstream delivered £1.25m efficiencies in 2021/22.

Planning has started to establish a new Occupational Therapy (OT) service. This, working alongside a new reablement offer for people with LD&A went live in July 2021 and will enable more people to live independently. We have already started to increase the use of technology to enable people to live more independently.

Key milestones for 2022/23

- Strengths-based reviews - overdue reviews completed Q4
- Strategic shift to independent living - people have potential continue to move into supporting independent living - Q4
- Modernising Day Services - new day opportunities and employment explored for priority people - Q4
- Transforming care and modernising services - reduced the numbers of occupied inpatient beds - Q4

Market Management

Key Deliverables

• **Market Position Statements** - Development of a Market Management Strategy, including Market Position Statements for all categories, taking into account the demand of balancing strategic and local requirements.
• **Residential/Nursing Strategy** - Development of the residential and nursing strategy to include market shaping, reviews of in-house provision and the development of a dynamic purchasing system (DPS).
• **Market Management Systems** - Commissioning of a systematic strategic purchasing tool /arrangement for residential, nursing, and supported living (MH &LD). An enhanced intelligence capacity will enable us to drive up quality standards at the same time as facilitating greater consistency across the service. The system will be co-designed with stakeholders to deliver the following functions:
  ○ Quality Assurance
  ○ Contract Management
  ○ Digital Brokerage
  ○ Provider Portal
  ○ Market Management/Insight
• **Central Brokerage Function** - To redesign the brokerage function to provide both brokerage and market oversight capability across the full range of ASC services.

Progress to date
Residential/Nursing • Developed the older people's strategy and commissioning intentions and agreed the market management approach to residential and nursing care for older people with work underway to do the same for Learning Disabilities (LD), Mental Health (MH) and Physical and Sensory Disability (PSD). The older people's strategy is due to be signed off by Cabinet in November 2021. • Completed the pricing strategy, which has been signed off by ALT, and have agreed the market management approach to residential/nursing care as well as the approach to choice guidance, capital threshold, third-party agreements and deferred payment agreements. All of these have been signed off by ALT. • Completed self-funder checklists to inform residents on residential /nursing care of finance options. • Updated the website and third-party guidance for residents. • The tender documentation was launched in December 2021 which includes the pricing schedule, specification and placement protocol • We will also agree the long-term pricing strategy for residential nursing during this phase and the brokerage approach for placements. **Market Management Systems**

- We have completed an analysis of the market management systems requirements in respect of:
    - Quality Assurance
    - Contract Management
    - Digital Brokerage
    - Provider Portal
    - Market Management/Insight
- The next milestone is to take part in an ASC 'Digithon' in December 2021 to determine the way forward eg development of an 'in house' model or the commissioning of an external provider such as the London Management Information Tool.

Central Brokerage Function

- Redesigned the central brokerage function as a brokerage and market oversight function and secured agreement to recruit to the 'new' posts that will provide us with capacity to deliver this.
- The next stage will be to integrate the new roles into the team to deliver the full range of functions for e-sourcing including Learning Disability, Mental Health and Physical and Sensory Disability.

Key milestones for 2022/23

- Central Brokerage Function - tender for a new system Q1
- Market Management Systems - evaluate and purchase a market management insight tool and/or develop in-house systems Q1 and Q2
- Residential/Nursing Strategy - new DPS contract goes live Q1; full understanding of requirements for DPS go live for *all* adults in April 2023 Q3

Mental Health

Key Deliverables
• **S117 joint review programme with health partners** - A dedicated joint s117 review team as a central resource to ensure ASC and health compliance with statutory duties under the Mental Health Act by supporting health and ASC to increase the rate, quality and timeliness of s117 reviews. • **Robust and tested improved s117 business processes -** A central library of resources (policies, case studies, processes), knowledge and information for reference by all relevant workers to support sustainable learning and consistency of practice. • **Robust and tested data management and reporting systems** - Influence the development and effective use of s117 data management and reporting systems. This will enable confident reporting, monitoring and management of s117s both within the organisation and as a system.
Progress to date
• **Service model and structure** - Implemented a management model that supports an increased focus on strategic work with local accountability for performance and the delivery of a safe and effective service. - the implementation of permanent ASC mental health Hospital Discharge and Duty teams to support effective pathways and flow between health and social care. - embedding of a strengths-based approach eg building Occupational Therapy capacity and developing a Mental Health Reablement service. • **Data reporting and performance data** – development of improved reporting systems. • **Improved interface between services** - development of some joint working principles for a more seamless approach to responding to people with both mental health needs and learning disabilities / autism. • **Training & Development** - reviewed and in process of implementing the essential Mental Health staff training matrix. Training will be delivered to all ASC mental health staff. Training to date has focussed upon compliance with the Care Act, other social care legislation and using ASC systems. Training planned for 2022 will include Mental Health awareness, hoarding, personal safety and de-escalation, lone working, risk assessments and refresher training on the Care Act, safeguarding and S117. • **Housing, Accommodation & Support** – joint work with Boroughs and Districts Housing services and Surrey & Borders Partnership Trust (SABP) to refresh the joint Surrey Mental Health Housing protocol ready for relaunch. • **Co-production with people with lived mental health experience** - has been informing service improvement. • **Hospital flow** - continued work with SABP and CCG colleagues to develop a strengthened mental health hospital pathway to support admissions avoidance, create better bed flow and reduce current, significant system wide pressures. This work now feeds into the

Surrey Mental Health Improvement Plan. This is a plan that has been issued by the Surrey Mental Health Partnership Board and which has been supported by Heartlands and the Surrey Health & Well Being Board.

- **Section 117 Aftercare** - developing consistent and sustainable long-term ways of working as a system, improved recovery-focussed outcomes for the individual and risk reduction around the management of s117 Aftercare in Surrey.

Key milestones for 2022/23

- Transition to BAU for most elements of the ASC Modernising Mental Health Programme – Q1
- S117 joint discharge policy in place and s117 clients no longer eligible for aftercare will begin to be reviewed and discharged as appropriate - Q1
- A definitive way of tracking s117 completed reviews - Q1
- Majority of ASC frontline staff have received s117 training - Q4
- Final report to ASC on how to manage s117 as business as usual - Q3

Conclusions:

12. The ASC transformation programmes are making steady progress towards delivering transformational change. All the programmes have been impacted to some degree by the Covid-19 pandemic and plans continue to be adjusted to deliver in different ways.

Recommendations:

13. Members of the Adults & Health Select Committee are invited to note the update and to raise any challenges they feel appropriate.

Next steps:

14. Continue work to deliver the milestone planned for 2022/23.

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Sources/background papers:

- Adult Social Care Bespoke Peer Review, September 2018
- Adult Social Care Directorate Plan 2021/22
- Adult Social Care Investment Bids for 2022/23

Case Study – Accommodation with Care & Support – Extra Care Housing and Supported Independent Living

This short film provides an indication of how we plan to deliver affordable Extra Care Housing to support older residents in Surrey to continue to live independently for longer.

- Promotional material for the Extra Care Housing Strategy. Affordable Extra Care Housing in Surrey (accessible version) - YouTube

This short film provides an indication of how we plan to deliver Supported Independent Living in Surrey

- Promotional material for the Supported Independent Living Strategy. Supported Independent Living in Surrey - accessible version - YouTube

Case Study – Care Pathways - Adult Social Care Webchat

Background

The Digital Front Door project will identify digital tools and system improvements that will help to manage service demand and enable social care staff to focus on those people in need of support from Adult Social Care. The project consists of multiple streams covering the different areas of Adult Social Care activity.

What we did

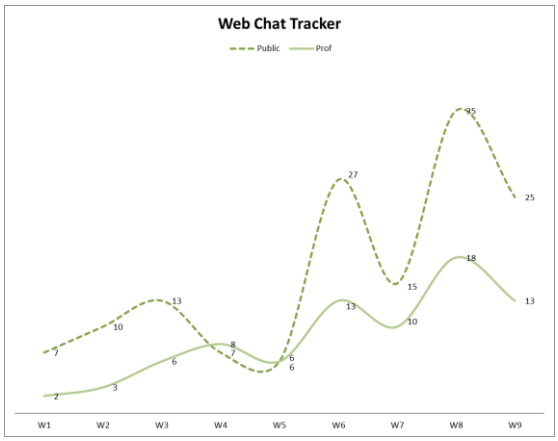
The ASC digital front door may be improved using digital tools that are already in use within SCC. The stream looking at optimising web content is driving to better answer questions online, rather than using other contact routes.
This is being initially tackled in two ways, firstly changes to the Adults Social Care webpages, based upon feedback and data. This will make information more accessible to residents and easier to navigate. Secondly a trial, using the existing Surrey webchat function, was run to understand the benefits of webchat and type of enquiry made. The goal was to keep customers online and answer queries first time, rather than use alternative communication methods. Webchat is an interaction with a real person, not robotic responses. A key benefit of using webchat is that a contact centre agent can handle more than one enquiry at once and can also be doing other work when there aren't any webchats happening.

Pilot

A selection of the ASC webpages were identified as places that could result in questions resulting in a call to the contact centre. These were added to the webchat function. We reconfigured this to work with two teams (the existing general enquiries and the ASC Contact Centre). We initially planned to run the pilot for two weeks, however this was extended to 2 months by working in an agile manner, making a series of changes and improvements to gain valuable usage data.
The change that created the largest impact was to add a photo to the webchat button rather than having the Council logo. It was felt that this would have a more human touch. One of our supervisors Kim agreed to have her image used as the face of ASC Webchat.

Results

- The webchat usage grew throughout the period
- 2/3 of contacts were made by the public
- 1/3 by Health and care professionals
- Over 95% of contacts were kept online without a follow-up call
- A very small number needed an immediate call back
- A limited webchat function has been maintained on the "Contact Us" page



Future

Following the pilot we have agreed that Webchat will be introduced to the appropriate ASC webpages as a business

Case Study – Care Pathways – Communities and Prevention

The Communities and Prevention Team have run a small grants programme to mobilise community-led support and empower communities to act on the issues that matter to them. Two organisations to benefit were Space2Grow and Be My Hope.

Space2Grow

Space 2 Grow is Farnham's community wellbeing garden set up to benefit the mental health and wellbeing of local people through horticulture and conversation. Using their acre of land, they offer a range of activities run by a combination of volunteers and paid staff, some open to everyone and others by referral to support people with a higher level of need.

They received a small grant from Adult Social Care's Supportive Communities Fund to support their new shed project and the increase in demand they have seen since the pandemic started.

Working in partnership with Transform Housing to support men experiencing mental ill health and homelessness, Space2Grow have begun a "**Men in Sheds**" style programme. This supports the health, wellbeing, and skills development of those involved. They shared progress on their project…

"The new shed for Men in Sheds was purchased in November, with the help of the Supportive Communities Fund. The men have just begun working away in their new space!

The men have created and delivered an outdoor wooden storage community cupboard for Hale Community Centre as part of their 'Fridge and Cupboard' food-waste reduction scheme. A fantastic scheme which is open to all to donate, share and swap food items, reducing waste and, importantly, giving vital access to those in need over the Christmas period.

And new tools have been purchased for use by the many local people who are isolated and alone and who have found working in the space2grow garden a lifeline during lockdown, as evidenced by the feedback from our referrers."

Gardening groups are a core activity at space2grow and demand has grown since the pandemic began. Space2grow groups have increased from twice weekly to daily and the numbers attending each session is growing all the time as they receive direct referrals from a range of organisations supporting vulnerable people, including social prescription services.

To support this increase in demand, they needed some new gardening equipment (wheelbarrows and hand tools) and some spring flower bulbs. They received a small grant from the Supportive Communities Fund to create a new **community garden pond**. They shared their progress…

"We continued through the cold start to 2021 and muddy ground didn't stop planning work on the pond project. The site resembled an archaeological dig as earth was gently moved in search of the edge of the pond liner. Work continued this week on clearing the area behind the pond with some unusual discoveries of some old carpet and a rusty metal trailer frame! For other volunteers some general weeding and pruning was their activity of choice."

Space2 Grow received the following feedback from one organisation who prescribes their services

"On behalf of Welcome to Volunteering and the wider Voluntary Action South West Surrey team we would like to send our heartfelt congratulations to everyone at space2grow for winning Jeremy Hunt's South West Surrey Heroes Award - really well deserved!

Welcome to Volunteering have a long-standing relationship with space2grow and have had the pleasure of seeing several volunteers blossom there over the years. The thing that makes space2grow a unique place to be is that all volunteers are valued whatever their background or experiences. The contribution they make to the acre is always appreciated and their ideas for future development listened to and nurtured.

"Whatever the time of year the kettle is on and there is always a friendly face on arrival. As those reading this who have worked with us will know we always describe it as the 'secret garden', much like the book, as you walk through the large wooden door you leave your troubles behind you and the healing power of being out in nature and in good company begins."

Be My Hope

Be My Hope is a community group that aims to promote social inclusion and wellbeing among individual of Black-African and Minority Ethnic (BAME) groups across Surrey who feel excluded from society due to cultural differences, social or economic circumstances.

In the past few years, the community group has been self-funded from volunteers' personal resources and could only work with a few people. Prior to Covid-19 pandemic they were aware that many people from the BME community faced a variety of difficulties, so started making plans to expand and cater to more people.

Since then, they kept hearing how Covid-19 was worsening existing problems and/or introducing new ones. So, using a small grant from the Supportive Communities Fund, Be My Hope, began helping people through support groups, 1-2-1 emotional support meetings or phone/video calls and practical assistance. They also conducted a research project to consider the impact of Covid-19, as well as issues that may have presented beforehand too.

As a result, they were able to support 78 clients and their families across Surrey.

Case Study – Enabling You With Technology

Pioneering home sensors help people live independently for longer | Surrey News (surreycc.gov.uk)

Hi-tech sensors fitted in everyday objects around the home are enabling older people to live independently for longer as part of a pioneering scheme in Surrey.

The County Council teamed up with Mole Valley District Council to trial the use of a revolutionary home monitoring system which can help identify early warning signs of declining health or mobility and help prevent falls.

Sensors fitted to appliances such as kettles and fridges are used to monitor movement and daily routines in a discreet way without the need for cameras or microphones, with all the information fed into a central dashboard which is monitored by an alarm receiving centre (ARC). If subtle changes are detected which may indicate something is amiss, the individual, their family and health or care worker is alerted.

The trial scheme involving 53 residents in Mole Valley proved so successful at enabling greater independence and providing reassurance to families that the pilot has been extended to two further Surrey areas, Tandridge and Reigate and Banstead.

The findings from the expanded pilot will then help to roll out the technology to other parts of the county and also enable people who fund their own social care to gain access to the system. Self-funders would be able to purchase the devices and a subscription to monitoring services.
Sinead Mooney, Surrey County Council's Cabinet Member for Adult Social Care and Health, said: "This is a really exciting development in our use of new technology to help residents with daily living because it enables us to be proactive about picking up on problems and preventing them getting worse.

"For some time in Surrey, we've been using technology to help keep people safe at home – such as alarms to call for help if needed – but this system which analyses information from a network of smart gadgets around the home takes that to a whole new level.

"Now that we've tested the technology with our residents and staff, working with our trusted and forward-thinking partner Mole Valley District Council, we can really see how it supports people to live independently in their own homes and reduces the need for them to go into residential care or be admitted to hospital.

"Feedback from families has been really positive too because they've been able to check in on their loved ones remotely which has given them reassurance they are safe at home.

"The service is intended to enhance and complement face-to-face care and is one of a number of ways in which we're looking to harness technology to transform and modernise care for the benefit of our residents."

For the scheme, the County Council partnered with Mole Valley Life, the district council's technology enabled care service. Councillor Caroline Salmon, Cabinet Member for Community Services at the district council, said: "Through our team of Trusted Advisors and our Alarm Receiving Centre in Leatherhead, Mole Valley Life promotes independence and dignity providing solutions to people who may require assistance in their everyday lives. Offering professional, in-house support and advice, our friendly and dedicated teams draw

on our 35 years' worth of experience to ensure that people feel comfortable with new technologies and remain connected to their communities.

"This initiative, delivered through the Mole Valley Life team, is a leap forward in both: allowing our most vulnerable citizens to feel that they can stay safely in their homes, and in providing reassurance to families who can't be with them 24 hrs of the day. I hope that our partnership with the county and neighbouring councils will support many more residents to live safe and well at home for longer."

The pilot scheme began in January and worked with people who were becoming frail or had recently been discharged from hospital.

Using technology from data and analytics company Cascade3d, a network of sensors and smart plugs was installed in their homes and linked to a dashboard which is monitored around the clock from Mole Valley's alarm receiving centre (ARC) in Leatherhead.

In one example of how the technology helped a resident, the system flagged an increase in frequency of visits to the bathroom outside the normal routine of the person, raising concerns of a urinary tract infection. The community nurse confirmed the diagnosis and secured antibiotics, probably avoiding a return to hospital for the resident.

This pioneering technology can be complemented by more traditional Technology Enabled Care (TEC), such as a falls detector, which when activated, will send an alert to the ARC which will be able to escalate the finding in line with the individual's care plan, speeding up help and support.

Sue, whose mum has had the system installed said: "Mum wants to be in her own home as long as possible and we want the same. It's put my mind at rest a lot, just to know that mum's safe. I think it would suit a lot of people." Watch the family's story here

ADULTS AND HEALTH SELECT COMMITTEE

14 January 2022

Joint health and social care dementia strategy for Surrey (2022-2027)

Purpose of report

This report presents the joint health and social care dementia strategy for Surrey (2022-2027) for the Committee's views and input during the consultation period, which runs until 21 January 2022.

Introduction

1. This joint health and social care dementia strategy has been developed in light of local and national strategies that impact on the wellbeing and independence of people with dementia and their unpaid carers. The Dementia Strategy Action Board in Surrey, which was formed to implement the previous strategy, agreed it was timely to refresh existing dementia strategies and make one Surrey wide direction of travel, with a clear focus on tackling inequality and making sure no-one is left behind.

2. We have listened to people in Surrey who have dementia and their families and carers, to help us understand how Surrey can be a better place to live and how we can deliver better quality services for people with dementia and their carers. We have also listened to the views of staff and organisations that care for them.

3. This strategy sets out the collective ambitions we want to achieve across Surrey to improve the dementia care pathway. In developing this strategy, Adult Social Care in Surrey County Council, Surrey Heartlands Clinical Commissioning Group and Frimley Clinical Commissioning Group have worked with people with dementia and their unpaid carers, organisations that support people with dementia, their staff, the local voluntary sector and other partners.

4. The strategy provides the chance to reaffirm our commitment and determination to help people with dementia and their unpaid carers, to support their health and wellbeing by achieving outcomes they have identified matter most to them. The strategy has been developed in collaboration with Healthwatch Surrey to provide a baseline of people's experience of living with dementia in Surrey.

Background

5. The Surrey Dementia Strategy Action Board ('the Board') was formed in 2019 to deliver the previous dementia strategy. The Board has a clear vision for every person with dementia, and their unpaid carers and families, to receive high quality, compassionate care along the dementia pathway from pre-diagnosis through to end of life care. This applies to all care settings, whether home, hospital or care home.

6. The Board agreed we must now become more focused on tackling inequality and access to services and making sure no-one is left behind, as we know people with dementia and their unpaid carers and families can face multiple challenges in living and ageing well.

7. To ensure there is parity of esteem across Surrey we have brought together and refreshed the two existing dementia strategies; one covering Surrey Heartlands and East Surrey and one for Surrey Heath. In the new strategy, we have been able to celebrate progress made and outline areas for further development across Surrey.

Developing the strategy and our ambitions

8. The Mental Health Delivery Board and the Health and Wellbeing Board approved the development of one joint dementia strategy for Surrey, welcoming the focus on reducing inequalities and making sure no-one was left behind.

9. The strategy has been developed based on the national and local strategic context, qualitative data and feedback and performance of current services. It is framed around the well pathway for dementia which is available in Annex 1. The voices of people with dementia, their unpaid carers and families have been central to the development of the strategy.

10. Throughout the consultation period, from 7 December 2021 to 21 January 2022, we are seeking views on whether we have captured the right ambition, and the most important priority areas to be included in the Surrey five-year joint health and social care Dementia Strategy. The draft strategy is available in Annex 2.

Our ambitions

11. Preventing well: our aim is to continue to raise public awareness and activities around dementia and the actions people can take to prevent dementia. Priorities include:

    i. Develop consistent public health messages around how to prevent dementia

    ii. Prioritise a focus on reducing inequalities

    iii. Ensure we have accessible material for people e.g. Easy Read or a video to enable people to access the information they require

    iv. Enhance post diagnosis health support for people diagnosed with a mild cognitive impairment

    v. Increase early identification of carers of people living with dementia.

12. Diagnosing Well: our aim is for people to have equal access to dementia care; understanding where communities may not be accessing dementia diagnosis and post diagnostic support. We will address the inequalities and gaps in service with partners to overcome barriers. Priorities include:

    i. Make sure dementia navigators are equally available to meet the needs of people across Surrey

    ii. Support the Dementia Connect service which has a keeping in touch contact service for people and their carers following diagnosis which provides access to the service 7 days a week via telephone and website

    iii. Increase access and uptake of baseline assessments for people with Down's Syndrome

    iv. Make sure people in East Surrey have access to a new dementia practitioner who will work with others to improve dementia diagnosis rates in the community

    v. Ensure adequate immediate post-diagnostic support for individuals and their carers and families is available.

13. Living Well: our aim is to make sure everyone has the opportunity to live life to the full following diagnosis. Priorities include:

    i. Focus on establishing dementia friendly communities and dementia action groups across all areas of Surrey

ii. Have more robust and consistent post-diagnostic support for individuals and their carers and families

iii. Consider full roll out of the technology integrated health management system (TIHM) and related technologies across Surrey for all people and their families

iv. Have dementia day support for those with young onset dementia

v. Have a young onset dementia accommodation with support offer.

14. Supporting Well: our aim is to engage with our communities and faith groups to ensure we reach out to people with dementia and their carers. Priorities include:

i. Include information on the Alzheimer's Society website regarding local resources to ensure people have access to the range of support groups that are available across Surrey

ii. Expand crisis support available for people with dementia and their carers and families

iii. Routinely identify carers and have regular monitoring of the caring situation so carers have access to carers assessments and reviews

iv. Have care within in the home available to enable people with dementia to have personalised care and support, and give carers a break

v. Have small scale specialist dementia residential and nursing care available to meet a range of needs.

15. Dying well: our aim is to make sure care is coordinated to enable the person with dementia to live their life as independently as possible until their death. To enable this, we endorse the 6 ambitions from the end of life care strategy. Priorities include:

i. Everyone is seen as an individual, with care tailored to meet their needs and wishes

ii. Everyone has equal access to palliative and end of life care

iii. People are made to feel comfortable and their wider wellbeing needs are met

iv. Care is coordinated, with different services working together

v. Staff have the skills and knowledge to provide the best care

vi. Communities come together to provide help and support.

Initial feedback on the strategy from Adults and Health Select Committee

16. During agenda planning, the Adults and Health Select Committee Chair and vice Chairs reviewed the draft strategy; comments and clarifications are outlined below and will form part of the formal strategy consultation feedback. Page numbers refer to the joint health and social care dementia strategy for Surrey (2022-2027) that is currently out for consultation.

i. Page 6: The contract variation with Alzheimer's Society Dementia navigator service is due to be signed shortly. This will enable the provider to flex capacity to meet demand rather than by postcode as was the case historically.

ii. Page 6: Continuity of care means a single journey of care for the individual and their carer (s) without hand offs between providers: an integrated approach to care.

iii. Page 7: What is being done to level discrepancies between Surrey Heartlands and Surrey Heath/Frimley? This will be included in the strategy action plan. Identifying variations reinforces the importance of taking a strategic overview of Surrey as whole, so differences between integrated care systems can be monitored, and actions progressed to improve performance.

iv. Page 13: In East Surrey, the new enhanced practitioner role is currently being advertised and there is interest in the post. This new role will provide parity of esteem with the rest of Surrey for people with dementia and their carers.

v. Page 14: What is the methodology for reaching Black and Minority Ethnic (BAME) community? Three South East Asian workshops were held with key stakeholders, service users and carers explaining how to engage with BAME communities. The learning from the South East Asian workshops is being replicated with other BAME groups through different media campaigns with the aim to reduce inequalities of access.

vi. Page 14: To provide more information, a learning disability update will be presented to the January 2022 Dementia Strategy Action Board, so more detail will follow after that date. The Learning Disability Partnership Board

is also engaging in the strategy consultation at their meeting in January 2022.

vii. Page 15: Three delirium educational webinars were delivered to hospitals, care home staff, primary care and community staff to improve the understanding of how delirium can affect a person with Dementia. Evaluations demonstrated that there was an improvement in knowledge for participants.

viii. Page 17: Qualitative feedback has indicated that there is a gap in specialist provision for people with dementia in the residential and nursing care home market. The new tender opportunity for residential and nursing care, a joint approach with health, has now gone live. These new arrangements will be in place from May 2022 and will mark a significant change in how we work with NHS colleagues, the care home market and how we purchase care and support for Surrey residents. This will provide the opportunity to stimulate the market to develop the provision we need now and into the future.

ix. Page 20: Partners that would be involved in dementia friendly communities include: Alzheimer's Society, Age UK Surrey, Borough and District councils and all statutory partners support this development. A pilot is to run in Mid Surrey with results being shared across other areas.

Conclusions

17. Our draft strategy highlights our progress and achievements over the past 4 years and sets out an ambitious plan for further improvements, with a focus on equality of access, experience and outcomes.

18. We welcome the opportunity for the Select Committee to discuss and contribute to the new joint health and social care dementia strategy for Surrey (2022-2027). Individual responses to the survey are also most welcome.

Recommendations

19. Adults and Health Select Committee to review the draft joint health and social care dementia strategy for Surrey (2022-2027)

20. Select Committee comments and views to be included in consultation feedback, informing the final version of the strategy.

Next steps

21. Consultation closes on 21 January 2022. Survey feedback will be analysed and inform a revised version of the strategy.

22. The revised strategy will be shared with the Dementia Strategy Action Board, taken to the Mental Health Delivery Board on 25 February 2022 and to the Health and Wellbeing Board in March 2022 for final approval.

Report contact

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Sources/background papers

Healthwatch Surrey (2021) How people find advice and support to live well in the early years after dementia diagnosis

Annex 1: Well pathway for dementia

Annex 2: DRAFT joint health and social care dementia strategy for Surrey (2022-2027)

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NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA

PREVENTING WELL

Risk of people developing dementia is minimised

"I was given information about reducing my personal risk of getting dementia"

STANDARDS:

- Prevention(1)
- Risk Reduction(5)
- Health Information(4)
- Supporting research(5)

DIAGNOSING WELL

Timely accurate diagnosis, care plan, and review within first year

"I was diagnosed in a timely way"

"I am able to make decisions and know what to do to help myself and who else can help"

STANDARDS:

- Diagnosis(1)(5)
- Memory Assessment(1)(2)
- Concerns Discussed(3)
- Investigation (4)
- Provide Information(4)
- Integrated & Advanced Care Planning (1)(2)(3)(5)

SUPPORTING WELL

Access to safe high quality health & social care for people with dementia and carers

"I am treated with dignity & respect"

"I get treatment and support, which are best for my dementia and my life"

STANDARDS:

- Choice(2)(3)(4), BPSD(6)(2)
- Liaison(2), Advocates(3)
- Housing (3)
- Hospital Treatments(4)
- Technology(5)
- Health & Social Services (5)
- Hard to Reach Groups(3)(5)

LIVING WELL

People with dementia can live normally in safe and accepting communities

"I know that those around me and looking after me are supported"

"I feel included as part of society"

STANDARDS:

- Integrated Services(1)(3)(5)
- Supporting Carers(2)(4)(5)
- Carers Respite(2),
- Co-ordinated Care(1)(5)
- Promote independence(1)(4)
- Relationships(3), Leisure(3)
- Safe Communities(3)(5)

DYING WELL

People living with dementia die with dignity in the place of their choosing

"I am confident my end of life wishes will be respected"

"I can expect a good death"

STANDARDS:

- Palliative care and pain(1)(2)
- End of Life(4)
- Preferred Place of Death(5)

References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.

RESEARCHING WELL

- Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change.
- Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries.

INTEGRATING WELL

- Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care.

COMMISSIONING WELL

- Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice.
- Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources.

TRAINING WELL

- Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community.
- Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes.

MONITORING WELL

- Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each.
- Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation.

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Joint Health and Social Care Dementia Strategy for Surrey

DRAFT FOR CONSULTATION December 2021

Foreword

This joint health and social care dementia strategy for Surrey has been refreshed in light of the myriad of strategy that impacts on the wellbeing and independence of people with dementia. The Dementia Strategy Action Board in Surrey, which was formed to implement the previous strategy, agreed it was timely to refresh existing strategies and make one Surrey wide direction of travel, with a clear focus on tackling inequality and making sure no-one is left behind. This is especially important given the disproportionate impact the Covid-19 pandemic has had on those people with dementia and their carers identified in a report produced by the Alzheimer's Society in 2020.

In this strategy we are pleased to introduce our new and refreshed vision for the Dementia Care pathway, which seeks to improve outcomes for people with dementia and their unpaid carers and families. In this context, we are defining a carer as someone who provides unpaid help and support to a family member, partner, friend or neighbour. Carers include adults, parents or children and young people. They might be adults looking after other adults, parent carers looking after children with a disability and young carers under 18 years of age. Carers may provide emotional as well as physical support, including care for those with mental health concerns and addictions. Without the care they give, those benefiting from their help would find difficulty managing or may be unable to cope.

We wish for all people living with dementia and their unpaid carers to live in dementia friendly communities where they feel empowered and know where to go to seek information, advice and help. In addition, we aspire that people have access to the care and support that enables them to live well at home for as long as possible and to die with dignity.

About the strategy

This strategy sets out the collective ambitions we want to achieve across Surrey to improve the dementia care pathway. In developing this strategy, we have worked with organisations that support people with dementia, their staff, the local voluntary sector and other partners.

The strategy provides the chance to reaffirm our commitment and determination to help people with dementia, and their unpaid carers to continue caring if they are willing and able, and to support their health and wellbeing by achieving outcomes they have identified matter most to them. The strategy has been developed in collaboration with Healthwatch Surrey to provide a baseline of people's experience of living with dementia in Surrey. We have listened to people in Surrey who have dementia and their families and carers, to help us understand how Surrey can be a better place to live and how we can deliver better quality services for people with dementia and their carers. We have also listened to the views of staff and organisations that care for them.

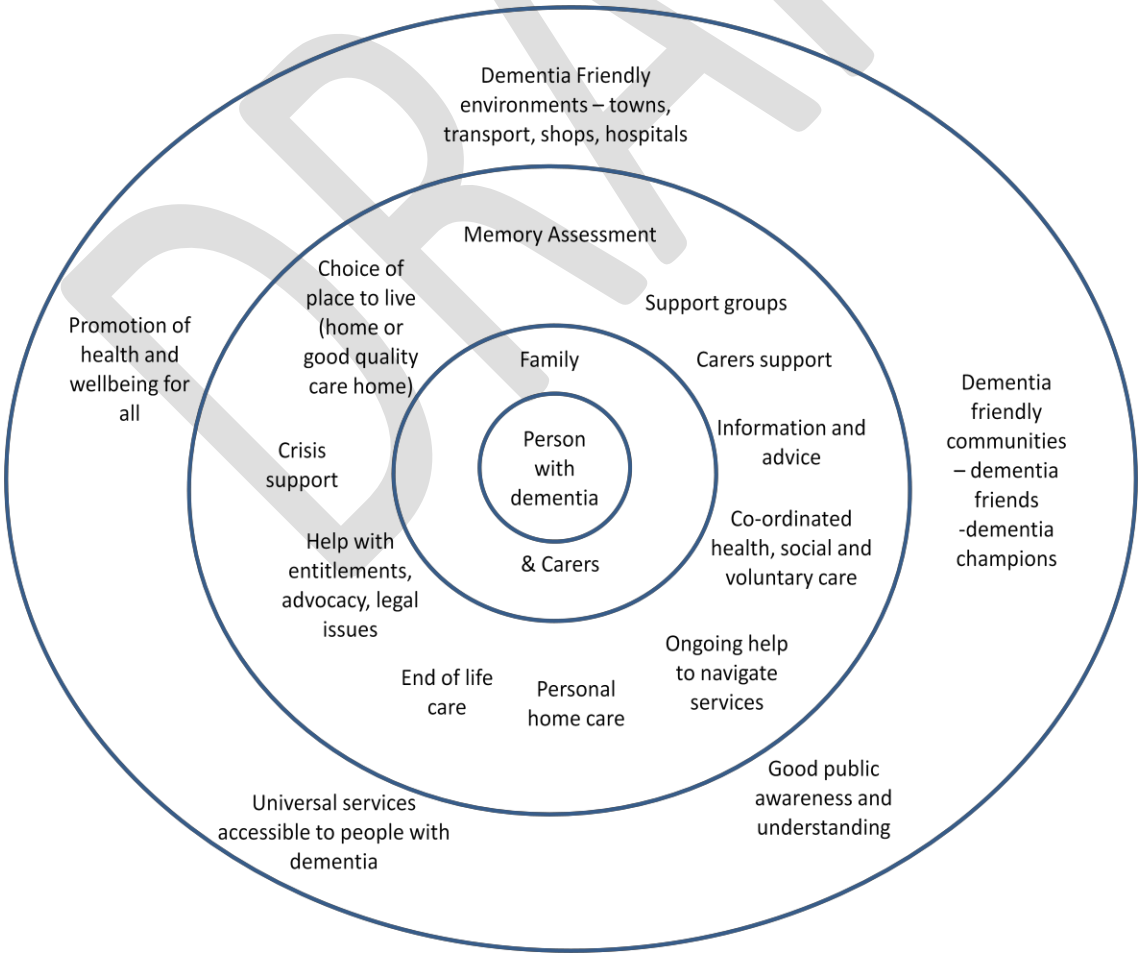
Our vision

We wish for all people with dementia and their carers to live in dementia friendly communities. They will know where to go to seek information, advice and help. They will have access to the care and support that enables them to live well at home for as long as possible and to die with dignity in their place of choice.

Introduction

Surrey County Council and NHS colleagues have worked together with local stakeholders to develop this strategy for people with dementia and their carers. Working in collaboration has enabled us to identify the changes required since the last joint health and adult social care dementia strategy (2017-2021) and set the direction of travel for our services.

This refreshed strategy (2022-2027) recognises the challenges of delivering services at scale (Surrey wide) whilst acknowledging the needs of place-based care in the towns and neighbourhoods in Surrey to ensure people with dementia and their carers receive seamless and localised care. Figure1 demonstrates support and care for a person with dementia and their carer (s).



The direction of the refreshed strategy has been led by the previous strategy and its outcomes. There are a number of national policy statements and pieces of legislation and stakeholder engagement reports that have formed its development including those listed below:

- The Prime Minister's Challenge on Dementia in 2020
- The Care Act 2014
- Dementia 'A state of the nation report on dementia care and support in England
- Alzheimer's Society reports: 'Worst hit – Dementia during coronavirus; Dementia diagnosis to end of life; Ethnic minorities increasing access to diagnosis, Hospital and care homes- increasing access to diagnostics; Report on regional variations and access to diagnostics

Alongside the national direction, local data including the views of local people with dementia and their carers together with staff and organisations involved in their care helped shape the strategy. There is a strong commitment from all members of Surrey's Dementia Action Strategy Board to make positive changes for people with a lived experience and their carers.

Currently there are many strategic developments across Surrey that impact on people with dementia and their carers and families, for example:

- Adults Social Care's commissioning strategy for older people
- The joint health and social care carers' strategy
- End of life care strategy
- Local place based integrated partnerships driven frailty and crisis response strategies
- Surrey County Council's accommodation with care and support strategy
- The joint recommissioning of Care within the Home services, between Surrey County Council and NHS continuing healthcare
- New Discharge to Assess arrangements, supporting people leaving hospital and their families/carers

These are supported nationally by the NHS Long Term Plan (LTP) and the drive for more personalisation for citizens. The LTP has also driven the development of an enhanced contractual relationship between care homes (including care homes for people with a learning disability) with General Practice and primary care through a Directly Enhanced Service (DES). This DES provides a strong base to build better support for those with dementias and help to reduce the inequalities they face.

The health and wellbeing strategy for Surrey identifies that dementia is a particular issue in Surrey as people with dementia have a higher number of hospital admissions with longer lengths of stay and higher emergency admissions compared to people the same age without dementia. To meet the health and wellbeing strategy target of reducing emergency admission rates of people with dementia from 3,272 to 2,496 per 100,000 we must do things differently.

Public Health England, Public Health Scotland and the Dementia Statistics hub clearly outline the areas of inequality faced by people with dementia, their carers and families:

- Health inequalities persist into old age and many of the risk factors for dementia are associated with socio-economic inequality such as living in an area of deprivation
- 67% of people with dementia are women, most likely because women live longer than men
- Dementia risk increases with age
- Dementia affects people with a learning disability at a younger age, and people with learning disabilities over 60 are 2 or 3 times more likely to have dementia than the general population
- The estimated prevalence rates for dementia in the black and ethnic minority (BAME) community are similar to the rest of the population with the exception of early onset (presenting before 65 years) and vascular dementia which have been found to be more prevalent
- Caring for someone with dementia puts a huge strain on the carer's physical and mental health. It can also strain, at times to breaking point, the relationships with other family members
- The majority of recipients of unpaid care are older parents or spouses and partners and changes in the make-up of our population indicate that the number of dependent older people in the UK will increase by 113% by 2051. Carers experience poor physical and mental health, but also have unmet care needs themselves
- Women are 2.3 times more likely to provide care for someone with dementia for over 5 years
- 60 -70% of carers for people with dementia are women
- 63% of carers for people with dementia are retired while 18% are in paid work. 15% of dementia carers say they are not in work because of their caring responsibilities

There are similar inequalities when looking at preventing dementia:

- Studies with the general population have shown that active treatment of hypertension in middle aged (45–65 years) and older people (aged older than 65 years) without dementia can reduce incidence of dementia
- Research suggests that interventions for other risk factors including more childhood education, exercise, maintaining social engagement, reducing smoking, and management of hearing loss, depression, diabetes, and obesity might have the potential to delay or prevent a third of dementia cases
- Some of the risk factors highlighted above are more prevalent amongst people from BAME backgrounds, people living in areas of deprivation, people with severe mental illness and people with learning disabilities

Views of local people and codesign section

During the summer of 2021 Healthwatch Surrey completed a survey and interviewed people with dementia and their carers to find out how the diagnosis and supporting well pathways had worked for them. Some quotes have been added to the body of the strategy to illustrate both good practice and gaps in the support people can access. Below is a list of the three recommendations from the report:

Recommendations

1. Build access to Dementia Navigators (or other professional/managed navigator roles). Ensure adequate resource:

    a. In every locality, iron out postcode lotteries so people in all parts of Surrey have access to a Dementia Navigator when needed

    b. For Dementia Navigators to proactively contact everyone with a diagnosis of dementia on a regular schedule (frequency to be dictated by their individual needs but may be as much as monthly or weekly at times of crisis).

2. Undertake a strategic overview of Support Groups (mapping, funding/stability); build provision in areas with weaker support; help groups become resilient; support dissemination of high-quality information through groups; provide pathways for signposting to groups.

3. Empower Primary Care to signpost effectively by providing primary care networks, GP surgeries and community care with a single point of access to signpost patients to. e.g., local navigator, Dementia Connect.

Alongside this work conducted by HealthWatch, a substantial amount of feedback was also received as part of the co-production of Surrey County Council's commissioning strategy for older people.

With regards to accommodation with care and support for people with dementia, there was positive feedback about staff within care homes. Some individuals stated that staff have a good understanding of dementia and that it was a good place for people to recover when they needed help.

Ensuring the right home is selected in the first place, one that offers the right training for staff and support for residents, was regularly raised along with other suggested improvements for the sector. These included the need for more specialist care homes, dedicated to those with higher needs or advanced dementia. There was a clear gap identified around dementia support for care homes, training for staff and support from community teams for residents that have high needs.

Other feedback focused on the need for a person-centred approach for everyone, with better communication and more activities to offer a better continuity of care for residents.

Specific engagement work has also been conducted by Surrey County Council on day opportunities. This survey, enhanced by qualitative interviews conducted by HealthWatch Surrey, highlighted day activity, such as day centres, played a valuable role in supporting people with dementia and their carers. However, there was not an equitable offer across Surrey and transport to the centres could be challenging.

What is clear from both local feedback and the national picture is that a whole system approach to support people with dementia is essential, whether this is supporting care homes and other providers of dementia services or enabling unpaid carers to have a break from caring.

In addition, we have linked up with Alzheimer's Society to establish a local Dementia Voices group that will ensure we understand the views of people with dementia and their carers when implementing service transformation.

Public health data

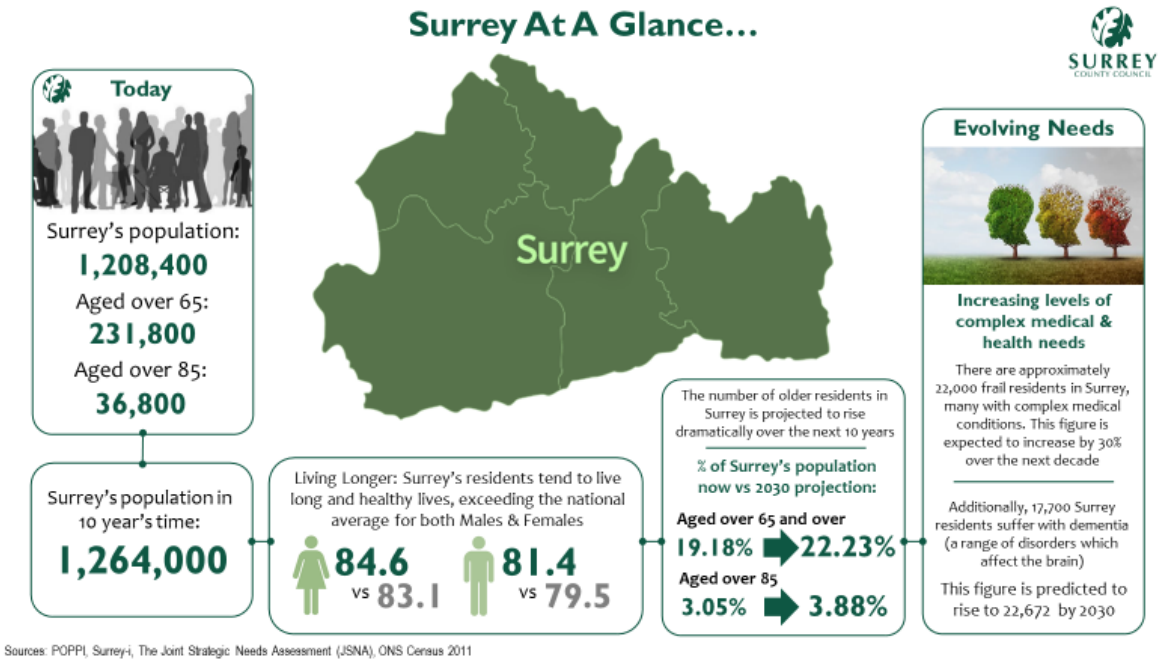
Data for Surrey Heartlands and Surrey Heath is available on a national level. This data indicates performance on the key indicators for dementia and is summarised in table 1 below.

Indicator	Surrey Heartlands	Surrey Heath
Estimated dementia diagnosis rate (aged 65 and over)	62.8%, better than England average of 61.9% (as at 31st October 2021)	63.4%, better than England average of 61.9% (NHS Frimley CCG as at October 2021)
Percentage of people with dementia prescribed anti-psychotics in past 6 weeks	9.2%, similar to England average of 9.3% (as at 31st October 2021)	7.8%, better than England average of 9.3%) (NHS Frimley CCG as at 31st October 2021)
Dementia care plan has been reviewed in last 12 months	75.5%, similar to England average	71.6%, lower than England average
Quality rating of residential and nursing care home beds (aged 65 and over)	71.3%, worse than England average	78%, better than England average
Dementia rate of emergency admissions	3,248, better than England average	3,788, worse than England average
Dementia deaths in usual place of residence	73.1%, better than England average	80.7%, better than England average

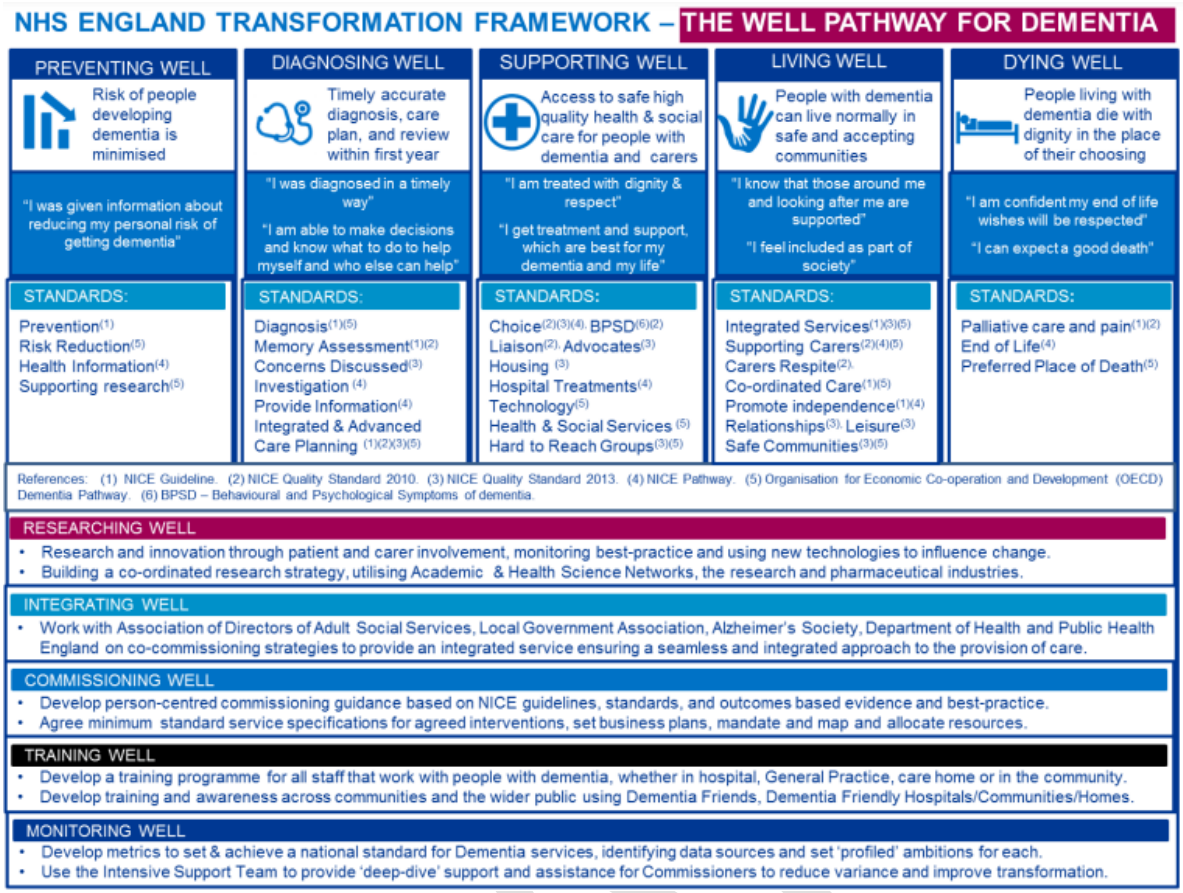
Local Context

Dementia is most common amongst older people and in Surrey it is estimated that between 2020 and 2030 the overall number of people with dementia is forecast to increase by 28%, from 17,700 to 22,672 older people. It is also estimated that there are around 105 people with a learning disability who have dementia.

Most people with dementia will have at least one other condition and this is being identified as part of the developing work on frailty in the different placed based areas. The growing demand for services by people with dementia and their carers means we need to address this challenge with integrated and proactive care for all parts of their journey of care. Figure 2 below shows the demography of older people in Surrey at a glance.



The well pathway for dementia is shown in Figure 3 below.



The outcomes in the well pathway for dementia are illustrated by "I" statements centred on the person with dementia, such as 'I was diagnosed in a timely way'. There are equally important carer centred statements in 'Making it real for carers' which include: having the information I need, when I need it; keeping friends, family and place; my support my own way; feeling in control and safe.

Each section of the well pathway for dementia is expanded on below and describes what we have achieved and what we need to do to improve the pathway for people with dementia and their carers.

Ambitions- Preventing Well

Our aim is to continue to raise public awareness and activities around dementia and the actions people can take to prevent dementia.

What have we done?

- There has been a reduction in smoking prevalence and improved identification and treatment of hypertension supporting a reduction in dementia prevalence. One You Surrey is Surrey's only specialist stop smoking service, commissioned by Surrey County Council. It has been operational since April 2019 and has helped 3405 smokers to date to achieve a better quality of life. For 2021 through to 2025 One You Surrey has been awarded an additional contract to deliver

adult weight management support.

- The increase of resources into Social Prescribing and the provision of Additional Roles Reimbursement Scheme (ARRS) roles in primary care has provided additional support to families reducing social isolation. Surrey has recently won a £500k grant to develop green social prescribing which will further increase resources and coordination in this area.
- The Kent Surrey and Sussex Academic Health Science Network (KSS AHSN) has a number of studies in various stages of set up which may help with prevention: 1. Understanding access to social care for Black and Minority Ethnic (BAME) communities; 2. Co-designing digital 'tracking' tool for people discharged from memory assessment services (MAS) with mild cognitive impairment (MCI)3. PhD looking at outcomes after MCI diagnosis.

What do we need to do?

- Develop consistent public health messages around how to prevent dementia. New messages focused on encouraging the population to participate in the over 40 health checks to promote healthy lifestyles and encourage a better understanding of healthy eating, drinking and exercise. The health checks could also be used for initial memory and cognitive assessment.
- Prioritise a focus on reducing inequalities - Early onset and vascular dementia are more prevalent in people from BAME backgrounds. Currently we do not know if people accessing memory assessment services are proportionate across the demographics of people living in Surrey.
- Ensure we have accessible material for people e.g., Easy Read or a video to enable people to access the information they require.
- Enhance post diagnosis health support for people diagnosed with Mild Cognitive impairment (MCI) and improve pathways and knowledge around when to refer people diagnosed with MCI back to the community mental health team for older people (CMHT-OP) for further assessment.
- Increase early identification of carers of people living with dementia; this should happen at diagnosis (the number of carers of people living with dementia registered with their GP as a carer).

Ambitions- Diagnosing Well

Our aim is for people to have equal access to dementia care; understanding where communities may not be accessing dementia diagnosis and post diagnostic support. We will address the inequalities and gaps in service with partners to overcome barriers.

What have we done?

- Pre-covid there had been a sustained increase in dementia diagnostic rates (DDR) enabling people with the disease to be signposted to support services and be considered for clinical trials of new treatments. In October 2019 Surrey, for the first time, achieved the 66.7% dementia diagnosis rate target by collaborative working across professionals and disciplines driven by clinical leadership. Unfortunately, the DDR rate fell nationally due to Covid: the current

DDR rate for Surrey Heartlands is 62.8%% and the national rate is 61.9% against a target of 66.7%. There are two main factors thought to be contributing to the downward fall in DDR:

1. Covid, as evidenced in the Covid mortality rates disproportionately affected people with dementia. ONS figures show that 27.5% of people who died of Covid had dementia (from 1 March to 30 May 2020). This will have impacted on the existing prevalence calculation and discussions are taking place at a national level as to whether this needs to be readjusted.
2. There was a reduction in the number of people accessing memory assessment services due to older people staying away from health services/not accessing primary care because of shielding/Covid risk perception and services re-establishing through remote consultations during Covid. Virtual services can be more challenging for those without digital literacy or internet access, as well as cognitive or sensory impairments. In addition, access to MRI scans for accurate diagnosis (ruling out other causes) was delayed and at one point completely suspended due to pressures from Covid.

- In the restoration and recovery phase the focus is on increasing the memory assessment clinics capacity and, for those who continue to require more stringent social distancing, encouraging virtual assessment where appropriate. To increase capacity, we support the introduction of memory assessment within our developing integrated hubs utilising the skills of clinicians with a special interest in Dementia. The post diagnostic support will be provided through Admiral Nurses (Guildford & Waverley) /Enhanced Care practitioners (East Surrey) / Dementia Nurse specialist (Northwest Surrey and Mid Surrey) to prevent crisis, reduce emergency acute and psychiatric admissions that have seen recent increase in the placed based areas/localities. These schemes will utilise the additional Dementia diagnosis and post diagnostic resources allocated to Surrey. The roles in each place are slightly different due to different pathways in the placed based areas.
- We have promoted the FORGET tool in primary care which enables GPs to do a telephone cognitive assessment before referral to Memory Assessment Service (MAS).
- We have worked closely with the Care Home sector and the Surrey and Borders Partnership Foundation Trust (SABP) care home pathway to ensure dementia diagnosis is completed in a timely manner.
- Our Mental Health Practitioners based in frailty/locality hubs are now included in the Integrated Frailty Multidisciplinary Team meetings to improve diagnosis for this cohort of people.
- We have a Clinical Lead for dementia in Surrey Heartlands who is continuing to work with local practices and secondary care to support an increase in the diagnostic rates. Surrey has had strong engagement and support with the national and regional NHS teams.
- The Surrey wide Dementia Strategy Action Board meets bimonthly, with aim to increase dementia diagnosis rates to pre-covid rates, as well as improving post-diagnostic support for people with dementia and their families
- Young Onset Dementia (YOD) - Surrey and Borders Partnership Foundation Trust (SABP) have established a dedicated young onset diagnosis service, with specialist YOD consultant psychiatrists and clinicians across each area in Surrey. Pre-covid there was a year-on-year increase in referrals, reflecting

establishment and promotion of the new service. There was reduction in referrals during covid, reflecting fears about attending for assessments and limitation to services.

Year	Total referral numbers to young onset dementia services
2017	194
2018	208
2019	310
2020	131
2021 (to Nov)	206

- SABP also have a learning disability assessment service. Surrey was one of the first areas in the country to begin to develop a database and services for people with Down's syndrome who develop dementia. It has been the focus of the UK's longest running Down's Syndrome and Dementia longitudinal study, which has been running for 20+ years, resulting in a major impact on clinical practice nationally and the development of a range of projects, including development of resources, DVDs and Quality Outcome Measures.

  The team have led the development and publication of national guidance Dementia and People with Intellectual Disabilities: Guidance on the assessment, diagnosis, interventions and support of people with intellectual disabilities who develop dementia published by the BPS (2009, 2015). SABP have been operating an assessment, diagnostic and support service for individuals with Down's syndrome since 1999, and have assessed over 500 people to date.

  The service currently supports 54 adults with Down's syndrome diagnosed with dementia and a further 32 adults with a learning disability.

- Acquired Brain Injury and Alcohol Related Brain Damage: These have previously been identified as gaps within memory assessment services. SABP is working with alcohol and neurological services to implement pathways and protocols between these services and SABP, to close the gap.
- Mental health practitioner pathways in community services - Each Place Based Partnership, apart from East Surrey, has mental health practitioners (MHPs) located within their integrated hubs or community service provider to carry out memory assessment and dementia diagnosis. Work has been completed to implement primary care and secondary care database (EMIS and SystmOne) access for the MHPS.
- MSNAP (Memory Services National Accreditation Programme) - MSNAP Accreditation has been achieved for all CMHT-OPs apart from East Surrey, and North West Surrey is under review. The CMHT-OPs are currently taking part in the National Audit of Dementia memory services with the results due to be published in Feb 2022.
- Dementia Navigators Referrals at Diagnosis- As part of the post diagnosis pathway people are referred to the dementia navigator service. Some of the

CMHT-OPs have co-located dementia navigators within the clinics.

- KSS Remote MAS Study -Remote MAS study is just concluding and will be releasing a remote MAS toolkit/patient video. Surrey participated in this study.
- Advice and Guidance e-RS CMHT-OP - Advice and Guidance access through e-RS (electronic referral service) has been launched, for enhanced primary care access to SABP CMHT-OPs. This provides a documented route for primary care to access specialist advice for people with dementia who do not need to be fully assessed by mental health services. This streamlines referral routes for advice and guidance, freeing up capacity in the CMHT-OP for more complex cases. This project is being developed further with a pilot in Mid Surrey to allow care home staff to access a dedicated mental health resource for people with dementia requiring more management support

What did some of you say about the diagnostic pathway?

The following quotes are from people interviewed by Healthwatch.

'*Mary's issues were explained as mild cognitive problems. No follow up was given'.*

'It was five weeks after discharge before their GP asked to see them and made the referral to the Older Persons Mental Health Team'.

'A telephone assessment was undertaken in October 2020. This identified "a cognition problem and anxiety". M was referred for a brain scan and commenced on Citalopram. A follow-up telephone appointment (due to covid) in December 2020 resulted in a letter to the GP that states: "Probable Alzheimer's Disease and anxiety". A follow-up post diagnosis phone call in March 2021 (as recorded in a letter to the GP) discharged M back to GP'.

'The family were told that it was vascular dementia, but they were not informed about the type of dementia and how it would affect B'.

What do we need to do?

- To iron out the postcode lottery of access we have established a pilot to enable the dementia navigator resources to be shared across Surrey on the basis of demand rather that historic funding arrangements. This will enable the service to meet growing demand with shared capacity across the county.
- The Dementia Connect service rolled out in June 2021 and includes a keeping in touch contact service for people and their carers following diagnosis, which will provide access to the service 7 days a week via telephone and website.
- Increase access and uptake of baseline assessments for people with Down's Syndrome (DS)
- Mental health practitioner pathways in East Surrey community services work differently to other areas as employed by the Community Trust with no direct supervision from SABP. A new enhanced practitioner role will provide supervision and support with the pathway to improve dementia diagnosis rates in the community.

- Ensure adequate immediate post-diagnostic support for individuals and their carers and families is available; whilst all CMHT-OP have a post diagnosis pathway, not all of the memory assessment clinics across Surrey have access to a dedicated post diagnosis clinic.

Ambitions- Living Well

Our aim is to make sure everyone has the opportunity to live life to the full following diagnosis

What have we done?

- Mind the Gap: awareness raising with Surrey's South East (SE) Asian population. Provided health & social care professionals with a better understanding on how to attract SE Asian population into local services in order to address low uptake by these communities. The model will be used to further develop links with BAME communities.
- Social prescribing has signposted people to various virtual groups during the pandemic and active groups after lockdown.
- Enhanced Technology Integrated Health Care Monitoring (TIHM) in response to the challenges posed by Covid; the project is now supporting just under 650 people with dementia and their carers to manage their physical and mental health and social care needs in the home environment during the pandemic (and continuing to do so) through remote monitoring. The service provides digital access to Surrey Well Being, Surrey Active Portals, Alzheimer's society Dementia Connect service and the Surrey Dementia Roadmap.
- Research conducted into the impact of dementia on those with a learning disability and their carers reported to the dementia strategy board with full support to the Mental Health Partnership Board leading to approval for additional resources to support people with a learning disability.
- Progress on integrated pathways between the acute, community services and primary care. Integrated pathways have been developed in a number of Place Based Partnerships across Surrey. Each Place (except East Surrey) has mental health practitioners in their community services who are clinically supervised by consultants in their community mental health team for older people. Of particular note is the one involving the frailty hubs in North West Surrey. This has addressed a long-standing concern that people were being discharged with uncertain diagnosis status back into the community.
- Both health and social care have continued to support the dementia navigators' contract and implemented the dementia connect model. This vital service continues to support people and their carers after they have been diagnosed with dementia. The board has supported the implementation of change in triage model from an answerphone to a staffed telephone and digital dementia connect service
- Dementia action alliances groups (DAGs). The 25 Surrey DAGs have been transitioned though the ending of the national Alzheimer's society contract which provided them with support and facilitation as well as setting up new groups. We see these groups as vital community assets for the support of

people with dementia and their carers, and would like to support them into Alzheimer's supported dementia friendly communities. Discussions are ongoing with the voluntary sector to support a Dementia Friendly Co-ordinator role for Surrey.

- Psychoeducation for carers of people with dementia. CrISP Carer Information and Support Programme (CrISP) training has been funded by the carers workstream, and is being rolled out across Surrey through virtual and face to face courses.
- Young Onset Day Activities. Surrey Heath has implemented a young onset day time activity service facilitated by Younger People with Dementia Berkshire
- Intergenerational Music Project. A Surrey Downs project in care homes linking young people with older people
- Delirium Educational Webinars. SABP hosted webinars for care homes, community staff and primary care to improve delirium identification and management.

What do we need to do?

- Focus on establishing Dementia friendly communities (DFC) across all areas of Surrey to provide people with dementia and their carers the support they need living in a supported community.
- More robust and consistent post-diagnostic support for individuals and their carers and families. This will support the person with dementia and their carer with a better understanding of the disease and how to manage it and consequences of progression and support carers in their caring role.
- Consider full roll out of TIHM and related technologies across Surrey for all people and their families with dementias.
- Dementia day support for those with young onset dementia. Individuals and carers of people with young onset dementia may have different peer support needs to those of older age diagnose with dementia and activities are not necessarily suitable e.g., singing songs/talking about things from a different era to their childhood. If appropriately funded, there is scope to expand the Surrey Heath Day time activity model throughout Surrey.
- Young onset dementia accommodation with support offer. People with young onset dementia face inequality across many areas; we need to develop an equitable offer around accommodation with support.

Ambitions- Supporting Well

Our aim is to engage with our communities and faith groups to ensure we reach out to people with dementia and their carers

What have we done?

- Frailty Hubs across Surrey are in development and these have provided much needed integration across the system.
- End of life and Carers strategies. The development of these strategies has built a common purpose across Surrey which will enable converging approach of

support to emerge.

- Dementia Care Plans in primary care. 75.5% of people with dementia in Surrey Heartlands, and 71.6% Surrey Heath, had a dementia care plan review in primary care in 19/20.
- Guidance for primary care and carers managing non cognitive symptoms. The guidelines were produced in 2019 and available on Surrey PAD (prescribing advisory database). In 2020 10% of people with dementia in Surrey Heartlands and 9.6% in Surrey Heath were prescribed an antipsychotic medication: this is a similar level to national average. Building on the success of the guidelines, there is now a focus on continued audit of patients with dementia prescribed antipsychotics and plans to relaunch of the guidelines with an educational event.
- Acute hospital admission data. The data shows we do better than the England average for rates of emergency admissions in Surrey Heartlands, but worse in Surrey Heath.
- Community Outreach projects e.g., the Alzheimer's Bus visited Camberley high street and engaged with local people. This supports awareness of services and reducing stigma.
- Development of place based Local dementia partnership board in some of the areas e.g., Surrey Heath, Guildford and Waverley and East Surrey. These Boards bring together local partners to improve communication and awareness of dementia services and increased working relationships to improve care and support for those with dementia and their families/carers.
- Crossroads respite for carers. These are home based breaks funded by Surrey County Council and the NHS providing regular weekly 3.5-hour respite breaks for those who care and aims to make sure the same Carer Support Worker attends each visit.
- Carers prescription offer and Action for Carers. The Q2 2021/22 analysis has shown SABP have made a strong start to the year.
- Post diagnostic pathway for people with a learning disability. For people with a learning disability there is a robust post diagnostic pathway which continues to offer support to the person, their carers/ staff through to end of life, via a minimum of a 6-month brief review and an annual review, with other interventions including cancer screening programmes available as required.

What did you say about supporting well?

The HealthWatch report identified that support information was sometimes reported as feeling overwhelming or irrelevant. It also identified that those with rarer dementias and under a neurologist were more likely to be offered research opportunities. A few carers had found their own way to research studies and we also interviewed some in the TIHM2 programme.

'*A was referred (by a person called Linda) fairly soon after diagnosis to the Elmbridge day centre and the Alzheimer's Café in Elmbridge'.*

'She is in the THIM study. She has sensors on the doors and hall, and it reports her temp/pulse/sats/bp daily'.

'While C was being assessed an Alzheimer's Navigator, came out to see me and said "My job is to look after you, sir". That was the beginning of a very productive relationship'.

What do we need to do?

- Improve information. Information has been included on the Surrey Dementia Roadmap and groups have been requested to include information on the Alzheimer's Society website regarding local resources to ensure people have access to the range of support groups that are available across Surrey. In addition, Dementia Connect has been publicised to primary care with information included on the Surrey Roadmap for Dementia to ensure primary care is aware of the support pathways.
- Improve crisis support/expansion of home treatment team. A pilot is being developed in Mid & East Surrey to develop more support for older people in a crisis and prevent hospital admission. Gaps in the care pathway to be identified and rectified, exploring why some carers only present in a crisis. Regular monitoring of the caring situation with access to carers assessments and reviews.
- Improve carers breaks. Home care for people with dementia and equitable offer of day opportunities for people with dementia. Trained and skilled home care staff enable people with dementia to have personalised care and support, and give carers a break. Without this, people may not have adequate support to enable them to live at home. Appropriate day opportunities enable people with dementia to have access to meaningful activity and social interaction, whilst also enabling carers breaks.
- Enhance accommodation with care and support for people with dementia. Small scale specialist dementia residential and nursing care is a gap; people with dementia may not receive the high quality and affordable care they require and this is an inequality. People with a learning disability and dementia may not have access to appropriate care if dementia care homes are not skilled in working with people with a learning disability. Conversely, non-specialist dementia care homes may not be able to meet the needs of people with a learning disability if they develop dementia. A person-centred approach should be taken, to allow different options as appropriate e.g., enabling with person with a learning disability to remain in their current home, with extra support if needed. Alongside this, we need to have a whole system approach that enables support to wrap around care home residents, with training for staff and support from community teams for residents that have high needs.

Ambitions- Dying well

Our aim is to make sure care is coordinated to enable the person with dementia to live their life as independently as possible until their death. To enable this, we endorse the 6 ambitions from the end of life care strategy:

- Everyone is seen as an individual, with care tailored to meet their needs and wishes

- Everyone has equal access to palliative and end of life care
- People are made to feel comfortable and their wider wellbeing needs are met
- Care is coordinated, with different services working together
- Staff have the skills and knowledge to provide the best care
- Communities come together to provide help and support

What have we done?

- The palliative and end of life care and the carers strategies have been published and these areas of work are prioritised in Surrey. The development of these strategies has built a common purpose across Surrey, which will enable converging approaches of support to emerge in the placed based areas.
- People dying in their usual place of residence - Mortality data indicates that in Surrey we have significantly more people with dementia dying in their usual place of residence, and significantly less people with dementia dying in hospital. There are processes in place that enable people to access hospice or home-based care according to their health and personal circumstances.

What do we need to do?

- Improve integration of the system to support people with dementia and their carers with clear approaches to coordination of end-of-life care support for all those with dementia and their carers wherever they live across Surrey.
- We need to ensure that individuals have advocates to support them with health and welfare decisions to ensure the wishes of the individual living with dementia are included in care plans.
- Align with planned national GP contract PCN (Primary care network) specifications which will be driving the delivery of anticipatory care and personalised care models for people not in care homes.
- Ensure there is mental health representation in the multidisciplinary team for people in care homes supported by the Enhanced Health in Care homes Framework.

Dementia Research:

We have opportunities to develop, support, and implement locally and regionally important research driven activity in our Dementia strategy and practice. Through engagement with regional research organisations, including the Applied Research collaboration and the clinical research network Applied Research Collaboration, the Clinical Research Network, and Dementia collaborations/communities of practice with key stakeholders across the system, we can develop locally important research and evaluation opportunities that benefits our population, improve research capacity in our workforce, and build innovation and evidence into our programmes of work and commissioning decisions.

Some of the research programmes focussed on dementia are listed as follows:

- Time for Dementia
- Problem adaption therapy for depression in dementia,

- Technology Integrated Health monitoring (TIHM)
- Measuring outcomes of people with dementia and their carers
- Patient satisfaction with a remote memory clinic in Covid 19 restrictions
- Supporting independence at home for people with dementia.
- Various PhDs (Transitions in care, MCI, decision making, non- beneficial care)

Next Steps

The proposals co-produced within this document describe how we will:

- Work together
- Develop local services by seeking funding to support the developing programmes
- Measure the impact of our plans on people with dementia and their carers
- Update our key stakeholders on the implementation of this strategy.

The following plan details what we need to deliver and by when to have a positive impact on services for people with dementia and their carers.

Preventing Well: our aim is to continue to raise public awareness and activities around dementia and the actions people can take to prevent dementia	✓ **By April 2022** develop consistent public health messages around how to prevent dementia ✓ **By April 2022** we will prioritise a focus on reducing inequalities ✓ **By April 2022** we will ensure we have accessible material for people e.g., Easy Read or a video to enable people to access the information they require. ✓ **By April 2023** enhance post diagnosis health support for people diagnosed with a mild cognitive impairment ✓ **By April 2023** Increase early identification of carers of people living with dementia
Diagnosing Well: our aim is for people to have equal access to dementia care; understanding where communities may not be accessing dementia diagnosis and post diagnostic support. We will address the inequalities and gaps in service with partners to overcome barriers	✓ **By March 2022** we will support the Dementia Connect service which has a keeping in touch contact service for people and their carers following diagnosis, which provides access to the service 7 days a week via telephone and website ✓ **By March 2022** we will increase access and uptake of baseline assessments for people with Down's Syndrome ✓ **By May 2022** we will make sure dementia navigators are equally available to meet the needs of people across Surrey ✓ **By June 2022** we will make sure people in East Surrey have access to a new dementia practitioner who will work with others to

	improve dementia diagnosis rates in the community ✓ **By June 2022** we will ensure adequate immediate post-diagnostic support for individuals and their carers and families is available
Living Well: our aim is to make sure everyone has the opportunity to live life to the full following diagnosis	✓ **By April 2022** we will have assessed if full roll out of the technology integrated health management system (TIHM) and related technologies across Surrey for all people and their families is a viable option ✓ **By September 2022** we will focus on establishing dementia friendly communities and dementia action groups across all areas of Surrey ✓ **By September 2022** we will have more robust and consistent post-diagnostic support for individuals and their carers and families ✓ **By November 2022** we will have a young onset dementia accommodation with support offer ✓ **By April 2023** we will have dementia day support for those with young onset dementia
Supporting Well: our aim is to engage with our communities and faith groups to ensure we reach out to people with dementia and their carers	✓ **By April 2022** include information on the Alzheimer's Society website regarding local resources to ensure people have access to the range of support groups that are available across Surrey ✓ **By September 2022** have a broad offer of carers breaks available including care within the home to enable people with dementia to have personalised care and support, and appropriate day opportunities to enable people with dementia to have access to meaningful activity and social interaction, and give carers a break ✓ **By September 2022** we will have a whole system approach that enables community mental health support to wrap around care home residents, with training for staff and support from community teams for residents that have behaviours that challenge ✓ **By April 2023** we will improve the accommodation with care and support offer to have small scale specialist dementia residential and nursing care available to meet a range of needs ✓ **By April 2023** expand crisis support available for people with dementia and their carers and families

Dying well: our aim is to make sure care is coordinated to enable the person with dementia to live their life as independently as possible until their death. To enable this, we endorse the 6 ambitions from the end of life care strategy	✓ **By April 2022** we will ensure that individuals have advocates to support them with health and welfare decisions to ensure the wishes of the individual living with dementia are included in care plans ✓ **By June 2022** we will ensure there is mental health representation in the multidisciplinary team for people in care homes supported by the Enhanced Health in Care homes Framework ✓ **By April 2024** we will align with planned national GP contract PCN (Primary care network) specifications which will be driving the delivery of anticipatory care and personalised care models for people not in care homes ✓ **By April 2024** we will improve integration of the system to support people with dementia and their carers with clear approaches to coordination of end-of-life care support for all those with dementia and their carers wherever they live across Surrey
Actions that will help us to achieve delivery of our priority areas	✓ **By April 2022,** a dedicated clinical leadership role is in place to take forward the dementia strategy ✓ On an ongoing basis, emerging research will be used to inform decision making and new service developments

Acknowledgements

This document has been created through partnership and with collaboration from:

- The Dementia Strategy Action Board in Surrey
- People with dementia and their carers
- Alzheimer's Society
- Dementia UK
- Healthwatch - Surrey
- Surrey and Borders Partnership Foundation Trust
- District & Borough Councils
- Surrey County Council
- Surrey Heartlands and Frimley Clinical Commissioning Groups
- Ashford & St Peter's hospital, Royal Surrey County hospital, Surrey & Sussex NHS Trust

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ADULTS AND HEALTH SELECT COMMITTEE

14 JANUARY 2022

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

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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
16 December 2021	Scrutiny of 2022/23 Draft Budget and MTFS to 2026/27	<u>Recommendations</u> The Select Committee agrees that, subsequent to this meeting, the Adults and Health Select Committee will agree wording for inclusion in the report to Cabinet regarding the draft budget and Medium-Term Financial Strategy, which is to be prepared jointly by the Council's four select committees. <u>Actions</u> The Cabinet Member for Adults and Health to feed back to the Select Committee her views and findings of the care home shadowing work she will be undertaking.	Adults and Health Select Committee Cabinet Member for Adults and Health	Wording will be agreed by the Select Committee prior to the Cabinet meeting on 25 January 2022.

16 December 2021	Adult Social Care Complaints April – September 2021	Recommendations The Select Committee recommends that a way of formally monitoring "issues of concern" is developed to ensure complaints and comments made by residents and staff that do not go through formal complaints process are logged, monitored and learnt from, and that the Council works closely with Healthwatch Surrey to ensure that as wide a range of feedback as possible is collected as part of this process. Actions	Senior Programme Manager (ASC)	The Senior Programme Manager has been contacted for a response.
		i. Senior Programme Manager to ensure complaints literature is replenished in all settings across Surrey. ii. Senior Programme Manager to provide the Select Committee with an example of an E-Brief.	Senior Programme Manager (ASC)	The Senior Programme Manager has been contacted for a response.

		iii. Senior Programme Manager to provide the Select Committee with an example of a summary of complaints provided to the leadership team. iv. Senior Programme Manager to ensure that future Adult Social Care Complaints reports include: a. Detailed summaries of complaints where learning was identified and implemented (as referenced in Paragraph 29), b. Key messages relating to complaints received by providers and how they are being addressed (as		

		referenced in Paragraph 31), c. Work being done to ensure that Adult Social Care is reaching and receiving feedback from residents from all demographics across Surrey, d. A breakdown of complaints received regarding the Learning Disabilities, Autism and Transition service and the specific areas to which these complaints are related.		
20 October 2021	Enabling You With Technology Transformation Programme	<u>Actions</u> The Cabinet Member for Adults and Health and Scrutiny Officer are to explore the possibility of organising a site visit for	Cabinet Member for Adults and Health	A site visit is in the process of being organised and dates on which it might take place are being identified. Due to the current Covid-19 situation, this is likely to take place in March 2022.

		Select Committee members to see what technology-enabled care looks like in action.		
20 October 2021	Covid-19 Recovery Programmes and Preparation for Winter Pressures	<u>Recommendations:</u> The Select Committee recommends that Frimley and Surrey Heartlands: 1. Work closely with Surrey County Council's Public Health team to create and deliver a communications campaign that highlights to residents the importance in following 'Hands. Face. Space' and social distancing to help reduce the pressures being put on hospitals over the winter months 2. Work with residents and Members to co-design standardised communications that hospitals can provide to the next of kin of those being	Director of Recovery and Transformation, Surrey Heartlands ICS Executive Lead for Urgent and Emergency Care, Frimley CCG	Responses were attached to the Recommendations Tracker as Annexes 1-6 in the 16 December 2021 meeting agenda papers. The implementation of the Select Committee's recommendations will be monitored going forward and regular updates will be provided.

		discharged into care, and for these to clearly detail their care needs and questions they need to be aware of 3. Explore ways in which they can highlight to patients the right services for their needs to ensure they do not attend A&E when their condition does not require them to		
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 with Judge and Priestley Solicitors when it has progressed	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.
3 March 2021	General Practice Integrated Mental Health Service Overview and Service Model	Actions The Clinical/Managerial Lead (Integrating Primary and Mental Health Care) for Surrey and Borders Partnership is to share with	Clinical/Managerial Lead (Integrating Primary and Mental Health Care), Surrey and	It was agreed that the Select Committee would be updated in summer 2021. The Clinical/Managerial Lead has been contacted for a response.

		the Select Committee the reablement pilot referral rates for BAME residents and people with long-term health conditions	Borders Partnership	The Clinical/Managerial Lead has been contacted for an update.
3 March 2021	Covid-19 Vaccination Programmes	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	Surrey Heartlands ICS, Frimley Health and Care ICS	The responses are attached as Annex 1.

		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		
19 January 2021	Adult Social Care Transformation Update	<u>Recommendations</u> The Select Committee requests that Members of the Select Committee attend and observe staff motivational interview training	Deputy Director, Adult Social Care	The Deputy Director has been made aware of this and will pass on more 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

		Actions 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	Scrutiny Officer, Democratic Services Assistant, Cabinet Member for Adults and Health	appropriate with regards to staff attending the training. 1. Information on the Care Pathway programme of work has been included in the Adult Social Care Transformation Programmes Review report that will be presented to the Select Committee at its 14 January 2022 public meeting.
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	In-person visits will be scheduled for a suitable time due to the effects of the Covid-19 pandemic.
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	Officers in Adult Social Care and Democratic Services are working together to identify suitable ways pre-prepared text and JPEG images can be shared with Members to help aid future recruitment campaigns.

Annex 1

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.

Response: working with our Surrey county council communications colleagues we have continued to ensure key Government messaging is included in all our communications and at every opportunity there is to reinforce these key messages.

2. Expand their communications messaging to as wide a variety of social media websites and applications as possible to help tackle vaccine disinformation.

Response: Again, working closely with Surrey county council and other communication colleagues across the county we have continued to widen out our communications channels for both the vaccination programme and wider Covid-19 and infection prevention messages. This has included social media platforms including twitter, facebook, Instagram, NextDoor, YouTube, Spotify and use of the Ringo app to reinforce certain messages (NB: Tiktok was discounted as it's not possible to tailor messaging locally, only at national level); in tackling vaccine misinformation we have also worked closely with our community champions, local community and voluntary groups to widen out opportunities to spread messaging. Regular communication updates have also been provided to the Local Outbreak Engagement Board and the Health and Wellbeing Board.

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.

Response: We have continued to target all residents through a variety of communication channels including local radio, print media, on leaflets and via our community champions and local community and voluntary sector partners as above

Adults and Health Select Committee
Forward Work Programme 2022

Adults and Health Select Committee Chairman: Bernie Muir I Scrutiny Officer: Ben Cullimore I Democratic Services Assistant: Emily Beard						
Date of Meeting	**Type of Scrutiny**	**Issue for Scrutiny**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Cabinet Member/Lead Officer**
3 March 2022	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.	Empowering communities, tackling health inequality	Nikki Mallinder – Director of Primary Care, Surrey Heartlands ICS

	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.	Empowering communities, 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.	Empowering communities, tackling health inequality, growing a sustainable economy so everyone can benefit	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.	Empowering communities, 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

5 October 2022	Overview, policy development and review	**Preparation for Winter Pressures**	For the Select Committee to receive a report on the measures put in place across the health system to mitigate against pressures during the 2022-23 winter period.	The Select Committee will review plans to mitigate against pressures during the 2022-23 winter period, taking into consideration the associated impact on Surrey residents.	Empowering communities, tackling health inequality	Helen Coe – Director of Recovery and Transformation, Surrey Heartlands ICS Fiona Slevin-Brown – Executive Lead for Urgent and Emergency Care, Frimley CCG Philip Astle – Chief Executive Officer, South East Coast Ambulance Service
	Overview, policy development and review	**Enabling You With Technology Transformation Programme Implementation Review**	At its public meeting on 20 October 2021, the Select Committee considered a report on the Enabling You With Technology Transformation Programme. It was subsequently agreed that a follow-up report would be presented to the Select Committee at the conclusion of Phases 2 and 3.	The Select Committee will review the progress of the Enabling You with Technology Transformation Programme and plans for its future development, making recommendations accordingly.	Empowering communities, tackling health inequality	Sinead Mooney – Cabinet Member for Adults and Health Toni Carney – Head of Resources, Adult Social Care

	Overview, policy development and review	**Surrey Safeguarding Adults Board Annual Report**	The Surrey Safeguarding Adults Board is a multiagency partnership that has representation from organisations that support adults who have care or support needs. Safeguarding Adults Boards have a statutory duty to publish an annual report.	The Select Committee will review the Safeguarding Adults Board Annual Report to better understand key themes, provide comment and recommendations, and highlight opportunities for future scrutiny.	Empowering communities, tackling health inequality	Simon Turpitt – Independent Chair, Surrey Safeguarding Adults Board
Items to be scheduled						
Date of Meeting	**Type of Scrutiny**	**Issue for Scrutiny**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Cabinet Member/Lead Officer**
	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.	Empowering communities, tackling health inequality	To be confirmed

	Overview, policy development and review	**Discharge to Assess**	In development.	In development.	Empowering communities, tackling health inequality	Sinead Mooney – Cabinet Member for Adults and Health Simon White – Executive Director of Adult Social Care
	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.	Empowering communities, tackling health inequality	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	The Task Group will seek to contribute to the reduction of health inequalities being faced by Surrey residents, contribute to the Council's	Tackling health inequality	Angela Goodwin (Chairman), Trefor Hogg, Riasat Khan, Carla Morson,

		being made on tackling these, and contribute to the development of future policies.	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, 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.		Bernie Muir (ex-officio)
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**
7 January 2022	**Surrey and Borders Partnership NHS Foundation Trust**	For Members of the Adults and Health and Children, Families, Lifelong Learning	Select Committee Members will better understand	Tackling health inequality,	Professor Helen Rostill – Deputy Chief Executive,

		and Culture Select Committees to gain a greater understanding of the work being undertaken to provide services both adults and children by Surrey and Borders Partnership.	the work being undertaken by Surrey and Borders Partnership, helping them to plan what areas could be scrutinised and how this might be undertaken.	empowering communities	Surrey and Borders Partnership Trudy Mills – Executive Director for Children's Community Services, Surrey and Borders Partnership
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.	Empowering communities, tackling health inequality	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 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.	A sub-committee of the South West London and Surrey Joint Health Overview and Scrutiny Committee has been established to scrutinise the Improving Healthcare Together 2020-2030 Programme as it develops.	Empowering communities, tackling health inequality	Bernie Muir, Angela Goodwin (substitute)
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	The Joint Committee is to scrutinise the Hampshire Together programme of work and associated changes in the	Empowering communities, tackling health inequality	Trefor Hogg, Carla Morson (substitute)

		programme of work, and Surrey County Council was invited to attend meetings as a standing observer.	provision of health services.		

Standing Items

- **Recommendations Tracker and Forward Work Programme:** Monitor Select Committee recommendations and requests, as well as its forward work programme.