Notice of Meeting

Adults and Health Select Committee

Date and Time	Place	Contact	Web:
Wednesday, 4 December 2024 10.00 am	Council Chamber, Woodhatch Place, 11 Cockshot Hill, Reigate, Surrey, RH2 8EF	Sally Baker, Scrutiny Officer SallyRose.Baker@surreycc.gov.uk	Council and democracy Surreycc.gov.uk **Twitter:** @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.

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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 OCTOBER 2024

(Pages 5 - 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 *(28 November 2024)*.
2. The deadline for public questions is seven days before the meeting *(27 November 2024).*
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 CABINET RESPONSE TO SELECT COMMITTEE RECOMMENDATIONS (Pages 33 - 34)

Purpose of the item: For the Committee to consider the response of Cabinet to the recommendations of this select committee throughout the scrutiny of the budget-setting process.

6 SCRUTINY OF 2025/26 DRAFT BUDGET AND MEDIUM-TERM FINANCIAL STRATEGY TO 2029/30 (Pages 35 - 66)

Purpose of the item: Scrutiny of the Draft Budget and Medium-Term Financial Strategy

7 REVIEW OF PROGRESS MADE TO IMPLEMENT THE JOINT HEALTH AND SOCIAL CARE DEMENTIA STRATEGY FOR SURREY, 2022-2027 (Pages 67 - 114)

Purpose of the item: The Committee has asked to review the progress made to implement the joint health and social care dementia strategy for Surrey, 2022-2027. The Committee would like to see a focus on ensuring sufficient preventative measures are being provided to reduce dementia, as well as improving the dementia care pathway for the Surrey population. The Committee wish to understand what developments have been implemented across Surrey.

8 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 115 - 136)

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 6 March 2025 at 10:00am.

Terence Herbert
Chief Executive
Published: Thursday, 21 November 2024

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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.

MINUTES of the meeting of the **ADULTS AND HEALTH SELECT COMMITTEE** held at 10.00 am on 10 October 2024 at Council Chamber, Woodhatch Place, 11 Cockshot Hill, Reigate, Surrey, RH2 8EF.

These minutes are subject to confirmation by the Committee at its meeting on Wednesday, 16 October 2024.

Elected Members:

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

Co-opted Members:

r Borough Councillor Abby King
r District Councillor Caroline Joseph
Borough Councillor Victoria Wheeler

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

18/24 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Cllr Angela Goodwin, Cllr Robert Evans, Borough Councillor Victoria Wheeler, Sinead Mooney, Cabinet Member for Adult Social Care, Graham Wareham, Chief Executive, Surrey and Borders Partnership NHS Foundation Trust, Helen Coombes, Outgoing Interim Executive Director of Adults, Wellbeing and Health Partnerships (SCC), Helen Coe, Director of Operations & Recovery, NHS Surrey Heartlands ICB and Stephen Dunn, Director of System Flow and Delivery.

19/24 MINUTES OF THE PREVIOUS MEETINGS: 10 MAY 2024 [Item 2]

The minutes were **AGREED** as a true and accurate record of proceedings.

20/24 DECLARATIONS OF INTEREST [Item 3]

The Chairman declared he was a community representative to NHS Frimley. Cllr Carla Morson declared that she had a relative that worked at Frimley Park Hospital. The Chairman declared on behalf of Cllr Victoria Wheeler that she worked for a company that provided consultancy advice to the NHS generally.

21/24 QUESTIONS AND PETITIONS [Item 4]

None were received.

22/24 CANCER AND ELECTIVE CARE BACKLOGS [Item 5]

Witnesses:
Professor Andrew Rhodes, Professor of Critical Care at the University of London and the Chief Medical Officer for Surrey Heartlands Integrated Care Board (SHICB)
Lucy Hetherington, Associate Director of Planned Care for Surrey Heartlands Integrated Care Board
Alexander Stamp, Deputy Chief Operating Officer– Planned Care Frimley Heath Foundation Trust (FHFT)
Orlagh Flynn, ICS Programme Director Elective Care, deputising obo Stephen Dunn, Director of System Flow and Delivery (Frimley NHS Trust)

Key point raised during the discussion:

1. The Chief Medical Officer (SHICB) provided a brief introduction to the report about the elective delivery of the waiting lists relating to outpatient surgery, diagnostics, and cancer.

2. The Chairman referred to the serious impact on those on the waiting list for long periods, and that there were further challenges to waiting lists over the past 12 months due to industrial action in addition to the impact of Covid. The Chairman asked if Surrey Heartlands Integrated Care Board (SHICB) had a system in place to cope with this and asked what the outlook was. The Chairman also asked whether SHICB expected to bring their waiting lists back to the required standards and how confident they were that the data available was accurate. The Chief Medical Officer explained that waiting lists had not recovered since the Covid pandemic. Industrial action further impacted waiting lists. SHICB's hospitals learnt to manage and mitigate industrial action over time. Industrial action had since finished, and it was hoped it would not continue. Waiting lists were expected to take several years to return to required standards. This involved aligning capacity against demand, ensuring the right staff, facilities and infrastructure was in place.

3. A Member asked if there were any outstanding patients waiting over 78-weeks that did not relate to patient choice or conflicting

medical needs. If this was the case, the Member asked how these patients were being prioritised. The Chief Medical Officer (SHICB) noted that a year prior, SHICB had patients waiting over two years, but had been resolving some of these long waits. The current aim was to see all patients within 65-weeks. The 78-week wait time had broadly disappeared. There were still a few patients at this wait time, usually due to the complexity of a patient's caseload. Patients were prioritised against clinical need, by treating the most complex and high-risk patients first. The aim to get all patients seen within 65-weeks by the end of September 2024 was expected to be achieved by the end of 2024. The next focus would then be to reduce the wait to 52-weeks by mid2025.

4. The Member referred to NHS Frimley Integrated Care Board's (ICB) increased waiting list and its increase post-EPIC system implementation. The Member asked what actions were being taken by NHS Frimley ICB to manage and reduce the waiting lists, and when they would be under control and exceeding expected standards. The Member asked how NHS Frimley ICB was supporting patients with long waits to manage their conditions. The Member also asked for consideration to be given to referrals for elective surgery usually being made when the condition was already causing serious pain and impact on daily life.

5. The Board Director of Healthwatch Surrey asked if regular feedback was received from patients on their waiting experience and what had worked well for them and if it would be improved. The Board Director asked if it had been used to improve the quality of the wait journey.

6. The Deputy Chief Operating Officer (FHFT) explained that FHFT's waiting list was increasing up until EPIC's implementation due to organisational pressure. FHFT had a challenging winter position with Urgent and Emergency Care (UEC) pressure, which put pressure on elective services and pathways. FHFT had improved coping with elective challenges. FHFT' Heatherwood Hospital was a Getting It Right First Time (GIRFT) accredited elective hub which helped elective pathways. Changes in how EPIC handled referrals resulted in an unaccounted-for waiting list change. There was reduction in activity as FHFT's team acclimatised to EPIC, which increased waiting lists. The waiting list growth over time was due to demand on some of FHFT's services. FHFT understood their waiting list and had high-quality data, such as validation levels of waiting list size. FHFT took assurance in their position and waiting list accuracy. A challenge for FHFT was service demand. Covid caused a significant backlog and system pressure. FHFT reviewed services to assess demand and identify needed

interventions. FHFT was reviewing services to understand the demand and interventions needed. Reducing waiting lists to constitutional standards would be a multi-year approach. A big organisational change and work with Integrated Care System (ICS) colleagues was in managing primary care demand. Intervention being reviewed and developed should bring improvements.

7. The Deputy Chief Operating Officer (FHFT) explained that FHFT was fairly active in communicating with patients regarding their position on the waiting list when they achieved a certain threshold. FHFT encouraged patients as part of this process to outline any concerns they had on the impact of their condition deteriorating. If a patient had concerns, FHFT's general policy was that the patient should first visit their General Practitioner (GP) who had a route to expedite referrals to hospitals. The Deputy Chief Operating Officer (FHFT) was not fully cited on feedback from patients regarding the process, but was open to further discussions and review to what FHFT could do better.

8. Regarding SHICB's Data Quality (DQ) issues, following the Cerner installation during 2023/24, which resulted in some patients waiting extended periods of time, the Vice-Chair asked if all DQ issues had been identified and asked what ongoing work was being done with NHS Trusts to identify and mitigate further DQ issues. The Chief Medical Officer (SHICB) explained that Guildford and Ashford & St Peter's Hospitals NHS Foundation Trust had experienced serval difficulties with the Cerner system that led to DQ issues. Cerner was complex and needed a high level of training for staff. This training was not where it was needed during Cerner's implementation which caused issues, and there was now a focus to ensure staff were properly trained to use the system. Several DQ issues were identified and resolved as part of this. It was unclear if all DQ issues were resolved, as some could still be unidentified. The priorities were to reduce waiting lists which made data validation easier and put in place staff training for Cerner ensuring appropriate controls and mitigations were in place. SHICB were confident they were in a better place than before but could not be certain other problems would not arise, as seen elsewhere in the country.

9. Regarding ensuring sufficient diagnostic capacity to support cancer and elective activity and reduce wait times, the Chairman asked how the committee could be reassured that the NHS England's current expectation that no patient should wait more than 65-weeks for elective care by September 30 2024 had been met, and asked how it would continue to improve. The Chairman questioned if the target was not met, what was being done to accelerate this. The Chief Medical Officer (SHICB) noted that

SHICB performed well in diagnostic capacity but recognised that earlier diagnosis enabled patients to be treated sooner. The national focus was to move much of SHICB's diagnostics into the community. The Woking site was used to develop community, and the Caterham site was being utilised for community diagnostics. Space Belfry Shopping Centre in Redhill would potentially be used. The aim was to increase capacity and to enable earlier diagnosis, outside of hospitals. SHICB were looking to transform diagnostic delivery outside of hospitals closer to primary care colleagues, and simultaneously aim to increase capacity to deliver surgery. An elective operating site was being developed at Ashford hospital in line with government policy to split elective and emergency procedures. The Royal Surrey Guildford's cancer centre was being redeveloped and its capacity was being increased to deliver interventions and reduce wait times.

10. The Chairman noted that NHS Frimley was in the process of building a new diagnostic and imaging centre at Frimley Park Hospital, providing 74 extra beds.

11. A Member asked if there was a timeline for SHICB's plans. The Chief Medical Officer (SHICB) explained that the elective operating centre would be working by the end of 2024. The appointment of staff to this centre to fully utilise capacity was an ongoing process. Some staff groups such as the anaesthetic staff that were more critical than others, not only for their role but there was a shortage of such staff which might cause delays. The Ashford sites elective centre provided significant additional capacity in the system. SHICB was working with all their organisations, so capacity was not looked at just within an organisational boundary but across Surrey. Patients were beginning to be asked to move around to free capacity so they could be treated earlier.

12. The Member raised that collaboration was key and suggested it would be two years before waiting lists would be reduced to the expected level. The Chief Medical Officer (SHICB) explained that returning to the waiting list constitutional standards was a multi-year approach. National guidance was to return to these standards within the next parliamentary cycle, and within the next 4 years. There was not complete reassurance that this would be delivered in all parts of the country. Surrey's waiting lists were reducing faster than anywhere else in the country, but there was still a long way to go.

13. A Member asked what some of the achievements in collaborative approaches had been, what difficulties remained, and how were improvements being achieved. The Chief Medical Officer (SHICB) explained that as SHICB developed the elective

centre in Ashford, there was work occurring to ensure SHICB was reviewing their waiting lists across Surrey, rather than just within organisations and the hospitals. Waiting lists could then be segmented for example, by the geography, ethnicity and deprivation, to ensure inequalities across Surrey were addressed. SHICB had digital tools which were being developed, to improve the ability to move patients between different organisations to free-up capacity and treat patients more quickly.

14. A Member asked about what was required to meet the constitutional standard, referred to as the referral-to-treatment (RTT), up to the target of 92% of patients waiting no more than 18-weeks for referral to the first consultant-led treatment, and if this figure was accurate. The Member also asked what the main issues were in meeting the RTT target. The Chief Medical Officer (SHICB) explained it was expected to take 3 to 5 years to achieve the RTT target. The key was to reduce waiting lists, which stood at around 150,000 people. They needed to reduce to pre-Covid levels of around 90,000 people to be within or near the constitutional standard. Therefore, SHICB needed to treat more patients, which was part of the work to increase capacity to deliver interventions. Demand needed to be managed and understood. Surrey's population was increasing, which also increased demand. Surrey County Council's (SCC) data showed there would be another 30% of people aged 85 in Surrey by 2030. This age group accessed SHICB's services most often.

15. The Vice-Chair asked about SHICB's waiting well initiative that was introduced in Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH). The Associate Director of Planned Care explained that ASPH introduced a patient portal. Every 4-weeks there was a process where patients could be contacted. Patients could relay questions and concerns through a feedback mechanism. ASPH was seeking additional support for a wider multi-disciplinary team to support patients in the waiting process with pain management and other concerns. SHICB was looking at this across the system to pass on to other partners.

16. The Chairman raised that consideration needed to be given to the accessibility of communication. The Chairman asked what both SHICB and Frimley Integrated Care Board (FICB) were doing to ensure patients were getting valid communication with appropriate messaging around what they should be doing, particularly during the waiting period. The Chairman also raised that a large part of the population did not understand complex language and NHS acronyms. The Chief Medical Officer noted that communication was key. The patient portals were being introduced across SHICB's organisations. Feedback indicated the patient portals were well-received and enabled access to correspondence. Whether individual communication was

appropriate was challenging to understand. The use of plain English was important.. The Chief Medical Officer referred to a visit he had to a primary care service that had implemented Artificial Intelligence algorithms to correspondence, which translated GP's referrals to plain English. Initial hospital feedback was that this improved the quality of referrals. Some people not able to access the NHS App were recognised, and hard-copy correspondence was still used.

17. A Member noted the importance of keeping patients informed. The Chief Medical Officer (SHICB) noted there was an expectation for patients to be kept aware of what was going on. The majority of SHICB's patients got to sign appropriate consent forms and were communicated with after a procedure.

18. A Member asked how it would be ensured that patients with no digital awareness could still access their records. The Chief Medical Officer (SHICB) explained that hard-copy records were still used. There was work being undertaken to understand this patient group to support and use other communication methods.

19. The Chairman asked how SHICB worked with other organisations to deal with cancer and elective care backlogs, such as private hospitals and neighbouring NHS trusts, to make effective use of capacity. The Chief Medical Officer (SHICB) explained there was capacity in Surrey's traditional NHS organisations. Capacity could be used in other NHS organisations outside of Surrey and in the independent sector, such as private organisations and other health organisations (profit or non-profit) within Surrey. A government policy was to utilise all capacity available. In the last few years, all SHICB's organisations improved on utilising their assets, such as moving from a 5- to 6-day, and sometimes 7-day operating. The traditional 8-to-10-hour day increased to 10-to-12-hour days. A challenge was the staff's ability to keep up with demand. As demand increased for the SHICB workforce, there was a risk of staff burn-out which could impact safe working. SHICB needed to maintain the balance in maximising use while also deploying its workforce safely.

20. The Chairman brought attention to Heatherwood Hospital and the GIRFT report, that showed running the same type of surgery consecutively had efficiency gains, underlining the benefits of an elective surgery centre, with emergency care arrivals not diverting the production line approach. The Chief Medical Officer (SHICB) noted SHICB was working on this. A modern estate that was well-kept and built for purpose enabled productivity gains. Some of the estates that SHICB organisations use to operate in were old and not maintained to expected standards, impacting on productivity.

21. The Chairman asked about the constraints of the estates and what the strategic approach was to deal with them. The Chief Medical Officer (SHICB) explained that the strategic approach was to split SHICB's elective planned care services away from their emergency sites. Secondly, the approach was to ensure there was adequate and well-maintained infrastructure in place, such as adequate air handling in operating theatres for well-maintained infection control. Financial support structures enabled this approach to occur in a timely manner.

22. The Chairman referred to the impact of the time a patient spent in hospital after an operation and asked what was being done around the hospital discharge process. The Chief Medical Officer (SHICB) explained that SHICB was moving many surgical interventions into day-case surgery, where a patient was discharged from hospital on the same day as their operation, which required the right facilities. This was done well in some parts of Surrey, but other areas did not have the amount of day-case infrastructure and support in place. SHICB also needed to ensure that processes within their hospitals were aligned to getting patients mobilised and home in a timely and safe manner. For example, an ambition was to get hip replacement surgical patients discharged within a day. Some parts of the country were achieving this at 70-80%, but SHICB had an average of 2.8 days for discharging these patients. The quicker patients were discharged the more support was needed outside of hospital to stop patients returning to hospital, which was a challenge.

23. Regarding physical estates, the Deputy Chief Operating Officer (FHFT) added that although FHFT had good and well-utilised estates, Frimley Park Hospital was impaired by Reinforced Autoclaved Aerated Concrete (RAAC) and had lost two theatres as a result. RAAC would be an ongoing challenge, up until the new hospital was built, which was planned for 2030. FHFT was working to mitigate the impact of RAAC, which often involved the use of Heatherwood Hospital. There was a RAAC multi-year programme of inspections.

24. In reference to the report the Chairman stated that SHICB was scrutinising the data in detail at a speciality level in relation to waiting times and asked if there were any issues identified. The Chief Medical Officer (SHICB) raised that the specialty area that had the biggest problem tended to be orthopaedics, such as hip, knee, and shoulder replacement surgeries. The volume of patients coming through to this area was more than could currently be managed, which further increased waiting lists. Another challenging speciality was optometry, specifically for cataracts surgery, due to a high volume of patients that

outstripped demand. Therefore, additional capacity was being put into the elective site in Ashford. There were several other providers that came into this marketplace to provide support. Some of the major cancer pathways remained challenged due to complexity and rarity. The report highlighted the challenges concerning complex gynaecological procedures, especially for endometriosis, which required simultaneous co-ordination between different teams for a long period of time.

RESOLVED:

1. Surrey Heartlands NHS ICB to clearly communicate learnings from the Cancer Inequalities Programme especially in relation to the effectiveness of actions taken in terms of improving outcomes and experiences for patients.

2. Keep the Adults and Health Select Committee updated on the Surrey Heartlands NHS ICB Cancer Inequalities Programme and its impact on both the Health and Wellbeing Priority Areas and groups experiencing inequalities.

3. To improve accessibility, and to ensure that communication is effective and does not disenfranchise those who aren't able to use technology in one way or another.

Meeting paused for a break at 11.08am

Meeting resumed at 11.45am

23/24 RIGHT CARE RIGHT PERSON [Item 6]

Witnesses:

Mark Nuti, Cabinet Member for Health and Wellbeing, and Public Health
Liz Uliasz, Director for Mental Health, Emergency Duty Team (EDT) and Prisons- Adults, Wellbeing and Health Partnerships (AWHP)
Simon Brauner-Cave, Deputy Director of Mental Health Commissioning- NHS Surrey Heartlands ICB (SHICB)
Alexander Jones, Consultant Nurse Mental Health crisis care, Surrey and Borders Partnership (SaBP)
Helen Wilshaw-Roberts, Strategic Partnerships Manager- South East Coast Ambulance Service (SECAmb)
Maria Millwood, Board Director, Healthwatch Surrey

Key points raised during the discussion:

1. The Chairman raised that it was World Mental Health Day and noted that the theme was workplace mental health. The Director for Mental Health, EDT and Prisons, and the Deputy Director of Mental Health Commissioning (SHICB) provided a brief introduction to the Right Care Right Person (RCRP) report. The

Director for Mental Health, EDT and Prisons stated that the police shared their policy procedure. The police delayed the RCRP implementation on request when Surrey County Council (SCC) were planning to involve the Children, Families, Lifelong Learning and Culture directorate, and that those under18 years old were not part of RCRP. If a child was involved, the police would deploy as normal. The police delayed by about 6-weeks to give groups time to ensure practice was embedded.

2. A Member asked how the monitoring of RCRP was being managed collaboratively regarding staff training and how issues were dealt with. The Director for Mental Health, EDT and Prisons explained that all organisations did their own training based on information shared by the police. Training was monitored by the bronze, silver and gold groups that continued to meet since RCRP's implementation. Prior to RCRP's implementation, the bronze group, looking operationally, reviewed case studies and people's potential journeys. This escalated to the silver group, where learning was reviewed tactically. Issues were quickly raised with police and data was challenged where necessary. The Director for Mental Health, EDT and Prisons rolled out training and staff awareness sessions to around 1000 SCC staff, which may be repeated. Prior to RCRP's implementation, each organisation undertook a Red, Amber, and Green rating at the Silver Tactical group meeting on their readiness for RCRP. The Adults, Wellbeing and Health Partnerships directorate (AWHP) had a dedicated email where staff could raise issues. Organisations created their own guidance for staff, which included a Surrey system agreed escalation process.

3. The Consultant Nurse (SaBP) stated that SaBP socialised their staff and reviewed training provided by the police. He took part in the bronze and silver meetings, where case reviews and issues around RCRP were assessed and corrected. Outside of these meetings, SaBP had regular interfaces, where good practice was discussed to ensure that things worked well and that people received the support required from the right service. SaBP went back to their teams to ensure awareness of the escalation procedure was clear, and issues were raised in the Bronze group. Initial RCRP learning with the police was around welfare checks, where people may be used to online reporting for welfare checks. SaBP communicated with teams that, to follow the RCRP process they needed to talk with a call handler who would use the THRIVE (threat, harm, risk, investigation, vulnerability and engagement) risk assessment model.

4. The Member asked whether face-to-face or online training was undertaken, highlighting the benefit of in-person training. The Director for Mental Health, EDT and Prisons explained that

SCC's training was conducted online to reach more people. Training included an opportunity for question-and-answers and the training pack was shared with staff. In-person training could be explored for future training. The Consultant Nurse (SaBP) expanded that SaBP had a similar approach but had face-to-face discussions in business meetings and governance forums to socialise teams further on RCRP. The use of a Patient Safety Incident Response Framework (PSIRF) was explored to consider how teams could be quickly gathered to re-embed learning.

5. The Board Director of Healthwatch Surrey asked about the relevant training being integrated across the whole system, including voluntary organisations such as Healthwatch Surrey. It was noted that Healthwatch Surrey saw an increase in people contacting their helpdesk in crisis, and not wanting to go where Healthwatch signposted them. The Director for Mental Health, EDT and Prisons explained that SCC encouraged the police to contact voluntary organisations. The police rolled-out some training for some voluntary sector colleagues. SCC had asked the police to contact East Surrey care providers. If Healthwatch Surrey felt there were gaps in the training, this could be relayed to the police and the silver group to encourage it to be looked at.

6. The Chairman asked how the staff at the South East Coast Ambulance Service (SECAmb) were managing the RCRP initiative and how it was monitored. The Strategic Partnerships Manager (SECAmb) explained that RCRP had so far not proven to represent a noticeable increase in police activity re-directed to ambulances. The escalation process supported providing the discussion where alternative agencies attendance was required. SECAmb saw an increase in mental health calls, but it was difficult to associate it directly with RCRP. SECAmb has a clear process to manage incidents from a mental health call that may be a result of RCRP. Escalations were made from operations by raising an internal DATIX (incident reporting mechanism). DATIX's were and continue to be monitored for specific case reviews. Partner colleagues were informed of case reviews, either for a specific case or at weekly Bronze group meetings. One recurring theme was when ambulance crews encountered a patient with a 'history marker' for mental health concerns. SECAmb anticipated a police presence prior to contacting the patient, but sometimes the police did not respond as it was viewed as a perceived risk, not an actual event. When the emergency operations centre felt an incident required police presence, they used the Surrey system agreed escalation process. Police assured NHS Trusts that if crews experienced violence or aggression, they would respond. If SECAmb noticed incidents that could have been better dealt with, this would be relayed to partner group forums, specifically the weekly Bronze

group. If a case review warranted earlier discussion, SECAmb gathered with partners to do so for a specific case review.

7. A Member asked what increase in support had been required since RCRP's implementation. The Strategic Partnerships Manager (SECAmb) explained that RCRP had not shown a noticeable increase in police activity redirected to ambulances but that RCRP implementation has improved communication between agencies. The presence of specific policies around RCRP and an escalation process between the contact centres indicated when a different response was required. There were cases where SECAmb believed there was a need for a police presence for mental health related calls, particularly if a patient had a history marker for mental health. If there was an immediate risk to the patient or to staff, or if staff experienced violence or aggression, the police would respond, facilitated by the emergency operations centre and the contact centre. Some DATIXs showed times where SECAmb arrived on the scene, requested police assistance, but had not always received that response. When SECAmb decided a Section 136 under the Mental Health Act was required for a patient, SECAmb would escalate for police support.

8. The Member asked about Surrey's support services and further increases needed after RCRP's implementation. The Deputy Director of Mental Health Commissioning (SHICB) explained there was consistent messaging in the Silver Tactical group from stakeholders that additional demand was not yet seen across Surrey's services. The Bronze group was sampling calls to the police to see if there was activity not visible to Surrey's services and what some of the longer-term implications might be.

9. The Member asked if there was a specific contact point to hand over a patient at the hospital and end police involvement. The Consultant Nurse (SaBP) explained that if the police had concerns around someone's physical health the individual could be taken to an emergency department, and that highlighting RCRP was not exclusive to mental health. Other areas that implemented RCRP had sought additional funding to support the transfer from police to different services, for example Kent and Hampshire commissioned a private ambulance service to wait with people. Surrey has not sought additional funding. There were existing systems in Surrey to monitor Section 136, such as sub-groups that reviewed police activity around Section 136 use and body-worn footage. Police Officer's decision-making was explored and whether advice had been sought from a registered health professional before a Section 136. Surrey did not have a system for a handover process, so officers would still attend emergency departments. It was for police officers and the emergency departments to decide when there could be a safe

handover. In SaBP's Health Based Places of Safety, SaBP sought their own staff and mental health professionals to take over from the police. There was work to try to ensure there was space in the Health Based Places of Safety to prevent conveyance to emergency departments and help discharge the police back to the community quicker.

10. The Chairman asked about SECAmb's face-to-face 'Conflict Resolution Training' (CRT) for frontline staff, how much staff this covered, how the extra workforce responsibility was manageable without additional resources, and what reporting on the training was in place. The Strategic Partnerships Manager (SECAmb) explained CRT had covered at least 700 staff. Complete roll-out of CRT would take a further 12 to 18 months due to staff rota requirements. CRT was adapted from police training with a focus on threat assessment, removal from situations and calling for help. Clinical restraint, such as a soft hands-on approach instead of physical restraint was a training focus for SECAmb's staff. Staff assault was a reducing trend in recent months, which felt like a correlation with CRT. Approved Mental Health Professional (AMPH) services and SECAmb collaborated to provide mental health training to increase frontline staff's understanding to support themselves in highly emotional, complex situations. Other mental health initiatives included mental health first aid, ASIST (applied suicide intervention skills training) to support frontline services with complex mental health patients. Around 500 to 600 staff members went through this training in 2024. Additional resources were not yet needed for the additional Mental Health activity post RCRP rollout. Ambulance crews had an operational team leader for support if they were struggling on-scene.

11. A Member referred to the end-to-end reviews conducted when an appropriate responding agency was not initially identified, potentially leaving a vulnerable person without the needed care. Regarding these cases, which were minimal, the Member asked where the appropriate agency was not identified, what lessons were learned and shared. The Strategic Partnership's Manager (SECAmb) explained that the DATIX process identified incidents where SECAmb had concerns for patient safety or how it was managed in the instant review. Some concerns were recently seen and some DATIX was raised about a cohort of patients seen by ambulance crews that were deemed to have capacity over their own decision making and did not want an intervention. At times, the only option was to leave these patients at home with a safety plan. Some cases were emerging where patients may require a specific care plan to be reviewed and discussed at a multi-agency level. Through collaboration between agencies and the police, SECAmb focused on how individual specific care plans could be improved to create a clear plan for all agencies

supporting a patient. The use of a Section 136 was reviewed when the patient had capacity not wanting to go to an emergency department but SECAmb felt it was in the patient's best interest. In this case, the escalation process was utilised for police attendance. SECAmb also had a partnership review meeting scheduled to consider reviewing and amending current guidance through specific case learnings.

12. The Vice-Chair referred to data provided by Surrey Police highlighting that in the first 13-weeks of phases one and two there were over 4000 RCRP related calls. Of these, 1,562 did not meet the criteria for a police response. The Vice-Chair raised that this felt concerning for residents, who were used to a police presence during a mental health crisis. The Vice-Chair asked how staff were managing without a police presence, adding that the police often created an aura of calm and authority. The Vice-Chair also asked how the fire service could support RCRP. The Director for Mental Health, EDT and Prisons stated that the Surrey Fire and Rescue Service (SFRS) were involved in the planning, the Silver group's Tactical meetings and her task and finish group. SFRS were involved in the health and well-being visits, and in risk assessing. Some SFRS staff attended the RCRP training. If the police were not deployed to a situation, people should be provided with an appropriate contact. The police's flowchart informed call handlers of appropriate contacts for different situations. For AWHP, a main concern was the welfare visits and how that would impact, and the focus was on a change in practice, using a process and doing all they could before going to the police. They have not seen a sudden influx at present.

13. The Consultant Nurse (SaBP) raised that SaBP helped teams working with someone from a mental health perspective focus on contingency and safety planning at an early stage, including consideration around how to ensure the person's support network was well joined-up, especially regarding welfare concerns. Police attendance could sometimes be containing and supportive, but it could also feel agitating and intrusive for some due to the context of a situation but not necessarily because the police did anything wrong. SaBP's call handlers had floor walkers for the first 6-months of RCRP's phase 1. This was effective as it allowed call handlers to draw on the officer's additional experience in working with people's differing needs. Call handlers were instructed to ensure there was a handover of duty and a clear pathway in place even if there was not a police deployment to the scene at the time.

14. The Deputy Director of Mental Health Commissioning (SHICB) added that SHICB had commissioned mental health response vehicles. This was not a blue-light service, but a year's pilot and

would be staffed by SaBP clinicians. The Vice-Chair raised interest in the mental health response vehicles. The Deputy Director of Mental Health Commissioning (SHICB) explained that the mental health response vehicles were separate from RCRP. It was a programme within the NHS, inside the NHS long-term plan. The vehicles were being varyingly introduced across the country as non-blue-light responders to mental distress in the community. The model varied depending on locality. Commissioning and mobilisation of the vehicles had started. Vehicles would be staffed by 2 people, providing a clinician on-scene to provide a therapeutic environment with reassurance, support and intervention. The Member asked if SHICB had received extra funding for the vehicles. The Deputy Director of Mental Health Commissioning (SHICB) confirmed there was additional funding through crisis funding. The vehicles were a test as there was not the data to indicate a need which created difficulty to commission the vehicles. Responses would be collated regarding whether the vehicle was a therapeutic environment rather than any other vehicle and it was agreed to report back to the committee on this data.

15. The Consultant Nurse (SaBP) added that Surrey's mental health response vehicles would be piloted in Guildford and co-crewed by mental health staff, with close links with SECAmb for deployment. Testing the vehicles over the year was important to ensure understanding on their added value and compare with existing areas that co-crewed the vehicles with ambulance and mental health staff, such as in London and Hampshire. The Vice-Chair responded that the committee would be very interested to learn how that pilot progressed.

16. A Member asked what some of the challenges were around ensuring Safe Havens were effectively communicated to increase public knowledge of them, and if it would be manageable. The Deputy Director of Mental Health Commissioning (SHICB) explained there were significant challenges but considers them to be manageable and there was a plan in place. Changing the way police operated on the ground around Safe Havens and changing their behaviour was a challenge. A challenge was getting another organisation to cascade information down. Time was spent speaking to strategic side of the police force to engage them in workshops with the Safe Havens to describe what they did and how they could be used and develop communications and effective ways of working. There was a lot of police staff turnover, which meant regular communication with the police was important. A suggestion was to look at a physical resource for the police to refer to such as on personal devices or in police cars. Consistent communication needed to be led partly by the police and

SHICB's providers. This would be part of the review and SHICB's commissioning of Safe Havens going forward.

17. The Chairman asked if there was confidence as part of SCC's task and finish group exercise that all risks were understood, and if there was a process in place for incorporating lessons learned. The Director for Mental Health, EDT and Prisons explained that the task and finish group included various partners such as Public Health, Legal, SFRS and colleagues in the Children, Families and Lifelong Learning and Culture directorate. SaBP shared their draft staff guidance with SCC who used it as the basis for their staff guidance, providing a consistent approach. It was about consistent understanding of the risks and understanding the mitigations. The Director had met with the County Council lead, some of the sub-groups and some task and finish group members to ensure risk awareness was robust. There was confidence and lessons-learned was an ongoing process through the different bronze, silver and gold groups. It was a task to review the guidance and training offer, after RCRP had been in place for 6-months, and there was always room for improvement and learning.

18. The Consultant Nurse (SaBP) noted that involvement from a Surrey Police superintendent who reached out to partner agencies and continued to be accessible through the process helped SaBP to have transparent conversations about concerns at a level where it felt actions could be taken.

19. Regarding Safe Havens and Safe Harbour, the Board Director for Healthwatch Surrey asked if the patient's experiences were collected under the newer model and measured to understand the impact on vulnerable people, improve services, and involve people in reviews of these services. The Deputy Director of Mental Health Commissioning (SHICB) confirmed this. SHICB was starting to review the Safe Havens. The Safe Harbours were new initiatives that provided daytime support and were not being reviewed yet. Patients would be involved in Safe Haven reviews. SHICB had a group of people that did co-productive insight work that were suspected to be commissioned to work alongside service users to drive out those experiences. The commissioning team was going through existing user experience and service insight as part of their operational routine monitoring recognising there is quite a lot of work to do there.

20. The Vice-Chair asked if SHICB was evaluating and hoping that the outcomes for the patient would be better under this scheme. The Deputy Director of Mental Health Commissioning (SHICB) confirmed this and explained that Safe Havens were outside RCRP and were core provision services under the NHS's long-term plan to look after people, prevent people getting less well

and escalating into crisis. SHICB was looking to improve these services and ensure there was good learning across the different Safe Havens.

21. The Chairman explained that Safe Havens were an extremely valuable provision and RCRP pushes our thinking in that direction. The Chairman asked about future challenges and raised an issue around change and the pressures created on staff. The Chairman asked if there had been changes in staff turnover and if any risks would result in more work and resource requirements. The Consultant Nurse (SaBP) explained that a significant challenge was that the evidence base regarding what worked for people during a crisis was still developing. SaBP had evidence around things such as crisis resolution and treatment teams regarding initiatives such as Safe Havens, Safe Harbours and crisis houses, which was still being built upon. SaBP need to closely observe each of these developments and how they interfaced with partner agencies such as the police, regarding RCRP. More collaborative partnerships with the third sector and other providers were important. When people presented in crisis, components could be different, such as mental health, domestic violence, financial and housing struggles. Coordinating these different strands with different organisations could be challenging. Some work with the 'Crisis Care Concordat', was to try to ensure there was coordination with approaches and look at how organisations were evaluating the impact on the people they served. Regarding staff, particularly paramedics involved in a lot of trauma and stressful situations, recognising the need to consider how to ensure the development of effective and collaborative working, that there was a robust system around staff to ensure they were protected and that there were provisions in place to support staff.

22. The Director for Mental Health, EDT and Prisons added that frontline AMPHs who also experienced trauma worked closely with the police and noted the importance to look after staff and their wellbeing. For example, there were reflective practice sessions, and it was ensured staff had access to a de-brief and to Employee Assistant Programmes. Staff turnover was monitored, and exit interviews were conducted. For some staff, particularly working on the mental health frontline for a long time, they needed a change or to take a break. AWHP had to be mindful of demand and complexity increases for their staff.

RESOLVED:

1. It is recommended that all parties agree a common approach to monitoring and reporting with an emphasis on identifying and preventing vulnerable people being subjected to less-than-optimal support.

2. It is recommended that the delivery performance of staff training in changed processes is monitored and published, together with actions taken to maximise the uptake of training

3. Staff welfare is a major consideration; the committee would like to be updated on how the (non-blue light) Mental Health responder service vehicles are operating and receive information on that.

Actions/requests for further information:

1. Director for Mental Health, EDT and Prisons (AWHP) to review opportunities to conduct in-person staff training**.**

2. Director for Mental Health, EDT and Prisons (AWHP) to contact the Silver Group/ Police colleagues and encourage them to review any potential gaps in the training offered to voluntary organisations, such as Healthwatch Surrey.

3. Deputy Director of Mental Health Commissioning (NHS Surrey Heartlands ICB) to update the committee on the learnings gathered from the pilot mental health response vehicles (non-blue light responder services) being conducted.

Meeting paused for a break at 1.02pm

Cllr Carla Morson and Cllr John Furey left the meeting at left the meeting at 1.03pm

Meeting resumed at 1.24pm

24/24 MENTAL HEALTH IMPROVEMENT PLAN- FOCUS ON WORKING AGE ADULTS [Item 7]

Witnesses:

Mark Nuti, Cabinet Member for Health and Wellbeing, and Public Health
Liz Uliasz, Director for Mental Health, Emergency Duty Team (EDT) and Prisons- Adults, Wellbeing and Health Partnerships (AWHP), Surrey County Council (SCC)
Lucy Gate, Public Health Principal, Mental Health Surrey County Council (SCC)
Rebecca Brooker, Communities and Prevention Lead, (AWHP) Surrey County Council (SCC)
Lorna Payne, Chief Operating Officer, Surrey and Borders Partnership NHS Foundation Trust (SaBP)
Georgina Foulds, Associate Director for Community Transformation, leading Surrey Heartlands Community Transformation Programme (SaBP)

Simon Brauner-Cave, Deputy Director of Mental Health Commissioning- NHS Surrey Heartlands ICB (SHICB)

Key points raised during the discussion:

1. The Public Health Principal provided a detailed introduction to the report.

2. The Chairman asked what the data explains about the number of people of working age in Surrey who were not working because of mental health issues, what are the gaps in the current provision and how these gaps could be filled. The Public Health Principal explained that in Surrey there were around 100,000 fit notes for people signed off from work due to ill health, the majority of which were mental health or MSK (musculoskeletal) related. It was not known how many of these get repeat fit notes, but it showed a population level need. The Communities and Prevention Lead, (AWHP) added that steps were being taken to address gaps in understanding to provide a good service to residents and help those most in need. Research had been done with people living in work poverty, people furthest from the labour market and with employers to understand what this meant to them. Mental health emerged as a common theme in this work. Specific and targeted work was being undertaken around impacts on employment, looking both at the impact of sickness absence for businesses' economic productivity and resulting effects on SCC's system in terms of service demand and waiting lists, and the impact on individuals and wellbeing as well as qualitative and quantitative research on what experiences have been. Planned ways to engage with people on this included connecting into things such as Men's Pitstops (mental health group). SCC would also look at their own staffing and how they can understand sickness levels and how that impacted on local productivity.

3. The Chairman raised that careers and satisfying employment were key to dealing with mental health issues, and asked what focus was on skills and career development and what the thinking was on that direction. The Communities and Prevention Lead, (AWHP) explained SCC was working in a person-centred way, recognising every individual was different and wanted different things out of employment. There were two vanguard programmes through Department of Work and Pensions funding (DWP), which gave SCC £12m to support people into good quality work. This was being delivered across the system in partnership with health and voluntary sector colleagues, and district and boroughs. Both programmes had a person-centred approach with residents and included provision to work with employers to encourage workplaces to have structures and support for staff's mental health. Work was done around work

poverty to understand how mental health's impact on people's ability to move into strong and healthy careers. A programme was put in place called 'More and Different' which was created to identify entry level roles and how they could develop into long-term careers. SCC created spaces for schools and employment support provision to come together in a network to enable practice improvements and support people back into good quality work in a system way.

4. The Director for Mental Health, EDT and Prisons added that AWHP had the adult social care academy which looked at opportunities for SCC's staff such as preceptorships for newly qualified therapists and occupational therapists (OT), apprenticeship programmes into social work and OT training, assessed and supported year in employment (ASYE) for newly qualified social workers. Career progression for non-registered staff that might not was to be a social worker was also looked at. SHICB also had an academy that SCC linked in with to look more widely across other cohorts such as social care providers.

5. The Vice-Chair recognised that improvements were underway but asked how it was discovered that things were being done differently compared to before due to the Improvement Plan, and if examples could be provided. The Communities and Prevention Lead, (AWHP) explained that in terms of innovation, 'Work Wise' and 'Work Well' were innovation programmes with the idea to test, develop practice and learn. There were opportunities to test new things locally and inform national policy. SCC had introduced time-unlimited support for people. The 'Work Wise' programme could be accessed for as long as needed. SCC was introducing rapid support through the 'Work Well' programme. When people were off work under a fit note, the ability to access support was limited and rapid support would help get to people earlier in their mental health experience and see how this prevention made a difference. There was national and local evaluation ongoing for these programmes.

6. A Member referred to the £6m investment from DWP to help innovation programmes and asked what mechanisms there were to utilise this, and how SCC would demonstrate how it would demonstrate how it was being utilised. The Communities and Prevention Lead, (AWHP) agreed to provide the committee with more detail on the work of the innovation programmes. Both the 'Work Wise' and 'Work Well' programmes were available to all Surrey's residents and in different locations to be accessible. The programmes support included someone to help a person navigate a range of holistic support services, such as skills development and mental health support. There was evaluation in place to help deliver these programmes to a high standard as

well as understanding their own processes and learning what was and what was not working.

7. The Vice-Chair raised that districts and boroughs were in receipt of the UK's prosperity fund and asked if this fund was being used to help SCC with the innovation programmes, and if there was coordination with the districts and boroughs. The Communities and Prevention Lead, (AWHP) explained that SCC allowed districts and boroughs, who had autonomy of their Shared Prosperity Fund, to do what they felt was right for their residents. This was done in an environment where SCC could collaborate with them. SCC was developing a worker health approach, aiming to bring all people doing things together into one space to build understanding of all of Surrey's work and health offer. This meant SCC could maximise what the district and boroughs were doing through things such as the Shared Prosperity Fund. SCC were working together with districts and boroughs in a range of ways on the 'Work Wise' and 'Work Well' programmes where possible.

8. A Member asked what the current cost to businesses in Surrey was from staff unable to maintain a role due to poor mental health and if it was too early to show the improvements and comparisons in any one area and what did the data tell us. The Communities and Prevention Lead, (AWHP) explained there was currently not a lot of localised data around this. SCC could see things from national research Part of DWP's funding would be used to understand the local picture. SCC would gather a snapshot of the local picture and monitor this overtime to see how SCC was making a difference and how it changed based on things, such as new government policies. There were important areas of skill demand in Surrey, such as green skills and health and care skills. Work would be done to understand what this meant locally. The Communities and Prevention Lead, (AWHP) would share the data with the committee when they obtained it.

9. The Chairman asked if there was collaboration with Surrey Adult Learning. The Communities and Prevention Lead, (AWHP) confirmed that they were connected with Surrey Adult Learning as part of their collaborative network and there is more to do on how they can better connect together.

10. Regarding the 'One System, One Plan' approach, a Member asked how the data had improved patient reported outcome measures because of the Community Mental Health Transformation programme, and a new place-based Integrated Model of Primary and Community Mental Health Care. The Associate Director for Community Transformation explained that SaBP had achieved the roll-out of the specialist integrated mental health services in primary care across all of SaBP's

footprint. It was important to understand the impact of this and to review improved outcomes for people. SaBP commissioned a company called Unity Insights to undertake an independent evaluation completed in March/April 2024. It had positive findings around improvements in access, experience and outcomes. The report could be shared with the committee.

11. The Associate Director for Community Transformation added that the second phase of the Community Transformation Mental Health programme was a continuation of the work achieved so far. In this phase, integration with places and neighbourhoods was looked at. Whilst they embedded the new primary care service in the primary care networks (PCNs), they wanted to bring together community services with partners to work collectively and address local community needs. In the second phase's governance structure, working with each place to scope what integrated teams would look like and start to build on what was in place. Pathways forums for all agencies and GPs to come together to discuss how to meet people's needs, rather than risk a person being bounced around the system was embedded well and received positive feedback.

12. A Member asked what was being done to support people with enduring mental health difficulties in the community, to be kept out of hospital or transitioned out of hospital and helped back into employment, and what is the scale in comparative terms of such problems, and how well are you managing that. The Chief Operating Officer (SaBP) explained that SaBP provided psychology support such as talking therapies, and secondary care. SaBP was trying to intervene earlier through community-based support. The Associate Director for Community Transformation added that in January 2023 SaBP mobilised a new service called the Home First approach, which was for people who had complex needs to prioritise their attention and resources with the intention to stop people going into hospital as much as possible or reduce the length of their stay. There was 85 people under the Home First approach and undertook evaluations on the approach which provided positive data on supporting people not to go into hospital, reduce the length of hospital stay, and reduction in the use of the Mental Health Act. The impact of the approach, which had so far been positive, was closely monitored. The Deputy Director of Mental Health Commissioning (SHICB) added that because of the Home First Approaches' positive evidence, SHICB had chosen to invest further resource into the Home First team, particularly to address personality disorder which SHICB currently underprovided for. The second phase of the Community Mental Health Transformation Programme would draw in specialist services to come together and make referrals easier into services through one simple process rather than multiple referrals. The Director of

Mental Health, EDT and Prisons added that adult social care's focus was more on recovery, such as by working with people to identify their goals and help get people back into employment.

13. A Member asked how it could be ensured that the most urgent mental health needs were identified and what was being delivered to support some of the most vulnerable people in communities to ensure a greater focus on reducing health inequalities. Additionally, the Member asked what methods were being used to measure success, what level of success was achieved so far and what more could be done. The Chief Operating Officer (SaBP) explained that according to NHS England's mental health population needs index, Surrey Heartlands Integrated Care System had one of the lowest levels of population need, but had one of the lowest levels of mental health spend per person, which was challenging. Surrey had a higher-than-average mortality rate for people with severe mental illness, and significant challenges and a high level of inequality for those suffering severe mental illness. SaBP developed a model using patient level electronic records, which found Surrey's definition of severe mental illness included a broader set of diagnostic codes compared to the Quality Outcomes Framework.

14. The Public Health Principal (SCC) added that work was done with Surrey University to understand Surrey's population with severe enduring mental health needs. Surrey was recognised as having a low level of need, as needs were calculated based on Surrey's demographic. The Quality Outcome Framework only included certain coding and diagnosis, so work was undertaken with King's College London and Surrey University to understand the level of need and some of the wider coding, called ICD-10 codes in secondary care and SNOMED codes in primary care. This had established more than what was available on the Quality Outcome Framework or national estimates, which allowed for population health management work to understand how SCC could target and prioritise interventions. Scenario modelling was done to understand some of the possible high-impact changes for this population and review areas such as Accident and Emergency attendance and hospital admissions. There was a Severe Mental Illness (SMI) Health Inequalities Board and a multi-agency action plan would be explored to support the implementation of the board recommendations.

15. The Chief Operating Officer (SaBP) added that SaBP found around 22,000 individuals thought to fit into the SMI category, whereas on the Quality Outcome Framework only found around 5,700 people. Key neighbourhoods of deprivation had a significantly higher proportion of people with SMI, and there were gender disparities with nearly twice as many women as

men in the SMI population but more men with SMI were likely to have more mental health admissions. SMI population had substantially longer A&E waits. Community teams tried their best to support people to live longer in their own homes. Ongoing work with The Richmond Fellowship was important to ensure that people with SMI get work they were good at and interested in.

16. A Member raised the importance of getting meaningful measurements of people's mental health needs and concerns regarding the equations and coding's used as it is not completely accurate in identifying peoples lived experiences of those people most in need. The Chief Operating Officer (SaBP) agreed but highlighted diagnosis was sometimes not straightforward and could take time.

17. The Vice-Chair referred to the idea of engaging with employers to encourage the employment of people with mental health issues and asked how much focus there was on working with Surrey's economy to address the situation. The Chief Operating Officer (SaBP) highlighted work with The Richmond Fellowship who worked with a range of employers and would an important part of recovery in terms of avoiding hospital admission and helping with employment and accommodation. The Associate Director for Community Transformation added that SaBP integrated employment support with their core offer within primary and secondary care. The provider had 'link workers', which were embedded in SaBP's core community services, involved in case discussions and ensuring earlier help for people. SaBP also had good outcome reports from the provider 'Way Through'. The Vice-Chair suggested it would be proactive to have a programme that sought out employers to help support employment for people with mental health issues. The Director for Mental Health, EDT and Prisons agreed.

18. A Member asked what the benefits would be to residents from the all-age and place-based approach to developing a 'Mental Health System for Population Health Gain', which was being developed in the Public Health and Communities team, with Places and other partners, and what the potential issues were. The Public Health Principal explained that the approach involved working with population health management to understand the level of need in different places. This involved working with places across NHS footprints to understand their populations of SMI, common mental health disorders and lower level need such as sleep. It also involved close working between the Public Health, Communities and Prevention team and teams around the community teams to embed interventions such as the 'How are you?' Surrey workforce wellbeing programme. Part of this involved supporting organisations to prevent mental ill health

and enable access to early interventions and work with communities to strengthen connectivity. The care sector and routine manual workers were being prioritised in the priority neighbourhoods. Once organisations were ready to support mental wellbeing, they could then be supported to employ people who may be more vulnerable. Community resilience was being supported through the team around the community model where a toolkit programme on the 5 ways to wellbeing was used for communities to develop tailored action plans.

19. The Communities and Prevention Lead, (AWHP) added that there was a service that supported employers to take on people with all kinds of disabilities, including mental health concerns, supporting employers to place the person within their team and help the person stay in the role and succeed. There was an offer to all businesses to help improve their understanding.

20. The Vice-Chair outlined that the report stated that the number of people out of the labour market due to ill health was at an all-time high, and in-work ill-health was rising. The Vice-Chair asked if the measures outlined being taken by SCC would lead to a positive outcome. The Communities and Prevention Lead, (AWHP) explained that SCC believed they would bring about the desired change, indicated through the initiatives undertaken and the bid to be national vanguard sites for the 'Work Well' and 'Work Wise' programmes. The Public Health Principal added that the programmes outlined across the system were evidence-based or evidence-inspired and were being tested which was key. The next step was around how the initiatives would be integrated to understand how the system was working to support populations and identify need. The governance fit in three separate places, and a challenge was to pull this together to understand if the system response was correct and if it can be improved. The Deputy Director of Mental Health Commissioning (SHICB) added that the new 10-year plan expected following Lord Darzi's report would include more emphasis. Therefore, requests for more funding was expected around employment, as an expected theme was around how the NHS was to support people in the wider economy.

RESOLVED:
The Select Committee noted the contents of this report and the actions being taken by partners across Surrey to address the link between mental health and employment, and the Committee supports the programmes and the 'One System One Plan' approach to improving mental health and the economic activity

The committee recommended:

1. Set clear, measurable performance objectives for each of the initiatives being undertaken

2. Implement effective reporting on the performance objectives

Actions requests for further information:

1. The Communities and Prevention Lead, (AWHP) to provide the committee with more detail on how the innovation programmes, 'Work Wise' and 'Work Well' were working and the support these programmes offered.

2. The Communities and Prevention Lead, (AWHP) to share further information/data on the work being conducted to understand Surrey's local picture regarding the cost to Surrey's businesses and Surrey's economy from staff unable to maintain a role due to poor mental health.

3. Associate Director for Community Transformation to share the commissioned independent evaluation report on the impact of the specialist integrated mental health services in primary care.

25/24 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 8]

Committee had no further comments.

26/24 DATE OF THE NEXT MEETING [Item 9]

Chairman noted the next meeting would be held on 4 December 2024.

Meeting ended: 2.32pm

Chairman

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CABINET- 26 November 2024

Cabinet Response to the Interim Recommendations from Select Committees Following Budget Deep Dives and Budget Briefing Sessions

Adults and Health Select Committee:

I. The committee urges Cabinet to review the planned efficiencies and savings targets for FY 25/26 to be delivered via the Transformation Programme to ensure these are realistic and achievable.

Cabinet Response:
It is recognised that delivery of the efficiencies and saving targets in the financial year 2025/26 and beyond will be challenging. The plans for the transformation programme in 2025/26 have been robustly scrutinised. They focus primarily on the delivery of the opportunities identified in the recent diagnostic carried out by Newton Europe. They used a tried and tested methodology to identify opportunities for efficiencies based on data and insights and with engagement from across the Directorate, including front-line practitioners. The leadership team have now reviewed the findings and have developed a Directorate owned plan for delivery. This is being further tested and some assumptions refined to further ensure confidence in delivery. The delivery of the diagnostic internally will strengthen capabilities within the Directorate and mean the changes are sustainable.

In the meantime, transformation continues in 2025/26 and beyond through the Market Shaping and Commissioning programme. A longer term more sustainability approach is being implemented through the transformation of the models of care offered in Surrey, including the focused work on Community Opportunities for Everyday Living, the development of new models of housing with care and support, and expanding the use of technology enabled care solutions. Supported by focused work to deliver the Council's direct payment strategy this approach will ensure that people who draw on care and support services can exercise greater choice and control over their care and support arrangements, helping them to live more independently for longer.

II. The committee acknowledges the challenges the transformation plan presents to the Adults, Wellbeing & Health Partnerships directorate (AWHP). Members of the committee have requested to be kept up to date on the delivery of transformation, ensuring key milestones are met.

Cabinet Response:

The Chair of the Select Committee, Cabinet Members and Executive Director will review the forward plan for the Select Committee to ensure that there is regular reporting on the progress of the transformation programme.

III. The committee recommends a review of discretionary services in all areas across the directorate, ensuring they are aligned with key pressures on managing

demand and delivering good outcomes. The committee expects to see evidence to demonstrate this.

Cabinet Response:
The AWHP directorate is conducting a review of all discretionary areas of expenditure that are designed to prevent demand for services to review performance and the extent to which services are mitigating more costly services, primarily care packages. The outcomes of this review will be considered as part of formulating AWHP's proposed final budget for 2025/26 and MTFS to 2029/30 which will be reviewed by Cabinet in January 2025 and Full Council in February 2025.

IV. The directorate continues to prioritise joint working and integration ensuring that everyone gets best value and outcomes.

Cabinet Response:
The AWHP directorate continues to prioritise working collaboratively with its partners across the Integrated Care Systems and across Surrey as a whole.
Key examples of this joint working include:

- The Mental Health Investment Fund, which is an excellent example of a collaborative programme of work led jointly by the AWHP directorate and with partners in Surrey Heartlands ICB that has had made a real difference to health and wellbeing of many Surrey residents.

- The work the AWHP directorate continues to progress related to Surrey's Better Care Fund, working closely with partners across the VCSE sector and both Frimley and Surrey Heartlands ICBs to ensure that a holistic approach is taken to commissioning services and that no-one is left behind.

- The joining up of the Surrey-wide Health and Wellbeing Board and the Surrey Heartlands Integrated Care Partnership to create a truly partnership space to improve collective oversight, collaboration for strategic decision-making and streamlined governance.

ADULTS AND HEALTH SELECT COMMITTEE

WEDNESDAY 4TH DECEMBER 2025

Scrutiny of 2025/26 Draft Budget and Medium-Term Financial Strategy to 2029/30

Purpose of report: Scrutiny of the Draft Budget and Medium-Term Financial Strategy

Introduction:

1. Attached is a summary of the 2025/26 Draft Budget and Medium-Term Financial Strategy (MTFS), particularly focussing on the budgets for the Adults, Wellbeing & Health Partnerships Directorate (AW&HP).

2. The 2025/26 Draft Budget & MTFS to 2029/30 was presented to Cabinet on 26th November 2024. The Final Budget for 2025/26 will be approved by Cabinet in January 2025 and full Council in February 2025. It is good practice to, as far as possible, set out in advance the draft budget to allow consultation on, and scrutiny of, the approach and the proposals included. There will be no movements in the Draft Budget position until the provisional Local Government Finance Settlement is published, which is expected later in December, when the implications can then be considered.

3. The production of the 2025/26 budget has been developed through an integrated approach across Directorates, Corporate Strategy and Policy, Transformation and Finance, ensuring that revenue budgets, capital investment and transformation plans are all aligned with each Directorate's service plans and the corporate priorities of the organisation.

Context:

4. The Local Government financial climate is extremely challenging. The national picture for public services is one of constrained financial resources. A number of local authorities, across the Country, are struggling to balance available funding with significantly increasing demand and cost pressures.

5. Local Government funding remains highly uncertain, with a number of factors likely to result in significant changes to our funding position over the medium-term. The first opportunity to understand in detail the direct impact of funding

arrangements for the Council will be with the provisional Settlement itself, which is expected in late December 2024, with a final settlement in January 2025.

6. The overall outlook for 2025/26 is one of significant challenge. Budget envelopes are not anticipated to increase significantly, however, substantial increases in the cost of maintaining current service provision and increased demand result in pressures increasing at a higher rate than forecast funding.

7. While many of the demands we are experiencing are not unique to this Council, we cannot rely on Government, or anyone else, to solve the issue for us. We need to reduce our costs and take difficult decisions in order to ensure our ongoing financial resilience. Being realistic about our ambitions, underpinned by an earned confidence in our ability to deliver efficiencies, will enable us to continue to deliver the Council's priorities.

8. Although good progress has been made over the last few months, there remains a provisional budget gap for 2025/26 of £17.4m, driven primarily by continued high demand and price pressures. Further actions will have to be agreed to close the gap, which will be extremely challenging, given the forecast level of pressure. The level of Council Tax raised and the extent to which further efficiencies will need to be identified, will be dependent in part upon the Local Government Finance Settlement in December, and confirmation of District and Borough Council Tax Bases in January.

9. We need to be prepared for what will continue to be a difficult financial environment over the next few years. The gap is expected to continue to grow over the medium term financial strategy period.

10. The Council recognises that tackling this gap will require a focus not only on addressing the pressures in 2025/26, but simultaneously looking to address the medium-term horizon. Our financial resilience is crucial and part of the strategy will be to ensure we have adequate reserves to ensure we can transform, alongside making sure we provide for any changes to funding or unexpected effects on costs.

Engagement:

11. Over the summer of 2024, the council engaged with residents to inform the draft budget. Mindful of the current financial context, we have taken a prudent approach to our consultation and engagement activity. By using internal survey tools, costs have been limited to the creation of accessible formats of our engagement material, however, this means the results illustrate the preferences of those who chose to take part but does not provide data representative of Surrey residents. A summary of the results are available in Annex 1.

12. For this phase of engagement, the council asked for insight from stakeholders on:
    - The importance they placed on each of 11 outcomes, based on the Community Vision for Surrey in 2030 and Organisation Strategy 2023 – 2028:
        a. Better roads and pavements
        b. Providing care for adults and children who need us most
        c. Making our communities safer
        d. Better public transport connections for easier, more predictable journeys
        e. Enabling people of all ages to access education and skills
        f. Promoting better health and wellbeing for all residents
        g. Tackling climate change and protecting Surrey's countryside and biodiversity
        h. Reducing waste and increasing recycling
        i. Reinvigorating town centres and high streets
        j. Stronger community relations through local community networks and support
        k. Supporting local businesses to prosper and grow the economy
    - How the budget should be allocated.
    - Approaches to balancing the budget.
    - Conditions for supporting a council tax increase.

13. Data was gathered from nearly 1,600 stakeholders using:
    a) An open survey on the Surrey Says platform (28 Aug - 30 Sep 2024) with 1,495 participants. Survey respondents were self-selecting, which means the results should not be treated as representative of the whole of Surrey's population.
    b) Community events and reference groups, engaging nearly 90 residents.
    c) Promotion via social media, the Surrey Matters website, newsletter, and local council members.

14. We will be consulting with residents and other stakeholders on the measures being taken to balance the budget for 2025/26 after the approval of the draft Budget by Cabinet on 26 November. The results of this exercise will be reported to Cabinet and Council in January and February 2025.

15. Impacts of budget proposals, both positive and negative, are considered by services in a variety of ways, including through services' own consultation and engagement exercises and the use of Equality Impact Assessments (EIAs). EIAs are used to guide budget decisions and will be included in the final Budget paper alongside an overview of the cumulative impact of proposed changes. At Surrey, we consider impacts not just on the nine protected characteristics, but also other vulnerable groups, for example, those at socio-economic disadvantage, Gypsy, Roma and Traveller communities, those experiencing

homelessness, and so on. An overview of impacts of efficiencies pertinent to the areas covered by this committee are included in Annex 1.

Budget Scrutiny

16. Annex 1 sets out the budget proposals for AW&HP, including the latest calculated revenue budget requirement compared to the current budget envelopes based on the Council's estimated funding, the service budget strategy, information on revenue pressures and efficiencies and a summary of the Capital Programme. Each Select Committee should review in the context of their individual Directorates, exploring significant issues and offering constructive challenge to the relevant Cabinet Members and Executive Directors.

17. Members should consider how the 2025/26 Draft Budget supports the Council in being financially stable whilst achieving Directorate and Corporate priorities and the Council's Vision for 2030. The budget aims to balance a series of different priorities and risks with options on investment, efficiencies and increases in the rate of Council Tax. It is appropriate for the Committee to consider how successful the budget is in achieving this.

Conclusions:

18. The provisional Local Government Finance Settlement in December, to be finalised in January 2025, will clarify the funding position for the Council. Once funding is clear, Directorate pressures, efficiency requirements, the level of Council Tax and the Capital Programme will be finalised.

Recommendations:

19. That each Select Committee agrees a set of recommendations to the Cabinet, pertinent to their area, which will be reported to Cabinet in January 2025.

Next steps:

20. Between now and February 2025, when the budget is approved by full council, officers and Cabinet Members will work closely together to close the current budget gap; challenge and refine assumptions and finalise the development of the Capital Programme.

21. The recommendations resulting from Select Committee scrutiny process will be compiled and reported to the Cabinet meeting on 28th January 2025.

Report contact

Nikki O'Connor – Strategic Finance Business Partner (Corporate)

Contact details

nicola.oconnor@surreycc.gov.uk

Annexes:

Annex 1: 2025/26 Draft Budget Report and Medium-Term Financial Strategy to 2029/30 – Scrutiny Report for AW&HP.

Sources/background papers

- 2025/26 Draft budget and medium-term financial strategy report to Cabinet 26th November 2024.

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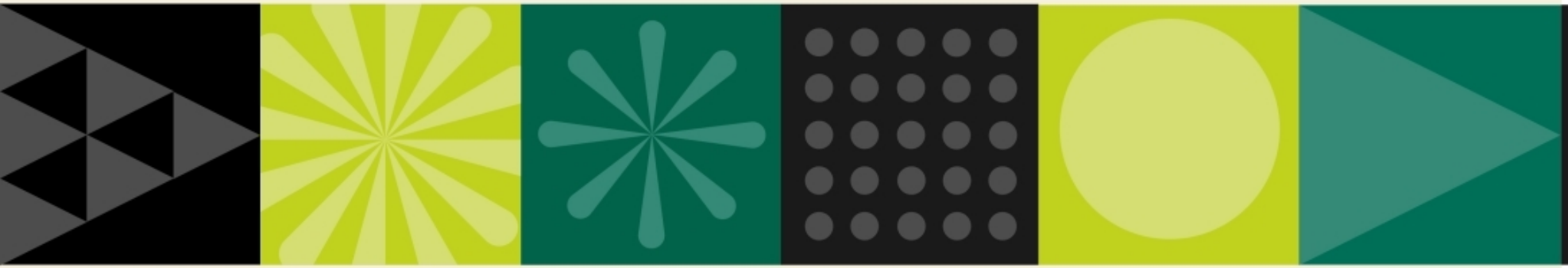
SURREY
COUNTY COUNCIL

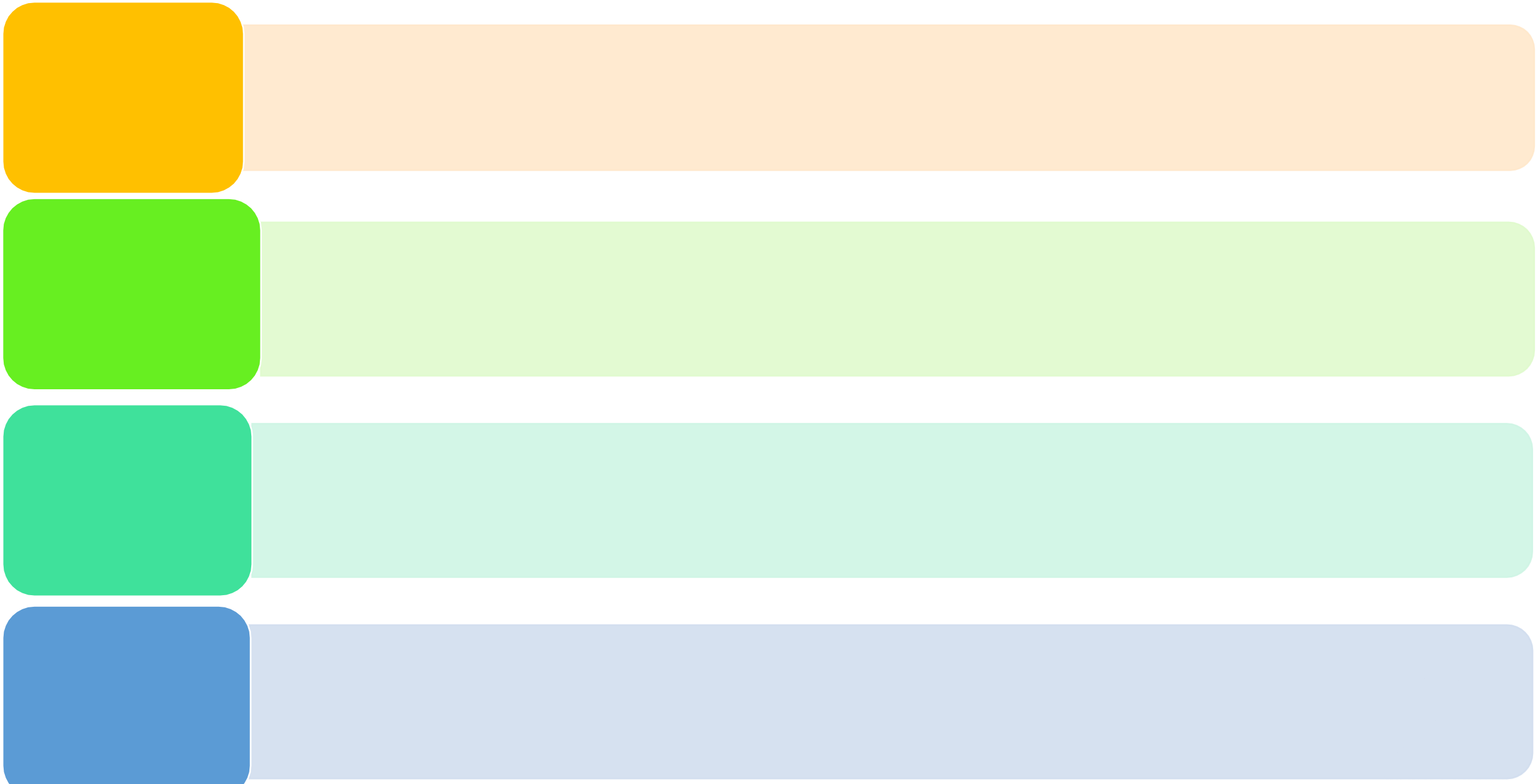


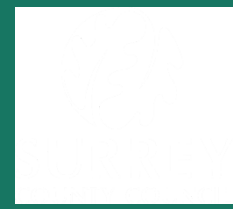
THE SURREY WAY

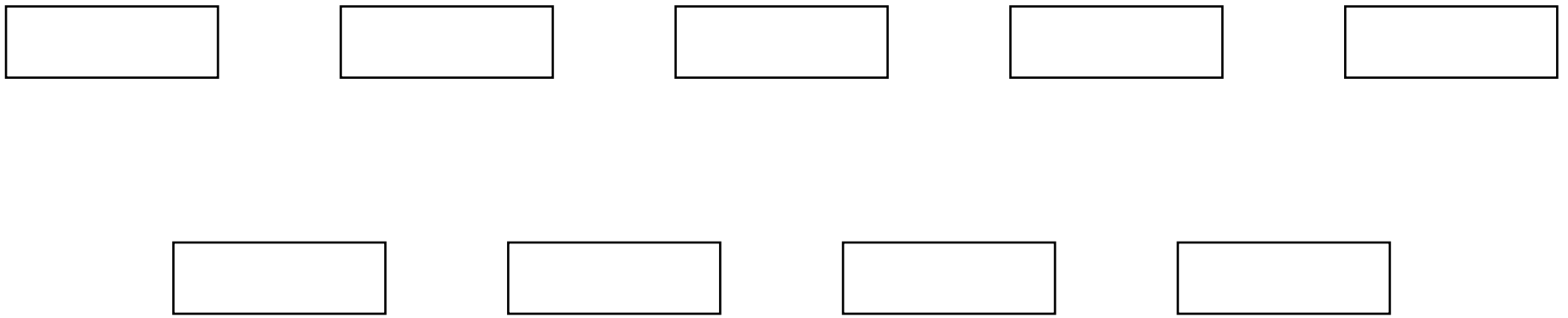
OUR PURPOSE

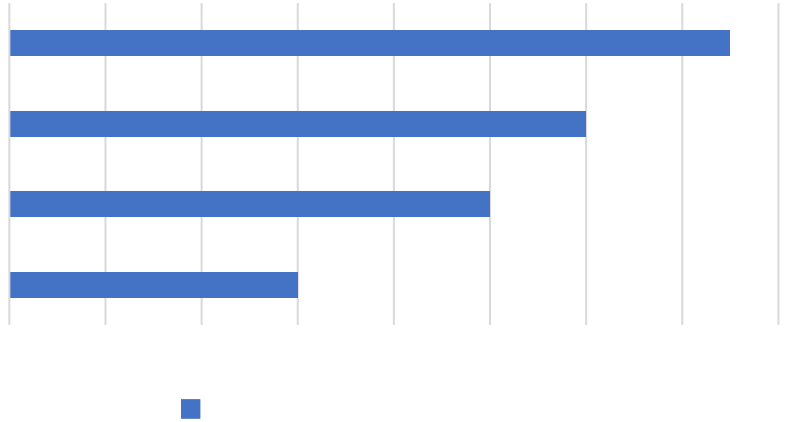
OUR PEOPLE

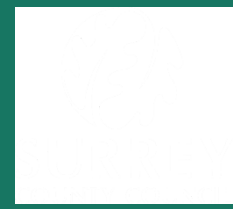
OUR ORGANISATION



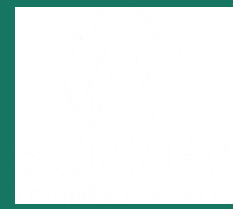








Directorate	Base Budget 23/24 £m	Additional Funding Estimate £m	Identified Pressures £m	Identified Efficiencies £m	Total Budget Requirement £m
Adults, Wellbeing & Health Partnerships	505.9		50.1	(31.6)	524.4
Children, Families & Lifelong Learning	291.6		29.6	(11.1)	310.1
Environment, Infrastructure & Growth	187.4		14.5	(2.6)	199.3
Community Protection & Emergencies	43.9		1.3	(0.8)	44.4
Customers, Digital & Change	49.3		4	(2.9)	50.4
Comms, Public Affairs & Engagement	2.8		0.1	(0.2)	2.7
Finance & Corporate Services	27.0		1.6	(1.4)	27.2
Central Income & Expenditure	100.6		7.1	(6.5)	101.2
Directorate Total	1,208.4	0.0	108.3	(57.1)	1,259.7
Central Funding	(1,208.4)	(33.9)			(1,242.3)
Council Total	-	(33.9)	108.3	(57.1)	17.4



Total AWHP directorate position	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	Total
	£m	£m	£m	£m	£m	£m	£m
Brought forward budget	505.5	505.5	524.5	546.6	567.2	590.2	
Virements		0.5					
Pressures		50.1	39.7	39.1	40.6	43.2	**212.7**
Identified efficiencies		(31.6)	(17.6)	(18.5)	(17.6)	(12.7)	**(97.9)**
Total budget requirement		**524.5**	**546.6**	**567.2**	**590.2**	**620.8**	

Pressure	Description	Net Pressure					
		2025/26 £m	2026/27 £m	2027/28 £m	2028/29 £m	2029/30 £m	Total £m
ASC price inflation (care packages & contracts)	Estimated cost of price inflation taking into account forecast increases to key inflation indicators including the NLW & CPI. Pressures are currently costed based on a 5.77% NLW uplift in 2025/26, 4% in 2026/27 and 3% per year thereafter. CPI is budgeted at 2% per year across the MTFS period. Pressures will need to be reviewed in light of the Autumn Statement and pending the Draft Local Government Finance Settlement. Assumptions are made about the proportion of packages for each market sector that will receive uplifts based on the inflation principles proposed for each sector. The gross inflationary pressures shown here are before any planned efficiencies to mitigate inflationary pressures.	20.028	15.722	13.135	13.363	13.764	**76.013**
ASC assessed fees & charges inflation	Estimated inflationary increases in income received from residents who are financially assessed under the Care Act to contribute towards the cost of their care packages. This is driven by factors such as changes to pension and benefit rates.	(2.675)	(2.026)	(2.075)	(2.126)	(2.178)	**(11.081)**
Public Health contract inflation	Estimated contract inflation on PH commissioned contracts (approximately 2% per year)	0.645	0.655	0.668	0.681	0.695	**3.344**
Care package carry forward pressure from 2024/25 - current trajectory	The estimated extent that care package net expenditure commitments will be above the 2024/25 budget by year end and therefore carry over as a pressure into 2025/26 based on the current care package expenditure trajectory prior to actions planned to mitigate the current trajectory which are included in efficiencies	16.121					**16.121**
Care package demand in future years - current trajectory	The estimated increased expenditure on care packages in future years due to increases to the number of people receiving care funded by SCC and increases to the cost of care packages excluding inflation based on the current care package expenditure trajectory prior to actions planned to mitigate the current trajectory which are included in efficiencies	10.663	22.942	24.818	26.087	28.184	**112.695**
Community equipment demand	ASC's share of the estimated increased expenditure requirement on the joint community equipment store (a pooled budget with ICB health partners) based on rising demand.	0.313	0.375	0.438	0.500	0.563	**2.188**
Pay inflation across the AWHP directorate	Estimated cost of pay inflation modelled at 3% 2025/26, and 2% 2026/27 - 2029/30	2.840	1.999	2.042	2.086	2.130	**11.097**
Other staffing budget changes across the AWHP directorate	Reduction in the vacancy factor built into the ASC budget reflecting increased recruitment to roles to delivery core statutory duties, £0.5m underachievement against 2024/25 workforce reconfiguration target,pay progression and non-pay inflation for staffing budgets.	3.225					**3.225**
Communities functions	A proportion of the total investment in the communities function is based on one off funding arrangements for community based work and roles that ends in March 2025. This pressure reflects the end of that funding prior to planned actions to achieve efficiencies	0.988	0.039	0.041	0.043	0.044	**1.156**
Changing Futures	Investing in sustainable funding for the Changing Futures Programme. There is continuing ambition to secure funding from system partners. £1.3m is the maximum amount needed to maintain the programme.	1.300					**1.300**
Increase to Better Care Fund income	Estimate of potential increased BCF income for ASC based on the trend in recent years	(3.000)					**(3.000)**
Changes to other ASC grants	Assumes that Social Care in Prisons and ASC's share of Local Reform & Community Voices grant funding that was received in 2023/24 but was not included in the 2024/25 budget continues in 2025/26. All other grant funding assumed to continue at 2024/25 levels	(0.393)					**(0.393)**
Total Pressures		**50.056**	**39.707**	**39.066**	**40.634**	**43.201**	**212.664**

ADULTS AND HEALTH SELECT COMMITTEE

Wednesday 4 December 2024

Review of progress made to implement the joint health and social care dementia strategy for Surrey, 2022-2027

Purpose of report

The Committee has asked to review the progress made to implement the joint health and social care dementia strategy for Surrey, 2022-2027. The Committee would like to see a focus on ensuring sufficient preventative measures are being provided to reduce dementia, as well as improving the dementia care pathway for the Surrey population. The Committee wish to understand what developments have been implemented across Surrey.

Executive Summary

1. It is estimated there will be almost 23,000 people with dementia in Surrey by 2030. The joint health and social care dementia strategy for Surrey, published in 2022, uses the 'well pathway for dementia' as a framework to outline the ambition to improve care and support for people with dementia, their carers and families.

2. There has been a focus on reducing risk factors for dementia. Awareness raising around 'what is good for the heart is good for the head' has been undertaken, alongside work on promoting healthier lifestyles. There are specific services available to support healthy lifestyle choices, including for people with a learning disability, who are more like to get dementia.

3. Surrey and Borders Partnership NHS Foundation Trust have been working hard to promote their memory assessment services across a range of local partner organisations. The dementia diagnosis rates in both Surrey Heartlands and Frimley ICBs have been on or over the national target since January 2024, and well above the England average.

4. The range of information available for people with dementia and their carers has improved, localised support is available and a comprehensive carers support offer is available across the county. Technology enabled care and homes (TECH) is available that can support many people living with dementia

and their carers to live at home safely for longer and with increased independence.

5. It is important that people with dementia and their carers and families have equal access to palliative and end of life care. Advanced Care Plans (ACPs) and ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms are used across Surrey, and access to fast track end of life care pathways and support to give carers a break is available.

6. Alongside the good progress made in improving the dementia care pathway for the Surrey population over the first two years of the strategy, we still have work to do. This includes keeping abreast of new disease modifying treatments and planning for the impact of these.

Introduction

7. Dementia is most common amongst older people and in Surrey it is estimated that between 2020 and 2030 the overall number of people with dementia is forecast to increase by 28%, from 17,700 to 22,672 older people. NHS digital data estimates that there are around 105 people with a learning disability who have dementia, although provider feedback is that these numbers appear low.

8. Dementia is highlighted as an improvement area in the recent Darzi independent investigation of the NHS in England. In their submission to the Investigation, the Alzheimer's Society argued that there are "high levels of unwarranted variation in access to diagnosis and treatment [and] insufficient adherence to clinical guidelines". As society continues to age, there is an important challenge to improve both the quality and quantity of care for people with dementia.

9. Most people with dementia will have at least one other condition and this is being identified as part of the developing work on frailty in the different NHS Place-Based Partnerships in Surrey. The growing demand for services by people with dementia and their carers means we need to address this challenge with integrated and proactive care for all parts of their journey of care.

10. The joint health and social care dementia strategy was co-produced throughout late 2021 and early 2022. The voices of people with dementia, their unpaid carers and families were central to the development of the strategy, alongside national and local evidence of need.

11. The strategy is framed around the well pathway for dementia which looks at five areas: preventing well; diagnosing well; supporting well; living well and dying well. Additionally, the strategy has a clear focus on tackling inequality.

12. This report focuses on the preventative measures in place across Surrey to reduce the risk of dementia in the population. It also highlights residents' experiences of services across the dementia pathway, to illustrate the progress that has been made to implement the ambitions of the dementia strategy. It also makes recommendations about the work still to be done to improve the lives of people with dementia and their carers, making sure no-one is left behind.

Reducing the risk of dementia

13. Our aim is to continue to raise public awareness and activities around dementia and the actions people can take to reduce the risk of dementia. The following progress has been made.

14. The strategy was formally launched with a range of media, including via a press release, following a period of engagement. To ensure the strategy is available and accessible to a wide range of people, it is available in a range of formats, including easy read. Other easy read accessible information and resources for people with dementia are readily available.

15. A feature in our Surrey-wide resident e-newsletter in 2023 titled "Seven healthy habits which can reduce your risk of dementia" signposted to key Surrey services which can support people to make lifestyle changes and was among the most-clicked articles for the year, with further awareness-raising on social media. Wider work has focused on promoting healthier lifestyles including stopping smoking, reducing drinking and "knowing your numbers" for blood pressure.

16. The Healthy Surrey website hosts printable content (Appendix 1) for both residents and professionals focusing on proactive steps people can take to reduce their dementia risk, again linking to key Surrey services which contribute to preventing dementia. The content draws out the links between heart and brain health and focuses on building brain-healthy habits including managing blood pressure, keeping to a healthy weight, getting socially active, quitting smoking and keeping your mind active. There's ongoing work to raise awareness of the content among professionals, partners and residents, including through newsletters.

17. There is a further communications campaign planned for winter 2024 which will continue to signpost to key services. The campaign will include capitalising on the new year with messaging about a healthier fresh start and is also planned to include printed materials.

18. Surrey County Council commission NHS Health Checks as part of our Public Health Agreements with primary care. A key aim of the NHS Health Check, particularly for individuals aged 65 – 74 years old, is to increase population awareness of dementia. As part of our service specification we require providers to include a dementia NHS Health Check leaflet with their invitation letter/text/e-mail (NHS Health Check - Dementia resources) which details what dementia is, myths surrounding dementia, it's key symptoms and advice on reducing risk to dementia such as physical activity, alcohol and smoking.

19. We have just procured a data management system which integrates with systems used by GP Practice. This will automatically populate data dashboards with aggregated demographic information about those accessing NHS Health Checks, and the outcomes of these checks. Public Health will now have the ability to target their promotion of NHS Health Checks in particular areas where activity is low. By widening access of NHS Health Checks across Surrey's population, we give individuals the ability to identify and discuss their symptoms that lead to increased dementia risk, such as high blood pressure, smoking, excessive alcohol intake and physical inactivity.

Stop smoking

20. There is strong evidence to show that smoking increases a person's risk of developing dementia. This includes whether someone smokes in mid-life or later life. Smoking increases the risk of vascular problems (problems with the heart and blood vessels). These vascular problems are also linked to the two most common forms of dementia: Alzheimer's disease and vascular dementia. The evidence says that stopping smoking reduces your risk of dementia. Research also shows that ex-smokers do not have an increased risk of dementia.

21. In 2023-24, the locally commissioned stop smoking service One You Surrey supported 1,500 people to quit smoking, with an average age of 52. 53% of successful quitters were aged 50 and over. As smoking can increase a person's risk of developing dementia, the smoking cessation service is playing a vital role in supporting the preventing well agenda of the dementia strategy.

22. SCC has received an additional grant to support a further 15,000 smokers to set a quit date over the next 5 years, thus these efforts can contribute to the work of preventing dementia among our residents. To achieve our targets, we have increased the capacity of our stop smoking service and support available for all residents who smoke, with a focus on key neighbourhood areas and populations with highest smoking rates such as routine and manual workers, NHS workforce, people from ethnic communities and people who are in treatment for substance use.

23. A mass media stop smoking campaign, ‘Its Well Worth It’, was launched in September targeting routine and manual workers aged 25-55 across Surrey. The campaign comprised of out of home (bus stops) and digital advertising for 5 weeks. The digital campaign made over 1 million impressions, resulting in 25,000 clicks. Printed materials were distributed to libraries, pharmacies and GP Practices.

24. Public Health have also commissioned a piece of research looking at the barriers and motivators for current smokers accessing stop smoking support services. The findings will be presented in December and will inform future comms and marketing campaigns in 2025.

Healthy Weight

25. What we eat affects our overall health and maintaining a healthy weight reduces the risk of dementia. Public Health Surrey have commissioned two weight management services, one for adults One You Surrey and the other for children and their families Be Your Best. These programmes are free to people living and working in Surrey and offer a variety of programmes within them.

26. In May 2024, Public Health published Whole System Food Strategy. Work driven by Surrey Food Partnership is ongoing and includes a complete overhaul of food and wellbeing for the Looked After Children service. In development is a “Making Every Contact” Count food and wellbeing workshop which will be available for stakeholders across Surrey. Public Health are taking a “Food in All Policy” approach which addresses food and health, food insecurity together with sustainable food and climate change.

Alcohol

27. Heavy drinking damages our health, including our brain health. It is also related to an increased risk of lots of health conditions including dementia, cancer, stroke and heart disease. There is also a rare type of dementia that is caused by long-term heavy alcohol use, called Wernicke-Korsakoff syndrome.

28. Alcohol prevention is now a core part of the Surrey Combating Drugs Partnership (CDP), focusing on reducing alcohol-related harm alongside drug-related initiatives. It has three main priorities:

    - Alcohol prevention: Raising awareness about the health and wellbeing impacts of alcohol on individuals, families, and communities. From July 2023 to October 2024, 2,509 residents were alcohol screened online as part of the alcohol awareness campaign. Results indicated 25.2% at low risk, 36% at increasing risk, 11.5% at higher risk, and 27.3% potentially dependent on alcohol.

- Early Intervention and Education: Embedding the “Making Every Contact Count” (MECC) approach with Alcohol training across partners and service providers. Since January 2024, 187 members of the Surrey workforce across 30+ organisations have completed MECC Alcohol training.

- Collaboration and Intelligence Sharing: Strengthening partnerships and sharing insights to improve alcohol harm reduction. An increase in suspected Alcohol-Related Brain Damage (ARBD) cases has been identified in acute hospitals and treatment services. A CDP subgroup is exploring a streamlined, co-designed pathway to improve ARBD diagnosis, post-diagnosis management, and long-term support. This initiative aims to strengthen links between specialist, community, and social care services.

People with a learning disability

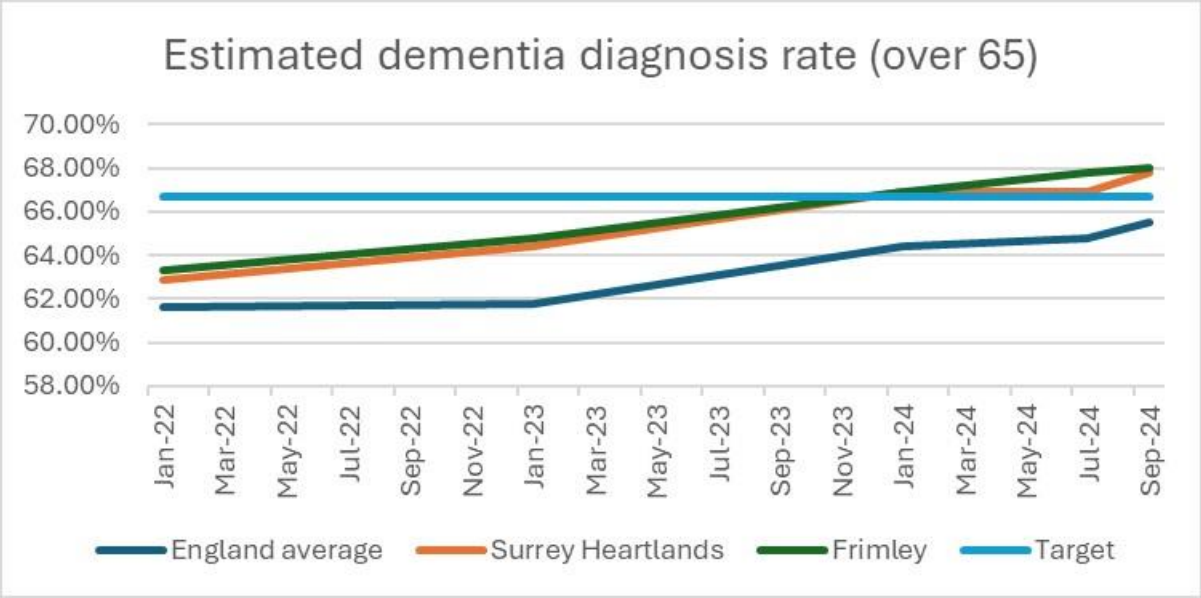
29. Dementia affects people with a learning disability at a younger age. The people with learning disabilities chapter in the joint strategic needs assessment (JSNA) shows that people with a learning disability aged over 60 are two or three times more likely to have dementia than the general population.

30. Surrey and Borders Partnership NHS Foundation Trust operate a tailored dementia assessment, diagnostic and support service for individuals with Down’s syndrome. They also have a focus on preventing dementia. The new brain health baseline assessment process provides the person with resources to adopt a proactive approach now to minimise the risk of dementia. A personalised brain health plan is then developed from the information gained from the person’s baseline assessment. This includes information about the importance of keeping your brain healthy and tips to keep moving, keep your heart healthy, spend time with family and friends, try something new and get enough sleep.

Improving the dementia care pathway in Surrey

Diagnosis

31. Our aim is for people to have equal access to dementia care; understanding where communities may not be accessing dementia diagnosis and post diagnostic support.



32. Both Surrey Heartlands and Frimley ICBs have been on or over the target for dementia diagnosis rate since January 2024. Diagnosis rates in Surrey are significantly above the national average. This means that Surrey is doing well in diagnosing people with dementia, as the diagnosis rate is calculated by comparing the number of recorded dementia diagnoses with estimated dementia prevalence (which takes into account our older population).

33. The higher the percentage of dementia diagnosis rate, the more people have access to the care and support they need. The above average rate in Surrey demonstrates the impact of the improvement work that has been done, outlined below.

34. Community Mental Health Teams for Older People (CMHTs OP) who provide memory assessment services for Surrey and Borders Partnership NHS Foundation Trust (SABP), have worked closely with system partners to enhance working relationships and promote their memory assessment services. This has included contributing to East Surrey Ageing Well Steering Group, the Guildford Waverley Integrated Frailty Group, along with the development and strengthening of interface meetings and ongoing communication with referrers.

35. In addition, CMHTs OP are running drop-in sessions within community settings with local voluntary, community and social enterprise (VCSE) partner organisations, for those with a diagnosis and those who may have concerns and unsure how to seek assessment.

Surrey Heath CMHT OP are proud of their post diagnostic service which offers personalised follow-up support to every person diagnosed with dementia and their families/carers. This includes the opportunity to take part in successful Cognitive Stimulation Therapy (CST) groups. They are also improving ways to involve service users and their families/carers in the

service, for example in staff recruitment & training, in policies & procedures and in developing the service.

36. The SABP Integrated Care Mental Health Practitioners sit within primary care integrated care teams (ICTs) and can support access to secondary care mental health services, especially for those people who have physical co-morbidity and frailty, and cognitive impairment. These practitioners can also offer assessment and diagnosis without the need for onward referral into a CMHT OP.

37. Further work is planned to analyse dementia diagnosis rates by GP practice level. This is to further explore and act on any unexpected variation, particularly within our priority populations which are communities of identity and geography which are often overlooked and are most at risk of experiencing poorer health outcomes.

Information and support available in Surrey

38. There is a range of information available across Surrey to support people with dementia and their unpaid carers. A strategic review of the support groups for people with dementia across Surrey has been completed. All the support groups have been mapped and this information shared with Connect to Support Surrey, to help people explore and access the local care and support in their area.

39. Alongside this, Surrey County Council run the dementia information project. This project aims to enhance dementia care and support through strategic initiatives such as building a network of dementia information champions and accessible training on dementia for unpaid carers.

40. The dementia information project team recently conducted a survey to help co-design the offer of training and support for unpaid carers with dementia. This survey highlights the significant demand for more information and flexible training options among unpaid carers, as well as the need to address the low attendance at carers groups across Surrey. The survey team recorded the following when they visited a day care facility for people with dementia and their carers:

'I was talking to Mrs E about her experience with her husband who had dementia. She explained that they received a diagnosis quite late as her husband was reluctant to go to the GP. The only reason he was seen by a GP was because he was still driving and had a minor accident in his car. The police were involved, which led to a GP appointment and subsequent diagnosis. Mrs E said that she was relieved when he was finally diagnosed as she had suspected it for a while. She said that following on from the diagnosis, they got very little help in terms of direction and what needed to be

done next. She said they felt very much alone and that she had had no experience with dementia up until the diagnosis.

Mrs E said that she would have really liked to have had the opportunity to take part in some training as she had no idea what to expect or how to live with the diagnosis. She explained that her husband used to get aggressive towards the end of his illness and she found that hard to cope with. She would have liked to have had the opportunity for respite care for a day or even overnight, but it was never offered. Mrs E said that her husband's diagnosis had changed everything and that he had always taken care of everything, so it had a massive impact on their lives. Mrs E said she would have liked clearer information in smaller chunks as and when she needed it'.

41. There are other information resources available to help people live well with dementia (Appendix 2). The living well with dementia implementation team at the Applied Research Collaboration Kent, Surrey and Sussex (ARC KSS) have published the My Choice booklet (Appendix 2). It gives people accessible and evidence based information to help people live well following a diagnosis of dementia.

42. Health Place-based partnerships have developed localised support for people with dementia. For example, Guildford and Waverley Health and Care Alliance provide dementia care and support through neighbourhood teams, which include Admiral Nurses who provide more tailored support to people with dementia and their carers.

43. A carer has provided testimony of receiving support from the Admiral Nurse:

'My mum was diagnosed with dementia in March 2023, but her memory had been declining since 2018. As her carer I had not received any support prior to the visit from the Admiral Nurse. I was referred to the service via the care within the home agency who support my mum. The support and advice that the Admiral Nurse provided I found hugely beneficial for a variety of reasons:

1. *They are the only professionals who have made the time to listen to the amount of strain and pressure the diagnosis has placed on me and my young family. I work full time job and have 2 young children.*
2. *They listened in an empathetic and non-judgmental way. They challenged the amount of pressure I place on myself and family to support my mum and explained that things could be done differently to alleviate this.*
3. *Signposted me to organisations who could help e.g. the Hive and Age UK.*
4. *Explained that I remain open to the service and can contact them at any point.*

5. *Referred my mum to Adult Social Care, which supported the referral I had made.*
6. *Followed up the visit with an e-mail and that another visit would be arranged.*

To have a trained professional listen to me as a carer and alleviate the huge amount of pressure and guilt that I feel all of the time has had a positive impact on my mental wellbeing and enabled me to change how we support my mum'.

Technology enabled care and homes (TECH)

44. Surrey County Council is developing a more personalised and outcomes focused technology offer for residents. Technology enabled care and homes (TECH) can support many people living with dementia to live at home safely for longer and with increased independence. It can also provide reassurance for carers who care from a distance.

45. There are several priority areas of focus for TECH which will benefit people with dementia and their carers. There are plans to digitise social care and virtual wards, by exploring with Health colleagues the use of new technologies and motion sensors to expedite discharge from hospitals and to enable care homes to be more confident about taking people with complex needs.

46. To support people with long term conditions, including dementia, to manage their medications, a YOURmeds pilot is planned. YOURmeds is a smart medication management system that allows real-time monitoring of medication adherence. It is estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended. Correct use of medication enables an individual to have a greater level of choice and control remaining independent within their own homes for longer and delaying the total cost of care.

47. A TECH paper is going to Surrey County Council's Cabinet in January 2025 which will provide more detail on the strategy to maximise technology impacts for Surrey residents.

Rishna's story

Rishna's home is her sanctuary, it is very important to her, and she longs to remain in it as long as possible with her 4 cats. Rishna is in her mid-70's and has been diagnosed with Alzheimer's disease. Rishna values her independence and has a strong bond with her 2 sons despite them living far from her. Rishna has recently separated from an abusive marriage which has been a big life event for her.

It became clear to Rishna's sons, who were previously not allowed in the property, that she was having difficulty with her memory and the house was becoming uninhabitable due to the level of hoarding from her ex-husband. Rishna's sons were able to support to clean the property and reset things for their Mum now that she has split from her husband, and they try to visit her weekly.

Rishna had stopped attending to her personal care, though she will say she has washed there is no evidence of this within the bathroom. Rishna would say that she was cooking from scratch, however there had been no space to do this in the kitchen due to the hoarding and there was out of date food with maggots in the fridge. Rishna does not consistently lock her front door and the door had been left open on several occasions overnight. Everyone is concerned about Rishna's safety.

An assessment was completed by the Adult Social Care locality team who identified that Rishna would benefit from four calls per day to meet her care and support needs. The practitioner, with support from the Technology Enabled Care and Homes (TECH) team, decided to implement various technologies to support Rishna to remain safely in her own home.

The technology included motion sensors in the rooms of her home including in the fridge, smart plugs on appliances and a video doorbell. Rishna's care workers were actively involved and used the dashboard app to review the data from the motion sensors and monitor her in between care calls. Through tactful use of data, they could call and prompt Rishna to eat and drink in between care calls and close the front door.

The use of technology provided evidence that Rishna was sleeping well, her nutrition improved, increased mobility and showed no evidence of nighttime needs. It also provided evidence that she would access the fridge at least four times a day, use a kettle at least twice, and use the microwave at least three times per day.

As a result, Rishna was able to live a fulfilling and independent life in her own home with just one daily care call. The technology has strengthened her relationship with her regular care workers who allow her the right to a private life and use the data appropriately and proportionately also provided reassurance for her sons.

Support for unpaid carers

48. There is a range of support available for carers of people with dementia in Surrey. Action for Carers Surrey talk to carers about their caring situation and suggest ways to help and signposting to further sources of help available. They also have support groups running regularly across Surrey, including some just for carers of people with dementia.

49. We would encourage all unpaid carers to register as a carer with their GP. This allows the GP to prescribe services to support carers in their caring role, including a £300 one off payment to pay for services or equipment that support carer wellbeing.

50. Surrey County Council also commission carer wellbeing breaks services, where carers of people with dementia can have a break from their caring responsibilities. In addition, the carers team are piloting services specifically focused on increasing support for carers of people with dementia. These schemes include the Clockhouse carers group run by Age UK Surrey; Tapestry day club and intergenerational music making.

A carer's feedback on receiving a wellbeing break from Crossroads

She (the carer) feels the sessions are going extremely well and they are enabling her to have a respite break. She noted that her husband's mood has changed recently and the support worker is very calm and understanding and is able to communicate with him. Having the support worker around helps to keep her husband content and happy and his mood is always different after the session. The support worker speaks Spanish, and Spanish is the husband's first language, so they are able to talk in Spanish together and talk about Spain. The carer feels it has been a perfect match.

Whilst the support worker is there the carer is able to focus on administrative duties and she is hopeful over time that she will be able to go out and look for activities and carry out household tasks in the community such as shopping.

Support at end of life

51. Our aim is to make sure care is coordinated to enable the person with dementia to live their life as independently as possible until their death. It is important that people with dementia and their carers and families have equal access to palliative and end of life care. To enable this, we endorse the 6 ambitions from the end of life care strategy.

52. Advanced Care Plans (ACPs) and ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms have been rolled out across Surrey to ensure that people's wishes around their treatment and what is important to them is formally recorded. There has been a focus on improving the quality and number of ACPs, alongside an active education and training workstream. In addition, people's preferred place of death is being captured by partner organisations.

53. A select number of community pharmacies are able to provide palliative care drugs to support people living and dying in the community in order to avoid excessive travel for families and carers.

54. The Surrey Care Record has been embedded as a single sign in for each acute trust in Surrey to make it more accessible.

55. Continuing Health Care are funding fast track end of life care pathways where the person's condition is deteriorating to support them to have care in their own home, or at an appropriate setting.

56. There are plans to understand whether bereavement needs are being met which will be explored as part of the review of lived experience.

Conclusions

57. Alongside the good progress made in improving the dementia care pathway for the Surrey population over the first two years of the strategy, we still have work to do. Looking to the future, the dementia strategy action board are focusing on the following areas of work.

58. Continuing to understand and improve support for unpaid carers of people with dementia, including the roll out of training for unpaid carers of people with dementia.

59. Developing a robust national and local dataset to monitor the progress we are making for people with dementia and their carers in Surrey. This will include the recording and reporting of protected characteristics and analysis of dementia diagnosis rates by GP practice level. This is to further explore and act on any unexpected variation, particularly within our priority populations which are communities of identity and geography which are often overlooked and are most at risk of experiencing poorer health outcomes.

60. Identifying all the specialist dementia support available across the Surrey system, to assess gaps and areas for development; building on support group mapping (to include Admiral Nurses, local dementia care co-ordination and care navigation).

61. Planning for impact of new disease modifying treatments for dementia. NHS England (NHSE) released a statement on 22nd August 2024 stating 'Lecanemab is the first disease modifying treatment for Alzheimer's disease with a market approval in the UK, and to ensure the health system is prepared for future advances in treatments, a dedicated NHS team is also looking ahead

to 27 other drugs which are currently in advanced clinical trials that could be potentially approved by 2030'.

62. On the same date NICE released draft guidance for consultation *not* recommending Lecanemab for use in the NHS because it is not a cost-effective use of limited NHS funding. The public consultation on the draft the NICE guidance closed on 20th September 2024 and the independent committee will consider all responses at a second committee meeting later in the year before producing its final recommendations. On 22 October 2024 NICE released its draft guidance for consultation *not* recommending Donanemab for use in the NHS on the same basis.

63. Disease Modifying Treatments (DMTs) are for a very specific group of individuals and research related to this is still in its infancy. The requirements for such a service to be delivered are far beyond the realm of simply adding into an Older People's Mental Health Service or Memory Assessment Service. This would require a whole of systems approach to ensure if the DMTs are approved for use within the NHS, that the right structures and pathways are in place to meet the needs of the service provision.

Recommendations

64. The Select Committee notes the content of this report and endorses the work to improve the dementia care pathway within the Surrey population.

65. The Select Committee supports a continued focus on reducing the risk of dementia, with Public Health interventions and communications highlighting what people can do to reduce their risk factors.

66. The Select Committee supports a focus on priority populations within the next phase of work of the dementia strategy action board.

Report contact

Jane Bremner, Head of Commissioning Mental Health, Adults, Wellbeing and Health Partnerships, Surrey County Council

Simon Brauner-Cave, Deputy Director of Mental Health Commissioning, NHS Surrey Heartlands Integrated Care Board

Contact details

jane.bremner@surreycc.gov.uk

simon.brauner-cave2@nhs.net

Sources/background papers

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

Joint Health and Social Care Dementia Strategy

Easy read joint health and social care dementia strategy for Surrey, 2022-2027

Dementia Strategy Summary Surrey CC

NHS England, The well pathway for dementia, 2016

dementia-well-pathway.pdf

The dementia chapter in the joint strategic needs assessment (JSNA)

SCC JSNA Dementia | Tableau Public

The people with learning disabilities chapter in the joint strategic needs assessment (JSNA)

People with learning disabilities | Surrey-i

Surrey Health and Wellbeing Strategy- update 2022

Surrey Health and Well-Being Strategy - update 2022 | Healthy Surrey

Lord Darzi independent Investigation of the NHS in England, 2024

Independent Investigation of the National Health Service in England

NICE 2023, YOURmeds for medication support in long-term conditions

The technology | YOURmeds for medication support in long-term conditions | Advice | NICE

Surrey Heartlands palliative and end of life care strategy, 2021-2026

download.cfm

Consultation on NICE guidance for treating mild cognitive impairment or mild dementia caused by Alzheimer's disease

Project information | Lecanemab for treating mild cognitive impairment or mild dementia caused by Alzheimer's disease [ID4043] | Guidance | NICE

Dementia resources:

Easy Read dementia information | Alzheimer's Society

macintyrecharity.org/download/file/2811/

Reduce your dementia risk | Healthy Surrey

Connect to Support Surrey

https://arc-kss.nihr.ac.uk/resource-library/527-my-choice-booklet/file

Carers of people with dementia | Action for Carers

Reduce your dementia risk

Looking after your health can benefit your brain too.

Research has shown that up to 40% of dementia cases are down to factors we can influence. This page gives advice and information about services which can help.

Here in Surrey, around 17,700 people are living with dementia. Numbers are projected to rise by more than a quarter, to 22,600, between 2020 and 2030.

Many dementia cases are linked to things we can't change, such as our age and genes, but evidence is becoming stronger that dementia isn't always inevitable and there are steps we can take to influence our risk of developing the condition.

If you're planning to make healthy lifestyle changes, make positive changes for your brain health too.

Looking after your health can benefit your brain

Did you know that keeping your heart healthy can reduce your risk of developing dementia? There's growing evidence that all the habits we understand to be good for the heart are also good for the brain.

Research has shown that **up to 40% of dementia cases are down to factors we can influence** but surveys also suggest that few people are aware it's possible to reduce their risk of getting the condition later in life.

In fact, just as you can improve aspects of your physical health, you can also take steps to keep your brain healthy.

Getting active, managing blood pressure, keeping a healthy weight and stopping smoking are among the habits you can build into everyday life to give yourself the best possible chance of avoiding the heartbreak of a dementia diagnosis in the future.

Brain-healthy habits

There's a wealth of tips, support and local services available to help make brain-healthy habits stick.

1. Manage your blood pressure

If you're aged 40 to 74 with no pre-existing conditions, make sure you get your free NHS health check which includes some simple tests including blood pressure. You can get them every five years. Visit the **health checks** web page to find out how. You can also get a quick and easy **blood pressure** check at a participating pharmacy to check your blood pressure and pulse rate.

2. Get active

With stunning scenery on our doorstep, Surrey offers a wealth of opportunities to be active. Head to the **Get Active** web page to find activities to suit you, even if you can only fit in 10 minutes. You can also explore ideas for connecting with nature on our **31 tips** web page.

3. Keep to a healthy weight

Visit our **adult weight management** web page to try a quick and easy quiz about your diet and lifestyle and also to find your body mass index (BMI). You'll be able to find out about the support available to help you get down to a healthy weight and stay that way for good, including the **NHS Better Health** website where you'll find free weight loss plans. Check out **Health Unlocked** to join a supportive group of people.

4. Enjoy a healthy diet

The **adult weight management** web page shows how much of what we eat overall and what should come from each food group to achieve a healthy, balanced diet. Also check out the **One You Easy Meals app** for healthy recipes or visit the **NHS Better Health** website.

5. Get socially active

Find ways to get involved in your local community, or look for befriending services, through the **Connect to Support Surrey** website.

6. Keep within alcohol limits

The **DrinkCoach alcohol test** is a quick and confidential way you can see if your drinking is putting your health at risk. Depending on your result, you may be **signposted to services** which can help you change your drinking habits.

7. Quit smoking

If you're a smoker, **quitting for good** is the most important step you can take to protect the health of your heart while also giving your brain a break. The **One You Surrey stop smoking service** has all the support you need to make 2023 the year you kick the habit once and for all.

8. Keep your mind active

Keeping your brain active and challenged may help reduce your dementia risk. Ideas include reading, doing puzzles or crosswords, or learning a second language. Why not check out **Surrey Adult Learning**?

Related articles

Healthy hearts
Do you know much about cardiovascular health? It will enable you to take steps to maintain or improve your health.

Get active

Get going every day. Being active every day helps us to all to stay healthy.

Healthy Surrey

Access the local health and wellbeing services available to you as a Surrey resident, as well as self-care information that can help you lead a healthier life.

ID: 396213

NHS

My Choice

The information you need to help you to Live Well with Dementia

CONTENTS

We suggest you make your way through the booklet section by section, at your own pace. If you are accessing this digitally you can click on the relevant section in the contents page to be taken straight to that section.

Why ‘my choice’?

A diagnosis of dementia can be worrying and have a big impact on you and those close to you. It can take time to adjust to your diagnosis and process all the information you have been given. Sometimes people can feel overwhelmed by too much information, while others can feel they are given too little information.

It is important that you understand what can help you manage your symptoms, how to live well with Dementia, and how to prepare for the future. This includes what you and those around you can do, as well as how to access activities and services that are available to support you.

The aim of ‘my choice’ is to give you accurate and accessible information in a way that helps you make informed choices to support your health and wellbeing now and for the future.

What you choose to do, and how you do that is your choice. It is very important that you feel comfortable and enjoy the things you do. But don’t be afraid to try new things, or to do things differently. This can feel overwhelming at first, and you might need some support when trying new things, but it is often worth it in the longer term.

What information is included in ‘my choice’?

‘My choice’ includes information based on the most up-to-date evidence available on treatments, interventions and activities that aim to help people to live well with dementia.

We have only used research that has been published in recognised and trusted medical and health-related journals. The thumb signs show you the level of evidence available at the current time, and the blue star means this advice is relevant to everyone as they age. There is a lot of dementia research underway, so recommendations may change in the future, and as that happens, this booklet will be updated.

The green thumbs up sign means there is a good level of evidence that a treatment, intervention or activity works to support health and wellbeing in dementia.	
The yellow sideways thumb means there is currently not enough evidence to know if the treatment, intervention or activity works to support health and wellbeing in dementia.	
The red downward thumb sign means there is enough evidence to suggest that the treatment, intervention or activity doesn't work to support health and wellbeing in dementia.	
The blue star means the interventions and activities can help protect people against dementia as they age, and are also helpful for people with mild cognitive impairment.	

Where it is relevant, we have also included National Institute of Health and Care Excellence (NICE) recommendations. NICE provides evidence-based guidance, advice, quality standards

and information to health and care services in the UK, and makes several recommendations for dementia care.

The topics and recommendations included in this booklet all have the same aim: to help you to live well with dementia, to support your cognition (brain function), and to help you feel mentally and physically well.

The effects of dementia change over time, and we are all different, so some things may work better at different stages, and you might need to try a few different things to find the ones that work best for you.

Where can I find more information?

In each section we have provided details on where to find more detailed information from trusted organisations that support people living with dementia.

For any questions about your health and medications, your GP surgery is your first point of contact. You do not need to wait for your annual reviews to get in touch with them.

For most other activities, different locations have different services available, so it is worth asking your dementia or health and care support worker for local contacts. It's also worth getting in contact with local groups and charities that support people in your community.

At the back of this booklet, we have added additional information we think you may find helpful, including about benefits you may be entitled to.

Glossary of terms:

Cognition: this includes thinking skills, processing, understanding, responding to, and remembering information.

Dementia support worker: this is someone allocated to support you after your diagnosis. This is set up differently depending on where you live and may be called dementia navigator, support worker or coordinator.

Intervention: an action taken to help improve a situation. E.g. doing puzzles to stimulate your brain.

Eating Well

This section also includes advice on keeping hydrated, alcohol, and food supplements.

Why is eating well important for people living with dementia?

Eating well (healthy nutritious food) helps maintain general health and wellbeing and in addition eating certain foods may help slow and manage cognitive decline in dementia.

Some foods are proven to be more likely to cause inflammation and toxin build-up in the brain that can contribute to dementia symptoms. Some foods can also increase the risk of heart and blood vessel disease and diabetes, which can also contribute to dementia symptoms.

What works?

There is some evidence that the following diets may help people living with dementia:

- The Mediterranean diet: mainly plant-based foods, fish, and olive oil.
- MIND (Mediterranean and DASH for Neurodegenerative Delay): vegetables, berries, 'good' carbohydrates, nuts, and olive oil.
- Omega-3 rich diet: eating fresh and oily fish, nuts and seeds, and oils
- A healthy, balanced diet: eating a wide variety of foods in the right proportions.

These diets currently do not have enough evidence that they help people living with dementia:

- Paleo diet: fruits, vegetables, lean meats, seafood, eggs, nuts and seeds, and avoiding grains, beans and dairy products.
- Ketogenic diet: high fats, moderate proteins and minimal carbohydrates such as bread and pasta.

National Institute of Health and Care Excellence recommendation:

NICE recommends healthy eating to support health and wellbeing.

How can I eat well?

What you decide to eat is a personal choice and may be influenced by your culture, preferences, health and food tolerances. Before making big changes to your diet it is

important you seek advice from relevant healthcare professionals, especially if you have other medical conditions. You should see your GP if you have any unintentional weight loss.

Keeping hydrated

 It is important to drink plenty of fluids, especially water, to keep hydrated and support general health and brain function. Keeping well hydrated also helps prevent problems such as infections and constipation, which can make people with dementia more confused and unwell.

Alcohol

 It is best to avoid alcohol if you have been diagnosed with dementia. Even moderate drinking can negatively affect brain function and brain health, worsen your memory, and your general health and wellbeing. If you need support to reduce your alcohol intake, please speak to your GP so you do this safely.

Food supplements

Most vitamins, herbs and other food extracts are natural substances that can help improve nutrition and wellbeing, however, there is less evidence about the benefits of vitamins compared to prescribed medications. If you have a vitamin deficiency, your GP may arrange blood tests and prescribe certain vitamins for you.

 Vitamins A, B12, C and D have mixed evidence that they may help with dementia. Your doctor could prescribe vitamins A, B12 and D if you have a deficiency.

Ginkgo Biloba and Turmeric also have mixed evidence that they may help brain function.

 Vitamin E, Selenium, Coconut oil and Ginseng do not have enough evidence to support their use in dementia.

NICE does not recommend offering Ginseng, vitamin E or herbal supplements to treat dementia.

If you choose to try any over-the-counter supplements, speak to your pharmacist or GP first about doses and side effects, or potential interactions if you are taking other supplements or medications.

Additional information available online:

www.alzheimers.org.uk/get-support/daily-living/eating-drinking

www.dementiauk.org/get-support/health-issues-and-advice/eating-and-drinking/

Heart Health

Why is heart health important in dementia?

Controlling blood pressure and cholesterol levels is important and may reduce the risk of heart disease, stroke, and associated complications for people living with dementia.

Our hearts (including our vascular system) are essential to our general health and wellbeing. High blood pressure, high cholesterol, and high blood sugar levels (diabetes) can cause or worsen heart disease. There is evidence of links between heart disease, diabetes and dementia- which are still being researched. Certain populations and ethnicities are also more at risk of heart disease and diabetes, which also puts them at increased risk of dementia.

What works?

The following interventions support heart and diabetic health and can help people to live well with dementia:

- Keeping active, eating a healthy diet - particularly a diet like the Mediterranean diet, reducing your alcohol intake, stopping smoking, and maintaining a healthy weight.
- Regularly checking your blood pressure, cholesterol and blood sugar levels to ensure they stay within healthy levels.
- Taking prescribed medication if your blood pressure, cholesterol or blood sugar levels are too high- which will need monitoring to ensure you are on the right treatment.

National Institute of Health and Care Excellence recommendation:

NICE recommends lifestyle changes such as stopping smoking, keeping a balanced diet, physical activity, reducing alcohol intake, cholesterol management and lowering blood pressure to prevent risk of heart disease.

How do I look after my heart health?

Lifestyle changes can make a big difference.

Arrange regular blood pressure monitoring and cholesterol blood tests. If you are prescribed medication, take it as prescribed and have regular blood pressure and medication reviews.

Speak to your diabetes healthcare team about how to best manage and keep your diabetes under control.

Additional information available online:

www.bhf.org.uk/informationsupport/heart-matters-magazine/research/blood-pressure/blood-pressure-tips

www.diabetes.org.uk/guide-to-diabetes/managing-your-diabetes

Hearing and vision

Why is hearing and vision important for people living with dementia?

Monitoring for changes in hearing and sight is very important for people with dementia to support communication and reduce confusion.

Hearing and seeing well supports communication and interactions with other people and the world around us. Changes to hearing and vision can negatively affect our perception and ability to interact and communicate with others, and can increase misunderstanding and confusion for people living with dementia. There is some evidence that hearing loss may be a risk factor for some types of dementia.

Some people with dementia may also experience visual disturbances, noise sensitivity and visual and auditory hallucinations, which can be distressing and cause confusion. This is related to the brain's interpretation of vision or hearing rather than their actual vision or hearing. Additional information about reducing problems due to changes in visual perception is available in the box below.

What works?

These interventions all have evidence they help people living with dementia:

- Regular hearing and vision assessments. It is also important that you:
  - Wear prescribed hearing aids and make a routine for cleaning and battery replacement.
  - Wear prescribed (and clean) glasses.
- You can also do other things to help, including:
  - Minimise background noise and distraction when communicating.
  - When speaking with someone, ensure you can see their face clearly.
  - Reduce the number of people talking at any one time.
  - Don't shout and ask others not to shout as this can distort sound.
  - Use magnifying glasses to read and subtitles to support your hearing.
  - Use adjustable lights in your home to support your vision.
  - Talk to friends, family and carers about any changes they may notice to your hearing and vision.
  - Review surroundings and decorations, including patterns and colours, to reduce problems associated with visual perception.

Visual perception and dementia

Visual perception changes can result in difficulty judging space, distance, and objects. To reduce confusion, disorientation, and the risk of falls, the following may be helpful:

- Reduce glares and shadows that may cause confusion or disorientation with good lighting.
- Use different colours and patterns to improve the visibility of important objects. For example, use contrasting colours for toilet seats, handrails, doors, tables and plates; this will make things easier to distinguish from each other and more recognisable.
- Reduce visual clutter by removing unnecessary decorations, patterns on flooring or walls, and excess furniture, and arrange things in a neat and orderly manner. This will reduce visual confusion.
- Remove any trip hazards that may increase the risk of falling.

National Institute of Health and Care Excellence recommendation:

NICE recommends people with dementia have eye tests and hearing assessments every two years.

How can I manage my hearing and vision?

If you experience visual or hearing changes or disturbances, speak to your GP. Your GP can assess whether this is related to your dementia and also refer you for hearing and vision assessments, or you can go to an optician for an eyesight or hearing assessment. Always wear prescribed glasses and hearing aids. You can also make some changes around the home that may help with any difficulties as a result of changes to visual perception.

Additional information available online:

www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/sight-hearing-loss

www.scie.org.uk/dementia/living-with-dementia/sensory-loss/hearing-loss.asp

www.specsavers.co.uk/hearing/hearing-loss/dementia-and-hearing-loss

www.specsavers.co.uk/home-eye-tests/why-choose-specsavers-vision-care-at-home

You can do an online hearing test here: https://rnid.org.uk/information-and-support/take-online-hearing-check/ and if you have any hearing changes you can use this to ask your GP for a referral for a hearing test.

Mental Health

Why is mental health important for people living with dementia?

Having hobbies and being socially and physically active can reduce depression and anxiety in dementia and improve quality of life.

Mental health conditions include depression, anxiety and agitation, and can result in feelings of sadness, increased tension, and loss of interest or enjoyment in the things you'd usually enjoy. Changes in mental health can happen at any time, including when adjusting to a dementia diagnosis, and it is important to tell someone and seek help as soon as possible if this happens to you.

Mental health conditions can negatively affect wellbeing and can also affect behaviour. People with dementia may not always be able to express that they are sad, depressed or anxious. Instead, this may be observed by others through changes in behaviour, distress, or lack of interest in things you'd normally enjoy. Unmanaged depression and anxiety can make dementia symptoms and outcomes worse.

What works?

Evidence shows that keeping socially and physically active, maintaining good quality sleep, and participating in enjoyable activities (such as group activities, music and reminiscence therapy, and talking to others) may help people improve and maintain their mood.

Activities work best if they are related to a person's interest and maintain a sense of belonging and self and could include singing, dancing, pottery, gardening, and other hobbies or activities that interest them. Others may benefit from complementary therapies, including massage, acupuncture and aromatherapy.

Evidence is mixed for psychological therapies and medication to treat depression, anxiety and agitation for people with dementia. In some people medications may cause harmful side effects. Speak to your GP or dementia specialist if you want more information about medication.

National Institute of Health and Care Excellence recommendation:

NICE recommends non-medicine interventions to reduce distress in people living with dementia. Medication is only recommended in more severe cases and only in combination with other interventions.

How can I get support for mental health?

If you are worried about changes in your mood or behaviour, please see your GP.

Try to keep involved in activities and groups that you already enjoy. Sometimes, you and others may need help to adapt how you do things to make activities easier to access. Even small changes like changing the 'rules' of an activity to make it more manageable, can make a big difference and can mean you can carry on enjoying the activities for longer.

You can also speak to your dementia support worker and local charities about activities available in your area, including dementia-friendly groups.

Additional information available online:

www.alzheimers.org.uk/about-dementia/treatments/dementia-drugs/non-drug-approaches-changes-mood-and-behaviour

www.nhs.uk/conditions/dementia/living-with-dementia/behaviour

Sleep

Why is sleep important for people living with dementia?

Good quality sleep is important to maintain health and wellbeing, mood, daytime functioning, and cognition in dementia.

Poor-quality sleep can lead to the build-up of toxins in the brain and impact wellbeing and behaviour. People with dementia are more likely to experience poor-quality sleep.

What works?

The following interventions to help sleep are supported by some evidence they can help people living with dementia:

- Music therapy: listening to personalised playlists that support relaxation and sleep can improve sleep and reduce anxiety.
- Light therapy: using bright light in the daytime (including exposure to sunlight) can improve daytime functioning and sleep.
- Keeping lights low in the evening and minimising activity or disturbances in the evening could promote restful sleep during the night.
- 'Sleep hygiene', which means maintaining a consistent bedtime routine, and may include music and light therapy and reducing stimulus at bedtime.
- Being physically active during the day, including daylight exposure.
- Carer training to support people with dementia with good sleep habits.
- If you have persistent problems medications may be prescribed by specialists for people with specific sleep disorders. Their use should be closely monitored by the professionals who prescribe them and should be used for the shortest possible time.

These sleep interventions currently don't have enough evidence to show if they help people living with dementia.

- Using weighted blankets to promote sleep and reduce anxiety and depression.
- Mindfulness: a technique to improve relaxation and reduce stress and depressive symptoms.
- Lavender oil administered in an aroma stream may reduce agitation and may help improve sleep for people with dementia.

Medication:


Melatonin can be prescribed by your doctor, but there is mixed evidence that it is effective in improving sleep in dementia, especially when no sleep disorder has been diagnosed. If you feel medication to help you sleep may be needed, speak to your doctor first.


Nytol contains an over-the-counter drug called diphenhydramine, which has been shown to increase the risk of dementia, and as a result, the benefit for people with dementia is less clear**.**

National Institute of Health and Care Excellence recommendation:

NICE does not recommend Melatonin to manage insomnia for people with Alzheimer's Disease. NICE recommends a personalised multi-component sleep management approach that includes sleep hygiene education, exposure to daylight, exercise and personalised activities.

How can I support my sleep?

You can try most of these interventions, with support from family, friends, carers or your dementia support worker if needed. Supportive technology can help, for example, by setting a sleep schedule and by timing music and lighting (see Supportive technology section below).

Some medications to help you sleep will need to be prescribed by your GP. Sleep medications may have lingering side effects the following day, may cause dependency, lose some of their effectiveness with prolonged use, and may cause side effects.

Additional information available online:

www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/sleep

Physical Activity

Why is physical activity important for people with dementia?

Physical activity improves and maintains health, wellbeing, and quality of life and what you do is down to your personal preferences and abilities

Physical activity involves movement and some physical effort, such as housework, gardening, walking, moving to music, chair yoga, or an exercise class.

Physical activity promotes heart health, supports your immune system, and can reduce the risk of falling and injury. It can improve mood, and reduce cognitive and behavioural changes. It can be combined with other benefits by doing activities with other people and going outside to get exposure to nature and sunlight

What works?


Physical activity has been shown to be an important part of living with dementia, and there is good evidence that it:

- It improves mood, whilst reducing depression and anxiety symptoms.
- It reduces the risk of heart and vascular disease, cancer, and diabetes.
- It reduces the risk of falls and fractures.
- It keeps your bones strong and reduces the risk of osteoporosis.
- It supports your brain health because it requires cognitive effort to be physically active.

National Institute of Health and Care Excellence recommendation:

NICE recommends people living with dementia are supported to undertake health-enhancing activities, including exercise, according to a person's preferences.

How can I be physically active?

You can do things to maintain your activity at home like keep doing housework and gardening. Overly strenuous activities may not be advised for specific medical conditions, so it's important to check with your GP before you commence more extensive training programmes.

Additional information available online:

www.nhs.uk/live-well/exercise/exercise-guidelines/physical-activity-guidelines-older-adults/

Social Activity

Why is social activity important for people with dementia?

Social activity is about being with other people to do things you enjoy, and it is important for maintaining wellbeing in dementia

Social activity is about keeping engaged and involved with your family, friends and communities, doing things that you enjoy. This could include gardening, cooking, walking, volunteering, being active in your place of worship, creative activities, going to events, visiting family and friends and anything else that involves interacting with other people.

What you do is entirely about your personal preference, and it needs to be interesting, enjoyable or meaningful to you. Different cultures will have different customs and activities that can provide a supportive environment for people with dementia. You can also be socially active online from the comfort of your own home using supportive technology, but it is important you also have in-person interaction in a meaningful way.

What works?

Keeping socially active has good evidence it can:

- Help people living with dementia enjoy life better, feel more connected to their community and have a sense of purpose.
- Help to stimulate the mind, leading to improved cognitive functioning.
- Help to reduce feelings of boredom, loneliness and depression.
- Help to increase physical activity, which can help improve physical health.
- Help to improve communication skills, which can help with maintaining relationships.
- Help to stimulate memory and cognition.

National Institute of Health and Care Excellence recommendation:

NICE recommends person-centred care for people living with dementia, and this includes recognising the importance of relationships and interactions with others and their potential for promoting wellbeing.

How can I be socially active?

You can keep engaging with friends, family, communities and activities you are already involved in, and find out about new opportunities from your dementia support worker and local dementia charities. Some people may find social engagement in larger groups

overwhelming, so it is really important you get involved in groups and activities that you find enjoyable.

Supportive technology may help you keep in contact with friends and family living further away.

Additional information available online:

www.alzheimers.org.uk/get-support/your-dementia-support-services/activity-groups

www.nhs.uk/conditions/dementia/activities/

Cognitive Activity

What is cognitive activity, and why is it important for people living with dementia?

Cognitive stimulation activities improve cognition, memory, concentration, and mood, and can slow the rate of cognitive changes by keeping the brain active. Doing a mixture of different and new types of activities engages different parts of the brain.

Cognitive stimulation comes from any activity that stimulates thought, focus and memory by stimulating different parts of the brain. Activities include word and number puzzles (e.g. crosswords), jigsaws, board games and computer games. It also includes talking with others about new topics, such as current affairs and engaging in new and different social and physical activities.

Cognitive Stimulation Therapy (CST) is a structured course of therapy over a number of weeks. It involves participating in activities that aim to promote cognition and foster social interactions and a sense of belonging.

What works?


Evidence shows that participating in activities that provide cognitive stimulation and engage different parts of the brain improves cognition, helps social interaction and communication, improves quality of life and reduces symptoms of depression in people living with dementia.


Evidence also suggests that Cognitive Stimulation Therapy (CST) may potentially slow the rate of cognitive change in people with mild to moderate dementia.

National Institute of Health and Care Excellence recommendation:

NICE recommends group cognitive stimulation therapy for people living with mild to moderate dementia.

How can I access cognitive stimulation?

Cognitive Stimulation Therapy may be accessed by discussing with your dementia support worker or doctor. Other cognitive stimulation activities such as word and number puzzles, jigsaw puzzles, board games, computer games, and reading books and newspapers can be undertaken at home. You can also join organised social activities and classes (see the Physical Activity, Social Activity and Mood sections of this booklet).

Additional information available online:www.dementiauk.org/cognitive-stimulation/ www.alzheimers.org.uk/categories/treatments-and-therapies/cognitive-stimulation-therapy-cst

Helpful Habits

Why are helpful habits important for people living with dementia?

Helpful habits are strategies and routines that can help people with dementia manage day-to-day activities. It is helpful to get into the habit of doing activities and routines that can support you and your memory now and in the future.

What works?

There is evidence that adopting helpful habits and using memory aids can help people living with dementia live well and independently for longer. These include:

- Ensuring you see your GP for your annual health check, as well as for other health checks like medication reviews, blood pressure checks, hearing and vision tests, annual vaccinations, and testing for any other issues that may contribute to cognitive problems (for example, vitamin deficiencies).
- Making notes and lists about tasks and daily activities such as:
    - Shopping lists
    - What you are having for lunch and how to prepare it
- Using a calendar to write down meetings and appointments, and repeating this every time you make a new appointment.
    - You can do this on a paper calendar or use the calendars on a smartphone or computer (if you are comfortable using one).
- Setting alarms to remind you when you need to do something like make lunch or go for an appointment.
- Choosing a place to keep important things you use regularly and get into the habit of using that place. As an example, keep your keys safe and easy to access near your front door.
- Putting up signs in different parts of the house to remind you to do things, such as turning off the cooker or locking the door.
- Labelling food so you are reminded about how long it has been in the fridge and when it needs to be eaten.
- Get a medication organiser or ask your pharmacy to put your medication in weekly boxes to help you remember when to take it safely.
- Keep contact details of family, friends and your healthcare team in a safe and accessible place.
- Set up direct debits for your essential bills.

- Start to use and get used to technology that has been designed to support people living with dementia to live at home independently (we will cover this in more detail in the next section: supportive technology).

How can I adopt helpful habits?

You can ask your healthcare provider to refer you to an occupational therapist who specialises in dementia, and they can advise more on activities that will help you. You can also try some of these strategies on your own or with help from family and friends.

Additional information available online:

www.alzheimers.org.uk/get-support/staying-independent/memory-aids-and-tools

Supportive technology

What is supportive technology, and why is it important for people living with dementia?

Supportive technology is designed to help people live safely and independently at home for longer.

There are lots of different types of technology that can help enable people to live well, independently, and safely with dementia. Some of these are specifically designed for people with dementia, while some are already commonly found in people's homes.

Technology does not replace the importance of human interaction, but it can be used to support people with dementia and their carers.

Examples of supportive technology include:

- Communication and video devices that help family, friends and carers keep in contact
- Monitoring devices/sensors – like movement sensors around the home that can pick up on problems such as falls
- Location devices – that can locate you if you get lost
- Memory aids like calendars with reminders
- Medication dispensers and reminders
- Household aids like automatic light switches
- Games and tools that can support your social, physical and cognitive engagement

What works?

The right technology, used in the right way, has the potential to help people with dementia live independently for longer, and support carers too. Overall, there is good evidence supportive technology can be helpful for people living with dementia.

However, each type of supportive technology is designed differently and will have different levels of evidence to show whether it works or not. Technology is not always designed for people living with dementia, and you may need additional support from family and carers to use it.

How can I access supportive technology?

Care providers may provide some of this technology, such as home sensors, location devices and communication devices when you need it. You can also access this technology privately at an earlier stage, including with the support of family and friends.

There are many technologies to choose from, and not all will suit everyone- this is down to your preferences and needs. Some people may also be worried about management, security, losing independence and privacy. It is good to make your concerns and preferences known to family, friends and caregivers. As your condition changes, the opportunity for technology to support you may also change.

Additional information available online:

www.scie.org.uk/dementia/support/technology/stay-independent

www.alzheimers.org.uk/get-support/staying-independent/what-assistive-technology

www.scie.org.uk/dementia/support/housing/design

Planning for the future

Why is planning for the future important for people living with dementia?

Planning for the future helps you maintain control and choice about what happens in the future. It also helps your loved ones and healthcare team ensure your wishes are known and respected.

Planning for the future is about making your preferences, choices, and wishes known before this becomes more difficult to do in the future. This involves talking to your loved ones and your healthcare team about what is important to you, such as what treatment you'd want, and where you want to live in the future.

You can also choose who you want to make decisions on your behalf, as an example to help manage your finances or to make decisions about your healthcare when you are less able to do this yourself. When thinking about this, some people also find it useful to think about where they live, including making plans to adapt their home before their health may start to change.

Three main documents help you record your wishes:

- A lasting power of attorney for health and welfare
- A lasting power of attorney for property and finances
- An advanced care plan

What works?

Lasting powers of attorney are legally recognised once they are registered. The link below tells you how to set up a power of attorney and register it online. You can also do this via a solicitor, which might be recommended if your dementia is more advanced.

An advanced care plan needs to be held by your healthcare providers. Your dementia support worker and other healthcare workers can help you do this. It is important to give your GP and loved ones a copy of your advanced care plan.

Lasting powers of attorney and advanced care plans are a well-evidenced way to ensure your wishes are considered when you may not be able to make them known or make decisions for yourself.

National Institute of Health and Care Excellence recommendation:

NICE recommends that everyone with conditions like dementia are supported to make advanced care plans and appoint powers of attorney.

How can I plan for the future?

The following government website allows you to make and register a power of attorney yourself: www.gov.uk/power-of-attorney. There are details of how to find a solicitor to support you, if that's needed, below. As your dementia progresses, you may need a solicitor to support this process.

Dementia charities and your healthcare workers can provide advice on advanced care planning and templates that you complete yourself.

Additional information available online:

www.gov.uk/power-of-attorney

www.lawsociety.org.uk/public/for-public-visitors/common-legal-issues/power-of-attorney

www.dementiauk.org/wp-content/uploads/2020/02/ACP-Booklet-A4-2018-online.pdf

Other useful information

Dementia Treatment and Research

There have been recent advances in dementia treatment; however, new treatments are likely to be limited to people at the very earliest stages of dementia, and the advice in this booklet still applies. It is best to speak to your dementia doctor or GP about medication for dementia that may help you.

Additional information about medication can be found online here: www.nhs.uk/conditions/dementia/treatment/

www.alzheimers.org.uk/about-dementia/treatments/dementia-drugs/drug-treatments-and-medication-alzheimers-disease

There is also research underway to test new treatments and interventions to support people with dementia. Ask your healthcare team if you would like more information or would like to be involved in dementia research.

You can also register to be involved in dementia research here: www.joindementiaresearch.nihr.ac.uk/

Financial support (benefits)

Most people diagnosed with dementia will be entitled to benefits, as will any carers who are undertaking caring activities over multiple hours a week.

If you are of state pension age and have a dementia diagnosis, depending on your current care needs, you may be entitled to an attendance allowance: https://www.gov.uk/attendance-allowance

If you are below state pension age and have dementia, depending on your current care needs, you may be entitled to personal independence payments (PIP): https://www.gov.uk/pip

If you are a carer of someone living with dementia and they are receiving PIP or attendance allowance, you may be entitled to carer's allowance: www.gov.uk/carers-allowance

If you receive an attendance allowance, PIP, or carer's allowance and meet other criteria, you may also be eligible for council tax discounts: www.alzheimers.org.uk/get-support/legal-financial/discounts-disregards-exemptions-council-tax#content-start

It is important to reapply for benefits if your situation changes to ensure you are receiving the right level of financial support for your changing circumstances.

If you need help applying for these benefits, you can ask someone from the Department for Work and Pensions to support you. See www.gov.uk/support-visit-benefit-claim

Age UK also provides a benefits support service via their advice line: 0800 678 1602.

If you are unwell

It is important you are seen as soon as possible by your GP or other health care worker if you start to feel unwell, if any of your symptoms become difficult to manage, or if you are struggling at home.

In people with dementia, acute confusion can be the first sign there is an underlying health problem like an infection. This type of confusion is called delirium, and its effects can continue long after the initial cause of the confusion is treated, so it is important to see your GP if you suddenly start getting very confused.

Try to prevent infections by:

- Washing your hands regularly
- If you know someone has an infection such as flu, it is advisable to avoid unnecessary contact with them while they are unwell.
- Get an annual flu vaccination from your GP.
- Drinking plenty of fluids and keeping well-hydrated
- Ensure you eat foods that are prepared well and are in-date

People with dementia are often admitted to the hospital as an emergency due to falls, medication, and infections, therefore, prevention is advisable:

- It is important to keep active at the same time as reducing your risk of falling (see physical activity, hearing and vision, and supportive technology sections).
- Your pharmacist should regularly review your medication. You can ask for medication dispensers such as weekly boxes to help ensure these are taken safely (see helpful habits and supportive technology sections).
- Reduce your risk of infections (as above).

If you need to have surgery or go to the hospital for a planned admission, speak to your medical team about how best to reduce the risk of complications due to your dementia. Medical procedures like general anaesthetics can make people with dementia more confused and unwell.

Travel

Visiting friends and family and keeping active and engaged in things you enjoy is important. However, when travelling, in particular overseas, unfamiliar environments and routines can be stressful; they may cause confusion which can worsen your symptoms. If you travel, plan this carefully to reduce the risk of associated health issues and make this as easy as possible. Ensure you take out travel insurance if you are travelling abroad.

Driving

Changes to memory and attention can affect your driving ability. After a diagnosis of dementia, you will need to report your condition to the DVLA and your car insurance provider. If you are able to continue driving, your doctor may advise you have on-road driving assessments every six months to assess if you are safe to continue driving.

Additional day to day support

You may find you, or your loved ones, need more support day to day in the future.

If you start to need help with social care (as an example for washing, dressing, cooking, shopping, help to access activities, or to take medications) you can request a social service needs assessment.

To get a needs assessment you will need to speak to your local council. This website: https://www.gov.uk/apply-needs-assessment-social-services will connect you to your local councils website.

Social workers will review your care needs and help make a plan based on your individual needs. Depending on your financial situation, this can either be provided and paid for by social services, or you may have to contribute to, or cover the costs yourself.

If you need to cover costs yourself, you may also need to find the support you need yourself and these websites may be helpful:

For care in your home: https://www.nhs.uk/service-search/other-services/Care-at-home/LocationSearch/1833/

For residential care: https://www.alzheimers.org.uk/get-support/help-dementia-care/care-homes-who-decides-when

All care providers are monitored by the Care Quality Commission, so it is worth looking at what rating each care provider has before making a decision.

It is also important that you get reassessed by social services if and when your needs or finances change, to ensure you continue to get the right support.

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Katherine Sykes (Living Well with Dementia Implementation Lead)
Health Innovation Kent Surrey Sussex and NIHR Applied Research Collaboration, Kent, Surrey and Sussex

Azeezat Aminu (Living Well with Dementia Research Assistant)
NIHR Applied Research Collaboration, Kent, Surrey and Sussex

Lived Experience Advisory Group
Sussex Partnership NHS Foundation Trust

Professor Naji Tabet (Old Age Psychiatrist)
Centre for Dementia Studies
Brighton and Sussex Medical School

Dr Nicolas Farina (Associate Professor in Dementia Research)
University of Plymouth

Alison McLaren, (Librarian)
Surrey and Sussex Healthcare NHS Trust Library and Knowledge Services

Dr Rebecca Atkinson (Research Fellow)
NIHR Applied Research Collaboration Kent Surrey Sussex
Brighton and Sussex Medical School

Dr Dorina Cadar (Associate Professor in Cognitive Epidemiology and Dementia)
Brighton and Sussex Medical School
UK Health Security Agency

Professor Ramin Nilforooshan (Old Age Psychiatrist)
University of Surrey
Surrey and Borders Partnership NHS Foundation Trust

Dr Khalid Ali (Reader in Geriatrics)
Brighton and Sussex Medical School
Ageing research lead in Kent, Surrey, and Sussex Clinical Research Network

Professor Catherine Evans (Nurse Consultant – Palliative Care)
King's College London
Sussex Community NHS Foundation Trust

Dr Theo Fotis (Reader)
Centre for Digital, Cultures and Innovation,
University of Brighton

Dr Kathryn Hart (Registered Dietitian and Senior lecturer in Nutrition & Dietetics)
University of Surrey

Dr Tom Balchin (Visiting Professor in Rehabilitation, Bolton University)
Director, ARNI Institute & Charity for Stroke Survivors

Dr Nigel Best (Optometrist)
Specsavers UK

Gordon Harrison (Audiologist)
Specsavers UK

Alison Keiser (Nurse Consultant - Dementia/ Delirium)
Sussex Community NHS Foundation Trust

Fran Hamilton (Deputy Dementia Lead and Occupational Therapist) Sussex Community NHS Foundation Trust

Professor Sara Arber (Emeritus Professor of Sociology)
University of Surrey

ADULTS AND HEALTH SELECT COMMITTEE
ACTIONS AND RECOMMENDATIONS TRACKER
December 2024

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KEY			
	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	**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	Strategic System Conveners 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 was contacted to provide an update.
7 March 2024	**Healthwatch Surrey**	**AHSC 1/24:** To ensure that language used for automatic responses			13 May 2024	Distributed 15 March 2024

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		reflects a friendlier approach.				
10 October 2024	**Cancer & Elective Care Backlogs**	**AHSC 23/24:** Surrey Heartlands NHS ICB to clearly communicate learnings from the Cancer Inequalities Programme especially in relation to the effectiveness of actions taken in terms of improving outcomes and experiences for patients.			25 November 2024	Distributed to officers for response on 15 October 2024.
10 October 2024	**Cancer & Elective Care Backlogs**	**AHSC 24/24**: Keep the Adults and Health Select Committee updated on the Surrey Heartlands NHS ICB Cancer Inequalities Programme and its impact on both the Health and Wellbeing			25 November 2024	Distributed to officers for response on 15 October 2024.

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		Priority Areas and groups experiencing inequalities.				
10 October 2024	**Cancer & Elective Care Backlogs**	**AHSC 25/24:** To improve accessibility, and to ensure that communication is effective and does not disenfranchise those who aren't able to use technology in one way or another.			25 November 2024	Distributed to officers for response on 15 October 2024.
10 October 2024	**Right Care Right Person**	**AHSC 26/24:** It is recommended that all parties agree a common approach to monitoring and reporting with an emphasis on identifying and preventing vulnerable people being subjected to less-than-optimal support.			25 November 2024	**Response:** Liz Uliasz, Director for Mental Health, EDT and Prisons in Adults Wellbeing and Health Partnerships has confirmed that the service will continue to monitor and report through the existing governance structure whilst ensuring to keep the vulnerable person at the centre of everything they do.

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

10 October 2024	**Right Care Right Person**	**AHSC 27/24:** It is recommended that the delivery performance of staff training in changed processes is monitored and published, together with actions taken to maximise the uptake of training			25 November 2024	**Response:** Director for Mental Health, EDT and Prisons advised the service will update training and guidance as necessary and monitor attendance.
10 October 2024	**Right Care Right Person**	**AHSC 28/24:** Staff welfare is a major consideration; the committee would like to be updated on how the (non-blue light) Mental Health responder service vehicles are operating and receive information on that.			25 November 2024	**Response:** Director for Mental Health, EDT and Prisons acknowledges that staff welfare is of paramount importance, and that as per Simon Brauner-Cave's (Deputy Director of Mental Health Commissioning for Surrey Heartlands Integrated Care System) response to the committee's action for him to update on learnings from the pilot

ADULTS AND HEALTH SELECT COMMITTEE
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KEY			
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						a update will not be possible for at least 12 months as the pilot run is not currently live.
10 October 2024	**Mental Health Improvement Plan**	**AHSC 29/24:** 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, and the Committee supports the programmes and the 'One System One Plan' approach to improving mental health and the economic activity			25 November 2024	**Response:** Acknowledgment noted with thanks.
10 October 2024	**Mental Health Improvement Plan**	**AHSC 30/24:** Set clear, measurable performance objectives for each of the			25 November 2024	**Response:** This is work in development. Both Liz and Simon are looking at performance measurers and

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

		initiatives being undertaken				welcome the committee's recommendations.
10 October 2024	**Mental Health Improvement Plan**	**AHSC 31/24:** Implement effective reporting on the performance objectives			25 November 2024	**Response:** As above this is in development.

Actions

Date	Item	Action	Responsible Member/Officer	Deadline	Progress Check	Action response. Accepted/implemented
10 May 2024	**MINDWORKS [Item 5]**	Mindworks team to share the completed Transformation Plan with the Children's, Family Lifelong Learning and Culture Select Committee in October 2024.	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 and action agreed. They will be on time for sharing with select committee in October. **Update:**

ADULTS AND HEALTH SELECT COMMITTEE
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December 2024

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					November 2024	They have provided a Mindworks Neurodiversity Transformation Plan - Teams Briefing n October 2024 and an ND Seminar with AHSC Chair and Vice Chair in November 2024.
10 October 2024	**Right Care Right Person**	Director for Mental Health, EDT and Prisons (AWHP) to review opportunities to conduct in-person staff training		12 November 2024		**Response received on 12 November 2024:** Liz Uliasz, Director for Mental Health, EDT and Prisons in Adults Wellbeing and Health Partnerships has confirmed that she will be holding refresher updates for yet unspecified dates in the new year.
10 October 2024	**Right Care Right Person**	Director for Mental Health, EDT and Prisons (AWHP)to contact the Silver Group/ Police colleagues, and encourage them to		12 November 2024		**Response received on 12 November 2024:** Liz did contact the Silver Group/ Police colleagues, and encourage them to review any potential gaps in the training

ADULTS AND HEALTH SELECT COMMITTEE
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		review any potential gaps in the training offered to voluntary organisations, such as Healthwatch Surrey.				offered to voluntary organisations, and they advised that they have delivered training to Transform Housing, the Surrey Care Association Registered Managers Forum in July, and most recently to the Learning Disability and Autism Hub last week, along with a few 1-2-1 meetings with representatives from the Voluntary, Community and Social Enterprises (VCSE). VCSE representatives are invited to bronze and silver meetings, and they are included in email distribution list, and continue to receive all relevant updates and documents. The Police also continue to offer 1-2-1 meetings to any representatives who want a more detailed discussion at every bronze and silver meeting.

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10 October 2024	**Right Care Right Person**	Deputy Director of Mental Health Commissioning (NHS Surrey Heartlands ICB) to update the committee on the learnings gathered from the pilot mental health response vehicles (non-blue light responder services) being conducted.		12 November 2024	October 2025	**Response received on 12 November 2024:** Simon Brauner-Cave, Deputy Director of Mental Health Commissioning for Surrey Heartlands Integrated Care System advises that the request was for him to update on learnings from the pilot when it has been up and running and learnings have been identified, but this will not be available for at least 12 months.
10 October 2024	**Mental Health Improvement Plan**	The Prevention & Communities Lead to provide the committee with more detail on how the innovation programmes, 'Work		12 November 2024		**Please see combined response to point 5 below.**

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		Wise' and 'Work Well' were working and the support these programmes offered.				
10 October 2024	**Mental Health Improvement Plan**	The Prevention & Communities Lead to share further information/data on the work being conducted to understand Surrey's local picture regarding the cost to Surrey's businesses and Surrey's economy from staff unable to maintain a role due to poor mental health.		12 November 2024		**Response received on 12 November 2024:** Rebecca Brooker, Communities and Prevention Lead, Surrey County Council as advised that in response to these queries they are developing a briefing opportunity to allow members to learn more about these programmes, how they complement each other and support Surrey's residents, and how they respond to the research findings, some of which is complete and some of which is still in progress. Further details on this will be shared in due course. In the meantime, members may wish to review:

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						- Overview of the WorkWise programme: Work Wise: Supporting people to get work - Surrey County Council - Overview of the WorkWell programme: WorkWell Overview - external - Findings from the research into the experiences of residents furthest from the labour market: NOLB skills and employment - Surrey CC_Report draft_Final 190523.pdf - Findings from the research into employers experiences of recruiting and retaining in employment those with additional barriers: Surrey Employers Standalone deck 2008-compressed.pdf - Findings from the research into the experiences of Surrey

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KEY			
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						residents experiencing in-work poverty: In work poverty report FINAL copy with no images.pdf
10 October 2024	**Mental Health Improvement Plan**	Associate Director for Community Transformation (SaBP) to share the commissioned independent evaluation report on the impact of the specialist integrated mental health services in primary care.		12 November 2024	20 November 2024	**Update on 12 November 2024:** Georgina Foulds, Associate Director for Community Transformation (SaBP) due to respond.

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
6 March 2025	pre-decision	**Access to Primary Care and the process of making major changes**	To understand the operational changes with Frimley South NHS changing access to GP services replacing e-consult with an A.I. tool th.at will support 24x7 access including elements of triage and self-booking of appointments plus extra resource, Frimley are also closing the Aldershot Urgent Care Centre and moving it to Frimley Park and changing its role	To understand the issues and the reasons for the changes and learn about the operational processes and how this is benefiting residents	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC) (Frimley NHS Trust Contacts TBC)

6 March 2025	pre-decision	**All-Ages Neurodiversity** paper that brings in what is being done for Adults as well as children and young people (CYP). (SaBP) (TBC)	There is significant concern that large numbers of Adults remain undiagnosed and that ends up creating other Mental Health issues. Neurodiversity is a lifelong condition and doesn't just affect CYP.	This will allow for a limited public update on the progress with the Mindworks Transformation	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC) (SaBP Contacts TBC)
6 March 2025	pre-decision	**Review changes to the specification of minor injury units/walk-in centres across the Surrey Heartlands to become urgent treatment centres following the national NHS England mandate**	Following the national NHS England mandate and Surrey Heartlands' intention to change the specification of the minor injury units/walk-in centres across the Surrey Heartlands area (of which there are a number) to become urgent treatment centres, the Committee Chairman would	The Committee want to scrutinise recent changes to Primary Care following the national NHS England mandate within Surrey Heartlands ICS and understand some operational changes with practices deploying A.I. tools and how this affects residents.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC) (Surrey Heartlands NHS ICS)

			like to understand and scrutinise the changes.			
15 May 2025	pre-decision	**The "One System Plan Strategy"** (A system-wide strategy on an Integrated Community Mental Health Offer)	The committee will want to understand what impact it is having on the wider system.		Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)
15 May 2025	pre-decision	**CQC outcomes following inspection into ASC at SCC** (TBC)	The committee will want to review the CQC report and understand what the main issues have been, what needs to be improved, and what measures will be implemented to do that.		Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit. Growing a sustainable economy so everyone can benefit.	(Contacts TBC)
	pre-decision	**South East Coast Ambulance NHS service** (SECAmb) (TBC) Mental Health hubs	To hear about how the transformation to a Virtual Hub approach being put in place in Surrey is going and learn about progress with	The committee will want to understand the progress and scrutinise what the approaches have been and how the hubs will develop.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)

			prototyping the virtual hub			
15 May 2025	pre-decision	**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 the hospitals have put in place service changes to deliver a safe and effective maternity service.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)
11 July 2025	pre-decision	**Adult Social Care - Performance Trends concerning Mental Health (AWHP)** (TBC)	The committee would like to understand what the trends and issues are related to Mental Health Performance and understand what needs to improve and what is being done to show that.	To see what measures are being taken to address areas and understand how improvements can be achieved.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)

11 July 2025	pre-decision	**Surrey Heartlands Joint Forward Plan 2023 to 2028** **Joint Health and Wellbeing (ICP)** (TBC)	The committee to review the Joint Forward Plan which sets out how local NHS, partner local authorities, voluntary, community and social enterprise (VCSE) sector, the Places and Neighbourhoods will deliver the ICS strategy and NHS Long Term Plan commitments for the local population over the next five years. To learn about how this is working with integrated care partnerships and how they are delivering care differently.	To learn about what developments are occurring, the challenges and where improvements need to be made. To recognise the significant financial challenges and understand how Surrey Heartlands Health and Care Partnership is working together to achieve financial sustainability as they integrate and transform the way they are working.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit. Growing a sustainable economy so everyone can benefit.	(Contacts TBC)
11 July 2025	pre-decision	**Joint Strategic Needs Assessment (JSNA)** (TBC)	To review the JSNA re the current and future health and social care needs of the local community.	Understand how this has helped to reduce inequalities and improve health and wellbeing outcomes and how the challenges	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)

				have been overcome.		
8 October 2025	pre-decision	**Industrial 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 to understand the impacts on service delivery and mental health within the ICBs and ICS.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)
8 October 2025	pre-decision	**Winter Pressures and the impacts on the National Health Service (NHS)** (TBC)	The Select Committee is to receive a report/reports from Surrey Heartlands ICS, Frimley ICS, and SECAmb outlining the preparations in place for the pressure of the Winter months on Healthcare Services.	The Select Committee will review and scrutinise the preparations for the Winter, making recommendations accordingly.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)

2 December 2025	pre-decision	**Residential Care Strategy** (TBC)	To review the developments and understand the impacts of the challenges of this large-scale engagement activity with residents, staff, members, partners and businesses to shape our vision for Surrey in 2030.	Reassurance of where things are with the delivery of the strategy, sufficiency of capacity, delivery of capacity to plan and what is being done to manage the challenges.	Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit. Empowering communities to thrive, tackling health inequality, growing a sustainable economy so everyone can benefit.	(Contacts TBC)

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	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)

		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.			
Ongoing	**Hampshire Together Joint Health Overview and Scrutiny Committee**	On 3 December 2020, the Hampshire Together Joint Health Overview and Scrutiny Committee, comprising representatives from Hampshire County Council and Southampton City Council, was established to review the Hampshire Together programme of work, and Surrey County Council was invited to attend meetings as a standing observer.	The Joint Committee is to scrutinise the Hampshire Together programme of work and associated changes in the provision of health services.	Empowering communities, tackling health inequality	Trefor Hogg, Carla Morson (substitute) David Lewis (observer at JHOSC)
Ongoing	**Frimley Park Hospital Joint Health Overview and Scrutiny Committee**	In March 2024, The Frimley Park Hospital Joint Health Overview and Scrutiny Committee was	The Joint Committee is to scrutinise the Frimley Park Hospital –	Empowering communities, tackling health inequality	Trefor Hogg – JHOSC Chairman (SCC) Bill Withers – JHOSC Vice-Chairman (HCC) and further representatives (SCC)

		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.	development of a new hospital for Frimley Park programme of work and associated changes in the provision of health services.		Carla Morson, Michaela Martin, Richard Tear.

Standing Items

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