MINUTES of the meeting of the **ADULTS AND HEALTH SELECT COMMITTEE** held at 10.00 am on 3 March 2021 as a REMOTE MEETING.

These minutes are subject to confirmation by the Committee at its meeting on Wednesday, 14 July 2021.

Elected Members:

* Dr Bill Chapman (Vice-Chairman)
* Mrs Clare Curran
* Mr Nick Darby (Vice-Chairman)
* Mr Bob Gardner
* Mrs Angela Goodwin
* Mr Jeff Harris
* Mr Ernest Mallett MBE
  Mr David Mansfield
* Mrs Marsha Moseley
* Mrs Tina Mountain
* Mrs Bernie Muir (Chairman)
* Mrs Fiona White

Co-opted Members:

* Borough Councillor Neil Houston, Elmbridge Borough Council
* Borough Councillor Vicki Macleod, Elmbridge Borough Council
* Borough Councillor Darryl Ratiram, Surrey Heath Borough Council

In attendance

Karl Atreides, Chair, Independent Mental Health Network
Nick Markwick, Co-Chair, Surrey Coalition of Disabled People
Kate Scribbins, Chief Executive, Healthwatch Surrey
Patrick Wolter, Chief Executive Officer, Mary Frances Trust

11/21 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

None received.

12/21 MINUTES OF THE PREVIOUS MEETING: 19 JANUARY 2021 [Item 2]

The minutes were agreed as a true record of the meeting.

13/21 DECLARATIONS OF INTEREST [Item 3]

None received.

14/21 QUESTIONS AND PETITIONS [Item 4]

Witnesses:
Ruth Hutchinson, Director of Public Health, Surrey County Council
Dr Sally Johnson, Clinical Lead for Covid Vaccinations, Surrey Heartlands
Sinead Mooney, Cabinet Member for Adult Social Care, Public Health and Domestic Abuse

1. A member of the public asked the following question in advance of the meeting: “How many of Surrey's care home residents have tested positive for COVID-19 since the Government lifted the last national lockdown on 2 December 2020?”

2. The following response was issued by Surrey County Council Public Health in advance of the meeting: “The Public Health England line listing of case data derived from our Power BI platform identifies 1,647 records of care home residents testing positive for COVID-19 since 2 December 2020 (up to 28 February 2021). Data included on the National Capacity Tracker estimates that the total number of care home residents in Surrey is approximately 9,799.

   Please note: due to data quality issues related to provider input, this data is subject to change.”

3. Having received this response, the questioner asked the following supplementary question at the meeting: what impact had the level of infections indicated in the response above had on COVID-related hospitalisations and deaths of care home residents during the same period, as well as on the rollout of the vaccine, since it was understood that vaccinations could not occur in care homes where there was an outbreak taking place?

4. It was agreed that a written response would be provided after the meeting.

5. The Clinical Lead for Covid Vaccinations stated that it was in fact possible to vaccinate residents and staff even when there was an outbreak in a care home. A risk assessment would have to be conducted, and vaccinations for people who had tested positive for the coronavirus would have to be delayed, but outbreaks in care homes had not hampered the vaccination programme significantly.

6. Members enquired whether the figure for Covid-19 cases in care homes was particularly high in Mole Valley and whether there were any other pockets across Surrey that had similarly high figures. The Select Committee requested to see comparative figures for each district and borough. The Director of Public Health agreed to include information on the prevalence of Covid-19 in care homes and the population as a whole in each district and borough in the written response.

7. The Co-Chair of the Surrey Coalition of Disabled People emphasised that domiciliary care should also be taken into account, not just care homes. The figures for domiciliary care were often ignored, yet domiciliary care clients and staff were impacted significantly by Covid-19. The Cabinet Member for Adult Social Care, Public Health and Domestic Abuse agreed to provide, where possible, data on the cases of hospitalisation or death of Adult Social Care clients in a domiciliary setting.

Actions/further information to be provided:

1. The Director of Public Health to provide a written response to the questioner’s supplementary question, including information on the

number of hospitalisations and deaths in care homes and domiciliary care settings for each district and borough.

15/21 COVID-19 VACCINATION PROGRAMMES [Item 5]

a SURREY HEARTLANDS COVID-19 VACCINATION PROGRAMME [Item 5a]

Witnesses:

Jane Chalmers, Covid Director, Surrey Heartlands
Ruth Hutchinson, Director of Public Health, Surrey County Council
Dr Sally Johnson, Clinical Lead for Covid Vaccinations, Surrey Heartlands
Giselle Rothwell, Associate Director of Communications and Engagement, Surrey Heartlands

Key points raised during the discussion:

1. The Covid Director provided an update on the data since the report had been published. The total number of vaccinations to date within the Surrey Heartlands area stood at approximately 330,000. Approximately 320,000 of these were first doses. About 27% of the Surrey Heartlands population had received at least the first dose of the vaccine. The roving model of vaccination used by the programme included administering vaccinations to homeless people and hard-to-reach groups. An important part of the programme now was understanding why some of the people who had been offered the vaccine had chosen not to take it up.

2. A Member asked what was being done to appeal to people who had been offered but declined the vaccination. The Director of Public Health emphasised that the programme was long-term. Whether people took up the vaccination when it was offered to them depended on the 'three Cs': confidence, convenience and complacency. The Director agreed to send a link to the Select Committee containing intelligence on vaccine hesitancy data. There was clear evidence on which population groups were less likely to take up the vaccine; these included black, Asian and minority ethnic (BAME), Gypsy, Roma and Traveller, and Pakistani and Bangladeshi communities, as well as people coming from certain economic backgrounds. As the vaccination cohorts were worked through and younger age groups came to be vaccinated, it was anticipated that patterns might also emerge of age groups that were less confident in taking the vaccine. Regarding the convenience of being vaccinated, it was important to understand the barriers to access and to work with affected groups to minimise barriers. This might involve making the vaccination experience accessible for people with disabilities, or ensuring vaccination sites were easy to reach by public transport. Regarding complacency, there was a need to understand complacency in some groups and develop solutions. Young people might be more likely to be complacent about taking up the vaccine. There was a comprehensive action plan and Equalities Impact Assessment (EIA) for the three Cs.

3. The Associate Director of Communications and Engagement added that a video had been produced in Urdu with the help of the imam at a mosque in Woking, and it was hoped that a trusted, local leader would help encourage people to come forward for the vaccine. A vaccination site had also been set up at this mosque. There was a Gypsy, Roma

and Traveller community service lead, who was working to develop a video of someone from within that community having their vaccine. Moreover, Surrey Heartlands was working with Surrey Care Association to dispel some common misconceptions and answer questions for care home staff. There were care homes that had vaccinated every member of staff, and those could be used as case studies to encourage other care home staff to take up the vaccination.

4. A Member expressed concern that once people had received the first dose of the vaccine, many mistakenly thought that they could not contract Covid-19 or transmit the virus. The need to maintain social distancing and abide by lockdown rules, even after vaccination, was not always mentioned verbally at the point of vaccination. The Clinical Lead for Covid Vaccinations replied that Surrey Heartlands was asking all of its staff to verbally emphasise at all vaccination appointments the need to continue to socially distance and wear a mask post-vaccination. Nevertheless, this would be restated to staff, to ensure it happened in every case. There was also a Public Health England leaflet that emphasised the need to continue to abide by restrictions post-vaccination.

5. A Member expressed concern that digital exclusion may lead to some people missing out on the vaccine, particularly elderly people or those who are not registered with a GP. The Clinical Lead for Covid Vaccinations stated that it could be difficult to contact people who were not registered with a GP. However, digital technology was not relied upon as the only method of contact for those who were registered with GPs; people were contacted about their appointment through landline phone calls and letters, and some GPs had even visited the houses of people they were particularly concerned about in order to ensure they could make an appointment to be vaccinated. Patients whose contact details were not in the system could be harder to contact, but it was key to remember that people did not have to have ever been registered with the NHS to be eligible for the vaccine. Anyone could phone the vaccination service or a GP and ask to be vaccinated, even if they were not registered. The Associate Director of Communications and Engagement added that the service was working with district and borough councils and local Covid champions to communicate information about the vaccine.

6. A Member asked how it was decided whether a person would receive the Oxford/AstraZeneca or Pfizer/BioNTech vaccine. The Covid Director responded that the supply of each vaccine to vaccination sites depended entirely on the national supply. Both vaccines were equally effective. The Clinical Lead for Covid Vaccinations added that a small number of people would not receive the Pfizer vaccine due to their medical history; this could include conditions such as severe anaphylaxis.

7. A Member asked for confirmation on whether the Epsom Downs Racecourse vaccination centre would close for the Epsom Derby in 2021 and whether it would reopen afterwards. The Covid Director stated that, while there would certainly be no closure of the vaccination centre in April 2021, it was possible that the centre might close temporarily in May 2021 for the Derby. If the centre was closed for the

Derby, this would be communicated to residents, alongside alternative vaccination plans for this period.

8. The Chair of the Independent Mental Health Network remarked that consumption of news media from traditional channels, such as television, was becoming less common, and many people now consumed news media through newer channels such as social media. He suggested that social media channels such as TikTok, which was popular amongst young people in particular, could be used to publicise and educate people on the vaccine. The Associate Director of Communications and Engagement agreed that using avenues such as TikTok should be looked into. Also, Surrey Heartlands had already made its own educational videos on the vaccine.

9. A Member asked whether Surrey Heartlands was in contact with the universities in Surrey about communicating the importance of the vaccine. Communicating with university students could be an effective way of reaching multi-generational households. The Associate Director of Communications and Engagement replied that Surrey Heartlands worked with the Multi-Agency Information Group (MIG) across all stakeholders including universities, and agreed that this could be a useful way to reach multi-generational households.

10. A Member expressed concern about a disconnect between the national and local vaccination systems, which could cause difficulty with booking appointments. The Covid Director stated that improvements had been made on this, although the system was not perfect.

11. A Member enquired what help was available regarding transport to vaccination sites for people who had mobility issues, were isolated or lived in a rural location. Was transport available and was it offered automatically, or could people contact someone and ask for assistance? The Associate Director of Communications and Engagement said that there was no formal national service for transport to vaccination appointments, but that the national booking service for vaccination appointments did offer the closest available appointment, meaning the distance of travel to the appointment should be minimal. The Clinical Lead for Covid Vaccinations added that the community transport service was transporting patients to appointments with the help of volunteers.

12. The Co-Chair of the Surrey Coalition of Disabled People asked how many people with protected characteristics had taken up the vaccine and requested more information on what the Equalities, Engagement and Inclusion Working Group had achieved since it had recently been set up and what actions from the stakeholder reference group for the EIA had been taken into account. The Associate Director of Communications and Engagement agreed to share the EIA and the initial findings of the Equalities, Engagement and Inclusion Working Group with the Select Committee.

13. The Co-Chair of the Surrey Coalition remarked that there were often no hearing loops installed at vaccination sites; these should have been installed earlier to ensure the sites were accessible from the

beginning. The Clinical Lead for Covid Vaccinations stated that a checklist of amendments that needed to be made at vaccination sites – including the installation of hearing loops – had now been put together. Staff had been working hard for some months and had not necessarily had the time to install hearing loops or other amendments so far.

14. The Co-Chair of the Surrey Coalition commented that, when a person had two or more carers, only one of the carers would qualify for the vaccine. Why was this? He expressed concern that unpaid carers might be overlooked. The Clinical Lead for Covid Vaccinations replied that there had been some challenges in defining 'carers' according to the national guidance. The definition now was the sole or primary carer of a clinically extremely vulnerable adult. She acknowledged that whether or not a person received the vaccine was ultimately down to the discretion of their GP, which could lead to inconsistencies. It was important to comply with the order of cohorts for vaccination, particularly in the early stages of the vaccination programme.

15. The Chief Executive of Healthwatch Surrey stated that the feedback Healthwatch Surrey had received about the vaccination programme was predominantly positive, particularly with regards to the experience at the vaccination centre itself. The clinical commissioning group (CCG) helpline had also been a useful place to refer residents.

16. A Member remarked that some people who had been amongst the first cohort to be vaccinated had not been able to book their second dose. How was the booking of second dose appointments being managed? The Clinical Lead for Covid Vaccinations responded that people who had received their first dose through the national booking system had been able to book their second appointment at the appointment for the first dose. All others who had received their vaccine at a local site would be contacted within the next few weeks and receive details of their second dose.

17. A Member asked who would contact residents about the second dose. The Clinical Lead for Covid Vaccinations stated that this depended on the vaccination site, but generally a text message would be sent by either the local vaccination site or the GP surgery, which worked closely together.

18. A Member mentioned recent evidence showing that the Covid-19 vaccinations were highly effective after just one dose. He suggested that this could be included in communications, to help persuade people to take up the vaccine. The Associate Director of Communications and Engagement agreed to raise this with NHS England, from whom they took their lead on messaging.

b FRIMLEY HEALTH AND CARE COVID-19 VACCINATION PROGRAMME [Item 5b]

Witnesses:

Sarah Bellars, Executive Director of Quality and Nursing, and Director of Infection, Prevention and Control, Frimley Collaborative
Paul Corcoran, Senior Quality Manager, Frimley Collaborative
Ruth Hutchinson, Director of Public Health, Surrey County Council

Key points raised during the discussion:

1. A Member noted that it had recently been announced in the media that the Pfizer/BioNTech vaccine could be stored at standard pharmacy freezer temperatures (originally, it had been thought that it had to be stored at extremely low temperatures). Would this discovery affect the rollout of the vaccine? The Executive Director of Quality and Nursing replied that the Frimley Collaborative received its direction from NHS England, and it had not received any direction regarding a change in the Pfizer/BioNTech storage temperature, so the vaccine continued to be stored at very low temperatures in accordance with official guidance.

2. A Member asked what the response of BAME communities had been to the vaccination programme. The Executive Director of Quality and Nursing stated that the Frimley Collaborative had been working on uptake and health inequalities from the start of the vaccination programme. It was important to adapt to different communities. The Frimley Collaborative had been successful in its work with BAME communities with regards to the vaccine so far.

3. A Member enquired how successful the programme had been in care homes in the Frimley area. The Executive Director of Quality and Nursing said that Frimley had been part of the national pilot in care homes and that all care home residents in the area had been offered the vaccine by the end of January 2021, well before the deadline of 15 February 2021.

4. A Member asked what Frimley's approach was to vaccinating people with learning disabilities and autism. The Executive Director of Quality and Nursing responded that steps had been taken such as simplifying settings for people with learning disabilities, utilising national tools such as easy-read materials and making the vaccination sites a comfortable, safe environment.

5. A Member requested more information on how hard-to-reach people were being reached for vaccination. The Executive Director of Quality and Nursing replied that a meeting had been held in a community hall to understand vaccine hesitancy amongst the Gypsy, Roma and Traveller community, and insights from that meeting had been taken on board. Also, vaccines for homeless people were being brought forward in terms of priority, in order to offer vaccinations to homeless people when they were more accessible during the period of cold weather. The Senior Quality Manager added that in the Surrey Heath area (at the Lakeside site), special clinic sessions with fewer attendees and more allocated time had been set up especially for clinically extremely vulnerable people who might be concerned about attending busy clinic sessions.

6. A Member stated that there had been some publicity encouraging people who were not registered with a GP to come forward for a vaccination; this message seemed to have fallen away recently. Should this message be reintroduced? The Executive Director of Quality and Nursing responded that unregistered patients such as homeless people or private patients could contact a GP surgery to ask

to receive the vaccine. She agreed to raise the possibility of reemphasising this point with NHS England.

Recommendations:

The Select Committee congratulates Surrey Heartlands and Frimley Health and Care on the successful rollout of their Covid-19 Vaccination Programmes and recommends that they:

1. Ensure that the need to continue following government guidelines on social distancing and mask wearing is both verbally communicated to all residents at their vaccination appointments and included in a prominent position in all leaflets;
2. Expand their communications messaging to as wide a variety of social media websites and applications as possible to help tackle vaccine disinformation;
3. Ensure that those residents without access to mobile phones and/or the internet receive all required vaccination information in a timely manner, and that steps are taken to identify and support those who are digitally excluded as quickly as possible.

Actions/further information to be provided:

1. The Director of Public Health is to share with the Select Committee a link to intelligence on vaccine hesitancy data that is in the public domain;
2. The Associate Director of Communications and Engagement for Surrey Heartlands is to the share with the Select Committee a copy of the Equality Impact Assessment;
3. The Director of Public Health is to share with the Select Committee the initial findings of the Equalities, Engagement and Inclusion Working Group;
4. The Associate Director of Communications and Engagement for Surrey Heartlands is to raise with NHS England the issue of including in communications messaging data on the success of the vaccination programme to date and evidence of the protection vaccines provide after the first dose;
5. The Executive Director of Quality and Nursing for the Frimley Collaborative is to raise with NHS England the possible reintroduction of messaging around residents not needing to be registered with a GP to receive a vaccine.

16/21 GENERAL PRACTICE INTEGRATED MENTAL HEALTH SERVICE OVERVIEW AND SERVICE MODEL [Item 6]

Witnesses:

Georgina Foulds, Associate Director for Primary and Community Transformation, Surrey and Borders Partnership
Rebecca Isherwood-Smith, Interim Mental Health Programme Lead, Surrey Heartlands
Dr David Kirkpatrick, Clinical/Managerial Lead (Integrating Primary and Mental Health Care), Surrey and Borders Partnership
Dr Maria Nyekiova, GP Partner and Mental Health Lead for COCO Primary Care Network
Paris Wilson, GP IMHS Service User

Key points raised during the discussion:

1. The Clinical/Managerial Lead introduced the report, emphasising the importance of configuring mental health services in a way that was not harmful itself to service users' mental health (for example, a high threshold for access to the service could cause deterioration of the mental health of someone who has just failed to meet the threshold). The introduction of the General Practice Integrated Mental Health Service (GPIMHS) aimed to help resolve this. The quality of service users' experience of accessing care was as important as the quality of the care that they were accessing. Social determinants of mental health could not be resolved by the mental health foundation trust alone; this must also involve the community. Surrey was fortunate to have a high standard of mental health services in general and strong links between partners, including the voluntary sector and primary care.

2. The Clinical/Managerial Lead continued to explain that it was important to have good mental health services in place in GP surgeries so that mental health issues could be recognised at the first point of contact and in order to ensure primary care staff felt supported with the skills to provide mental health support. GPIMHS would allow residents to go to a GP surgery and quickly have access to a mental health professional or Community Connector without having to reach a high threshold. GPIMHS was part of a vision for a 'no wrong door' system; in other words, the idea that residents would be able to access consistently high-quality mental health services by presenting initially anywhere in the system. The Clinical/Managerial Lead showed a case study, which illustrated the experience of a GPIMHS service user who was able to access help quickly and felt well-informed. Also, carers were an important part of mental health services, and were often not taken into account as much as they should be. Whether the service user had a carer or was a carer – including a young carer in particular – would always be taken into account as part of GPIMHS.

3. The GP Partner and Mental Health Lead for the COCO Primary Care Network (PCN) stated that prior to GPIMHS, many patients would experience a disconnect between the criteria for different services, meaning they would become stuck in a cycle and struggle to access the support they needed. GPIMHS, on the other hand, provided a useful bridge between primary care, secondary care and the community, and would hopefully resolve this disconnect. GPIMHS allowed for communication between multiple agencies – including, for example, substance abuse services and housing services – and could therefore be tailored to service users' individual needs. This may also allow for multiple mental health conditions to be recognised more easily. Since GPIMHS had been introduced, patients' care had improved significantly.

4. The GPIMHS Service User detailed her experience of the service. Having been discharged from the community mental health service in a London borough, she was subsequently disappointed in the comparatively inefficient mental health services she experienced after returning to Surrey. In Surrey, she tried to access the Community Mental Health Recovery Services (CMHRS) and Improving Access to Psychological Therapies (IAPT) services but did not meet the

threshold of criteria for these. She returned to her GP and asked to stop being referred to CMHRS, as it was proving unhelpful, at which point her GP told her about GPIMHS. Her GP referred her to GPIMHS who were significantly better than other mental health services she had experienced: GPIMHS staff were helpful and kind, she felt listened to and supported by psychiatrists, and she felt that they were comfortable with managing her psychiatric medication, whereas staff in other services had not seemed comfortable with this. GPIMHS focused not on her diagnoses, but rather on the actual symptoms that she was experiencing, which was helpful. Her only concern was that GPIMHS had not been publicised well enough – she had not heard of the service prior to her referral – and she wished she could have been referred there more quickly.

5. The Chief Executive Officer of the Mary Frances Trust agreed with the comments made so far and stated that referrals to Community Connections services had increased significantly in areas where GPIMHS operated. In the past, Community Connections would struggle to receive direct referrals from GPs, but GPIMHS had helped change this. GPIMHS had provided an important link between primary and secondary mental health services.

6. The Chair of the Independent Mental Health Network (IMHN) expressed concern that the CMHRS in Surrey did not work well and this could lead to deterioration in people's mental wellbeing.

7. The Chair of the IMHN asked who would run the carers' support groups mentioned in the report. The Clinical/Managerial Lead replied that this was part of the managing emotions pathway (MEP), which could involve self-referral.

8. The Chair of the IMHN asked whether the reablement pilot mentioned in the report was the same as the enabling independence programme. The Associate Director for Primary and Community Transformation explained that these were different, and the reablement pilot was a new programme. It had been delayed because of recruitment difficulties. The pilot would run for a year and would be integrated with GPIMHS. During this year, the progress of the pilot would be reviewed every six weeks. The pilot would be able to deliver some services that GPIMHS and MHICS (mental health integrated community services) could not deliver, such a conducting home visits.

9. The Chair of the IMHN enquired what the referral rate to the reablement pilot was for black, Asian and minority ethnic (BAME) people and people with long-term health conditions. The Clinical/Managerial Lead agreed to provide this information.

10. The Chair of the IMHN questioned why GPIMHS could not conduct face-to-face appointments during the Covid-19 lockdown, while other services such as safe havens and some GP appointments were offered face-to-face. The GP Partner responded that, if it was deemed necessary for the patient, GPIMHS appointments could be held face-to-face, but this required a large room with the windows open, and the wearing of face shields, in order to decrease the risk of coronavirus transmission. While GP appointments were typically only around

seven minutes long, GPIMHS appointments lasted from 30 minutes to an hour, meaning the risk of transmission was higher. The Clinical/Managerial Lead added that there was certainly value in face-to-face appointments, and it was important to give patients the choice between having some appointments face-to-face and others as telephone or video appointments. As Covid-19 restrictions were lifted, this would be communicated to PCNs.

11. The Chair of the IMHN suggested that, as well as telephone appointments, video appointments should continue to be offered to people with known mental health needs, even after the pandemic. The Associate Director for Primary and Community Transformation agreed to explore this.

12. A Member praised the report and the success of the GPIMHS programme. He asked whether there were funding issues, how likely it was that the service would receive sufficient funding, and how staffing issues could be addressed early to ensure that funding would not be refused due to staffing issues. The Associate Director for Primary and Community Transformation stated that funding issues had not yet been resolved. At present, the decision on the amount of funding to be provided to the transformation programme was being processed across NHS system partners. The service was doing everything it could to support sufficient funding for GPIMHS, and GPIMHS representatives would be meeting with NHS England soon in order to understand funding streams over the next few years. While this was not yet resolved, it was being worked on and the Select Committee's support in pushing for the funding was appreciated. The plans for the GPIMHS service had been approved and the service was preparing to mobilise expansion in the next one to two years; it was just the detail of the finances that remained to be resolved. Moreover, there was concern about staffing and recruitment to GPIMHS. The service had been fortunate in recruitment so far, and the innovative way of working was attractive to potential staff. While the Associate Director could not give complete assurance on recruitment in future, the service had done well with recruitment so far. It was also important to ensure that GPIMHS did not drain staff from core services.

13. The Select Committee expressed its eagerness to support GPIMHS. In addition to supporting the programme in the recommendations of this meeting, further ways that the Select Committee could offer its support would continue to be explored.

14. The Clinical/Managerial Lead explained that a potential challenge for GPIMHS that was currently being overshadowed by the Covid-19 pandemic was the stock of rooms and clinical spaces at primary care sites that could be used for face-to-face GPIMHS appointments. This would prove a key issue once the pandemic had subsided. A Member suggested that community or high-street spaces could be used for GPIMHS appointments if there was not sufficient space in GP surgeries. The GP Partner responded that the possibility of holding some appointments in community or high-street spaces could be explored, but when seeing some higher-risk patients, GPs may require access to an alarm bell for their own safety. There were lots of benefits

to hosting multiple services in the same building, but the services offered had simply outgrown the buildings.

15. A Member asked what support was offered to people in the 18-25 age group specifically. The Interim Mental Health Programme Lead responded that a young adult reference group had been created in order to incorporate young people's views into mental health work. These groups included a variety of stakeholders, such as carers and CAMHS (child and adolescent mental health services) staff. The work of the reference group had included workshops, surveys, focus groups and user voice participation groups. A key outcome of this work was the notion of providing transition packs to young people to prepare them for the transition from children's to adults' services. Another finding was the importance of training for clinicians on the use of language, particularly when interacting with people who had recently transferred from children's to adults' services. Moreover, the service was looking at creating a young adults' section on the Healthy Surrey website or somewhere similar, to make it easy for young adults to access tailored information in one place. The GPIMHS Service User, who had been involved in the young adult reference group, added that the group had discussed piloting young safe havens especially for young adults, as young adults sometimes felt that they could not access the more general safe havens that currently existed. The Select Committee requested more information about young safe havens and written copies of the introductions witnesses had provided to this item, if possible.

16. A Member asked whether the service was engaging with young adults on platforms such as TikTok, with creative and fun content for young people. The Interim Mental Health Programme Lead stated that the young adult reference group fed into work on this.

Recommendations:

The Select Committee:

1. Offers its support for the GPIMHS and MHICS approach and will explore ways to assist its continued development;
2. Acknowledges that in Surrey Heartlands conversations are happening about the acceleration of the GPIMHS rollout and encourages a rapid implementation of the service across the entirety of Surrey;
3. Requests a further update on the progress made regarding funding and workforce at a future meeting.

Actions/further information to be provided:

1. The Clinical/Managerial Lead (Integrating Primary and Mental Health Care) for Surrey and Borders Partnership is to share with the Select Committee the reablement pilot referral rates for BAME residents and people with long-term health conditions;
2. The Associate Director for Primary and Community Transformation for Surrey and Borders Partnership is to liaise with GPs on the possible continuation of offering video appointments for patients;
3. The Interim Mental Health Programme Lead for Surrey Heartlands is to provide the Select Committee with more information on the work being done regarding young safe havens;
4. Witnesses are to provide the Select Committee with written versions of the introductions they gave at the start of the item.

17/21 UPDATE ON THE IMPLEMENTATION OF MENTAL HEALTH TASK GROUP RECOMMENDATIONS [Item 7]

Witnesses:
Sinead Mooney, Cabinet Member for Adult Social Care, Public Health and Domestic Abuse
Stephen Murphy, Head of Mental Health Commissioning (Adult Services), Surrey Heartlands
Liz Uliasz, Assistant Director of Mental Health, Surrey County Council

Key points raised during the discussion:

1. The Chairman of the Select Committee informed those present that she had sent a letter to the Secretary of State for Health and Social Care on the work of the Mental Health Task Group and the possibility of further progress in this area. The letter is annexed to these minutes.

2. A Member asked how voluntary sector organisations were responding to the work that had arisen from the work of the Task Group, and whether they had seen any changes arising from it. The Assistant Director of Mental Health replied that the work of the Task Group had focused attention on what needed to be delivered and raised the profile of mental health. The Cabinet Member for Adult Social Care, Public Health and Domestic Abuse added that the Task Group's focus on the issue of commissioning of voluntary sector mental health services was important and had ensured a better approach.

3. The Chief Executive Officer of the Mary Frances Trust emphasised the usefulness of the Task Group's recommendations and stated that voluntary sector organisations were now being included more widely in work with NHS- or Council-run mental health organisations. However, there was still more work to be done, particularly around the commissioning of services; sometimes contracts and conditions were still not adequate from the point of view of voluntary sector organisations. Overall, though, a change had been made and voluntary sector organisations wished to see a continuation of this direction of travel. The Cabinet Member stated that it was important to note that longer-term contracts did not suit all providers; some providers preferred the flexibility of shorter-term contracts. In future, there would be a tailored approach to all contracts.

4. The Head of Mental Health Commissioning (Adult Services) emphasised the value of voluntary sector organisations, particularly with regards to patient experience. The possibility of a forum of providers was being considered.

5. A Member requested an update on the workforce resilience hub mentioned in the report. The Head of Mental Health Commissioning responded that the hub had originally been set up to in response to the Covid-19 pandemic, during which many health and social care staff had experienced extreme stress. The hub had started by primarily offering psychological therapies and had since been expanded to offer peer support. It was important to acknowledge that people often sought mental health support after the event and the service was mindful of the need to prepare for this. Also, the IAPT (improving

access to psychological therapies) service offered mental health support to as many people as needed it.

6. A Member enquired whether there would be mental health training for Members during the induction after the May 2021 local government election. The Cabinet Member acknowledged the importance of keeping the mental health agenda high-profile once new Members had joined the Council after the election, including ensuring Members had good knowledge on legislation and the political agenda with regards to mental health. She would research this and provide more information to the Select Committee.

7. The Cabinet Member mentioned the Mental Health Partnership Board, which had now had a few meetings and was in the process of agreeing its terms of reference. The Cabinet Member agreed to share the terms of reference with the Select Committee and to report back to the Select Committee on the progress made by the Board as part of the next update report on the Mental Health Task Group recommendations.

8. A Member asked whether the two wards that had been worked on at the Abraham Cowley Unit of St Peter's Hospital had now been completed. The Head of Mental Health Commissioning said that environmental improvement work on two wards had been completed, and work had begun on the third and final ward.

Recommendations:
The Select Committee:

1. Notes the significant work underway to implement the recommendations set out in the Mental Health Task Group;
2. Recognises the role of Priority 2 of the Health and Wellbeing Strategy, and the newly established Mental Health Partnership Board, in continuing to progress the mental health agenda, including the Mental Health Task Group recommendations;
3. Requests an update on the activity of the Mental Health Partnership Board in the next Mental Health Task Group recommendations update report.

Actions/further information to be provided:

1. The Cabinet Member for Adults, Public Health and Domestic Abuse is to update the Select Committee on the mental health awareness training offer for Members;
2. The Cabinet Member for Adults, Public Health and Domestic Abuse is to share with the Select Committee a copy of the terms of reference for the Mental Health Partnership Board, once agreed.

18/21 ADULT SOCIAL CARE DEBT [Item 8]

Witnesses:
Toni Carney, Head of Resources, Adult Social Care
Pamela Hassett, Lead Manager (Financial Assessment and Income Collection), Adult Social Care
Sinead Mooney, Cabinet Member for Adult Social Care, Public Health and Domestic Abuse

Key points raised during the discussion:

1. The Head of Resources gave an overview of the report. Income from collection of care charges from clients represented a significant section of the Adult Social Care (ASC) budget. There had been a reduction on income collected in this area this year compared to last year, which was largely due to the impact of the Covid-19 pandemic and the new discharge to assess model. It was important to note that the majority of people paid their care charges promptly. Direct Debit was the service's preferred method of collection, which was more popular with people whose charges were regular and consistent, and less popular with those whose charges fluctuated. The rate of Direct Debit use to pay care charges had remained static at 64%. The actual amount of debt overdue currently stood at circa £17m, but a large proportion of that amount was secured against property.

2. The Head of Resources continued to explain that the ASC income collection team had good working relationships with the Legal services, with whom they worked to recover debts. The Council had started using Money Claims Online, a service provided by HM Courts and Tribunals for claimants and defendants to make or respond to a money claim, and had had good results so far. This service would continue to be used for debts under £10,000. Also, the Council had employed Judge and Priestley Solicitors to work on 10 cases. The firm's specialist skills would help the Council with probate work, and the early indications were that the work with Judge and Priestley was going well.

3. A Member requested that officers report back on the work with Judge and Priestley Solicitors once this had progressed.

4. A Member asked what could be done to increase the proportion of people who paid by Direct Debit above the 64% figure. The Head of Resources stated that, when conducting a financial assessment with a resident at the beginning of the care charges process, the officer conducting the assessment would always mention the Direct Debit option to the resident. Often people did not actually sign up to a Direct Debit at that stage, as they did not yet know the charges they would pay, but it was mentioned then and continued to be mentioned at every stage in the process. There were understandable reasons why someone might not want to pay by Direct Debit; for instance, if someone's care charges fluctuated, they may not want to use Direct Debit, and for some people having to pay a Direct Debit every month could be a financial worry. Residents could now pay care charges over the telephone, and the Council was looking at this and other ways to encourage payment in instances when residents preferred not to use Direct Debit to pay care charges. At a later date, the Council would also conduct a campaign encouraging use of Direct Debit.

5. A Member asked what benefits would arise out of the replacement of SAP with a new enterprise resource planning (ERP) system. The Head of Resources replied that the service was hoping to achieve better age debt reporting through the new ERP system, which would be available from December 2021 onwards. It was also hoped that the new system would improve the understanding of age debt. The Member asked whether the new ERP system would allow for the

identification of patterns and pre-empting of problems in payment. The Head of Resources said that it was possible that this would be the case, but the real problem at the moment was age debt; clear analysis on age debt using the new ERP system would be useful. The Council would have to see what the new system could offer and then work using this.

6. A Member enquired whether the Council knew if the discharge to assess model, introduced during the Covid-19 pandemic, would be extended. The Head of Resources responded that a decision had not been made on this yet. It was hoped that the model would be extended, but as it stood it was due to end on 31 March 2021. However, the principles of discharge to assess would be extended and it might become the norm in future, as it ensured that adequate assessment on discharge from hospital was in place. The Council was working with NHS organisations to mitigate any negative impact of the cessation of discharge to assess funding.

7. The Head of Resources clarified that the 64% of clients who paid by Direct Debit roughly reflected the proportion of clients whose charges remained stable from payment to payment. Apart from this information, it had not been possible to analyse a profile of people who paid by Direct Debit, but it was hoped that the new ERP system would allow officers to do this.

Actions/further information to be provided:

1. The Head of Resources (Adult Social Care) is to provide the Select Committee with an update on the work being undertaken with Judge and Priestley Solicitors when it has progressed.

19/21 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 9]

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

The Chairman of the Select Committee requested that, as much as possible, the recommendations and actions were responded to within this Council term (before 6 May 2021).

20/21 DATE OF THE NEXT MEETING [Item 10]

The next meeting of the Adults and Health Select Committee would be held on 14 July 2021.

Meeting ended at: 1.04 pm

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Chairman