Notice of Meeting

Adults and Health Select Committee

Date & time
Thursday, 15 June 2023 at 10.00 am

Place
Woodhatch Place
11 Cockshott Hill
Reigate
Surrey, RH2 8EF

Contact
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Chief Executive
Joanna Killian

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@SCCdemocracy

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Omid Nouri, Scrutiny Officer on 07977 595 687.

Elected Members
Helyn Clack, Nick Darby, Robert Evans OBE, Angela Goodwin (Vice-Chairman), David Harmer, Trefor Hogg (Chairman), Rebecca Jennings-Evans, Frank Kelly, Riasat Khan (Vice-Chairman), David Lewis, Ernest Mallett MBE, Michaela Martin and Carla Morson

Independent Representatives:
Borough Councillor Neil Houston, Borough Councillor Abby King, District Councillor Charlotte Swann

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 MEETINGS: 13 APRIL 2023 (Pages 5 - 22)

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

3 DECLARATIONS OF INTEREST

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

I. Any disclosable pecuniary interests and / or

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

NOTES:

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

4 QUESTIONS AND PETITIONS

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

NOTES:

1. The deadline for Members' questions is 12:00pm four working days before the meeting *(9 June 2023)***.**
2. The deadline for public questions is seven days before the meeting *(8 June 2023).*
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 SURREY HEARTLANDS INTEGRATED CARE STRATEGY (Pages 23 - 28)

Purpose of the item: To inform Select Committee on the delivery of the Surrey Heartlands Integrated Care Strategy and highlight main areas of co-ordination with Surrey County Council Priorities.

6 MENTAL HEALTH IMPROVEMENT PLAN UPDATE (Pages 29 - 78)

Purpose of the item: To provide an update to the Adults and Health Select Committee on progress since the October 2022 meeting.

7 **REPORT ON THE FINDINGS AND RECOMMENDATIONS OF THE HEALTH INEQUALITIES TASK GROUP** (Pages 79 - 136)

Purpose of the item: To provide the Adults and Health Select Committee with a detailed report on the findings and recommendations of the Health Inequalities Task Group, which was set up to explore Health Inequalities/disadvantages amongst key priority population groups within Surrey.

8 **RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME** (Pages 137 - 192)

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.

9 **DATE OF THE NEXT MEETING**

The next public meeting of the committee will be held on 4 October 2023 at 10:00am.

Joanna Killian
Chief Executive
Published: Tuesday, 6 June 2023

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MINUTES of the meeting of the **ADULTS AND HEALTH SELECT COMMITTEE** held at 10.00 am on 13 April 2023 at Council Chamber, Woodhatch Place, 11 Cockshot Hill, Reigate, Surrey, RH2 8EF

These minutes are subject to confirmation by the Committee at its meeting on 15 June 2023

Elected Members:

* Nick Darby
* Robert Evans OBE
  Chris Farr remote
  District Councillor Charlotte Swann
  Angela Goodwin (Vice-Chairman)
* Trefor Hogg
* Rebecca Jennings-Evans
* Frank Kelly
* Riasat Khan (Vice-Chairman)
* Borough Councillor Abby King
  David Lewis
* Ernest Mallett MBE
  Borough Councillor Neil Houston
* Carla Morson
* Bernie Muir (Chairman)
* Buddhi Weerasinghe

(= present at the meeting)*

9/23 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Neil Houston and Angela Goodwin. David Lewis attended remotely.

10/23 MINUTES OF THE PREVIOUS MEETING: 16 FEBRUARY 2023 [Item 2]

The minutes of the Adults and Health Select Committee held on 16 February 2023 were formally agreed as a true and accurate record of the meetings.

11/23 DECLARATIONS OF INTEREST [Item 3]

Trefor Hogg declared his interest as a community representative for NHS Frimley and as such, had assisted in developing the mental health graphic on page 30 of the Access to GPs Update paper from Frimley in

addition to involvement in the some of the work referenced on in paragraph 18 on page 32 of the same paper.

Nick Darby declared his position as Trustee of Surrey and Borders Partnership NHS Foundation Trust.

12/23 QUESTIONS AND PETITIONS [Item 4]

None received.

13/23 ACCESS TO GPS: UPDATE FROM SURREY HEARTLANDS AND FRIMLEY [Item 5]

Witnesses:
Mark Nuti – Cabinet Member for Adults and Health
Liz Uliasz - Chief Operating Officer, Adult Social Care
Nikki Mallinder – Director of Primary Care, Surrey Heartlands
Pramit Patel – Primary Care Clinical Leader, Surrey Heartlands
Katrina Watson - The Associate Director for Primary Care and Primary Care Network (PCN) Development for Surrey Heath, Frimley

Key points raised during the discussion:

1. The Vice Chairman asked if plans existed to enable GP surgeries to return calls during times suitable for patients, particularly given that some patients may be working full-time, on zero hours contracts or caring for someone. The Primary Care Clinical Leader, Surrey Heartlands explained that work to manage the demand of unscheduled inbound calls was progressing, communication with patients was required to advise when they would receive a response as the urgency of need was dependant on the clinical query in question. Outbound planned appointment calls would continue in the same way as face to face appointment requests.

2. The Vice Chairman queried what provision was in place for weekend calls. The Primary Care Clinical Leader, Surrey Heartlands confirmed that extended access for routine appointments was available outside of the general practice contracted hours of 8.00am until 6.30pm, Monday to Friday adding that out of hours calls backs had been subcontracted to 111 resulting in urgent need callers receiving a call back from the out of hours provider following their initial call to 111.

3. The Chairman said that despite the report noting that 98 per cent of practices had moved to the new telephony system, barriers remained for some when contacting practices by telephone and queried how could be addressed. The Director of Primary Care, Surrey Heartlands said that whilst 98 per cent of practices in Surrey Heartlands had moved to the new increased functionality cloud based telephony system, providing the system alone was not enough and in partnership with Redmoor Health, a change programme was being

rolled out to help each of the 104 practices to determine a set of standards for patients to address those that still faced barriers.

4. The Chairman asked if training packages had been purchased with the new telephony systems and queried who had been trained and how. The Director of Primary Care, Surrey Heartlands explained that telephony systems purchased by each practice were sourced from an NHS England procurement framework with each provider required to confirm a required set of purchase standards. Training differed between providers and Redmoor Health had been contracted regionally to provide any required additional learning.

5. The Chairman asked if the basic training on any new telephony system was provided by the technology provider. The Primary Care Clinical Leader, Surrey Heartlands confirmed that a basic hardware support package was provided by the technology provider and there was confidence that the technology procured across 98 per cent of practices could now achieve the expectations within the development toolkit.

6. The Chairman said that the paper did not reflect the experiences of people that had not been able to use the telephone system successfully and asked what were the health implications of patients that drop out whilst waiting in a telephone queue. The Director of Primary Care, Surrey Heartlands said that each practice was required to provide telephone data, these numbers did reflect drop out numbers and could be shared with Committee Members following a sensible period of reporting. **Action - The Director of Primary Care, Surrey Heartlands**

7. A Member asked if the language line services noted in paragraph 10, page 27 of the Frimley report were centralised or geographically based and queried how patients were made aware of these services, was there evidence to indicate the extent to which these services were being utilised and what were the clinical and mental health ramifications of not being able to access these services. The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley summarised the successful use of language line and BSL services in Surrey Heath noting that the system had been used 628 times over the last year covering 34 languages. The service was promoted through the carers network, various events and by practice staff who have had or would receive training. The Member noted concerns at the feedback he had received, particularly from Ukrainian visitors that they had experienced difficulties in connecting and engaging with services. The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley agreed that more could be done to make these cohorts of patients aware of the services available and undertook to investigate this further. **Action - The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley**

8. The Mental Health Lead, Surrey Coalition of Disabled People queried the accessibility features of the new telephony systems, in particular SMS reminders and the accessibility for people who were deaf or hard of hearing. The Mental Health Lead, Surrey Coalition of Disabled People also ask if any consideration had been given to people with home care needs who may not be able to access appointments in the morning. The Primary Care Clinical Leader, Surrey Heartlands explained that work with the Surrey Coalition of Disabled People following the procurement of the Surrey Heartlands online portal would result in all interfaces having a more simplistic feel. The Chairman queried the consequences of failure to implement these aspects. The Director of Primary Care, Surrey Heartlands confirmed that Surrey Heartlands would help practices comply to the contractual requirements.

9. A Member queried current Surrey Heartlands & Frimley access for patients that may struggle to book appointments by telephone such as non – verbal residents or those with mental health issues. The Primary Care Clinical Leader, Surrey Heartlands confirmed that consideration of how to work with such patients would be undertaken and the help of local councillors to share the message with communities would be needed.

10. A Member asked if there were targeted efforts to overcome challenges around digital exclusion. The Director of Primary Care, Surrey Heartlands confirmed that a Surrey Heartlands workstream under the digital portfolio had focused on bringing together a program to support those that did not have access to services digitally and this would help to free up resources for other patients that would access services in a more traditional way. The Primary Care Clinical Leader, Surrey Heartlands added that a partnership with Barclays Tech Angels had resulted in a patients champion which meant that people could be signposted to a location set up to provide digital support and guidance. The Member said that it was important to know who was not accessing services so their needs could be identified and addressed.

11. The Chairman said that additional information and detail about the figures included in the report tables was required so that the Committee could fully understand the approach being taken.

12. The Cabinet Member for Adults and Health championed the actions taken by Surrey Heartlands and Frimley in recognising demand and identifying solutions to educate people to access the right services for their needs.

13. A Member, in referencing a recent personal experience where a receptionist was not able to book an appointment, queried how digitally excluded residents could access appointments. The

Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley said that this should not have been the case and requested further information for investigation. The Chairman noted that this was not a one off occurrence and as such, it was essential that those being turned away with no further offer were recorded and included in the data. The Primary Care Clinical Leader, Surrey Heartlands said that practices would be supported to implement the contractual changes to address the specific inclusion of on the day assessment of need included in the new contract.

14. The Vice Chair asked to what extent patients were being made aware of how to decide if they should approach their GP or attend Accident and Emergency (A&E) in the event of becoming unwell and did reception staff receive training around this. The Director of Primary Care, Surrey Heartlands said that national communication around this had restarted and would run alongside communications about how to access available services. The Director of Primary Care, Surrey Heartlands added that there was work was underway with practice receptionists and care coordinators to focus on responding to and directing people to the appropriate service.

15. The Vice Chairman asked if it would be possible to record and monitor when patients are advised to attend A&E rather than being offered General Practice (GP) appointments. The Director of Primary Care, Surrey Heartlands confirmed that all A&E demand was captured.

16. A Member questioned what was being done to ensure that mental health patients were directed to safe havens as opposed to A&E. The Primary Care Clinical Leader, Surrey Heartlands agreed that it was important that patients were seen by the right service the first time around and said that the appointment of new mental health practitioners as part of the additional roles reimbursements scheme would work closely to ensure services work effectively.

17. A Member asked how continuity of care was being optimised to improve clinical outcomes as well as patient experience and how could any barriers to achieving effective continuity of care be overcome. The Primary Care Clinical Leader, Surrey Heartlands said that there were 64,000 high users of healthcare of which 1 per cent (624) were 'very' high users. This 624 cohort had 1900 A&E attendances, 500 in patient stays, 500 outpatient appointments and 54000 GP contacts. This cohort now has a PCN multidisciplinary team wrapped around them and early reports suggest the number of hospital attendances had started to significantly drop.

18. A Member asked what prevention measures were being taken to ensure a proactive, rather than reactive approach to providing care and asked for more detail about national and localised prevention measures. The Primary Care Clinical Leader, Surrey Heartlands

noted the focus on prevention within the Fuller Stocktake report and explained that work was underway within Surrey Heartlands to make every contact count and to reach out and create simple pathways. An example of this was encouraging patients to have blood pressure and weight monitoring checks to prevent chronic cardiovascular disease. The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley explained that Frimley ICB had been focusing on developing multi-disciplinary core models of care to make every contact count. Health on the High Street work through the spring booster campaign had been used to help to boost blood and weight tests to identify patients as they presented alongside the management of long term conditions to improve targets and help the patient recover in a more holistic way.

19. A Member asked what was being done within primary care to address the issue of elective treatment waiting lists. The Primary Care Clinical Leader, Surrey Heartlands said that the demand for general practice had increased and the development of an interface between primary and secondary care was being progressed. The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley agreed that the elective care backlogs had resulted in an increased demand in primary care and multi-disciplinary teams were being utilised to support patients whilst they waited for surgery on certain pathways.

20. The Local Healthwatch Contract Manager, Healthwatch Surrey asked if all sources of patient experience were being considered together to consider themes and ensure system developments could be implemented to achieve better outcomes for all and how was the information being captured and measured. The Director of Primary Care, Surrey Heartlands said that it had been difficult to pull together the entire picture to date because general practice complaints had originally been retained by NHS England and not delegated down to Integrated Care Systems (ICS). This data was now being brought over and combined with the other data, would allow an understanding of all the issues faced by patients. The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley said that regular meetings with Healthwatch representatives and direct access to practice managers helped to consistently address any patient experiences and complaints.

21. A Member queried what processes in place to identify if individual learning and training of practice staff was adequate. The Director of Primary Care, Surrey Heartlands noted that each practice was an independent contractor and as such, the human resources (HR) function of staff would fall directly with the practice. Support to train and educate from Surrey Heartlands would be provided and the Care Commissioning Committee in Surrey Heartlands continued to have

the responsibility for overseeing the delivery of general practice in Surrey.

22. A Member asked if practitioners would continue to routinely receive mental health training, and would such training be mandatory. The Primary Care Clinical Leader, Surrey Heartlands explained that a the locally commissioned Severe Mental Illness service provided specific training requirements for administrators and clinicians with performance measured through the Primary Care Commissioning Committee.

23. The Chairman queried how monies were allocated in the Additional Roles Reimbursement Scheme (AARS). The Director of Primary Care, Surrey Heartlands confirmed that the national Carr-Hill formula was used for the entirety of the contract and considered various demographics of the population being served. The Primary Care Clinical Leader, Surrey Heartlands added that whilst the funding had been provided for the additional roles, they would still require training and supervision to be undertaken by GPs and their practices as this had not been taken into account within the multiyear deal. The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley confirmed that systems were in place to train to the AARS roles within Frimley which were PCN led to support the needs within the communities.

24. The Vice Chairman asked what was the process for monitoring GP surgery performance and would additional and special assistance be offered to practices performing poorly. The Director of Primary Care, Surrey Heartlands noted the responsibility of the Primary Care Committee in the commissioning and delivery of general practice with practice performance considered monthly to ensure targets were met. Targets would be measured against metrics, access visits and Quality Care Commission (QCQ) inspections. Any poorly performing practices were referred for assistance to the delivery team in Surrey. Any issues would be identified by The Director of Primary Care, Surrey Heartlands; each area has a team of people looking after Practice, on top we have metrics and measurement. Access visits annually with specific questions and the CQC had its own standard for measurement. The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley confirmed the same processes for Frimley including quality and resilience monthly meetings to address any upcoming issues, weekly practice meetings regular practice visits to ensure issues were flagged as quickly as possible.

25. The Primary Care Clinical Leader, Surrey Heartlands welcomed Members to a further session outside of the Committee to discuss the Development Toolkit in more detail and address some of the issues that have been discussed.

Recommendations:

Primary Care Leads at Surrey Heartlands & Frimley Integrated Care Systems:

1. To develop explicit strategies to tackle digital exclusion, and to help increase access for residents with challenges who may struggle to utilise digital platforms.

2. To work on enabling GP surgeries to receive/return calls during times that may be more suitable for patients; taking into account patient's working hours or caring commitments.

3. To expand the reach of language-line services, and to increase patient awareness of these services.

4. To increase public awareness of all the available avenues for GP access, and to improve understanding of the challenges of increased demand for GP services.

5. 5. To work on optimising continuity of care to improve clinical outcomes as well as patient experience, particularly for patients with Long Term Conditions or those on long waiting lists

6. To continue to formulate a robust system of monitoring the performance of individual GP practices, including the development of records of patients being declined appointments, and for adequate measures to be taken to aid the improvement of surgeries seen to be performing poorly.

Actions/ requests for further information:

i. Further figures and information to be shared with the Committee following a sensible period of reporting regarding telephone call 'drop out,' and to include the health implications for patients that hang up. **Action - The Director of Primary Care, Surrey Heartlands**

ii. Further investigation to be undertaken around how cohorts can be made more aware of services such as language line availability and access. **Action - The Associate Director for Primary Care and PCN Development for Surrey Heath, Frimley**

14/23 CANCER AND ELECTIVE CARE BACKLOGS: UPDATE FROM SURREY HEARTKANDS AND FRIMLEY [Item 6]

Witnesses:
Mark Nuti – Cabinet Member for Adults and Health

Professor Andy Rhodes – Joint Chief Medical Officer Surrey Heartlands
Louise Stead – CEO Royal Surrey NHS Foundation Trust and Chair of the Surrey & Sussex Cancer Alliance
Helen Coe – Director of Operations & Recovery, Surrey Heartlands
Jo Hunter – Director of Planned Care, Surrey Heartlands
Nicola Beech – Programme Director, Surrey & Sussex Cancer Alliance
Orlagh Flynn – Integrated Care System Programme Director Elective Care, Frimley
Liz Howells – Director of System Planned Care, Frimley

Key points raised during the discussion:

1. The Chairman asked how the current strikes would impact the backlogs. The Joint Chief Medical Officer Surrey Heartlands said that some assessments and surgery scheduled had been postponed because of the strike action. The Chairman asked if cancellations figures as a result of the strikes were available. The Director of System Planned Care, Frimley advised that 2,700 patients had had their appointments cancelled for the four day strike period and patients had been offered new appointments at the time of cancellation.

2. The Chairman asked for further information to be brought back to the Adults and Health Select Committee in a few months' time to include how long patients had waited for their appointment before they were cancelled and how long the subsequent wait for their new appointment would be in addition to the physical and mental impact of this. **Action - Director of System Planned Care, Frimley/ CEO Royal Surrey NHS Foundation Trust and Chair of the Surrey & Sussex Cancer Alliance**

3. A Member asked how the imperative to reduce backlogs whilst ensuring that patients receive the most focused and effective care possible was balanced. The Director of Operations & Recovery, Surrey Heartlands said that the focus was to clear patients with the highest clinical priority in addition to considering innovation in treating patients differently such as fit tests and self-care initiatives. The Programme Director, Surrey & Sussex Cancer Alliance said that patient on the cancer pathway was monitored and reviewed frequently to ensure the next action was in place following clinical validation undertaken to conversations with patients and if required, patients being treated more urgently as a result.

4. A Member asked for further information about the aforementioned self-care initiative. The Director of Planned Care, Surrey Heartlands explained that this involved regular contact with patients in addition to providing them with diabetic home tests, blood pressure and ECG monitors with access to digital platforms to upload results. This enabled patients to take responsibility for their own care and provided a way for clinicians to monitor from a distance. The Member asked

for further statistics about patients accessing self-care and fit tests. The Director of Planned Care, Surrey Heartlands undertook to investigate methods of reporting these figures back to the Committee. **Action - Director of Planned Care, Surrey Heartlands**

5. A Member asked how extensive was the use of teledermatology and had the process helped to relieve pressure in skin cancer diagnosis and treatment. The Director of System Planned Care, Frimley said explained as the programme had started in the autumn of 2022, infoarmtion would be provided to the Committee in the longer term. The Integrated Care System Programme Director Elective Care, Frimley confirmed that the programme was available to all GP practices across the ICS and work continued with them to encourage patient use with 2600 people accessing the programme since September 2022 with hospitals experiencing a reduction in patients requiring acute treatment.

6. A Member questioned what measures would be taken to help increase confidence and knowledge amongst males regarding prostate cancer and queried the effectiveness of prostate cancer prevention measures. The Programme Director, Surrey & Sussex Cancer Alliance explained that a five month pilot study in 2022 had invited those at high risk of prostate cancer to meet with a nurse and discuss information prostate cancer, raise awareness and offer Prostate Cancer Screening (PSA) through their GP. The pilot received successful feedback from those that attended and there was a proposal to roll out to other areas. A project for a mobile van to visit busy areas such as shopping centres and car parks to access those unlikely to visit their GP was also proposed for late 2023. The CEO Royal Surrey NHS Foundation Trust and Chair of the Surrey & Sussex Cancer Alliance added that the government was considering the implementation of a national screening programme for prostate cancer for men at higher risk.

7. The Chairman queried if there were enough resources for the Mutual Aid System referenced in paragraph 47, page 166 and asked how many people were benefiting from it. The Director of Planned Care, Surrey Heartlands said that resources were dependent on specific situations.

Rebecca Jennings-Evans left the meeting at 12. 53.

8. A Member asked how figures were impacted by patients residing outside of Surrey choosing to be on waiting lists within the county. The Director of Planned Care, Surrey Heartlands confirmed that there were two waiting lists, one to reflect the numbers of those resident in Surrey and one to reflect the size of those trying to access care in Surrey.

9. A Member asked to what extent were patient records sufficiently accurate and synergised for the purposes of cancer and elective care. The Joint Chief Medical Officer Surrey Heartlands explained that whilst the implementation of both platforms had been challenging, particularly on the administrative side, there were huge clinical advantages in bringing all records together adding that a recent external audit process would bring about the resolution of any data problems to drive the benefits forward.

10. A Member asked Frimley to expand on some of the benefits and advantages of utilising the EPIC system referenced in paragraphs 34 to 37, pages 164 to 165. The Chairman asked what was the cause of any challenges with EPIC. The Director of System Planned Care, Frimley noted that here were initial issues with the recording of data such as duplication which had resulted in it not being ready for publication.

11. The Chairman, in referring to the Harm reviews noted in both reports, asked for a definition of Harm. The CEO Royal Surrey NHS Foundation Trust and Chair of the Surrey & Sussex Cancer Alliance said that the Harm reviews were a clinical review and addressed any deterioration in a patient's condition.

12. The Local Healthwatch Contract Manager, Healthwatch Surrey asked what reassurance were there that patients and carers were communicated with regularly and given the updates about when to expect their treatment and given advice. The Director of Planned Care, Surrey Heartlands noted that the Frimley patient portal would enable more effective, timely and efficient communication to those on waiting lists. The 'My Planned Care' website was also available, however the information provided was high level and would not break down clinical priority. A National Health Service England (NHSE) programme called 'Waiting Well' encouraged better engagement across primary and secondary care to help patients wait well and avoid deterioration by maintaining a healthy lifestyle whilst waiting for surgery.

13. A Member questioned to what extent was patient choice a factor in prolonged waiting times. The CEO Royal Surrey NHS Foundation Trust and Chair of the Surrey & Sussex Cancer Alliance explained there were many reasons for patients choosing to cancel appointments or planned surgery such as school holidays and patients could choose to postpone up to three times before a conversation took place with them to provide information on which to base their decision.

14. The Chairman, in referring to item 19 on page 173 of the Surrey Heartlands report which noted that ethnic minority groups were less likely to access services and were therefore not visible to analysis asked for further information about this as requested previously by

the Select Committee. **Action – Director of Planned Care, Surrey Heartlands**

15. A Member asked what work was involved in the Surrey Heartlands and Surrey Minority Ethnic Forum (SMEF) development of the digital exclusion strategy referenced in paragraph 20, page 173 and queried how this would help to address the issues of lack of access and the digital skills required to enable ethnic minorities to attend virtual consultations. The Director of Planned Care, Surrey Heartlands said that whilst most of the work was being undertaken in the community by primary care colleagues, tech angels were working as support outreach workers to identify those that found it more difficult to access services. SMEF had identified populations that clinical colleagues could have conversations with and signpost to tech sessions. The Director of System Planned Care, Frimley noted the specific work to target the homeless population utilising some of the learning from the COVID pandemic to achieve this.

16. A Member questioned what steps would be taken to increase prevention and awareness of cervical cancer amongst Black, Asian and Minority Ethnic (BAME) Women, particularly given the potential taboos surrounding sexual health within elements of these communities. The Director of Planned Care, Surrey Heartlands said that specific engagement had taken place with BAME communities regarding cervical screening and work underway with the pathology network to develop self-test kits for women to use in the privacy of their own home in addition to pilot clinics for anxious women from any background.

17. A Member asked how the quality of packages upon discharge was monitored and coordinated and queried to what extent families and carers were involved in or received guidance on how to provide effective aftercare. The Director of Operations & Recovery, Surrey Heartlands explained that many of the discharge care decisions were made at the preoperative assessment to inform and support the process upon discharge with families and carers involvement. The Chairman noted a previous recommendation made by the Committee around the thorough provision of discharge notes and information being readily available for families and carers, however this was still not routinely available and suggested a survey was conducted to ensure satisfaction.

18. A Member asked what mechanisms were in place to ensure the recording and measurement of patient feedback bearing in mind those that were digitally excluded. The CEO Royal Surrey NHS Foundation Trust and Chair of the Surrey & Sussex Cancer Alliance said that complaints and information from the Patient Advice and Liaison Services (PALS) were used alongside conversations with Healthwatch Surrey and friends and family gradings. Other efforts include a patient story heard by the board every two months and a

patient panel and a review of social media at the Royal Surrey Hospital to include the voice of residents.

Recommendations

1. To look into increasing Community Diagnostic Centres to enable greater reach and to reduce the need to rely on hospital settings.

2. To continue to work on reducing backlogs in Cancer and Elective care, whilst ensuring that each individual patient receives the most effective care possible.

3. To continue to improve Aftercare packages, and for the effectiveness of these packages to be adequately monitored.

4. To proactively work on Cancer prevention measures so as to reduce the prospect of future backlogs.

5. To pursue more work with Ethnic Minorities and residents with other challenges (such as Learning Disabilities) so as to improve access to cancer and elective care services amongst these groups, and to improve cancer and elective treatment outcomes for these individuals.

6. To monitor the impact of medical strikes on the acuity of cancer and elective care patients' conditions, and to share details of any potential delays to cancer and elective surgeries as a result of strikes (including numbers of surgeries delayed and the associated impact on patient conditions). Reporting of this should include the period since patients were originally referred for cancer & elective care treatment; to consider cancellations for patients already on long waiting lists.

Actions/ requests for further information:

i. Further information to be presented to the Committee in a few months' time to reflect waiting times experienced before cancellations due to the junior doctors strike to include the physical and mental impact of the delays. **Action - Director of System Planned Care, Frimley/ CEO Royal Surrey NHS Foundation Trust and Chair of the Surrey & Sussex Cancer Alliance**

ii. The Committee to be provided with statistics regarding the numbers of patients using self-care and fit test initiatives. The Director of Planned Care, Surrey Heartlands, to investigate methods of reporting these figures back to the Committee. **Action - Director of Planned Care, Surrey Heartlands**

iii. The Chairman, in referring to item 19 on page 173 of the Surrey Heartlands report which noted that ethnic minority groups were less likely to access services and were therefore not visible to analysis asked for further information about this as requested previously by the Select Committee. **Action – Director of Planned Care, Surrey Heartlands**

15/23 COMMUNITY MENTAL HEALTH TRANSFORAMTION PROGRAMME: UPDATE ON PROGRESS AND EFFECTIVENESS [Item 7]

Witnesses:
Mark Nuti - Cabinet Member for Adults and Health
Liz Uliasz - Chief Operating Officer, Adult Social Care
Andy Erskine – Deputy Chief Operating Officer, Surrey and Borders Partnership (SABP) NHS Foundation Trust
Georgina Foulds – Associate Director for Primary and Community Transformation, Surrey Heartlands
Ane Sosan – Community Mental Health Transformation Programme Manager
Colette Lane - Lived Experience Development Lead
Laura Parrington-Neads - Senior Recovery Coach, Managing Emotions Programme
Damien Taylor – Community Transformation Lead for Older Adults
Patrick Wolter – CEO, Mary Francis Trust
Christine Gee – Reaching Out Operational Manager, Surrey and Borders Partnership (SABP) NHS Foundation Trust
Hina Ashraf – Health Project Lead, Surrey Minority Ethnic Forum

Key points raised during the discussion:

1. The Chairman asked what was the impact of the annual allocation of transformation funding on page 184, Item 11, Table 1 and said that an explanation for each box in the table was required for better understanding. A further discussion took take place regarding sustainable funding for the third sector and The Deputy Chief Operating Officer, SABP committed to come back to the Committee following further considerations of the changes in funding indicated in the table. **Action. Deputy Chief Operating Officer, SABP/ CEO, Mary Francis Trust**

2. A Member, in noting the need required to transform and modernise the traditional service model referenced in paragraph 8, pages 182-183 asked what were the pitfalls of the traditional service and how could the new model overcome them. The Associate Director for Primary and Community Transformation, Surrey Heartlands explained that fragmentation had occurred with the introduction of new services and focus was required to ensure that the wide range of services work together across primary and secondary care. The Community Transformation Lead for Older Adults said that from an

older adults perspective, the focus was to ensure that there was a wraparound service to provide support at the right time, in turn identifying those that need support earlier.

3. A Member asked if the cost-of-living crisis had increased poor mental health and in addition to signposting, what steps were being taken to improve mental health for residents struggling with their mental health. The Deputy Chief Operating Officer, SABP confirmed that the cost of living crisis had resulted in an increased and sustained demand at every level. The community transformation work had resulted in more people being seen more quickly. The Associate Director for Primary and Community Transformation, Surrey Heartlands said that since the transformation programme had launched, highly specialised clinicians were in place in addition to partners from social care and the voluntary sector working together to intervene earlier and address increasing need more efficiently.

4. A Member questioned what was involved with the Managing Emotions Programme carers course referenced in paragraph 30, page 194, how was its effectiveness measured and what had the uptake been to date. The Senior Recovery Coach, Managing Emotions Programme explained that the course which began in April 2021 had been aimed at carers for those who found it difficult to regulate their emotions. The course was promoted and advertised on the GP integrated mental health service (GPimhs) and the personality disorder section of the Surrey and Borders website.

5. The Chairman requested that further information on the initiatives included in the reports be provided to the Committee to include cohorts, location, funding, funding term, key performance indicator (KPI) monitoring, promotion of the initiatives, geography, communications, marketing and reach. The Deputy Chief Operating Officer, SABP committed to take this action to provide the Committee with further information regarding the scale and impact of effectiveness of the initiatives. **Action – Deputy Chief Operating Officer, SABP**

6. A Member asked what were the timescales for the four 2023 PCN rollouts referenced in appendix 6 on age 219 and had the recruitment been successful to date. The Associate Director for Primary and Community Transformation, Surrey Heartlands confirmed that Redhill and Phoenix had just launched with plans for the remaining three to go live in the next three months, dependant on recruitment.

7. A Member asked if there was confidence that young people were transitioning smoothly to adult care. The Reaching Out Operational Manager, SABP explained that the workstream included an initiative to provide all young people from 17 years and nine months to 18 years and 3 months with a support worker to support them with their

transition from children and young people's services to adults services or transitioning out of mental health services.

8. A Member asked what was being done to stop people from being bounced and how effective had this been to date. The Associate Director for Primary and Community Transformation, Surrey Heartlands explained that the new model of integrated primary and community mental health care has a specific requirement from NHS England to address the 'bounce' that historically existed for people with unmet need in primary care who were not 'ill enough' to be seen by secondary community mental health teams or were too complex for NHS Talking Therapies (formerly IAPT). Since 2019 the new GPimhs/MHICS PCN teams have been filling this gap, supporting people with significant mental health needs preventing 'bounce' back to their GP. Their work includes forming bridging teams with system partners via weekly pathways forums to support adults stepping up or down between primary and secondary community mental health teams, enabling that person to access the help they need without repeat assessments or referral screening between services. The Chairman requested a detailed report with comprehensive data about bouncing. **Action - Associate Director for Primary and Community Transformation, Surrey Heartlands**

9. A Member questioned what additional efforts were being taken to reduce waiting times and were the impacts of waiting times on the acuity of peoples mental health conditions being examined. The Associate Director for Primary and Community Transformation, Surrey Heartlands said that under the transformation programme the expectation was for a four week wait in the new model of primary care.

10. The Chairman queried when the Unity Insights report noted in paragraph 35, page 196 would be available to the Committee. The Community Mental Health Transformation Programme Manager confirmed that the first interim report would be ready by the end of April 2023.

11. A Member said that information about explicit criteria through which the measurement of outcomes and effectiveness of the delivery of the programme was required. The Associate Director for Primary and Community Transformation, Surrey Heartlands agreed that there had been a lack of formal evaluation due to the COVID pandemic and now that issues around data being inputted into an interim system had been addressed, there was confidence that more information would be available going forward.

Recommendations

1. To implement greater flexibility in recruitment so as to take into account and harness the benefits of lived experience in the delivery of this programme.

2. To support ICB executive recommendations locally and to NHSE for more sustainable funding and contracts for third sector organisations providing mental health services.

3. To continue to support the Mental health Improvement Plan on reducing the tendency for patients bouncing between services, and to provide future explicit evidence of how the Community Transformation Programme is achieving this within the scope of the programme.

4. To develop more meaningful data that demonstrates robust work is taking place to support carers who are supporting mental health patients.

5. To ensure processes are in place to attract and retain both clinical and non-clinical workforce, including experts by experience.

6. To mitigate challenges associated with transitions for Young People who will continue to require non-urgent community based mental health support and services.

7. To improve communications, reach, and public awareness of any initiatives under this programme.

Actions/ requests for further information:

i. The Committee requested further explanations for the figures included in each box in the Annual Allocation of Transformation table 1, item 11 on page 184, and for the updated information to include a consideration of the changes in funding indicated in the table. **Action. Deputy Chief Operating Officer, SABP/ CEO, Mary Francis Trust**

ii. Additional information was requested about the scale and impact of effectiveness of the initiatives referenced in the report to be shared with the Committee to include cohorts, location, funding, funding term, KPI monitoring, details about the promotion of the initiatives, geography, communications, marketing and reach. **Action – Deputy Chief Operating Officer, SABP**

16/23 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 8]

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

17/23 DATE OF THE NEXT MEETING: 15 JUNE 2023 [Item 9]

The Committee noted its next meeting would be held on 15 June 2023.

Meeting ended at: 3.35pm

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Chairman

ADULTS AND HEALTH SELECT COMMITTEE

THURSDAY, 15 JUNE 2023

SURREY HEARTLANDS INTEGRATED CARE STRATEGY

Purpose of report: To inform Select Committee on the delivery of the Surrey Heartlands Integrated Care Strategy (ICS) and highlight main areas of co-ordination with Surrey County Council Priorities.

Introduction:

1. The Surrey Heartlands Integrated Care Partnership was responsible for delivering the Integrated Care System strategy which was formally approved in December 2022 and launched at the ICS Expo event in February 2023.

2. The work was led by the Health Integration Policy team with the Joint Executive Director of Public Services Reform, Rachel Crossley, as Executive Lead.

3. The Strategy centres on the theme of co-ordinating a system approach to health and care and clearly articulates how partnership working can drive delivery and drive improvements for our local population.

4. The strategy is based on knowledge we have of our populations' needs (from the Joint Strategic Needs Assessment (JSNA) and the visions/ambitions set out in existing strategies and plans.

5. We focused on aligning this strategy with existing strategies and ambitions already present across the system, such as the Health and Wellbeing Board (HWB) Strategy, and the ICS Strategy is now being used to drive the development of the ICS Joint Forward Plan.

6. The strategy provides our high level ambitions as a system and is supported by the Surrey Heartlands Joint Forward Plan (JFP) to be published at the end of June 2023 and updated annually thereafter. The Joint Forward Plan describes the changes our system will make to move towards realising our strategic vision for health and care services in Surrey Heartlands, drawing on work already underway through the Community Vision Surrey in 2030 and Surrey Health and Well-being Strategy. Once this plan has been formally approved, it can be shared with members of the Adults and Health Select Committee.

7. This paper aims to highlight the key features of the strategy document, but also show how it interlinks with Surrey County Council's mission and purpose.

Strategy Content

8. Delivering this vision is a process and one which we will continue to refine based upon the JFP and the needs of our partners. The existing strategies and ambitions we drew from each have their own set of metrics and deliverables. We are working on drawing these together so there is clear oversight of the actions taken and outcomes realised. This remains a programme of work in process.

9. The primary focus of the strategy is on improving health outcomes for the Surrey Heartlands population. In order to do this, we developed three overarching system ambitions:

Ambition One: Prevention

10. This section of the document focuses on what are we doing to reduce health inequalities and is a direct mirror of the Health and Wellbeing Strategy.

11. The ICS strategy describes the three priorities and associated outcomes from the Health and Wellbeing Strategy and uses the same metrics to measure impact.

12. The prevention agenda is central to Surrey County Council's strategic vision and has been clearly and thoroughly described in the Health and Wellbeing Strategy. It was therefore important this was reiterated in the ICS strategy both to highlight its importance, and to show synergy across the system.

Ambition Two: How we will deliver care differently

13. This section describes our ambition around how our population will be able to access care and what they can expect when they need to access our services.

14. It pulls much of its content and direction from the document "Next Steps in Delivering Integrating Primary Care: Fuller Stocktake Report" describing the vision of building neighbourhood teams and the ambitions of our providers in delivering care in a way which is centred around the individual.

15. Deliverability against this ambition will be measured utilising the same metrics used to measure delivery of the Fuller Stocktake Report.

Ambition Three: What needs to be in place to deliver these ambitions

16. This section describes our ambitions around the core enabling functions and what will help us operate most efficiently in delivering on ambitions one and two.

17. This information has been drawn from existing strategies or ambition documents, including the Health and Wellbeing strategy, and summarises our ambitions around how we work with communities, data, digital, workforce, estates and finance.

18. The success of this ambition will be demonstrated by the delivery against ambitions one and two and relevant metrics within the existing subject-area strategies.

19. An update on the Surrey Wide Data Strategy is scheduled for the June 2023 Health and Wellbeing Board.

20. A system wide project group has been established to plan and develop a roadmap for the IT systems and platforms required to deliver the data strategy. A Strategic Outline Case (SOC) was completed in December 2022 and more recently, the next stage of the Outline Business Case (OBC) has been signed off by Surrey Heartlands ICS, and Integrated Care Board (ICB). The OBC describes how we are going to implement the recommendations from the Surrey Data Strategy through the development of an Integrated Digital & Data Platform (IDDP) by the end of financial year 2024/2025. This will commence with a focus on integrated health and care across the system, but with a capability to expand to wider services in the near future. The next step and final gateway is to complete a Full Business Case (FBC), providing final costings and delivery plans for approval and onward delivery.

Synergy with Surrey County Council's Strategic Priorities

21. There is a direct link between the strategic priorities of Surrey County Council and the ICS strategy. The core mission of "no-one left behind" is encapsulated by the partnership approach taken in developing the strategy, and the recognition that by delivering these ambitions, we will positively impact every resident of Surrey, therefore leaving no-one behind.

22. Growing a sustainable economy so everyone can benefit.

    1.1 This directly reflects the fourth purpose of ICS': "Help the NHS support broader social and economic development", therefore working as a system to deliver this purpose will equally deliver against Surrey County Council's strategic priorities.

1.2 Having a sustainable economy will positively impact prevention and help tackle health inequalities. It will also support the third ambition of the ICS Strategy as a sustainable economy will attract people to the area who will enable the health and care workforce ambitions.

23. Tackling health inequality.

1.1 This priority of Surrey County Council is directly reflected by the first of the ICS ambitions and the Health and Wellbeing Strategy: Prevention. In order to prevent poor health from occurring; we need to tackle health inequalities.

24. Enabling a greener future.

1.1 A positive working and living environment not only supports the wider determinants of health, and therefore the prevention agenda, but also attracts people to live and work in the area thereby supporting the delivery of ambitions one and two.

25. Empowered & thriving communities.

1.1 This priority is a core part of ambition three of the ICS Strategy and what is needed to ensure delivery against the first and second ambitions.

1.2 Enabling our communities to manage their own health and wellbeing and providing them the support and tools to proactively seek help when needed is central to what we want to achieve as Surrey Heartlands. Health should not be "done to" a person; people need to be empowered to manage their own health needs proactively.

Conclusions:

26. Surrey Heartlands will continue to work as a system to deliver the ambitions set out in the Integrated Care Strategy. Partnership working and engaging with communities is central to its success.

27. The Joint Forward Plan will provide further information on how these ambitions will be delivered and has been developed in collaboration with partners across the system.

Recommendations:

28. Note the Surrey Heartlands Integrated Care Strategy

Next steps:

29. Continue to embed the strategy into our approach as a system.

Report contact

Lucy Clements – Health Integration Policy Lead, Public Service Reform

Contact details

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Sources/background papers

Our strategy - ICS (surreyheartlands.org)

Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)

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ADULTS AND HEALTH SELECT COMMITTEE

THURSDAY, 15 JUNE 2023

SURREY COUNTY COUNCIL

MENTAL HEALTH IMPROVEMENT PLAN: UPDATE

Purpose of report: To provide an update to the Adults and Health Select Committee on progress since the October 2022 meeting.

1. Introduction

1.1 An update on the delivery of Surrey's Mental Health Improvement Programme (MHIP) was provided to the Committee in October 2022.

1.2 We agreed to provide a further update in the first quarter of 2023 and this report describes the collective system work to deliver the MHIP.

1.3 Delivery of the MHIP is set against a background of continuing pressures within the mental health operating environment, especially with sustained high demand for crisis and inpatient services across children's and adult services, ongoing workforce challenges and financial pressures.

1.4 The Surrey mental health resourcing review undertaken as part of the MHIP in 2021 has given us a better understanding of need within our system and the capacity available to meet it. The recent Joint Strategic Needs Assessment 2023 adds further depth to this picture and identifies some specific areas for action to promote good emotional wellbeing and prevent poor mental health.

2. Context

Our ambition is articulated in the coproduced vision:

> *'Together we will build and nurture good mental health and emotional well being for all. If anyone needs help, they will find services on offer for themselves, their famly and carers, which are welcoming, simple to access and timely. No-one is turned away from a service without being given support to get the help they need'.*

2.1 Since the update to the committee last October there has been a range of system wide work underway to deliver this vision and address the 19 MHIP recommendations. The priority programmes of work have particularly focused

around early intervention and prevention, no bounce, and crisis and flow, all supported by specific data and workforce enabling workstreams.

2.2 It is important to recognise the context in which we are aiming to deliver the improvements set out in the plan relating to wider operational and resourcing pressures.

3. Context – Covid and Cost of Living

3.1 We have seen a significant demand for mental health crisis support across all services since the onset of the Covid-19 pandemic in 2019/2020. The destabilising emotional impact of the pandemic has been further exacerbated by the cost-of-living crisis and global political unrest.

3.2 Citizen's Advice Heartlands past quarterly report "The Cost of Living is resulting in exceptional pressures on everyone, and for those who are on the lowest income those pressures are greatest. The consequent impact on mental health is well documented, and during this quarter we have been working on a separately commissioned research project, investigating the local impact of the cost of living". Citizens' Advice Runnymede & Spelthorne have been piloting a dedicated Primary Care Mental Health Caseworker Service to people referred by GP Integrated Mental Health Service (GPimhs) Primary Care Network (PCN) teams in SASSE networks 1, 2 & 3 and COCO (primary care mental health transformation see also section X) since 2022 which has been extended to end 31 March 2024. Funding for Surrey Heartlands coverage to extend to all areas of deprivation was not agreed. Frimley South in contrast has a commissioned dedicated primary care service within its existing Citizens Advice Rushmoor contract for secondary care.

3.3 The newly published '**Emotional and Mental Wellbeing in Surrey Adults'** JSNA chapter **(**Emotional and Mental Wellbeing in Surrey Adults | Surrey-i (surreyi.gov.uk) includes a section on 'Socio-economic, Cultural and Environmental conditions: The Current Context' which details the cost of living crisis.

See below for specifics.

4. Food Insecurity

4.1 Estimated increase in the rates of people experiencing food insecurity at 4.7 million across the UK (Kings Fund 2022) with wider factors such as increase in energy prices, combined with rising inflation, stagnant wages and uncertainty about benefits further leading to an increase in people living with food insecurity or fuel poverty.

4.2 These factors combined with the uncertainty can cause considerable anxiety. People already experiencing poor mental health (for example those living with an severe mental illness (SMI) or living with a disability are more likely to be affected. In addition, the uncertainty of the benefits system, and the negative

emotions such as stigma associated with accessing food banks further lead to poor mental health.

4.3 Fuel poverty has been found to correlate with a variety of well-being outcomes, even when controlling for lifestyle factors. Two thirds of therapists in a national survey say cost of living concerns are causing a decline in people's mental health. British Medical Journal research says that the surge in prices over recent months is exacerbating insecurity and harming people's mental health.

5. Debt

5.1 Another issue related to financial uncertainty is debt; significantly linked to poor mental health. Those with problem debt are three times more likely to consider suicide. Around 60 per cent of those who had three or more debts experienced mental health problems.

5.2 The Health and Wellbeing Board has identified 21 priority areas across Surrey where substantial opportunities for population-wide health and wellbeing improvements exist. We know poverty and its associated effects are a key health and wellbeing risk factor, so the importance of understanding these communities has only become more acute as a result of the rising cost of living.

5.3 There are already a lot of health and wellbeing interventions active in these communities. Surrey County Council will be undertaking mixed methods research in early 2023 to better understand health and wellbeing issues in these communities as well as understand what assets they define as valuable. This will help us develop a measure for healthy and thriving neighbourhoods to help us focus our resources on what will have the most impact.

5.4 As findings become available, they will be published within the JSNA website and used to inform planning.

6. Context: The Emotional and Mental Wellbeing in Surrey Adults JSNA

6.1 The newly published chapter outlines the most up to date intelligence of expressed and expected need for mental and emotional wellbeing in Surrey. There remains a considerably higher prevalence of mental health problems among the general population than the number of people receiving treatment (Adult Psychiatric Morbidity Survey).

6.2 There was a predicted 1.3 per cent increase in mental disorder (diagnosed and undiagnosed) in those aged 16-64 years between 2017/ 2020 (prior to impact of COVID and cost of living challenges). We expect this figure to increase further in the wake of the pandemic (and see above regarding the cost of living crisis). A recent report published by the National Audit Office in February 2023 indicates that there was a 44 per cent increase in referrals to mental health services between 2016-17 and 2020-2021, going from 4.4 million to 6.4 million. The same

report estimates that there are 8 million people with a mental health need not in contact with services nationally.

6.3 Primary Care QOF data shows the prevalence of recorded depression almost doubling across Surrey in five years (from 6.2 per cent in 2014/15 to 11.1 per cent in 2020/21).

6.4 In 2020/21 6,765 individuals were registered Serious Mental Illness (SMI), 0.73 per cent compared to 0.95 per cent nationally and the prevalence of SMI was 28 per cent higher in the most deprived decile compared to the least deprived decile.

6.5 Nationally we know there is life expectancy gap of about 20 years for people with SMI compared to peers and a recent report by the Office for Improvement and Disparities published in January 2023 suggests that this gap is increasing not reducing. Excess mortality for people with SMI is significantly higher in Surrey compared to the national average, underpinned by higher rates of cardiovascular, respiratory, and liver disease.

6.6 Whilst below England figures, age-standardised suicide rates in Surrey have grown from 9.6 to 10.0 per 100,000. When taking a closer look at the Surrey data, there is clear economic influences with problem debt featuring three times more amongst those likely to consider suicide. Other identified risks include existing mental illness and/or history of self-harm, relationship problems and bereavement.

6.7 The JSNA recommends a number of key actions:

Area 1: Population prevention: Promote place-based population wellbeing approaches, including the determinants of wellbeing.

Area 2: Communities. Work with communities, people with lived experience and VCSE to co-produce community-based wellbeing and mental health solutions.

Area 3: Address current and predicted unmet need with further equality impact assessments in key areas.

Area 4: Develop pathways that support holistic approaches.

Area 5: Ensure seamless read across with children and young people's needs assessment to inform whole family responsive pathways.

6.8 Under 'Area 1', place-based plans are being presented to the Mental Health System Delivery Board to ensure alignment starting in June 2023.

6.9 Under Area 3: Address current and predicted unmet need with further equality impact assessments in key areas has been taken up by the Early Intervention

and Prevention Programme has been picked up within Programme One Early Intervention and Prevention under Work Area 2 and Work Area 4 (more later in the report). However, the results of the findings and further equality impact assessments will be used to inform the entire plan and all programmes including the cost of living data and in section

6.10 Under area two, working with communities, the Independent Mental Health Network (IMHN) and Surrey Minority Ethnic Forum (SMEF) ran an insight survey into the effect of covid 19 on the mental health of people from minority ethnic communities in Surrey and NE Hants in 2020 (finished 2021) which highlighted barriers to engaging with services and ways the system could work better with these communities. It produced wide ranging co-produced recommendations.

6.11 The Mental Health peer research and IMHN team are currently doing a 2nd research piece. This research projects explores the cultural, religious and language barriers South-Asian adults' and their carers may experience in Surrey and North-East Hampshire's mental health services. They are currently fully immersed in the focus group stage of this (Pathways to Change Survey - Surrey Coalition of Disabled People).

6.12 Finally, Surrey Coalition for Disabled People are also supporting SABP Community Transformation work which includes a focus on improving access for minority ethnic communities to Gpimhs/mhics and they run a bi-monthly mental health stakeholder group for people which can also offer feedback and be used to raise discussions.

7. Context: Competing operational pressures

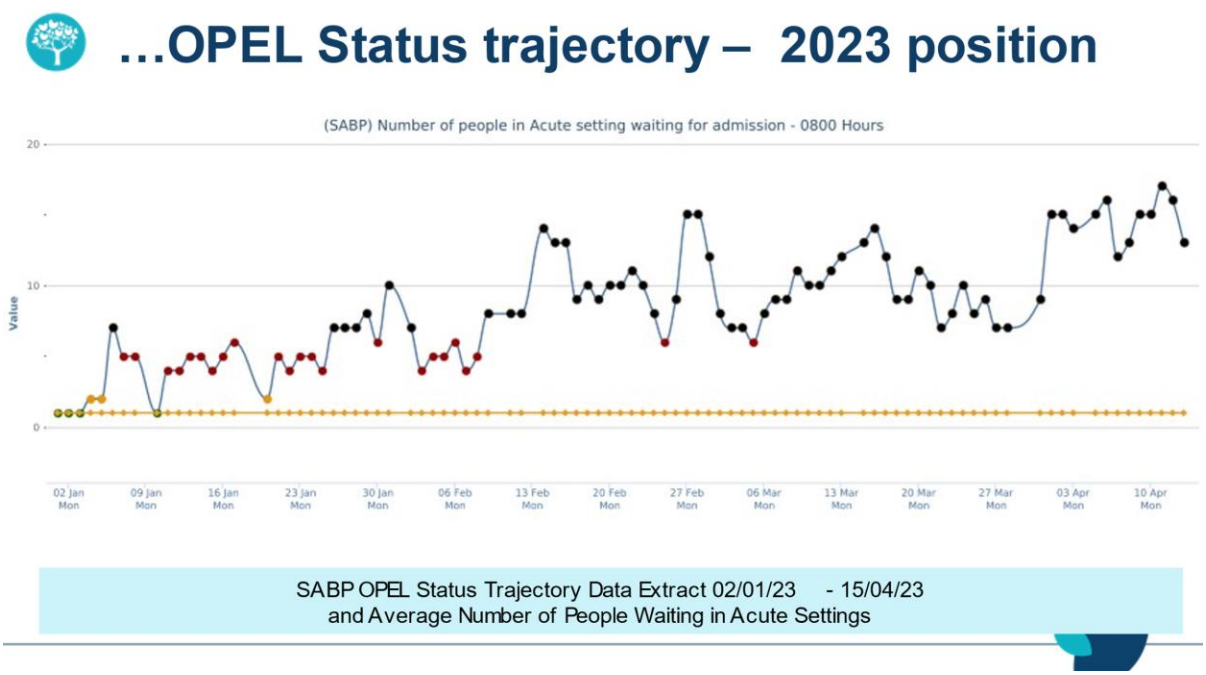
7.1 The commissioned Carnall Farrar report (Recommendation 7: Resourcing review) into resourcing for the MHIP in December 2021 indicated:

- Approximately 63,000 people were in contact with mental health services during 2020/21 but 180,000 people in Surrey would benefit from contact with mental health services

7.2 Waiting lists for all services and a detailed analysis of these can be provided at a later date.

7.3 However, the **urgent and emergency mental health pathway** in Surrey continues to experience a significant and unsustainable demand and capacity gap in meeting the needs of people experiencing a mental health crisis, with a forecast additional 25% growth in referrals to SaBP by 2025/26, compared to 2019/20 levels.

7.4 The graph below shows Surrey and Borders' OPEL trajectory between January and April 2023. OPEL is a measure of operating pressures used across the NHS, with OPEL Black being the highest level of pressure. The graph shows a sustained period of OPEL Black within the mental health system.



7.5 High demand and increasing complexity for the mental health urgent and emergency care pathway is resulting in ~30 patients identified at the threshold of acute mental health admission on a regular basis and impacting flow through inpatient services. Delays in discharging people once they are clinically ready is adding to the pressures. We know that 3 in 10 people do not return to their original accommodation following admission which increases length of stay (LOS) and reduces flow. The median length of stay where people go back to their usual place of residence is **28** days but if their accommodation needs change the length of stay increases to **39** days for temporary accommodation (typically District & Borough emergency accommodation) and **106** days for Local Authority (typically supported living).

7.6 There are significant challenges identifying appropriate discharge options for a number of vulnerable individuals with complex needs, including those who are neurodiverse, leading to very long stays in hospital which is not the right setting to meet their needs (see the vulnerabilities panel and accommodation with care and support section later). This situation is not unique to Surrey and neighbouring systems are experiencing similar issues, considering local provider and demographic differences. However, in Surrey Heartlands we have approx. half the number of beds per 100k than average and are the 2nd lowest funded MH system in England

7.7 Significant work is underway as part of the Crisis and Flow Programme to divert/develop alternatives to admission, improve support for people in crisis to wait safely at home, and improve flow through mental health acute services.

7.8 We are also experiencing very high year on year demand for our children and young people's emotional wellbeing and mental health services, with a continuing upwards trend. In response there has been significant additional non recurrent funding in the last two financial years to purchase additional capacity to undertake assessment for diagnosis and to provide additional capacity for early intervention across partners. This level of demand creates a bottleneck at the service access point leading to increased waiting times for the services.

7.9 The children and young people's emotional wellbeing and mental health services known as Mindworks Surrey closing year 2 position (April 2022- March 2023) demand and activity level as a total alliance was:

7.10 Referrals - YTD M12 Mar 2023: total alliance position at 34,731 referrals against total annual contracted target of 19,074 (+82%)

7.11 Activity - YTD M12 Mar 2023: total alliance position at 166,376 of total annual contracted activity of 135,703 (+22%)

7.12 Demand at Partnership Level

- Learning Space- Demand has exceeded Annual Contracted levels at 710 referrals received YTD. M12 position YTD Variance +107%
- National Autistic Society (NAS) - Demand has exceeded Annual Contracted levels at 1,828 referrals received, M12 position YTD Variance +110%. However low volumes received for ASD 1:1 service at -72% YTD Variance
- Barnardo's - In general demand has exceeded Annual Contracted levels at 2,469 referrals received YTD. M12 position YTD Variance +98%
- Surrey Wellbeing Partnership (SWP) - Demand at 8,783 referrals received, M12 position YTD Variance -5%.
- SABP - Demand at 20,941 referrals received, M12 position YTD Variance +74%.

7.13 Activity at Partnership Level

- SABP - YTD M12 a total of 7,210 (4,201) assessments carried out at +117% (+26%) of annual contracted target of 3315 Assessments. YTD M12 total of

72,204 treatments delivered YTD variance +36%. YTD M12 a total of 79,414 assessments and treatments delivered YTD variance +41%.

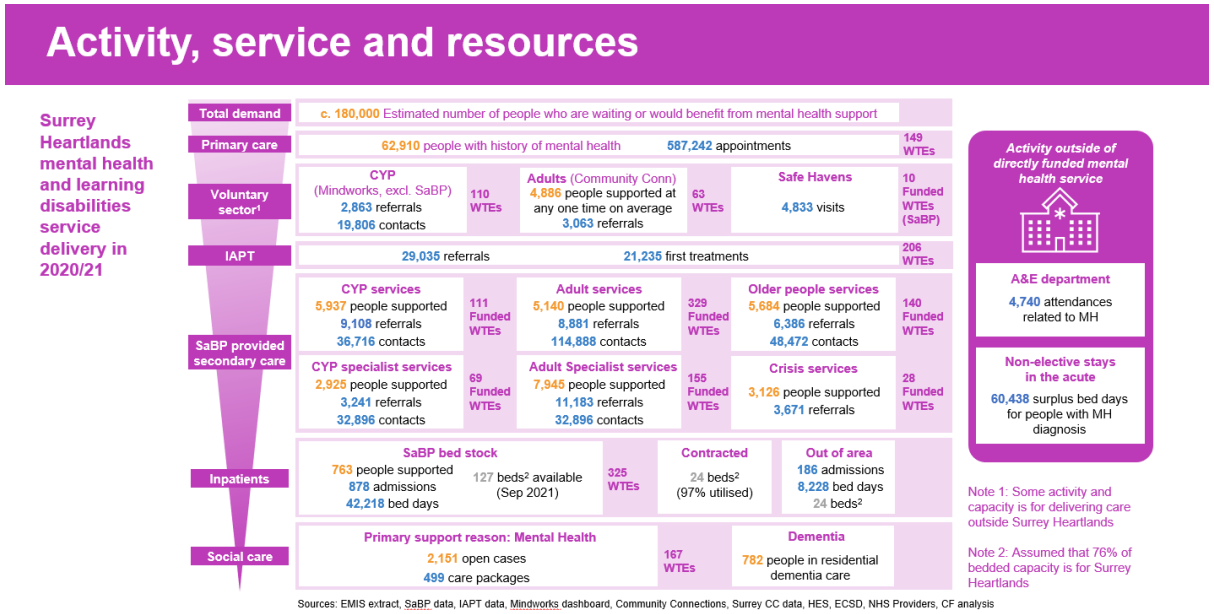
- Learning Space - In general activity is at 5,523 YTD variance +64%
- NAS - In general activity is at 5,298 YTD variance +2%.
- Barnardo's - In general activity is at 6,647 YTD variance -13%
- SWP - In general activity is at 69,560 YTD variance +11%

8. Context: Resourcing challenges to meet the need

8.1 Based on the resourcing review undertaken in response the MHIP recommendation 7, it is estimated that in Surrey we are only reaching 63,000 people out of an estimated 180,000 who need support (based on national Adult Psychiatric Morbidity Survey). Of the 63,000, using 2020/21 data, 6,765 individuals were registered with serious mental illness (SMI). When looking at the IMD Mood and Anxiety Disorders indicator, the five Lower super output areas (LSOA's) with the highest levels of mental health needs are in Reigate and Banstead. Future reports can consider these against the 21 Health and Wellbeing priority areas.

8.2 We recognise that workforce supply and retention remain particular challenges for all partners in Surrey and Nationally. SABP continue to see pressures recruiting to specialist roles such as Nursing, Psychiatry and Psychology. Recruiting to other roles within the VCSE and the Talking Therapy services has also become more challenging. There is a range of creative work underway to address vacancies, including working with Health Education England and our local Integrated Care Systems to develop new roles such as Graduate Mental Health Workers and developing our lived experience workforce.

8.3 The infographic below shows a summary of activity, services, and resources available in the mental health system and is taken from the 2021 Resourcing Review.



8.4 The funding position within Surrey remains a critical part of the context, particularly given the financial challenges which we are facing as a system:

- Compared to other systems, Surrey receives less funding from the national allocation formula, due to an assessment of low complexity and population need. Surrey Heartlands ranks 130 out of 134 ICBs in the national needs assessment for mental health; whilst Surrey Heath has the lowest index in the country.

- Resource allocation is a function of deprivation levels and historic population health. The formula used to set national resourcing levels is based on the prevalence of Serious Mental Illness (SMI). Surrey averages 0.78 and all of its 6 geographical "Places" rank in the lowest quartile of need in this model. Consequently, this limits resources to 43% below the national average (Second lowest for all MH providers).

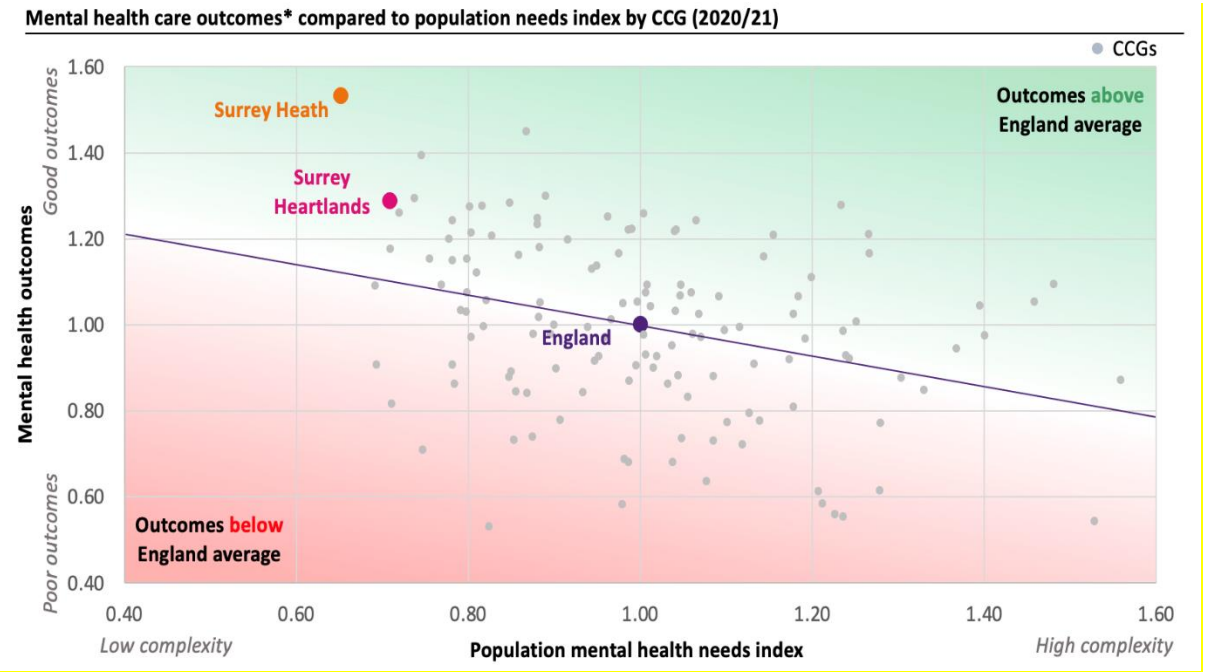
8.5 Consequently, Surrey spends less on mental health per GP registered population, £161 compared to the national average of £202. However, as the table below shows Surrey delivers more resources per service user for less funding.

National Funding £ per head	Surrey Heartlands	England Average	Surrey Heartlands vs England Average %
Real Purchasing Power	£161	£202	80%

Market Forces Factor adjusted	£142	£189	75%

8.6 Despite this, in absolute terms, Surrey achieves comparatively good outcomes even after adjusting for population need.

8.7 Mental health outcomes index for Surrey and most of its peers are higher than the national average. Compared to peers, Surrey generally has good service delivery. However, there are lower outcomes for people with SMI, and service delivery is lower than the national average for perinatal mental health and general children's mental health services.



9. Context: Scale of Transformation

9.1 There is a considerable amount transformation work underway both within and outside the context of the MHIP and a limited resource of programme support to manage the scale of change. Resourcing challenges as outlined above mean we need to prioritise best use of our resources which is under review by the Mental Health System Delivery Board as it moves forward with the development of a unifying transformation plan for Surrey Heartlands.

10. Context: Staff Wellbeing

10.1 Our people continue to feel the emotional pressures of covid as well as the ongoing cost of living challenges and unrest within the sector related to pay awards etc. Anxiety and depression is one of the leading causes of sickness absence and it

is critical that we prioritise support for our workforce. The 'Here for you hub'.is part of the package of support to staff to support their health and wellbeing and over a two year period (Jan 2021-Jan 2023) the service provided support to c4500 staff across Surrey. They see people with unmet & complex needs, some of whom present with significant risk and who have no other service they can use.

10.2 NHSE funding ceased on 31st March 2023 and SABP were unable to secure funding by all ICS partners. However, SABP offer developed with options for partners to buy into the service with funding secured post April 2023. Partners which have secured further funding to access the offers include Surrey County Council, SABP, some of the Acutes, Primary Care Networks and the voluntary sector.

11. Context: Culture

11.1 Changing and developing our system culture to align with the recommendations of the Linguistic Landscape's review will take time and requires the senior leadership to prioritise time investment in relationship building. We are making good progress with the development of new alliances and collaborations but there is more to do to create a more inclusive and valuing environment across our partnership.

12. Context: Digital and Data Insights

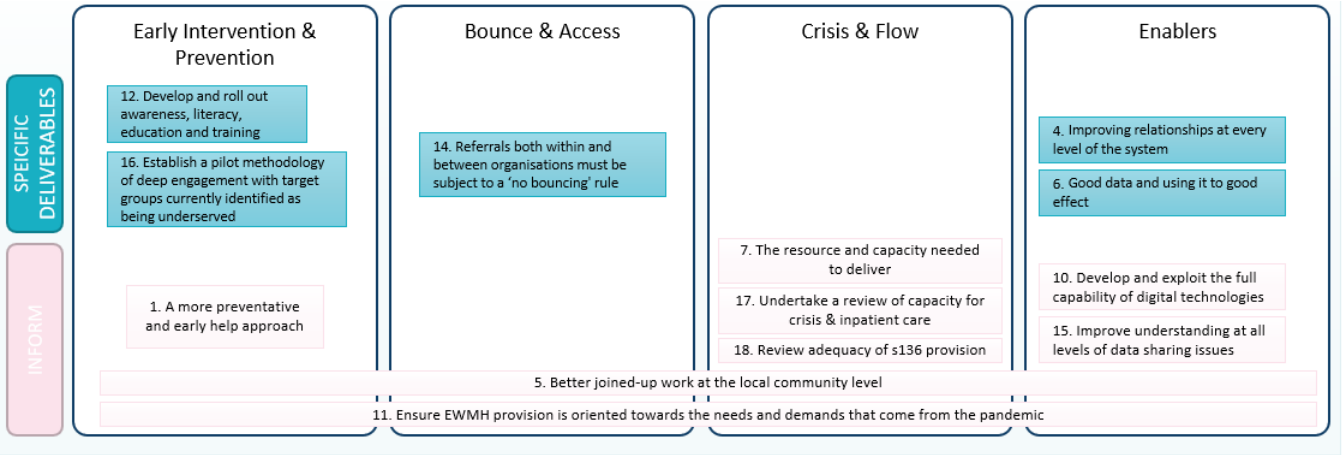
12.1 This report has demonstrated areas of progress and innovation to improve our use of digital and data insights. However, we are conscious that significant gaps remain in our understanding of population need and our ability to report population level impact. Digital fragmentation still creates challenges for people using services and those delivering support.

13. Update on MHIP progress since October 2022

13.1 Programme Architecture

The original 19 recommendations were mapped into four overarching programmes, mapped to other parts of the system or closed where they were completed.

This mapping exercise was signed off by the Mental Health System Delivery board in February 2023 and is detailed below.



The four priority programmes are:

13.2 Programme 1: Early intervention and prevention

Mapped to this were:

- Recommendation 1. A more preventative and early help approach
- Recommendation 12. Develop and roll out awareness, literacy and training
- Recommendation 16. Establish a pilot methodology of deep engagement with target groups identified as underserved

13.3 Programme 2 Bounce and Access

Mapped to this was:

- Recommendation 14. Referrals both within and between organisations must be subject to a 'no bouncing' rule

13.4 Programme 3: Crisis and Flow

Mapped to this were:

- Recommendation 7. The resource and capacity needed to deliver
- Recommendation 17 Undertake a review of capacity for crisis and inpatient care
- Recommendation 18. Review adequacy of s136 provision

13.5 Programme 4: enablers (culture, data and digital and workforce)

Mapped to this were:

- Recommendation 4. Improving relationships at every level (culture)
- Recommendation 6. Good data and using it to good effect (data)
- Recommendation 10. Develop and exploit the full capabilities of digital technologies (digital)
- Recommendation 15. improve understanding at all levels of data sharing issues (data)

13.6 Mapped across and to inform all 4 programmes were recommendation 5 (better joined up work at the local and community level) and 11 (ensure EWMH provision is oriented towards the need and demands that come from the pandemic) and subsequently the cost-of-living crisis.

13.7 In regard to wider recommendations, some of these have been picked up and incorporated into existing "in flight" system programmes including (not exhaustive):

- Recommendation 3. Resilience, early support and helping people understand and access it (P2 of the HWBB)
- Recommendation 8. Engaging and supporting schools (part of wider CYPS work)
- Recommendation 19. Review the funding, commissioning, and provision of the six IAPT services (part of wider integrated commissioning work)

13.8 The closed recommendations were:

- Recommendation 2: A shared co-produced vision
- Recommendation 7: Resourcing review
- Recommendation 9. Simplify and streamline MH governance (this is detailed later in the paper as work in ongoing)
- Recommendation 13. Surrey-wide communication campaign

14. Progress made across the key 4 priority programmes

14.1 Programme 1: Early intervention and prevention

14.2 Outline of the work

During 2022 it was decided that the early intervention and prevention recommendations from the MHIP be integrated with the Health and Wellbeing (HWB)

Strategy's Priority 2, 'Supporting the mental health and emotional wellbeing of people'.

The Priority 2 Outcomes, following the summer 2022 refresh, are:

- Adults, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources.(Outcome one).
- The emotional well-being of parents and caregivers, babies and children is supported (Outcome two)
- Isolation is prevented and those that feel isolated are supported (Outcome three).
- Environments and communities in which people live, work and learn build good mental health (Outcome four).

A Mental Health Prevention Oversight & Delivery Board (MHPODB) was established in September 2022 to oversee and drive forward this programme of work and ensure alignment with the emerging Integrated Care Strategies for Surrey Heartlands and Frimley.

14.3 **Funding**

This Board does not have a budget beyond allocated officer and members' time but aims to influence and coordinate spending to align with Priority Two outcomes, including steering the targeting of the £9.5m Mental Health Investment Fund. The Board will also contribute to the proposed system wide prevention spend mapping exercise being proposed for mental health by the population health management team in Surrey Heartlands.

14.4 **What we have done**

The MHPODB has developed a Work Plan which sets out specific priorities of work and activities operating through four work areas, focused on Surrey's Priority Populations, informed by Place and draws on public mental health evidence of preventative interventions which will impact:

- Work Area 1 - Steer and oversee the HWB Strategy Implementation Plans for Priority Two projects and programmes, in alignment with the MHIP's early intervention and prevention deliverables.
- Work Area 2 - Identify gaps in provision or under-developed support for Surrey residents as priorities for investment, including through working with communities, based on an enhanced understanding of Place, HWB Strategy Priority Populations and Key Neighbourhoods.

- Work Area 3 - Continue to develop improved and shared approaches to measuring, monitoring and reporting impact of projects and programmes for preventing mental ill health, within and across the HWB Strategy and MHIP.

- Work Area 4 - Assess, share and use new regional, national or international research and report findings as appropriate, within the Surrey Data Strategy approach.

14.5 **What Have We Achieved**

The JSNA 2023 has been completed for mental health and sits under Work Area 2. The outputs and recommendations from the JSNA are included in appendix one. Prevalence data and recommendations align with the detail in this report.

14.6 **Impact**

The following are examples of work drawn from December 2022 – June 2023 Highlight Reports to HWBB demonstrating change and improvement linked to the 4 Priority 2 outcomes:

- AFloaT is a new service taking professional referrals in the Surrey Heartlands area to support those affected by moderate to severe mental health difficulties as a result of maternity experiences (Outcome 1)

- SABP has recruited 6 Surrey Additional Reimbursement Roles Scheme Mental Health & Well Being Practitioners in September, through the new ARRS in primary care networks to be embedded in primary care practices to support people with mild to moderate mental health needs. (Outcome 1)

- Dementia Strategy delivery resulted in new, accessible resources for targeted groups, following a review mapping all voluntary services around dementia and part of a wider campaign (Outcome 1)

- Extensive consultation took place during 2022 on the refresh of the Emotional Wellbeing and Mental Health (EWMH) Strategy for Surrey's children and young people, and an action plan has been established across its six themes (Outcome 2)

- A Draft Best Start for Surrey Strategy 2022-27 has been published on where we need to work collaboratively to improve outcomes for pregnant people, babies, children, and families in the earliest years (Outcome 2)

- End Stigma Surrey has published its toolkit on how to reduce stigma, a directory for how to challenge discrimination and blogs of Lived Experience Champions' stories (Outcome 3).

- Through the HWB Strategy's implementation plan refresh, support was given to developing a logic model to re-design the Green Social Prescribing programme into a broader Surrey-wide approach to Green Health & Wellbeing (Outcomes 3 & 4)

- A Future NHS Green Health Collaboration Platform was launched on 3 November 2022 to build a strong, skilled and connected network of Green Health and Wellbeing professionals across Surrey (Outcome 4)

- A Prevention (Mental Health) working group for key neighbourhoods in Reigate and Banstead (incorporating ICB, SCC and R&B Community leads) has been set up to understand the key issues for residents and current provision (Outcome 4).

14.7 Next steps

MHPODB meeting 22nd May 2023 is considering key priorities and projects in the context of the HWBS Implementation Plan Refresh including continued discussion on the alignment with the other priority areas of the Health and Well Being Strategy which also impact mental health.

The MHPODB will continue to update the HWB Board on progress.

15. Programme 2: Bounce and access

15.1 Outline of the work

The bounce programme was developed from 'Recommendation 14. Referrals both within and between organisations must be subject to a 'no bouncing' rule' and 'Recommendation 5. better joined up work at the local and community level'.

15.2 What we have done

Scoping of the programme began in detail in January 2023 including mapping other major programmes addressing 'bounce'.

A series of focus groups and workshops took place which defined the problem and identified potential solutions on areas if improvements.

The initial focus group in January 2023 was led by Surrey Coalition's Independent Mental Health Network (IMHN) comprised of people with lived experience (including broader written feedback), followed up with conversations within the placed based independent mental health networks comprised of people with lived experience and front-line staff and clinicians.

People with lived experience told us:

15.3 What have we achieved

- Recognising that although this is a much debated and long-standing phenomenon within Surrey, that no definitive definition existed a working definition was co-designed, which is:

"*Bounce occurs when a person (and their carers/family):*

- *Has difficulty getting into services;*
- *Is passed between services; and/or*
- *Is 'dropped' by services*

in a way which results in that person's needs not being met and an accompanying feeling of rejection."

- A new 'no bouncing' principle has been drafted:

"If the first point of contact can't meet your needs, someone will hold responsibility for getting you to the place(s) where your needs can be met, and you and your carers/family will know who that person is and be able to contact them."

- Mapping of work and identifying particular places in the systems where there are challenges and opportunities for focussed work

- A logic model has been developed which provides the framework on how outcomes and impact can be measured going forward. The identified areas of focus include:
    - Culture shift – Services supporting person centred approach
    - Increase expertise to provide care (Knowledge)
    - Communication & collaboration across services
    - Further service resourcing & funding

Against each of the impacts above are draft outcomes and activities.

15.4 Evidence of impact

An evaluation framework for the programme is being developed by Unity Insights to ensure current programme and projects addressing bounce plus any additional areas of focussed work/projects needed to address bounce have the desired impact of reducing if not eliminating bounce.

As part of the mapping work, 2 specific projects have been identified already actively addressing bounce. These are detailed below.

15.5 Changing Futures: Bridge the Gap Trauma Informed Outreach: working with people experiencing Multiple Disadvantage

Changing Futures is a funding programme to improve systems and services in order to achieve better outcomes for people with multiple disadvantage. Surrey was awarded £2.8M (August 2021 – 31 March 2024) and SCC public health are currently preparing a bid for a further year of funding against a funding offer of 70% of full year funding.

15.6 Bridge the Gap reducing "bounce" around Surrey's systems:

Bridge the Gap (BTG) offers a place-based prevention service by offering a Trauma Informed relational model of intervention with our valuable VCSE partners who are embedded within our communities. The BTG workers work to build a therapeutic relationship with their client so that positive facilitation can be conducted included 'navigating' appropriate support for their client collaboratively with pertinent multiagency partners.

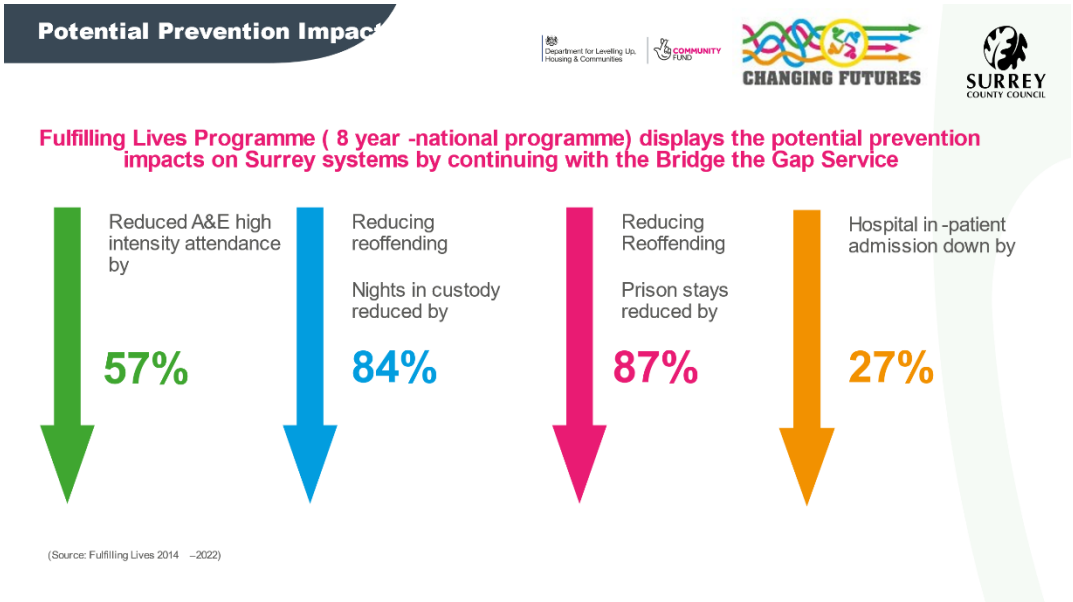
Anecdotal reports demonstrate positive outcomes including reduced:

- Accident and Emergency attendances
- Antisocial behaviour orders

- Ambulance Call outs
- Criminal justice issues
- Drug related deaths
- GP attendances
- Emergency police and fire service call outs
- Failure through accessing wrong doors – mental health if neurodivergent
- Failed appointments
- Pharmacy emergencies

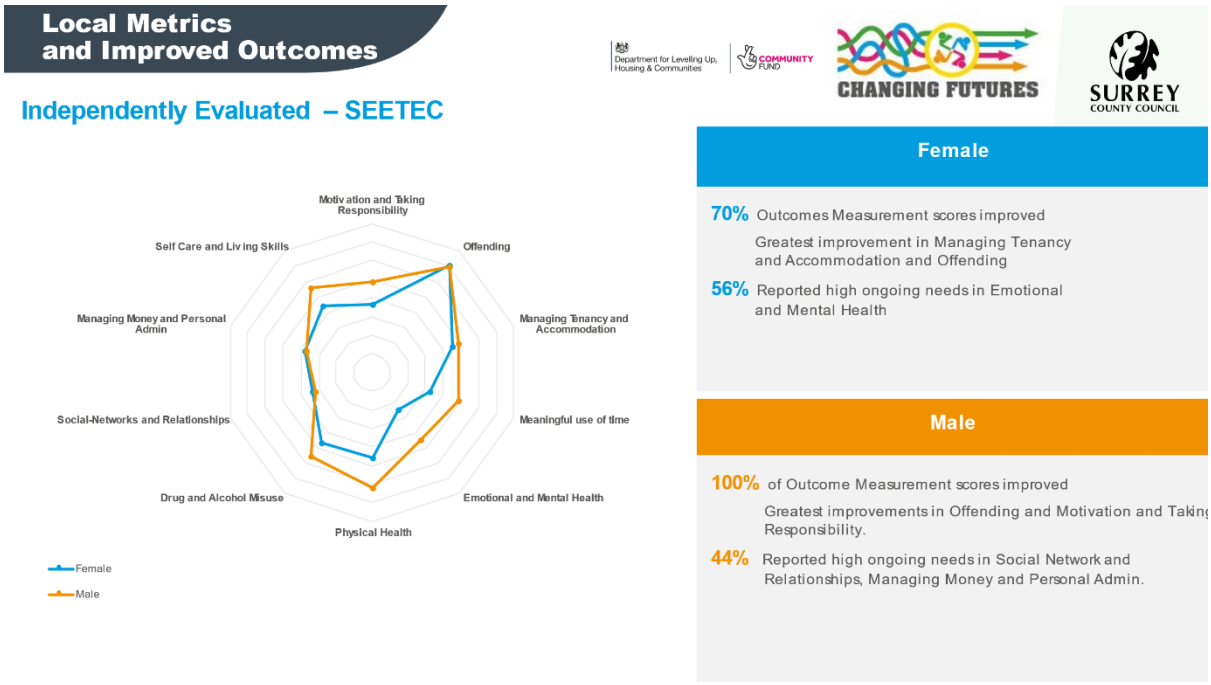
And improved accommodation sustainability, reduced homelessness and rough sleeping, substance use reduction, engagement into planned treatment and health care services, harm reduction / Suicide prevention, health benefits (including wound care, dentistry, chiropody, respiratory issues, immunisation, smoking cessation, cardiovascular), VCSE partnership and workforce skills and development and community connections.

Published evidence from a similar national programme (Fulfilling Lives) which operated for eight years across 12 areas of the country (excluding Surrey) demonstrate the following reductions for people with multiple disadvantage:



To date we have been focussing on recording improved outcomes for the 65 beneficiaries in receipt of the Bridge the Gap Trauma Informed Outreach Services.

The slide below is an extract from an independent local evaluation of the Bridge the Gap service.



Some of the measures above in are already recorded. The team will shortly be working with system analysts within the Public Health Intelligence Team and Surrey Heartlands to apply the measures to a costing formula to provide a local picture.

15.7 **Community Transformation:** GPimhs

- A first independent evaluation report (of a series) was received in March 2023 and provides preliminary insight into the impact and efficiency of GPimhs within Surrey Heartlands.
- Results indicate an overall decrease in estimated bounce from the GP to the Community Mental Health Recovery Service (CMHRS) at the stage of referral via SPA, as presented in Figure 28.
- This demonstrates that GPimhs is likely to reduce the effect of patients bouncing around services and redirected back to primary care without receiving support. It should be noted that the Community Transformation Programme is due to complete roll out in 2023/24 and that more mature sites are having a greater impact given the time it takes to embed this new way of working.

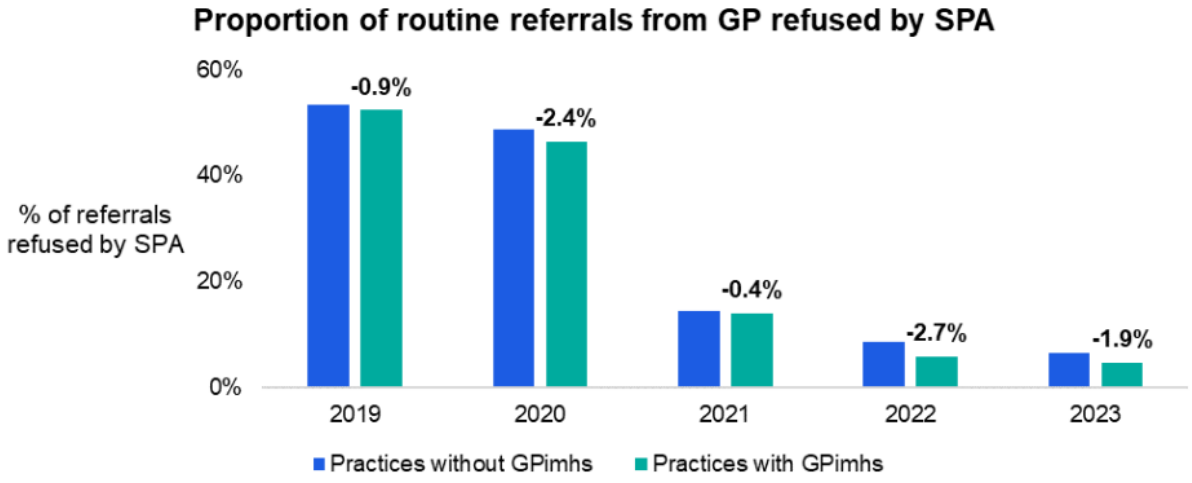


Figure 28: Chart showing the proportion of routine referrals from GPs that were refused by SPA, comparing referrals from practices with and without GPimhs (SystmOne).

15.8 **Funding for GPimhs**

NHS Long Term Plan funding for community mental health is the biggest investment in mental health since the inception of the NHS, because of historic timely access and quality gaps. Across Surrey Heartlands and all of Frimley South (North East Hampshire and Farnham) the NHS is investing £35.9 million, in 5 years of transformation (2019/20 to 2023/24), to recruit new workforce and radically redesign community-based mental health services in partnership with PCNs as well as local authorities and the VCSE sector, service users, families and carers. By 2024/25 the new recurrent services implemented during transformation, will be fully operational in business as usual. The majority of spend is on new workforce across both the NHS and VCSE commissioned partners (Andover MIND, Catalyst, Mary Frances Trust and Richmond Fellowship).

With regard to the overall MHIP 'no bounce' priority, there are currently no further resources allocated to this programme to manage delivery and any new identified projects will need to be funded.

15.9 **Next steps**

- Continue to socialise the definition and the 'no bouncing' concept and principle.
- Share the logic model and begin an iterative process with stakeholders including people with lived experience to share and finalise the model which will then drive the focussed work/ projects for delivery to address 'bounce'.

- By June 2023 develop an evaluation approach for the programme to include a critical assessment through various robust and real-world processes to understand whether solution meets its objectives/aim, offer greater insight into the effectiveness, efficiency, acceptability, equity, and feasibility and help to show real-world impact to accelerate the spread and adoption i.e., evidence-based practice.

16. **Programme 3: Crisis and Flow**

16.1 **Outline of the work**

The Crisis and flow programme was set up as a formalised programme in October 2022, led by Surrey and Borders Partnership Trust working collaboratively with system partners e.g., Community Connections, Surrey County Council, and the ICB.

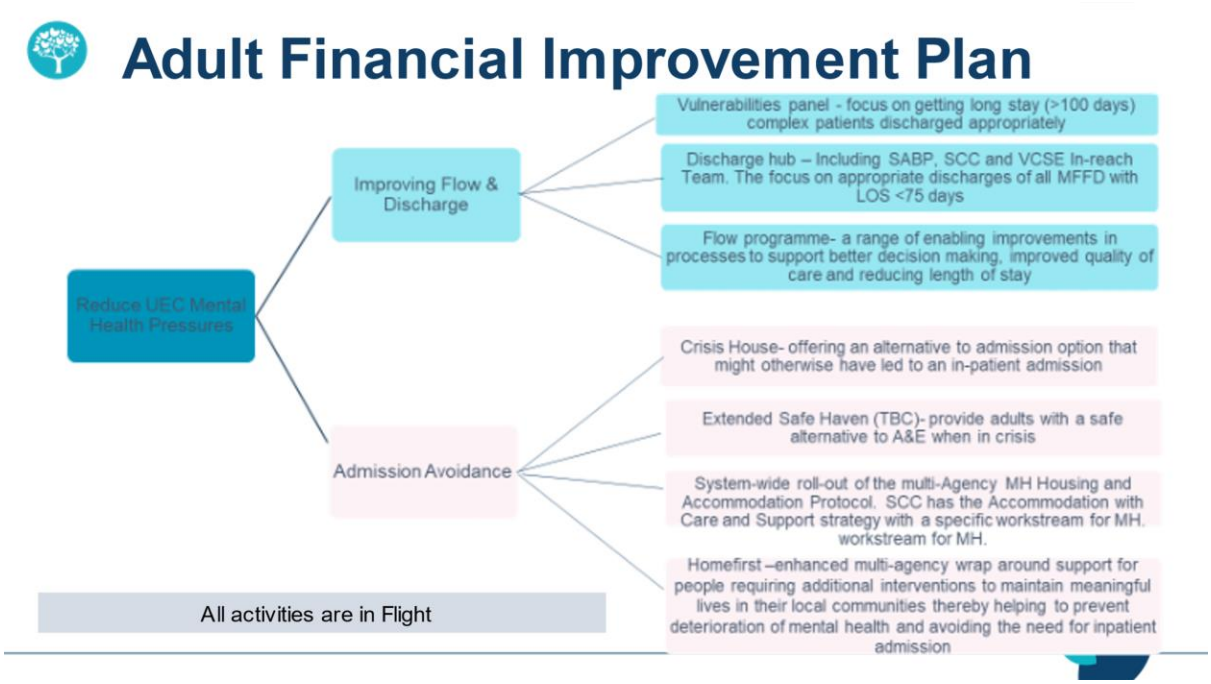
This addresses 'Recommendation 7. The resource and capacity needed to deliver', 'Recommendation 17 Undertake a review of capacity for crisis and inpatient care'; and 'Recommendation 18. Review adequacy of s136 provision'.

This programme also forms the basis of the adult Financial Recovery Plan and aims to:

- Reduce demand pressure
- Improve patient flow processes
- Reduce Length of Stay (LOS)
- Eliminate out of area placements
- Reduce spend on private sector beds and agency premium
- Development of workforce competencies to support gatekeeping/ signposting
- Develop clear and effective discharge processes
- Optimisation of opportunities through digital-enabled technologies/processes

16.2 **What We Have Done**

The driver diagram sets out the programme of work:



Adult basis for financial recovery:

We are using significantly more in-patient beds above our plans (40-50 people at any one time) an seeing continued high demand for in-patient services, and increased acuity and complexity of needs.

As a result, we are:

- Spending more on inpatient beds
- Commissioning more beds from independent providers at higher bed day rates (c 3 x higher than NHS bed)
- Spending more on agency staff to meet rising demands
- Impacting negatively on poor patient experience

(The children and young people narrative '*Mindworks Surrey challenges ahead'* is included as Appendix Two).

16.3 Prevention HOMEFirst

HOMEFirst launched in early 2023 and provides an increased level of intervention for people with complex mental health needs who require enhanced levels of support to live in the community to enable people to live well at home; preventing any future deterioration in their mental health, or the need for in-patient admission.

We know supporting people to live well with their families and friends in their local communities is the best way of managing any decline in mental health and aid recovery and those with a long-term mental illness who have experienced repeated episodes of mental ill health or have a history of inpatient admission, can fare better with the right care and support at home.

HOMEFirst provides the means for a wide range of agencies to work successfully together to offer enhanced levels of care and support that will help people maintain a stable condition for longer. This includes SABP, Surrey County Council and Community Connections.

16.4 **Evidence of Impact**

Since March 2023, weekly multi-agency My SharedCare Forums are now operational in 3 localities across the whole of the Surrey Heartlands footprint.

- 31 clients are now under the care of the HomeFirst approach
- A further 32 planned new cases are being taken forward into a My SharedCare forum to develop a personalised care package
- 2 clients have had a potential admission prevented
- 1 client has had a reduced length of inpatient stay with HomeFirst working with the discharge hub to prepare an enhanced package of care and facilitate early discharge

16.5 **Next Steps**

1. Working with colleagues to develop an automated reporting dashboard to track impact of HomeFirst as it moves from project mobilisation to business as usual.
2. Recruitment is underway to build the core HomeFirst team to include Lived Experience practitioners, Carer support, dedicated pharmacy support, housing advisor, additional clinical and administrative support.
3. Ongoing engagement with system partners to socialise the HomeFirst approach and build on the success to date.
4. Develop further the supported housing outreach model
5. Discussions underway to rollout out the HomeFirst approach into Frimley South, working with Hampshire County Council and Frimley ICS

16.6 **Funding for this project**

The programme has been built into the existing community transformation work already underway. Some additional funding has been invested to accelerate the work.

The financial recovery interface with HOMEFirst is based upon admission avoidance.

16.7 Crisis House

The 'Maple Tree Lodge Retreat' opened in December 2022 and offers a short-term, intensive community-based 6 bedded crisis house as an alternative to hospital admission for people who find themselves in significant mental distress, which is recognised to be potentially less stigmatising, coercive and institutionalised.

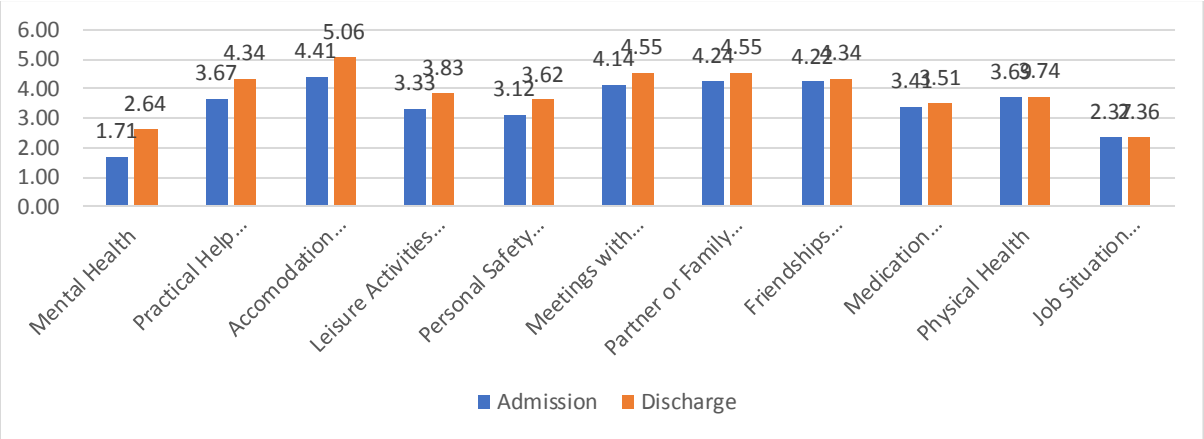
This is provided by Surrey and Borders NHS Foundation Trust in partnership with Comfort Care Service and is based in Knaphill, Woking, catering for people across the whole of Surrey, offering 3-to-7-night stays, 24/7, 365 days a year.

Suitability for admissions is based on assessment of risk, level of disturbance, consent and co-operation with the service offer against eligibility criteria.

16.8 **Evidence of Impact:**

From the 2nd December 2022 to 3rd April 2023, 49 people have completed their admission to the Retreat.

We are already seeing evidence of improved outcomes and on average, patients experience improvements across nearly all sub-domains of the DIALOG scale*, but the first five on the left are those with the greatest improvements.



* *DIALOG is a scale of 11 questions. Patients rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. DIALOG provides a score for subjective quality of life and a score for treatment satisfaction.*

16.9 **Funding**

Funding has been agreed for 12 months to demonstrate return on investment and it is anticipated that 6 crisis beds will save the cost of 9 contracted beds with cost savings attached through 3,285 contracted beds days saved per annum (linked to the financial recovery programme).

16.10 **Next steps**

- Continued development of the service to increase occupancy rates
- Continued development of outcome measurements and measuring admission avoidance

16.11 Flow Programme

The workstreams outlined below sit under the Flow Programme (see driver diagram). These enabling projects are a critical part of the wider improvements to crisis, flow 16.12 and inpatient transformation and will support operational and financial efficiency.

16.12 Admission Avoidance & Gatekeeping

The Admission & Gatekeeping workstream supports a number of key-enabling workstreams that make up the wider Crisis, Flow & Inpatient Transformation Programme (covering working age adults).

16.13 **What have we done to date**

The workstream includes operational improvements and reviews including:

- Development of new digital products/tools to support improved admission gatekeeping operational processes (i.e. Reducing the use of Out of Area Placements, development and)
- Improving functionality and optimisation of SystmOne (SABP Electronic Patient Record) to improve the patient pathway, develop better record keeping and aid better decision making. This also supports releasing time to care by reducing the admin burden on clinical teams.
- Identification of new ways of working where flow of patients and transition of patients can be improved with patients being managed better in the community through the introduction of virtual wards (for CMHRS/HTT teams)
- Redesigning diagnosis pathways to ensure that patients are only admitted to an acute inpatient ward when absolutely appropriate.
- Improving Home Treatment Team services through the introduction of new digital tools to manage caseloads better and to review/increase capacity of skills across the service (including implementation of the HTT SBAR, HTT workforce structure and operating model, HTT Springboard on S1)

16.14 **Evidence of Impact**

- Since July 2023 when there was a targeted focus to reduce OAPs, we have consistently been at 0 OAPs since February 2023.

- In April 2023, a working group led by a specialist doctor have begun to map out the Emotionally Unstable Personality Disorder pathway. Whilst this is early on in the discovery phase, it is felt that some people admitted with EUPD could be redirected to an alternative setting. The SABP Patient Flow dashboard suggests that of people admitted to an Adult Acute/PICU bed, 15% of these people were diagnosed/coded as having personality disorder (which is comparable to other Trusts who report between 12-20% of people admitted as having personality disorder). We are working through this in more depth to support defining a high-level condition-specific pathway. This feeds into other work we are doing around condition-specific pathways to focus on improving and optimising patient journey's and facilitating more meaningful and effective admission and discharge.

- HTT SBAR went live in November 2022. The data suggests that the MDT meetings have been reduced by 30-60 minutes on average, which for just one HTT team equates to upwards of 3,500 hours of potential clinical time saved per year, meaning staff have more time to prioritise patient care. Entering the MDT updates directly into SystmOne has also removed the time spent by Administrators copying information from Excel into SystmOne at the end of each MDT (previously around 2 hours per day), removing the need for overtime and the associated costs.

- The CFIT leadership team are working with the Locality teams and HTT lead to identify what the ideal team structure would look like. We are working with HR colleagues to explore ways to support recruitment and retention in this space. This will support sustainability of new ways of working culminating in a clearly defined operating model.

16.15 **Next steps**

- To continue to develop the diagnosis pathway mapping identifying opportunities to improve operational efficiency and patient experience

- To continue to monitor benefits realisation for the digital products that have been implemented across SABP

16.16 **Funding for this project**

This work is part of the wider Crisis, Flow and Inpatient Transformation Programme that to date has been funded through the Digital Directorate.

As this is an enabling project, there is not a true 'cost saving' attached to this, however the work contributes to the wider financial recovery work and is expected to support reduction in overspend and support ongoing financial efficiency.

16.17 Enhanced Bed Management

The Enhanced Bed Management workstream supports a number of key-enabling workstreams that make up the wider Crisis, Flow & Inpatient Transformation Programme (covering working age adults).

16.18 **What have we done to date**

The workstream includes operational improvements and reviews including:

- Improving Bed Management team structure and operating model to support improved operational management and optimisation of bed flow across WAA beds at SABP.

- Review of existing digital processes to support data validation (i.e. electronic transfers of care/readmission rates)

- Rollout of eObs to monitor and record patient observations. This helps clinical teams to manage inpatients more effectively

- Optimisation of smartboards following implementation on inpatient wards to support MDT, improved ward rounds and improved visibility/visualisation.

16.19 **Evidence of Impact**

- Data validation work is underway to analyse our readmission rates. This to understand true readmissions vs transfers of care (either from contracted beds to SABP beds or from PICU to Acute beds). The CFIT programme has requested this data regularly so that we can track and monitor.

- Initial work with the bed management team around structure and ways of working has proven positive. We are having a team away day in June to develop the operating model further with a view to improving operational processes.

- Smartboards were implemented on Juniper, Mulberry, Magnolia and Rowan wards. Whilst these are being used well, there is opportunity to fully optimise the use of these. The team are working to support teams with use of these. We are also updating the Clinical MDT room on a ward to be an MS Teams room which will improve operational processes and handover.

16.20 **Next steps**

- Continue to develop the bed management operating model.

- To identify further opportunities to optimise the smartboards working with clinical teams.

- Scale and adoption of eObs and to include physical MH observations in this work.

- Scoping of SAFER+/Red2Green work and benefits realisation work

16.21 Improving Discharge

The Improving Discharge workstream supports a number of key-enabling workstreams that make up the wider Crisis, Flow & Inpatient Transformation Programme (covering working age adults).

16.22 **What have we done to date**

The workstream includes operational improvements and reviews including:

- Design and implementation of Discharge Planning Tool to help improve admission and identify early on, barriers to discharge. The information capture has also been streamlined supporting improved operational efficiency.

- The 'Medically Fit For Discharge' nationally reported metric was recently changed to Clinically Ready for Discharge (CRFD).. Digital work was undertaken to mobilise this change and data capture requirement in the patient EPR.

16.23 **Evidence of Impact**

- The Discharge Planning Tool was piloted in February & March 2023 and has now been fully implemented. This has had a positive impact on identifying barriers to discharge as well as individual's personal circumstances much earlier in the patient pathway. The digital tool has been well received and adopted well and is proving positive in recording this information.

- 'Clinically Ready for Discharge' (CRFD) has been live since April 2023, however it is still going through the process of outlining the reporting and data representation, as the old 'DTOC (delayed transfers of care) needs to be closed off from a reporting perceptive. The Impact has been positive in outlining cases that are clinically optimised for discharged and has aligned itself to the inpatient operational processes that enables barriers to be unlocked with system partner. This is evidenced and gives the system an easy process to easily identified those CRFDs in 4 broad categories that can be used to improve the system and gain more awareness/ improvement within the discharge pathway

16.24 **Next steps**

- To continue to fully implement initiatives including those that support the financial recovery (i.e. discharge hub and vulnerabilities panel for complex patients)

- To explore Discharge to Assess Pathways and identify potential impact opportunity for SABP

17. Discharge Hub

17.1 **Outline of work**

The discharge hub brings together team members from **Surrey Social Services** (Social Services Manager and Social Workers), Community Connectiond **In-reach Team** (In-reach manager and workers) and **SABP staff members** (bed management team, including but not limited to Bed Flow Administrators, Discharge Co-ordinators, Bed Flow Managers), Administrators, Matrons, HTT Discharge Facilitators and our Associate Director of Flow and Bed Optimisation

This co-located multi-disciplinary team of professionals, focus on supporting people who are currently admitted to an SABP funded inpatient bed who may have potential barriers to a timely and safe discharge.

The aim of the hub is better help and manage the capacity of our inpatient SABP funded beds and support safe and timely discharges of people who are currently admitted.

17.2 **What have we done**

The team co-located in early 2023 and brought together relevant and appropriate external and internal team together into a physical space to enhance collaborative working

The team have developed better ways of taking practical steps to resolve the barriers that have been delaying safe and timely discharges.

What have we achieved:

- An identified physical space, located at Fern Lodge to benefit from the engagement, communication and accountability from in-person presence.
- Act on the known assumption that early identification and action on potential barriers can prevent unnecessary delays
- Multi-agency commitment to resolve the identified barriers to discharge, including regular updates from in-reach and social services
- Improve information flow between partner organisations through regular contact
- Improve access to our wards for our external partners through fob access and car parking
- Week-day morning meetings where the teams focus on the early discharge planning of people newly admitted to SABP funded inpatient beds. The meeting focuses on actions with attention on following up on those actions and the action owners. the team is now starting to address required actions for some people who have been in hospital a while and will focus on 5 people each week, and the daily associated actions to progress their safe and timely discharges.

- The Team review one case-study each week and what led to the admission of the person using our services (to start soon)
- Encourage, (and encourage more) the specific ownership of actions through the meeting.

17.3 **Evidence of impact**

The hub is aiming to:

- Reduce variation in the number of discharges per week
- Increase in the number of safe discharges per week
- Reduce length of stay upon discharge
- Reduce number of people with a length of stay over 75 days
- Early signs are already showing that reduction in length of stay of between 13-26 days:

17.4 Next steps

- Focus on people already admitted as well as new admission
- Aim to have input from brokerage in the hub meetings
- Newly appointed HTT Discharge roles

18. Vulnerabilities panel

18.1 **Outline of work**

A new cross panel comprised of senior leaders and commissioners has been set up facilitate immediate decision making around discharge for people with the most complex needs who have very long length of stays (100+ days) and require bespoke and complex individual community packages of support.

18.2 **What have we done**

There have been 3 panels which have reviewed 8 people who have been referred predominantly through the complex discharge panel.

18.3 **What have we achieved**

- Signed off terms of reference and confirmed the right system leadership attendees

- Recognised that the required support for people with presenting complex needs and circumstances are complex and as such require bespoke solutions which requires strategic commissioning support (which has been instigated)

18.4 **Evidence of impact**

- All of those seen by the panel have discharge plans in place/ have been discharged.

18.5 **Next steps**

- Expanding the panel to look at those known to be at risk of admission with similar profiles (including those on the dynamic support register)

- Strengthening the complex package of care through more innovative approaches. This includes working alongside strategic commissioning to further explore the market to identify providers who can offer bespoke packages of care under the Improving accommodation programme (see below)

18.6 **Funding**

There is no funding attached to the panel.

19. Improving accommodation with care and support for people with mental health needs

19.1 **Outline of work**

A Surrey County Council (SCC) programme of work is now in flight which builds on the formal approval of the inclusion of mental health into the accommodation with care and support (AwCS) programme. The programme focus is on prevention and addressing service gaps; alongside improving outcomes for people with mental health needs.

There are three key areas of work to help achieve the above:

1. A place to call home – accommodation that meets people's long-term needs

2. Support to recover - medium term accommodation to help people recover and become more independent

3. Short-term support - accommodation with support options to help prevent a hospital admission, manage a crisis or to avoid homelessness

19.2 **What have we done**

- Analysis of projected demand for supported independent living (SiL) for people with mental health needs indicates we will need an additional 185-210 units of SiL by 2030

- Analysis also indicates we need SiL specialisms for people with more complex needs and individual self-contained units and also outlines geographical gaps in service provision

- Workshop held with ASC, ICB and SABP colleagues in April 2023 with key actions arising around:

    - Further joint analysis with SABP of admissions/discharge data to be clear on what we need to approach the provider market to provide for the more complex and long stay cases

    - Joint work on the supported independent living specifications with new dynamic purchasing system to be in place by April 2024

    - Joining up of data around home treatment/home first team to demonstrate the need to invest further and scale up the offer to keep people in their accommodation and avoid unnecessary admissions

- Developed our Mental Health Accommodation with Care and Support Delivery Strategy which was approved by Cabinet in April 2023

19.3 **What have we achieved**

- Recruited a dedicated mental health supporting independence team to review people in existing SiL

- A review of in-house SiL, the Move to Independence service, and agreement to expand the provision

- Review of housing related support funded services, which provided greater certainty for providers and increased their commitment to working together to improve services

- Significant co-production to inform and develop new service specifications for SiL, with a new working age adult SiL dynamic purchasing system being tendered from September 2023, which will cover mental health and

disabilities. Proposal to separate services into support to recover and a place to call homes services.

- Exploring the opportunity to develop council owned land for SiL

- Agreement for the Sunbury hub development to include 6 units of self contained units of SiL for people with mental health needs

- Five sites have been allocated capital funding for feasibility assessments and allocated as in-principle for Supported Independent Living. These future developments are subject to successful feasibility assessments, full business cases and approval by Cabinet. The site names and locations are confidential and not in the public domain.

19.4 **Next steps**

- Continue to work with partners including SABP, the ICBs, District and Borough councils, providers and people with lived experience to deliver the strategy

- Bring together a task and finish group across health and social care to agree the action plan and any follow up task and finish group activity to progress the work identified in the April workshop

- Conduct feasibility studies on the 5 sites identified to confirm if they are suitable for mental health SiL

20. Extended Safe Havens (see annex also)

Under the financial recovery programme and on behalf of VCSE partners a funding bid to the Mental Health Investment fund was submitted unsuccessfully for additional resource to increase the daytime offering of the Safe Havens for three years to extend hours to deliver the service between 8am and 6pm at the Leatherhead and Woking sites at an annual cost of £585K.

21. Additional Update for Children and Young People

Under Recommendation 8. 'Engaging and supporting schools (part of wider CYPS work)'.

21.1 Mindworks Schools offer in District and Borough Clusters

- **Surrey's Mental Health Support Teams (MHST):** Overall planning and recruitment for next teams has commenced and remaining 4 MHST expected to start September 23. This will expand the team's growth and bring the total number of MHST up to 13 across Surrey.
- **School Based Needs Team:** School based needs team consist of Primary Mental Health staff, Community Wellbeing Practitioners, Early Intervention

Co-ordinators and MHST. Latest report from Primary Mental Health Teams: (Q4 23/24 data) Consultation sessions: 1325 of which 943 on direct CYP issues, top three being anxiety 14%, school refusal 13% and anxiety/ND 9% - self harm ~6%. There is a current caseload of 162 and all are being seen within 16 weeks. High satisfaction scores and lots of examples of positive feedback. Issues: access points / staff retention and recruitment / outcomes reporting.

21.2 Emotional Well Being and Mental Health Wider Strategy

- **EWMH Strategy**: The launch of the strategy was delayed due to staff sickness and delays in some engagement / feedback from NHSE / Stakeholder. It is now scheduled for mid-May following final agreement through CFLL LT on May 17th and Mental Health Prevention Oversight Board on 22nd May.
- **18 – 25 Transitions:** The YP Mental Health Transitions group have finalised the criteria for the Service Development Funding (SDF) investment for 23/24 to ensure there is a needs-based approach to improvement. Awaiting confirmation of SDF value and implementation process.

22. Progress against the 3 enabling workstreams

22.1 **Culture**

Under Recommendation 4. 'Improving relationships at every level (culture)'.

22.2 **Outline of work**

The quality of care we deliver, our openness to learning and improvement, and the degree to which our workforce feels valued and supported are all underpinned by our culture and approach to leadership. As such, culture change sits at the heart of the Surrey Mental Health Improvement Plan as a key enabler. As part of the wider MHIP, the MH Delivery Board are overseeing this workstream championing and supporting a reset of attitudes, values, goals, and ways of working.

The committee will be aware that Linguistic Landscapes were commissioned to undertake an independent review of culture with a focus on the fracture points in the system which impacted care delivery back in 2021/22.

A series of key findings and recommendations were made relating to 3 specific areas of change needed:

- Make relationships better: Relationships are not a 'nice to have' – they are essential to our work

- Have honest conversations: We need to interact differently to creatively solve problems together

- Remember we all care about the same thing: We all care about the individuals we're supporting – it's good to remember we're all in this together

22.3 **What have we done**

Given the resourcing constraints relating to this workstream and the ability to take the work forward, the areas of work where we have been focussing effort has been on:

1. MHIP programmes each to a identify culture priority
2. Evaluation framework (explore with Unity Insights)
3. Introduce system Schwartz rounds
4. Share findings widely with key partners
5. Scope and plan OD programme for MHSDB

22.2 **What have we achieved**

Changing culture and ways of working takes time. However, we have through the formation of the MHIP seen evidence of positive impact and greater collaboration across the system. Some examples are given below:

- **Surrey Heartlands Provider Collaboration:** A new Provider Collaborative involving three of the acute providers, Surrey and Sussex Healthcare NHS Trust, Royal Surrey NHS Foundation Trust, and Ashford and St Peter's Hospitals NHS Foundation Trust, and the mental health provider, Surrey and Borders Partnership NHS Foundation Trust has now been set up to look at better ways of integrating physical and mental health.

by:

- Transforming the experience of people with a long-term physical health condition who are twice as likely to have a mental health problem as their peers
- Improving the experience of people in mental health crisis who also require urgent and emergency physical health support
- Taking concerted action to address health related conditions and behaviours leading to a 20+ year life expectancy gap that persists for people with a serious mental illness.
- Working to ensure that people in mental health crisis are treated with the same degree of care and compassion as those requiring urgent and emergency care for a physical illness.

Change ideas have currently been developed which are now being worked through in detail to inform what rapid work can start and what longer term areas can be improved over time.

- The **Surrey Adult Mental Health Alliance** brings mental health provider organisations together around the shared vision of building good mental health and wellbeing for all the people of Surrey. Members of the Surrey Mental Health Alliance include VCSE, NHS and Local Authority delivery partners, local commissioning bodies of mental health services, and organisations representing people with lived experience. The purpose of the Surrey Adult Mental Health Alliance is to enable cooperation and joint working, at both strategic and operational delivery levels, ensuring that if anyone needs help, they will find services on offer for themselves and their family and carers which are welcoming, simple to access and timely. A key commitment of the Alliance is that no-one is turned away from a service without being given support to get the help they need. First established in 2021, the Surrey Adult Mental Health Alliance was formally constituted in March 2023 with the signing of an Alliance Agreement and the formation of the Adult Mental Health Alliance Board.

- The **Mindworks Alliance** has brought together statutory health and social care partner and voluntary sector partners to deliver emotional wellbeing and mental health services for Surrey children and young people.

- The **Coproduction and Insight Group** brings together a broad spectrum of system partners and people with lived experience. The monthly meeting always starts with a story from someone with lived experience where there is an opportunity to learn from both good and poor experience, including enabling closing the loop around escalations where needed.

23. Data and Digital

Under Recommendation 6. 'Good data and using it to good effect (data)' and Recommendation 15. 'Improve understanding at all levels of data sharing issues (data)'.

23.1 **Outline of work**

A recommendation from the October 2022 paper was '*For the Chair of the Mental Health System Delivery Board, the Joint Strategic Commissioning Convenors and Surrey and Borders Partnership, to use quantitative and qualitative data to direct the decision making process of the Mental Health Improvement Programme; and to update the Adults and Health Select Committee in a future formal meeting, on imminent/ensuing Mental Health System Delivery Board decisions on how to plan*

the delivery of the Mental Health Improvement Programme Plan, and on what data was utilised to direct these decisions'.

As part of the recently published JSNA chapter the Senior Responsible Officer noted caveats that big gaps remain in the data and the chapter and SRO recommendations include both a review of place based data and a commitment from the Surrey Analytics hub to take a key objective to manage availability and sharing of mental health data.

23.2 **What have we done**

To kick start this work an initial data pack was developed for the Mental Health system delivery Board (MHSDB) which collated and mapped all the system data where we record on mental health activity. Given the temporary withdrawal of support from the Analytics hub, the data pack was simply there to describe what data is available rather than undertaking any analysis of need.

The data included the key performance indicators for the NHS Long Term Plan deliverables for mental health. This is included as Appendix One.

However, the JSNA (despite noting there are gaps) has provided a significant pack of data and progress has been made on the patient record (see below).

23.3 **Patient Record**

The committee had previously requested details on the patient record, so the following explains and updates progress in the Surrey Care Record (SyCR).

The SyCR draws together and presents patient information from a range of settings including primary, secondary and community care, mental health and social care to provide an overview of a citizen's health and care status.

SABP are sharing the following data for MH:

- Demographics
- Referrals
- Care Programme Approach
- Diagnosis
- Mental Health Act
- Early intervention in psychosis

SyCR is currently accessible to the following organisations for Surrey Heartlands patients:

- All of our acute hospital trusts
- All of our main community providers
- Surrey Heartlands GP practices
- Our mental health provider
- Our 111 & OOH provider
- Surrey County Council (social care)
- A number of hospices
- The SECAmb control room records

SyCR does display ethnicity this data under 'demographics' when it is sent through by partners. The quality of this data is a question for those managing the EPRs where the data is captured e.g. SABP. The PSC completed a review of the recording of protected characteristics for the South East region and have had subsequent conversations with SABP to progress this.

There are plans to enable to VCSE colleagues to view SyCR. This is part of the Integrated Digital and Data Platform outline business case (which details future developments for key digital capabilities including SyCR) which got approval from the ICB Executive Board to move to full business case (FBC). We are anticipating the FBC being approved in September 2023 which will enable providing the resource to do so.

23.4 **Next steps**

- As a next step, the MHSDB has requested that a 'use case' approach is adopted to help navigate the available data when analytics capacity is identified.
- System leaders are currently trying to address the data issues and have now planned a Hackathon in June 2023 including population health management colleagues to further develop the 'use case' approach.
- To follow through on the JSNA SRO recommendations to complete a review of place based data and the commitment from the Surrey Analytics hub has taken a key objective to manage availability and sharing of mental health data.

24. Digital

Under Recommendation 10. ‘Develop and exploit the full capabilities of digital technologies (digital)’.

Adults and Health Select Committee in October 2022 received a paper title ‘MENTAL HEALTH IMPROVEMENT PLAN TECHNOLOGY UPDATE’ which provided the Committee with an update on use of technology and digital tools in the Mental Health Improvement Plan.

25. Workforce

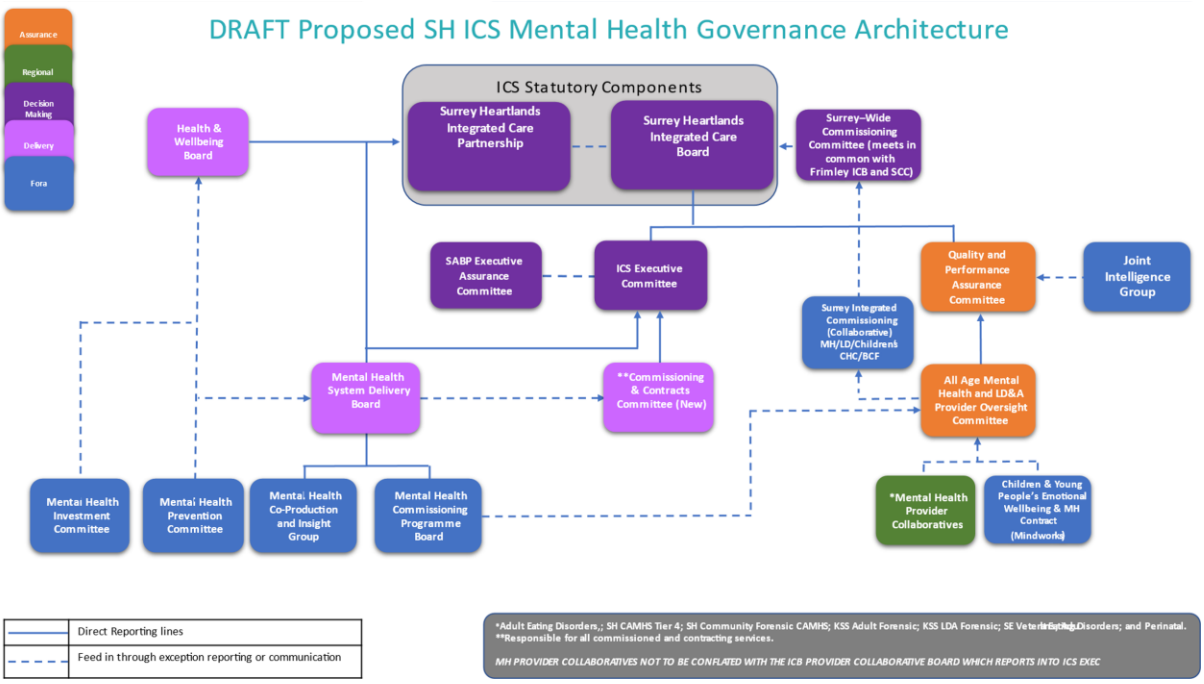
Workforce recruitment and retention remains a challenge across the Integrated Care System.

Mental Health System Delivery Board have set aside a significant slot for a workforce deep dive for the June Board and requested an update inclusive of data from all system partners in regard to mental health workforce including their current position in regard to recruitment and retention and work being done to address challenges. The MHSDB membership also requested that workforce wellbeing be considered.

This will build upon and add additional detail to the regular updates all partners submit to the Surrey Heartlands People’s Committee and the NHS focussed workforce data submitted as part of the annual operating plan 2023/24. Commitment was made by all partners including SABP, SCC (operations and commissioning) and the VCSE and providers.

26. Governance

Recommendation 9 was to ‘simplify and streamline MH governance’. The ***draft*** proposed entire SH MH system architecture is below and work is continuing to simplify and streamline the governance as also outlined below:



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The **Mental Health System Delivery Board** (the 'Board') oversees the improvement and transformation of mental health and emotional wellbeing in Surrey.

The scope of this work covers the full range of these services for all ages in Surrey. In particular, it includes the following existing and sometimes overlapping areas of work:

- The 19 recommendations underpinning the Mental Health Improvement Programme published in 2021 ('MHIP');
- 'Priority 2' of Surrey's Health and Wellbeing Strategy;
- Sustainability and financial recovery requirements of the health systems in Surrey;
- Delivery of the NHS Long Term Plan; and
- System ambitions around place, in line with local priorities and the recommendations of "Next steps for integrating primary care: Fuller stocktake report" published in 2022.

The remit of the Board includes all ages and covers the whole of the county of Surrey.

The Board does not have a role in assuring 'business as usual' delivery of mental health services or the awarding or management of contracts for these services. This function is performed by All Age MH and LD&A Oversight Committee.

System leaders continue to draft and develop the architecture.

Liz Bruce verbally presented the following suggested improvements to May MHSDB 2023:

1. Consider retitling the MHSDB to clarify the 'transformation' aspect of the Board remit.

2. MHSDB to report All Age MH and LD&A Oversight Committee as a formal Board (which in turn reports to Quality & Performance Assurance Committee 'QPAC') and up to the Integrated Care Board. The aim is to empower the board with more authority and reporting lines, and to be able to influence funding prioritisation and gaps in commissioning.

3. Rebalance the Board to ensure it does all ages (recognising that the Board business to date has been predominantly focused on adults).

4. Continue to develop and strengthen the remit of CPIG as a group that enables the voice of lived experience and stakeholders to feed into MHSDB

27. Programme Challenges (risks/mitigations/Table of risks)

During the context section risk were highlighted but are revisited below:

- Competing operational pressures
- Resourcing challenges to meet the need
- Funding position
- Scale of Transformation

- Staff Wellbeing
- Culture
- Digital and Data Insights

28. Conclusion

- The current **context** including the **funding allocation** is and continues to pose a significant challenge.

- The **Early Intervention and Prevention** programme is integrated and progressing.

- The **Bounce** Programme is a multi-faceted programme in development taking into account a vast array of pathways, stakeholders and experiences. It is at an early stage and will remain critical to deliver against.

- The **Crisis and Flow** Programme continues to deliver both projects and enabling projects to enable better flow and crisis response, led by SABP.

- Access to **data** remains a high risk. The planned Hackathon will enable the 'use case' approach to be articulated and bring together system partners including population health management and the Surrey Analytics hub to ensure the plan has the data needed.

- **Workforce** deep dive is scheduled for June 2023.

- Strengthening and streamlining **governance** will ensure a more direct route into the ICB for decision making, escalation and discussions on allocating of resources. This will improve the visibility of mental health priorities at a system level.

- In addition to the summary above, we recognise there is a significant amount of transformation work within mental health being undertaken outside of and in addition to the MHIP led by SABP, Surrey County Council, Mental Health commissioning, the VCSE, across our Acute Trusts and wider blue light services in response to the NHS Long Term Plan (LTP) deliverables and year on year operating planning and in response to emergent system challenges. **One integrated system mental health plan** would simplify this and support delivery and is agreed as the right approach by all system leaders.

- The **one integrated system MH plan** is proposed as multiyear to enable investment and resource planning, and to ensure opportunities such as those afforded by strategic commissioning and procurement can be planned in and realised.

- The one integrated system mental health plan would benefit strongly from being mapped against all other major health and social care programmes relevant e.g. Core 20+5; physical health and there are opportunities to articulate this approach e.g. within the aspirational Joint Forward Plan. As this report indicates, **programme and project management resource** is vital to deliver the broad range of mental health transformation under way in Surrey and the MHSDB Char and Deputy Chair recognise the need to resource adequately the all age MH transformation. There is a proposal for strengthening the Mental Health commissioning/programme capacity to

deliver on the MHIP and NHS LTP as well as developing Mental Health Integrated Commissioning Priorities and funding is being sought. There has been a formal request from Joint Executive Director **Adult Social Care & Integrated Commissioning** for time limited resourcing via underspends of vacant MH convenor role (vacant for over a year) and underspends in section 75 posts (previous requests have not been successful).

29. Recommendations

The Select Committee is asked to:

- Acknowledge the current challenging context.
- Offer any support to address the issue of funding allocation.
- Acknowledge and support the bringing together of all mental health transformation into one system Mental Health plan with allocated programme management resource.
- Acknowledge the progress made to date on the three major programmes and enablers.

Report contacts

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Contact details

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Sources/background papers

Emotional and Mental Wellbeing in Surrey Adults | Surrey-i (surreyi.gov.uk)

Pathways to Change Survey - Surrey Coalition of Disabled People

Surrey Minority Ethnic Forum (SMEF) and the Independent Mental Health Network (IMHN) Surrey & NE Hants: 'The Mental Health impact of Covid-19 on people from BAME groups and barriers to accessing services and support'.

Appendices

1. NHS Long Term Plan Year end data pack

SHICB Mental Health Report APRIL-23_v3.p

2. **Children and Young People:** *Mindworks Surrey challenges ahead*

- *In response to increasing number of referrals and activity, Intensive Support Services increased the workforce numbers to help meet the demand and needs of children and young people. The impact has left SABP in a deficit position making it unsustainable to continue running the Intensive Support service at the current cost. We are working with the Surrey Heartlands ICB, and plans are in place to address the cost pressures and look at how Mindworks may be able to meet the needs of children and young people in other ways through early intervention and support.*

- *SABP are working through this challenge as an Alliance and a children's system and remain committed to delivering the Mindworks vision and objectives. However, the impact of the plan is likely to result in the agency workforce in SABP decreasing and children needing clinical intervention may well have to wait longer before an assessment or treatment.*

- *To manage this situation further, transformation in the current offer is required. Mindworks partners are collaboratively working together with schools and families to see how a more robust and comprehensive family resilience offer can be developed, offer more intervention packages for under 10's / primary school /CYP in transition, expand the use of groupwork as well as strengthening work collectively with wider partners to have a Surrey wide early intervention support approach and embed THRIVE more firmly so that risk support is available from Mindworks to teams within schools and wider Children's services so they can be confident in their response to risk. How these ideas will be funded has not yet been agreed but one of the avenues to be explored is the new Mental Health Improvement Fund launched this year and funded by Surrey County Council and the Health System.*

- *Acknowledging this current context along with the financial deficit position described earlier requires significant transformation, to bring the contract costs back into balance otherwise managing down the spend will simply result in costs and care being shunted to other organisations in Surrey and worse outcomes for children and young people. Further thought regarding investment to these services and what radical transformation, such as how all schools could receive an offer like MHST that wraps around them and their children, could have influence on the lives of CYP, families and partner organisations. These matters are being explored through the Financial Recovery process overseen by the Surrey ICB.*

Annex:

Safe Havens

Within the admission avoidance section of the financial recovery driver diagram we included the extension to the safe haven offer to support people during daytime working hours and act as a diversion, particularly for the mental health liaison services based in the Surrey acute hospitals.

Four Safe Havens in Surrey and one in Frimley ICB continue to be run in:

- Aldershot, (NE Hampshire Place)
- Guildford, Surrey (Guildford & Waverley Place)
- Epsom, Surrey (Surrey Downs Place)
- Woking, Surrey (North West Surrey Place)
- Redhill, Surrey (East Surrey Place)

The Safe Havens in Epsom, Guildford, Redhill and Woking are open every day, including public holidays and operate between 18:00 and 23:00. The Safe Haven in Aldershot operates between 18:00 and 23:00, Monday to Friday and between 12.30 and 23:00 on weekends and bank holidays. Operating as an out of hours walk-in service, individuals can access the service through self-referral and signposting from a variety of organisations and services including but not limited to:

  - Community Connections
  - Child & Adolescent Mental Health Services (CAMHS)
  - Community Nursing Services
  - Talking Therapies

- Community Mental Health Recovery Service (CMHRS)
- General Practice Staff
- Citizen's Advice Services
- Employment Support Services
- Acute Hospital A&E including Psychiatric Liaison Services
- Police Services
- Ambulance Trusts
- Patient and Carer Representatives
- Housing Associations
- Homeless Centres
- Drug and Alcohol Services

The aims of the Safe Haven service are to reduce emotional and psychological distress by:

- Providing a safe environment, as an alternative provision to attending ED, for anyone experiencing or at risk of escalating to a mental health crisis
- Offering a safe, supportive and therapeutic environment, promoting independence, opportunity and recovery for all adult mental health service users in the community
- Promoting empowerment of service users by giving them the opportunity to identify their own needs; making their own choices about what will help them; develop their own coping strategies and tools, recognise their own strengths and talents; encourage hope and to work towards improving their own emotional wellbeing
- Developing partnerships with service-users, carers and statutory and non-statutory organisations, in order to provide more integrated preventative and crisis management provision
- Providing an environment which is physically and emotionally safe and welcoming for service users, carers and staff

- Encouraging service users to make use of their own social network and link into and be signposted to local services
- Delivering this service in an equal partnership between statutory health and social care services and the voluntary sector

The service is available for anybody aged 18 years and over.

A no 'wrong door' approach to access will be in place.

Any young people aged 17 and below that accesses the service are offered immediate support according to operational protocols and sign-posted to the appropriate Child and Adolescent Mental Health Services (CAMHS).

Anyone between the ages of 18-25 are able to access the Young Adult Safe Haven (YASH) in Guildford. The co-produced model is non-clinical with access to the Third Sector MH Practitioner at the adjoining service, if required, and will run 365 days a year from 17:00 – 21:00.

Each of the five Safe Havens also offer people experiencing a mental health crisis access to an out of hours virtual service. This means people are able to receive expert guidance and support from mental health nurses and trained mental health practitioners at a Safe Haven without leaving home. The virtual Safe Havens open from 18:00 – 23:00, seven days a week – the same hours as the Safe Haven sites. The Aldershot Safe Haven is open longer at weekends, from 12.30 to 23:00.

Evidence of current impact

The data below shows that in February 2023:

- Aldershot supported just over 120 individuals where the majority of support provided was to individuals experiencing a crisis
- Epsom supported 80 individuals where the majority of support was for crisis prevention
- Guildford supported 120 individuals where the majority of support was for crisis prevention
- Woking supported 80 individuals where the majority of support was for crisis prevention
- Redhill supported around 75 individuals where the majority of support was a mix between crisis and preventative support

Funding

Funding for Safe Havens will continue as planned. Each Safe Haven costs £250K per year to operate.

Under the financial recovery programme and on behalf of VCSE partners a funding bid to the Mental Health Investment fund was submitted unsuccessfully for additional resource to access when in crisis by increasing the daytime offering of the Safe Havens for three years to extend hours to deliver the service between 8am and 6pm at the Leatherhead and Woking sites at an annual cost of £585K.

Next steps

Surrey Heartlands ICB are currently continuing to explore additional funding which can be invested into this service.

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ADULTS AND HEALTH SELECT COMMITTEE

THURSDAY, 15 JUNE 2023

REPORT ON THE FINDINGS AND RECOMMENDATIONS OF THE HEALTH INEQUALITIES TASK GROUP

Purpose of report: To provide the Adults and Health Select Committee with a detailed report on the findings and recommendations of the Health Inequalities Task Group, which was set up to explore Health Inequalities/disadvantages amongst key priority population groups within Surrey.

Acknowledgements:

1. Task Group Members wish to offer great thanks and appreciation to all those who kindly participated with the Task Group and expressed their insights, expertise, and experiences with us. The witness sessions as well as the written submissions significantly contributed to both the findings as well as the recommendations of this project.

2. Any errors, factual inaccuracies, or inconsistencies within this report will be the sole responsibility of the Task Group alone, and not of those who provided their time, insights and experiences which were ultimately utilised to develop this report.

Introduction:

Context

3. During a private induction meeting on 14th July 2021, the Adults and Health Select Committee held a forward planning session, during which it was emphasised that reducing health inequalities should constitute an important focus area. Consequently, the committee agreed to form a task group to investigate health inequalities in Surrey and what is being done to tackle these issues.

4. The overarching objective of the task group was (and remains) not only to investigate some of the root causes and characteristics of Health Inequalities, but to utilise and harness these insights for the purposes of formulating sound, relevant, and timely recommendations that can contribute to policy by adding value. Achieving this involved a three-pronged process of the following:

    - Acquiring information/insights into Health Inequalities, including the causes of such inequalities and how they are manifested within Surrey.

- Investigating some of the existing measures in place to tackle such Inequalities.

- Discovering and proposing new ways in which such inequalities can be reduced (through producing recommendations).

5. The imperative to examine Health Inequalities has stemmed from three factors.

    - Firstly, the Covid-19 pandemic has exposed and deepened stark health inequalities across the nation. Those residing in deprived areas are more inclined to die from the virus amongst those diagnosed with Covid-19. This increasing susceptibility to death as a result of contracting the virus is an important indicator of inequalities that have existed for several years across all aspects of health, but have been increasingly exposed by the pandemic.

    - Secondly, tackling Health Inequalities is one of Surrey County Council's four priority objectives. This was also outlined in the Council's Organisation Strategy, and agreed by full Council on December 8th 2020.

    - Thirdly, the Health and Wellbeing Strategy for Surrey, initially published in May 2019, also emphasises the imperative to "reduce health inequalities so no one is left behind". The Health and Wellbeing Strategy's most recent update was published in 2022[1]. The strategy emphasises that by 2030, Surrey should constitute a County where residents have a "great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community and no one is left behind. The strategy essentially encapsulates a refreshed and holistic understanding and overview of Health and Wellbeing, which revolves around encouraging policies, measures, and initiatives to improve the overall quality of life of residents. This marks a transition away from a reactive model of healthcare, toward a model that seeks to improve the lives of residents in a manner that could also potentially reduce susceptibility to illness.

6. The task group has conducted this investigation into Health Inequalities with a similar logic in mind; one that calls for a holistic model of Health and Wellbeing that seeks to reduce Health Inequalities by not merely reacting to Health conditions where and when they arise, but by emphasising a model that encompasses a wider contextual understanding of Health. The task group has adopted this as an overarching logic in its investigations of Health Inequalities as well as in the recommendations it has produced.

Objectives of Task Group:

7. The broad and overarching objectives of the Task Group are to:

    - Develop an understanding of the lived experiences of those residents experiencing health inequalities and the barriers they face.

[1] https://www.healthysurrey.org.uk/__data/assets/pdf_file/0008/299798/Surrey-Health-and-Wellbeing-Strategy-Update-2022.pdf

- Develop an understanding of the data, strategies in place and work being undertaken by the Council and its partners to help tackle health inequalities.

- Develop an understanding of good practice elsewhere and how this might be applied in Surrey.

- Develop a set of recommendations to help assist the Council and its partners in continuing to tackle health inequalities across Surrey.

- Communicate its findings to partners both locally and nationally.

8. The members of the Task Group were:

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

Task Group Methodology

Task Group themes:

9. In seeking to investigate Health Inequalities within Surrey and the associated impacts, the Task Group agreed to narrow the scope of its focus to ***three*** specific **themes/population groups**. These three populations groups are amongst several other "priority populations" as have been identified in Surrey's Health and Wellbeing Strategy. The task group sought to examine how specific groups tend to suffer from Health Inequalities and disadvantages which in many respects has impacted their capacity to live Healthy and fulfilling lives. The themes/priority groups that the task group investigated are threefold:

    - Individuals from BAME/GRT Communities.

    - Individuals experiencing Homelessness, Drug, and Alcohol abuse.

    - Individuals experiencing Domestic Abuse.

10. The reasoning and rationale behind selecting these three groups is fourfold. Firstly, these groups per se tend to suffer from Health Inequalities and disadvantages relative to other population groups. Secondly, these three groups are amongst the priority populations identified in Surrey's Health and Wellbeing Strategy, and so the timing and relevance of an investigation into these groups is pivotal so as to add value to policies that aim to reduce inequalities for these groups. Thirdly, selecting these groups in this way is constructive for any investigation into Health Inequalities within Surrey in that individuals who fall under these group categories may also fall into several other priority population categories identified by the Health and Wellbeing Strategy. Fourthly, more attention and focus on these groups is crucial at a time when System-Wide

efforts are underway within Surrey to help to identify and reduce Health Inequalities for residents within the County; and thus the timing of the selection of these population groups is vital.

11. Additionally, in terms of the nature of how information was gathered and received, the task group adopted an amalgam of a top-down and bottom-up approach, which involved conducting witness sessions and receiving evidence from key organisations responsible for conducting Health and Wellbeing Policies (such as Surrey County Council as well as the NHS), as well as third sector organisations involved in providing on-the-ground support to residents from the three groups mentioned above who may be suffering from health Inequalities.

Witness Sessions

12. Between December 2021 and April 2023, the Task Group conducted 17 separate evidence-gathering sessions with multiple witnesses from a wide range of organisations.

13. A list of the witness sessions conducted by the Task Group is attached as Annex 1.

14. There are two sets of Key lines of enquiry (attached as Annex 2) that were formulated and adopted by the Task Group. One was developed before the **first stage** of the Task Group which sought to brainstorm what "Health Inequalities" implies. The second set of KLOEs were adopted by the Task Group for the witness sessions undertaken in the context of the **second stage** of the project which conducted the deep-dive into the three aforementioned priority population groups. These were shared with all witnesses in advance of meetings and updated throughout the evidence-gathering process in response to findings from each witness session.

15. Members were very pleased with the wide range of witnesses that engaged with the Task Group.

Written Evidence

16. The task group's findings were also derived from written evidence, which stemmed from two avenues. First, the task group also received written evidence in the form of qualitative and quantitative data from the organisations that participated in the witness sessions. Such data was valuable in further substantiating as well as providing additional contributions to the verbal insights received during the witness sessions. Some of the insights extracted from these written evidences have been incorporated into the main text of this report; whilst other parts of this information have been incorporated as Annexes to this report. Details for each of the annexes are outlined immediately subsequent to the conclusion section of this report. Second, written evidence from other academic and policy/related research was also utilised, some of which has been referenced/footnoted within the main text of this report.

Task Group Recommendations

17. Below are the full list of recommendations that the task group believes will help reduce Health Inequalities within Surrey, particularly for the three aforementioned population groups that the task group focused on. These recommendations have been incrementally formulated throughout the course of this project, and have been informed by the research findings of the task group.

Recommendations for the BAME/GRT Community:

1. That mental health support services increase investment in Equality, Diversity and Inclusion leads, and that staff receive further training for cultural competence and unconscious bias.

2. To implement measures to help raise awareness of Mental Health Issues amongst the BAME Community, and to help overcome the negative stigma surrounding Mental Health within these communities.

3. To help reduce language barriers in healthcare in a manner that enables ethnic minorities who are not fluent in the English language to still receive appropriate and effective healthcare as and where it is needed.

4. That increasing efforts are made for mental health support to be provided in the first language of service users. This is particularly crucial for ethnic minorities to receive the best possible mental health support in the most explicit and transparent manner.

5. For exceptions to be made for individuals arriving from abroad with full medical history records to be directly referred to specialist services. This can help to bypass longer waiting times for a repeat diagnosis.

6. To ensure that cultural sensitivities are taken into account when providing healthcare services, including requests to be treated by health practitioners from the same sex.

7. That greater efforts are undertaken to improve the health and wellbeing of GRT communities through enhancing access to GP and other health services, reducing distrust of mainstream services amongst these individuals, tackling discrimination against these groups, and for targeted healthcare provision to those on GRT living sites.

Recommendations for Homelessness, Drug, and Alcohol Abuse:

8. That efforts are made to tackle negative and false labels against the homeless as part of initiating a new culture change that is more understanding and supportive of homeless individuals.

9. That work to support the homeless is conducted in a Trauma-informed manner across all services. It is believed that given that the homeless often come from a place of trauma, this will lead to better health outcomes both Mentally and Physically.

10. That efforts are undertaken to increase access to dental care for the homeless, including rough sleepers.

11. That homeless residents are able to access GP appointments and services as easily and as efficiently as possible, without any complexities in them being able to access frontline healthcare.

12. To continue to advance efforts to tackle rough sleeping by providing sheltered accommodation for the homeless, and for there to be greater coordination between all actors within the Surrey System, to ensure that this is achieved.

13. That efforts are made to increase access to mental health safe havens for homeless individuals who experience a mental health crisis.

14. For Surrey County Council to work more closely with District and Borough Councils, to provide more sustainable temporary accommodation facilities to help homeless individuals to remain in a stable environment through which they can access support for their mental health.

15. That homeless individuals suffering from poor mental health are provided with access to counselling and cognitive behaviour therapy to help them to cope with and to ultimately overcome their mental health challenges.

16. That there is joint commissioning for high quality mental health and drug and alcohol services that focuses on meeting individuals' core needs rather than the current presenting problem.

<u>Recommendations for Domestic Abuse victims:</u>

17. To undertake work to support not simply the victims of, but also perpetrators of domestic abuse in a manner that helps perpetrators understand the ill effects of abuse and how to avoid resorting to such abusive conduct.

18. That commissioning arrangements are such that long-term support and commissioning is provided to key organisations involved in providing support to domestic abuse victims.

19. To continue to ensure that domestic abuse victims are provided with an easy point of access for support, including for accommodation, in the event of victims seeking refuge.

20. That greater support is offered to tackle mental health as well as domestic abuse for Women during pregnancy, and that efforts are made to raise awareness of such support amongst pregnant Women.

21. To continue to undertake efforts to increase awareness of support for domestic abuse available to residents.

Key Findings for BAME/GRT Communities

18. The task group chose to examine some of the key Health Inequalities and disadvantages experienced by ethnic minority groups within Surrey. The overarching reason for this is that these ethnic groups do constitute priority populations as have been identified in the Health and Wellbeing Strategy, and the Task Group sought to investigate some of the key Health challenges these groups face, particularly given that these can often constitute hard-to-reach communities. The Task Group recognises that it is not a simple case of the BAME/GRT communities being side-lined by Health and Wellbeing services. Rather, in some cases, elements of these communities may actively choose to isolate and distance themselves from mainstream services. This could stem from a variety of reasons as will be outlined in some of the key findings below.

19. Demographically speaking, Surrey remains not as diverse as other areas nationwide. 83.5% of the population reported their ethnic group as being white British in comparison to 79.8% in England as a whole[2]. According to estimates from the 2011 census which were adjusted for 2020 demographic patterns, approximately 9.6% of Surrey residents have a non-white minority ethnic background[3]. That just under 10% of Surrey's residents are from minority backgrounds is a sufficient reason for the task group to examine the Health and Wellbeing prospects of these population groups, and to call for improvements in the Health and Wellbeing of these residents.

BAME Community Language Barriers:

20. A key finding from the task group's witness sessions, particularly with Healthwatch Surrey, was that some members of the BAME community suffer from language barriers which often reduce the quality of medical care and services that may already be available for them. The task group heard that language barriers can undermine the Health and Wellbeing of elements of the BAME communities who are not proficient in the English language in three ways as outlined below.

21. Firstly, in one project commissioned by the CQC to examine the barriers that BAME communities face when accessing care, it was found by Surrey Healthwatch that the lack of face-to-face appointments resulted in difficulties of those for whom English is not a first language to communicate effectively in their telephone appointments. It was found that such BAME community members lacked the confidence to communicate over the phone. This resulted in complications in the patient being understood, as well as in the patient's own understanding of what is being communicated to them by healthcare professionals. Or, in some cases, the patient may be able to inform doctors

[2] The Surrey Context: People and Place – Surrey-i (surreyi.gov.uk)
[3] The Surrey Context: People and Place – Surrey-i (surreyi.gov.uk)

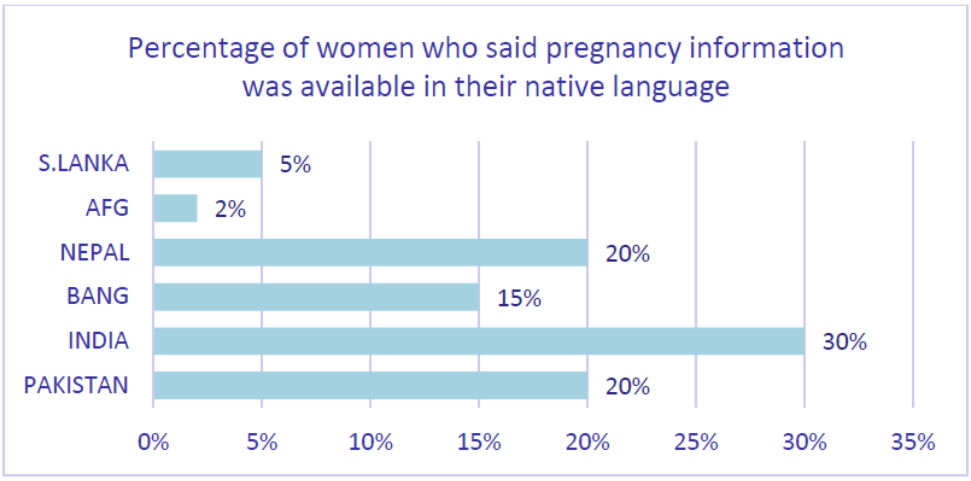
of their symptoms but would find it difficult to comprehend the advice or following steps that would be undertaken as part of their care. Added to this was the fact that this posed a privacy problem as it entailed that another close relative of theirs would have to assist them during such phone appointments.

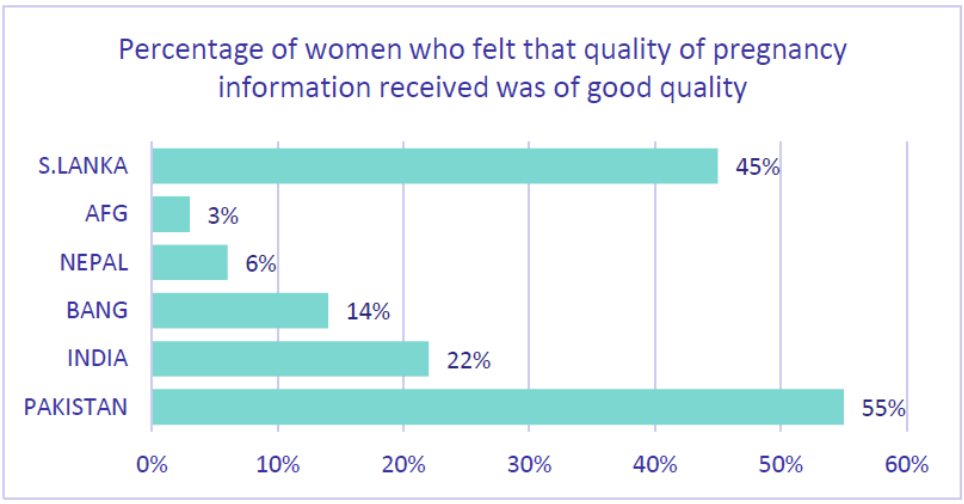
22. Secondly, the task group heard that it can often be difficult for less technology literate members of these communities to access, as well as to make effective use of technology and online services, which have also been increasingly utilised by GP practices. Some individuals have less access to the internet, or even a computer or a smart phone. Some even found online services or websites to be too complex to utilise. Again, such residents often have to rely on the support of relatives or friends who may be more technologically literate. However, the issue of privacy again also arises in this context.

23. Thirdly, the task group also heard that in some cases, translation services were not always readily available to patients in Primary Care. This means that in some instances, patients are having to attend appointments (whether virtually or in person) without fully comprehending what they are being informed by the healthcare professional; in which case crucial medical information or advice may not be fully processed by the patient. Additionally, in cases where such patients who cannot secure translation services resort to taking a relative along to an appointment for assistance in translation, often these relatives are not medically literate and hence crucial medical information is lost in the translation provided by them. It was also heard that this absence of consistently available translation services has also affected BAME community Women who utilise maternity services; where it can often be difficult for such Women to understand crucial antenatal advice and instructions being provided by Midwives.

24. In one recent study conducted by Surrey Minority Ethnic Forum, who also participated in a witness session for this task group, it was found that many Women from BAME backgrounds felt that information about pregnancy was not available in their native language; and that for those whom information in their own language was provided to, many felt that the information shared with them was not of good quality. The two-part figure below indicates this trend.

Figure A: Experience of women about information and attending appointments during pregnancy:





25. Hence, **the task group recommends that work is undertaken to help reduce language barriers in healthcare in a manner that enables ethnic minorities who are not fluent in the English language to still receive appropriate and effective healthcare as and where it is needed.**

Mental Health disadvantages for BAME Community:

26. In its witness session with "With You" (a national charity organisation providing support for Surrey residents with mental health, drug, or alcohol problems), it was reported that BAME community mental health clients can often feel uncomfortable about sharing their Mental Health experiences before an interpreter who may be from a similar ethnic background. This tendency particularly affects the South Asian Community, and partly stems from fears of being negatively judged by an interpreter. This is especially the case if such residents experience drug or alcohol addictions that are either a result of

or a cause of their mental health decline. This complicates these residents' ability to express their symptoms and to receive adequate mental health support. As such, the task group understands that it is not sufficient to simply advertise and provide mental health services and support for such communities, but to take adequate measures to increase these resident's confidence and comfortability in being able to utilise and maximise the benefits of these services.

27. Furthermore, With You also reported that through their experience of providing mental health support to Afghan refugees in hospitals and other settings, they learnt that it was pivotal to be able to provide mental health support by practitioners/support workers who communicate to patients in their own language. This enables one to understand a refugee's mental health symptoms and challenges, and to be able to provide adequate support through effective communication. That such refugees should receive support in their own language is imperative given that refugees may often not be proficient in the English language.

28. As such, based on the above, **the task group recommends that mental health support services increase investment in Equality, Diversity and Inclusion leads, and that staff receive further training for cultural competence and unconscious bias.** Additionally, **the task group recommends that increasing efforts are made for mental health support to be provided in the language that service users are proficient in**. This can ensure that such support is effective, and can help to establish a rapport between mental health practitioners and service users, which is pivotal for such service users to feel comfortable about expressing their feelings or symptoms in a confident manner.

29. The task group also heard that some members of the South-Asian community, particularly women, tend to suffer from Social Isolation. This entails not having a healthy network of friends or relatives that live nearby that they are able to socialise with. Such isolation can result in increases in Mental Health decline amongst such residents. That social isolation can elicit mental health decline is an issue that has been found in multiple studies. In one crucial study conducted jointly by the University of London and the World Health Organisation in 2017, it was concluded that Social Isolation can result in the development of mental health issues, including severe anxiety and depression[4]. Therefore, tackling isolation, including amongst ethnic minorities in this instance, can help to reduce incidences of mental health decline, thus reducing the strain on Surrey's mental health services.

30. Moreover, in its witness sessions (with Surrey Minority Ethnic Forum, Healthwatch Surrey, and with We Are With You), it was heard that there is a negative stigma around mental health amongst the BAME Community, particularly within the South Asian communities. It is often felt that mental health is not a phenomenon that genuinely represents a health issue. Consequently, some individuals actively choose to conceal the fact that they may be suffering from ill mental health due to feeling embarrassed to express this. Such individuals may choose to conceal this information not merely from

[4] Wang, J., Lloyd-Evans, B., Giacco, D. et al. Social isolation in mental health: a conceptual and methodological review. Soc Psychiatry Psychiatr Epidemiol 52, 1451–1461 (2017). https://doi.org/10.1007/s00127-017-1446-1

close relatives, loved ones or friends within their community, but also from health practitioners that may be from the same ethnic community as their own.

31. According to research conducted by the University of Glasgow in 2011, the negative stigma surrounding mental health within BAME communities can form a sense of shame. This sense of shame can render such individuals, particularly males, to endeavour to conceal their poor mental health for fears of appearing to be either too soft or lacking control of themselves[5].

32. Hence, the task group **recommends that measures are taken to help raise awareness of Mental Health Issues amongst the BAME Community, and to help overcome the negative stigma surrounding Mental Health within these communities.**

BAME Women and Male Health Practitioners:

33. A notable theme the task group encountered in its witness sessions and wider research revolved around the effects of having health practitioners from the opposite sex to patients, and how this contributed to health inequalities. In its witness sessions with Surrey Minority Ethnic Forum as well as Healthwatch Surrey, it was reported that in some instances, Women from ethnic minority backgrounds, particularly from Arab or South Asian ethnicity, prefer to be treated by health practitioners who are from the same sex. The reasoning for this is twofold:

    1. *Cultural reasons*: Some of these Women feel that it is not culturally appropriate to be in close proximity to a member of the opposite sex, particularly in enclosed settings.

    2. *Religious reasons*: Some of these Women feel that it is a religious obligation to do their utmost to avoid being treated by members of the opposite sex, particularly in contexts where their husband is not present also.

34. Indeed, some pregnant Women who have been admitted to hospital for childbirth may make special requests in their birth plans to be treated by members of the same sex. However, this may not always be taken on board in some situations, either due to a lack of a thorough review/analysis of birth plans, or due to unforeseen circumstances such as female practitioners or doctors not being available at a specific moment in time.

35. This has health inequalities implications in that such Women who have this aforementioned preference may deliberately choose to refrain from receiving healthcare or to attend appointments if their requests for being treated by female health practitioners are not met. In some instances, such Women also experience delays in being able to access GP appointments due to their requests for female doctors not being accommodated efficiently enough.

[5] https://www.tandfonline.com/doi/abs/10.5172/hesr.2012.21.3.287

36. As such, the task group recommends that **cultural sensitivities are taken into account when providing healthcare services, including requests to be treated by health practitioners from the same sex.**

Lack of Understanding of how the Health System operates:

37. The task group believes that an important aspect of reducing health inequalities and in ensuring effective healthcare provision is for residents to be aware of how the health system operates. Residents need to be aware of the services available to them, as well as how to embark on accessing these services, if they are to be able to equally benefit from healthcare as much as any other residents.

38. Part of this aforementioned challenge stems from language barriers, although this is not the only obstacle. In some instances, residents who have not lived in Surrey or the United Kingdom for substantial periods have a lack of understanding of how the health system operates. For example, they may not be aware of referral procedures for specialist treatment, or may not be aware of how to access a dentist appointment. The task group also heard that some ethnic minorities may embody a slight suspicion of Healthcare Services, or even feel that they are subjected to racial discrimination and not granted the appropriate level of care relative to majority ethnic groups.

39. Related to the above is also the fact that some ethnic minority residents are not aware of which transportation systems are available to help them reach appointments, or perhaps any support that might be available to help with transportation (or costs of transportation) to reach appointments.

40. Additionally, in its witness session with Surrey Minority Ethnic Forum, the task group learned that some BAME residents, particularly those who may have not lived in the United Kingdom for long, can often struggle with understanding how prescription systems operate. They may not understand where or how to order prescriptions from doctors, or in some cases not understand how to collect medications that have been prescribed. Hence, such BAME residents may not be able to sufficiently benefit from the very services that most residents may sometimes take for granted, simply due to a lack of understanding of how systems operate in Surrey and Nationwide. It is therefore vital that BAME residents are able to navigate through the healthcare system in order to fully and efficiently benefit from health services available to them. This could also be achieved through increasing the availability of guidance for patients on how to book appointments, how to collect prescriptions, or even how to access appointments through transportation routes.

Diagnosis/Medical records from abroad:

41. Another fundamental issue that was brought to the task group's attention related to patients from the BAME community who have arrived from abroad and wish to access and make use of healthcare services in Surrey. These may either be residents who have just arrived from abroad, or in some instances, may have lived in Surrey previously but have spent prolonged periods abroad. Such residents often experience issues with being able to utilise medical records which they brought from abroad to

enable them to access healthcare services in Surrey without the need to undergo initial diagnosis.

42. Such residents may often have detailed medical records which provide results from blood tests, scans, and other medical assessments which, if provided with the opportunity to do so, could easily be utilised to speed up treatment and referral processes without the need to experience long waiting lists as part of diagnostic stages. This is particularly crucial for BAME patients who have serious medical conditions and diseases such as Cancers, whereby any delays to treatments can result in the spread and proliferation of tumours, particularly in cases where the Cancer is malignant in nature.

43. Hence, the task group **recommends for exceptions to be made for individuals arriving from abroad with full medical history records to be directly referred to specialist services. This can help to bypass longer waiting times for a repeat diagnosis.**

Vaccine Hesitancy:

44. Another issue that was brought to the task group's attention through its witness sessions related to vaccine hesitancy. Specifically, it was reported that some elements of the BAME as well as the GRT Communities experienced a hesitancy toward vaccinations, and in particular Covid-19 vaccines. In one research study conducted from 2020—2021, which was published by the NHS Confederation, it was found that although there has been increased vaccination uptake amongst ethnic minority communities from 0.66 per cent in February 2021 to 38.35 per cent in May 2021, Covid vaccine hesitancy was still more prevalent amongst ethnic minority communities as a whole relative to majority ethnic group categories[6]. Indeed, the hesitancy toward vaccinations could result in increasing susceptibility to contracting viruses including Covid-19 as well as the Flu. Although some work has been undertaken through Surrey County Council as well as Surrey Heartlands and Frimley ICSs to increase confidence in Vaccines amongst ethnic minorities, the task group heard that such hesitancy still precludes elements of these communities from taking vaccines, particularly those from lower-income and refugee backgrounds, who may often base their perceptions of vaccines on rumours or conspiracy theories from their close networks. Indeed, that vaccine intake continues to be subject to hesitancy amongst elements of these communities is a cause of greater vulnerability and physical health disadvantages experienced by these groups relative to other communities in Surrey. According to research conducted by the University of Harvard in a 2021 study, the decision to avoid taking vaccines can result in greater susceptibility to viral infections which, in the long run, can result in longer-term side effects to one's overall Health and Wellbeing relative to those who do regularly vaccinate[7].

GRT Community demographics and trends:

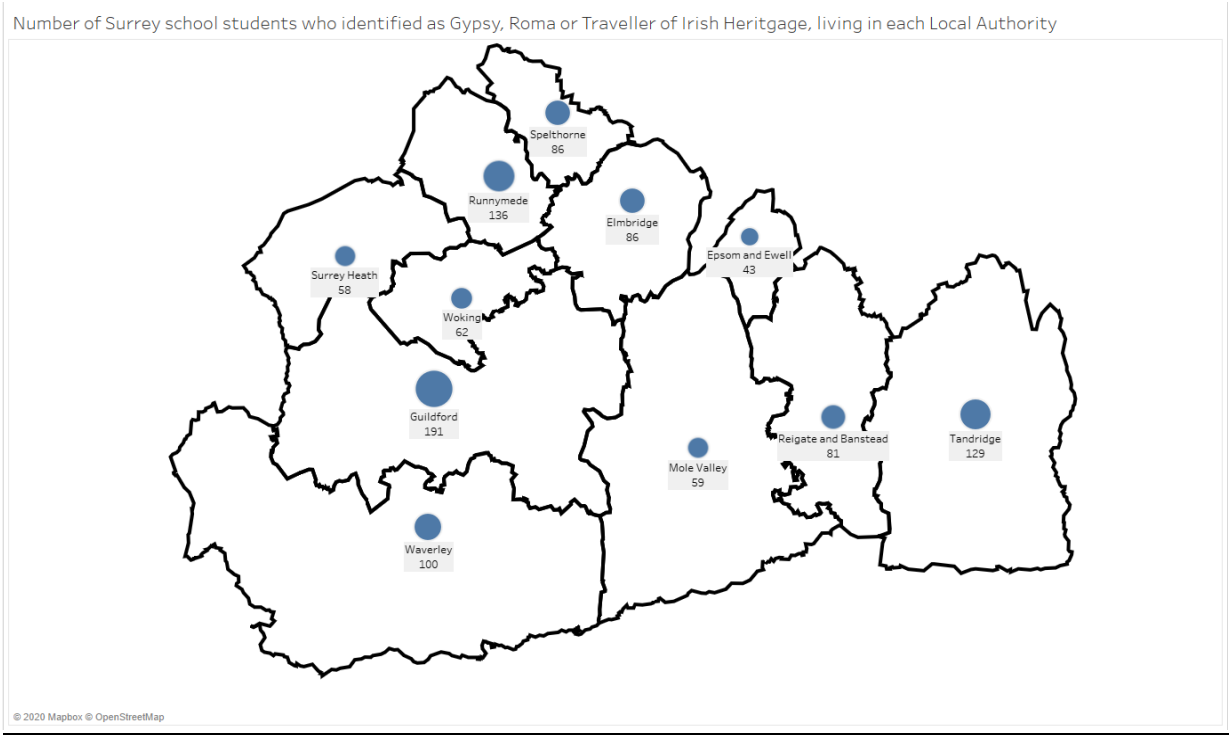
[6] Addressing vaccine hesitancy in different ethnic communities | NHS Confederation
[7] Vaccines | Free Full-Text | Antibody Focusing to Conserved Sites of Vulnerability: The Immunological Pathways for 'Universal' Influenza Vaccines (mdpi.com)

45. Given that the task group focused on the Health disadvantages faced by Ethnic Minorities as a whole, this included some insights into the GRT Community. Demographically speaking, the GRT community remains relatively small within Surrey. According to the 2011 census, this community constitutes less than 1% of Surrey's total population[8]. However, it is worth noting that there is a belief that the demographics of this group remain underreported within the census. The GRT community suffer from greater health disadvantages relative to any other ethnic group, both within Surrey as well as globally. According to the Office of National Statistics as of 2014, it was found that 14% of Gypsy/Travellers felt that they suffered "bad" or "very bad" health; and this community were over twice as likely to report this than White British ethnic groups[9].

46. According to the GRT Rapid Needs Assessment for Surrey, which was conducted during the height of the Covid-19 Pandemic, the GRT community share some common characteristics. These include: an emphasis on family bonds and networks, living a nomadic life, opting for self-employment over working for others, and experiences of poorer health outcomes. It is estimated that approximately 10-12,000 of Surrey's residents are from GRT backgrounds[10]. At present, there is limited data to indicate the geographical spread of GRT communities within Surrey, although proxy data on the ethnicity of students attending Surrey's schools indicates that most students from GRT backgrounds live in Guilford. The figure below indicates this geographical spread of GRT students, which can provide indications as to the areas with the greatest concentration of GRT residents:

Figure B: Numbers of school students across Surrey identified as GRT within every Local Authority:

[8] The Surrey Context: People and Place | Surrey-i (surreyi.gov.uk)
[9] Achieving better health outcomes for Gypsy, Roma and Traveller communities - Committees - UK Parliament
[10] Gypsy Roma Traveller RNA.pdf (surreyi.gov.uk)



GRT Health Challenges:

47. The task group learned that within the GRT Community lies a tendency to feel distrust and suspicion toward mainstream services. This distrust also manifests in a proclivity to avoid accessing or seeking healthcare services. In its witness session with Surrey and Borders Partnership, the task group heard that GRT communities may not always feel that mainstream services have their best interests at heart. It is this very distrust and suspicion of health services, including NHS services, that renders these communities more susceptible to developing poor physical and mental health. Below are some of the key tendencies and vulnerabilities experienced by GRT communities in Surrey. It is noteworthy that these tendencies and vulnerabilities significantly contribute to the poorer health outcomes and disadvantages experienced by these communities:

    1. *Lower Education/Literacy Outcomes:* According to a Needs Analysis that informed Surrey's Brighter Future's Strategy (2014-2017), GRT communities generally have lower educational outcomes as well as poorer literacy rates. This is partly shaped by preferences amongst many GRT families for self-employment. Whilst not directly impacting health outcomes for these communities, the task group understands that this has an indirect impact through reducing these communities' understanding of health and healthcare services, as well as their ability to access relevant medical information and advice.

    2. *Life Expectancy:* The life expectancy of GRT residents is ten years lower when compared to the national average[11]. Additionally, compared to the national population, GRT communities have infant mortality rates that can often be twenty

[11] Gypsy Roma Traveller RNA.pdf (surreyi.gov.uk)

times more. These lower life expectancies are elicited by a multitude of factors including; not being able to access health services, not being registered with a GP, displaying distrust toward mainstream health services as a whole, and living in poor conditions.

3. *Poor Living Conditions:* These communities can often reside in sites that may be overcrowded or that may not be suitable for a healthy and fulfilling lifestyle in general. This results in poorer physical but also mental health outcomes for some GRT residents. Often, such individuals may experience immense uncertainty and instability with accommodation, which can also result in deteriorating their quality of life. In one national study conducted in 2016 by Bucks University as well as the Traveller Movement, it was found that over 60% of GRT residents residing within traveller sites felt that their physical and mental health was deteriorating, not merely due to the very fact of living on a traveller site, but due to existing societal arrangements and services not necessarily being conducive to their wellbeing as well as their chosen way of life.

4. *Poor Mental Health:* The task group learnt that GRT communities are also more likely to develop poor mental health outcomes. This is elicited by a variety of factors including; living in insecure accommodation arrangements, not accessing mental health services (for some of the reasons outlined above), and experiencing greater susceptibility to domestic abuse. It is also the case that mental health may often be underestimated, misunderstood, or even treated as a taboo. Individuals suffering from poor mental health outcomes within these communities may often feel too embarrassed at the thought of expressing their poor mental health to fellow community members or even loved ones.

5. *Domestic Abuse:* Individuals from GRT backgrounds, particularly Women, are more prone to suffering domestic abuse. This could either be direct physical abuse from their partners, or indirect abuse through cultural expectations that Females should, from early ages, adopt key domestic roles including motherhood and caring for Children and wider family networks.

48. Hence, on the basis of the above findings, **the task group recommends that greater efforts are undertaken to improve the health and wellbeing of GRT communities through enhancing access to GP and other health services, reducing distrust of mainstream services amongst these individuals, tackling discrimination against these groups, and for targeted healthcare provision to those on GRT living sites.**

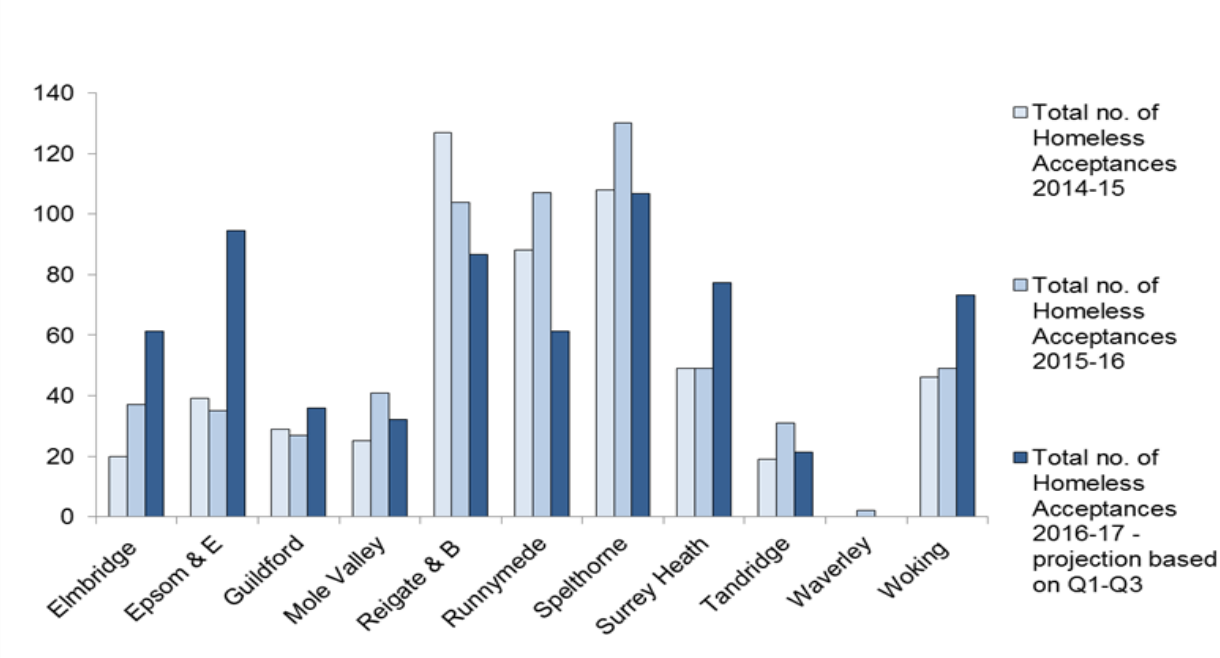
Key Findings for individuals experiencing Homelessness (including Associated Drug and Alcohol Abuse).

49. Being homeless can have significant impacts on an individual's Health and Wellbeing. According to the Royal Society of Medicine, being chronically homeless can have negative impacts on an individual's health and overall quality of life, and can often

result in premature death[12]. With this in mind, the task group has adopted a holistic approach to examining health inequalities and disadvantages experienced by those experiencing homelessness, drug, and alcohol abuse. This involved examining the effects of being homeless and suffering from drug and alcohol abuse on an individual's physical, mental and wider determinants of Health as outlined by all three priorities of the Health and Wellbeing Strategy.

50. Homelessness within Surrey has gradually increased since 2015. According to data identified by Surreyi, the number of homeless acceptances within Surrey has increased since 2015 in eight of the eleven borough and district Councils within the County. The graph below indicates this trend.

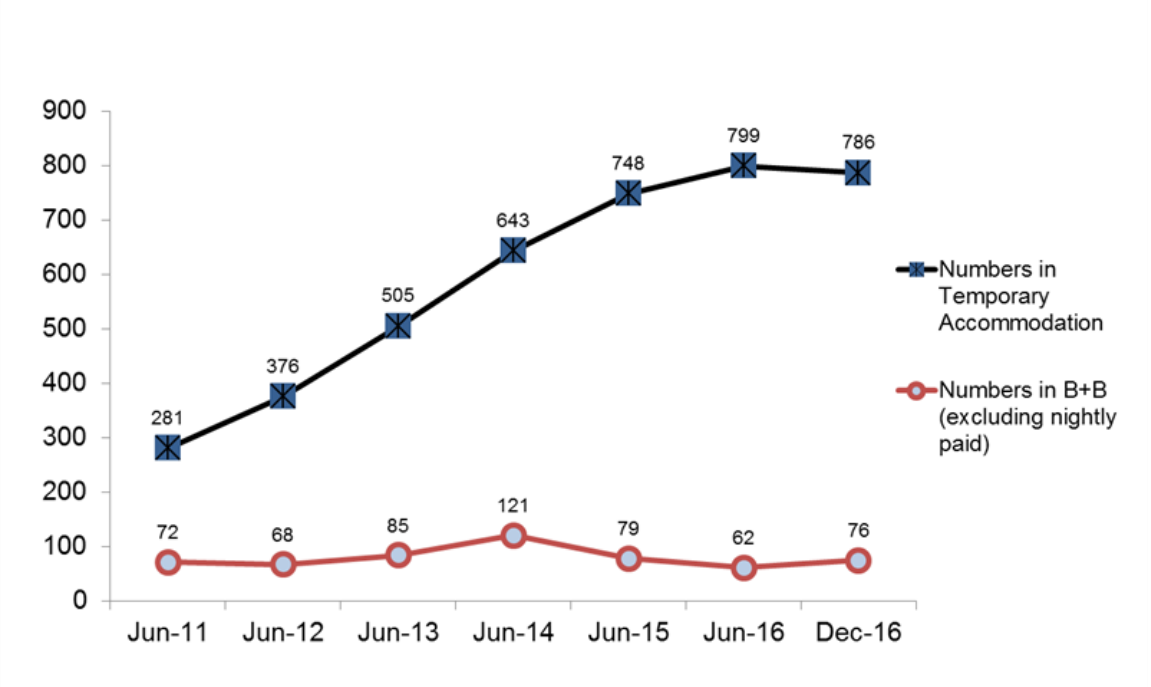
Figure B: Homeless Acceptances in Surrey 2015-16 and projections for 2016-2017



[12] Hewett N, Halligan A. Homelessness is a healthcare issue. Journal of the Royal Society of Medicine. 2010;103(8):306-307. doi:10.1258/jrsm.2010.10k028

51. In addition to the above, according to data released by Surrey Districts from Government (P1E) returns, between 2011 to 2016, the number of households residing in temporary accommodation has also increased. The figure below indicates this trend.

Figure C: Temporary Accommodation/B&B All Surrey authorities – up to Dec 2016



52. As such, given that Homelessness has increased within Surrey, the task group has conducted witness sessions with a vast array of organisations which have expertise on, or which in some cases directly provide support for, those experiencing homelessness and the drug and alcohol abuse associated with this. These insights are outlined below.

53. In its witness session with Guildford Action, an organisation which supports homeless individuals in Guildford and which receives support from Guilford Borough Council for doing so, the task group heard that the homeless often experience needs that are highly complex. The complexity of their needs often presents challenges for their ability to access mainstream health and wellbeing services. It was explained to the task group that homeless people often come from a place of trauma, which has been aggravated by remaining in rough living conditions for prolonged periods of time. Additionally, such homeless individuals are often subjected to negative and unhelpful labelling; entailing accusations or false impressions that the homeless are partially responsible for being homeless, and that they are somehow not taking adequate steps to resolve their homelessness. It is labels such as the above which lead to assumptions that it is homeless individuals themselves that do not wish to seek medical treatment. **Thus, the task group recommends that efforts are made to tackle negative and false labels against the homeless as part of initiating a new culture change that is more understanding and supportive of homeless individuals.**

Homelessness and Physical Health:

54. Through its witness sessions, the task group learned that homeless residents within Surrey are experiencing various challenges to their overall physical health. Details of some of the physical health complications induced by homelessness are outlined below.

55. In its witness session with Guilford Action, the task group heard that rough sleepers often suffer from poor foot health, which is caused by their feet becoming infected as a result of inadequate footwear. Such infections can result in the need for hospital treatment. However, as is often the case when those with infected feet often go to A & E, they are patched up and released back onto the streets. Rather, the dressing for such infections/wounds requires regular changing; which is a service that rough sleepers often cannot receive. According to the Surrey Homelessness Needs Audit of 2016, almost 10% of homeless individuals reported as having problems with their feet.

56. Another issue that rough sleepers often experience is hypothermia, which includes severe physical symptoms such as cold skin and shivering, as well as cognitive symptoms such as confusion and slurred speech. This is caused by a lack of adequate clothing and warm shelter. According to research conducted by the National Centre for Biotechnology Information, rough sleepers who suffer from hypothermia are more than twice as likely to develop further health complications from those who are not homeless[13].

57. Moreover, the task group heard that rough sleepers have greater proclivities to experience infected nails. Part of this stems from the lack of adequate protection and sanitation for their hands and being consistently exposed to unhygienic environments. The inability to access shelter entails a lack of access to taps, sinks, and soaping facilities which raises this susceptibility to nail infections. These nail infections can result in swelling and excruciating pain, particularly for those who cannot access treatment swiftly.

58. Furthermore, the task group learned that rough sleepers are becoming more prone to developing diabetes. This is partly due to poor dietary choices stemming from an inability to purchase or access healthy and balanced dietary meals. Upon developing diabetes, rough sleepers are unable to access appropriate medication and treatment such as metformin tablets or insulin injections. The absence of regular treatment and medication further deteriorates the overall health and wellbeing of diabetic rough sleepers.

59. As such, on the basis of the aforementioned physical health challenges that rough sleepers are facing within Surrey, the **task group recommends that homeless residents are able to access GP appointments and services as easily and as efficiently as possible, without any complexities in them being able to access frontline healthcare.** Additionally, given that rough sleeping per se can raise susceptibility to physical health problems, **the task group recommends for the**

[13] Singer J. Taking it to the streets: homelessness, health, and health care in the United States. J Gen Intern Med. 2003 Nov;18(11):964-5. doi: 10.1046/j.1525-1497.2003.30903.x. PMID: 14687285; PMCID: PMC1494948.

continuing advancement of efforts to tackle rough sleeping by providing sheltered accommodation for the homeless, and for greater coordination between all actors within the Surrey System, to ensure that this is achieved.

60. Another key concern that the task group heard related to poor dental health amongst the homeless, most notably amongst rough sleepers. Rough sleepers face rapidly deteriorating dental issues such as tooth decay and tooth/gum infections. These are caused by a consistent lack of access to dental appointments, where even basic check-ups would have been able to identify such early signs of dental decline. The 2016 Homelessness Health Needs Audit reported that over 20% of homeless males and nearly 13% of homeless females experienced dental problems. This Audit also found that over 42% of those who participated in the study were not registered with a dentist in the local area. In some cases, the homeless struggle to gain access to toothbrushes and sink facilities to routinely maintain their dental hygiene. Indeed, as the NHS has also concluded, the absence of regular check-ups and dental hygiene results in long-term exposure to more serious conditions such as Oral Cancer[14]. **As such, the task group recommends that efforts are undertaken to increase access to dental care for the homeless, including rough sleepers.**

Homelessness and Mental Health:

61. During its witness sessions with Surrey and Borders Partnership, the King's Fund and Guilford Action, the task group heard that homeless individuals, particularly those experiencing rough sleeping, are significantly more prone to developing mental health issues. Given that mental health needs can stem from a place of trauma, being homeless can increase one's susceptibility to mental ill health. According to research conducted by King's Fund, over 80% of individuals experiencing homelessness report having mental health difficulties[15].

62. Homeless individuals are more prone to developing a stronger sense of paranoia, which is partly elicited by consistent and negative labelling and stigmatisation of the homeless. This paranoia often results in a deeper disconnect between the homeless, particularly rough sleepers, and wider society. According to a 2017 study by the University of Southampton, being homeless is more likely to cause paranoia, but being in a prolonged state of paranoia can actually prolong one's homeless condition due to greater isolation from society and a suspicion of mainstream services[16].

63. Furthermore, the task group heard that homeless residents, including rough sleepers in Surrey, are more inclined to develop psychosis. This often manifests with symptoms such as delusions or visual and audio hallucinations. According to the Homelessness Health Needs Audit of 2016, nearly 12% of males and 8% of females experienced psychosis. This psychosis is often induced by a multitude of factors experienced by the

[14] https://www.nhs.uk/conditions/mouth-cancer/causes/
[15] https://www.kingsfund.org.uk/publications/what-are-health-inequalities
[16] Powell K, Maguire N. Paranoia and maladaptive behaviours in homelessness: The mediating role of emotion regulation. Psychology and Psychotherapy: Theory, Research and Practice. 2018 Sep;91(3):363-79.

homeless; particularly a sense of helplessness, isolation, and prolonged physical symptoms of pain and discomfort. Such mental health issues often go undiagnosed or even untreated as a result of a prolonged lack of access to GP services, let alone to mental health services. Therefore, as stated in the recommendation outlined in the previous section, the task group strongly recommends that GP access is enhanced for homeless individuals, as this can help to identify and tackle not merely the physical, but also the mental health challenges that these individuals experience.

64. It is not only rough sleepers who are more prone to mental health issues, but also homeless residents who are having to "squat" and constantly move around the homes of friends or relatives. Such "squatters" often feel a sense hopelessness and a loss of control over their housing situation or their overall lives. This sense of loss of control results in an increase in anxiety and depression, which leads to a constant and negative cycle of remaining in a consistent state of poor mental health which further debilitates their wellbeing and capacity to overcome their homelessness.

65. The task group found that the lack of availability of mental health services for the homeless has impeded their exposure to treatment. For instance, Community Foundation for Surrey reported to the task group that there is a lack of availability of mental health practitioners as well as qualified counselling staff within Surrey; and that this has resulted in the homeless being left far behind in the list of those requiring mental health support.

66. The task group also heard that homeless individuals who experience a mental health crisis, particularly rough sleepers, often do not receive the urgent and immediate support required. For instance, they struggle to gain access to Mental Health Safe Havens, and in some cases when they attend A & E departments, they are not provided with the adequate and appropriate support required for an individual undergoing a mental health crisis.

67. Hence, the **task group recommends that efforts are made to increase access to mental health safe havens for homeless individuals who experience a mental health crisis**. In addition, the task group also importantly **recommends that homeless individuals suffering from poor mental health are provided access to counselling and cognitive behaviour therapy to help them cope with and to overcome their mental health challenges.**

68. Furthermore, in its witness session with Surrey and Borders Partnership, the task group heard that there are complex barriers which increase difficulties for rough sleepers or homeless individuals to receive mental health support. Such barriers include:

    1. Homeless individuals often struggle to prove that they are Surrey residents in the very first instance, which can create complications for seeking support or being referred to services.

    2. Homeless individuals often struggle to fill in forms to register with GP surgeries or to simply apply for GP appointments.

3. Homeless individuals are often subjected to being “bounced” between different services. Whilst the tendency to be bounced around services is not unique to homeless individuals, these individuals are more inclined to suffer from this, particularly if they are rough sleepers.

4. Homeless individuals that are granted temporary accommodation are sometimes relocated outside of Surrey, which makes it difficult for them to continue to access Surrey-based mental health services.

5. Homeless individuals need to be in environments where they are in a position to be able to start thinking about improving their overall health and wellbeing and accessing mental health services. This includes the need to have more sustainable temporary accommodation arrangements for the homeless; particularly those who are suffering from poor mental health.

69. As such, **the task group recommends for Surrey County Council to work more closely with District and Borough Councils, to provide more sustainable temporary accommodation facilities to help homeless individuals to remain in a stable environment through which they can access support for their mental health.**

Drug and Alcohol Abuse:

70. The task group learned that homeless individuals in Surrey have a greater proclivity to resort to drug and alcohol use and even misuse. This tendency to resort to alcohol and drug abuse is fuelled by the physical and mental distresses of remaining homeless for prolonged periods. Thus, remaining in a state of addiction and misuse often precludes homeless individuals in Surrey from being able to access housing. The 2016 Homelessness needs audit found that almost 20% of homeless individuals within Surrey consume Alcohol on a daily basis.

71. In its witness sessions with both Guilford Action as well as with “We You”(the aforementioned national mental health charity which is also a member of the Adult’s Mental Health Alliance in Surrey), the task group heard that local councils within Surrey are highly reluctant to provide housing support to the homeless until they overcome their drug or alcohol addiction. However, the drug and alcohol abuse experienced by the homeless could not be resolved or overcome whilst they were still in a state of homelessness or rough sleeping on the streets. Rather, it is the consistent rough sleeping on the streets which raises susceptibility to drug and alcohol abuse in the very first instance.

72. It was reported to the task group that an Alcohol-harm paradox exists in Surrey, whereby, in some instances, although residents in deprived areas may not drink as much as those in afflue nt areas, the impact of the alcohol on their overall health is greater given the other factors surrounding their living conditions and socio-economic situation. People from less deprived areas may consume more alcohol due to being able to afford it, although this does not translate into direct physical or mental harm as a result inasmuch as it does for those in more deprived areas.

73. It was also heard that residents with an Alcohol addiction, including those who are homeless, may often be refused assistance with their mental health. This may be due to negative and misleading stigmatisations that those who are suffering from Alcohol or Drug addictions are consciously eliciting harm onto themselves. As such, there is a need for greater sensitivity with how Alcohol or drug addiction are referred to, and terminologies such as "drunk" or "drug dependent" should be avoided when referring to such individuals in health and wellbeing settings where these individuals may be receiving support. Indeed, any indication of the use of the aforementioned terminologies can lead victims of Alcohol or Drug abuse to abstain from seeking support due to feeling uncomfortable with such labels.

74. Thus, the task group **recommends that there is joint commissioning for high quality mental health and drug and alcohol services that focus on meeting individuals' core needs rather than the current presenting problem**. Hence, if homelessness is a root cause of an individual's drug or alcohol addiction, then this should also be taken into account and support should be provided to help tackle this.

Key Findings for individuals suffering Domestic Abuse

75. Domestic abuse is a phenomenon that affects residents nationwide. According to the Office for National Statistics (ONS), 5.0% of adults (6.9% women and 3.0% men) aged 16 years and over experienced domestic abuse in the year ending March 2022; equating to an approximately 2.4 million adults (1.7 million women and 699,000 men)[17].The task group took a keen interest in this category of individuals for three reasons:

    1. Individuals suffering Domestic Abuse constitute one of the priority population groups within Surrey's Health and Wellbeing Strategy.

    2. Domestic Abuse victims may also fall under some of the other priority population categories found within Surrey's Health and Wellbeing Strategy.

    3. Domestic Abuse victims are more prone to experience physical and mental health challenges, and the task group believes that a more holistic approach needs to be adopted towards not merely understanding the complex and comprehensive nature of domestic abuse, but to reduce some of the Health challenges that these victims face.

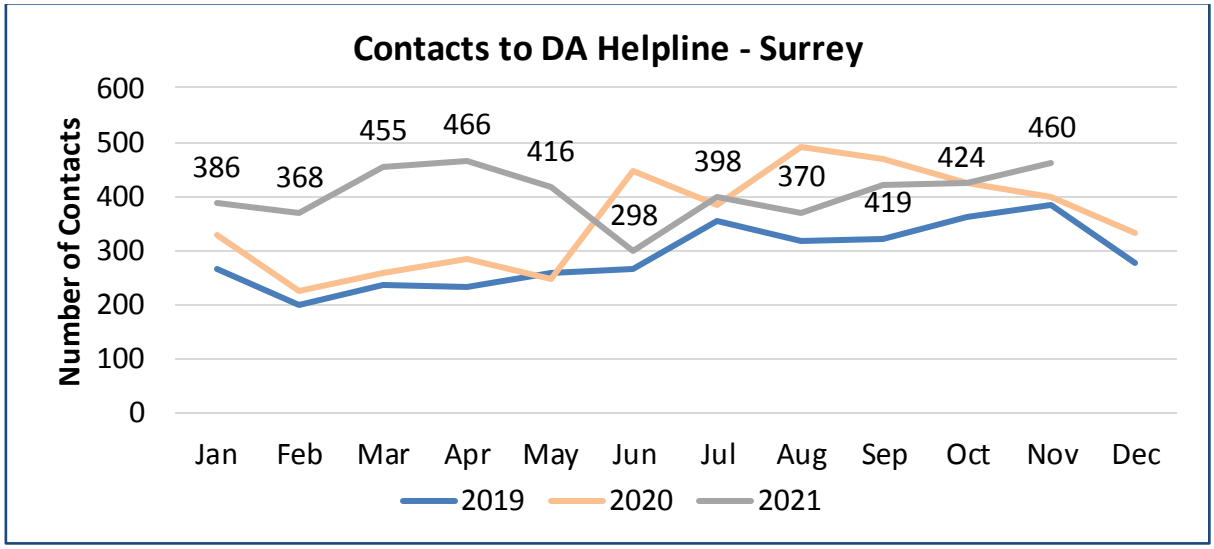
76. Domestic abuse is a comprehensive term. The task group believes that a holistic understanding of domestic abuse needs to be adopted, as only this can help to inform a holistic and comprehensive policy approach toward tackling abuse. Domestic abuse can either present as a pattern of incidences or as a single incident. However, the task

[17] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)

group has come to learn that most incidents of domestic abuse can often constitute part of a more consistent pattern of abusive incidences.

77. Incidences of Domestic abuse have increased within Surrey, particularly in the context of the Covid Pandemic and the advent of lockdown restrictions. This is evident in the fact that data on the number of contacts to Surrey's Domestic Abuse helpline indicates an increase in the number of contacts to Domestic Abuse Helplines from the period 2019-2021. Below is an extract from Surrey's Domestic Abuse Annual Report 2020-2021 which indicates this trend:

Figure D:



78. Additionally, data from Surrey Police indicates that approximately 14% of all recorded crimes within Surrey are related to various forms of domestic abuse.

79. The Task Group has conducted witness sessions, as well as received written evidence/documentation from multiple organisations which have provided insights into some of the Health challenges and disadvantages experienced by individuals suffering from domestic abuse. Witness sessions were conducted with representatives from Healthwatch Surrey, Surrey Safeguarding Adult's board, the South-West Surrey Domestic Abuse Service, and the Women's Support Centre. Below are some findings

on some of the common themes identified through the witness sessions as well as from data and research gathered from other avenues that the task group utilised.

Domestic Abuse in Rural Areas:

80. The task group has learnt that geography can constitute a crucial factor in domestic abuse patterns. According to a research project into domestic abuse conducted by the National Rural Crime Network in 2019, Rural Victims of Domestic Abuse are 50% as likely to report abuse when compared to victims in less rural areas[18]. For instance, in its witness session with the South-West Surrey Domestic Abuse Service, the task group heard that the Guilford and Waverly Boroughs have a substantial rural population, and that this has accounted for a reluctance to report domestic abuse in these areas. It is also the case that rural victims are more inclined to suffer abuse that is more consistent and continual relative to other areas. As such, victims who live in rural areas, including those in Guilford and Waverly, often feel a sense of isolation, and a lack of being protected and supported given the difficulties in being able to travel alone and independently through rural areas.

81. The task group heard that such isolation and lack of support can be felt amongst the victims of domestic abuse from the BAME community also. Living in rural areas, combined with taboos surrounding reporting abuse from partners as well as the presence of language barriers can result in some females from BAME communities to suffer in silence.

82. As such, it is imperative that residents in deprived areas are able to also benefit from domestic abuse protection and support services. The task group therefore **recommends for continued efforts to increase awareness of support for domestic abuse available to residents.**

Domestic Abuse and physical Health:

83. The task group learnt that one of the most significant aspects of domestic abuse involves physical harm. Although this does not constitute the sole form of domestic abuse, it nonetheless remains one of the key symptoms of abuse for Surrey residents. For instance, in its witness session with Women's Support Centre, it was heard that Women (who are statistically more prone to being victims of abuse) often present with direct harm or injuries in any parts of their bodies. Women who approach or who are referred to the Women's Support Centre for domestic abuse can often present with bruises or long-term bodily pain and aches in the back and shoulders. Often such victims have been physically beaten, tossed around, or slammed against objects or furniture.

84. That victims of domestic abuse can often suffer immense physical harm is also manifested in the fact that, according to data from the Femicide Census, 1 woman is killed by a man every 3 days in the UK, and that over 70% of these killings are perpetrated by partners, ex-partners, or family members[19]. Domestic abuse can also

[18] Captive & Controlled - Domestic Abuse in Rural Areas - National Rural Crime Network
[19] https://www.femicidecensus.org/

constitute a key factor in morbidity for Women. Indeed, according to the Safelives Pathfinder Project, domestic abuse is the highest cause of morbidity in women between the ages of 19-44, which is higher than morbidity from cancers, wars, or road traffic accidents.

85. Moreover, the task group heard that Domestic Abuse victims are more prone to developing dental health problems. This could be due to a multitude of factors including poor diet and nutrition, not being able to independently book dentist appointments or to travel to a dental practice, or due to being afraid and reluctant to approach health services for fears that this may result in their abuse or abuser being exposed. More insights into refraining from health services due to fears of exposure of abuse are outlined in further detail in this report in a section below.

Domestic Abuse and Miscarriages:

86. The task group heard that domestic abuse can often increase against Women during times of pregnancy. In its witness session with the Women's Support Centre, it was heard that such abuse can often elicit miscarriages in pregnant Women. There are two reasons that account for this:

    1. *Physical abuse* can often result in physical injury and trauma to the body. Such physical assaulting or sudden trauma can result in a miscarriage.

    2. *Mental abuse*, or even the proclivity to feel under a consistent pattern of mental distress due to extreme anxiety, can also result in Women experiencing a miscarriage. Indeed, according to research conducted by the University of London, Pregnant Women who experience extreme forms of stress and mental anxiety are over 50% more likely to experience a miscarriage.

87. As such, **the task group recommends that greater support is offered to tackle mental health as well as domestic abuse for Women during pregnancy, and that efforts are made to raise awareness of such support amongst pregnant Women.**

Victim's difficulties in gaining access to healthcare:

88. The task group learnt that it can often prove challenging for victims of domestic abuse to gain access to healthcare services. There are three reasons as to why this could be the case.

    1. *Fear of Abuser:* Victims fear that if the abuser discovers that they are seeking healthcare support, that could infuriate the abusers further and aggravate the victim's experience of abuse. Abusers may be suspicious that healthcare professionals may identify evidence of abuse.

    2. *Health records being used against Victim:* Victims can feel that if they report poor mental health as a result of abuse, that this could result in them permanently being labelled as suffering from mental health conditions. Victims may therefore feel that they may not be taken too seriously by health practitioners when reporting genuine

physical symptoms/poor physical health due to their records indicating that they suffer from poor mental health.

3. *Lack of awareness of Support Available:* Victims may genuinely not be aware of support services available, be this domestic abuse support, or even mental health support. For instance, many victims who suffer poor mental health do not know who to approach regarding this, and can often assume that GPs cannot help them with mental health issues but exist for the purposes of primarily dealing with physical health symptoms. This results in victims refraining from seeking to access mental health support. If victims were aware of their GPs ability to refer them for mental health support, they may be more inclined to bring the mental health ramifications of their abuse to their GPs attention and would therefore benefit from mental health support services available for domestic abuse victims.

89. As such, the **task group recommends for the continuation of efforts to increase awareness of support for domestic abuse available to residents.**

Domestic Abuse and Children:

90. As part of its holistic approach to domestic abuse, the task group understands that domestic abuse can have negative impacts on the health and wellbeing of Children. Through its witness sessions with Women's Support Centre as well as with the South-West Surrey Domestic Abuse Service, the task group heard that Children could suffer from domestic abuse either *directly* or *indirectly* as is outlined below:

1. *Direct abuse*: This could take the form of being physically abused, either through being beaten aggressively by a parent or close loved one. Or in some instances, and to a lesser extent, children could also be subjected to sexual abuse.

2. *Indirect abuse*: This could be from experiencing neglect due to being in a household where abuse is prevalent towards a parent. Or, in some cases, Children are indirectly affected by abuse through having to witness traumatic experiences of abuse between parents; which can result in prolonged mental health issues. In one study published by the journal of brain sciences in 2017, it was found that children who witness domestic abuse in their household are more susceptible to developing strong anxiety and depression; both during childhood as well as into adulthood[20].

Therefore, the task group believes that Children should also be considered as victims of domestic abuse in their own right, and hence should also benefit from receiving protection and support against both *direct* and *indirect* abuse so as to avert threats to their overall health and wellbeing.

Domestic Abuse and Safe Accommodation:

91. Victims of domestic abuse often require support which involves the provision of accommodation that is separate from the abuser. The logic is that if separated from the

[20] https://www.mdpi.com/2076-3425/7/10/133

abuser, the victim will suffer less physical, mental, or emotional harm, which can reduce poor health and wellbeing as a whole.

92. However, the task group discovered that it is not always the case that victims who require safe accommodation are provided with this. In some instances, despite receiving accommodation, the accommodation may not be entirely appropriate for them. This can have a knock-on effect on their overall health and wellbeing.

93. In 2021, the *Surrey Domestic Abuse and Safe Accommodation Needs Assessment* was published. This was undertaken to assess the current safe accommodation offer in Surrey and to identify any needs and gaps in the provision of safe accommodation for domestic abuse victims. This covered the provision of support to victims and their children residing in some/all of the following; Specialist Safe Accommodation, Refuge accommodation, Sanctuary Schemes, Dispersed Accommodation, Moved-on or Second Stage Accommodation.

94. Overall, the Needs Assessment concluded that there were gaps/needs that require further efforts to address. These include:

- There are no caravan or mobile homes for the Roma Gypsy and Traveller Communities.
- There is little (if any) accommodation provision for victims who are adult males.
- Accommodation may not be sufficiently large so as to meet the needs of larger families.
- Some of the accommodation provided does not suit the specialist needs of victims from BAME backgrounds.
- Social Housing staff lacked strong knowledge and understanding of the nature of domestic abuse and its various forms, and the associated impacts on victims who may urgently require accommodation separate from abusers.
- There is need to support letting agents and private landlords to improve how they deal with and respond to domestic abuse.

95. There is also a Sanctuary scheme as an initiative that is multi-agency. The objective here is to allow households who are at risk of physical abuse to remain in their homes whilst benefiting from the provision of increased security measures. This may also involve the designation of a 'sanctuary room' within the victim's homes. However, this scheme is only implemented when abusers are no longer residing in the victim's homes. Below is a table extracted from the Surrey Domestic Abuse and Safe Accommodation Needs Assessment, which provides a breakdown of existing data on referrals. It demonstrates that the most referrals for sanctuary schemes are from Woking.

Figure E:

District/Borough	Referrals
Woking	52
Guildford	20
Waverley	5
Epson & Ewell	19

Hence, based on all the accommodation-related information outlined in this section, **the task group recommends for the continuation of efforts to provide domestic abuse victims with an easy point of access for support, including for accommodation, in the event of victims seeking refuge.**

Post-Separation Abuse:

96. The task group heard that domestic abuse is not a phenomenon that is limited to the period in which an individual is within a relationship with another abuser. Rather, there also exists a tendency for abuse to occur even subsequent to separation. This is particularly the case for Women who have been victims of abuse in a former relationship.

97. According to funded research conducted by domestic abuse scholars in 2022, approximately 90% of victims of coercive abuse experience post-separation abuse[21]. Hence, the assumption that victims of abuse are safer once they leave a relationship is misleading. For instance, victims can continue to be subject to abuse for several years after leaving a relationship with an abuser.

98. According to the Women's Support Centre, of the 888 women killed by partners or former partners in the ten-year period 2009-2018, at least 378 (43%) were known to have separated, or taken steps to separate, from the perpetrator. Additionally, according to the Femicide Census, of the cases where women had separated, or made attempts to separate, the vast majority, 338 (89%) were killed within the first year and 142 (38%) were killed within the first month of separation[22].

99. Hence, it is imperative that victims of domestic abuse continue to receive support even subsequent to a separation from an abuser. Therefore, assuming that domestic abuse ceases once an individual is no longer in a relationship with an abuser is highly problematic and could risk continued harm to a post-separation victim's physical and mental health.

Conclusions:

100. Throughout this project, the Task Group has received a substantial amount of valuable evidence from witnesses. The Task Group members wish to express their thanks,

[21] https://www.domesticshelters.org/articles/legal/8-common-post-separation-domestic-abuse-tactics
[22] https://www.femicidecensus.org/wp-content/uploads/2022/02/010998-2020-Femicide-Report_V2.pdf

gratitude, and appreciation to all of those who dedicated their time to share their insights, expertise or experiences.

101. This report has summarised these insights, expertise and experiences to further understand the nature as well as the sources of the Health Inequalities and disadvantages experienced by the three population groups it has selected. The evidence accumulated during witness sessions was utilised to inform the development of recommendations for consideration by the Adults and Health Select Committee, Surrey County Council's Cabinet and other health partners.

102. The Task Group's recommendations are predicated on key themes identified during the witness sessions, as well as the frequency with which such themes were raised. The Task Group has also sought to develop recommendations that adhere to the SMART (specific, measurable, achievable, realistic and timebound) criteria.

103. The Task Group feels that the recommendations outlined in this report will contribute to reducing Health Inequalities.

Next steps:

104. The Task Group's report will be considered by the Adults and Health Select Committee.

105. The Task Group's report and recommendations will also be submitted to relevant commissioners and providers.

106. The Task Group will review the implementation of its recommendations every 6 months.

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Annexes:

Annex 1 – List of Health Inequalities Task Group witness sessions

Annex 2 – Health Inequalities Task Group key lines of enquiry

Annex 3 – A graph published by Public Health England, indicating the Age standardised mortality rates in laboratory confirmed Covid-19 cases by ethnicity and Sex in England.

Annex 4 – Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data into key Health disadvantages experienced by Individuals from BAME Communities.

Annex 5 – An extract from the Surrey Homelessness Health Needs Audit of 2016, which indicates the Mental Health challenges/Disadvantages experienced by individuals experiencing Homelessness within Surrey.

Annex 6 – An extract from the Surrey Homelessness Health Needs Audit of 2016, which indicates the Physical Health challenges/Disadvantages experienced by individuals experiencing Homelessness within Surrey.

Annex 7 - Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data & insight into key Health disadvantages experienced by Individuals suffering from homelessness.

Annex 8 - Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data & insight into key Health disadvantages experienced by Individuals suffering from Domestic Abuse:

Annex 9 - Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data on referrals to refuges for refugees experiencing Domestic Abuse. The data indicates an increase in the number of referrals for refugees from 2018-2021.

Annex 10 - Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data on the number of contacts to Surrey's Domestic Abuse helpline. The data indicates an increase in the number of contacts to Domestic Abuse Helplines from the period 2019-2021.

Annex 11 - Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data from Surrey Police on the number of contacts to Surrey's Domestic Abuse helpline. The data indicates the number of Domestic Abuse related incidents and crimes in 2020-2021. Although there has been a slight decline in Domestic Abuse crimes and incidents, 14% of all recorded crimes in Surrey were classified as Domestic Abuse related.

Annex 12 - Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data percentages from Domestic Abuse Outreach Services on the type of abuse experienced between April-September 2021. The data also indicates percentages for the victim's relationship to the perpetrator.

Annex 13 - Data supplied to the task group by Women's Support Centre, displaying Women's Support Centre referrals for 2021/22 and 2022/23 by district and borough.

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ANNEX 1 (Witness Sessions):

Below is a full list of the witness sessions that were conducted as part of this task group. The **first 8** witness sessions were conducted as part of the **First Stage** of this project which involved a brainstorming exercise to help define Health Inequalities, whilst the remaining witness sessions were conducted as part of the **Second Stage deep-dive** into the **three population groups** identified in the main text of this report.

The task group once more expresses great thanks and gratitude for the participation of the following individuals/organisations in this project on Health Inequalities within Surrey:

1. **6th December 2021 – Public Health Team at Surrey County Council**
   - Ruth Hutchinson – Director of Public Health
   - Helen Johnson – Senior Programme and Policy Manager
   - Helen Tindall – Policy and Programme Manager
   - Phill Austen-Read – Principal Health and Wellbeing Lead

2. **18th January 2022 – King's Fund**
   - Dave Buck – Senior Fellow, Public Health and Inequalities

3. **26th January 2022 – Comms Team at Surrey County Council**
   - Andrea Newman – Strategic Director (Communications)
   - Laura Downton – Account Manager (Adult Social Care Comms)
   - Sarah Archer – Senior Communications Officer (Public Health)

4. **2nd February 2022 – Priority 2 Leads**
   - Professor Helen Rostill – Priority 2 Lead
   - Phill Austen-Reed – Principal Health and Wellbeing Lead

5. **28th February 2022 – Learning Disabilities and Autism Leads**
   - Steve Hook – Assistant Director (Learning Disabilities, Autism & Transition), Surrey County Council
   - Liz Williams – Joint Strategic Commissioning Convener (Learning Disabilities & Autism), Surrey County Council & Surrey Heartlands ICS

6. **9th March 2022 – Surrey Coalition of Disabled People**
   - Clare Burgess – Chief Executive Officer
   - Helen Anjomshoaa – Operating Manager

7. **17th March 2022 – Independent Mental Health Network**
   - Immy Markwick – Mental Health Lead
   - Guy Hill – Co-Ordinator

8. **21st March 2022 – National Autistic Society (Surrey Branch)**
   - Sara Truman – Deputy Chair (Adults)
   - Carol Teunon – Chair
   - Gemma Fry – NAS Staff Member
   - Rachel Boyce-Davies – Parent Member

9. 25th October 2022 – Guilford Action

- Joanne Tester - Chief Executive (Guildford Action)

10. 28th October 2022 – Community Foundation

- Rebecca Bowden - Chief Executive (Community Foundation for Surrey)
- Denis O'Connor - Chair (Community Foundation for Surrey)

11. 1st November 2022 – Healthwatch Surrey

- Samantha Botsford - Local Healthwatch Contract Manager (Healthwatch Surrey)
- Katharine Newman - Intelligence Officer (Healthwatch Surrey)

12. 1st December 2022 – Surrey Safeguarding Adult's Board

- Sarah McDermott – Surrey Safeguarding Adult's Board Manager

13. 14th December 2022 – South-West Surrey Domestic Abuse Outreach Service

- Joanne H, Service Manager

14. 15th December 2022 – With You

- Hannah Willis - Director of Services – Mental Health
- Linda DeBardelaben – Mental Health Clinical Lead

15. 23rd January 2023 – Women's Support Centre

- Leanne Spiller – Women's Support Centre Manager
- Melanie - Domestic Abuse worker

16. 3rd February – Surrey Minority Ethnic Forum

- Suzanne Akram – CEO SMEF
- Hina Ashraf – Health Project Lead

17. 12th April – Surrey & Borders Partnership NHS Foundation Trust

ANNEX 2:

HEALTH INEQUALITIES TASK GROUP KEY LINES OF ENQUIRY:

Possible lines of enquiry:

- How can local authorities and local health services best work together to ensure there is an integrated approach to tackling health inequalities for the Task Group's 3 priority groups?
- What is being done/can be done to help identify individuals from these priority groups who are suffering from health inequalities?
- How can local authorities best work with residents from the three priority groups to learn more about/from their experiences?
- What can local authorities do to ensure residents are involved in making decisions about the services and support they receive?
- Are there any local authorities that are particularly good at tackling health inequalities for these three priority groups? What strategies and/or initiatives could Surrey learn from?
- Are there any potential impediments to being able to reduce health inequalities for the three priority group? What can be done to overcome these?

<u>BAME/GRT Communities:</u>

- Are there any specific health inequalities/disadvantages that BAME/GRT communities suffer from in regards to their physical health?
- BAME community language barriers?
- Vaccine encouragement to BAME Community.
- BAME community refraining from gaining maternity support/advice.
- Are there any specific physical conditions that BAME/GRT communities suffer from relative to other ethnic groups, and what can be done/what is being done to help address this?
- Are there any specific health inequalities/disadvantages that BAME/GRT communities suffer from in regards to their mental health?
  - To what extent is there a lack of awareness of mental health or its treatment as a taboo? How can this be overcome?
  - Are such communities aware of mental health services available within Surrey?
- Are there any wider determinants of health that affect the overall health and wellbeing of BAME/GRT communities? What can be done to address this?
- Are there elements of the GRT community that are wary of approaching health services/institutions, and how has this impeded their access to health services?
- Are the GRT's chosen way of living affecting access to medical services?
- What can help GRT communities feel confident/secure that they are receiving the appropriate medical assistance.

- What else can be done to improve the physical, mental, and wider determinants of health for members of the BAME/GRT community (any other specific recommendations that task group can make)?

Individuals suffering from Homelessness, Drug and Alcohol Abuse:

- Are there any specific health inequalities/disadvantages that people experiencing homelessness, drug and Alcohol abuse suffer from in regard to their physical health?
- Are there any specific health inequalities/disadvantages that people suffering from homelessness, drug and Alcohol abuse suffer from in regard to their mental health?
  - Have such groups experienced complications in gaining access to mental health services?
  - Are such groups aware of Mental Health services potentially available to them?
- Are there any wider determinants of health that affect the overall health and wellbeing of those suffering from Homelessness, Drug, and Alcohol abuse? What can be done to address this?
- What else can be done to improve the physical, mental, and wider determinants of health for this group? (any other specific recommendations that task group can make)?

Individuals suffering from Domestic Abuse:

- Are there any specific health inequalities/disadvantages that people suffering from Domestic abuse suffer from in regard to their physical health?
  - Does Domestic Abuse render such individuals/victims more prone to certain physical conditions.
  - To what extent has "neglect" caused such group's susceptibility to physical ill health?
- Are there any specific health inequalities/disadvantages that people suffering from Domestic abuse suffer from in regard to their mental health?
  - Are such victims aware of mental health services available? Do they have access to such services?
  - Are these victims more prone to developing ill mental health?
- Are there any wider determinants of health that affect the overall health and wellbeing of Domestic Abuse Victims? What can be done to address this?
- What else could Surrey CC do to help support domestic abuse victims?
- What else can be done to improve the physical, mental, and wider determinants of health for this group? (any other specific recommendations that task group can make)?

ANNEX 3 (BAME Community):

Graph published by Public Health England, indicating the Age standardised mortality rates in laboratory confirmed Covid-19 cases by ethnicity and Sex in England. The graph indicates that Black, Asian, and Mixed Ethnic groups suffer from a higher mortality rate per 100,000.

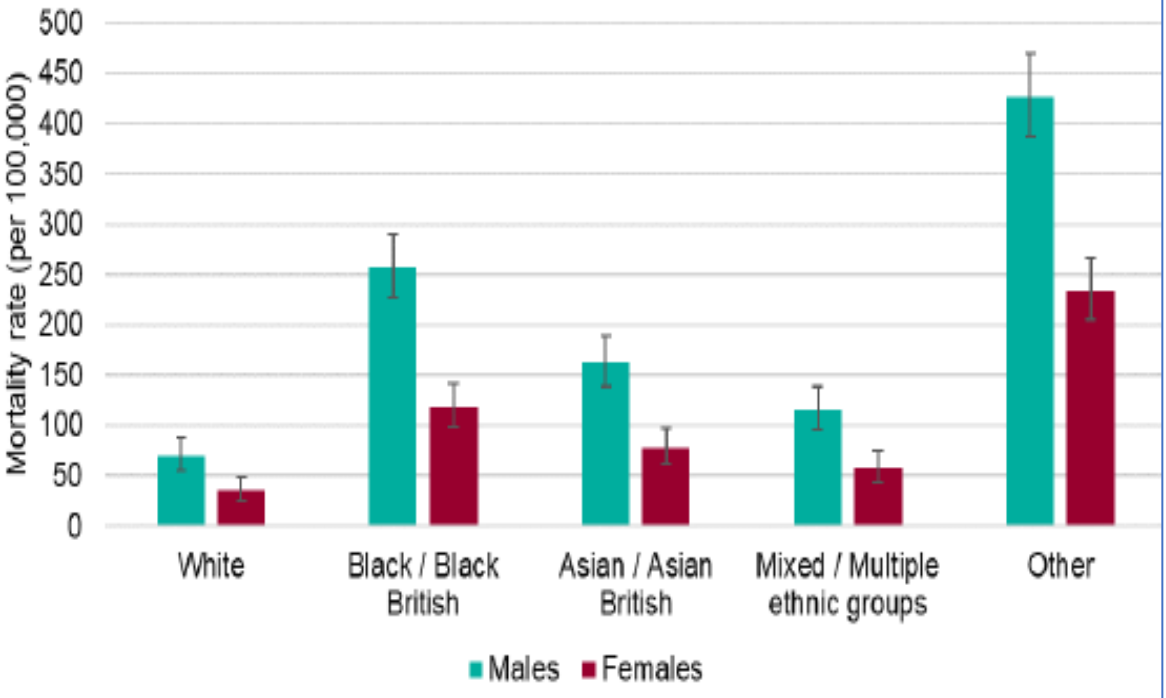

Figure 4.5. Age standardised mortality rates in laboratory confirmed COVID-19 cases by ethnicity and sex, as of 13 May, England. Source: Public Health England: COVID-19 Specific Mortality Surveillance System.

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ANNEX 4 (BAME Community):

Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data & insight into key Health disadvantages experienced by Individuals from BAME Communities.

Access to appointments - digital and language barrier

I have little English [an interpreter helped with the experience] and I can't use a computer. Whenever you call to make an appointment there is a long wait. You then get fed up and hang up .I am ill I can't sit or stand for long while I hang on the phone. This costs money too. If it's urgent I just go straight to the hospital.

There is also the language barrier. They should ask you which language you speak. I prefer face to face because of this. It's better for the language thing. I can speak a little English.

When you do get to see the doctor, they are very good, but the problem is trying to make an appointment. It's very difficult.

The main problem is that I can't get an appointment. I call all the time and get through to the answer machine. Then when you do eventually get through it's in 2 weeks' time. I last saw the doctor a month ago. I have been trying to get my son an appointment for the last 2 weeks.

I don't have a computer and so I can't book online.[Experience was taken through an interpreter] **Oct 22, 176581**

Difficulties with online/ Need face to face

I am at Maybury surgery. I find the situation very upsetting. During the day I have no one at home to help me. I can't access online appointments and I can't speak English. I need a face to face appointment. **Sept 22, 176522**

I can't get a dentist appointment. I am trying to get an appointment for my husband, and they say they have to speak to him directly but he is out at work. I struggle talking over the phone and I need face to face. Our dentist is in Sheerwater. At the GP surgery, I can't get a face to face appointment either. I can't even get a telephone appointment there. I am a carer for my daughter. It's difficult. Life is hard. **Sept 22, 176541**

Translation issues

My daughter in law does not speak English. She gave birth a year ago and asked for me to accompany her as a translator, but they would not let me and instead gave her an interpreter on the phone. The interpreter was a man which wasn't really ok, and they didn't speak our exact language. This left her very upset and scared. She was in tears. **175734, September 2022, North West Surrey resident**

Multi-generational household

I would like to be rehoused. I currently live with my son and his family. He has 3 children. There is only one bathroom for everyone. I have ill health, and this is a very stressful situation. The house is too crowded for us all. I have been waiting 8 months. **176575 October 2022**

Refugee separated from family

I am from Afghanistan. I have been separated from my son and I am very worried about him. He has been housed in Basingstoke. I worry about him, it's very hard. I am having problems with my teeth and I'm trying to get NHS dentist, but I can't get one. **176546 September 2022**

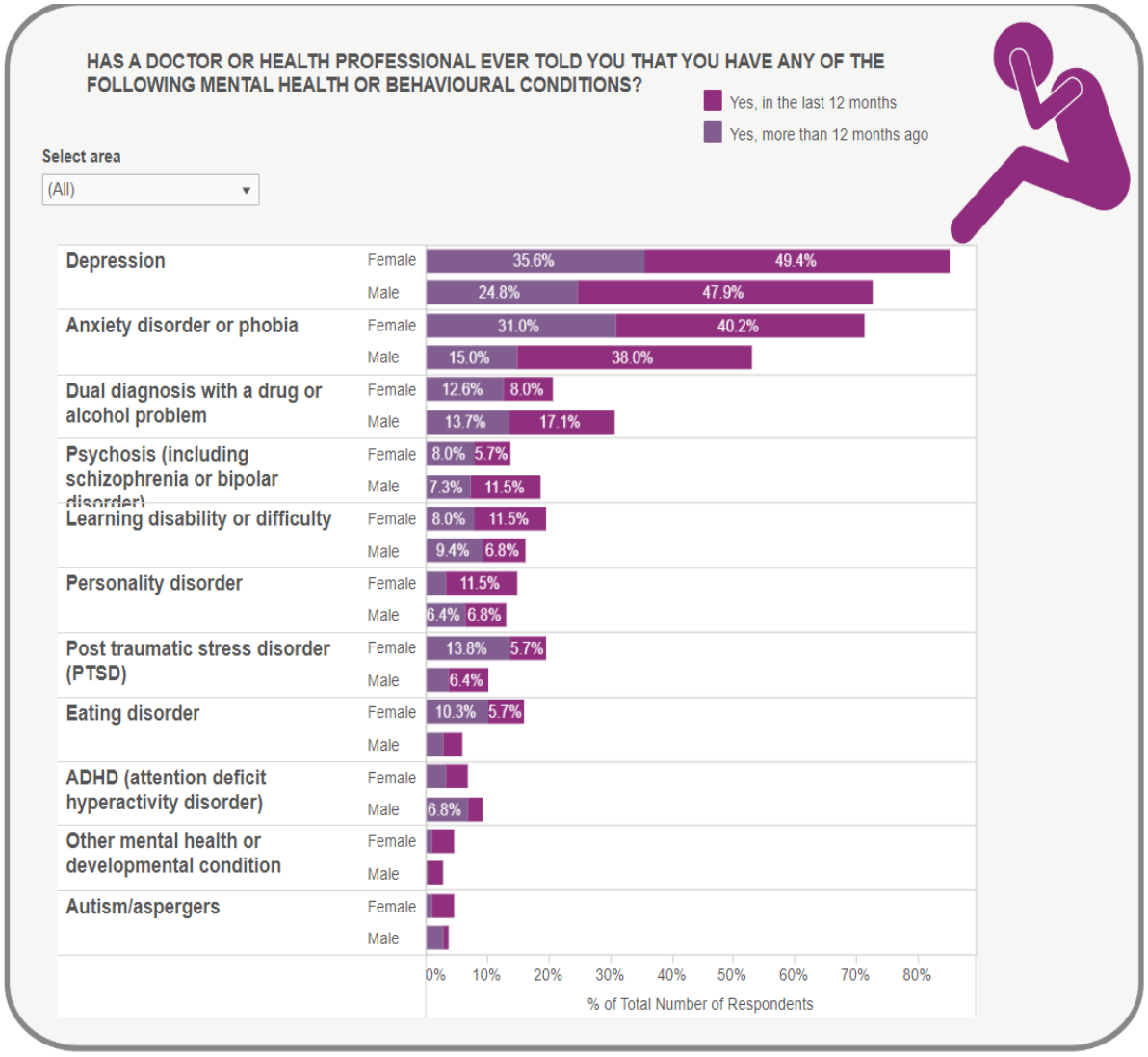
Social Isolation

My GP is a small practice. They are very quick with seeing the children but it's not so easy to get an appointment for an adult. All appointments have to be made online. Sometimes if they can't see me for an appointment, they refer me to another clinic such as Brockham. I don't drive so it's very hard for me to get there as I need to get a friend to take me. I could take a bus, but I have three young children so it's not quite that easy.

I had my younger two children at East Surrey hospital which was excellent. I moved over from Syria 5 years ago, so I have no friends or family here. The family centre here is an amazing support and is a real lifeline for me. **176409 September 2022**

ANNEX 5 (Homelessness):

An extract from the Surrey Homelessness Health Needs Audit of 2016, which indicates the Mental Health challenges/Disadvantages experienced by individuals experiencing Homelessness within Surrey.



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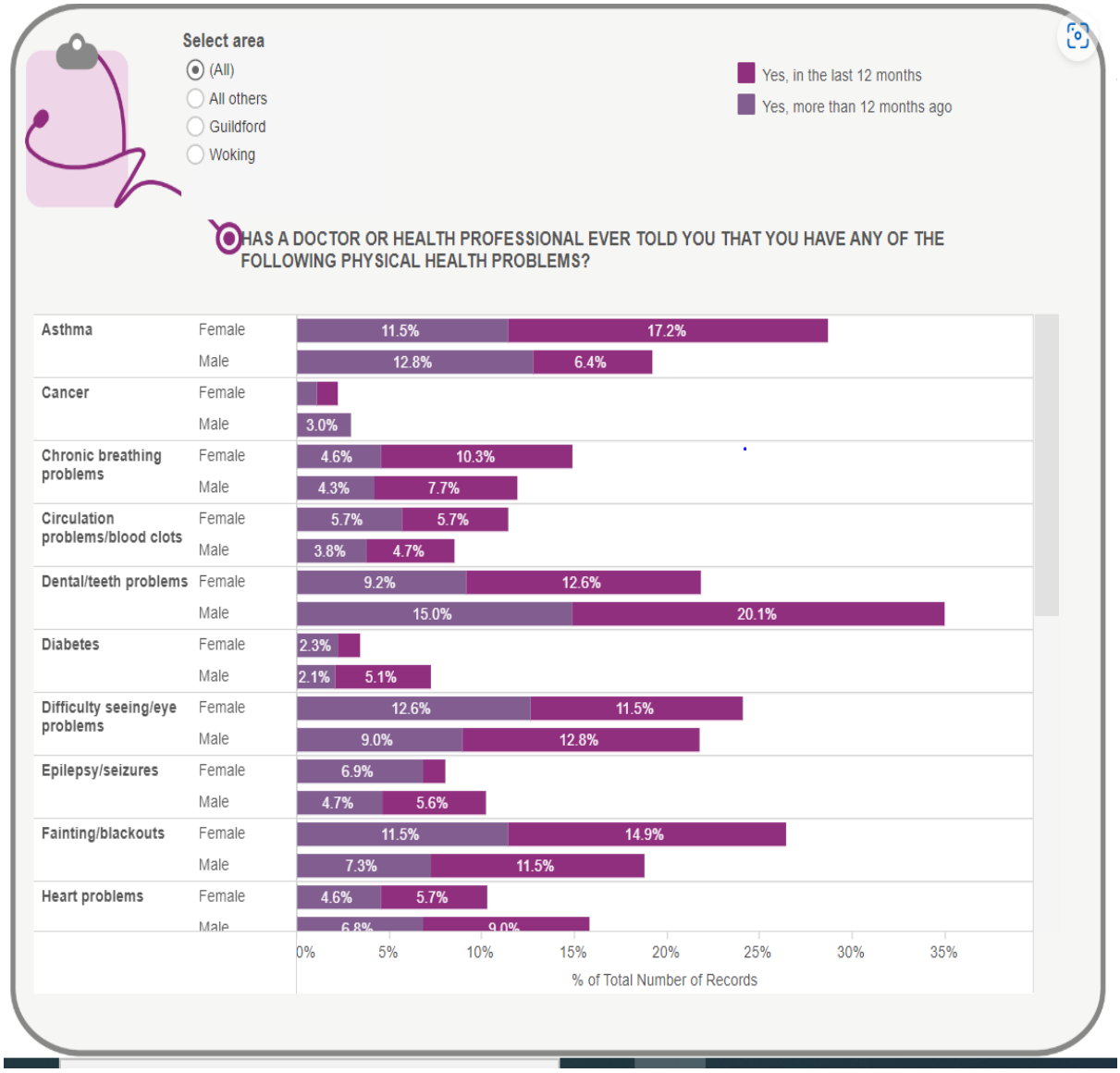
ANNEX 6 (Homelessness):

An extract from the Surrey Homelessness Health Needs Audit of 2016, which indicates the Physical Health challenges/Disadvantages experienced by individuals experiencing Homelessness within Surrey.



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ANNEX 7 (Homelessness):

Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data & insight into key Health disadvantages experienced by Individuals suffering from homelessness:

With my first baby, I was homeless when I gave birth, and it was the start of the pandemic. The hospital wanted me to leave before I had anywhere to go, so it was very difficult. The hospital staff did everything they could for me, but it was very difficult. I stayed for more than 10 days, and social services found me accommodation. **163003 July 2022** *Clearvoice Interpretation (Amharic) used for the call)**Black African (Eritrean) woman aged 31 yr.*

Patient was admitted to (St Peter's Chertsey). Patient has previously been diagnosed with emphysema, COPD and fibrosis of the lungs, possibly due to work they did long ago. They say it could be asbestosis, but there is no proof of that at this stage. Patient was suffering with severe breathing problems so was admitted to hospital, whilst patient was in a ward, another patient was brought into the same ward who seemed to be having breathing difficulties. The staff did not go into the room with this patient. Our patient asked for a mask worried that this might be a Covid19 patient. The next day our patient was moved to another ward and then again the next day to a third ward. At this point the patient was told they had to stay for 10 more days for Covid19 isolation. The patient did not manage to get an answer about whether the other patient brought into the patient's first ward had Covid19. The patient felt this was not good and the fact that they had to stay in longer meant they lost the temporary accommodation they so desperately needed as they are homeless and currently sofa surfing. **150189 September 2021**

Client is currently homeless and living in Guildford. For reasons that were not clear he should be helped off the streets by Runnymede Council who are flatly refusing to help him despite request from MASH and a court. Client was trying to find accommodation in Guildford and was waiting for a call from the council. He wanted help from Healthwatch Surrey with finding him accommodation {adviser explained Healthwatch Surrey remit and client terminated call] **159423 April 2022**

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ANNEX 8 (Domestic Abuse):

Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data & insight into key Health disadvantages experienced by Individuals suffering from Domestic Abuse:

Refuge users with healthcare access challenges and ongoing mental health challenges

[Foodbank User] I had to flee domestic abuse in 2020. I ended up in a refuge, I had to just leave but I managed to pack a bag. It was amazing and I'm thinking of working for them or volunteering for them. I had my own room, brand new bedding all still in its packaging, brand new toiletry bag, it was brilliant. They said they left everything in the packaging so that they could see that everything was new, and it was for me, and we were ready to start a new life.

I'm at the food bank today because we literally have no money now, I'm finding it hard to get work locally, as I don't drive. I used to be a nurse and I looked at getting to Royal Surrey but because of where I live in Farncombe it's really hard to get to the public transport in time and on a train and across Guildford to do the shifts, also it means you are paying a lot of your wages on public transport. Where I was before the transport links were so much better.

When we moved to the area, we registered at Binscombe GP surgery they've been amazing, really supportive and helped sort out lots of things. I'm also going through the menopause and the GP has been helping me with managing my HRT for menopause. I've been trying to manage my own hormones as I used to be a nurse and twice, I asked for changes to my HRT because I didn't think it was working and I needed a slightly different approach. The doctor has now changed the hormones as I've asked but I googled exactly what I had to say in order to get the changes made as I knew she couldn't give me certain hormones unless I said I had a lack of libido.

I was offered therapy via the refuge which was amazing, that was face to face and I found it was really good and appropriate. Last year I felt like I needed to talk to someone again and so I was able to refer myself to talking therapies [over the phone] that was CBT but you know it didn't really help and I thought I needed something more specialised, so I tried counselling by phone for PTSD I had eight weeks of it but I don't think people who are doing the talking really truly understand what it's like to be in a domestic abuse situation. I would have preferred someone with lived experience, they kept saying things like 'well you've got to look after yourself' which I found trite and really have been trying to look after myself since everything that has happened. They kept forgetting my story and I had to keep repeating myself and when you've explained something to someone a million times you kind of think what's the point, it's like starting again each session and then that it's not actually helping me anymore.

One of the problems I've had since I've moved to the area is finding a dentist. I've been at Farnham East Street dentist because my tooth was impacted they saw me but said it was a 52 week wait for it to be sorted out in a hospital. A friend paid for me in the end, and I got referred by East Street dentist to Eastleigh Dentist also in Farnham who did it privately. My daughter who is in her 30's also had problems with her teeth and 111 sent my daughter for help at Woking community dentist at the Woking hospital, it seemed like miles away especially when you're going by public transport.

All in all, we have decided we want to leave Waverley, it's not an easy place to make a new start without money. It's very expensive to live and hard to travel around cheaply we have given up with Waverley housing and have applied to be down in Exeter, so I can hopefully work down there and it's cheaper to live. I have no shame anymore and I have had to resort to using the foodbank to get by.
[Signposting: Back to GP if wanted further mental health support] 172252, July 2022

ANNEX 9 (Domestic Abuse):

Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data on referrals to refuges for refugees experiencing Domestic Abuse. The data indicates an increase in the number of referrals for refugees from 2018-2021.

Safe Accommodation

The table below shows the referrals received to the 3 refuge providers.

	Apr 2018 - Mar 2019	Apr 2019 - Mar 2020	Apr 2020 - Mar 2021	June 2020 -Mar 2021
RBWA	139	130	223	
RBWA Hill House				61
Your Sanctuary *	327	801	1051	
Salvation Army (SAHA)	48	54	67	
Total	514	985	1341	61

**Your Sanctuary referrals appear much higher. This is due to calls to the helpline being included in these numbers.*

- Since 2020, Surrey's Refuge capacity increased from 34 to 65 spaces. This is a 91% increase.
- The Council of Europe recommends one refuge unit per 10,000 head of population. With this research in mind, it is recommended that Surrey can offer 119 units, 183% its current offer.

- April 2020 – March 2021 saw 1,402 referrals across the refuges (this includes referrals to the new RBWA Hill House refuge).
- Refuges have seen a 173% increase in referrals from 18/19 (514 referrals) to 20/21 (1402 referrals)
- Most of the referrals to refuge were from women outside of the County. This would be expected due to victims of Domestic Abuse generally fleeing from the area they currently live to ensure that the risk to them and any children is significantly reduced.
- More than 70 referrals were not progressed across the 3 providers due to the complex needs of the victim and / or their children (It is difficult to track the number of women turned away due to the way in which referrals are made to refuges).
- SAHA accepting self-referrals from victims of domestic abuse from inside and outside of Surrey.

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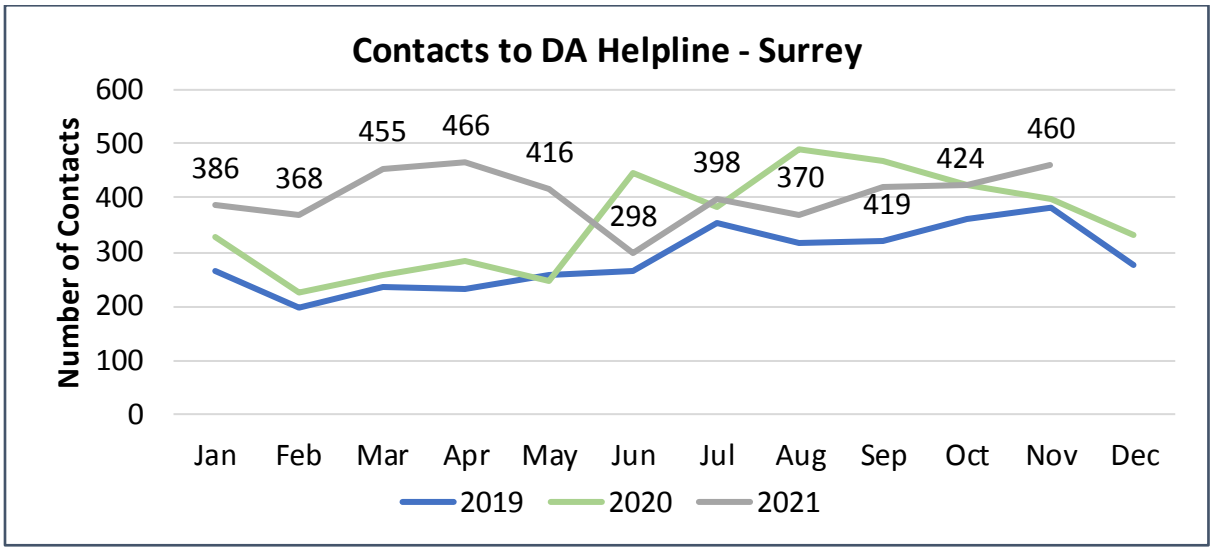
ANNEX 10 (Domestic Abuse):

Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data on the number of contacts to Surrey's Domestic Abuse helpline. The data indicates an increase in the number of contacts to Domestic Abuse Helplines from the period 2019-2021.



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ANNEX 11 (Domestic Abuse):

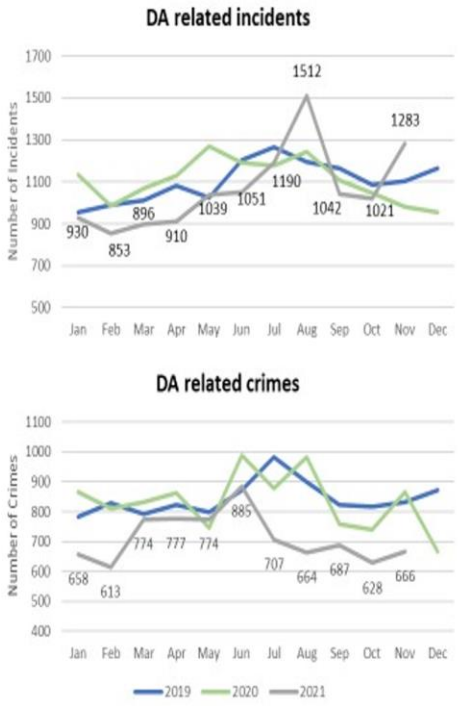
Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data from Surrey Police on the number of contacts to Surrey's Domestic Abuse helpline. The data indicates the number of Domestic Abuse related incidents and crimes in 2020-2021. Although there has been a slight decline in Domestic Abuse crimes and incidents, 14% of all recorded crimes in Surrey were classified as Domestic Abuse related.

Police Data

Year Ending March 2021*:

- 18% of all recorded crimes were classified as DA related in England and Wales
- 14% of all recorded crimes were classified as DA related in Surrey
- There were 32 arrests per 100 DA related crimes in England and Wales
- There were 42 arrests per 100 DA related crimes in Surrey

Surrey Police Data



Between Dec 2020 and Nov 2021

- The number of DA related incidents recorded by Surrey Police fell below levels seen for the same level the same period the previous year with the exception of June and November 2021 which had an increase of 22% and 31% respectively.
- The number of DA related crimes was generally lower than the previous year, and the number of crimes per month fell from June 2021

*Domestic abuse in England and Wales– Data tool - Office for National Statistics (ons.gov.uk)

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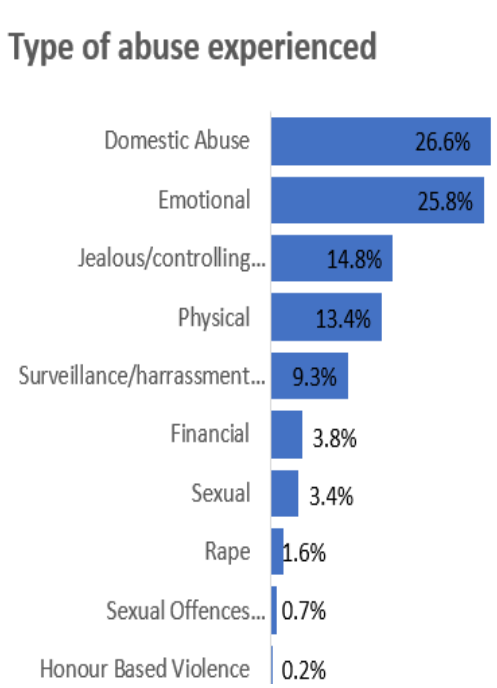
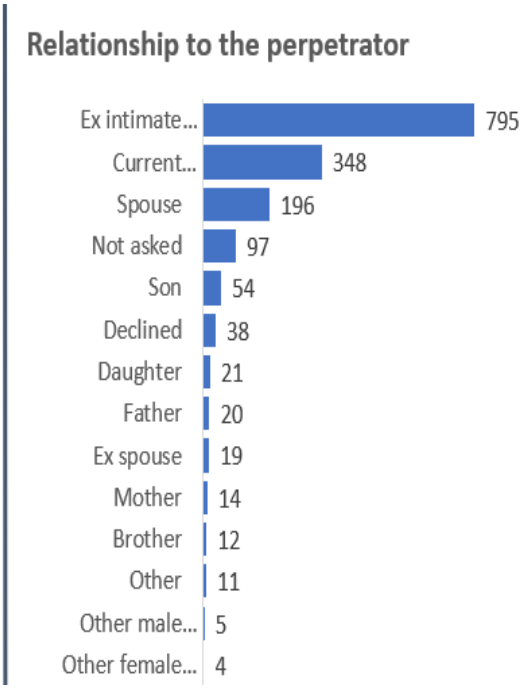
ANNEX 12 (Domestic Abuse):

Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data percentages from Domestic Abuse Outreach Services on the type of abuse experienced between April-September 2021. The data also indicate percentages for the victim's relationship to the perpetrator.





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ANNEX 13 (Domestic Abuse):

Data supplied to the task group by Women's Support Centre, displaying Women's Support Centre referrals for 2021/22 and 2022/23 by district and borough.

Over the year 2021/22 the Centre and worked with 671 women. This is compared to the year 2020/21 where the team worked with 747 women.

Area	Number of women referred	
	01.04.2021 - 31.03.2022 – data from 526 clients	01.04.2022 – 24.01.2023 – data from 498 clients
Elmbridge	12	13
Epsom and Ewell	11	10
Guildford	30	17
Mole Valley	3	3
Reigate and Banstead	21	11
Runneymede	15	20
Spelthorne	23	11
Surrey Heath	15	16
Tandridge	6	1
Waverley	37	8
Woking	121	81
Surrey – no D&B data.	232	307
	Narrative – although accurate for these clients, this is not a full set of data due to issues with changing database and reportable statistics. Year 2022/3 is not complete as yet and there is a 6 week period where no data is recorded, once again due to data transfer.	

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ADULTS AND HEALTH SELECT COMMITTEE

15 JUNE 2023

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

Omid Nouri, Scrutiny Officer

Contact details

07977 595 687 / omid.nouri@surreycc.gov.uk

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Adults and Health Select Committee
Forward Work Programme 2023

Adults and Health Select Committee Chairman: Bernie Muir I Scrutiny Officer: Omid Nouri I Democratic Services Assistant: Laila Laird						
Date of Meeting	**Type of Scrutiny**	**Issue for Scrutiny**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Cabinet Member/Lead Officer**
4 October 2023	Scrutiny	**Accident & Emergency Waiting times/Pressures.**	The Select Committee is to receive a report/reports from Surrey Heartlands and Frimley ICSs detailing some of the pressures and challenges experienced by A & E departments in Surrey's hospitals.	The Select Committee will review and scrutinise plans and measures adopted by Surrey's ICSs to address challenges experienced by Emergency Departments in Hospitals, making recommendations accordingly.	Empowering Communities, Tackling Health Inequality.	Mark Nuti – Cabinet Member for Adults and Health
	Overview, policy development and review	**Preparation for Winter Pressures**	The Select Committee is to receive a report/reports from Surrey Heartlands ICS, Frimley ICS, and SECAMB outlining the preparations in place for the pressure of the Winter months on Healthcare Services.	The Select Committee will review and scrutinise the preparations for the Winter, making recommendations accordingly.	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health

	Scrutiny	**SECAMB Update**	The Select Committee is to receive a report outlining continuing measures being taken by the Ambulance Service to address concerns raised by a recent CQC report, as well as to receive further insights into other key areas affecting the Ambulance Service.	The Select Committee will review and scrutinise the effectiveness of SECAMB's CQC improvement Journey (amongst other insights), making recommendations accordingly.	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health
7 December 2023	Scrutiny	**Adult Safeguarding in Surrey**	The Select Committee will receive a report on Adult Safeguarding policies/ practices within Surrey.	The Select Committee will scrutinise the details of Adult Safeguarding policies/practices, an the extent to which these are effective in protecting Adults from abuse.	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health Liz Bruce- Executive Director, Adult Social Care and Integrated Commissioning
		Discharge to Assess Processes	The Select Committee is to receive a report outlining measures taken to improve discharge to assess processes as well as the funding issues therein.	The Select Committee will review and scrutinise the effectiveness discharge to assess processes and measures taken to address funding challenges	Empowering communities, tackling health inequality	Mark Nuti – Cabinet Member for Adults and Health Liz Bruce- Executive Director, Adult Social Care and Integrated Commissioning
Items to be scheduled						

(Date)	*(Type)*	*(Issue)*	*(Purpose)*	*(Outcome)*		*(Cabinet Member/Lead Officer)*
	Overview, policy development and review	**Joint Health and Social Care Dementia Strategy for Surrey (2022-2027)**	The Select Committee is to receive a report outlining the progress made on the implementation of the new Joint Health and Social Care Dementia Strategy for Surrey (2022-2027), as agreed at its public meeting on 14 January 2022.	The Select Committee will review and scrutinise the implementation of the Joint Health and Social Care Dementia Strategy for Surrey (2022-2027), making recommendations accordingly.	Empowering communities, tackling health inequality.	Mark Nuti – Cabinet Member for Adults and Health Jane Bremner – Head of Commissioning (Mental Health), Surrey County Council
	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						
(Dates)	**Issue**	**Purpose**	**Outcome**	**Relevant Organisational Priority**	**Task Group Members**	
		For Members of the Task Group to	The Task Group will seek to contribute to the reduction of	Tackling Health Inequality	Angela Goodwin (Chairman),	

October 2021 – April 2023	**Health Inequalities**	develop an understanding of health inequalities in Surrey, scrutinise the progress being made on tackling these, and contribute to the development of future policies.	health inequalities being faced by Surrey residents, contribute to the Council's strategic priority to "drive work across the system to reduce widening health inequalities", support both the Council and the wider health and social care system in Surrey to understand how they can address and tackle health inequalities faced by residents, create a shared understanding of barriers being faced by residents with lived experiences of health inequalities, 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.		Trefor Hogg, Riasat Khan, Carla Morson, Bernie Muir (ex-officio)	
To be received in writing and informal briefing sessions						
(Date)	*(Issue)*		*(Purpose)*	*(Outcome)*		*(Cabinet Member/Lead Officer)*

Joint Committees					
Time scale of joint Committee	**Joint Committee name/structure:**	**Purpose**	**Outcome**	**Relevant organisational priority**	**Relevant Committee Members**
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 –**	In June 2017, Improving Healthcare	A sub-committee of the South West	Empowering communities,	Bernie Muir, Angela

	Improving Healthcare Together 2020-2030 Sub-Committee	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.	London and Surrey Joint Health Overview and Scrutiny Committee has been established to scrutinise the Improving Healthcare Together 2020-2030 Programme as it develops.	tackling health inequality	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	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)

		established to review the Hampshire Together 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.

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ADULTS AND HEALTH SELECT COMMITTEE
ACTIONS AND RECOMMENDATIONS TRACKER
JUNE 2023

The actions and 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	Recommendation/Action In Progress	Recommendation/Action Implemented

Recommendations

Meeting	Item	Recommendation	Responsible Officer/Member	Deadline	Progress Check On	Update/Response
23 June 2022	Mental Health Improvement Programme Stocktake after 12 months [Item 7]	**AH 20/22:** For Surrey Heartlands CCG, Surrey and Borders Partnership NHS Foundation Trust, and Surrey County Council to continue to campaign for a change in the National Allocation Formula that would accurately reflect some of the mental health issues faced by Surrey Residents.	Surrey Heartlands, Surrey and Borders Partnership, and Surrey County Council	2 August 2022	December 2022	**Interim Response:** We agree with this recommendation, which has the potential to affect funding flows in the longer term. System partners (including SaBP and SCC) have raised issues with the National Allocation Formula in regional and national forums and will continue to do so. We believe that our case will be stronger if we seek the support of other systems who are similarly disadvantaged by the formula, and we will discuss the case for change with them. We appreciate the support of elected representatives in campaigning and believe that members would have a key role to play in any successful attempt to change the National Allocation Formula.

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						A meeting will be arranged with the Scrutiny Officer to discuss this work further in due course.
5 October 2022	Enabling You with Technology [Item 6]	**AH 26/22:** For the Head of Resources for Adult Social Care to ensure that further and more sustainable funding is secured for the Enabling You With Technology Programme, and to provide a future informal briefing to the Adults and Health Select Committee, on any efforts to secure further Funding for the Programme in light of the timelines surrounding existing sources of funding.	Toni Carney, Head of Resources (ASC)	18 November 2022	December 2022	The officers have been contacted for a response.

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		AH 27/22: For the Head of Resources for Adult Social Care to pursue data capture in order to analyse the implications of a variety of conditions of service users, so as to better tailor provision and gain a more detailed understanding of these conditions and the associated impacts.	Toni Carney, Head of Resources (ASC)	18 November 2022	December 2022	The officers have been contacted for a response.
	Mental Health Improvement Plan [Item 7]	**AH 28/22:** For the MHIP Digital and Data Workstream Lead to ensure to increase awareness of the Kooth system, and to ensure that it is increasingly enabling Children and Young People to access appropriate online support for their mental	Liz Williams and Kate Barker, Joint Strategic Commissioning Convenors Surrey and Borders Partnership		December 2022	**Interim response:** Since our meeting, we have received Kooth's proposal for contract renewal into 2023/24. As part of the contract renewal process, we will be working with Kooth to increase the awareness of online support available to children and young people in Surrey by maximising the usage of Kooth's available capacity. This will include exploring how awareness of Kooth's services can be raised through schools, GPs

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		health; and to provide the Adults and Health Select Committee with a future written update on this.				or other routes. As an example, we have videos for both GPs and for other partner agencies providing them information about the services offered. We will update the committee on progress following the conclusion of the contract renewal process, and after allowing for a short period of further activity to demonstrate the impact of actions undertaken.
		AH 29/22: For the Joint Executive Director for Adult Social Care and Integrated Commissioning and Surrey and Borders Partnership, to develop a robust process to deal with complaints as well as Issues of Concern regarding mental health services, and to provide a written update to the	Liz Bruce, Joint Executive Director for Adult Social Care and Integrated Commissioning Surrey and Borders Partnership	18 November 2022	December 2022	The officers are preparing a response.

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		Adults and Health Select Committee on progress toward this.				
2 November 2022	The Accommodation with Care and Support Strategy Progress Update [Item 5]	**AH 36/22:** For Accommodation with Care and Support Strategy Leads at Surrey County Council to ensure that Extra Care and Supported Independent Living Accommodation is genuinely affordable in line with welfare benefits for individuals who qualify for such accommodation, and to provide a **future written update** to the Adults and Health Select Committee on this.	Accommodation with Care and Support Strategy Leads at Surrey County Council	12 December 2022	12 December 2022	**Response:** In working with strategic partners, the Accommodation with Care and Support Strategy Leads have stipulated that both rents for tenancies and service charges to pay for communal facilities will be fundable through housing benefit. We will work collaboratively with housing authorities to ensure that this is put in place on a sustainable basis. While some elements like personal use of utilities (metered in individual apartments) are not eligible for housing benefit, the cost exposure for individuals will be limited through careful design, e.g. through a highly energy efficient specification in the built environment which delivers against Surrey County Council's Climate Change strategic ambitions.

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						While we will ensure that all future tenants in Extra Care and Supported Independent Living Accommodation are given clear guidance on their entitlement to housing benefit and other welfare benefits, any relevant benefit applications and agreements will be completed in advance of any individual occupying their new home.
		AH 37/22: For Accommodation with Care and Support Strategy Leads at Surrey County Council to develop explicit plans on the specific and specialised facilities that will be available within the context of the Extra Care and Supported Independent Living Facilities/sites, and to provide a **future written update** to the Adults	Accommodation with Care and Support Strategy Leads at Surrey County Council	12 December 2022	12 December 2022	**Response:** Extra Care Housing To support the Accommodation with Care and Support strategic programme, Surrey County Council has produced generic building design principles for the self-contained housing units and communal facilities that will comprise future commissioned Extra Care Housing settings. These set out our key expectations for the built environment for construction partners. Ultimately, each Extra Care Housing setting will deliver a highly accessible environment

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		and Health Select Committee on this, including on what is included in the rent and what is chargeable.				which provide “homes for life" for its residents, enabling people to enjoy shared activities as part of a wider community on-site while providing easy access to varying levels of care and support. The communal facilities will be much more generous than those found in more mainstream housing settings and will comprise of the following as a minimum: Communal lounge A dining area and adjoining kitchen, which provides access to a café, restaurant or bistro and includes a tea kitchen A flexible space, which can be used for therapy or consultancy with health partners Activity spaces, which can also act as quiet spaces or hobby rooms Assisted bathroom Mobility scooter storage Landscaped garden areas Staff offices, which include changing and laundry facilities for the dedicated care staff

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						The Extra Care Housing settings will also be designed in such a way that they will support Surrey County Council's Climate Change Strategy, with low carbon technology and energy efficient infrastructure in line with LETI standards. While each setting will have at least one fully wheelchair accessible apartment (designed to M4(3) requirements), all of the other apartments have been specified to M4 (2) standards, which mean that they are highly accessible and adaptable as required by residents. In providing everyone with "their own front door", each unit will have all of the modern conveniences to allow people to live independently and to access the rest of the building and local community on their own terms – including fitted kitchens and laundry facilities, spacious living areas, double bedrooms, fully adaptable bathrooms and individual balconies. As stated in the first written response, funding arrangements will be put in place in such a

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						way that the tenancies and shared costs associated with the communal facilities will be covered through housing benefits. While there will be some elements which are linked to individual use and are therefore not eligible for housing benefit (e.g. electricity bills metered in each apartment), these will be kept to a minimum through the sensitive design of each setting. Supported Independent Living Within SCC developed SIL the specific and specialised facilities will vary between the self-contained flats and the shared houses. Rent and Eligible service charges are modelled to not exceed the expected Housing Benefit that individuals will receive when occupying specialist accommodation. Work has been undertaken to evaluate the level of Housing Benefit that individuals are likely to receive across the different D&B areas. Self-contained flats:-

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						Each flat will be entirely self-contained and have the ability to support tracking hoists and wheelchair access. White goods will be fitted and covered by warranty. Each flat will have metered utilities so that each tenant can pay for their energy and water consumption. This element will be chargeable to the tenant. Each block of flats has a communal lounge area with en-suite facilities. This space can be used flexibly and includes provision of a pull-down bed should a care worker need to provide a sleep-in service. The utilities for this space and all other communal areas (e.g. corridors, lobby areas) will be incorporated within the wider building charges and funded via rent and eligible service charge. The rent and eligible service charge will also cover the general maintenance and upkeep of the building (soft and hard FM). Shared Houses:- Each shared house will have 5 private bedrooms all with en-suite facilities with the

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						remaining areas being for communal use (e.g. lounge, Kitchen, Diner). Each room will have the ability to support tracking hoists and wheelchair access and in addition each house will have a lift. White goods will be fitted in communal areas and covered by warranty. It is not possible to meter individual rooms and therefore costs have been modelled to ensure that rent and service charge covers utilities and general maintenance of the building. In both types of setting (self-contained and shared) the 'lifecycle costs' relating to refurbishment and replacement of fixtures and fittings have been included in the rent and service charges. Itis important to note that, in each SIL model, the communal facilities will only to available to the residents living in the accommodation. The communal facilities are part of the individual's home and will not be accessible to the local community

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	Surrey All Age Mental Health Investment Fund Programme: Update on Phasing of Implementation Planning [Item 6]	**AH 40/22:** For the Joint Executive Director for Public Service Reform & the Joint Strategic Commissioning Convenors to formulate a focused list of criteria to determine the priorities and geographical spread involved in making parameters for the Mental Health Investment Fund.	The Joint Executive Director for Public Service Reform & the Joint Strategic Commissioning Convenors	12 December 2022	March 2023	Response: There is a clear list of criteria which the bids are assessed against and, following the first round of assessment, we will map the geographical spread of the awarded grants to ensure it is appropriate and maintains a good spread across the county. We are also targeting specific areas of need identified from the JSNA and MH improvement plan to ensure the MH priorities of the residents of Surrey are aligned with the MHIF parameters.
6 December 2022	ASC Complaints [Item 6]	**AH 51/22:** That frontline Adult Social Care Staff are receiving adequate mandatory and consistent training on improving staff conduct and attitude, and that training and staff conduct, including that of partner organisations, are routinely monitored, with consequences put in	Senior Programme Manager for Adult Social Care & Chief Operating Officer for Adult Social Care	27 January 2023	January 2023	Officers have been contacted for a response:

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		place for unacceptable failures to attend such mandatory training.				
		AH 52/22: That further progress is made toward increasing the timeliness of assessment processes.	Senior Programme Manager for Adult Social Care & Chief Operating Officer for Adult Social Care	27 January 2023	January 2023	Officers have been contacted for a response:
		AH 53/22: That Issues of Concern are more effectively recorded, including through exploring technological avenues to do so; and that these are also utilised to improve Adult Social Care Services.	Senior Programme Manager for Adult Social Care & Chief Operating Officer for Adult Social Care	27 January 2023	January 2023	Officers have been contacted for a response:
	Surrey Safeguarding	**AH 54/22:** That Adult Social Care service users and Adult Social Care	Adult Social Care Leads & Surrey	27 January 2023	January 2023	Officers have been contacted for a response

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	Adults Board Annual Report [Item 7]	frontline staff, are continuing to receive adequate Adult Safeguarding reassurances and support, and to raise awareness of such support available.	Safeguarding Adult's Board			
		AH 55/22: Formulate a concerted multi-agency plan to raise awareness of the various aspects of Safeguarding, and to help residents understand the distinction between Children's and Adult's Safeguarding.	Adult Social Care Leads & Surrey Safeguarding Adult's Board	27 January 2023	January 2023	**Interim Response:** The SSCP have been approached to work with the SSAB on this to develop a joint plan.
		AH 56/22: To collate data and insights from member agencies into Safeguarding training provision, and for this to	Adult Social Care Leads & Surrey Safeguarding Adult's Board	27 January 2023	January 2023	**Interim Response:** This recommendation will be considered as part of the QA framework for 23/24. For NHS health agencies this data is collected by Surrey

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		be incorporated into a future report for a formal Adults and Health Select Committee meeting.				Heartlands ICB and current data has been collected. This will allow the SAB to analyse that data and ask any further questions of health agencies.
		AH 57/22: That the Board further raise awareness of safeguarding adults and support available.	Adult Social Care Leads & Surrey Safeguarding Adult's Board	27 January 2023	January 2023	**Interim Response:** The Communication subgroup has recently met and continues to develop the workplan. A communication strategy is in development and will be finalised by April 2023. The SAB team has also been strengthened the team with a new Partnership Post whose responsibility will be engagement and communication which will support taking this recommendation forward.
13 February 2023	Access to NHS Dental Services in Surrey [Item 5]	**AH 1/23:** To improve access to dental care for vulnerable individuals; including the homeless, deprived communities, Domestic Abuse Victims, those suffering ill Mental Health, and residents with	Dentistry Leads at Surrey Heartlands & Frimley ICS	Ongoing	May 2023	**AH 1/23:** Community Dental Services provide access for patients whose treatment management needs means they struggle to use primary care services. Many patients described above have increased treatment needs. The Community Dental Services can set aside more time for the treatment of

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		Learning Disabilities and Autism. **AH 2/23:** To reduce existing and future backlogs in dental care.				vulnerable patients and a wider range of means to manage their care including local anaesthetic, sedation and general anaesthetic. The service includes dentists trained in the care of children and special care adults. Community Dental Services are currently under review in the ICBs across NHSE S-E with the aim of commissioning accessible, sustainable and equitable services for people who need to attend these services on a regular basis and for those who attend only for episodes of care. The ICBs are also reviewing ways the primary care contract (high street dental practices) may be flexed to support increased access to primary care for more vulnerable groups. **AH 2/23:** In primary care, dental practices have been approached to take part in the Additional Access scheme which aims to provide more appointments focused on serving

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						the needs of patients who have faced difficulty accessing treatment. There are 5 practices involved in the scheme in the county. Additional monies have been invested into Community Dental Services to bring forward treatment of those who have been waiting the longest. This has been successful in reducing the numbers waiting for treatment for more than a year. There are on-going challenges with waiting lists and backlog, and plans are being developed to maintain this additional funding in 2023-24. In terms of long waiters for hospital treatment, there is a national Elective Recovery Fund where additional monies are being made available to all hospital specialties, including secondary dental, to reduce the numbers of patients waiting for planned care. This is with the aim of reducing the number of patients on waiting lists overall with a particular focus on

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		AH 3/23: To improve communications, vehicles for communications, and work better with partners, to ensure that residents are aware of dental services available to them.				achieving the NHS target of no patients waiting more than 65 weeks for treatment by 31st March 2024 with no-one waiting more than 52 weeks by March 2025. **AH 3/23:** As part of the national dental contract changes introduced in 2022 there was a requirement for dental practices to keep their patient facing information, about access to their services, up to date. The arrangements to monitor this are under review. The Surrey Heartlands ICB has agreed and is in the implementation stage of delivering actions in line with its Pharmacy, Dental and Optometry (POD) Engagement Strategy. Through this, a variety of means and mechanisms will be deployed to engage with and encourage closer collaboration and integration with the dental profession in the hope that jointly developed solutions, innovations and programmes can be delivered to forge improvements.

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		AH 4/23: To urgently campaign for improvements to NHS Dental Contracts to maximise potential for patient access and to retain and attract dentists to perform NHS treatments.				**AH 4/23:** National changes made to the dental contract in 2022 are designed to support improved access by increasing capacity by allowing higher levels of contract delivery, reviewing the frequency with which patients need to re-attend practices and encouraging the use of greater skill mix to support patient care. Dentists also receive increased remuneration for more complex treatments. It is understood that further changes are planned. Locally there are practices providing additional access sessions to support patients who have not attended local practices recently and have urgent treatment needs. The ICBs are also reviewing the possibility of flexing contracts to switch elements of the contract from activity targets to access sessions. This is designed to improve access for patients who have struggled to achieve access and recognises the workforce challenges facing dental practices where they may not have the capacity to do extra sessions. ICBs are

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		AH 5/23: To identify and implement strategies to work with schools to improve dental health.				currently working closely with the NHSE dental teams to scope local initiatives that will distribute unutilised UDAs and enhance access in a timely and proportionate manner. **AH 5/23:** Recent evidence points to the best outcomes being achieved by getting children to attend dental practices at regular intervals and from an early age. National programmes such as 'Dental Checks by One' and 'Starting Well' were getting under way prior to the pandemic. When the ICB seeks to commission any new practices, they are asked to provide services for children in line with national Starting Well guidance ; the Additional Access sessions are designed to support access for children and flexible commissioning is designed to focus on patient groups with greatest oral health need. The Community Dental Services provide oral health improvement programmes for children who attend their service on a regular basis. The ICBs are working closely with a range of

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		AH 6/23: In order to understand supply vs demand for appointments, it is recommended that a log is created, at all entry points into the system, of individuals denied dental appointments at NHS registered practices; and for this information to be centrally collated.				stakeholders, including colleagues in local authorities and Dental Public Health, to pursue evidence-based interventions to improve children's oral health. **AH 6/23:** The NHS Contact Centre captures data on the number of patients contacting them about access to dental services. In Surrey, the highest number of contacts have been made in Redhill and Guildford.
16 February 2023	Children and Young People's Emotional Wellbeing and	**AH 7/23**: To establish explicit criteria and SMART performance metrics for measuring the outcomes and		Ongoing	May 2023	**AH 7/23**: Mindworks produces monthly performance reports, which have been shared with the committee. The Scrutiny Officer is on the distribution list and receives these reports monthly to share with the committee members.

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	Mental Health [Item 6]	effectiveness of Children and Young Person's Emotional Wellbeing & Mental Health services in relation to total requirements for mental health support in Surrey; and to report performance against these metrics to the Adults and Health Select Committee and the Children, Families, Lifelong Learning and Culture Select Committee every three months from June 2023. **AH 8/23:** To collate and share data on priorities, areas of need, waiting times for assessment and treatment, and outcomes				These reports will continue to be shared on a monthly basis following the Mindworks Finance Contract Quality Performance committee. *Currently these reports <u>are not</u> for the public audience.* **AH 8/23:** Commissioners produce a bi-monthly update that includes priorities, areas of need, waiting times for assessment and treatment, co-production examples and outcomes for treatments as part of Children and Young

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		for treatments as part of Children and Young Person's Emotional Wellbeing & Mental Health services.				Person's Emotional Wellbeing & Mental Health services. This report will be made available to Select Committee via the above process. With regards to Outcomes reporting, there are two key priorities: 1. **Goal Based Outcomes**: In line with the NHS Five Year Forward View for Mental Health, Mindworks Partners are using one outcome measure – Goal Based Outcomes. It has been agreed to focus on ensuring Children and Young People are central to decision making and measuring improvements in goals set. This process, at present, is running in shadow form, where partners have submitted Q4 22/23 data and are now assuring the data quality and formulating the performance narrative.

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						By end of Q1, 23/24 the first manually-produced Outcomes Report will be available. This is one suite of indicators that is being explored to inform service improvement. From Q2/Q3 there will be a similar exercise as above to quality assure a collective experience measure. This work will also inform the specification for the digital solution. 2. **Digital Solution**: The Digital Team are working on a digital solution to enable learning from the shadow process, and purchasing a system that will migrate outcomes from all partner systems to a single Mindworks dashboard. Qualtrics is being explored but is affected by the Financial Recovery in place. Implications are being finalised. Note: The national NHS England CYPMH outcomes metric monitors the proportion of CYP (under 18) who were discharged with at

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		AH 9/23: To ensure that there is accuracy and synergy of patient records, and that all organisations involved in treating patients can access and update these records accordingly.				least two contacts and paired scores that show measurable improvement, using the validated outcome tools. Quarterly sharable reports will be available from end of Quarter 1 23/24 and can then be made available at the end of each quarter following the process outlined in the answer to question 1. **AH 9/23:** It can now be confirmed that a patient record system that oversees patients entering Mindworks has been agreed by all partners. An implementation plan will be finalised by mid-May 23. We will provide progress updates in the quarterly report sharing. We will continue to work collectively towards resolving the challenge of multiple partners with multiple systems. The ambition of the point above will be the first opportunity to test and develop improvements.

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		AH 10/23: For waiting times to be reduced across all pathways as part of all Prevention and Early Intervention measures, as well as through the process of Transitions. **AH 11/23**: To continue to advance social prescribing County-Wide, and to ensure that there are appropriate initiatives, workable processes, adequate funding, and sufficient resources for this.				**AH 10/23:** The NHS ambition on waiting times is that no-one waits longer than 18 weeks from your appointment being booked through to treatment / intervention start. This is the local Ambition. Waiting time information is available within the performance packs. **AH 11/23:** There is a social prescribing Surrey-Wide working group that aims to ensure social prescribing is developed to a high standard across Surrey, led by Public Health. To date there are two social prescribing projects for CYP who have EWMH issues in Surrey – both in East Surrey. These projects are working directly with CYP or family, depending on need, to provide brief interventions and also connect them with other local projects to improve social connections

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						and build resilience. The offers will be using Goal Based outcomes to demonstrate improvements. The overarching aim of the programme is to improve timely early access to EWMH support and reduce the need to access specialist / crisis support. Data on referrals to Mindworks broken down by PCN areas is being explored to support the evidencing of this ambition and is aimed to be available during Q1 23/24. There is 1 x CYP Social Prescriber in North Tandridge PCN who started in Dec 2021. This service has expanded in the last quarter (delay in latest data). There is also 1 x CYP Social Prescriber and 1 x CYP Health and Wellbeing Coach in the North Tandridge and Care Collaborative PCNs. Q4 data shows that the service received 40 referrals between 24th January and 14th April.

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		AH 12/23: To conduct a thorough review into training provision for Children and Young Person's Emotional Wellbeing & Mental				Of these, 26 CYP have been contacted and supported, with 14 on the waiting list. The top three presenting issues are: anxiety (29% of referrals) low mood (19%), social difficulties (13%). Outcomes data will be reported from Q1 23/23, subject to end of care offer. Links are being developed during Q1 23/24 to engage with the different providers who are working directly with CYP participation groups to ensure the programme is co-produced and jointly evaluated. Learning will be shared and will influence our future roll out plans. **AH 12/23:** Training is a priority and at present we have training offers that include mental health first aid, emotionally based school avoidance support, suicide prevention, self harm training and bereavement support. The next steps for training funded by Wellbeing

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		Health services frontline and managerial staff.				Education Return funding is to await confirmation of Service Development Funding, then allocate proportionately. We also have a number of training courses available from Tavistock and Portman detailed in the table below, as part of the Mindworks contract. Tavistock & Portman Training and development offer within Mindworks for professionals **Component of service delivery** / **How it is reviewed and monitored** THRIVE Training - Annual training programme / Mentimetre Pre and Post Training questions measuring improvement in understanding and

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								confidence applying objectives with feedback about experience and areas for improvement
								Attendance at training in relation to organisation/service representation
								Staff workforce survey
							Bespoke THRIVE Workshops - Team, Service, Agency or Workstream based	Mentimetre Pre and Post Training questions measuring improvement in understanding and confidence applying

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								objectives with feedback about experience of workshops and actions for team/service development
								Hours spent preparing, training co-facilitators etc
								Attendee feedback about experience and ideas for improvement
							Train the Trainer approach	***Still to establish an implementation plan which can be monitored – task for new service manager with***

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	input from General Manager
Development of a THRIVE like culture/system	Assessment tool
Clinical Training Placements and Supervision – 'Grow our own'	Establishment of trainee placements in Mindworks services Impact on service clinical activity Trainee-Qualified Clinician employed in Mindworks

The Tavistock and Portman Mindworks contract is scheduled for a review in 23/24 and will include a review of the implementation of a system-wide approach to THRIVE as well as the smaller courses above.

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		AH 13/23: For early diagnosis and appropriate mental health support for Children and Young Persons with Learning Disabilities and Autism.				Courses are evaluated and feedback from wide stakeholders informs future plans. At present, discussions have started to widen the reach of trauma informed care and solution focused approaches so a full scale review is not planned. **AH 13/23:** There is significant demand for ND pre-diagnostic support and diagnosis, which is seen nationally and locally. A Transformational Plan has been developed to build on a needs-based approach which aims to improve timely access to diagnosis. The present financial pressure within Mindworks has resulted in the need to step up the Transformation Plan and make some co-produced recommendations on the future delivery model. A key part of ensuring this is a joint decision, is that governance is supported through the Inclusion Steering Group and the High Needs and Disabilities Transformation Board.

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		AH 14/23: To monitor the impacts of waiting times for assessments and treatments on the acuity of Children and Young Person's mental health conditions, including the impact of the proposed reductions in treatment sessions aimed at reducing waiting times.				The next key milestone is a call for action event planned for end Q1 23/24 where options will be considered alongside recommendations, to ensure system wide stakeholder involvement in decision making. There is a process being implemented to ensure that CYP also have a voice in this decision making. **AH 14/13:** Currently we can and do monitor the waiting times via the performance and quality sub-groups, and the Finance Contract Quality Performance committee within the Mindworks governance. Information on waiting times is available via the monthly performance packs provided. For clarification, there are no proposed plans for reduction in treatment sessions to reduce waiting times. Treatment sessions are agreed within the THRIVE framework and are based on the presenting needs of CYP, clinical

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		AH 15/23: To review strategies across agencies for prevention and intervention surrounding bullying of Children.				recommendations, shared decision and goal-based outcomes. We are continuing to work across Mindworks to strengthen this Thrive approach, which includes providing agreed guidance on treatment sessions within the Thrive groupings. We are also increasing our group treatment offer, where appropriate, for CYP for whom one of the expected outcomes will be to reduce the waiting times for treatment. **AH 15/23:** At present the response to bullying across Surrey, where strategies are reviewed and developed, form part of the Surrey Healthy Schools Partnership (chaired by Liz Mills, Director of Education, Lifelong Learning and Culture). This will also be included in the monitoring of the action plan attached to the Emotional Wellbeing and Mental Health Strategy.

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		AH 16/23: To bring this item back to a formal Adults and Health Select Committee meeting with an update on all the above recommendations (with representatives from				Anti-Bullying was also a focus of the corporate parenting board (Autumn 22) as statistics according to the HRBQ demonstrate that a proportion of our YP believe that schools do not necessarily take bullying as seriously as they could. Health Related Behaviour Questionnaire | Surrey-i (surreyi.gov.uk) An agreed recommendation from the Corporate Parenting board is for all schools to develop a Surrey Healthy Schools approach, as this both holistically and specifically addresses anti-bullying and an inclusive climate. **AH 16/23:** Agreed

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		the Children's Select Committee present).					

Actions

Meeting	Item	Action	Responsible Officer/Member	Deadline	Progress Check On	Update/Response
23 June 2022	All-Age Autism Strategy Review [Item 5]	**AH 23/22:** The Director of Commissioning (CFLL) to provide additional information on annual reviews of EHC Plans.	Hayley Connor, Director – Commissioning, CFLL (SCC)	2 August 2022	December 2022	A response is being prepared.
5 October 2022	Mental Health Improvement Plan [Item 7]	**AH 34/22:** The Joint Executive Director for Adult Social Care and Integrated Commissioning to provide a further update on the Section 12 app.	Liz Bruce, Joint Executive Director - Adult Social Care and Integrated Commissioning	18 November 2022	December 2022	A response is being prepared.

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6 December 2022	ASC Complaints [Item 6]	**AH 61/22:** The Chief Operating Officer to share the revised training offer and academy once formulated.	Chief Operating Officer	27 January 2023	January 2023	Officers have been contacted for a response.
		AH 62/22: A breakdown of trends and data over the last few months regarding complaints made on social media to be provided.	Chief of Staff (ASC)	27 January 2023	January 2023	Officers have been contacted for a response.
13 February 2023	Access to NHS Dental Services in Surrey [Item 5]	**AH 1/23:** Dentistry Leads at Surrey Heartlands & Frimley Integrated Care Systems to look into developing mobile solutions for the provision of dental services in geographical areas underprovided for. **AH 2/23:** Dentistry Leads at Surrey Heartlands & Frimley Integrated Care Systems to look into receiving Corporate donations	Dentistry Leads at Surrey Heartlands & Frimley ICS	Ongoing	May 2023	**AH 1/23:** Mobile dental solutions have already been implemented across some parts of Surrey and it is our intention to review options for extending this to other areas across Surrey. **AH 2/23:** We are in discussion with the Local Authority, and it is our intention to continue to collaborate and implement oral health initiatives. We have contacted Oral

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		for toothbrushes and toothpastes for deprived communities. **AH 3/23:** Dentistry Leads at Surrey Heartlands & Frimley Integrated Care Systems to provide further details on the support available for homeless individuals on an area by area basis. **AH 4/23:** The Director of Commissioning and Assurance, SRO Delegated Commissioning, Frimley ICB, to feedback to the national contracts process and commit to consider a way of collecting these views.				B and Colgate with a view to requesting their support with the supply or toothbrushes and toothpaste. **AH 3/23:** We are working in collaboration with the Public Health colleagues to better understand the oral health needs of all our priority groups including the homeless. **AH 4/23:** There are on-going discussions about the future of the NHS dental contract.

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		AH 5/23: The Senior Commissioning Manager-Dental to provide the monthly reported NHS contact centre data regarding contact made by residents unable to access dentistry, including the survey work being undertaken by partners in this area. **AH 6/23:** The Director of Commissioning and Assurance, SRO Delegated Commissioning, Frimley ICB, to follow up on the availability and provision of clear information regarding the complaints process, including collation and analysis of Issues Of Concern.				**AH 5/23:** We attach the information that was shared on 20th February and although we can commit to continuing to share the NHS Contact Centre for the time being, we wish to highlight that from the 1 July 2023 all complaints and enquiries related to patient experiences will be dealt with directly by the ICB and at this stage a reporting mechanism has not been agreed. **AH 6/23:** The information about the complaints process is in the link below: https://www.england.nhs.uk/contact-us/complaint/complaining-to-nhse/ Information about numbers of complaints and MP letters is collated, analysed, and discussed

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		AH 7/23: The Senior Commissioning Manager-Dental to follow up and update the committee on resident's ability to find information regarding their nearest dentist, including the digitally excluded.				via the Liaison Group meetings which includes representation from the Local Dental Committees. **AH 7/23:** We are in the process of developing a Frequently Asked Questions Factsheet which we intend to make available to the local Healthwatch and community engagement officers and other local stakeholders. This will be helpful for people should they wish to find out more information about dental services without recourse to the internet.
16 February 2023	Children and Young People's Emotional Wellbeing and Mental Health [Item 6]	**AH 8/23:** To write to ICB Chairs with requests for further funding to be allocated for Mental Health. **AH 9/23:** For a meeting to be organised between relevant Cabinet Members, the Executive		Ongoing	May 2023	The actions and requests for further information have been sent to lead officers for a response.

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		Director for Children, Families and Lifelong Learning, and the Chair and Vice-Chairs of the Adults and Health Select Committee to formulate a plan to help implement Action 1. **AH 10/23:** The User Voice and Participation team to research and update the Adults and Health Select Committee and the Children, Families, Lifelong Learning and Culture Select Committee on the difficulties experienced by young people with autism and mental health issues combined.				**AH 10/23:** There is a CYP participation co-ordination group in Surrey that brings together all partners working in co-production and participation, including UVP, Mindworks Participation Lead, Commissioning Participation Lead, SCC, UVP and Amplify. By bringing these system leads together, there will be centralisation of the collective understanding of CYP voice, assurance that there will be evidence of their central involvement in decision making and a Surrey wide and placed-based

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		AH 11/23: The User Voice and Participation team to share their Action Cards with stakeholders relevant to the issues highlighted within these.				response to partnerships, projects etc. Central to this group is ensuring the needs of CYP from protected groups and CYP at higher risk of EWMH needs, including neurodiverse CYP. **AH 11/23:** UVP share their action cards relevant to the stakeholders required. In relation to EWMH they present monthly to the CYP Commissioners forum and to Mindworks Quality Subgroup, School Based Needs Group and SABP Quality Operations Group. There is also a newly formed CYP participation and co-production group which brings all CYP voice leads together from Mindworks, Surrey County Council,

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		AH 12/23: The Programme Director-Mindworks, to provide the Adults and Health Select committee and Children, Families, Lifelong Learning and Culture Select Committee with the Mindworks monthly performance packs. **AH 13/23:** The Chief Executive, Surrey and Borders Partnership NHS Foundation Trust, to provide the Adults and Health Select committee and the Children, Families, Lifelong Learning and Culture Select Committee with an integrated and data-informed outcome measure by April 2023.				Commissioning and PCNs to develop a Surrey Wide User Voice and Participation approach to service improvement and decision making. **AH 12/23:** Completed. **AH 13/23:** Outlined in AH 8/23.

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