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