Notice of Meeting

Adults and Health Select Committee

Date and Time	Place	Contact	Web:
Thursday, 10 October 2024 10.00 am	Council Chamber, Surrey County Council, Woodhatch Place, 11 Cockshot Hill, Reigate, Surrey, RH2 8EF	Sally Baker, Scrutiny Officer SallyRose.Baker@surreycc.gov.uk	Council and democracy Surreycc.gov.uk @SCCdemocracy

Committee Members:
Dennis Booth, Helyn Clack (Vice-Chair), Robert Evans OBE, John Furey, Angela Goodwin (Vice-Chair), David Harmer, Trefor Hogg (Chairman), Rebecca Jennings-Evans, Frank Kelly, David Lewis, Ernest Mallett MBE, Michaela Martin and Carla Morson.

Independent Representatives:
District Councillor Caroline Joseph, Borough Councillor Abby King and Borough Councillor Victoria Wheeler.

If you would like a copy of this agenda or the attached papers in another format, e.g. large print or braille, or another language, please email Sally Baker, Scrutiny Officer on SallyRose.Baker@surreycc.gov.uk.

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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: 10 MAY 2024

(Pages 7 - 32)

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

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 *(Friday 4 October 2024)*.
2. The deadline for public questions is seven days before the meeting *(Thursday 3 October 2024).*
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 CANCER AND ELECTIVE CARE BACKLOGS (Pages 33 - 62)

Purpose of the item: These reports outline the backlogs for cancer and elective (planned) care across Surrey Heartlands and Frimley ICS, the progress made in addressing these and actions being taken to reduce further. In addition, it outlines the work being undertaken to increase diagnostic capacity.

6 RIGHT CARE RIGHT PERSON (Pages 63 - 72)

Purpose of the item: Right Care, Right Person (RCRP) is a national Police led initiative that is an operational model developed by Humberside Police. A national partnership agreement was signed by NHS England, The Department for Health and Social Care and the National Police Chiefs Council.

Right Care Right Person is designed to change the way the emergency services respond to calls involving concerns about mental health.

This paper sets out the arrangements in place between the health and social care sectors and Surrey Police in response to the roll out of RCRP in Surrey.

7 MENTAL HEALTH IMPROVEMENT PLAN- FOCUS ON WORKING AGE ADULTS (Pages 73 - 90)

Purpose of the item:

1. This report has been prepared for the Adults and Health Select Committee. It reviews the number of people of working age in Surrey who are not working because of mental health issues. It will explore the issues that have led to this and how these issues can be addressed to deliver improvements for Surrey residents, especially those who experience the poorest health outcomes within the 21 Health and Wellbeing Strategy Key Neighbourhoods.

2. It reviews current data to ensure that the most urgent mental health needs are identified and sets out what is being delivered to support those who are some of the most vulnerable people within the community. This is to ensure a greater focus on reducing health inequalities, so no-one is left behind.

8 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 91 - 118)

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 December 2024 at 10:00am.

Terence Herbert
Chief Executive
Published: Wednesday, 2 October 2024

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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Thank you for your co-operation.

QUESTIONS AND PETITIONS

Cabinet and most committees will consider questions by elected Surrey County Council Members and questions and petitions from members of the public who are electors in the Surrey County Council area.

Please note the following regarding questions from the public:

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

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MINUTES of the meeting of the **ADULTS AND HEALTH SELECT COMMITTEE** held at 10.00 am on 10 May 2024 at Woodhatch Place, Reigate, Surrey, RH2 8EF.

These minutes are subject to confirmation by the Committee at its meeting on Thursday, 10 October 2024.

Elected Members:

r Dennis Booth
* Helyn Clack (Vice-Chairman)
* Robert Evans OBE
* Angela Goodwin (Vice-Chairman)
* David Harmer
* Trefor Hogg (Chairman)
* Rebecca Jennings-Evans
  Frank Kelly
* Riasat Khan
* David Lewis
* Ernest Mallett MBE
  Michaela Martin
* Carla Morson

Co-opted Members:

* District Councillor Paula Keay
  Borough Councillor Abby King

(*=Present at the meeting r=Remote attendance)

10/24 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Cllr Abby King and Cllr Michaela Martin. Cllr Dennis Booth attended virtually.

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11/24 MINUTES OF THE PREVIOUS MEETINGS: 7 MARCH 2024 [Item 2]

The minutes were agreed as a true and accurate record.

12/24 DECLARATIONS OF INTEREST [Item 3]

Cllr Trefor Hogg declared he was a community representative to Frimley Health. Cllr Carla Morson declared she had a close family member working in Frimley Park Hospital. Cllr Sinead Mooney declared she was a Council nominated governor for Surrey and Borders Partnership.

13/24 QUESTIONS AND PETITIONS [Item 4]

Key points raised during the discussion:

1. Six public questions were received.

2. A Member of the public asked a supplementary question on why the specific advice from NHS England (NHSE) regarding autism diagnosis was not taken on board. The Associate Director for Integrated Children's Commissioning stated that the NHSE report was correct in the ambition it set out, and it was a national challenge to implement it. There was hope with the work set out in the report that Mindworks could, more clearly, join up with the ambitions of the NHSE report and meet the needs of Surrey's population through support and an improved access to diagnosis.

14/24 MINDWORKS [Item 5]

Witnesses:
Sinead Mooney, Cabinet Member for Adult Social Care
Clare Curran, Cabinet Member for Children, Families and Lifelong Learning
Rachael Wardell, Executive Director of Children, Families and Lifelong Learning- Surrey County Council (SCC)
Suzanne Smith, Director of Commissioning for Transformation (SCC)
Trudy Pyatt, Assistant Director- Inclusion and Additional Needs (SCC)
Kerry Clarke, Head of Emotional, Mental Health & Wellbeing Commissioning- Surrey Heartlands Health and Care Partnership (ICS)
Harriet Derrett-Smith, Associate Director, Integrated Children's Commissioning- Surrey Heartlands Health and Care Partnership (ICS)
Graham Wareham, Chief Executive of Surrey and Borders Partnership NHS Trust (SaBP)
Professor Helen Rostill, Deputy Chief Executive and Director of Therapies Surrey and Borders Partnership Trust (SaBP)
Justine Leonard, Director of Children and Young People's (CYP) Services (SaBP)
Ann Kenney, Independent Chair at Surrey Wellbeing Partnership
Emma Ellis, Service Manager, National Autistic Society (NAS)
Kerry Oakly, Head Teacher at Carrington School
Alison Simister, SENCo

Children, Families, Lifelong Learning and Culture Select Committee (CFLLC) Members:
*Fiona Davidson (Chairman)
*Jeremy Webster
*Liz Townsend
*Fiona White
*Jonathan Essex
rChris Townsend

Key points raised during the discussion:
1. The Chairman of the Adults and Health Select Committee (AHSC) introduced the Mindworks item and highlighted it was a

joint scrutiny item in conjunction with Members of the Children, Families, Lifelong Learning and Culture Select Committee (CFLLC). The Associate Director for Integrated Children's Commissioning introduced the Mindworks report.

2. The Chairman of AHSC invited the Head Teacher of Carrington School to speak. The Head Teacher outlined that the school had a share of young people facing neurodevelopmental conditions, presenting with the need for Mindworks referrals. These children had difficulties accessing aspects of the curriculum and the social aspects of the school day. There was an increasing sensory need, such as requiring ear defenders and an amended timetable. Quieter spaces for young people also had to be found and as a new build school, this was not considered as part of the Department for Education (DfE) programme. The biggest challenge was getting Mindworks' referrals through quickly to people that could provide the support, as schools did not necessarily have the skills to manage young people with neurodevelopmental need. Process changes to Mindworks was a challenge, with long lead times such as for consultations. The pausal of Mindworks referrals resulted in school backlogs and an increasing number of non-attenders, whose complex needs were not being managed. It was acknowledged this was now changing, with some referrals now coming through. The working hours of Mindworks' telephone service was between 9am and 12pm which was during teaching hours, making it difficult to contact Mindworks. Parent's felt frustrated with the system, which led to schools being looked upon to provide young people with the help needed, which impacted on the relationship between schools and parents. Staff felt challenged despite work undertaken with NurtureUK and using trauma-based approaches with young people. The Mindworks process was time consuming, which took time away from the young people.

3. The Head Teacher of Carrington School wanted to see a greater ability to cope with the young people going through the Mindworks service. Mindworks' work hours outside of the school day was a suggested change along with a change in the speed of acknowledgement from Mindworks and triaging, to enable schools to provide reassurance to parents. More collaboration between Mindworks and schools was also a suggested change, and a streamlined approach to receive updates and make referrals, to reduce anxiety on families and school staff.

4. The Chairman of CFLLC asked how many children the Head Teacher felt required neurodevelopmental treatment at Carrington school. The Head Teacher explained that the school had around 1000 pupils, with around 5 and 10 pupils in a year

group of 180 to 210 students having signs of requiring neurodevelopmental (ND) treatment, which was increasing year on year. In the exam period, the school had over 30 children not able to sit in the main area to take exams due to Autism Spectrum Disorder (ASD) traits and mental health issues. This put extra pressure on school staff.

5. The Chairman of CFLLC asked if there was one thing the Head Teacher could immediately change what it would be. The Head Teacher stated it would be to engage in early communication with Mindworks to improve the likelihood in getting young people through Mindworks' system with a known timeline.

5. In reference to what Councillors were told by parents and schools, the Chairman of CFLLC asked why Mindworks had almost given up providing front line Neurodiverse (ND) support at the screening and assessment stage, handing the responsibility over to schools without proper transition or preparation. The Director of Children and Young People (CYP) services at Surrey and Borders Partnership NHS Trust (SaBP) explained that the ND Pathway was a partnership that worked with Surrey Wellbeing, Barnardo's, the National Autistic Society (NAS), and Learning Space colleagues, and there was a pathway and range of offers. SaBP predominately provided the assessment and diagnosis element of the ND Pathway, including deploying available expertise to ensure it came alongside the early help, support and strategies that families, schools and others were trying to implement to support a child in a school situation. Mindworks, had received around 4000 referrals in less than 6 months. There was not the capacity to be present in schools alongside parents, providing the immediate help and support. Mindworks' strategy to respond to the demand was to bring all the ND expertise together from across the partnership in a front-facing position alongside schools and families. In parallel, Mindworks was trying to empower schools to have good access to information, advice, support, and strategies which is what the guidance from The National Institute for Health and Care Excellence (NICE) advised for that worked for children and young people with ND needs. This was done through several methods including enhancing the website, consultations, and training. Mindworks' partners, Barnardo's, NAS, and Learning Space provided good pre-diagnostic support. Mindworks' consultations with schools could help identify more vulnerable children. Mindworks was trying to expand their universal offer, work together with children's support networks to increase the ability and confidence in supporting young people and to ensure that expertise was deployed to identify those more vulnerable.

6. The Chairman of CFLLC raised that the London Boroughs such as Richmond and Kingston, had shorter referral lead times,

better processes, and got through treatment pathway's waiting lists faster. The Chairman of CFLLC asked if the Mindworks team had benchmarked their performance, in terms of the referrals and diagnosis treatment pathway, with other organisations that appeared to be performing better. The Chief Executive of SaBP explained there had been a benchmarking process. Mindworks had employed a Commissioning Support Unit (CSU) to benchmark the Mindworks services. Changes that could be made were being reviewed to implement. Benchmarking had not been done against the London Boroughs, but, in terms of the effectiveness as a clinical model, the benchmarking suggested Mindworks was in range expected nationally. When Mindworks was set up a 1% prevalence rate was being worked towards. This prevalence rate had since increased which meant that demand had also increased, exceeding capacity meaning Mindworks had to do things differently. There was a danger that more effort would be put into diagnosis and not enough being put into support and treatment. The question Mindworks had was whether it had the right model in terms of emphasis on diagnosis versus emphasis on support. The underlying prevalence in London was higher across a range of health conditions. Shire counties all dealt with a similar set of problems.

7. The Chairman of the Adults and Health Select Committee (AHSC) introduced the Special Educational Needs Coordinator (SENCo) to speak on peoples' experience of Mindworks. The SENCo explained schools felt on the front-line and that information from Mindworks was limited. Once information was produced there was a delay with schools seeing the strategies, ideas, and support coming through. The SENCo presented a case study on the struggles experienced by a family using the Mindworks process, and the delays experienced. The parents were being supported by the primary school as much as it could offer but were now considering a private assessment for their child. The SENCo outlined a case study where a young person had been waiting 21 months for an assessment and was told the wait was 36 months.

8. In response to the SENCo's statement, a CFLLC Member asked for further clarification on the responsibility of SENCos to find the next level of support when the support provided by one agency appeared to stop. The SENCo explained that there was a particular gap between when children could be referred into the paediatric service and maybe discharged by the paediatric service. The official referral age into the paediatric team was 5.5 years old. If children reached the point of being seen by the paediatric team, children were more than 5.5 years old when an ND assessment may be required. There did not always appear

to be a consistent response, with children sometimes directed to Mindworks, and in other cases the ND assessment was done through paediatrics.

9. The Service Manager for the National Autistic Society (NAS) explained that NAS sat within a social model, providing support to families, young people, and schools funded by Mindworks. It was difficult to get the breadth of the NAS service out to people. NAS used methods such as school bulletins, talking at SENCo network meetings and foster carers network meetings to promote the service. A diagnosis of autism was not required for families to self-refer into NAS. In 2024, NAS was on target to produce about 450 workshop events and in NAS's main programme areas such as social communication, social interaction, sensory processing and how to manage distressed behaviour were being reviewed. NAS provided parents with skills, techniques and tools that could be implemented at home, and the knowledge could be taken to schools to explain why a child required adaptations. NAS were predominately in the family space but provided school training, such as a 2.5-hour training sessions provided as a whole school approach which covered key areas such as social interaction, social communication, and sensory behaviour. 100% of staff and teachers who attended the training would recommend the service to other schools. NAS did one-to-one support for parents in complex situations but due to the demand, NAS asked that parents did the group work first, to gain a foundation of knowledge. NAS had a support line which was open outside school hours from 5pm to 11pm, that teachers could use for specialist advice. This service had Attention Deficit Hyperactivity Disorder (ADHD) specialists from Barnardo's and Autism specialists from NAS.

10. A CFLLC Member raised that the pausing of the school's neurodevelopmental referral pathway was six months in without a timescale for the next stage. The solution of stopping the referrals by pausing the pathway did not make the issues go away, and it was only when a child or young person was in crisis that they may be accepted for assessment. The CFLLC Member asked for a response on this. The Director of CYP Services (SaBP) explained that there were medical treatments for a small percentage of children who may had a diagnosis of ADHD. Nationally, there was a problem with the supply of ADHD medication, and an update on this could be expected in July 2024. This was not the same pathway for children with mental health difficulties. There was confidence that children with mental health difficulties, waiting for a diagnosis or not, could access pathways and help without delay. Improvements had been seen with access to assessment and treatment for children who had routine needs. Regarding the consultation approach,

Mindworks' focus was on growing the offer of early help and support, as this made a difference.

Cllr Dennis Booth left virtually at 11.15am.

11. The Chief Executive of SaBP added that a post-diagnostic treatment for autism was offered by NAS. Why schools felt that post-diagnostic treatment that was available from Mindworks was not being received, needed to be thought about. The three treatment pathways included medication for ADHD, a social model treatment for ADHD and a social model treatment for autism. Mindworks needed to address the delays with prescribing ADHD medication, but recognised there was a national shortage of ADHD medication and issues around how Mindworks diagnosed and prescribed for ADHD. Mindworks needed to understand why schools felt there was no front-line support.

12. The Interim Assistant Director for Inclusion and Additional Needs (SCC) added that the Council intended to work with all its stakeholders and schools to ensure they were not feeling overwhelmed. The Council had specialist teachers in practice that worked closely with schools.

13. A Member asked how many children, who would have been referred to the ND pathway since it closed on 1 September, were still waiting for a referral, and how the outstanding referrals would be managed. The Member also asked how many children were currently on a diagnosis or treatment pathway and how this information was retained. The Director of CYP Services (SaBP) explained that there was not a wait for consultations. There were around 7,300 cases on the ND pathway, and around 3,600 children on the diagnostic pathway. Mindworks was working through a significant number of children and young people currently on the pathway, going through the diagnostic process. Mindworks had increased the capacity to diagnose, such as commissioning support. There were approximately 900 children waiting for ADHD medication.

14. The Member asked how Mindworks ensured that children still awaiting referral were not lost. The Director of CYP Services (SaBP) explained that electronic patient record was opened when referrals were received and a business intelligent system enabled Mindworks to know who was waiting on the ND pathway, and where on the pathway they were. The Member asked if there was regular communication with people waiting on the pathway. The Director of CYP Services (SaBP) explained that at the point of referral it was ensured families had good information about how to access help and support. Mindworks did not have the digital infrastructure to inform people how long

the wait on the pathway would be but could say how long children had been waiting on the pathway. Children were also currently being seen on a chronological basis on the diagnostic pathway. The Member raised that Croydon was able to communicate where people were on the pathway and suggested this should be considered.

15. A CFLLC Member raised that, by not diagnosing everyone, Mindworks were choosing to ration and delay who got support and when. The Member asked how Mindworks monitored the outcome of Mindworks change of approach, and the demand for screening and assessment. The Head of Emotional, Mental Health & Wellbeing Commissioning explained that Mindworks was informed by schools, Families, Children and young people about the want for swift access to direct support from trusted people, which came from the social model being implemented. Mindworks had invested in ND advisors and was expanding teams working directly alongside schools. Schools wanted access to parent support, which Mindworks' third sector partner NAS provided and Mindworks had a recruitment process to expand this support. Named leads Mindworks at a district and borough level were being reviewed to allow people to form relationships with partners, to enable direct support. The consultation process provided answers straight away and enabled all paperwork to be completed and a dialogue to be in place. SaBP and The Tavistock and Portman NHS Foundation Trust were evaluating the consultation process. From an ICB perspective, NHS Surrey Heartlands had to listen to information provided by SaBP around children and young people waiting too long on the pathway. Mindworks was trying to learn the best way to meet the needs of children and young people by hearing feedback and implementing change, which would take time as some recruitment was needed. Regarding pressure on access to services, Mindworks did not decide the criteria to access its services alone. Mindworks had to look across the system and view it from a quality and safeguarding perspective. Mindworks was not prepared to extend waiting lines to significant levels if it remained within the medical model of approach. The criteria to access Mindworks' services was a collective decision and Mindworks was now in the process of re-looking at this.

16. A CFLLC Member referred to the decision to notify schools of the paused Mindworks referrals in September 2023 and asked about the funding and resource required to get Mindworks to the level it needed to be. The Associate Director for Integrated Children's Commissioning explained that initial communications to the changes to the ND pathway, was agreed with Council colleagues, the ICB and SaBP collectively. The resourcing issue was about workforce and medication availability, some of which was improving, as well as financial issues. Mindworks had

brought in additional funding. For example, there was £0.5 million for several programmes from the ICB. Funding could be drawn down through the mental health investment fund which was a joint funding option across the ICB and the Council. Trying to get the right balance within the current resources available continued to be a challenge.

17. The Deputy Chief Executive and Director of Therapies (SaBP) explained there was a plan to step back and look at the Mindworks model, looking strategically at what was being done. This was being undertaken in the beginning of May 2024. There would be a wider workshop with partners to review key areas of transformation in June 2024. SaBP would articulate what the Transformation Programme looked like, what the milestones were, when to expect the delivery of the milestones and the impact of the changes. NHS England were leading a piece of work on how to tackle some of the issues faced. It was important to learn from areas of good practice.

18. The Chief Executive of SaBP explained Mindworks had seen a growth in the presentation of need. As prevalence grew there was recognition that the medical model was not the right solution, and a social model was needed. The Mindworks contract and THRIVE approach was the beginning of introducing a social model as a way of dealing with the change in prevalence. There was understanding that support for schools was not working, and the Mindworks team needed to work out why and change the services. This was part of the transformation work.

19. In reference to the CFLLC Member's point raised around Mindworks rationing diagnosis, which was effectively rationing the delivery of treatment, the Chief Executive of SaBP explained that waiting for a diagnosis within a social model did not delay practical support. There was a component of diagnosis around ADHD, where medication was delayed, due to a national shortage. Mindworks had now emphasised the importance of the social model but where there was continuing need, the medical model could be used. A diagnosis was not needed to provide social model solutions. Traits of neurodiversity could be used to formulate a care plan that addressed needs. Work was starting around mapping school need and working with schools to address the dissonance between what support Mindworks offered schools and what schools were experiencing.

20. The Independent Chair of Surrey Wellbeing Partnerships explained that Surrey Wellbeing Partnership represented around thirteen voluntary organisations that were part of the Mindworks alliance within the early intervention and prevention space. There was recognition that there should had been more

communication and planning around the changes to the diagnostic pathway. Mindworks was on a journey of transformation, and it was a challenge to ensure current needs were met whilst transforming. Mindworks had a fixed financial envelope, without a mechanism in the Mindworks contract to increase it, with recognition that demand had outstripped capacity since the Mindworks contract began. The voluntary sector recognised the increased prevalence in ND traits. Across the fourteen voluntary organisations within Mindworks, it was assured that all practitioners had been and continued to be trained in how to support children with ND traits, pre-diagnosis.

21. The Independent Chair of Surrey Wellbeing Partnerships explained that when children and young people arrived in the Mindworks service, their experience was good. The experience of people while waiting was also important and were several deep dives reviewing people's experiences and what could be done to improve people's experience and ensure people felt supported when waiting for the service. This piece of work was conducted through audits within Surrey Wellbeing Partnership and across Mindworks.

22. A CFLLC Member asked for further clarification on how children and young people could be treated without a diagnosis. The Director of CYP services (SaBP) explained that children and young people still had the opportunity to access the assessment and diagnostic pathway, but the difference was Mindworks was now offering a consultation for children and young people that were known to need support. Treatment was limited to children that might benefit from an ADHD diagnosis. The Director highlighted examples of help and support such as providing alternative arrangements for children undertaking school exams or providing help and advice to parents. Through consultation, could allow Mindworks to understand what a child's challenges were. There were several ways children may present with need, that may be indicative of an ND need and may also be indicative to, for example, difficulties with sleep, trauma and behavioural concerns. Instead of queuing children on a waiting list, Mindworks was trying to engage quickly, educate others, identify what might contribute to the child's difficulties and therefore the support that could immediately be made available. Mindworks had 183% more referrals than what was contracted in 2023/24, pre-consultation, with twenty-six staff. If Mindworks could not engage early with children and young people, in multiple ways, to provide support, the clinical team would spend time processing referrals without being able to diagnose.

23. The Chairman of CFLLC expressed concern that the issues raised by schools, in terms of how parents and schools were feeling was news to the Mindworks team. It was suggested that

if there was more listening to schools and parents the Mindworks response might be more appropriate. The Chairman of CFLLC did not feel assured there was a plan that had timelines, activities, accountability, and funding, designed to address what schools and parents felt. Parents were not aware of how to find the tools and techniques available from Mindworks, and the language Mindworks used was not accessible. The Chairman of CFLLC raised whether Mindworks was monitoring the effectiveness of the range of support services available.

A break was called 12.02pm and the meeting resumed 12.18pm

24. The Chairman asked about the support available for children and families, with reference to the pressures parents faced. The Service Manager (NAS) explained that NAS offered parents support through group workshops and ran family fun days in school holidays, providing an opportunity for parents and children to meet in person which received good feedback. The work undertaken by NAS was goal based. 93% of NAS's clients reported an improvement in all their goals, against the national average of 20% and a contractual target of 70%. This figure was 90% across the Midnworks alliance. In terms of parent support and mental health, NAS ran parent support groups. A network of parents that understood each other's experiences could be validating and supportive. In Surrey, NAS had 4000 Members. NAS provided days out for children, and different events for children and families to get together. There was an online moderated forum with around 1000 members where parents could get support from other parents. NAS supported parents to understand that a diagnosis was not needed to access special educational needs and disability (SEND) support, and to understand the adjustments parents could request at the early stage.

25. A CFLLC Member asked about what further was being done to replace the capacity of Learning Space, which was not going to be commissioned further, where there were 28 people in East Surrey and 23 people in West Surrey currently waiting. The Independent Chair of Surrey Wellbeing Partnerships explained that work was being done with Learning Space to see whether the service could continue. There was a period before Learning Space could exit the Mindworks Partnership. If Learning Space did exit the partnership there would be a procurement exercise to ensure continuity of service.

26. In relation to autism activity evenings and day events offered for children and young people with autism awaiting an adult social care assessment, the CFLLC Member asked what data was being recorded on how networks of support were benefitting the children and parents and what the learning had been. The

Service Manager (NAS) explained there was qualitative but not quantitative data that looked ahead. Feedback questionnaires were used to design services going forward and create new events that would meet parent's needs. It would be difficult to ask people about personal connections that were made going forward.

27. The Vice-Chairman asked the Service Manager (NAS) how easy and accessible it was to access its pre-diagnostic support. The Service Manager (NAS) explained there was a reliance on practitioners and individuals to make the support known as NAS's resources were limited. NAS tried to attend community events and get information in areas such as school bulletins. One of NAS's roles partly involved attending schools to talk to parents about neurodiversity and services offered. NAS had a website and attended local events however, work was limited to people's availability as there was no specific marketing or communications role at NAS's Surrey Hub. A newsletter went out bi-monthly, however people needed to join NAS to receive this.

28. The Head of Emotional, Mental Health & Wellbeing Commissioning explained that Mindworks had secured some investment to increase capacity of the type of activities undertaken by NAS. £1.2million from the mental health investment fund went to Surrey Wellbeing Partnership to support primary school children and their families. Mindworks was working on a single referral process and Information Governance (IG) arrangements were being signed off around this. Work was being undertaken on how to provide this digital solution, as it should not be the responsibility of families find the support from the different selection of partners available through Mindworks.

29. The Chairman of CFLLC asked how the Mindworks team was working with others to achieve the aims of Mindworks' Care Leavers Service and what the key issues were in reducing the risks of long-term mental health needs. The Chairman of CFLLC also asked what more needed to be done in this area to improve outcomes. The Director of CYP Services (SaBP) explained the New Leaf Service supported children who were looked after and those that had left care. This service included specialist support, such as support for unaccompanied asylum-seeking children. The service, from a clinical perspective, included a multi-disciplinary team that were expert in working with children that had experienced trauma. The multi-disciplinary teams networked and engaged with all agencies supporting the child and worked with families to support the child's needs. Mindworks' Reaching Out Service was aimed at children that were hard to reach and often challenged with mental health and ND needs. This service worked with children up to the age of 25. When a young person

needed to transition into adult services for example, there was a comprehensive offer to ensure this involved the young person and family, with consideration to their vulnerabilities. There were different approaches such as transition check lists and courses available to families and young people through the Transition Recovery College. Mindworks also aligned a support worker with a young person at more vulnerable points in their care journey.

30. The Chairman of CFLLC asked how a care leaver knew how to access the Mindworks support services. The Director of CYP Services (SaBP) explained that access to Mindworks' service may be through Surrey County Council. The Mindworks screening criteria would highlight vulnerabilities for review, such as if the child was a care leaver, prioritising their needs. There would be a direct referral to the New Leaf Service who would engage, offer support and network with agencies to support the young person.

31. The Chairman of CFLLC asked whether young people who could not immediately access the Mindworks service themselves had to be referred by an agency. The Director of CYP Services (SaBP) explained there was no self-referral option in the New Leaf Services, but for care leavers it was usually known that they were in the county and needed support. There were a range of services that young people could access through self-referral.

32. A Member asked how people could access signposting to know what services they were eligible for. The Member also asked whether the Mindworks team felt there was a joined-up approach to ensure a continuity of service and whether care leavers were made aware of the support available. The Director of CYP Services (SaBP) explained that the emphasis in the Mindworks partnership was to increase the presence of help and support in places where children and young people were, to enable immediate access to the service and through Mindworks' network of partners, build confidence in understanding the needs of young people, to ensure they could be directed and supported in the right way. Mindworks had fifteen mental health support teams, and its third sector and voluntary partners were present in schools and communities. Mindworks' Recovery College had a self-referral option and there was good information on related websites. Mindworks THRIVE approach was trying to grow competence and understanding of what was available for children and young people.

33. The Member asked if Mindworks felt confident that the signposting approach was working and was effective. The Independent Chair for Surrey Wellbeing Partnership explained that signposting available was put out in all channels possible. Work was done in communities across multiple organisations

with children and young people. There was a concerted effort to signpost the services available.

34. The Member asked what procedures were in place to see if signposting was effective and was ensuring people were not falling through the system. The Independent Chair for Surrey Wellbeing Partnerships explained that this related to Mindworks' focus on vulnerable groups, through the Reaching Out service. More demand than capacity indicated people were aware of Mindworks' support services. Mindworks had early intervention coordinators that worked with schools to ensure vulnerable pupils were supported and referred to the right partners if necessary. The Director of CYP Services (SaBP) added that Mindworks had a 24/7 mental health crisis support line. Posters were put in schools and cards were created that children could carry around. Emerge, a Mindworks partner, were present in emergency departments. Mindworks had CYP havens and worked with Amplify, who were young people themselves that connected with other young people to promote support available. Goal based outcomes helped Mindworks review how effective the services were in meeting the needs of children and young people. Mindworks tended to receive more compliments than complaints, with complaints related to waiting times for ND need.

35. The Member asked if social media was used. The Director of CYP Services (SaBP) confirmed it was. Consideration was given to certain times of year more difficult for young people, such as exam seasons, where Mindworks promoted access to crisis services and havens. The Independent Chair of Surrey Wellbeing Partnership explained that social media was important and was recently reviewed to add other platforms. Social media was used to promote key messages, particularly crisis numbers and signposting to the Mindworks website.

36. The Deputy Chief Executive and Director of Therapies added that SaBP was doing a piece of research with the McPin Foundation under a National Institute of Health Research Grant (NIHR) to look and learn from the experience of young people in transition services, to ensure needs of young people were met.

37. The Chairman of CFLLC asked what services were currently offered by the Mindworks Recovery College to young people with neurodevelopmental issues. The Chairman of CFLLC also asked what proportion of young people had taken the Recovery College offer, how more take up could be encouraged and if the Recovery College could be widened to include more support for parents. The Director of CYP Services (SaBP) referred to the transition course, which particularly vulnerable people were encouraged to attend. There were three specific courses that included an introduction to the autistic spectrum, understanding

adult ADHD and post-diagnostic ASD, and understanding adult ADHD courses, which were well attended. The Recovery College had self-referral options and were open to all, including parents and teachers. The courses had an emphasis on sharing information about people and their conditions, and it was more difficult to understand the proportion of attendees that had ND needs. The Deputy Chief Executive and Director of Therapies explained that a strategy to increase take up of The Recovery College was to instil anonymity, to challenge stigma. Reports from The Recovery College showed that most people did not want to disclose a diagnosis, and attendees were treated as students rather than as patients.

38. A CFLLC Member asked what Mindworks' plan was. Another CFLLC Member asked about the amount of funding needed and if it should sit within the Mindworks contract or be put in other areas. The Associate Director for Integrated Children's Commissioning explained that Mindworks needed to listen more to what was heard from children and families to make changes. In terms of the overarching plan, there were areas outlined in the report which the Mindworks team had heard from committee Members that it felt disparate, which was helpful feedback. A lot of work occurring around the All-Age Autism Strategy and improvement work around SEND. Mindworks needed to break down some of the siloes and bring it together. Mindworks tried to ensure funding from the ICB and needed to understand what the funding looked like for the year ahead.

39. The Deputy Chief Executive and Director of Therapies (SaBP) added that universal early year's provision was critical in supporting families and young people, recognising the gaps in this provision nationally. There was a risk that the transformation work would become siloed, and it was important to ensure it was well-connected. The plan was to ensure the transformation work was fed through a broader transformation board, chaired by the Director of Commissioning for Transformation as part of the Council, so it could connect into other aspects of work, such as SEND work, to allow for a more holistic plan. The financial plan would also be reviewed. Engagement with the right partners needed to be ensured to hear more from families and schools.

40. The Assistant Director for Inclusion and Additional Needs (SCC) explained that there was still a lot to do in support of schools and families. The Education and Lifelong Learning Directorate focus on this. The Ofsted inspection would be responded to, part of which was about having a cohesive plan to ensure the Council was working in close partnership. For the Council, mapping out the support and ensuring available support was clear to schools would be key. It was suggested that the Council's offer to schools, and the training and development for practitioners

needed to be reviewed. Learning from other local authorities facing the same issues could be beneficial.

41. The Chairman of AHSC raised that society as a whole needed to become more inclusive and support people with neurodiversity.

42. The Chairman of CFLLC asked what the timeframe was for the Transformation Plan. The Deputy Chief Executive and Director of Therapies (SaBP) explained that Mindworks had committed to present the Improvement Plan at a national conference in November, with the expectation of the plan to be ready over the next few months.

A break was called at 1.10pm and the meeting resumed at 1.47pm

Cllr Rebecca Jennings-Evans left at 1.17pm

Actions:

1. Mindworks team to look at the London Boroughs and benchmark their performance against them, in terms of the referral process and treatment pathways (and to share this information with Adults and Health Select Committee and Children's Select Committee Members).

2. Mindworks team to share the completed Transformation Plan with the Childrens, Family Lifelong Learning and Culture Select Committee in October 2024.

Resolved:

The Adults and Health Select Committee and the Children, Families, Lifelong Learning and Culture Select Committee jointly recommended that:

1. Mindworks must demonstrate how it proposes to regain the confidence of parents and schools, and that it is accepting responsibility for the services that it is commissioned to provide, by:
    - Publishing the Transformation Plan, with dates, times, and levels of performance with appropriate Key Performance Indicators (KPIs)
    - Providing research to identify the size of the problem.
    - Encouraging the partnership to improve resources for communicating early help prior to diagnosis from organisations such as NAS.
    - By scaling up supply to meet the level of demand, and secure sufficient support from the NHS England, and show how this is linked to the Transformation Project.

2. Recommend that the response to the Joint Targeted Area Inspection Report (JTAI) is extended to accommodate a joined

up Mindworks / Education, Health and Care Plan (EHCP) process.

3. The Surrey and Borders Partnership Trust Recovery College needs to be more accessible to people and encourage more local access, with better publicity and provision of outreach services. Ensure that the Recovery College is given more active publicity and has the capacity to take on extra workload. Establish skills and work coaches to help coach and support people to enable the transition with helping people to maintain employment and get into employment, and critically to help people with regards to the Recovery College.

4. Mindworks must provide a clear and simple information guide for parents on how to access services, so that pathways of access are coherent, accessible, and easily understood ensuring communication is clear, and consider how it could be further reaching, so that parents and schools are supported while children are on the waiting list.

15/24 ADULT SAFEGUARDING UPDATE [Item 6]

Witnesses:

Sinead Mooney, Cabinet Member for Adult Social Care
Luke Addams, Interim Director, Practice, Assurance, and Safeguarding
George Kouridis, Head of Safeguarding
Fiona Davidson, Chairman of CFLLC

Key points raised during the discussion:

1. The Interim Director for Practice, Assurance and Safeguarding introduced the report.

2. The Chairman of AHSC asked what improvements were implemented to the Improvement Plan since Healthwatch Surrey's reports, and how coordinated working amongst Integrated Care Boards (ICB) and Integrated Care Services (ICS) had improved the experience for families and carers. The Chairman also asked where the adult safeguarding team felt there were still issues. The Head of Safeguarding explained there was a series of individual cases highlighted in the Healthwatch reports that were noted by the adult safeguarding team. The main improvements were driven through the Safeguarding Improvement Plan. There was an existing Improvement Plan set up, in relation to preparations for CQC assessments, which was being updated for completion. A range of areas were being looked at such as how the volume of safeguarding enquiries was managed and the different trends across a range of areas.

3. The Cabinet Member for Adult Social Care added that there was commitment within Adult Social Care to improve safeguarding practice, which was highlighted in the report, along with a focus on improving communication across agencies. Since the Healthwatch report was published, the Cabinet Member met with the Chief Executive of Healthwatch Surrey to discuss the report and understand how adult social care and Healthwatch Surrey could improve communications and outcomes for vulnerable residents.

4. The Interim Director for Practice, Assurance, and Safeguarding explained that the senior director team met with Healthwatch Surrey. Data and case tracking audits were used to ensure understanding of the experiences in the Healthwatch report. At the Safeguarding Adults Board (SAB), system partners and health partners were worked with closely. The Executive Director of Adults Wellbeing and Health Partnerships met regularly with the Chief Nurse of Surrey Heartlands Health and Care Partnership. In terms of remaining safeguarding issues that needed addressing, there had been a risk-averse culture which led to significant volumes of safeguarding referrals. The Adult Safeguarding team wanted to shift to positive risk management, rather than risk averse. There was a risk enablement board to promote this proactive and positive approach to risk management within the Council's Adult Safeguarding framework. The primary goal was to facilitate a practice culture shift toward risk enablement that focussed on wellbeing, managing risk effectively, and reducing unnecessary section 42 enquiries.

5. The Chairman of CFLLC asked how poor communication was measured and improved amongst carers, NHS England, other organisations such social workers and between different family members that were often contacted at different times. The CFLLC Chairman also asked if there was a complaints process. The Interim Director for Practice, Assurance, and Safeguarding explained that the safeguarding team tried to engage more with users of the safeguarding service. There was a user survey, take-up of which had traditionally been low. The Adult Safeguarding team tried to make people and carers aware that there was a complaints process and encourage take-up of the survey. As part of the new practice assurance board, feedback received was taken forward as lessons learned. Complaints received through the Council's complaints process were measured. This was a single tier, statutory process. The nature of complaints were defined and analysed through the data recording process. The number of complaints received about specific issues could be understood, and the team tried to make best use of this communication to drive service improvements. Staff were reminded of the importance of consistent good communication, such as explaining eligibility and social care

processes from the outset. Training on complaints for staff was provided by the complaints department. Complaints also included Ombudsman investigations which were reported to the Council's Corporate Leadership Team and the Directorate Leadership Team. Under the new governance arrangements, lessons learned were taken from complaints to disseminate them across the County.

6. Regarding the SAB, the Chairman of AHSC raised that in a multi-agency approach, gaps and problems in communication sometimes occurred. The Chairman asked what improvement efforts were being taken to ensure this was not the case. The Interim Director for Practice, Assurance, and Safeguarding explained that Surrey's SAB endorsed several principles which underpinned the adult safeguarding approach. No single agency could create an effective safeguarding system by itself, and only a joined-up approach at a strategic level could deliver a better response. To test the effectiveness of strategic arrangements the adult safeguarding team always asked how the partnership made a positive difference to the lives and experience of local people. Local arrangements showed that ambitious, joined-up strategic partnerships had clear sight on lines of practice and on the experiences of local individuals. This is what all the partners involved in the SAB focussed on. Ambitions had been progressing to improve county-wide links and working, to improve the ability to understand communities across Surrey and strengthening the voice of people with lived experience. In early 2024, the SAB established a new communications network that had a broad membership from all sectors to inform and extend methods of raising awareness of all adult safeguarding issues. Main SAB meetings encouraged inclusive membership and were used to share learning, insights, local, regional and national practices and research, as well as Safeguarding Adult Reviews (SARs). The Independent Chair of the SAB was leading a review of the Adult Safeguarding team's approach to quality assurance and was working with the SABs quality and performance Sub-group. In the SAB, the team aimed to develop a new quality assurance framework, with a focus of a multi-agency approach to assurance. The Adult Safeguarding team asked partners a range of questions to fill any gaps such as where abuse took place, what the biggest risks were, and whether the views of local people were listened to.

Cllr Riasat Khan left at 2.25pm

7. With reference to those living in poverty, the Chairman of AHSC asked how the Improvement Plan and integrated collaboration with ICBs and the community helped improve safeguarding amongst vulnerable adults in Surrey's priority neighbourhoods, and where the biggest improvements were needed. The Interim

Director for Practice, Assurance, and Safeguarding explained there was a link between impoverished neighbourhoods and safeguarding. Priority neighbourhoods were set out in the Health and Wellbeing Strategy that were being used to target specific resources to prevent safeguarding issued. Prevention was a focus of the SAB and partnership work. Resources included, for example, local area coordinators to understand the need experienced by the neighbourhoods and enable better service access.

8. The Vice-Chairman of AHSC asked what improvements were being made to address difficulties in accessing professional help, and what improvements were being made to help people access the right support to reduce risk and promote wellbeing. The Vice-Chairman also asked what improvements to staff training and management had been implemented, and if any safeguarding protocols were implemented for clients and volunteers. The Interim Director for Practice, Assurance, and Safeguarding explained that improvements were being made to address the difficulties in accessing professional help. The Council's triaging process had been improved, with a single point of access approach being adopted, so people could be connected to the most appropriate service. The Interim director outlined Council initiatives such as the fuel poverty and energy efficiency network, warm welcome venues, and Community Link Officers that linked people to services needed. Work was also done with partners to make physical activities more accessible, and to connect people with safeguarding prevention programmes. There was an academy and dedicated sites within the Council which listed safeguarding training competences. The adult safeguarding team linked with the SAB competences framework to enable staff to identify specific training for each role and develop awareness. This was being audited as part of the safeguarding improvement plan, to ensure staff receive the right training. The Adult Safeguarding team were establishing no response guidance and agreed to the new process for handling low-level provider concerns.

9. A Member asked how the Adult Safeguarding team could assure the committee that there were better systems for reporting and recording safeguarding concerns and that issues would not be neglected. The Interim Director for Practice, Assurance, and Safeguarding explained that the team took every safeguarding concern seriously. Professional curiosity training was offered within the Council, and this training would be refreshed. Within Adult social care professional curiosity was about exploring issues until the team was satisfied about the concern.

10. The Member asked if there were unannounced visits to care homes. The Interim Director for Practice, Assurance, and

Safeguarding confirmed there was and explained it was part of the quality assurance process within commissioning. When monitoring visits were undertaken residents were actively spoken to and evidence of how residents were treated was reviewed. Each care home had whistleblowing policies, as well as the Care Quality Commission (CQC), which carers of family members were made aware of.

11. The Cabinet Member for Adult Social Care added that the SAB had a good and easy to navigate website. Regular meetings with providers occurred and there was also a provider forum where concerns and issues could be raised. Safeguarding was regularly on the agenda to discuss. There was co-production and discussions with stakeholders, providers and residents. The routes to raise safeguarding concerns were clear, but more could be done to raise awareness.

12. The Chairman of CFLLC asked how confident the adult safeguarding team felt that there were good whistleblowing policies in place and to what extent whistleblowing was followed through. The Chairman of CFLLC referred to Winterbourne View and the concern around this and similar experiences. The Interim Director for Practice, Assurance, and Safeguarding explained that all providers were required to have whistleblowing policies in place and publicise them. CQC inspections had tightened this up since Winterbourne View and was something the CQC looked for, as well as the Council's commissioners and quality assurance team. Whistleblowing policies worked in Surrey and were effective. Future reports could provide reassurance to the committee by including references of whistleblowing. The Cabinet Member for Adult Social Care suggested that the importance of whistleblowing should be reflected on the Adult Safeguarding website. The Interim Director for Practice, Assurance, and Safeguarding agreed.

13. The Chairman of AHSC asked how the Adult Safeguarding team was tackling issues around modern slavery and the vetting of organisations. The Interim Director for Practice, Assurance, and Safeguarding explained this needed to be taken away to consider and discuss with commissioning colleagues how providers were contracted to ensure issues of modern slavery was considered carefully.

14. In relation to Making Safeguarding Personal, a Member asked how support for carers could be ensured. The Head of Safeguarding explained that carers assessments were offered to unpaid carers to understand the carer's position. The adult social care role was to ensure there were right tools, skills and experience in place to find issues at an early stage, preventing escalation. The carers assessment process would be reviewed

to support carers and intervene at the right time. The Risk Enablement Board looked at how situations were risk assessed in a more positive way and at the right time.

15. The Cabinet Member for Adult Social Care explained that the importance of unpaid carers could not be underestimated. Some providers commissioned by the Council provided carers with respite. Support for carers was being looked at for opportunities to do more and may become part of the adult social care transformation plans over the next four to five years.

16. A Member asked how unpaid carers were specifically being supported in relation to safeguarding. The Head of Safeguarding explained that the main platform for supporting carers was the carer assessment process where the circumstances of the carer were identified. Timeliness was a key part in the carer assessment process, as carers tended to enter the process at a later point. At times people did not recognise themselves as a Carer. It needed to be ensured staff recognised this and offered carer assessments when, for example, other people were referred to the service.

17. The Chairman of CFLLC asked how the Adults, Wellbeing and Health Partnership's Improvement Plan was delivering improvements for safeguarding the most vulnerable adults, particularly those with communication difficulties who may not be able to alert others. The Head of Safeguarding explained that situations involving people with communication challenges would be treated individually. There were other risks for people with sensory challenges, which would involve ensuring that the workforce was appropriately skilled to understand the situations and keeping the individual at the centre of the safeguarding process was important. If an individual presented issues with their mental capacity the involvement of an independent advocate through a Section 42 enquiry would be considered. Necessary adjustments would be required and ensuring the workforce picked up on issues at the right time.

18. The Chairman of AHSC asked when the July 2023 audit report recommendation for the safeguarding workforce to undergo training in risk assessments, re-launch the risk assessment form and guidance, and improve management oversight and responsibility was expected and how it would improve processes. The Interim Director for Practice, Assurance, and Safeguarding explained that the recommendation was included as part of the safeguarding team's overall audit training offer. Each locality had its own safeguarding advisor that regularly delivered training, which was being reviewed by the Head of Safeguarding. This training was being standardised to ensure consistency and that it included appropriate risk assessment and

risk management. This would be concluded within the next month, and the safeguarding training audit would be completed in the next few months.

19. The Vice-Chairman of AHSC asked how the Safeguarding Improvement Group would oversee and drive continuous improvement in safeguarding practice and how the safeguarding team would work collaboratively to achieve improvements. The Head of Safeguarding explained that the Safeguarding Improvement Group started developing a safeguarding improvement plan which would be reviewed on an annual basis. The plan was informed by the current areas of focus that needed to be worked on moving forward. The plan was built on what was done in preparations for the CQC assessment. Now that the self-assessment was completed, the plan was intended to be expanded further. The plan was also informed by the data from the overall performance around safeguarding. The learning from SARs would also be reviewed through the Safeguarding Improvement Group. Close work with the academy to ensure the workforce had the right skills, knowledge and tools would be undertaken.

20. The Vice-Chairman of AHSC asked how collaborative work would be undertaken to ensure communication was responded to and that the timeliness of referrals would be ensured whilst the improvement work was under review. The Vice-Chairman also asked who would monitor the process improvements. The Head of Safeguarding explained that he had oversight from the multi-agency safeguarding hub, where all safeguarding referrals went. The Head of Safeguarding had regular meetings with the performance team on how the team did against key performance indicators. The Head of Safeguarding’s role was to work closely with the performance team and with the Multi-Agency Safeguarding Hub team to focus on identified areas that had blockages, to create a flow in the safeguarding system, to ensure timely responses to concerns. Whilst there was a range of monitoring and oversight, the Safeguarding team intended to enhance data further to allow for a more robust reporting framework. This work was expected to be completed soon. The Interim Director for Practice, Assurance, and Safeguarding added that the responsiveness to Section 42 enquiries and concerns had not always been as robust as desired. The Interim Director believed every enquiry was entitled to an acknowledgement. This was an area of improvement for the safeguarding team and steps were already taken to improve this.

Actions:

1. Safeguarding team to reflect the importance of whistleblowing (particularly on the safety aspect, such as around confidentiality) on the adult safeguarding website.

2. Regarding modern slavery, the Director of Practice, Assurance and Safeguarding to discuss with commissioners, the vetting of organisations, raising awareness and provide a written update to the committee.

Resolved:
The Adults and Health Select Committee recommended that the Adult Safeguarding team:

1. Provide an update from the new Safeguarding Panel on progress on the questions raised, particularly around communication and working in partnership, ensuring that people don't fall through the gaps.

2. Provide a measurement of feedback from staff, patients and from other services, so we can see what improvements have been made, and as a result can show how we deliver a safer environment.

3. Provide an analysis of how effective your measurement service is so we can be reassured on how effective the service is running, and that activities are resting in more resolve.

4. To examine best practise on whistleblowing, and to make every effort to provide a process that protects the individuals who are using the process, and that it is effective.

5. Continue improving the measurement of safety, and demonstrate that the service as a whole is actively eliminating problems.

16/24 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 7]

The Committee noted the recommendations tracker and forward work programme.

17/24 DATE OF THE NEXT MEETING [Item 8]

The Committee noted its next meeting would be held on 10 October 2024.

Meeting ended at: 3.05pm

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Chairman

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ADULTS AND HEALTH SELECT COMMITTEE

September 2024

Surrey Heartlands Cancer and Elective care backlogs

Purpose of report:

This report outlines the backlogs for cancer and elective (planned) care across Surrey Heartlands, the progress made in addressing these and actions being taken to reduce further. In addition it outlines the work being undertaken to increase diagnostic capacity.

Introduction:

1. Surrey Heartlands Integrated Care Board (SHICB) includes three acute trusts; Surrey and Sussex Healthcare NHS Trust (SASH), Ashford & St Peter's Hospitals NHS Foundation Trust (ASPH), Royal Surrey NHS Foundation Trust (RSFT) all of whom provide elective care and cancer services for the local population.

2. Waiting time targets have long been a part of the NHS performance requirements, however following the disruption and delays caused by covid the focus has been on addressing and reducing the number of patients waiting for treatment.

3. Prior to the covid pandemic, most patients were seen and treated within 18 weeks of their referrals. During the pandemic, waiting lists grew as services were reduced to redirect resources and keep the general public safe from risk of infection.

4. The last 12 months has seen further challenges in terms of reducing waiting lists due to the capacity lost due to Industrial Action that has been taken by doctors.

5. NHS England (NHSE) set out an ambition to reduce the volume of patients waiting long periods for elective care. Apart from patient choice and some allowance for complexity, the following timescales were originally set as follows:

   5.1. By March 31st 2022 no patient should wait over 104 weeks (2yrs)
   5.2. By March 31st 2023, no patient should wait over 78 weeks (1.5yrs)
   5.3. By March 31st 2024, no patient should wait over 65 weeks (1.25yrs)
   5.4. By March 31st 2025, no patient should wait over 52 weeks (1 year)

6. Due to challenges nationally in achieving these targets these have been amended and current expectations are:

   6.1. Zero 104 week waits
   6.2. Zero 78 week waits
   6.3. By September 30th 2024 no patient should wait more than 65 weeks
   6.4. By March 31st 2024 no patients should wait more than 52 weeks.

7. The three standards relating to cancer are as follows:

   7.1. Minimum of 77% of patients to receive their diagnosis or ruling out of cancer within 28 days of referral by March 25, moving to 80% by March 2026.
   7.2. Minimum of 96% of patients to commence treatment within 31 days of the decision to treat for all cancer patients
   7.3. There is a national ambition that 70% of patients will commence treatment within 62 days of their referral or consultant upgrade, with an ambition to increase this to 85%.

8. Ensuring there is sufficient diagnostic capacity to support both cancer and elective activity is recognised as a key contributing factor to a systems ability to reduce waiting times.

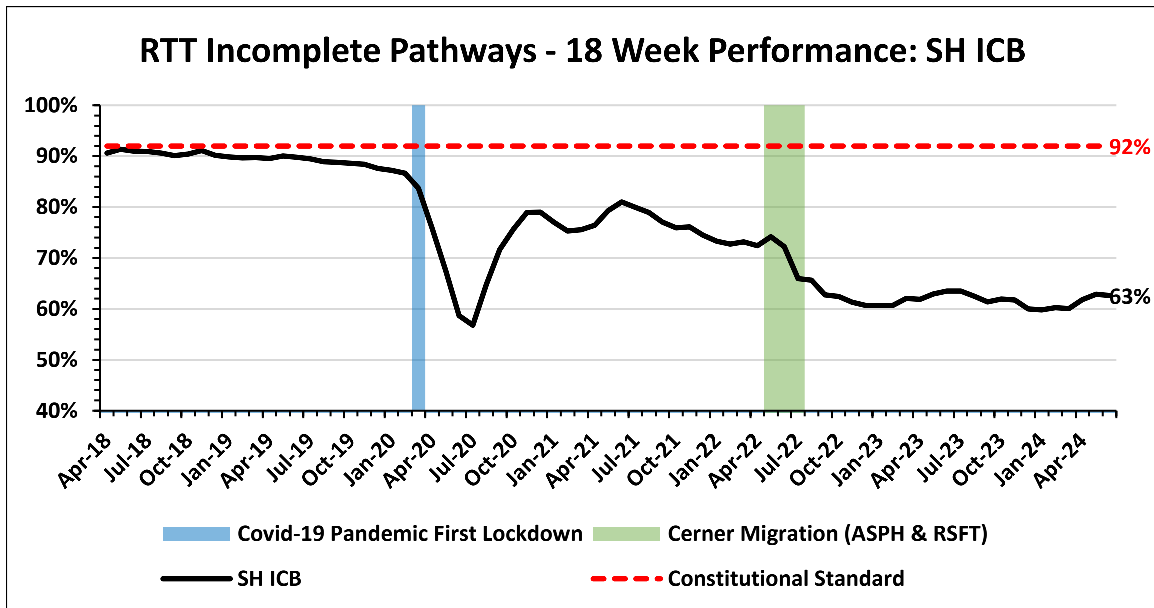
Current position

9. Restoring planned services equitably is a core principle of the NHS's elective recovery programme. Surrey Heartlands has continued to work closely with regional NHSE colleagues to reduce the volume of patients waiting for elective care.

10. During 2022 Ashford St Peters Hospital (ASPH) and Royal Surrey Foundation Trust (RSFT) upgraded their electronic patient record (EPR) with a single instance of a Cerner EPR. Cerner provides EPR systems at many NHS Trusts across the country and was already in place in Surrey and Sussex Hospital (SASH). SASH also undertook an upgrade of their version of the Cerner EPR. The benefit of an EPR system is that all patient information is contained in one place and will link together effectively, rather than multiple systems that do not always interface effectively. The roll-out of the new system caused operational pressures as well data capture, quality and reporting issues, which can be seen in some of the historic data shown throughout this report. There have been a small number of data quality issues identified in the last 12 months due to the new system, which have now all been addressed.

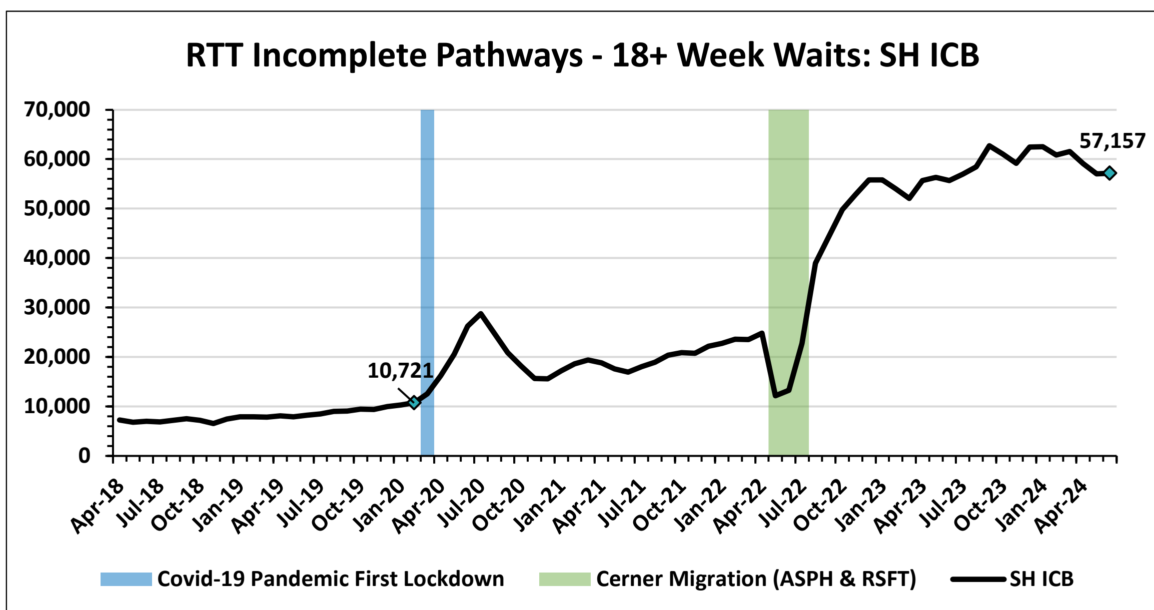
11. There is a constitutional standard, often referred to as the 18-week or referral-to-treatment (RTT) target, where 92% of patients should be waiting no more than 18 weeks from referral to first consultant-led treatment. Surrey Heartlands ICB 18

weeks performance currently (Jun-24) sits at 62.6% (95,702 out of total waiting list 152,859) and is ranked 10th out of 42 systems nationally.



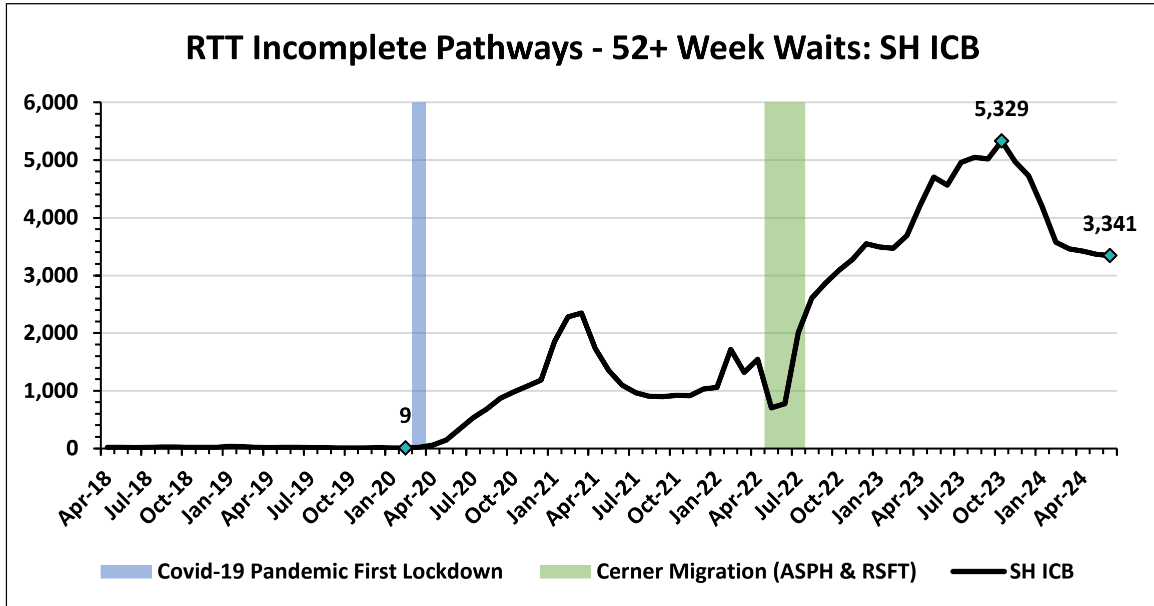
12. The following figures outline the long waiting patients and include all acute and independent sector providers with Surrey Heartlands registered patients on their waiting list:

12.1. Patients waiting more than 18 weeks for treatment were ~11,000 in February 2020. This fluctuated during the covid period. increasing to ~56,000 by January 2023. The latest data (Jun-24) shows ~57,000 patients waiting >18 weeks. Some of this rise is due to data quality. Many patients have been contacted to check whether they still require their hospital appointment as part of our process for validating the waiting list.

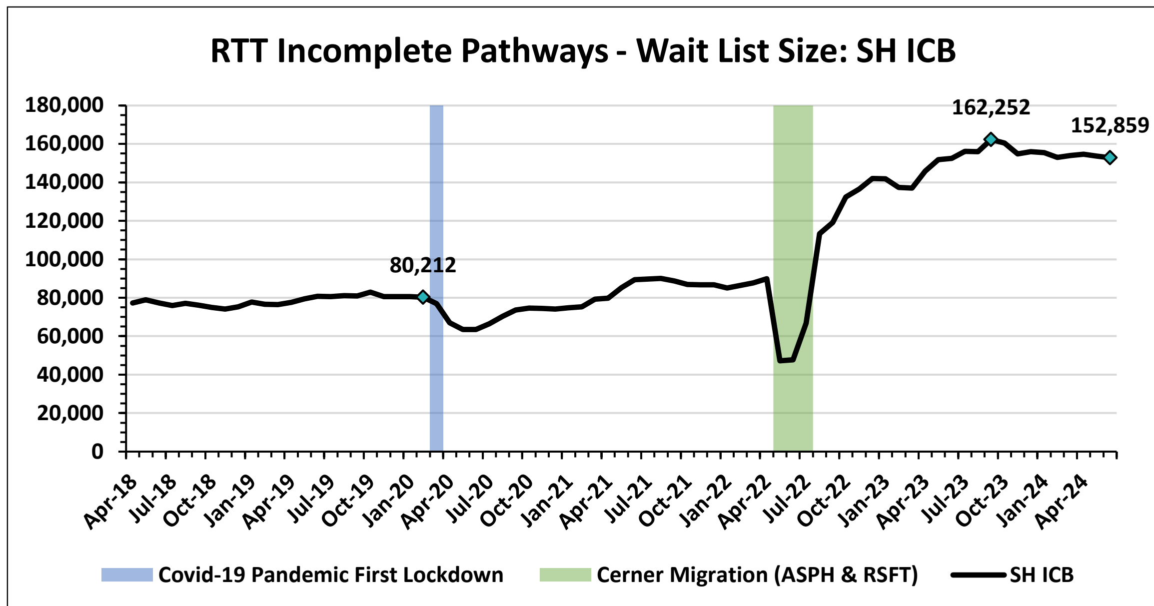


12.2. Surrey Heartlands ICB ranks 8rd out of 42 system (Jun-24) for the percentage of waiting list over 52 weeks, with 3,341 patients (~2.2% of wait list) currently waiting 52+ weeks.

12.3. In February 2020, just 9 patients were waiting more than 52 weeks for treatment. During covid this increased to a peak of 5,329 in October 2023. The latest data (Jun-24) shows this has reduced to 3,341.



13. IN April 2022 the wait list was ~90,000 (12% above the pre-pandemic position of ~80,000). Post Cerner migration, the wait list increased to a peak of over 162,000 in September 2023. The wait list size has reduced over the last 9 months to ~153,000 (Jun-24).



14. Five specialties make up around 40% of the total elective waiting list. These specialties tend to deliver a higher volume of routine procedures and therefore

these patient groups can wait longer than those in other specialties. The specialties are ophthalmology, orthopaedics, ENT (ear, nose and throat), gynaecology and oral surgery. (The table below shows the Surrey Heartlands ICB registered patients with provider breakdown, actual waiting list sizes will be larger as they will include non-Surrey Heartland registered patients).

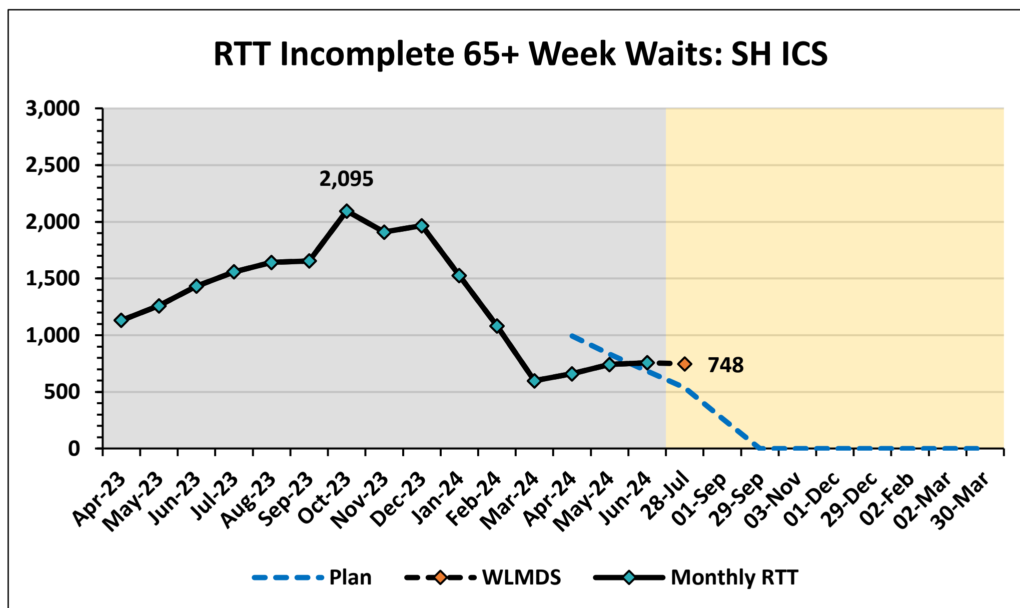
RTT Incomplete Pathways: Jun-24						
Treatment Function	Surrey Heartlands ICB					
	Total	ASPH	RSFT	SASH	ESTH	Other
Trauma and Orthopaedic Service	**20,194**	5,992	5,382	1,766	2,443	4,611
Ear Nose and Throat Service	**13,164**	4,015	3,245	2,682	923	2,299
Ophthalmology Service	**11,689**	4,123	1,985	1,758	1,137	2,686
Gynaecology Service	**9,524**	2,495	1,705	1,288	1,916	2,120
Oral Surgery Service	**6,649**	1,837	2,406	1,009	282	1,115

15. During 2023/24 a number of Data Quality (DQ) issued were identified following the cerner installation. This has led to some patients being found to have waited extended periods of time. Once identified trusts have worked to contact and treat these patients as quickly as possible. There is ongoing work with all trusts to mitigate further DQ issues.

16. During 2023/24 Surrey Heartlands has seen a small number of patients who have waited over 104 weeks for their treatment. These have predominantly been due to patient choice, and some which were identified through validation of the Data Quality issues.

17. There has been continued progress in reducing the number of patients waiting over 78 weeks, although there remain a very small number, due to the impact of industrial action and patient choice.

18. The national target is that zero patients will have waited >65 weeks by the end of September 2024. Trusts have been making good progress in reducing these numbers since the end of 2023, however there are still c200 patients who need to be treated.



Quality & Safety

19. All of our acute trusts continue to undertake regular waiting list validation as an ongoing process, this is in line with the ask from NHS England.

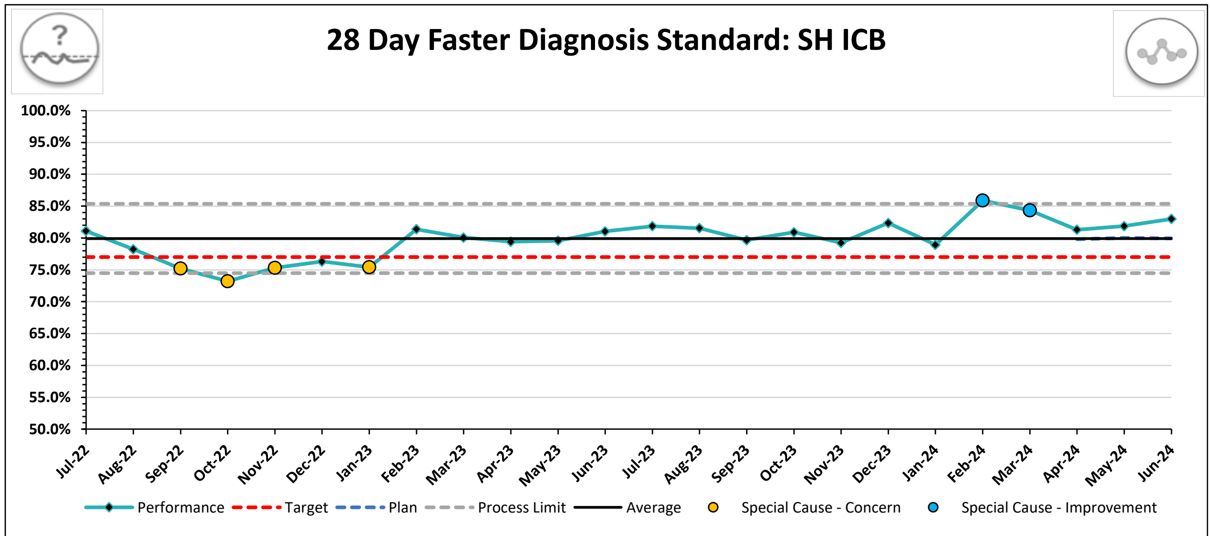
20. It is a requirement that trusts undertake a clinical harm review for every cancer patient who waits longer than 104 days for treatment. This is a well-established process. This has also been embedded for every patient on the elective waiting list who has waited over 52 weeks. This process is overseen by the clinical leadership teams within trusts.

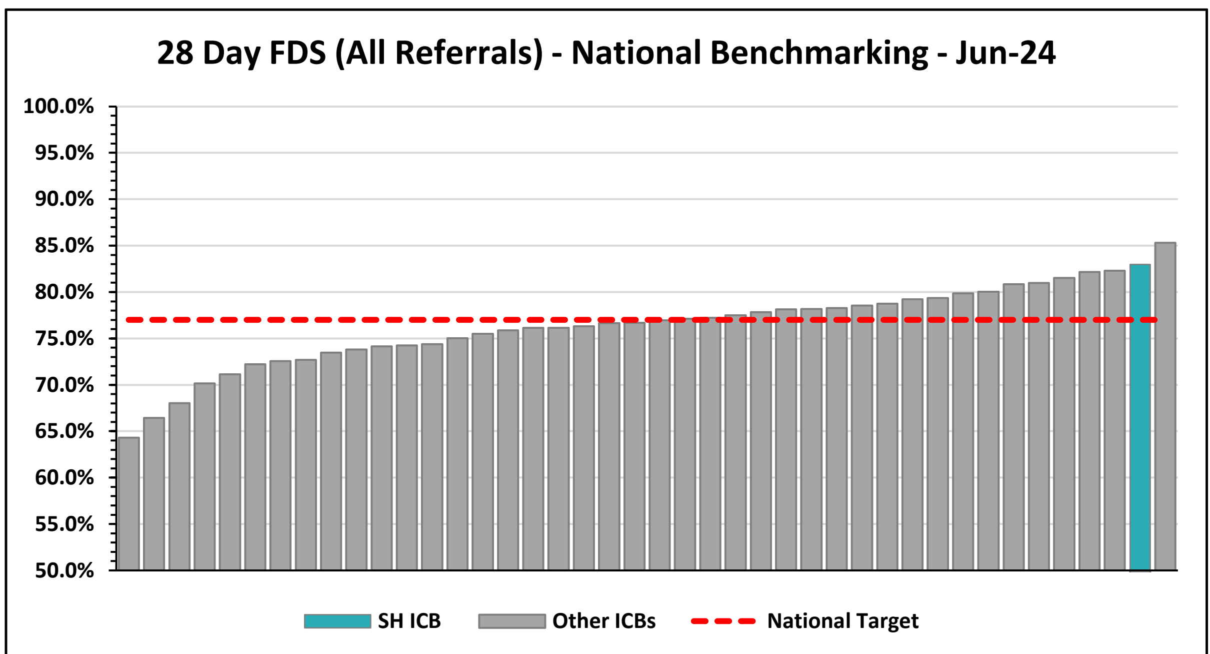
21. Ashford St Peters Hospital have introduced a waiting well initiative which ensures patients are regularly contacted throughout the time they are waiting to be seen in hospital and incorporates a process that looks at any potential harm that might be caused by extended waits.

Cancer performance

22. Patients on a cancer pathway are one of our highest clinical priorities. All providers have placed significant effort into ensuring that patients are treated as soon as possible with support from the Surrey and Sussex Cancer Alliance (SSCA).

23. The faster diagnosis standard requires a patient who has been referred with suspected cancer to have a diagnosis or ruling out of cancer by day 28 of a primary care referral. Surrey Heartlands Trusts have strong performance enabling the system to be one of the top performing systems in England, and exceeding the standard which is set at 75%.





24. Surrey Heartlands ICB ranks 1st out of 42 ICBs in England for the 62 day standard, achieving 83% in June. This puts us in a strong position for achieving the 70% ambition by the end of March 2025.

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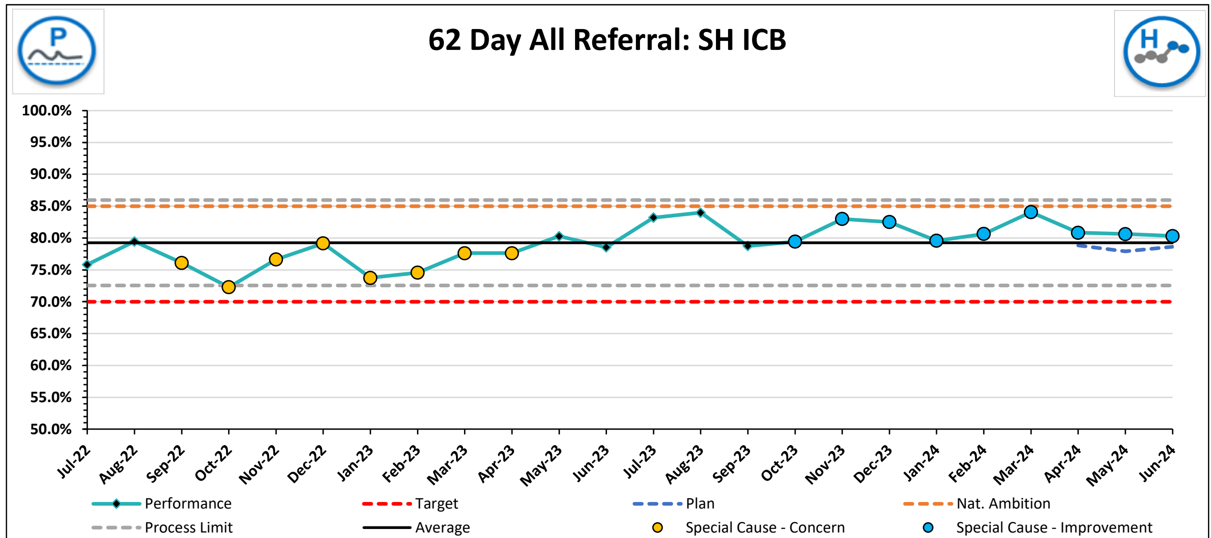
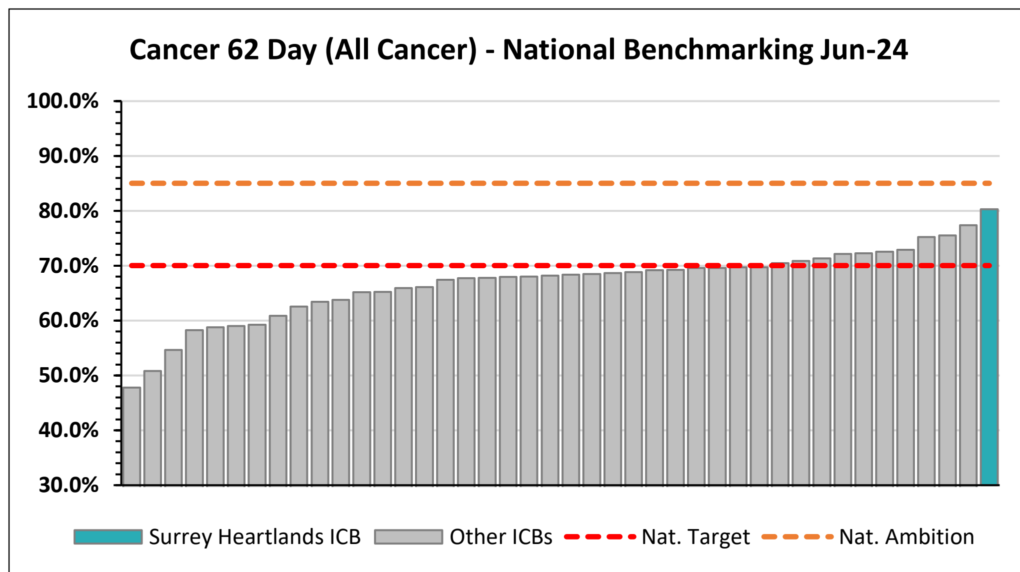
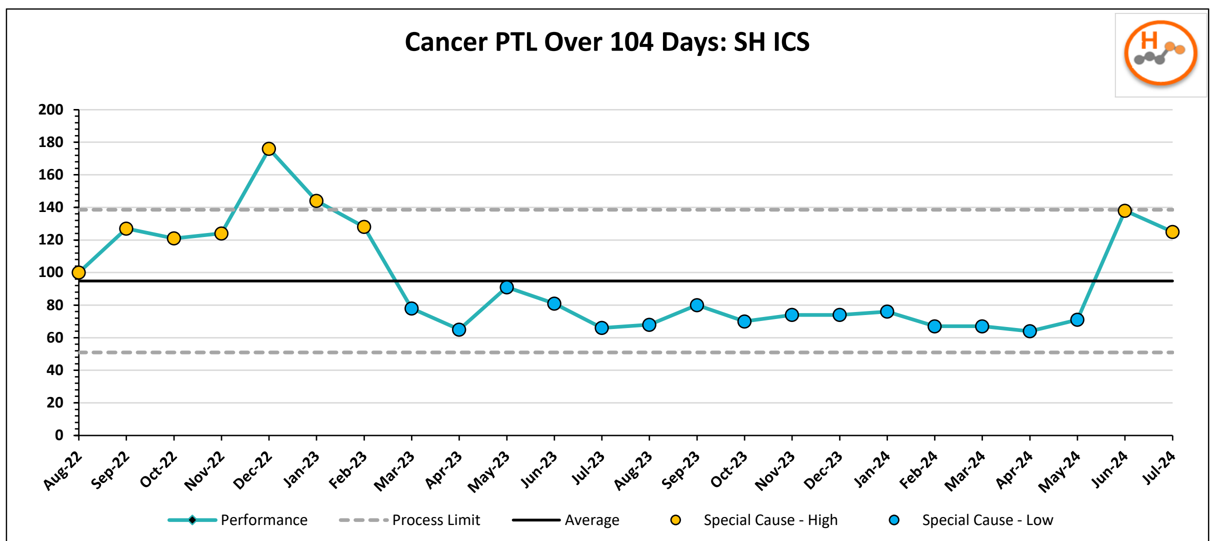




25. Surrey Heartlands ranks 26 out of 42 systems for having the lowest proportion of wait list at more than 104 days for cancer treatment in England.



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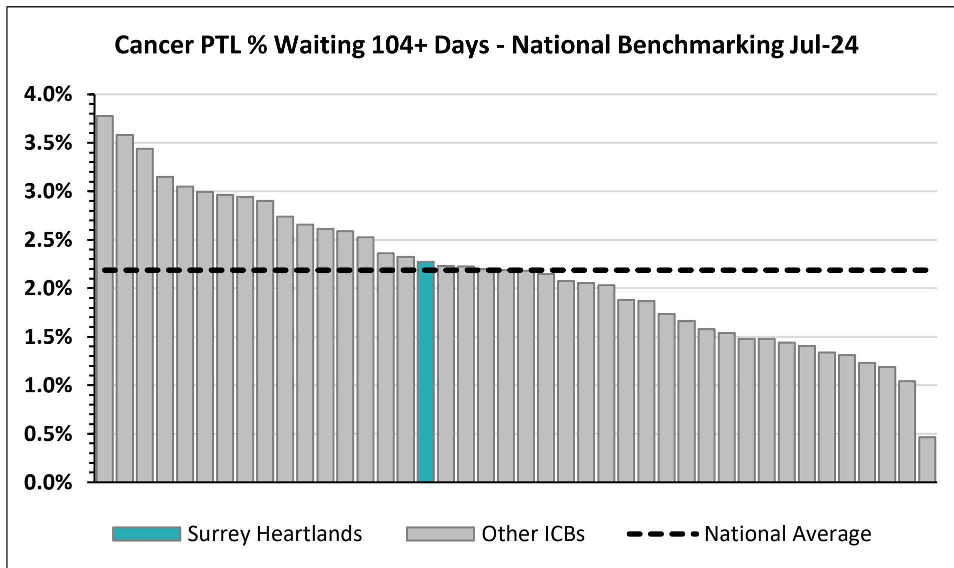
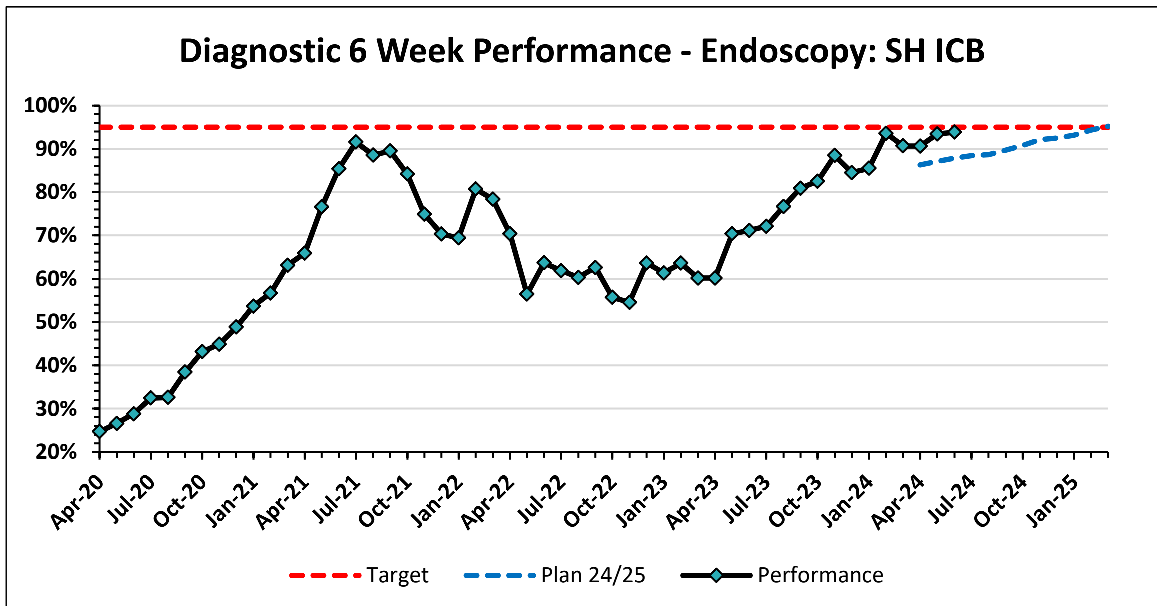


Diagnostic performance

26. Endoscopies were a key driver of long waits during the pandemic. However, Surrey Heartlands has focussed on solutions such as Faecal Immunochemical Test (FIT) plus creating capacity across the system. This has led to a significant improvement and reduced waits for patients on this pathway. (FIT tests are a new, markedly improved test that requires a single faecal sample which can detect the presence of very small quantities of blood in a sample).



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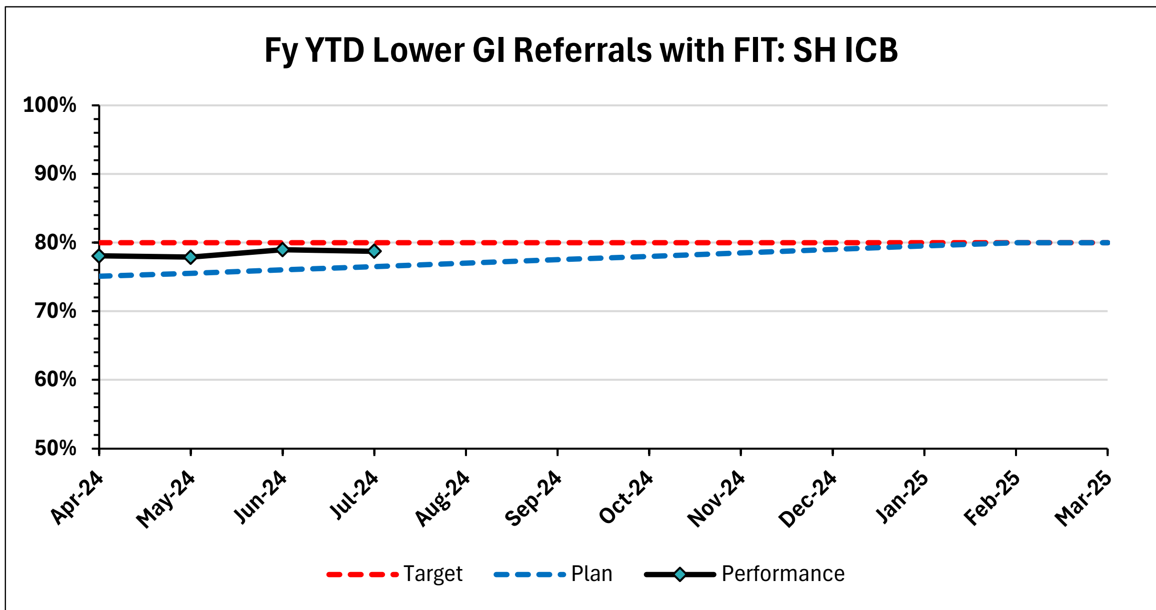
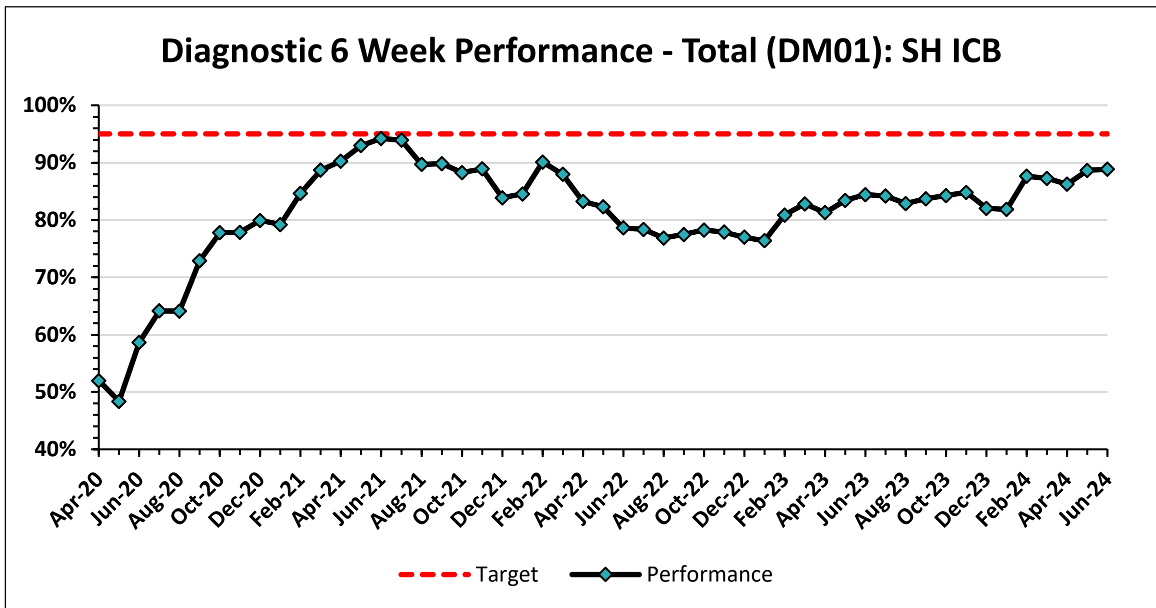
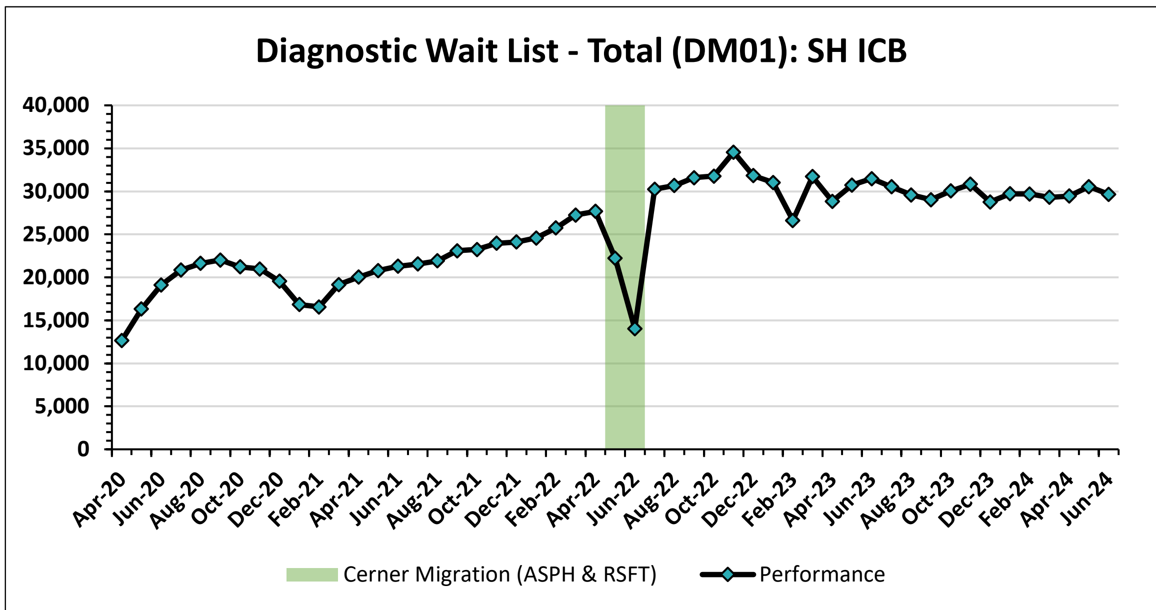
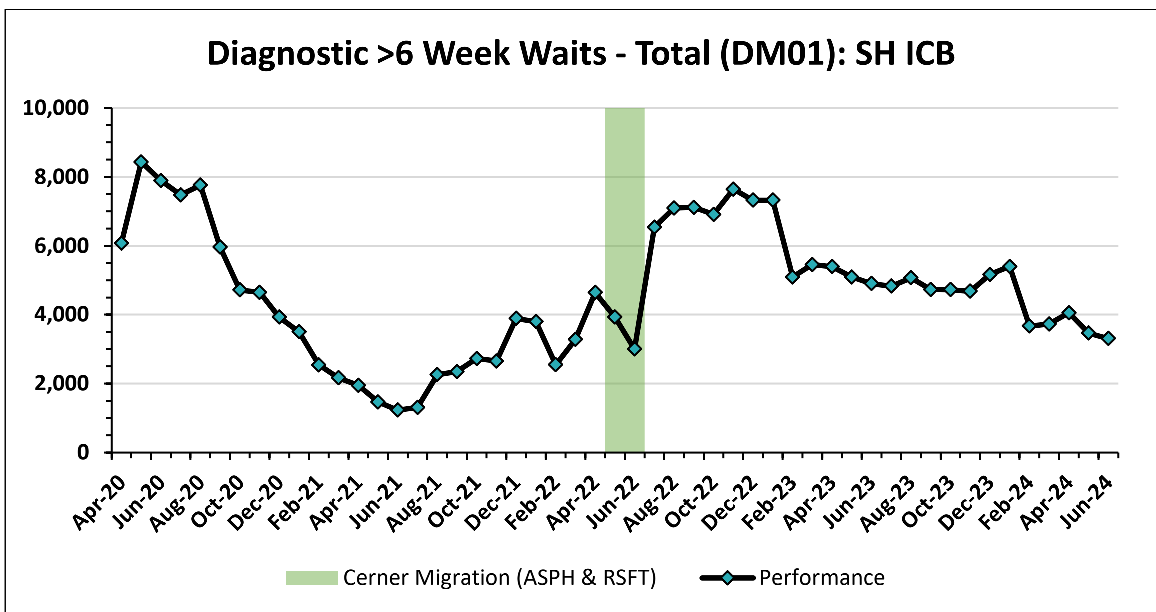


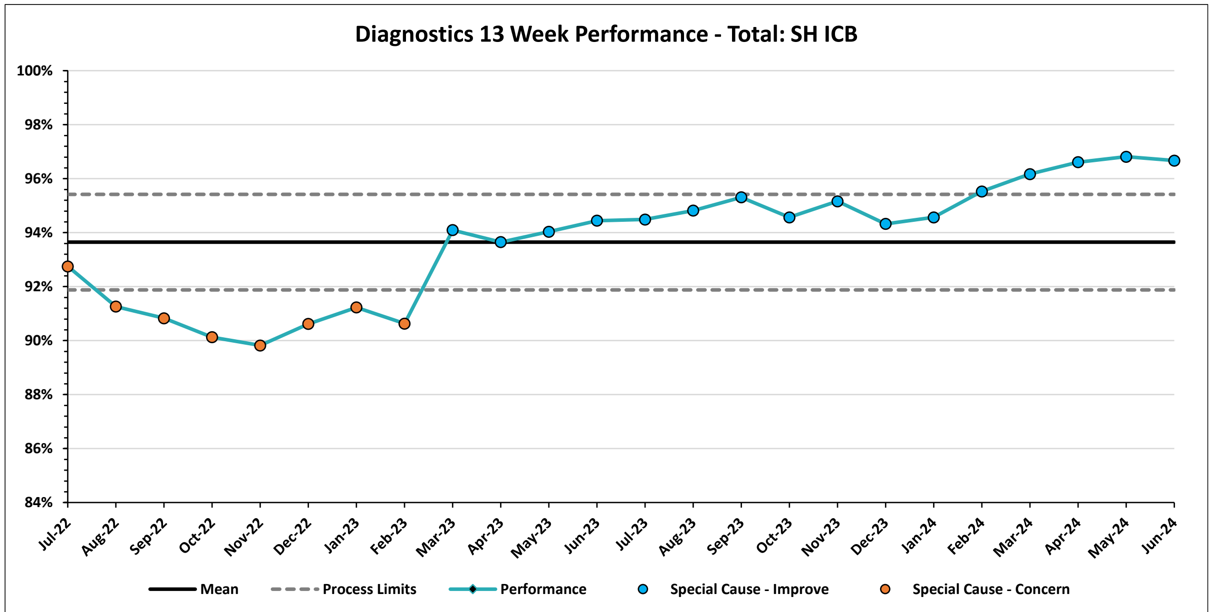
27. The national target for diagnostics is that by Mar-25, 95% of patients should be seen within 6 weeks of referral for their diagnostic test. Pre-Covid around 93% of patients were seen within 6 weeks. Performance reduced to <80% in 2022 but has improved throughout 2023 and 2024 to date with latest figures (Jun-24) showing performance of 89%.

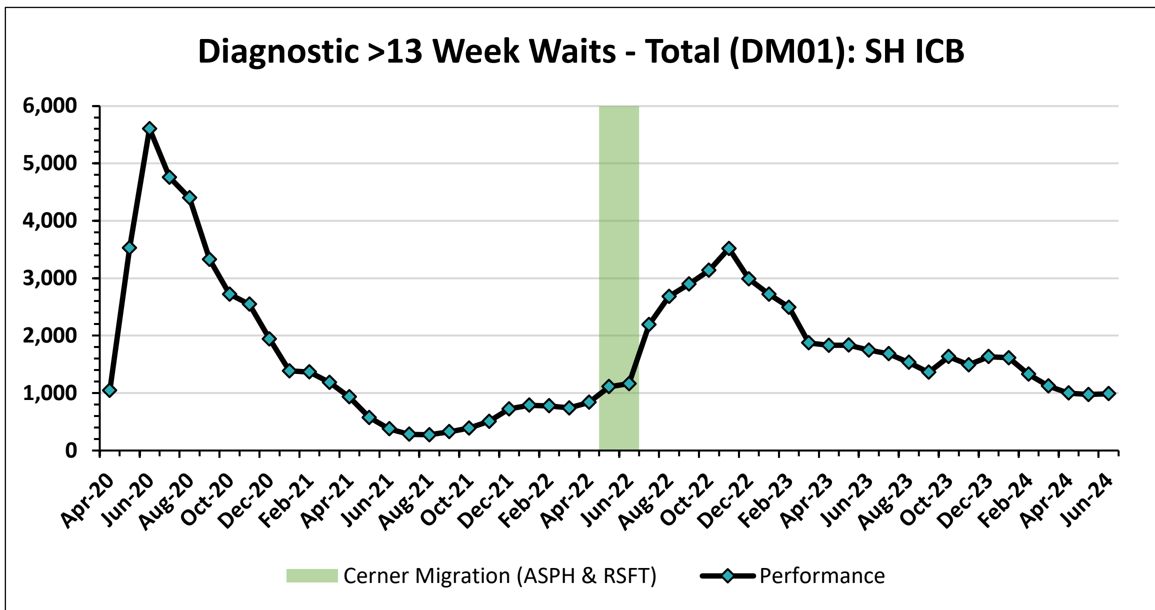




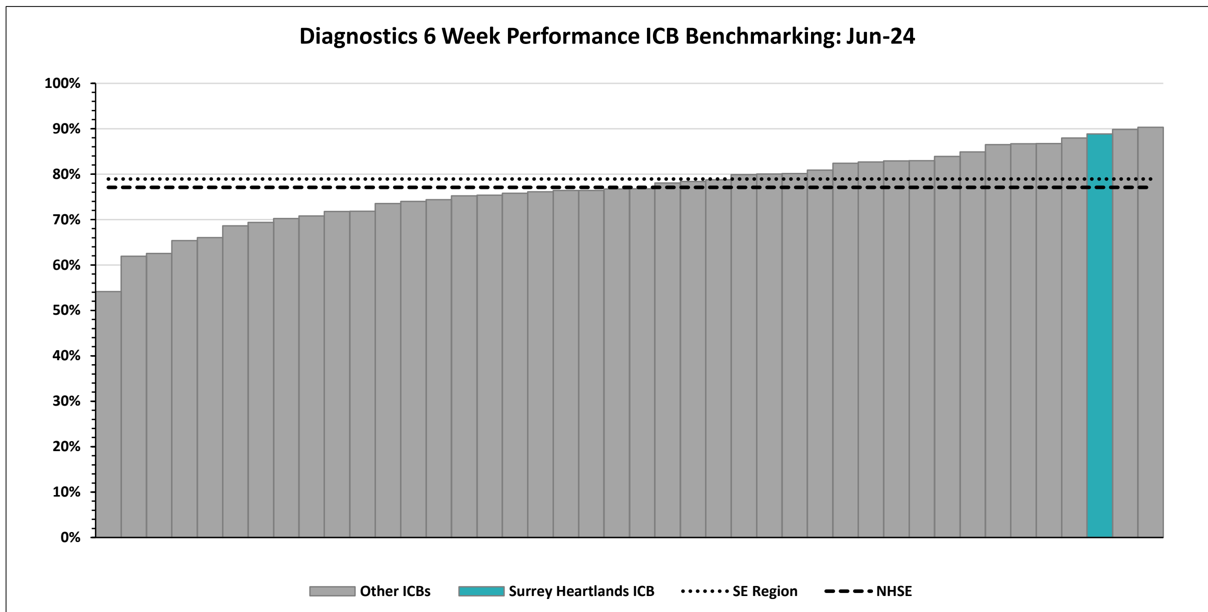


28. In July 2021 there were 280 (1.3%) people on a diagnostic waiting list who had been waiting more than 13 weeks which was comparable to pre-Covid levels. There was a significant increase from Jul-21 to Nov-22 where 13+ week waits peaked at 3,517 (10.2%). Numbers have now been reduced to <1,000 patients waiting 13+ weeks (3.3%).





29. Surrey Heartlands is currently ranked 3rd out of 42 systems for diagnostic 6 week performance. We are performing better than the Southeast (SE) Region and national average.



Digital Innovation

30. Our three acute Trusts have all implemented a patient portal in conjunction with their Electronic Patient Record (EPR) provider. Whilst this is still being rolled out the initial feedback from trusts and patients has been very positive. The patient portal will enable patients to book appointments, review information on their condition and other functions that put the patient in the driving seat of their care.

31. Surrey Heartlands continues to use virtual consultation software to enable patients to undergo meaningful consultations with a health professional without having to attend a face-to-face appointment

Actions taken to address backlogs

32. The Surrey Heartlands elective care team hold weekly meetings with trusts to review long waiters and provide support to help reduce this. In addition to this the SH teams meet with the regional NHSE team to share challenges and identify support and solutions.

33. Trusts undertake meetings a minimum of twice a weeks to review all long waiting and cancer patients, to ensure they are progressing their treatment as swiftly as possible and are fully sighted on any challenges associated with getting dates agreed.

34. All three trusts continue to validate their patient lists so they are confident that they don’t have any duplicates in the systems and pick up any errors in the way patients have been coded.

35. Surrey Heartlands trusts have all utilised the national DMAS (Digital mutual aid) system to facilitate transfer of appropriate patients to alternative providers where they can be treated safely in a shorter time period.

36. Mutual aid between the three NHS providers has also taken place, and increasingly the Ashford elective Centre has been able to accept patients in order to treat them more quickly than their existing trust.

37. Surrey Heartlands and all three provider trusts will continue to scrutinise the data, in detail, at a specialty level and put in place processes and support as needed to maintain and improve the level of progress.

38. We continue to work closely with the Surrey and Sussex Cancer Alliance (SSCA) to support improvements in cancer care and maintain our excellent performance. To support improvements and focus for these, during 24/25, the SSCA will be developing and implementing tools to support early identification and escalation areas of challenge. This includes developing and implementing a technical statistical process escalation process, supporting Trust implementation of the Alliance optimal timed pathways and introducing a pathway analyser tool.

39. Surrey Heartlands ICS has commenced a cancer inequalities programme to a) improve our knowledge and understanding of groups experience inequalities in relation to cancer outcomes and experiences of cancer care across Surrey and; b) provide recommendations to address inequalities in screening, diagnostics, referrals, treatment, personalised care, access, experience and outcomes. This 2-year funded programme commenced in April 2024 and is funded by Macmillan Cancer Support and hosted by Surrey County Council.

Conclusions:

40. Surrey Heartlands has made good progress in reducing their long-waiting patients across elective, cancer and diagnostic waiting lists. Whilst there remain some challenges, processes for review, escalation and support have been put in place.

Report contact:

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Contact details

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Sources/background papers

Surrey Heartlands assurance report

Surrey & Sussex Cancer Alliance Cancer Performance Report

ADULTS AND HEALTH SELECT COMMITTEE

September 2024

Frimley Cancer and Elective care backlogs

Purpose of report:

This report outlines the backlogs for cancer and elective (planned) care across Frimley ICS, the progress made in addressing these and actions being taken to reduce further. In addition, it outlines the work being undertaken to increase diagnostic capacity.

Introduction:

1. Frimley Integrated Care Board (FICB) covers one acute Trust - Frimley Health Foundation Trust (FHFT) which includes three main hospital sites – Frimley Park Hospital, Wexham Park Hospital and Heatherwood Hospital, all of whom provide elective care and cancer services for the local population.

2. Waiting time targets have long been a part of the NHS performance requirements, however following the disruption and delays caused by covid the focus has been on addressing and reducing the number of patients waiting for treatment.

3. Prior to the covid pandemic, most patients were seen and treated within 18 weeks of their referrals. During the pandemic, waiting lists grew as services were reduced to redirect resources and keep the general public safe from risk of infection.

4. The last 12 months has seen further challenges in terms of reducing waiting lists due to the capacity lost due to Industrial Action that has been taken by doctors.

5. NHS England (NHSE) set out an ambition to reduce the volume of patients waiting long periods for elective care. Apart from patient choice and some allowance for complexity, the following timescales were originally set as follows:

   5.1. By March 31st 2022 no patient should wait over 104 weeks (2yrs)
   5.2. By March 31st 2023, no patient should wait over 78 weeks (1.5yrs)
   5.3. By March 31st 2024, no patient should wait over 65 weeks (1.25yrs)
   5.4. By March 31st 2025, no patient should wait over 52 weeks (1 year)

6. Due to challenges nationally in achieving these targets these have been amended and current expectations are:

   6.1. Zero 104 week waits
   6.2. Zero 78 week waits
   6.3. By September 30th 2024 no patient should wait more than 65 weeks
   6.4. By March 31st 2024 no patients should wait more than 52 weeks.

7. The three standards relating to cancer are as follows:

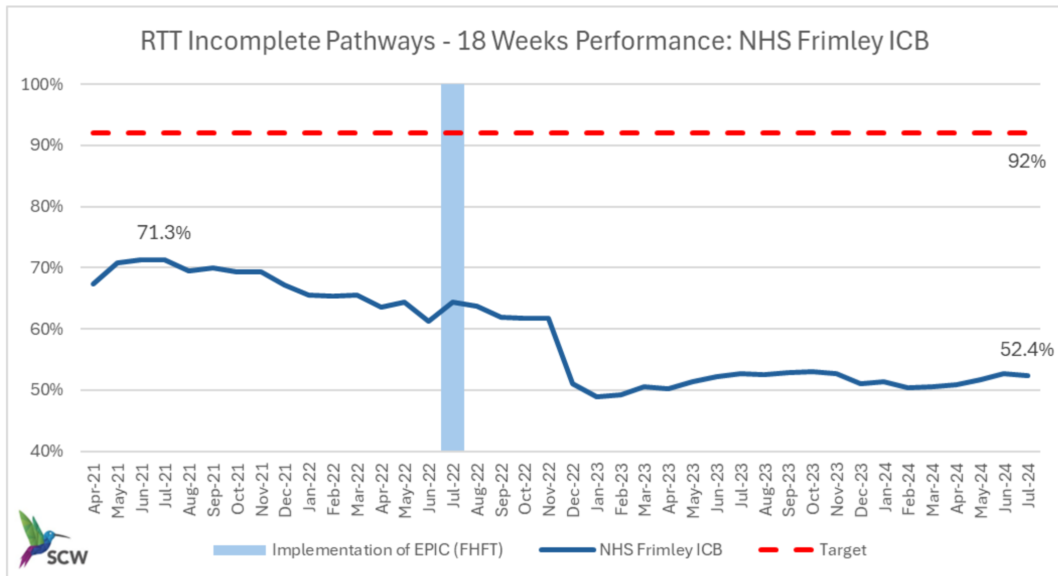
   7.1. Minimum of 77% of patients to receive their diagnosis or ruling out of cancer within 28 days of referral by March 25, moving to 80% by March 2026.
   7.2. Minimum of 96% of patients to commence treatment within 31 days of the decision to treat for all cancer patients
   7.3. There is a national ambition that 70% of patients will commence treatment within 62 days of their referral or consultant upgrade, with an ambition to increase this to 85%.

8. Ensuring there is sufficient diagnostic capacity to support both cancer and elective activity is recognised as a key contributing factor to a systems ability to reduce waiting times.

Current position

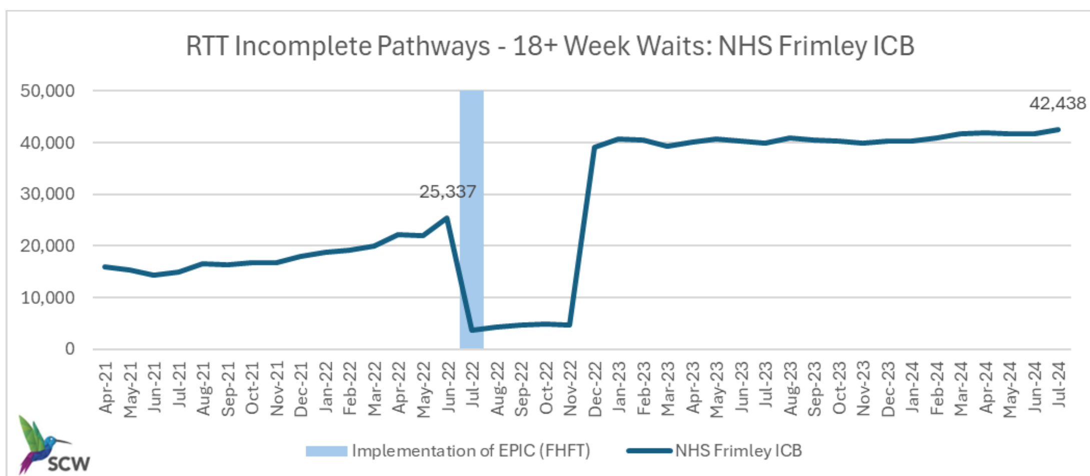
9. Restoring planned services equitably is a core principle of the NHS's elective recovery programme. Frimley ICS has continued to work closely with regional NHSE colleagues to reduce the volume of patients waiting for elective care.

10. There is a constitutional standard, often referred to as the 18-week or Referral-To-Treatment (RTT) target, where 92% of patients should be waiting no more than 18 weeks from referral to first consultant-led treatment. NHS Frimley ICB 18 weeks performance currently (Jul-24) sits at 52.4% (42,438 out of total waiting list 89,095). Performance has been improving since February-24.



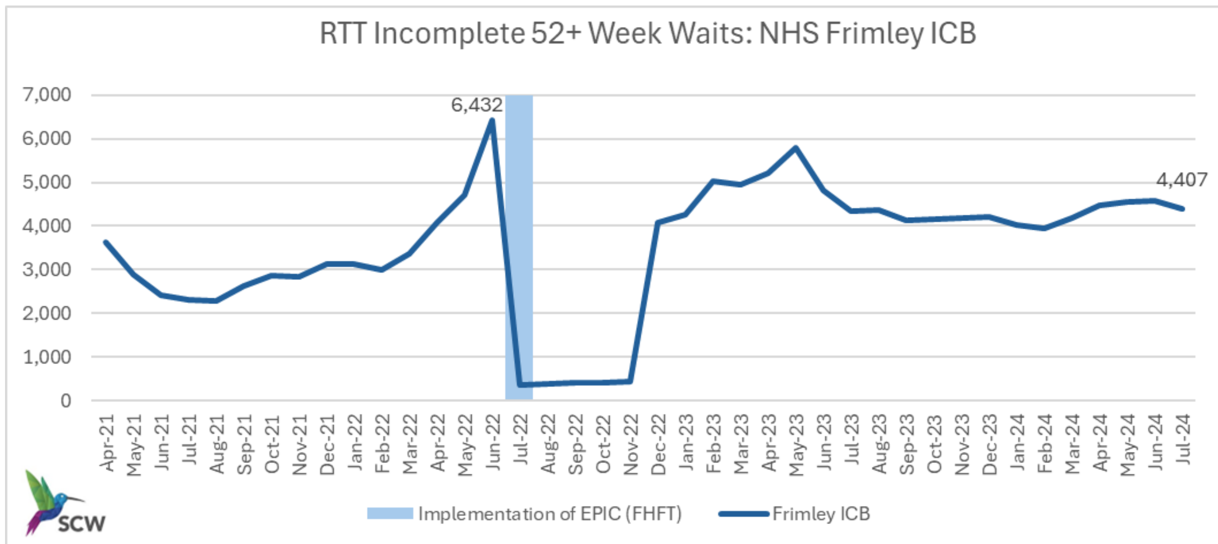
11. The following figures outline the long waiting patients and include all acute and independent sector providers with NHS Frimley ICB registered patients on their waiting list:

11.1. Patients waiting more than 18 weeks for treatment were 16,020 in April 2021. Numbers were on an upward trajectory prior to the implementation of the EPIC system at FHFT, increasing to 25,337 by June 2022. Some of this rise is due to data quality. The latest data (Jul-24) shows 42,438 patients waiting >18 weeks. Numbers over the previous months have been sitting around 40,000-mark month on month.

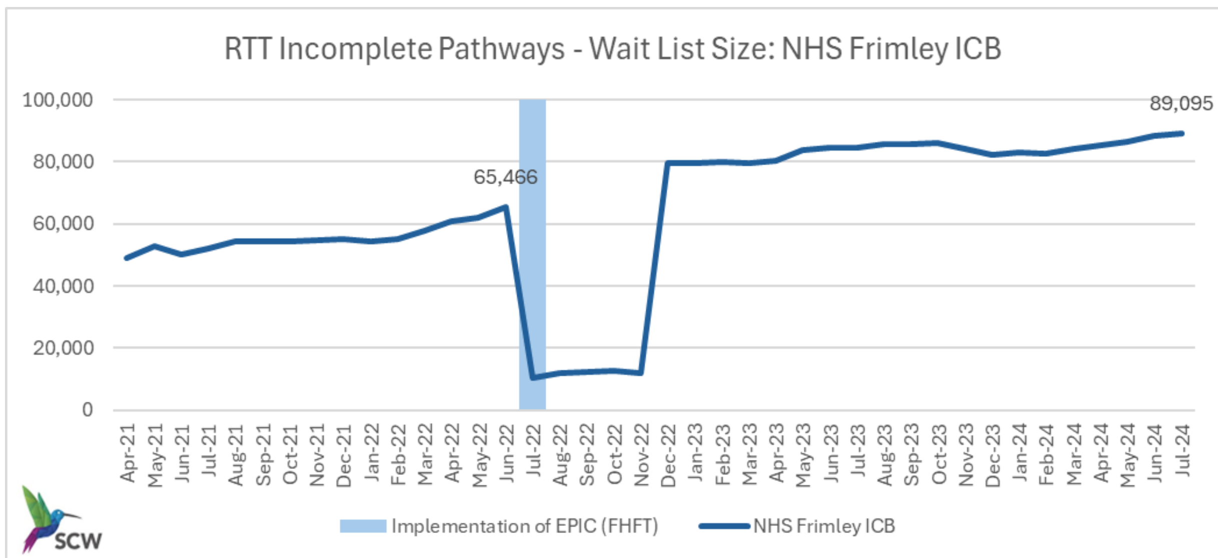


11.2. NHS Frimley ICB ranks 37th out of 42 system (Jul-24) for the percentage of waiting list over 52 weeks, with 4,407 patients (4.95% of wait list) currently waiting 52+ weeks.

11.3. In April 2021, 3,626 patients were waiting more than 52 weeks for treatment, increasing to its peak of 6,432 in May 2023. Numbers have continued to fluctuate since with the latest data (Jul-24) placing the patient count at 4,407.



12. From April-21, the Total Wait List were on an upward trajectory prior to the implementation of EPIC system at FHFT, placing at 65,466 in June 22. Post EPIC migration, the wait list increased to a peak of over 79,729 in December 2022, again some of this is due to data quality. The wait list size has increased over the last latest month 6 months to 89,095 (Jul-24).



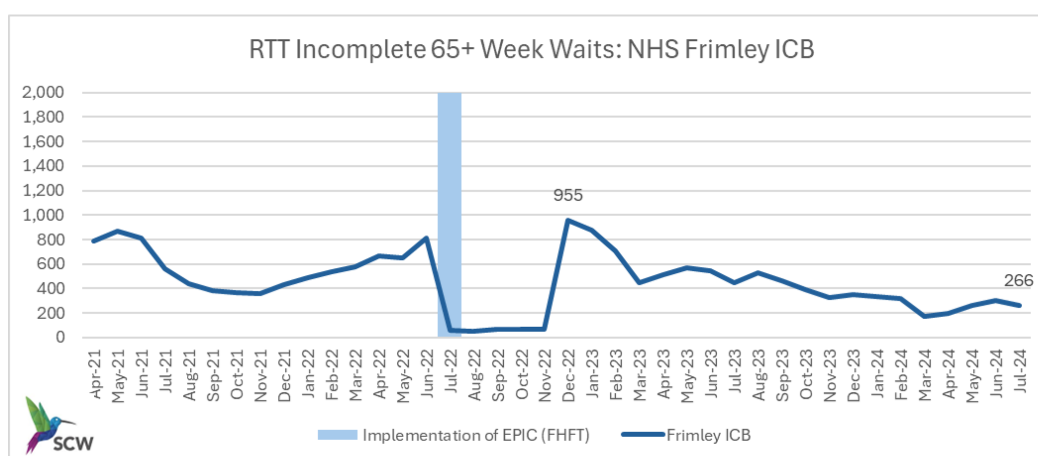
13. The eight specialties shown below make up around 60% of the total elective waiting list for Jul-24. These specialties tend to deliver a higher volume of routine procedures and therefore these patient groups can wait longer than those in other specialties. The specialties are T&O (Trauma and Orthopaedics), ENT (ear, nose and throat), Oral Surgery, Gynaecology, Ophthalmology, Cardiology and Urology. (The table below shows the Frimley ICB registered patients with provider breakdown, actual waiting list sizes will be larger as they will include non-Frimley ICB registered patients).

Treatment Function	RTT Incomplete Pathways: Jul-24					
	Frimley ICB					
	Total	FHFT	RSFT	RBFT	ASPH	Other
Trauma and Orthopaedic Service	**13,373**	11,932	229	133	128	951
Ear Nose and Throat Service	**9,043**	8,388	209	92	93	261
Oral Surgery Service	**6,535**	4,197	1,881	41	123	293
Gynaecology Service	**5,980**	5,389	114	79	126	272
Ophthalmology Service	**5,952**	4,134	74	1,144	67	533
Dermatology Service	**5,940**	5,352	--	33	178	377
Cardiology Service	**5,276**	4,462	94	109	64	547
Urology Service	**5,228**	4,816	96	66	43	207

14. During 2023/24 Frimley ICB has seen no patients who have waited over 104 weeks for their treatment.

15. There has been continued progress in reducing the number of patients waiting over 65 weeks and numbers have been a downward trajectory since May 2023. However, there remain a very small number, due to the impact of industrial action and patient choice.

16. The national target is that zero patients will have waited >65 weeks by the end of September 2024. Trusts have been making good progress in reducing these numbers since September 2023, however there are still c260 patients who need to be treated.



Quality & Safety

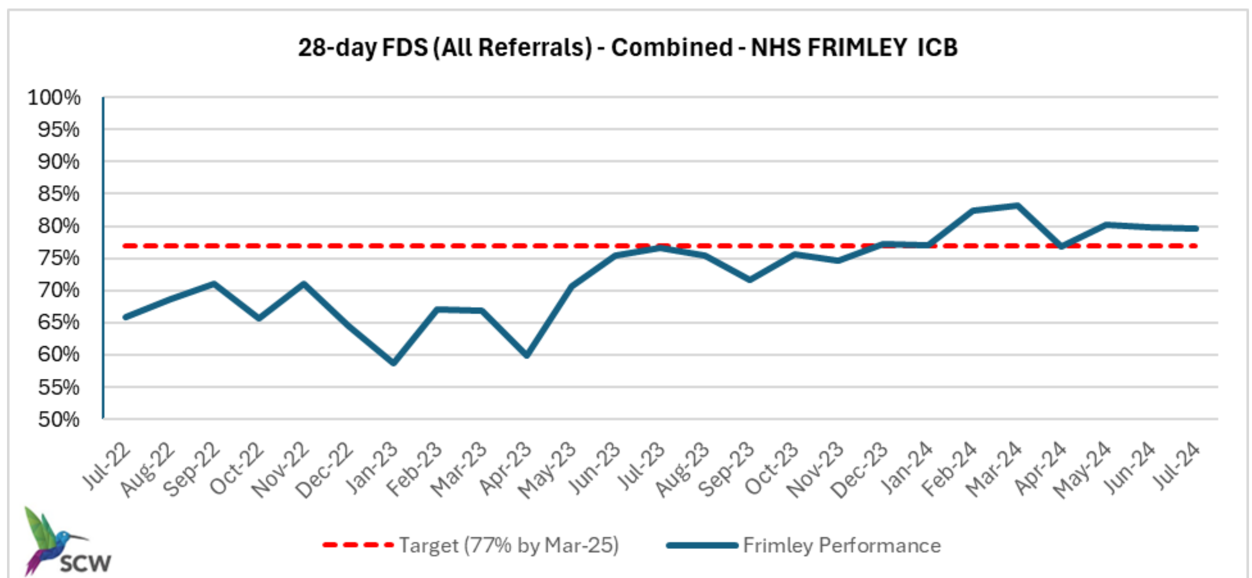
17. FHFT undertakes regular waiting list validation and is the highest provider in region for validation levels.

18. FHFT also undertake a clinical harm review for every cancer patient who waits longer than 104 days for treatment.

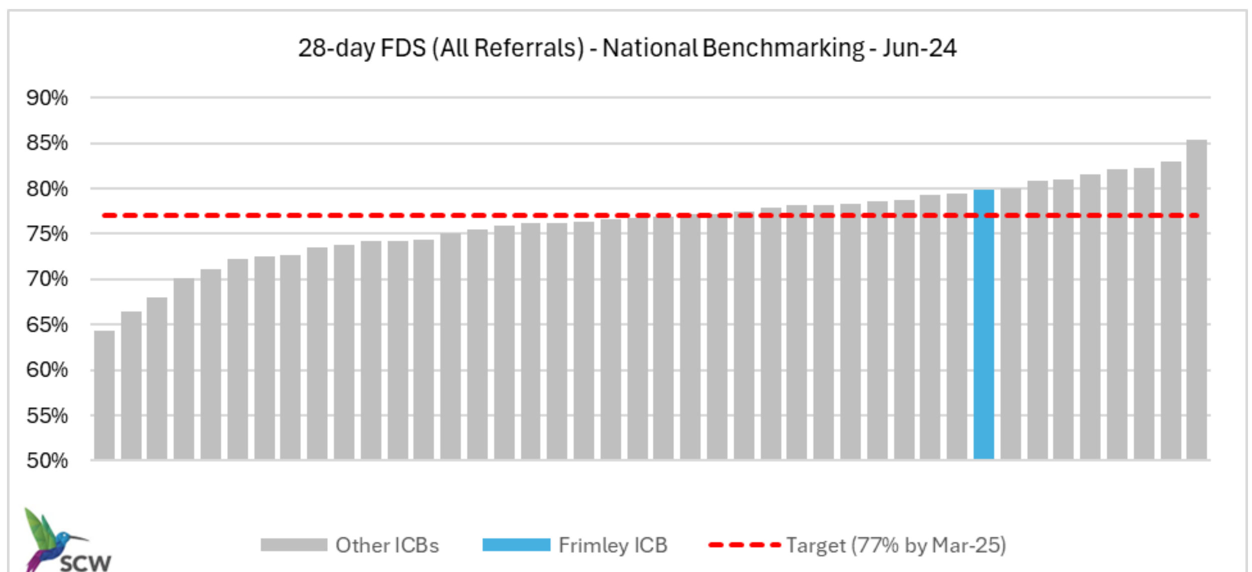
Cancer performance

19. Patients on a cancer pathway are one of our highest clinical priorities. All providers have placed significant effort into ensuring that patients are treated as soon as possible with support from the Surrey and Sussex Cancer Alliance.

20. The faster diagnosis standard requires a patient who has been referred with suspected cancer to have a diagnosis or ruling out of cancer by day 28 of a primary care referral. Frimley ICB have strong performance enabling the system to be one of the top performing systems in England, ranking 9th out of 42 for Jun-24. (11th in Jul-24) and exceeding the standard which is set at 75% for 24/25, (National Priority: *improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026* – (shown in the chart)).



June-24 Chart – rank 9th



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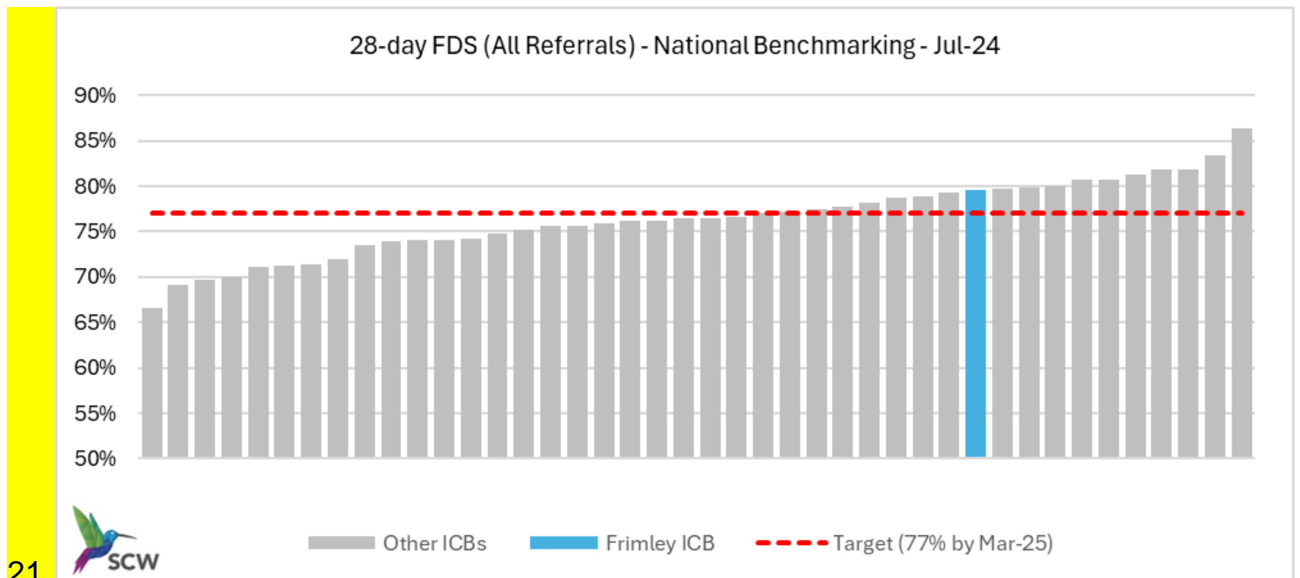
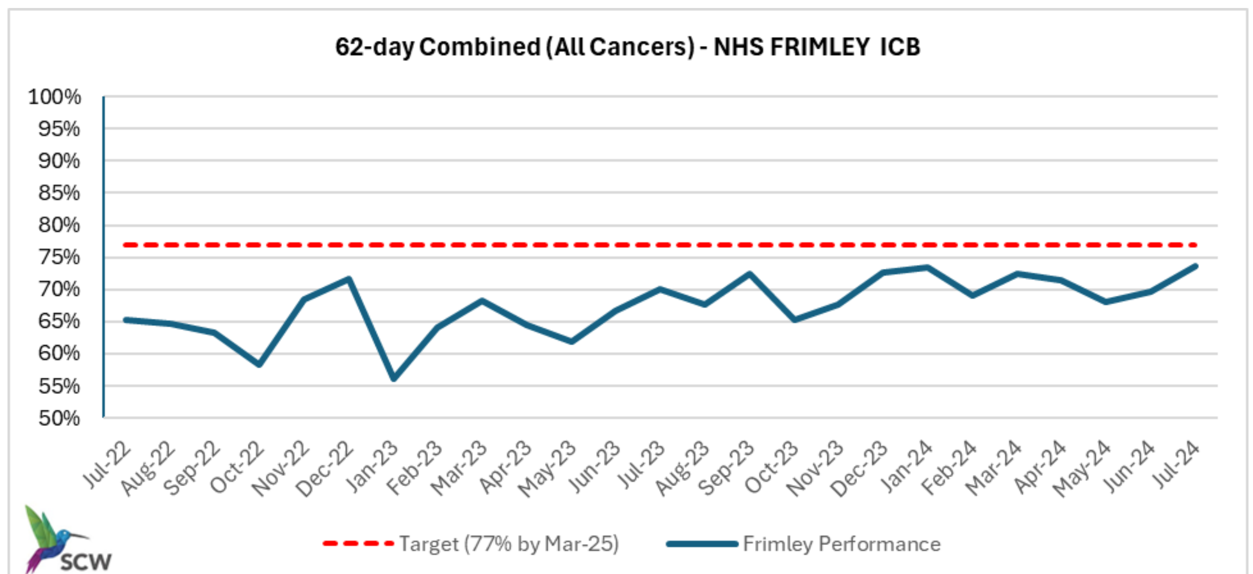
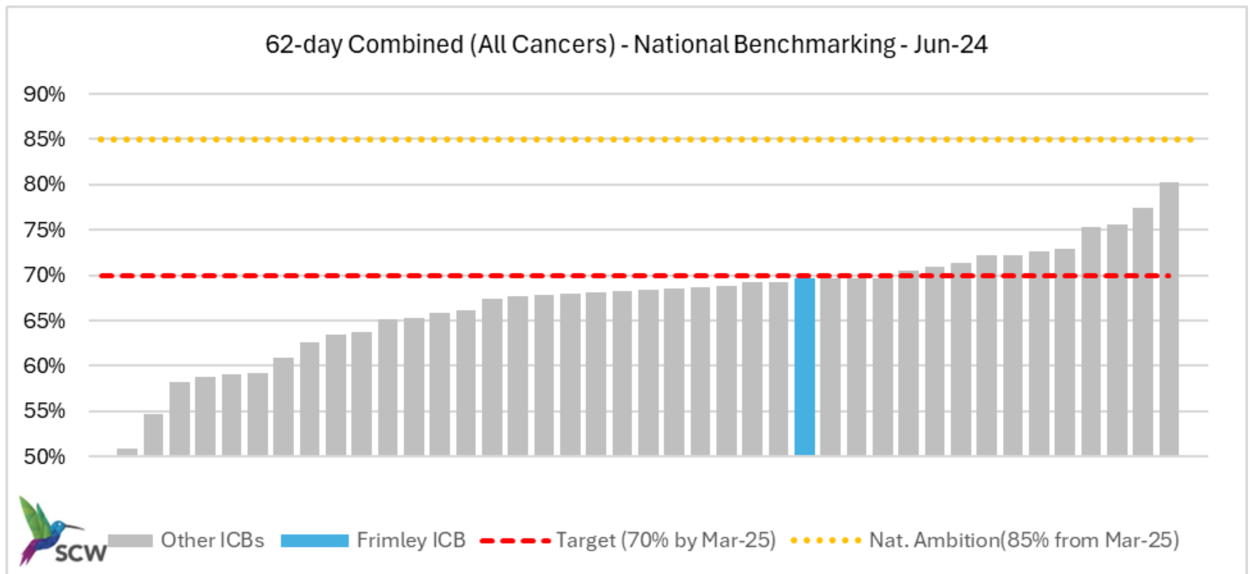
Jul-24 Chart – rank 11th



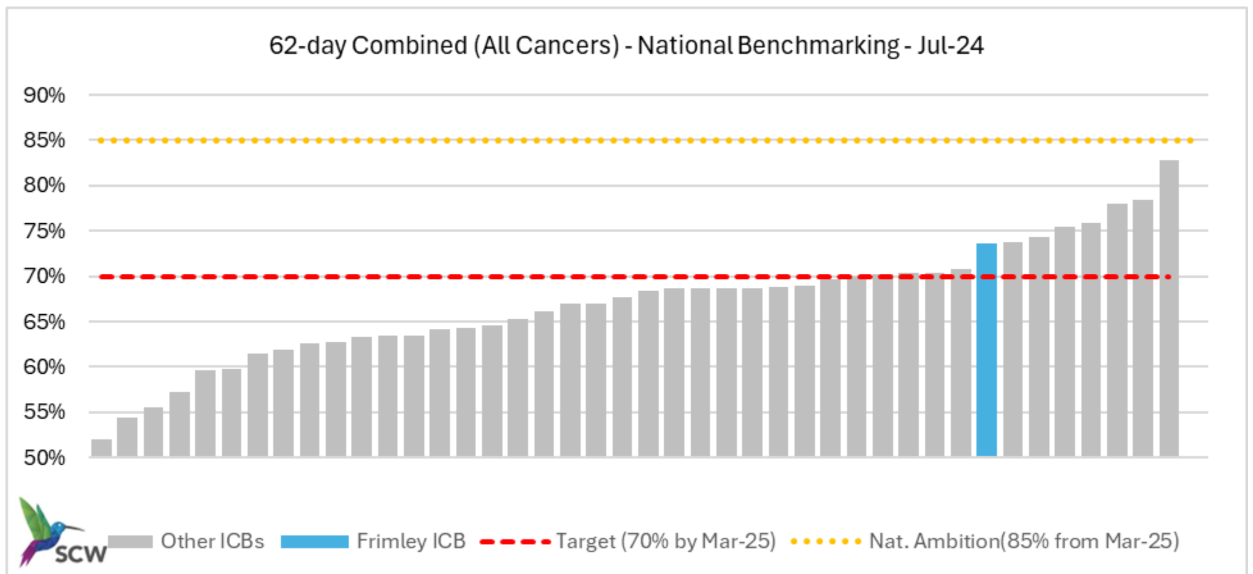
21. Frimley ICB ranks 15th out of 42 ICBs in England for the 62-day combined standard, achieving 70% in June, and 74% in July (ranking 8th out of 42). *(SH statement does not make current sense)*. Frimley ICB achieved the 70% ambition for Mar-24, achieving 72%.



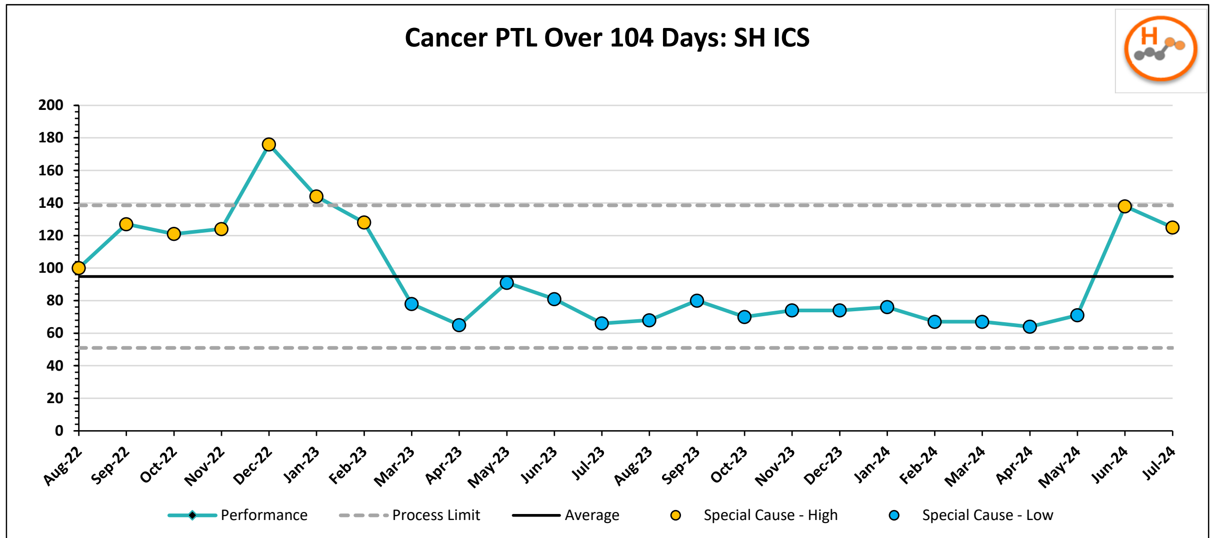
June 24 – Frimley Rank 15th (62 day waits)

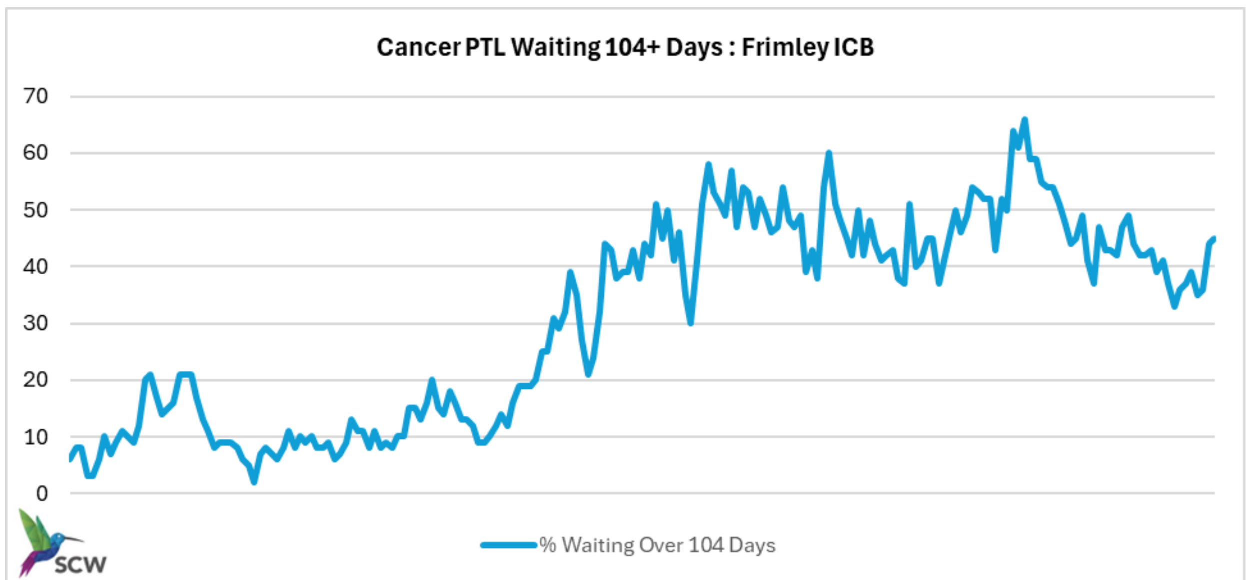


July 24 – Frimley Rank 8th (62 day waits)



22. Frimley ICB ranks 5th out of 42 systems for having the lowest proportion of wait list at more than 104 days for cancer treatment in England, as at 15th September 2024. (Frimley generally performs very well against this measure. Frimley ranks 4th out of 42 systems for the lowest proportion waiting over 62 days as well.





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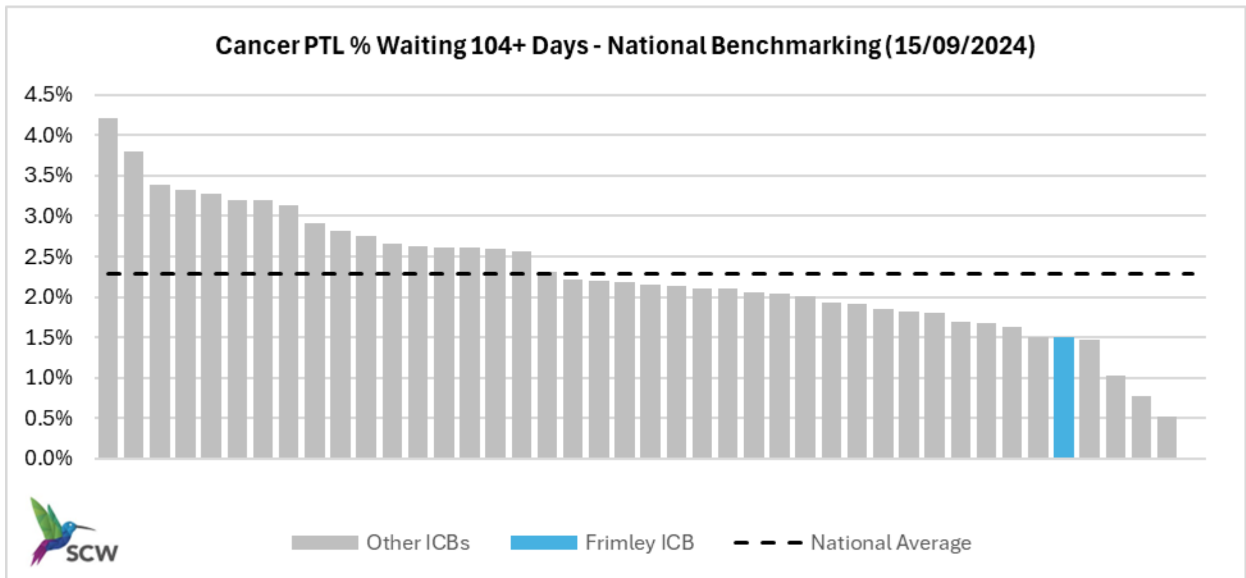
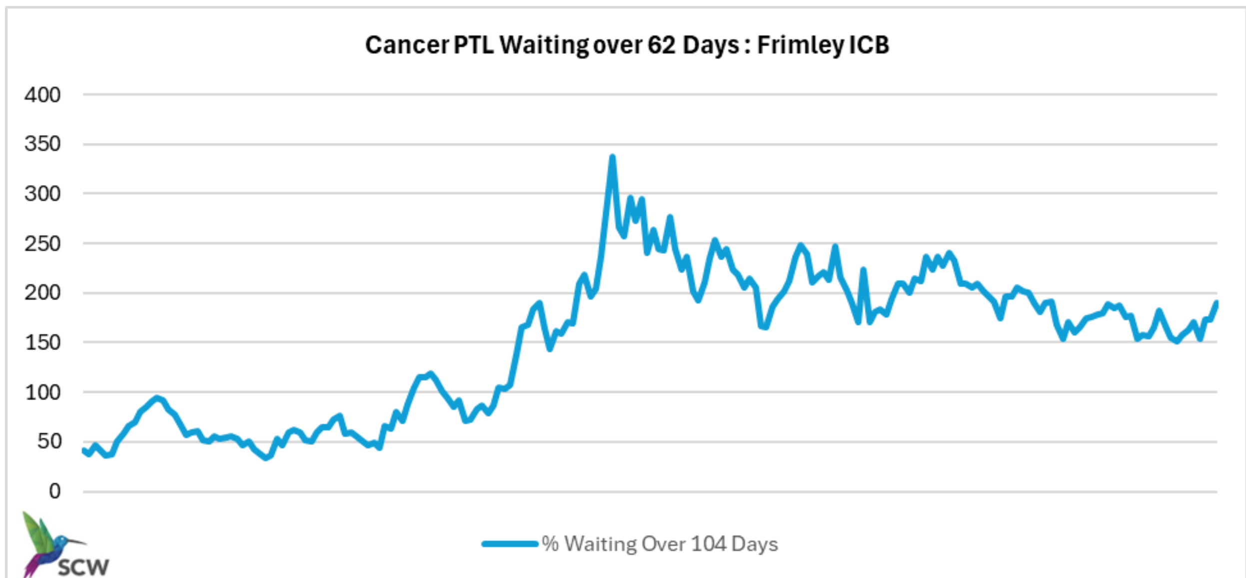
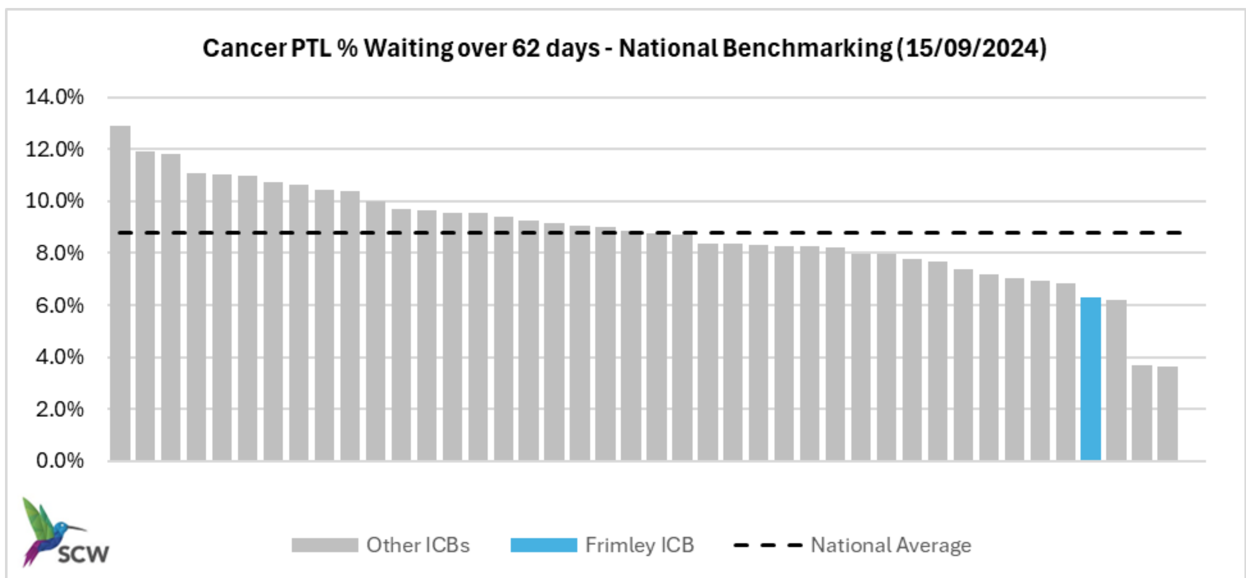
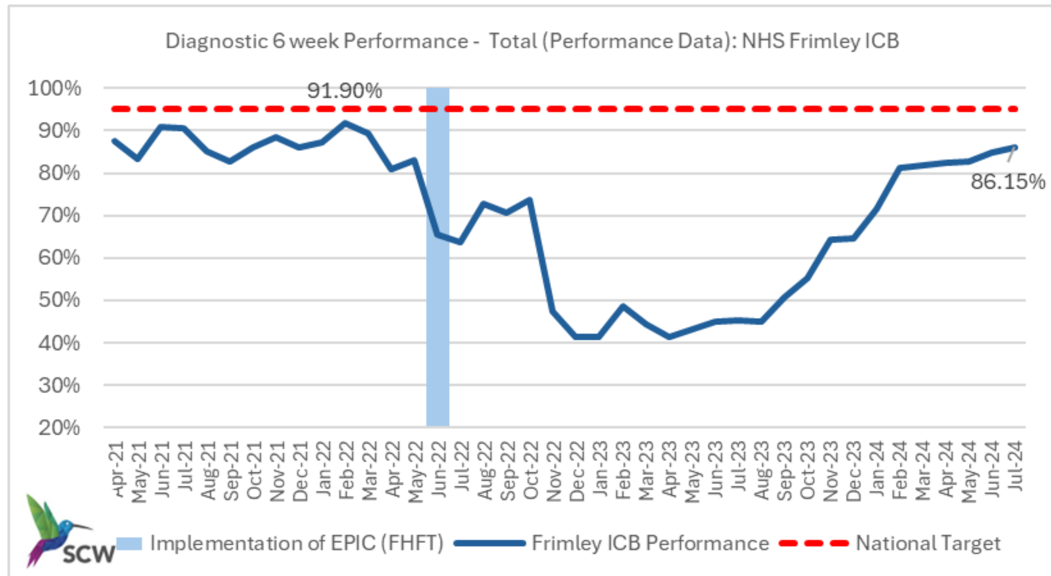


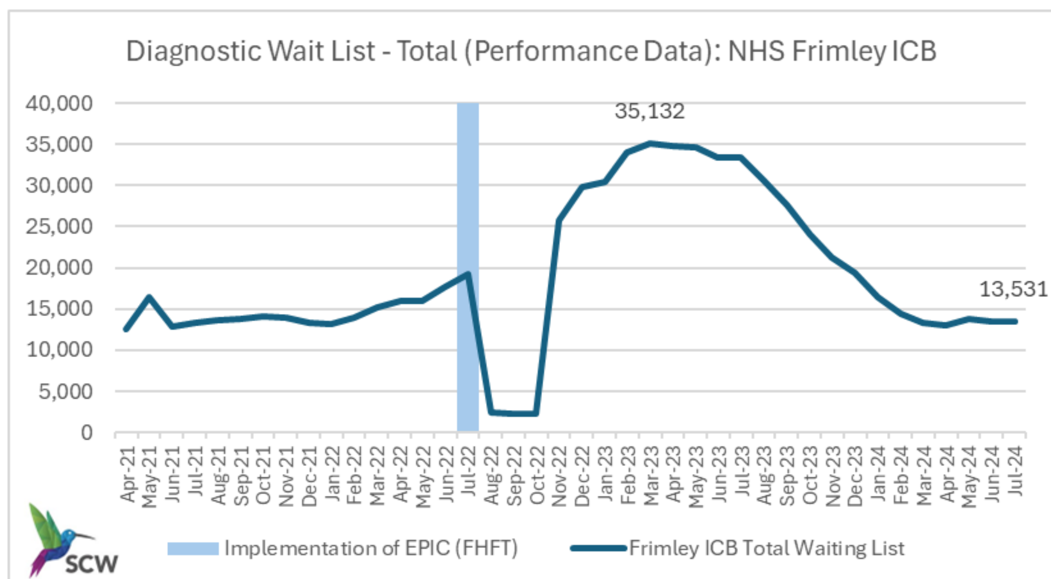


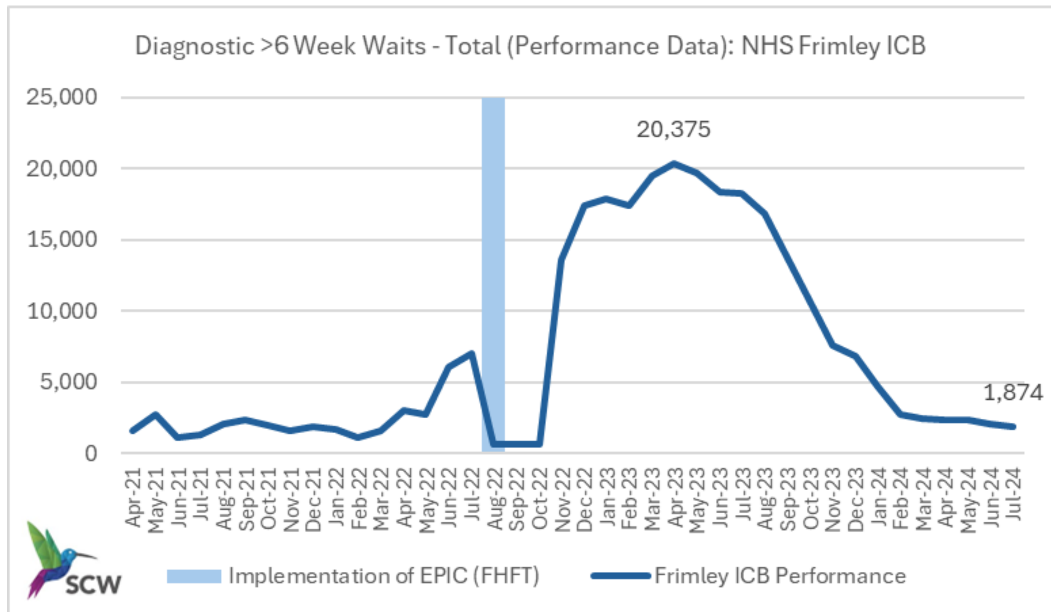


Diagnostic performance

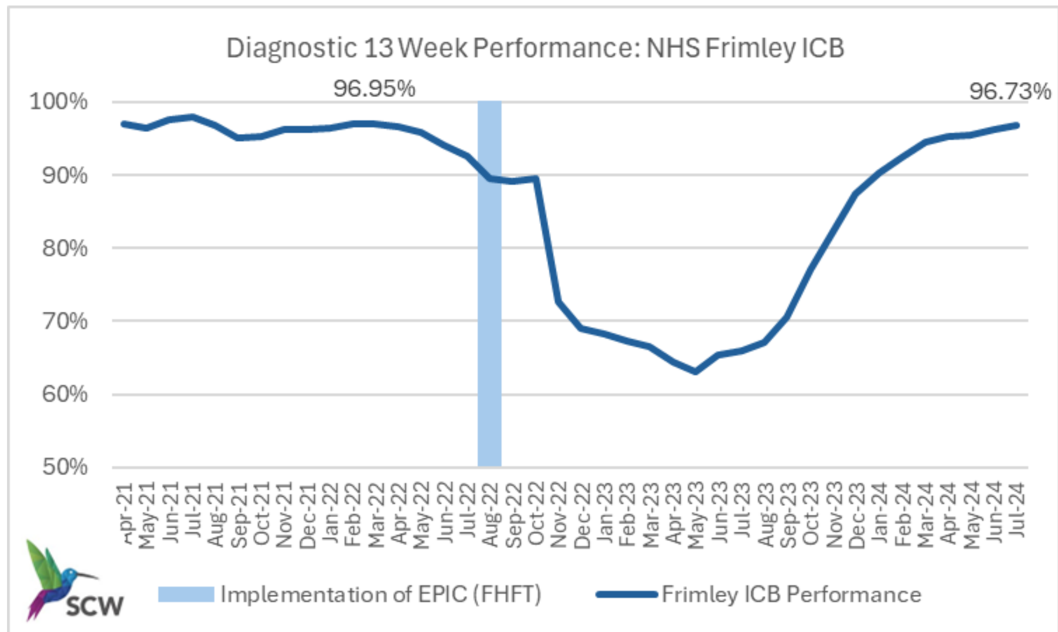
23. The national target for diagnostics is that by Mar-25, 95% of patients should be seen within 6 weeks of referral for their diagnostic test. Performance maintained around <85% pre-EPIC implementation and reduced to <41% in Jan 23. (This may be due to data quality issues). Performance has continued to improve month on month with the latest figures placing at 86% (Jul-24).

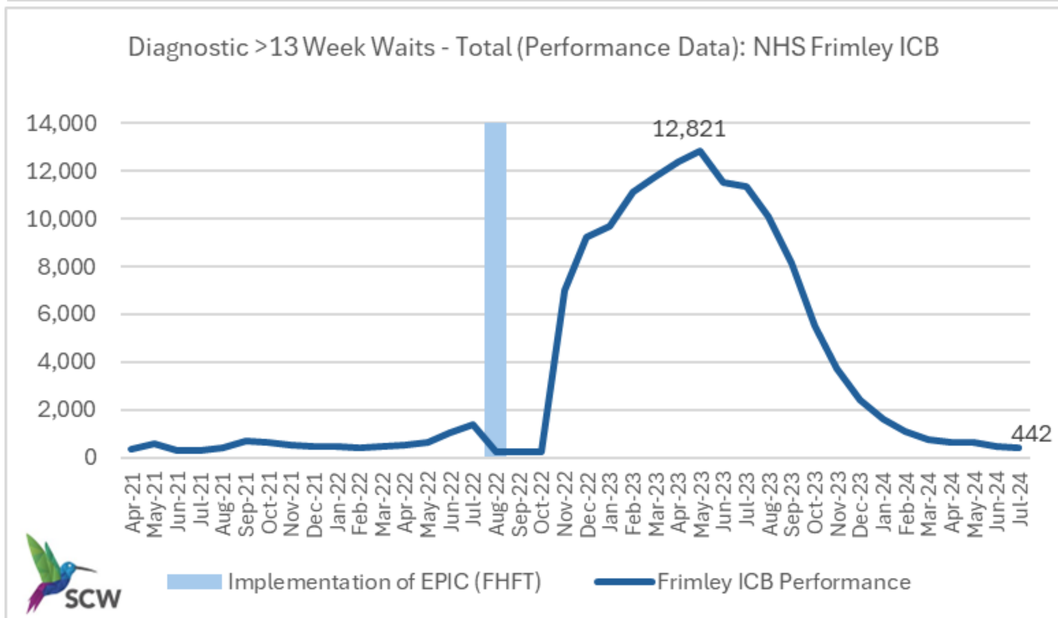




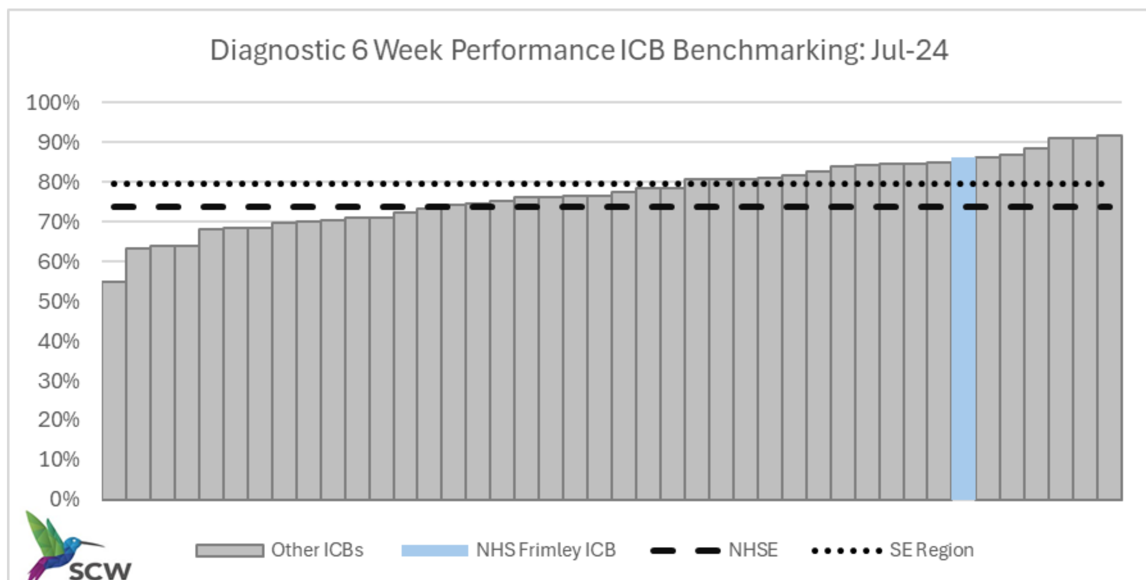


24. Pre-July 2022, on average each month, 3% of people on a diagnostic waiting list has been waiting more than 13 weeks. There was a significant increase from July 2022 to April 2023 where 13+ week waits peaked at 20,357 (35.5%). This was mainly due to data quality issues within the new EPIC system and industrial action. Numbers have now reduced to <500 patients waiting 13+ weeks as of July 2024 (3.2%).





25. NHS Frimley ICB is currently ranked 7th out of 42 systems for diagnostic 6-week performance in July 2024. Placing at 86.2% versus 91.6% for 1st place. July-2024's performance is also greater than both the SE Region (at 79.5% for July-2024) and the National Average of 73.6%.



Digital Innovation

26. FHFT introduced the EPIC EPR system in June 2022 and whilst this is still being embedded fully within the organisation, the initial feedback from trusts and patients has been very positive. As part of this new system there is a MyFrimley Health app which will enable patients to book appointments, review information on their condition and other functions that put the patient in the driving seat of their care.

27. FHFT continues to use virtual consultation software to enable patients to undergo meaningful consultations with a health professional without having to attend a face-to-face appointment.

Actions taken to address backlogs

28. Frimley ICS elective care team hold weekly meetings with trusts to review long waiters and provide support to help reduce this. In addition to this the ICS and Trust leadership teams meet with the regional NHSE team to share challenges and identify support and solutions.

29. FHFT undertake meetings weekly to review all long waiting and cancer patients, to ensure they are progressing their treatment as swiftly as possible and are fully sighted on any challenges associated with getting dates agreed.

30. FHFT continue to validate their patient lists so they are confident that they don't have any duplicates in the systems and pick up any errors in the way patients have been coded and rank first in region for validation levels.

31. FHFT has utilised the national DMAS (Digital mutual aid) system to facilitate transfer of appropriate patients to alternative providers where they can be treated safely in a shorter time period.

32. Mutual aid between sites within the Trust has taken place where required – typically utilising the Heatherwood site as our elective hub.

33. We continue to work closely with the Surrey and Sussex Cancer Alliance (SSCA) to support improvements in cancer care and maintain our excellent performance. To support improvements and focus for these, during 24/25, the SSCA will be developing and implementing tools to support early identification and escalation areas of challenge. This includes developing and implementing a technical statistical process escalation process, supporting Trust implementation of the Alliance optimal timed pathways and introducing a pathway analyser tool.

Conclusions:

34. Frimley ICS has made good progress in reducing their long-waiting patients across elective, cancer and diagnostic waiting lists. Whilst there remain some challenges, processes for review, escalation and support have been put in place.

Report contact:

Alex Stamp, Deputy COO – Planned Care, Frimley Health Foundation Trust

Contact details

Sources/background papers

Frimley ICB Planned Care reporting

Surrey & Sussex Cancer Alliance Cancer Performance Report

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ADULTS AND HEALTH SELECT COMMITTEE

Thursday 10 October 2024

Right Care, Right Person

Purpose of report:

Right Care, Right Person (RCRP) is a national Police led initiative that is an operational model developed by Humberside Police. A national partnership agreement was signed by NHS England, The Department for Health and Social Care and the National Police Chiefs Council.

Right Care Right Person is designed to change the way the emergency services respond to calls involving concerns about mental health.

This paper sets out the arrangements in place between the health and social care sectors and Surrey Police in response to the roll out of RCRP in Surrey.

Introduction:

1. Right Care, Right Person is a Police policy that is being implemented nationally. It provides a framework for assisting police with decision-making about when they should be involved in responding to reported incidents involving people with mental health needs.

2. RCRP was developed in Humberside following analysis by the Police force that they were being deployed to a high number of incidents that were concerned with welfare, mental health concerns or missing persons, including from hospital. The force was concerned that by attending these incidents, they were not providing the most suitable intervention to vulnerable members of the public who required specialist support. This was putting both the public and their officers at more risk. It also meant they were not responding to the public in the most effective manner. Humberside Police made the conscious decision to go back to basics and concentrate on the core policing duties. Originally developed by Humberside Police, this model is now being implemented across England, signifying a collaborative approach between police forces, health providers, and the Government

3. The RCRP initiative represents a transformative approach to managing emergency responses related to mental health concerns, vulnerable people, and welfare concerns. With successful deployment in several services, the initiative is for the responsibility of first response to transition from the police to the most appropriate agency, thereby optimising outcomes, alleviating the demand for

services, and ensuring the delivery of appropriate care by the designated provider.

4. The national partnership agreement was signed by NHS England, The Department for Health and Social Care and the National Police Chiefs Council. The National Toolkit was published in April 2023 and applies to the following areas:
    - Requests for Welfare Checks
    - Walk outs from Health Care Facilities
    - Absent Without Leave (AWOL) from a mental health establishment
    - Voluntary Attenders at a Healthcare facility
    - Section 136 Mental Health Act
    - Transportation of mental health patients

5. Police forces are operationally independent but are expected to work with a wide range of partner agencies to implement the principles of RCRP. Surrey Police has led the work in Surrey.

6. RCRP does not impede the police force from fulfilling its paramount duty of safeguarding individuals. In situations where there is an immediate and tangible risk to life or the potential for serious harm, be it self-harm or harm to others, police officers will continue to respond promptly, upholding their crucial role in ensuring public safety

7. RCRP considerations are only applied to calls for service relating to adults and not to calls regarding children under 18. If a call for service for an adult could be assessed under RCRP and a child is present, RCRP is not applied and there is an expectation of police deployment.

8. There has been no additional resource allocated for the implementation of RCRP locally or nationally.

Right Care Right Person' (RCRP) model

9. The 'RCRP model is a process used alongside other nationally embedded operating models such as THRIVE (threat, harm, risk, investigation, vulnerability, engagement) and the National Decision Model (NDM). These are used to triage incoming calls into the Force Contact Centre and to decide on an appropriate course of action (such as whether to deploy police resources to the incident).

10. The Police may have legal duty to act in the following scenarios:

    - Article 2 European Convention of Human Rights (ECHR)
    - Article 3 ECHR

- Police assumed responsibility or Police created risk
- Core policing duties to Protect Life & Property, Preserve Order, Prevent the Commission of Offences and Bring Offenders to Justice
- Protect other Emergency Services from identified risk.

11. If there is a real and immediate threat to life the Police will not apply the RCRP toolkit and will deploy as normal practice.

12. RCRP works by the call taker in the force control room assessing the circumstances using the RCRP toolkit, alongside existing tools THRIVE and the national decision model to triage calls. The call handler ensures that reasonable steps are taken to obtain information or check information to which they had access. Once they have applied the toolkits the call handler will decide whether the police should attend the call for service or whether another agency is better trained, equipped, and experienced to do so.

13. If the referrer is not happy with the decision, they are able to appeal or escalate the matter immediately and this will be dealt with whilst the caller is still on the line in fast time. If a non-deployment is challenged, the agreed Police and agency escalation process is activated. A well-defined escalation process has also been established for both the Ambulance Emergency Operations Centre (EOC) and frontline operational colleagues. This activity aims to minimise communication delays in cases where an incident is identified as unsuitable for an ambulance response or necessitates a joint operational intervention. The objective is to establish a streamlined and efficient protocol for incident handovers, ensuring timely and effective coordination.

Governance Structure

14. RCRP is Police led with multi-agency partnership representation by the following:

- 5 Acute Hospitals
- Surrey and Borders Partnership NHS Foundation Trust
- South East Coast Ambulance Service (SECAmb)
- Surrey Fire & Rescue Service
- Surrey County Council Adults, Wellbeing and Health Partnerships
- Surrey County Council Children’s Services
- Third Sector / Voluntary Community, Faith & Social & Enterprise (VCSE)
- Primary Care
- Surrey Heartlands and Frimley Health Integrated Care Boards

The partnership operates through bronze, silver and gold structures originally set up by Surrey Police and attended by partner agencies.

15. The Gold Strategic Board is chaired by the Senior Responsible Officer T/ACC and the co-chaired with the chair of Surrey Heartlands ICB. Its role is to oversee the implementation of Right Care, Right Person in the county of Surrey. The

Quarterly Gold Strategic Meetings have been in place since 22nd September 2023.

16. The Silver Tactical group is chaired by a Superintendent from Surrey Police and meets fortnightly. This group is responsible for the planning and implementation of the core strands of RCRP within Surrey. This meeting looks at the risks, capacity issues and readiness for RCRP. This meeting has been in place since 12th October 2023.

17. The fortnightly Bronze incident review meeting is operationally focussed and meets to review case studies and scenarios to understand any capacity and capability gaps and risks. This is attended by all partner agencies and issues are fed into the Silver Tactical meetings. This has been in place since 12th December 2023.

18. The governance structure remains in place to support the implementation of Phase 2 and monitor data and impact from Phase 1. Cases continue to be reviewed at the Bronze meeting and discussed at the Silver Tactical meetings.

19. At the National RCRP meeting, it was clarified that there are no current agreed national data requirements from each force regarding RCRP implementation. The national team agreed to scope out the national requirements for a Post-Implementation Review. In Surrey there is a review process managed in bronze and silver meetings – and there are plans for a 6 month post-implementation review to be undertaken.

Implementation

20. The implementation of the 6 strands RCRP is divided over two phases in Surrey.

21. Phase 1 went live on 22nd April 2024 for the following areas:

- Welfare:
    - These are calls where a general concern is raised about a person and the police have been asked to check on them.
- Absent Without Leave (AWOL) from a Mental Health Establishment**:**
    - A patient has been detained under the Mental Health Act leaves a mental health facility without proper authorisation of permission. This could be absenting self without leave, failing to return from leave or absenting themselves from a place they are required to reside.
- Walkouts of Health Care Facilities, including abandoning medical care or treatment:
    - This relates to people who have walked out of any healthcare setting. This may include general hospitals, emergency departments (ED), GP surgeries,

community services, and mental health services, when not held under a power for physical or mental health related issues.

22. To support partners Surrey Police:

- Shared their RCRP Policy, call handler scripts, escalation flowcharts, procedures and the Police Equality Impact Assessment with the partners.
- Held a training session for partners based on the training for internal police call handlers. This enabled partners to develop their own guidance and training for staff ensuring consistency in the approach.
- Developed a communication strategy which included input from partner communications teams.
- Led a readiness assessment at the Silver Tactical Board for Phase 1 prior to the go live date.

23. Phase 2: this work is currently in progress and comprises 2 main areas of focus:

24. The first area is Section 136 Mental Health Act (and associated transport provision). This is a power allowing police to detain someone to a place of safety, excluding when the person is in a private dwelling, if they appear to be in mental health crisis and are in immediate need of care or control. There is a multi-Agency group in place reviewing all policies and the practice. The focus of this work currently is to optimise our abilities to work together within current resources. An important part of this work is a multi-Agency (SABP/SECAmb and Surrey Police) review of s136 detentions (including body worn camera footage) to look at how we can support people in a mental health crisis as effectively as possible.

25. Although outside of the direct scope of RCRP there is also some complementary work looking at people who frequently come to the attention of emergency services or Emergency Departments who have mental health needs.

26. The second area is a safe handover process for voluntary attendees (mental health). This is creating an agreed process if Surrey Police are taking a person to a hospital for medical treatment or a mental health assessment when they are not detained under any legal section or under arrest

27. A policy and procedure has been created for voluntary attendees which will be incorporated into Surrey Police's RCRP Policy. This primarily relates to acute hospitals but can be used in other healthcare settings – and is due to launch in September 2024.

South East Coast Ambulance Service (SECAmb) Planning and Preparedness

28. SECAmb has maintained a strong collaborative approach to working with partners, particularly the Police and ensured attendance at key meetings across the three systems. This high level of engagement will be maintained until all phases of RCRP have been fully implemented and the programme transitions to ‘business as usual’
29. SECAmb put in place a Trust wide communications plan to ensure all staff are aware of the changes in Police practice and the escalation process, where needed was fully socialised. Additionally, the Trust has continued to roll out Face to Face ‘Conflict Resolution Training’ (CRT) for all frontline staff to support in the ability to evaluate threat and then apply appropriate safety measures, including how to communicate with highly emotional, mentally impaired, and deliberately difficult individuals. The training also includes breakaway techniques.

30. End-to-end reviews have been conducted for cases where the appropriate responding agency was not initially identified, potentially leaving a vulnerable person without the care they needed. Although these instances have been minimal, the lessons learned have been shared

Integrated Care Boards (ICB) Planning and Preparedness

31. Surrey Heartlands ICB has, together with partners, held additional meetings outside of the Bronze, Silver, Structure with the Police regarding meeting existing demand.

32. The ICB hold stakeholder meetings to gain a broader perspective on the RCRP work. These include sessions with other systems so that we can learn from their experiences and responses to RCRP. The ICB further plans to use the existing (but reformulated) Crisis Care Concordat meetings to support crisis and urgent care planning strategically.

33. The ICB has reviewed its UEC pathway and is monitoring demand through the Single Point of Access (SPA) and added that to our risk log. Demand has increased but it is currently believed this is being principally driven not by RCRP but by the introduction of Option 2 for Mental Health in 111 calls. The ICB have supported the ongoing work between Surrey Police, SECAmb and SABP to make increased use of the professionals telephone line into the SABP SPA. This has helped Agencies to work together and provide effective support to people in a mental health crisis in line with the RCRP principles.

34. The ICB are reviewing the models of the Safe Havens, funding Safe Harbours (which are mobilising now) and together, with partners (including Police), are facilitating comms and engagement around these alternatives to Emergency Departments to ensure they are understood and used by the Police. The ICB is also developing in year investment proposals to reduce bed demand and provide

resilience in the system, primarily by targeting high intensity users and extending an existing service to increase its capacity and scope. The ICB is currently testing the case for additional non-blue-light Mental Health Response Vehicles (MHRVs).

Adults, Wellbeing and Health Partnerships Planning and Preparedness

35. To support Surrey Police and partners with the implementation of RCRP adult social care staff attend all levels of governance meetings alongside Public Health and Surrey Fire and Rescue colleagues.

36. An internal task and finish group was set up and met to develop staff guidance and awareness sessions for staff. This group included mental health staff, children's services, SFRS, Public Health, SCC Legal team, Communications team and the Information and Advice team.

37. The SCC task and finish group met with the SABP internal working group to share risks and guidance and further meetings were held with health colleagues ensure that all risks are understood and mitigated.

38. Pre-go live six RCRP awareness sessions were held with attendance from approximately 1000 staff members. A guidance document for staff is in place for all staff, this includes the escalation process both in and out of hours. There is also a dedicated email address for staff in case of any specific RCRP queries.

39. A risk assessment has been completed and shared with the Corporate Resilience Group and Corporate Leadership Team and an Equality Impact Assessment has also been completed and published.

Surrey & Borders Partnership Trust (SABPT) Planning & Preparedness

40. SABP have had a diverse range of participants in the bronze, silver and gold meetings. The Consultant nurse for Crisis Care has supported case reviews and system learning for a number of Agencies. Existing meetings were also used to enhance the SABP interface with Surrey Police. Arrangements were also made to use an existing internal SABP email to monitor any impact from the launch of RCRP by Surrey Police.

41. SABP developed internal guidelines (following the information helpfully shared by Surrey Police) and these are available to all staff on the website. These have

also been shared with other partners within Surrey Heartlands and Frimley Health to aid the formulation of their own internal guidance.

42. Awareness sessions were held online to talk about RCRP and the Surrey approach and detail the SABP Guidelines. Presentations also took place within key meetings to ensure SABP were prepared for the launch of Phase 1.

Data

1. Data provided by Surrey Police has highlighted in the first 13 weeks of phases one and two, there were 4,233 RCRP related calls. Of these 1,562 did not meet the criteria for a police response (1440 welfare, 26 AWOL, 96 walkout). The 37% police non-deployments has remained consistent across the initial phases and phases three and four will also be going live in September.

2. Non-deployments redirected to SECAmb (direct calls from police) for weeks 1-13 totalled 495, representing 30% of the non-deployments. Thus far, this has not proven to represent a noticeably increase in police activity being redirected to ambulance and the escalation process followed has proven supportive in providing discussion where alternate agency attendances are warranted. For those where advice was given to the caller to contact an alternative service including ambulance the total is 135.

3. The monthly Association of Ambulance Chief Executives meeting brings together ambulance service representation from across the United Kingdom to discuss the implementation of RCRP. Feedback is given by each representative. All services have indicated difficulty in measuring the impact of RCRP on their service. This is primarily due to an overall increase in activity prior to and post the respective police forces implementing some or all the phases of RCRP.

4. London Ambulance Service has been able to evidence an increase in welfare calls but acknowledges the difficulty in fully attributing this to RCRP due to the multiple routes into their service. SECAmb is monitoring the increase in 'Concern for Welfare' call activity (excluding redirected activity from police) and preliminary analysis concurs with several other ambulance services who have also noted an increase in these types of calls, coinciding with the implementation of phase one (welfare). Further analysis is required to fully understand the SECAmb increase noted and identify the associated drivers.

5. SECAmb continues to monitor calls from the police which fall under RCRP and to date there are not concerns that the police are referring inappropriately, and a sampling of the incidents received showed appropriate referral for an ambulance response. Monthly reviews of DATIX (an online system for all staff to report any incidents and risks) relating to RCRP have been conducted and only a small number of cases have been noted. A recurring theme is that when crews encounter a patient with a 'history marker' for mental health concerns including

violence or aggression, they are anticipating a police presence prior to making contact with the patient. Police are not responding as this is a perceived risk and not an actual event. However, police have assured the Trust that if a crew are experiencing violence or aggression then they will respond.

Conclusions:

6. There has been a strong partnership approach to supporting the Police implementation RCRP. The Police report that there has been a low level of escalations which could indicate a good level of understanding of RCRP through training and guidance.

   The demand on mental health services remains high, at this stage it is not possible to identify if the implementation of RCRP has increased this pressure on partners.

7. The partnership will continue to monitor and review Phase 1.

8. The implementation of Phase 2 is underway and may present more challenges around the use of S136 of the mental health act.

9. It is understood that there was investment in Humberside as part of their initial work. Although the Humberside principles translated into the national RCRP initiative there has been no national funding for RCRP implementation. The lack of dedicated resource means that some potential improvements discussed in Surrey cannot be progressed.

Recommendations:

10. Each organisation to ensure that a mandatory training programme staff is in place for all relevant staff.

11. Records of attendance should be kept and monitored to ensure all relevant staff have undertaken the training.

Next steps:

Identify future actions and dates.

Report contact

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Adults Wellbeing and Health Partnership, Surrey County Council

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Surrey Heartlands ICB

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Sources/background papers

[List of all documents used in compiling the report, for example previous reports/minutes, letters, legislation, etc.]

ADULTS AND HEALTH SELECT COMMITTEE

Thursday 10 October 2024

Mental Health Improvement Plan – Focus on working age adults

Purpose of report:

1. This report has been prepared for the Adults and Health Select Committee. It reviews the number of people of working age in Surrey who are not working because of mental health issues. It will explore the issues that have led to this and how these issues can be addressed to deliver improvements for Surrey residents, especially those who experience the poorest health outcomes within the 21 Health and Wellbeing Strategy Key Neighbourhoods.

2. It reviews current data to ensure that the most urgent mental health needs are identified and sets out what is being delivered to support those who are some of the most vulnerable people within the community. This is to ensure a greater focus on reducing health inequalities, so no-one is left behind.

Introduction:

3. This paper has been produced by Surrey County Council Public Health and Communities team, with input from colleagues within Adults, Wellbeing and Health Partnerships, Surrey Heartlands Integrated Care Board and Surrey and Borders Partnership (SABP) NHS Foundation Trust. This paper will first offer relevant context with the national policy and research direction, particularly on how “early intervention and addressing the wider determinants of mental ill-health can prevent serious mental illness and economic inactivity” (OHID/ NHSE South East, 2024).

4. The paper will then provide specific insights on employment, challenges and where the gaps are, drawing on Surrey mental health service data and relevant current developments, alongside Public Health and wider programmes and other preventative interventions and support.

5. The emerging ‘One System, One Plan’ approach to mental health in Surrey Heartlands and its relevant priorities will then be set out as the key local framework, which includes alignment with an all age and place-based approach to developing a ‘Mental Health System for Population Health Gain’

being developed in Public Health and Communities, with Places and other partners.

6. Surrey County Council have been awarded £6.2m by DWP to support those with mental health challenges from leaving paid employment.

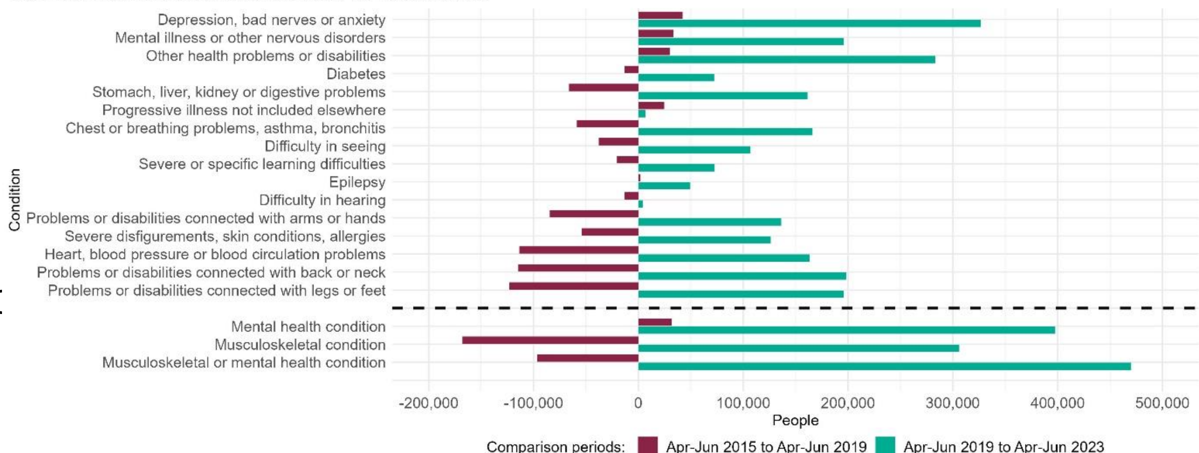
The national policy and research context:

7. It is recognised nationally that there has been a concerning rise in economic inactivity due to long-term sickness (Office for Health Improvement & Disparities OHID & NHSE South East).

8. The number of people out of the labour market due to ill health is at an all-time high and in-work ill health is rising. The Office for Budget Responsibility estimates that this rise in working-age economic inactivity and worsening health has already added £15.7bn to annual borrowing since the pandemic (The Health Foundation, 2024).

9. This matters not only because of the fiscal consequences but because ill health affects the quality of people's lives and because time spent out of work affects future employment and pay. In turn, a reduced standard of living can lead to deteriorating health. The relationship between health and work thus runs in two directions: work – of sufficient quality – has a positive impact on health, while good health enables people to participate in the workforce (The Health Foundation, 2024).

10. This rise includes a range of different categories and at national level this is seen to be largely due to increase in mental health and musculoskeletal conditions between 2019 – 2023 in the UK. The proportion due to long-term sickness has generally increased since 2019, reaching 24.3% in December 2023 (Annual Population Health Survey) and Surrey data also shows a similar rising trend (see point 22 below for Surrey). Data on the different elements defined within "long term sickness" is only available at the national level. The national breakdown and comparative increase are provided below to give an indication of proportion.



11. In 2022/23, work-related stress, depression, or anxiety led to the loss of approximately 17.1 million working days, accounting for over half of all working days lost to work-related ill health (HSE, 2024).

12. People in receipt of long-term support for a learning disability (16-64) and those in contact with secondary mental health services (aged 18 to 69) –who are also on the Care Plan Approach – experience proportionately higher levels of unemployment compared to the national unemployment rate (DHSC).

13. Men and women with lower economic status are more likely to report loneliness, social isolation, and lack of social support (Kung et al, 2022). The over 50s with poorest economic status are more likely to experience decreased enjoyment of life and increased loneliness (Bridson et al, 2024).

14. Studies show for people of working age there is a 40 percent increase in likelihood of reporting loneliness when unemployed. The severity of loneliness for people who are unemployed peaks at the ages of 30-34 and 50-59. Not only is loneliness more likely to be experienced following job loss but loneliness is also shown to be predictive of unemployment ‘suggesting potential bidirectionality in the relationship’ (Morrish et al, 2021).

15. Evidence suggests a need to tackle loneliness to address unemployment. ‘Reducing isolation and loneliness’ and ‘environments and communities in which people live, work and learn build good mental health’ are two of the four outcomes in Priority 2 (*Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being*) of the Surrey Health & Wellbeing Strategy.

16. National research shows that ‘decreased loneliness could mitigate unemployment, and employment abate loneliness, which may in turn relate positively to other factors including health and quality of life.’ (Morrish et al, 2021).

17. It has been suggested that changing work patterns during Covid-19 lockdowns that saw more people working from home or hybrid working increased people’s feelings of loneliness at work. However, a 2023 report of the British Red Cross on behalf of the All-Party Parliamentary Group on Tackling Loneliness and Connected Communities found that post-pandemic home workers are no more likely to experience loneliness than those working on site.

18. Gambling is also associated with higher rates of future unemployment and physical disability and, at the highest levels, with substantially increased mortality (Muggleton et al, 2021).

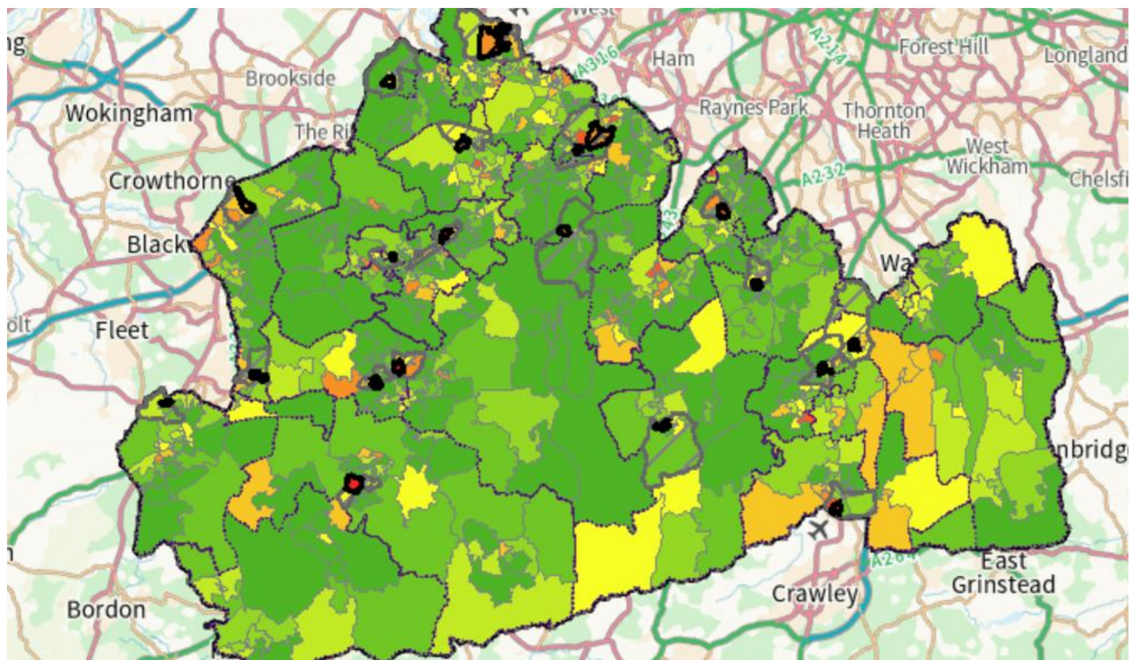
The Surrey Picture: relationship of those not in employment and having mental health issues in Surrey

19. NHSE Digital (2024) reported in quarter one 23/24, 29,845 sick notes (referred to as Fit Notes) were issued in Surrey Heartlands, most frequently for mental health reasons, with more than 50% lasting for 5 or more weeks. Although these may not all be issued to unique cases, the scale of this sickness absence from work is the equivalent to the population of more than three wards in Surrey each quarter. The total number of sick notes issued annually across Surrey Heartlands between 2019 and 2023 has consistently ranged between 104,151 and 130,370, demonstrating the population level need for support.

20. Data from the Annual Population Survey indicates that of the 16.1% of working age Surrey residents (those aged 16-64) recorded as economically inactive, 17.5% is related to long term sickness which includes Mental Health.

Priority Populations in Surrey

21. **21 Key Neighbourhoods Health and Wellbeing Strategy** Below is a map of the Employment Deprivation domain of Index of Multiple Deprivation (Green: least deprived to Red: most deprived), overlayed with the Health and Well Being Strategy's Key Neighbourhoods[1] (bold black outline).



[1] HWBS Key Neighbourhoods are drawn from the overall Index of Multiple Deprivation score rather than focusing on any one domain.

22. Nationally, unemployment activity is still low, though showing signs of increasing. In Surrey, the Annual Population Survey indicates that 1.5% of the working age population is unemployed compared to 3.9% for England, (October 2022 - September 2023).

23. The 2021 Census data also showed that Surrey residents who were economically inactive due to long-term sickness or disability consisted of 22,944 individuals, which is 2.4% of all Surrey residents aged 16 and over. This group makes up a lower proportion of all residents aged 16 and above in Surrey (2.4%) compared to the South East (3.1%) and England (4.1%).

24. This overall positive picture, and a tight labour market can however mask issues at a lower geographical level, for example two districts have lower disability employment rates than the national average, two with a disability employment gap 1.5 times worse than the national average, and four Lower Super Output Areas (LSOAs) in the 20% most deprived areas in England.

25. Surrey's many professional industries can also disadvantage people with disabilities who are less likely to be in professional roles, and 30% of whom earn less than living wage.

26. The Surrey-wide employment rates also mask disproportionate impacts for:

    - **Populations of identity (as outlined in the Health and Wellbeing Strategy),** such as people experiencing mental health issues, where their geographic dispersal makes it difficult to identify them from data sets and requires resource intensive hyper-local approaches. The annual Health and Wellbeing Strategy (summary) scorecard aims to provide an oversight of longer term system progress against the Surrey Health and Wellbeing strategy and includes a wide range of indicators. One area it highlights is that in Surrey for **adults in contact with secondary mental health services** the employment gap when compared to the general population is 8% bigger when compared with the South East and nationally (with a similar gap in relation to the numbers in stable and appropriate accommodation)[2].

- Rising employment rates include many people moving into low-paid, **insecure employment** which exacerbates health inequalities, and is a particular issue in relation to Surrey's high cost of living.
- **Surrey's care sector** has higher than average staff turnover (36% vs 28% nationally), higher than average vacancy rates (14% vs 10% nationally), 28% of the care workforce reaching retirement age, and the workforce growth of 29% needed by 2035. Surrey's leisure sector currently has around 210 vacancies, 40% of which have been unfilled for more than a

[2] Published data used in the index is drawn from DHSC fingertips and is the latest available however is from period prior to introduction of programmes referenced below.

year and community nursing vacancies are at 6.6% (vs 4.9% regionally). Above average skills pressures in Surrey are compounded by the highest sickness absence rates in these sectors.

- For Surrey residents who experience **multiple forms of disadvantage**, this can often lead to lower socioeconomic situation which in turn affects their access to resources such as education, impacting on their employment opportunities, and access to adequate housing. Lower socioeconomic position is a known determinant of health, influencing overall living conditions and wellbeing, with economic hardship being highly correlated with poor health (Bradley et al, 2008).
- People with **severe mental health conditions** are more likely to be excluded from employment, and when in employment, they are more likely to experience inequality at work (WHO, 2022).

Priority interventions/opportunities for prevention and early help

27. Alongside the delivery of NHS led adult mental health services, local authorities can play important roles in addressing the wider determinants of health. This can include **promoting high quality employment** though working with businesses (and as major employers themselves) (OHID/ NHSE South East).

28. Easing the strain of financial pressures through things like **debt advice services**, or local emergency/crisis funds (OHID/ NHSE South East).

29. **Reducing stigma**: Engagement with Surrey-based businesses such as McLaren, Barratt Homes and the Barber Collective, reported:

- reluctance from staff to disclose mental health issues to their employer, often citing alternative reasons for any absences,
- lack of confidence from line managers in knowing how to support colleagues.
- Feedback from men's mental health support groups in Surrey cited incidence of stigma and dismissal following disclosing mental health issues to their employer. Nationally 76% employees self-reported stress-related absenteeism in the past year[4] - a significantly higher level than is captured through fit note data in Surrey.

30. NICE recommendations on Mental Wellbeing at Work (NG212) include a recommendation for **organisation-wide approaches to prevention and early help within industry** that involve employees and workplace representatives. A South East England regional study indicates, "preventing mental health difficulties requires boosting mental health at work by

supporting organisational approaches to promoting mental health and wellbeing" (Centre for Mental Health, 2022).

The Surrey Picture: support in place and planned future activity

31. To build on the work to date and increase our insight into the impact of health and wellbeing on employment, Surrey County Council are leading a number of workstreams and working with partners across the system to join together existing initiatives to support early help and support for healthy employment:

Existing operational delivery

32. There is a significant amount of support available to Surrey residents to get them back into work or closer to being able to return when working. Whilst a proportion of this support is 'general' and accessible to all, regardless of age, health conditions etc, there is also a significant proportion of support that is tailored to those with health conditions and disabilities.

33. ***SCC led provision:***

Name of Programme, Project or Provider	Description
Work Wise (IPSPC)	A free employment service available to any person with a mental or physical health condition, disability, or neurodivergence (commissioned by SCC). The newly launched service **IPSPC**, delivered by Richmond Fellowship aims to integrate employment support into all Primary care clinical teams, making IPS accessible to anyone suffering with mental ill health or a chronic health condition. It is available to anyone aged 16 years and above. Employment Specialists work closely alongside GP's, Hospitals and Community Pharmacies, Social Prescribers, Community Connectors, Psychiatrists and MH Practitioners and receive referrals from both Professionals and self-referrals directly from patients. Value - £6.3m Target numbers - 2882
Work Well	Aimed at supporting people off work with a fitnote to recover and successfully re-enter the workplace. (Commissioned by SCC, live from October 2024) Value - £6.2m Target numbers - 7200

Local Supported Employment (LSE) - Surrey Choices	Support for residents including disabled people and autistic people and sensory and mental health needs. We will help our customers to look for vocational projects, supported internships and employment. (Funded by SCC)
How are you? Workforce Wellbeing Programme	Aimed at businesses and organisations (prioritising the care sector and employers in priority neighbourhoods) seeking to improve their workforce wellbeing strategies through NICE evidence-based interventions and resources. The programme is designed by industry and wellbeing experts to support organisations to improve their wellbeing strategies. (Funded by SCC) Base line evaluation data will be available from January 2025.

34. ***Employment support provision for those with health needs across Surrey:***

Name of Programme, Project or Provider	**Description**
AS Mentoring	Support neurodivergent people in employment, and in finding work.
Disability Initiative	Develop prevocational skills, help navigate a pathway toward voluntary work, work experience or paid employment.
Downs Syndrome Association - Workfit	Down’s Syndrome Association’s employment programme which brings together employers and jobseekers who have Down’s syndrome.
Fedcap – Intensive Personalised Employment Support	IPES has been designed to support individuals who are disabled and with health conditions into work and to empower those furthest away from the labour market to find sustainable employment or self-employment, or develop the skills to do so. Through the IPES scheme participants receive at least 15 months of intensive support to find and sustain employment. The scheme includes a further 6 months of in-work support. It is a flexible voluntary programme, available for people who are at least 18 years of age and don’t foresee getting into the workforce for at least 12 months
GPimhs	**GPimhs** have embedded Employment Specialists who receive direct referrals from the team, and ensure smooth provision of referrals or updates, as well as ensuring that a mental health employment perspective is incorporated into wider discussions

	around all care and support provided in GPimhs/MHICS. They consistently meet their primary aim of supporting individuals with mental health needs gaining, or remaining in, employment. Their involvement in discussions also empowers wider team members to have more confidence in both exploring and identifying employment needs for people using our services. In 2024/25, 311 people have been referred by GPimhs for employment support. Highest referrals to IPS services have come from the following primary care networks: North Tandridge; Dorking; West Waverley; North Guildford; Banstead and Care Collaborative (Redhill).
Headway Surrey	Support for adults with acquired and traumatic brain injury, and their families.
Include.org	Supported volunteering opportunities or people with learning disabilities and autism in East Surrey.
IPS	Surrey has the only supported employment service in UK covering 32 PCNs. Employment support is delivered to people across Surrey & NE Hants by VCSE partner Richmond Fellowship. Since 2018 they have delivered the **IPS** and have successfully integrated employment support into all secondary care mental health teams. The IPS pathway is for all clients who are receiving mental health support from a secondary care mental health team such as the EIIP or CMHRS. Employment Specialists work closely alongside the clinicians within these teams and receives referrals directly from the Professionals as well as self-referrals from the patients. 2023/24 on our IPS service. The partnership between SABP and Richmond fellowship is unique and something other NHS trusts and employment providers struggle to accomplish nationally.

Hard & Soft Outcomes

785 Hard outcomes!!

417 Were supported further

Job Starts	Retained Employment	Managed Exit	Volunteering	Education	Referred To Another Agency
412	373	150	70	57	417

Job Sustainability
3months = 90% (average)
6months = 84% (average)

Leonard Cheshire Can do Programme	Can Do is a skills development programme for individuals aged 16-35 with a disability or long-term health condition.
NACRO	Support for young people, homeless, women, care leavers; people with substance misuse issues, mental health issues, in the justice system, ex-service personnel
Oakleaf Enterprise	Provision of support, training and wellbeing activities for adults managing their mental health.
Reaching Out	A service offering the following support to young people: Assertive engagement to young people (8 – 16yrs) with mental health needs who are not in education/employment/training, who are homeless/at risk, and who have substance misuse issues. Reaching out offers mental health advice, assessment, support, goal focused sessions, engagement with formal services including employment. The service has integrated in the Youth Justice Health Team and receives referrals from SCC Education ACRAG Transition support to young people aged 17yrs 9m to 18yrs 3m and their carers who are transitioning from CYPS to adult services or anticipating discharge from mental health services.
Rethink	Careers support for individuals with mental health issues
Richmond Fellowship Improving Access to Psychological Therapies (IAPT) employment service	Employment support to people experiencing poor mental health who are accessing the IAPT's services.

Richmond Fellowship Mid and West Employment Service	Support for people living with or recovering from mental ill health to find employment, training or retain employment.
Surrey Choices Employability	Support for disabled people and employers.
Surrey Independent Living Council (SILC)	Tailored, supported, programmes for people with a disability or long-term health condition who have had a long period of unemployment, or have particular challenges or barriers with returning to work
The Grange Centre	Support for people with learning disabilities, including skills for life courses and work experience placements.
The Sunnybank Trust Futures Programme	Supports young adults with learning disabilities to find employment.
Thomas Pocklington Trust Works For Me employment programme	Supporting blind and partially sighted individuals into paid employment or a change of career.
Work and Health Programme (Maximus)	Voluntary employment support programme for people with a disability or health condition, have been long term unemployed or has been disadvantaged due to their circumstances.

35. Support for Priority groups (as outlined in 8)

Priority Population Group:	Support Offer
Key Neighbourhoods	5 ways toolkit supported in key neighbourhoods with community groups, delivery aligned to the Team Around the Community (TAC) model. Employers proactively supported to access to the 'How are You Surrey' workforce wellbeing programme
Secondary MH Care	As above targeted support (e.g. Richmond Fellowship) for those accessing secondary care for mental health
Multiple Disadvantage	Changing Futures. Bridge the Gap
Universal offer	First Steps Phoneline: Early help wellbeing phoneline with access to a listening support service which supports into hyper local community support, self-help, wider determinants support agencies, talking therapies and

	escalation to MH support as needed. De-escalation from the Crisis Line is also possible to support with wider issues as outlined above which exist outside of MH need. 5 Ways to Wellbeing Toolkit, a comprehensive resource designed to support residents, members of staff or volunteers, teams, or organisations to promote wellbeing by doing small actions to feel well. This toolkit is based on the 5 Ways to Wellbeing framework, which has been extensively researched and developed by the New Economics Foundation. Addressing Stigma Surrey Programme Debt Advice Crisis Fund

36. How will further need be identified?

- **Predictive Analytics**

This programme aims to identify predictive factors for health and care demand, informing how we may offer more effective early intervention. This programme will deep dive into the information held in contact centre and social care records and use machine learning to understand more about the drivers of demand. This analysis will include residents' experiences of access to employment as a barrier or enabler of independence and good health and wellbeing.

Interim findings from this analysis will be available from November 2024.

- **Preventative Intervention Evaluation**

This workstream aims to evaluate the impact of preventative interventions offered to residents in Surrey. As a result, we aim to understand whether current support is positively improving resident's health and wellbeing outcomes, including their ability to access or remain in work.

The programme will particularly evaluate preventative interventions offered to individuals absent from work under a fit note, or on the waiting list for adult social care or mental health support.

Findings from this evaluation will begin to emerge from October 2024.

37. How this work sits strategically:

As part of the bid for Work Well, there is an expectation from DWP that an overarching Work and Health Strategy for Surrey Heartlands is developed, work is underway to achieve this and to align fully with Frimley, ensuring a strategic approach across Surrey. As currently envisioned, the overall goal for this Work and Health Strategy is to build a comprehensive picture of work and health needs, assets, and activity, and co-design a system-wide delivery plan and common data set through:

- **Establishing a system-wide mandate to address work and health**
- **Joining up strategies and activities addressing work and health**
- **Maximising the opportunities of devolution**
- **Formalising a model of collaboration with the extensive community sector**
- **Understanding and prioritising the needs of residents and inform iterative development**
- **Increasing connectivity between operational providers**

The early help and prevention model is overseen by both the Prevention and Heath Inequalities Board and the Mental Health Prevention Board for the delivery of the Health and Wellbeing Strategy. The Mental Health Prevention Board workplan delivers on the prevention programme for Surrey Heartlands 'One System Plan'.

One System, One Plan and All Age Prevention:

38. In terms of evidence of 'what works' to inform Surrey system priorities, with rates of anxiety and depression increasing exponentially, treatment alone is no longer enough to adequately support people.

39. The Office for Health Improvement & Disparities (OHID), with NHS England (South East) has produced a new report which makes clear that:

    "Early intervention and addressing the wider determinants of mental ill-health can prevent serious mental illness and economic inactivity, reduce the incidence of suicide and self-harm, and promote relationship- and network-building, thereby easing the strain on health and social care services".

40. The report goes on to stress that "upstream interventions will be increasingly important in identifying and ameliorating issues before they require professional help"

41. Crucially, for this scrutiny's area of focus, the report states that:

"**Early intervention can help prevent long-term illness, reduce suicide rates, improve economic activity**, and allow people to form the kind of support, family and kinship networks that prevent isolation and loneliness in later life".

42. By way of return on investment, the Surrey Heartlands Clinical Strategy, 2024-29 (2024) shows that for the following prevention interventions, each £1 invested offers a median return in 5 years of £2.40:

    - Suicide and harm prevention
    - Work and School based mental health programmes
    - Support people in times of crisis.

43. In 2024/25 Surrey System Partners came together to develop the Surrey One System Mental Health Plan. It was formally adopted by all stakeholders in August 2024.

44. **The One System MH Plan has five priorities:**

    a. All Age Community Mental Health Offer:
    'Teams Around Communities' will provide timely health and social care and support near to patient homes, who will only need to tell their story once and receive access without multiple referrals to a range of teams including specialist mental health. Within the existing offer we operate employment support services – a general pathway for those with mental health and wellbeing needs and Individual Placement and Support (IPS) for those with serious mental health difficulties who want to work, find employment.

    b. All Age Crisis Pathway Offer
    Early support 'upstream' in the least restrictive setting to avert a mental health crisis and support residents to stay in the community through the provision of multi-agency services centred around the person.

    c. All Age Neuro-diversity (ND) Transformation
    Increase access to social and health support in the community with reasonable adjustments for ND people without the need for a formal diagnosis.

    d. Complex and under-served Groups
    Increased equitable support for complex and under-served mental health groups to achieve better outcomes and experience. Among these groups is the young adult or transitions cohort. Our focus with

this group will be integrated as they are likely to suffer poor mental health along with NEET.

And, pertinent to the All-Age Prevention approach there is a final One System Priority on 'prevention':

e. Prevention
Enabling the emotional well-being of our citizens by focusing on preventing poor mental health and supporting those with mental health needs so people have access to early, appropriate support to prevent further escalation of need, including parents and care givers

f. It should, however, be noted that 'prevention' is a common theme threaded through all One System Plan priorities, especially the 'All Age Crisis Offer' which emphasises the importance of early intervention and intervening 'upstream' to avert mental health crises.

g. A primary concern of the Surrey One System MH Plan is to deliver preventative strategies and interventions, and in the case of health establishing a preventative 'wellness' service and not service that waits until residents become unwell before intervening and providing support. These efforts in health are supported by joint system work across all health and wellbeing, social care and criminal justice agencies.

h. The work to deliver the Surrey One System Mental Health Plan Priorities is underpinned by a number of enablers to change and improve working practices and cultures of collaboration, share data and achieve interoperability to ensure there is a 'single version of the truth' that enables all agencies to work together to deliver one shared vision / plan and target services and support at the same group of residents who are high users of services across all organisations and also are multiple disadvantaged and deprived, lacking easy access to treatment and support.

Conclusions:

45. Nationally, people with poor mental health are more likely to be excluded from work or suffer inequality when at work.

46. Although Surrey has lower unemployment rates and low inactivity due to long term sickness compared to national averages, the picture of affluence masks areas of deprivation, including disability employment gaps.

47. Early intervention is essential in preventing long term mental illness and enabling positive emotional wellbeing and good health which in turn supports economic activity.

48. Surrey is taking a proactive approach to addressing these concerns through a workstream of health and wellbeing employment programmes which link through the health and wellbeing strategy, including "WorkWell", "'How are you?' Workforce Wellbeing Programme", "Predictive Analytics" and "Preventative Intervention Evaluation"

49. The Surrey Heartlands One System Plan provides the strategic mental health overview of these programmes and mental health provision and recognises the importance of economic activity in its contribution to improving Mental Health.

Recommendations:

50. The Select Committee notes the contents of this report and the actions being taken by partners across Surrey to address the link between mental health and employment.

51. The Select Committee supports the programmes and One System One Plan approach to improving mental health and economic activity.

Next steps:

To continue to deliver programmes to support residents of Surrey to maintain positive mental health and emotional wellbeing and remain economically active.

Report contact

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	No Progress Reported	Recommendation/Action In Progress	Recommendation/Action Implemented

Recommendations

Meeting	Item	Recommendation	Responsible Officer/ Member	Deadline	Progress Check On	Update/Response
5 October 2022	**Enabling You with Technology [Item 6]**	**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 and improve how provision is tailored to gain a more detailed understanding of these conditions and the associated impacts.	Dan Stoneman Head of Commissioning-Older Persons Lead for AWHP Technology Enabled Care and Homes	18 November 2022	2 September 2024	**Response:** Enabling you with technology is now entering a critical phase of transition. Pilots delivered under these arrangements, some of which have been in place since 2021, are now being evaluated. With a new team in place from July 2024 we will develop a forward-facing strategy for the longer-term provision of technology enabled care and homes services. We are seeking to formally commission and procure a partner(s) to develop a robust countywide infrastructure that will ensure no one is left behind and technology solutions

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						can be personalised for resident's specific needs. A key part of our next phase is to work with teams, residents and partners to clearly define what conditions, situations and outcomes our residents and workforce feel technology can support them with. This will include health, social care, professional and personal goals. Through this collaboration and detailed analysis, we will define a new delivery model(s) for technology enabled care ensuring we capture key requirements and evidence. This approach will enable us to demonstrate how we understand people's needs and conditions and critically how we are addressing these. We will ensure that we are measuring our impact through the better use of

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						technology solutions and monitoring services.
5 October 2022	**Mental Health Improvement Plan [Item 7]**	**AH 29/22:** The Joint Executive Director for Adult Social Care and Integrated Commissioning and SaBP, to develop a robust process to deal with complaints as well as Issues of concern regarding mental health services and provide a written update to the AHSC on progress toward this.	Liz Bruce, Joint Executive Director for ASC & Integrated Commissioning Surrey and Borders Partnership (SaBP)		15 January 2024 28 February 2024	Liz Williams and Kate Barker were contacted for an update. It has been passed onto the Children's Mental Health Commission Lead for further update. Graham Wareham, Chief Executive SABP, contacted.
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 training	Senior Programme Manager for Adult Social Care & Chief Operating	27 January 2023	19 April 2024 24 June 2024	Kathryn Pyper preparing a response. **Response:** Adults Wellbeing and Health Partnership do not have

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		and staff conduct, including that of partner organisations, are routinely monitored with consequences put in place for unacceptable failures to attend such mandatory training.	Officer for Adult Social Care			mandatory training specifically on staff conduct and attitude, although it is covered as part of soft skills in our induction offer. Any complaints regarding staff conduct and attitude, in either in-house services or commissioned services, are investigated via our complaints procedure and appropriate actions put in place to address. Supervision sessions provide a regular opportunity to reinforce expectations around conduct and attitude.
6 December 2022	**ASC Complaints [Item 6]**	**AH 52/22:** Further progress is required towards increasing the timeliness of assessment processes.	Senior Programme Manager for Adult Social Care & Chief Operating	27 January 2023	19 April 2024 2 May 2024	Kathryn Pyper preparing a response. **Response:** We are monitoring and reporting the following KPIs to help us focus

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			Officer for Adult Social Care			on improving our assessment timeliness and process: • Reducing the number of assessments waiting to be started: (adults and unpaid carers) • Reducing the number of assessments waiting to be started: occupational therapy led assessments Locality and specialist teams are undertaking the following improvement work around assessments: • Teams are defining targets to reduce the numbers, reviewing allocations waiting and prioritising them. • Triage processes are being strengthened with more management oversight • Strengthen front door approach (eligibility)

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						• Weekly allocations meetings Protected time given to staff to focus on this work
6 December 2022	**ASC Complaints [Item 6]**	**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	19 April 2024 2 May 2024	Kathryn Pyper preparing a response. **Response:** In May 2024 we are rolling out a Resident Experience Survey to all operational teams across Adult Social Care within the AWHP directorate. The survey, which was co-designed with residents asks about people's experience after assessment, support plan and review conversations. This will help highlight any areas that need to be addressed to improve practice. We will also shortly be using the Happy Or Not digital survey in the Customer Relations Team within AWHP. This is part of

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						the Council's trial to start capturing some customer satisfaction measures against our customer promise principles.
6 December 2022	**Surrey Safeguarding Adults Board Annual Report [Item 7]**	**AHSC 54/22:** That Adult Social Care service users and Adult Social Care frontline staff, are continuing to receive adequate Adult Safeguarding reassurances and support, and to raise awareness of such support available.	Luke Addams, Director- Adult Safeguarding	27 January 2023	2 September 2024	**Response:** We have continued to work with our staff, SSAB and partners to ensure that MSP (Making Safeguading Personal) is fully promoted and that adults at risk have a voice. Our staff are fully aware and this is captured in our improved performance in this area.
6 December 2022	**Surrey Safeguarding Adults Board Annual Report [Item 7]**	**AHSC 55/22:** Formulate a concerted multi-agency plan to raise awareness of the various aspects of Safeguarding, and to help residents understand the distinction	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.

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		between Children's and Adult's Safeguarding.				
6 December 2022	**Surrey Safeguarding Adults Board Annual Report [Item 7]**	**AHSC 57/22:** That the Board further raise awareness of safeguarding adults and support available.	Adult Social Care Leads & Surrey Safeguarding Adult's Board Luke Addams, Director- Adult Safeguarding	27 January 2023	January 2022 2 September 2024	**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. **Updated Response:** Our partnership officer continues to actively engage with partners involved in the SSAB and subgroups to ensure that safeguarding adults and communication / awareness

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						raising retains the high priority needed.
7 December 2023	**Adult Safeguarding Update [Item 6]**	**AHSC 58/23:** The responsible officers in AWHP (SCC) to manage processes in line with capacity versus demand needs and monitor improvements in how operations will be more efficient. Analysing the demand and capacity will enable improvements to be made that smooths the flow of service users through the system and helps to create a better patient and staff experience of the healthcare process.	Luke Addams, Director- Adult Safeguarding		2 September 2024	**Response:** We have moved from a risk averse culture to a risk enablement culture and following the introduction of a more proportionate approach at the triage stage of safeguarding concerns have raised awareness with partners and internal teams. This has helped reduce the number of inappropriate referrals that are not strictly safeguarding and ensure that adults at risk receive the most appropriate service at the earliest possible point.

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7 December 2023	**Adult Safeguarding Update [Item 6]**	**AHSC 59/23:** Implement the necessary processes which are needed to cope with demand to reflect the transformation work and help to improve the service.	Sarah Kershaw, Strategic Director - Transformation, Integration & Assurance		2 September 2024	**Response:** The committee have been updated on the progress of the transformation and improvement programme and a further informal update previously scheduled for the May committee meeting was postponed and an informal briefing is now scheduled to take place on 19 August.
7 December 2023	**Adult Safeguarding Update [Item 6]**	**AHSC 60/23:** To review the Healthwatch reports and incorporate any learning into the Improvement Programme	Luke Addams, Director – Adult Safeguarding & Dols		2 September 2024	**Response:** Further to the December recommendations, Committee will be aware that there has been further focus on Healthwatch concerns in the May committee and subsequent recommendations.

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						Committee can be assured that an approach has be developed for actively adopting the most appropriate response to applying lessons learnt. These are reviewed at our Practice Assurance Board and incorporated into Improvement plans as appropriate. Progress will then be then followed up via a tracking system
7 December 2023	**Adult Safeguarding Update [Item 6]**	**AHSC 61/23:** Make it clear that SCC supports the protections given in employment law for whistleblowers and provide a simple easy to access reporting route for them.	Chloe Stokes People Business Partner, People & Change		2 September 2024	**Response:** I can confirm that SCC supports the protections given in employment law for whistleblowers and provide a simple easy to access reporting route for them. Please find a link to Whistleblowing (sharepoint.com) which details how concerns can be raised via an independent service Navex Global.

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7 March 2024	**Healthwatch Surrey**	**AHSC 1/24:** To ensure that language used for automatic responses reflects a friendlier approach.			13 May 2024	Distributed 15/03/24
7 March 2024	**Discharge to Assess/Home First**	**AHSC 10/24:** We think it would be beneficial for Adult Social Care to produce a simple information booklet and ensure it is properly distributed amongst residents.			29 May 2024	Response Shared with Committee on 29 May 2024.
7 March 2024	**Discharge to Assess/Home First**	**AHSC 11/24:** To ensure that you are managing the demand of acute beds required and provide an update on what is being done to deal with the demand in acute capacity and the management of it.			29 May 2024	Response Shared with Committee on 29 May 2024.

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7 March 2024	**Discharge to Assess/Home First**	**AHSC 12/24:** To provide information on the vetting of care organisations, including what training is being provided for carers.			29 May 2024	Response Shared with Committee on 29 May 2024.
7 March 2024	**Discharge to Assess/Home First**	**AHSC 13/24:** To provide an update on what changes are being implemented to the transformation work in response to the report from Healthwatch Surrey on Discharge to Assess processes, and of how that is that being reflected within the transformation work			29 May 2024	Response Shared with Committee on 29 May 2024.
10 May 2024	**MINDWORKS [Item 5]**	**AHSC 14/24:** [1] Mindworks must demonstrate how it	Mindworks Alliance		Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.

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		proposes to regain the confidence of parents and schools, and that it is accepting responsibility for the services that it is commissioned to provide, by: [1.1] Publishing the Transformation Plan, with dates, times, and levels of performance with appropriate Key Performance Indicators (KPIs) [1.2] Providing research to identify the size of the problem. [1.3] Encouraging the partnership to improve resources for communicating early help prior to diagnosis from				

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		organisations such as NAS [1.4] By scaling up supply to meet the level of demand, and securing sufficient support from the NHS England, showing how this is linked to the Transformation Project.				
	MINDWORKS [Item 5]	**AHSC 15/24:** [2] Recommend that the response to the Joint Area Inspection Report (JTAI) is extended to accommodate a joined up Mindworks / Education, Health and Care Plan (EHCP) process.			Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.

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	MINDWORKS [Item 5]	**AHSC 16/24:** [3] The Surrey and Borders Partnership Trust Recovery College needs to be more accessible to people and encourage more local access, with better publicity and provision of outreach services. Ensure that the Recovery College is given more active publicity and has the capacity to take on extra workload. Establish skills and work coaches to help coach and support people to enable the transition with helping people to maintain employment and get into employment, and critically to help people			Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.

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		with regards to the Recovery College.				
	MINDWORKS [Item 5]	**AHSC 17/24:** [4] Mindworks must provide a clear and simple information guide for parents on how to access services, so that pathways of access are coherent, accessible, and easily understood ensuring communication is clear, and consider how it could be further reaching, so that parents and schools are supported while children are on the waiting list.			Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.
10 May 2024	**ADULT SAFEGUARDING [Item 6]**	**AHSC 18/24:** Provide an update from the new Safeguarding	Luke Addams George Kouridis		Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.

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		Panel on progress on the questions raised, particularly around communication and working in partnership, ensuring that people don't fall through the gaps.				
10 May 2024	**ADULT SAFEGUARDING [Item 6]**	**AHSC 19/24:** Provide a measurement of feedback from staff, patients and from other services, so we can see what improvements have been made, and as a result can show how we deliver a safer environment.	Luke Addams George Kouridis		Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.
10 May 2024	**ADULT SAFEGUARDING [Item 6]**	**AHSC 20/24:** Provide an analysis of how effective your measurement service is so we can be reassured on how	Luke Addams George Kouridis		Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.

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		effective the service is running, and that activities are resting in more resolve.				
10 May 2024	**ADULT SAFEGUARDING [Item 6]**	**AHSC 21/24:** To examine best practise on whistleblowing, and to make every effort to provide a process that protects the individuals who are using the process, and that it is effective.	Luke Addams George Kouridis		Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.
10 May 2024	**ADULT SAFEGUARDING [Item 6]**	**AHSC 22/24:** Continue improving the measurement of safety, and demonstrate that the service as a whole is actively eliminating problems.	Luke Addams George Kouridis		Tuesday 23 July 2024	Response Shared with Committee on 23 July 2024.

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Actions

Date	Item	Action	Responsible Member/Officer	Deadline	Progress Check	Action response. Accepted/implemented
10 May 2024	**MINDWORKS [Item 5]**	Mindworks team to look at the London Boroughs and benchmark their performance against them, in terms of the referral process and treatment pathways (and to share this information with Adults + Health Select Committee and Children's Select Committee Members).	Mindworks Partnership		1 July 2024	Response Shared with Committee on 1 July 2024.
10 May 2024	**MINDWORKS [Item 5]**	Mindworks team to share the completed Transformation Plan with the Children's, Family Lifelong	Mindworks Partnership		**October 2024**	**Interim response:** Mindworks have held two workshops to support the development of their transformation plan for the services, including ND. These are being written up

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		Learning and Culture Select Committee in October 2024.				and action agreed. They will be on time for sharing with select committee in October.
10 May 2024	**ADULT SAFEGUARDING [Item 6]**	Safeguarding team to reflect the importance of whistleblowing (particularly on the safety aspect, such as around confidentiality) on the adult safeguarding website.	Luke Addams George Kouridis		Friday 28 June	Response was shared with the committee on 28 June 2024.
10 May 2024	**ADULT SAFEGUARDING [Item 6]**	Regarding modern slavery, the Director of Practice, Assurance and Safeguarding to discuss with commissioners, the vetting of organisations + raising awareness and provide a written	Luke Addams George Kouridis		Friday 28 June	Response was shared with the committee on 28 June 2024.

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		update to the committee.				

Adults and Health Select Committee
Chairman: Trefor Hogg I Scrutiny Officer: Sally Baker I Democratic Services Assistant: Hannah Clark

Date of Meeting	Type of Scrutiny	Issue for Scrutiny	Purpose	Outcome	Relevant Organisational Priority	Cabinet Member/Lead Officer
4 December 2024	Process Scrutiny	**Dementia Strategy** (ASC) (TBC)	The Committee to review the Dementia Strategic objectives against the current needs of Surrey residents, with a focus on ensuring sufficient preventative measures are being provided to reduce dementia as well as improve the dementia care pathway within the Surrey population, and to understand what developments have been implemented across Surrey	The committee will review data concerning priority groups and the associated risk factors for dementia concerning the socio-economic inequality within Surrey's priority population areas	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	Mark Nuti, Cabinet Member for Health and Wellbeing, and Public Health Sinead Mooney, Cabinet Member for Adult Social Care Ruth Hutchinson, Director of Public Health Helen Coombes, Executive Director for Adults, Health, and Wellbeing Sarah Kershaw, Strategic Director of Adults, Health, and Wellbeing. Surrey Heartlands ICS (further contacts TBC) NHS Frimley (contacts – TBC)

4 December 2024	Process Scrutiny	**Committee Budget Meeting**: Formal public scrutiny of draft budget	A public scrutiny session by Select Committees on the draft budgets within their remits to test for sustainability, value for money, risk and alignment with Council's objectives.	Output: Formal Scrutiny of Draft Budget. Final Joint Select Committee report & recommendations to December Cabinet	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(see attendees) AHSC - SCC Finance, AWHP, Public Health, Cabinet Members
	Process Scrutiny	**Maternity services** (TBC)	A public scrutiny session to review the work being undertaken in light of the CQC ratings against several maternity units in Surrey that require improvement, and/or are rated Inadequate. The Committee want to understand more about why the service is struggling to meet a good rating and learn what is being done to improve as a result of the CQC findings.	To get reassurance of the measures and processes in place to improve leadership and safety within hospitals, and reassurance that hospitals understand what needs work on.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	To contact leads related to specific hospitals in Surrey (TBC)
	Process Scrutiny	**Industrial Strike Action** (TBC)	Review the impacts that continued GP strike action is causing within the County	Review the impacts on the sector as a whole and understand whether the safeguards in place are effective or what new measures are being put in place and understand the impacts on service delivery and	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)

				mental health within the ICBs and ICS are		

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	Trefor Hogg, Helyn Clack

Ongoing	**South West London and Surrey Joint Health Overview and Scrutiny Committee – Improving Healthcare Together 2020-2030 Sub-Committee**	In June 2017, Improving Healthcare Together 2020-2030 was launched to review the delivery of acute services at Epsom and St Helier University Hospitals NHS Trust (ESTH). ESTH serves patients from across South West London and Surrey, so the Health Integration and Commissioning Select Committee (the predecessor to the Adults and Health Select Committee) joined colleagues from the London Borough of Merton and the London Borough of Sutton to review the Improving Healthcare Together Programme as it progresses.	A sub-committee of the South West London and Surrey Joint Health Overview and Scrutiny Committee has been established to scrutinise the Improving Healthcare Together 2020-2030 Programme as it develops.	Empowering communities, tackling health inequality	Trefor Hogg, Helyn Clack (substitute)
Ongoing	**Hampshire Together Joint Health Overview and Scrutiny Committee**	On 3 December 2020, the Hampshire Together Joint Health Overview and Scrutiny	The Joint Committee is to scrutinise the Hampshire	Empowering communities, tackling health inequality	Trefor Hogg, Carla Morson (substitute) David Lewis (observer at JHOSC)

		Committee, comprising representatives from Hampshire County Council and Southampton City Council, was established to review the Hampshire Together programme of work, and Surrey County Council was invited to attend meetings as a standing observer.	Together programme of work and associated changes in the provision of health services.		
Ongoing	**Frimley Park Hospital Joint Health Overview and Scrutiny Committee**	In March 2024, The Frimley Park Hospital Joint Health Overview and Scrutiny Committee was formed. It comprises of representatives from Surrey County Council, Hampshire County Council, and Bracknell Forest Borough Council and was established to review the development of a new hospital to replace Frimley Park Hospital by 2030.	The Joint Committee is to scrutinise the Frimley Park Hospital – development of a new hospital for Frimley Park programme of work and associated changes in the provision of health services.	Empowering communities, tackling health inequality	Trefor Hogg – JHOSC Chairman (SCC) Bill Withers – JHOSC Vice-Chairman (HCC) and further representatives from SCC are: Carla Morson, Michaela Martin, and Richard Tear.

Standing Items

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