ADULTS AND HEALTH SELECT COMMITTEE

3 March 2022

UPDATE ON THE IMPLEMENTATION OF COMMUNITY MENTAL HEATLH TRANSFORMATION

Purpose of report: To provide the Adults and Health Select Committee with an update on the implementation of the Community Mental Health Transformation Programme in Surrey

Introduction:

1. At the Committee meeting on 3 March 2021 a report on the Community Mental Health Transformation Programme (CMHTP) within Surrey Heartlands, Surrey Heath, and Farnham was presented Report (surreycc.gov.uk). The report focused on stage 1 of the new integrated model of primary and community mental health. Stage 1 is primary care focused with the recruitment of a new workforce to embed our General Practice Integrated Mental Health Service (GPimhs) across Surrey Heartlands ICS and Mental Health Integrated Care Services (MHICS) across Surrey Heath and Farnham (part of Frimley ICS).

2. This document provides the Committee with further detailed information and update on the CMHTP (including GPimhs and MHICS).

National Context

3. The impact of Covid19 has led to increased demand for services, rises in those reporting mental health issues, and an upsurge in health inequalities. Research from the Mental Health Foundation shows a decline in resilience as the pandemic has continued, particularly amongst those with pre-existing mental health issues. Public health experts have described how “the mental health impact of the pandemic is likely to last much longer than the physical health impact.” Worsening financial situations are also having an impact on the mental health of individuals.

4. The CMHTP is being implemented as part of the NHS National Community Mental Health Transformation, which describes the NHS Long Term Plan (LTP) vision for a place-based community mental health model by 2023/24, and how community services should modernise to offer whole-person, whole-population health approaches, aligned with the Primary Care Networks (PCNs).

5. NHS England and NHS Improvement (NHSEI) also developed a new Community Mental Health Framework for Adults and Older Adults to support local systems in implementing the LTP vision. It sets out what the new should look like

6. The NHS Long Term Plan (LTP) includes ambitious targets for community mental health by 2023/24 (see Appendix 1).

7. From 2019/20 to 2020/21, an initial two-year period of testing took place in selected Integrated Care Systems (ICSs), on how the barriers between primary and secondary care can be dissolved. Surrey Heartlands ICS and Frimley ICS were 2 of the 12 early implementer sites. See Appendix 2 for key learning messages for all early implementer sites.

8. Early implementer findings are helping to inform the roll out of new models of integrated primary and community care at the national level.

Local Context

9. A dedicated CMHTP delivery team, is employed by Surrey's lead mental health service provider Surrey and Borders Partnership NHS Foundation Trust (SABP) to help drive forward implementation of 2 out of the 5 LTP key deliverables (see Appendix 1).

    a) **Core model**: A new, inclusive community-based offer based on redesigning mental health services around Primary Care Networks that integrates primary and secondary care, VCSE, and local authority services and improves access to psychological therapies for adults and older adults with severe mental illnesses (SMI).

    b) **Dedicated focus:** Improving access and treatment for adults and older adults with a diagnosis of 'personality disorder', eating disorders, and those in need of mental health rehabilitation.

10. Working closely with the CMHTP Delivery Team, Surrey Heartlands CCG is supporting Surrey to achieve the other 3 LTP key deliverables.

    a) **Physical health:** Delivering an annual six-point comprehensive physical health check and follow up interventions as required to people with severe mental illness.

    b) **Individual Placement & Support:** Providing employment support to people with severe mental illness via the Individual Placement and Support programme.

c) **Early Intervention in Psychosis:** Ensuring timely access and quality of care for people supported by Early Intervention in Psychosis.

11. The CMHTP Delivery Team has a robust governance structure that includes representation from primary care, social care, 3rd Sector Voluntary Community and Social Enterprise (VCSE) organisations and people with lived experience, including carers (see Appendix 3 for the governance structure).

12. Development of the new integrated primary and community mental health model in Surrey supports delivering:

a) **Priority two of the Health and Wellbeing Strategy** - enabling emotional wellbeing by focusing on preventing poor mental health and supporting those with mental health needs. Empowering people to seek out support where required to prevent further escalation of need, and creating communities and environments that support good mental health.

b) The **Surrey Heartlands Mental Health Improvement Programme** which is a system priority to improve emotional wellbeing and mental health services focussed on reducing bouncing between services, better integration and early intervention and prevention of placed based delivery of care.

13. SABP working in partnership with social services, GP physical health care, VCSE organisations, and people with lived experience is introducing and mobilising a new integrated primary and community model across Surrey for adults and older adults with significant mental health needs. The new model is forming integrated mental health services around local PCN populations – for the first time ever.

Core Community Model

14. The core service model is a fully transformational model that aims to dissolve the barriers between primary and secondary care community mental health services for adults and older adults with significant mental health needs. It is being expanded across Surrey PCNs in a 2-staged approach.

Stage 1: Primary Care Focused

15. This first stage was reported to the Committee on 3rd March 2021.

    15.1 The 2021 report described our initial **roll out of GPimhs/MHICS** between 2018 and 2020 to embed new integrated mental health teams within Primary Care Networks (PCNs), creating new roles and bringing together the NHS, Social Care and 3rd sector.

    15.2 Each GPimhs/MHICS PCN team consists of:

    a) Clinical Lead

    b) Mental Health Practitioner

    c) Community Connector (employed by the Voluntary Sector)

    d) Administrator (either employed by the GP Federation, Lead GP Practice or SABP)

    e) Consultant Psychiatrist (1 Session per week)

    f) Mental Health Pharmacist (1 Session per week)

    g) Assistant Psychologist (new introduced in December 2021).

16. GPimhs/MHICS are the building block of the core service model. These PCN teams are the first port of call for GPs in seeking support for managing people in their local population with significant mental health needs. They are aimed at improving the patient journey of accessing mental health services through removing the unnecessary barriers between primary and secondary care adult mental health services and having an easy-in and easy-out access to evidence based interventions where required.

17. GPimhs/MHICS provide quick and easy access in primary care to patients with significant mental health issues and their Carers whose needs are not met by the Improving Access to Psychological Therapies services (IAPT) and do not meet criteria for adult secondary care. This is therefore an opportunity for early intervention before patients may become further destabilised and unwell.

People do not need a mental health diagnosis, nor do they need to present with high levels of risk, however they will have experienced significant emotional distress and will present with varying degrees of complexity.

18. Further expansion of this new workforce has continued since 2021 for fully embedding GPimhs/MHICS teams across all Surrey PCNs by 2023. The table below shows yearly GPimhs/MHICS rollout across all Surrey PCNs (see map in Appendix 4).

SURREY HEARTLANDS

PCN Name	Number of GP practices	Reg'd GP population aged 18+	Index of need	Roll out sequencing (number of PCNs) 19/20	20/21	21/22	22/23	23/24
EAST ELMBRIDGE PCN	7	48,257	1.115			✓	✓	✓
WHAM PCN	4	34,650	1.153			✓	✓	✓
BANSTEAD HEALTHCARE PCN	5	38,075	0.881	✓	✓	✓	✓	✓
EPSOM PCN	7	46,309	1.123		✓	✓	✓	✓
INTEGRATED CARE PARTNERSHIP PCN	1	25,870	0.775		✓	✓	✓	✓
NORTH GUILDFORD PCN	4	51,141	1.636	✓	✓	✓	✓	✓
GUILDFORD EAST PCN	6	45,605	0.986		✓	✓	✓	✓
DORKING PCN	4	36,195	0.934				✓	✓
LEATHERHEAD PCN	6	52,009	1.223		✓	✓	✓	✓
CARE COLLABORATIVE (REDHILL) PCN	3	36,636	1.272			✓	✓	✓
HORLEY PCN	3	23,848	0.639				✓	✓
REDHILL PHOENIX PCN	3	22,101	0.743				✓	✓
COCO PCN	3	34,296	1.024	✓	✓	✓	✓	✓
SASSE NETWORK 1 PCN	4	41,620	1.079				✓	✓
SASSE NETWORK 2 PCN	5	31,358	0.836		✓	✓	✓	✓
SASSE NETWORK 3 PCN	4	33,754	1.028				✓	✓
NORTH TANDRIDGE PCN	5	43,169	1.101		✓	✓	✓	✓
SOUTH TANDRIDGE PCN	2	21,790	0.591				✓	✓
EAST WAVERLEY PCN	5	46,130	1.119			✓	✓	✓
WEST WAVERLEY PCN	4	37,282	0.880				✓	✓
WEST BYFLEET PCN	3	23,901	0.572				✓	✓
WOKING WISE 1 PCN	4	24,295	0.597		✓	✓	✓	✓
WOKING WISE 2 PCN	4	31,948	0.903		✓	✓	✓	✓
WOKING WISE 3 PCN	3	26,620	0.901		✓	✓	✓	✓
WALTON PCN	4						✓	✓
	103	**856,859**		**3**	**12**	**16**	**25**	**25**
FRIMLEY SOUTH (Surrey only)								
SURREY HEATH PCN	7	78,209	1.872		✓	✓	✓	✓
FARNHAM PCN	5	38,772	1.017		✓	✓	✓	✓
	12	**116,981**		**0**	**2**	**2**	**2**	**2**

19. The table below shows total GPimhs/MHICS staff currently in post by number of PCNs covered and the 2022 recruitment plan for covering the remaining PCNs by 2023.

GPimhs/MHICS Staffing - by number of PCNs covered	Clinical Lead	Mental Health Practitioner	Community Connector	Administrator	Assistant Psychologist	Consultant Psychiatrist	MH Pharmacist
Staff currently in post	18	19	15	14	4	14	13
Staff to be recruited in 2022 plan	9	8	12	13	23	13	14
Total Surrey PCNs covered	***27***	***27***	***27***	***27***	***27***	***27***	***27***

20. **Additional Roles Reimbursement Scheme (ARRS) Mental Health Practitioners:** ARRS Primary Care Mental Health Practitioners (MHPs) are a new addition introduced by NHSEI last year to support the community MH transformation. During March/April 2021, work was done jointly across with our PCN leads and colleagues to agree how the role can support the new community MH model within primary care. A joint job description was devised for the traditional MH practitioner role i.e. nursing positions. Most Surrey PCNs wanted to recruit to these new posts

20.1 The new ARRS MHP roles will sit within each PCN in accordance with the model agreed with the PCN Clinical Director i.e. front door day to day support at GP practice level. These roles will see people contacting the GP practice requiring additional support but with lower complexity than seen in GPimhs/MHICS. The new roles will provide triage, assessment and mental health advice in a timely way working as a part of the GP surgery MDT.

20.2 ARRS MHPs complement GPimhs/MHICS by supporting GPs and bridging support to connect the person to the most appropriate service. For the PCNs that do not currently have a GPimhs/MHICS Team, the ARRS MHPs will reach out to the relevant services in the normal way; then when GPimhs/MHICS is rolled out to that PCN, the ARRS MHP will become part of the integrated MH Team..

20.3 There are six PCNs in Surrey that have currently opted of having an ARRS MHP.

20.4 Due to ongoing challenges of recruiting to the traditional nursing role, an alternative ARRS MHP role approved by NHSEI has been developed with primary care colleagues. The alternative ARRS MHPs are Psychological Wellbeing Practitioners (PWPs) and Graduate Mental Health Practitioners, supported with locally commissioned training – focused on triage skills, risk assessment, existing comorbidities, and safeguarding. Each individual PCN is the decision maker on whether or not they want to have the alternative ARRS MH practitioner role added to their workforce

20.5 The table below shows total ARRS MHP staff currently recruited by number of PCNs covered and the 2021/22 recruitment plan for covering the remaining PCNs.

	ARRS MHP Staffing - by number of PCNs covered
Staff currently recruited	7
Staff to be recruited in 2021/22 plan	14
Total Surrey PCNs covered	*21*

21. The CMHTP supports the CCG in achieving the other 3 deliverables of the LTP in the following ways:

21.1 **Individual Placement Support (IPS):** Within GPimhs/MHICS PCN teams the identification of need for employment support is a key aspect of holistic assessment. Direct referrals are made to Richmond Fellowship, with identified Employment Specialists linked into each GPimhs/MHICS team and invited to join regular MDTs to ensure close working relationships and preventing people from "bouncing around the system".

21.2 **Early Intervention In Psychosis (EIP):** Within GPimhs/MHICS PCN teams, close working relationships with EIP teams are encouraged to enable consultation prior to referral to EIP. This prevents the likelihood of people not being accepted for EIP and "bouncing around the system". Typically people remain with the EIP service for up to 3 years but this new innovation offers people who are stable the opportunity for more local interventions through their primary care team. A further new development for Surrey is the NHSEI Partners 3 Research Trial, where patients with a diagnosis of bipolar, schizophrenia or psychosis may be supported by Care Partners in primary care with a "coaching model", which also has a focus on supporting the physical health and engagement in SMI Physical Health checks.

21.3 **SMI Physical Health Checks (PHC):** Surrey Heartlands has been chosen as a vanguard ICS – to play a leading role in the South-East Region for refining a target model for SMI PHCs and testing interventions to improve quality and uptake. The SMI PHC programme is involving people with lived experience to ensure their experiences of Physical Health Checks are used to identify existing issues, as well as potential improvements from a service user perspective.

a) Surrey Heartlands CCG is leading on commissioning additional resource through Physical Health Liaison Workers (PHLW) to support delivering the required checks.

b) When the PHLWs are recruited, GPimhs will link into these new teams to support implementation of prioritised interventions identified by the SMI PHC Vanguard Programme.

22. **Citizens Advice Caseworker Integrated with GPimhs/MHICS:** The social determinants and inequalities associated with the Covid19 pandemic and effects of lockdown are reported to have worsened the disadvantages people with significant mental health needs and their carers face. Citizens Advice services have reported a sharp increase in the number of people presenting for assistance around benefits, universal credit and with concerns around

employment. People with a mental health need will be especially badly affected by such issues. They will often be claiming Personal Independence Payment (PIP), formerly Disability Living Allowance (DLA), which regularly requires support to challenge initial negative responses to claims.

22.1 Recognising the impact of Covid19, a dedicated Citizens Advice (CA) Mental Health caseworker service for people aged 18+ receiving integrated primary mental health care support has been introduced.

22.2 This CA service has been integrated with MHICS PCN teams in Surrey Heath and Farnham since April 2021.

22.3 A pilot service is commencing with GPimhs PCN teams in Spelthorne, beginning with SASSE 2 in March 2022, expanding to SASSE 1 & 2 when GPimhs Teams go live in these PCNs.

22.4 This CA service enables those people accessing GPimhs/MHICS to obtain relevant advice & support services based on their individual needs. This addresses the gap in provision identified by CA for clients with mental health issues who struggle to access core CA services, CA services integrated with Community Mental Health Recovery Services, and other statutory services.

Stage 2: Integrated Primary and Community Mental Health ('One Team')

23. In 2021/22 the transformation of community mental health services has widened, moving into the final phase of eradicating barriers between primary and secondary care mental health services by 2023/24.

24. The 'One Team' approach is to integrate the new GPimhs/MHICS teams with existing Community Mental Health Recovery Services (CMHRSs) and Community Mental Health Teams for Older People (CMHTOPs), around their local PCN population. This is currently being piloted in Epsom.

25. This will benefit people currently in secondary care mental health services who are stable and would be well placed to alternatively receive recovery focused and integrated mental health care services in primary care, with seamless 'easy in' and 'easy out' as required.

26. The Epsom pilot site went live in November 2021 and is currently testing out new streamlined and effective referral processes for people stepping up to – and down from – specialist interventions in secondary care. People with lived experience and their carers are involved in co-producing the One Team approach.

26.1 The plan is to bypass the screening carried out by the Single Point of Access (SPA) and secondary care assessment by developing a new pathway for routine referrals with direct referral from GPimhs/MHICS Mental Health Practitioner.

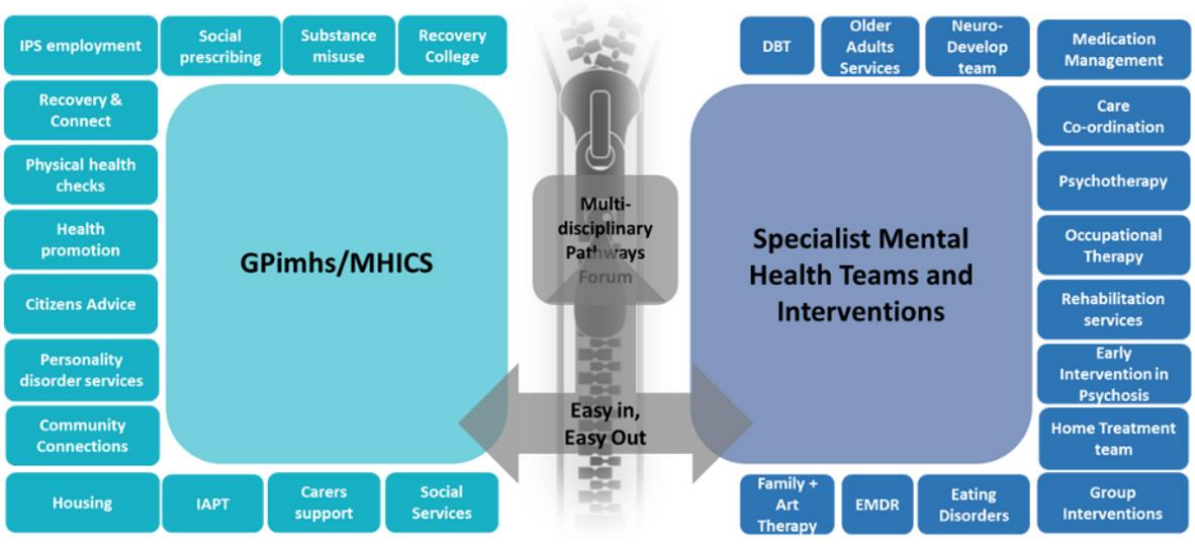
26.2 The intention is to get people more quickly to the right intervention or service, avoiding them being rejected by services and bouncing around the system.

26.3 For the person being stepped down, it will be important to ensure a good support plan is in place and people know how to re-access services. Urgent referrals will continue to go through the SPA in the new integrated system to ensure timely access to crisis services.

26.4 Referral decisions are being made by a newly established 'Pathways Forum,' consisting of GPimhs clinicians and key colleagues from the local PCNs geography (Epsom, Integrated Care Partnership and Banstead PCNs) including secondary care CMHRS/CMHTOP clinicians, VCSE partners and the local authority.

26.5 By using a Quality Improvement approach, a clear process for how all people should best flow through an integrated community mental health system will be tested before further roll-out across Surrey.

27. An overview of the 'One Team' model



28. This work will continue at pace to progress rolling out the 'One Team' model across all Surrey PCNs by 2023/24.

Dedicated Focus

29. Transformation includes work to improve care for specific population groups so that the various changes being made are mutually reinforcing. Aligned to GPimhs/MHICS are integrated care pathways teams with a dedicated focus, as specified in the NHS Community Mental Health Framework for Adults and Older Adults.

People with complex emotional needs (often associated with traits of, or a diagnosis of personality disorder)

30. The new Personality Disorders Pathway teams were included in the report to the Committee on 3rd March 2021. These teams are now fully mobilised, for adults and older adults with complex needs associated with traits of or a diagnosis of personality disorder and carers, informed by an ethos of embedding compassionate, trauma-informed care.

31. People with lived experience and carers were empowered to inform and shape the new PD service as it developed, and also continue to innovate (e.g., focus groups, working groups, working with Independent MH network and United Communities). Lived experience roles are also embedded at varying degrees of seniority in the PD pathway teams.

32. The PD pathway comprises of three teams:

MEP	**Managing Emotions Programme**: Psychoeducation courses and empathic support for people with traits/diagnosis of a personality disorder, and their carers. Courses are co-facilitated by Clinicians, Expert Trainers and Recovery Coaches, who have lived experience or are carers of those with Personality Disorder.
SUN	**Service User Networks**: Daily open access to peer support groups in the community for people with traits/diagnosis of a personality disorder. Co-facilitated by a Mental Health Practitioner and a paid Peer Support Worker with lived experience recruited through 3rd sector organisations.
PICT	**Psychologically Informed Consultation and Training**: Consultation, support, supervision and training for professionals in health and social care agencies. Consultation clinics co-delivered and training co-facilitated by a Lived Experience Facilitator and a Clinician.

33. The Managing Emotions Programme (MEP) is the only PD pathway team that receives referrals from GPimhs/MHICS. We therefore plan to further expand the MEP team in 2022/23 as we rollout GPimhs/MHICS to the remaining Surrey PCNs.

Adults with eating disorders

34. The COVID-19 pandemic has exacerbated the burden of eating disorders and simultaneously has highlighted the urgent need to raise awareness of these disorders. The Lancet reports that the pandemic has had particularly detrimental effects on people with or at risk of eating disorders, with an increase in the incidence of eating disorder behaviours or diagnoses in the community, or deterioration of eating disorders in patient populations, often with more severe symptoms and comorbidities since the start of the COVID-19 pandemic.

35. Surrey has made improvements in better supporting adults with eating disorders (AED), with a focus on early intervention work and strengthening community services and access. The current focus of community services has been on adults with moderate to severe eating disorders in line with commissioning arrangements. There are two strands to this community based treatment

    a) Outpatient service offering a range of evidence based treatment options in line with NICE guidelines on treatment of eating disorders. Location: Epsom and Guildford.

    b) Day hospital treatment offering intensive support 5 days a week and provision for up to 12 patients at any one time. Location: Guildford.

36. Within the current AED moderate to severe community service, there is a significant unmet need for people assessed as not reaching the threshold for moderate to severe eating disorders. CMHTP is addressing this unmet need through a new primary care integrated workforce to deliver the **Adult Eating Disorders Integrated Mental Health Service (AEDimhs)**.

37. AEDimhs is being implemented to effectively assess, treat, care for and support adults & older adults with mild and recent onset of eating disorders in the community setting (see AEDimhs model in Appendix 5).

    37.1 This new mild/early onset AED pathway will be providing evidence based treatment for people with eating disorders in line with National Institute for Health and Care Excellence (NICE) recommendations.

    37.2 The aim of AEDimhs is to provide seamless integration of care for people with mild or early onset eating disorder presentations, when they have low physical health risk. An AED forum will be co-developed to provide consultation on eating disorder cases to GPs, CMHRSs, and CMHTOP services, as well as being made available to our colleagues in the acute services.

37.3 In collaboration with VCSE providers an initiative akin to SHaRON (Support Hope and Recovery Online Network) delivered by Berkshire Healthcare will be offered. We will integrate the FREED Champion (see below) to support transitions from CYP services to Adults. As part of the GPimhs Multi-Disciplinary Team we will integrate AED with the Older Adults link professionals.

38. AEDimhs is due to commence with a phased launch in March/April 2022. The field test site will be Woking followed by progressively upscaling and rolling out the new integrated pathway to cover all PCNs across Surrey by 2023/24.

39. **FREED (First Episode, Rapid Early Intervention for Eating Disorders)** is for people within the transition age group (18 – 25 years) who are within the first 3 years of their illness duration. Specific emphasis is on the early and proactive engagement of this client group with a view to achieving improved outcomes and a significant lessening of illness duration.

39.1 A FREED field test was soft launched within Woking PCN localities in October 2021. This is currently being applied to SABP's existing service for people with moderate to severe eating disorders This corresponds with the AEDimhs pilot test site.

39.2 There will be a progressive roll out of FREED as we expand the AEDimhs transformation across the PCNs

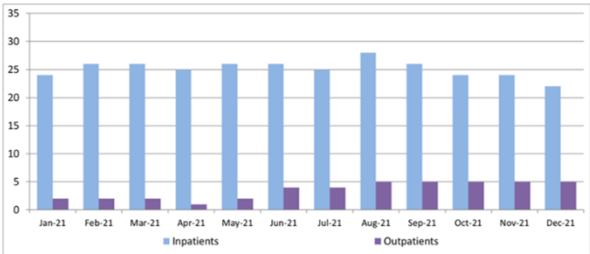
40. The table below shows the staff recruitment plan for the new AEDimhs team.

AEDimhs Staffing	Clinical Lead	Consultant Psychiatrist	Psychologist	Assistant Psychologist	Mental Health Practitioner	FREED Clinician	Service Manager	Administrator
Staff currently recruited	1	1	1	1	1	n/a	0	1
Staff remaining to be recruited in 2021/22	n/a	n/a	n/a	n/a	n/a	n/a	1	n/a
Staff to be recruited in 2022/23	n/a	n/a	n/a	n/a	1	1	n/a	n/a
Staff to be recruited in 2023/24	n/a	n/a	n/a	1	1	1	n/a	n/a
Total staff	*1*	*1*	*1*	*2*	*3*	*2*	*1*	*1*

Community mental health rehabilitation

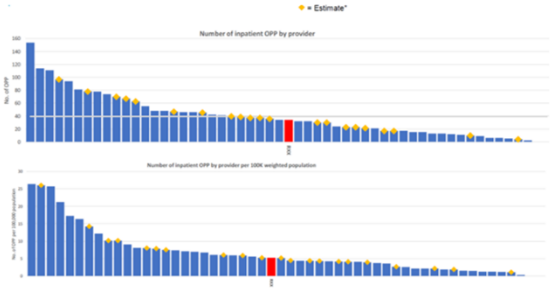
41. We have adopted a bespoke approach to community MH rehabilitation due to the lower number of Adult beds, including rehabilitation beds, and our use of Out of Area Placements is below average (see charts below).

Chart 1: Reflects SABP inpatient (and outpatient) caseload numbers for the last rolling 12 months



From this, we know that we have averaged at around 25 people in placements per month, funded by Delegated Commissioning. Most people are receiving Complex Care and Treatment within High Dependency Rehabilitation Units, however a smaller number of people are placed in Longer Term High Dependency Rehabilitation Units.

Chart 2: Benchmarks the number of people on SABP caseload for Inpatient Out of Provider Placements [extract from GIRFT pack]



The number of people receiving care outside of Surrey, has reduced throughout the last year. At the time of SABP submitting data to GIRFT (30th September 2019), we had 34 people in placements – we are now standing at 25 people in Out of Provider Placements

42. The community MH 'rehabilitation' service model is more inclusive focusing on rehabilitation and [re]-enablement.

43. Our approach to Community Mental Health Rehabilitation is to build on the existing Recovery and Connect Model (Surrey Community Connections).

43.1 This focus is for people who:

a) Have treatment-resistant symptoms associated with severe mental health problems e.g. psychosis

b) Significant impairment affecting social and everyday functioning wherever they are living in inpatient or community settings

c) May experience loneliness and have limited social contact

d) May experience recurrent admissions and extended stays in acute inpatient unit either locally or out of area

e) May be living in supported accommodation which is breaking down

f) May be receiving care from early intervention for psychosis service and likely to require mental health services now or in the near future.

43.2 We aim to build upon the existing Recovery and Connect model, and rather than introduce a new standalone team, we will create an alliance agreement whereby identified services will have an agreement in place to prioritise enhanced support and intervention to this group of individuals, by working together as a 'virtual' team to meet the person and their family's/carers needs. There will be a removal of barriers to access, with all services working to the same thresholds of service offer.

43.3 The proposed new model will work with the person and their families/support networks, by using a strengths-based approach, being

flexible and reactive to the individuals needs and timely interventions. It will focus on people's coexisting health problems and will provide support and guidance for family members, carers and key workers in the community.

a) Is an enhanced multi-professional and multi-agency service which 'wraps' around the person at any point in time or place.

b) The person and, carer and people in close contact with the person, will be offered the full range of psychological, social and occupational support to help the person manage their symptoms and live as independently as possible in least restrictive and stigmatising environments.

c) Will increase the intensity of treatment and support during periods of relapse and provide ongoing contact and support during any periods of acute in-patient care. It will also enable the person's discharge home at the earliest opportunity

d) Enables people to gain the skills and confidence to manage in more independent accommodation.

e) Connects people to their local communities and builds upon their support networks using voluntary, health, social care and mainstream resources.

f) Provides opportunities to increase friendships, connections and sharing of experiences with peers.

g) Recognises that people vary in their experiences and recover at different rates.

h) Offers a consultation and training approach to equip Carers, family members, people in close contact with the person e.g. housing providers with the knowledge skills and confidence to support people to live independently as possible in their communities.

i) The service will support people to have their physical health care closely monitored by primary care.

44. Mental Health Enablement. Working in partnership with Surrey County Council, a 6 month pilot commenced in March 2021 within three PCNs to have an integrated Occupational Therapy (OT) led Mental Health Re-Enablement service to address social care needs of people who have significant mental health problems in primary care.

44.1 Patient Groups:

Patient groups	Focus
Service users in primary care with unmet needs	Not meeting secondary care CMHRS and IAPT criteria, or not appropriate for IAPT; difficulty accessing right services; utilise services in potentially chaotic patterns; physical health concerns, medication dependence, substance misuse, co-morbid physical long term conditions contributing to poor mental health; 'held' by GPs as frequent attenders, absorbing excessive non-medical short term prop-up interventions.
People in secondary care mental health services that can alternatively receive recovery focused services in primary care	Seamless step-up and step-down as required; with potential shared care arrangements for medication. These typically comprise stable psychotic and mood disorders, and emotionally unstable personality disorder.

44.2 The Re-Enablement team worked with GPimhs to provide a local hub for integrated health, social care and support in primary care. Whilst the focus is on early intervention and prevention, the team agreed pathways to step-up intervention and support to secondary care and the Local Authority when required.

44.3 The aim was to review the development of mental health/substance misuse reablement in primary care and the impact of OT with skills gains to enhance recovery in a strengths based model. Recovery is a personal process by which individuals identify and work towards achieving the goals and aspirations that they have set for themselves to enable them to live their lives in a meaningful and fulfilling way:

a) To promote independence.

b) To reduce the need for ongoing or high level statutory services.

c) To include support to focus on coping techniques, self-help approaches to social inclusion, building self-esteem, goal setting and accessing the community.

d) To ensure individuals are supported to live the way they wish with participation in work, education, training and recreation.

e) To provide a goal focused, strengths- based short term support that aims to increase levels of independence.

45. Evaluation of the [Re]-Enablement pilot showed that 46% of referrals were reabled-no longer needing Adult Social Care support. The evaluation findings are very promising, however it is recognised that the length of time for pilot was limited to 6 months and took place in a small geographical area. In 2022/23 we

plan to further test the concept over a longer period of time and in a wider geographical patch to cover more Surrey PCNs.

Improving Care

Young adults transitioning from children and young people's (CYP) mental health services

46. Surrey's aspirations for young adults with significant mental health needs are bigger than the community mental health transformation programme. Wider system changes have been implemented over the last 12 months that are fully aligned with community transformation.

47. The establishment of a new children's Emotional Wellbeing and Mental Health Alliance called Mindworks, has brought together NHS providers - SABP (lead), Tavistock and Portman and a range of VCSE local and national charities to deliver a range of community and specialist services. Mindworks has embedded a whole system model designed to build a wholly different experience for children and young people and their parents/wider family members and deliver radically better outcomes. See Mindworks service model in Appendix 6.

48. Young Adult Safe Haven. The Young Adults Reference Group (YARG) established by the community mental health transformation programme has been instrumental in creating a dedicated time slot for 18-25 years to drop in without the need for an appointment in our Guildford Safe Haven Café – 5 - 9 pm, 7 days a week (see Appendix 6). This pilot commenced in November 2021, prior to this when young adults turned 18 they had to automatically transfer directly from the Children's Safe Haven to the Adult Safe.

49. Mental Health Transition Packs have been co-produced in 2021/22 by a task and finish group including reps from the Young Adult Reference Group (YARG) and User Voice and Participation Team, Children and Adolescent Mental Health Services (CAMHS), CYP Reaching Out Service, and adult Trauma Informed Care team.

    49.1 The Transition Packs will support different forms of transition by young adults i.e., if transitioning out of services completely, or transitioning to adult services.

    49.2 The MH Transition Packs will be piloted in a single CAMHS team, and across the new CYP Reaching Out service being launched to support vulnerable young people as they reach 17 years and 9 months where there are multi-agency concerns about their ability to access emotional

wellbeing and mental health support which could significantly enhance their ability to reach their full potential.

49.3 For vulnerable young people, Reaching Out Mental Health Psychological Wellbeing Practitioners and Reaching Out Support Workers support transition to adult community services in a smooth and streamlined way until they reach 18 years and 3 months.

50. In 2021/22 Transition Training Packages have been co-produced by a task and finish group including Recovery College, User Voice and Participation Team, Reaching Out Service, Lead Occupational Therapist and YARG.

50.1 These training packages have been developed both for young adults and supporters such as people in parent and carer roles, teachers, guardians (e.g. to increase their awareness of what it is like to be a young adult in today's society, what is helpful to do / say when working with a young adult). Both training packages will include awareness of transitions and pathways available in the community.

50.2 These training packages are being rolled out in 2022/23, jointly facilitated by a CYP Reaching Out MH Psychological Wellbeing Practitioner and a lived experience Young Adult for people aged 17+ to prepare for transition from CAMHS to Adult MH services (CMHRS or GPimhs).

50.3 These courses accessed via the Recovery College are to enhance communication skills, support development of individualised Mental Health Transition Packs, increase awareness of transitions / pathways and increase awareness of what is available in the community

50.4 The proposed sessions will provide specific information for young adults and supporters separately but have combined sessions at the beginning, middle, and end to have shared learning on some topics

Peer Support Roles

51. A Peer Support community team is being recruited to work alongside GPimhs/MHICS in innovative and flexible ways to support the needs of local communities at PCN level. People in Peer Support roles will use their own lived experience of mental health difficulties, or from caring for others experiencing mental health difficulties, to help other people. They will be employed and supported by our VCSE partners.

52. The roles will have flexibility to work across PCNs, and will respond to and reflect the local needs of the communities they support as much as possible, with a target on inequalities. We are aiming for a diverse and inclusive Peer

Support workforce; varying in ethnicity, gender, sexual orientation, socio-economic class, religion, disability and age.

53. The Peer Support roles will be shaped by local stakeholders, analysis of needs, local knowledge of communities and unmet need to identify groups where there may be barriers to accessing services; with the ability to flex and adapt. Roles will include general as well as specialities, which are currently being established - such as Gypsy, Roma and Traveller; Drug & Alcohol; College Students; and Nepalese communities.

Funding

54. The LTP has committed an investment of almost £1 billion new funding into community mental health services by 2023/24. A new transformation fund was introduced in 2019/20 to support the 2 year early testing of the LTP ambition.

55. From 2021/22 to 2023/24, all ICSs will receive a fair share of transformation funding to implement these new models locally, in addition to year-on-year increases in baseline funding for all NHS Clinical Commissioning Groups (CCGs) to bolster community mental health provision starting in 2019/20.

56. The majority of transformation funding must be spent on expanding the mental health workforce, including contracting with VCSE organisations.

57. The total amounts of transformation funding available nationally for the delivery of the new models are listed below, confirming that this is the biggest transformation area and the biggest priority area across the entire national MH programme.

National LTP transformation funding profile for community mental health:

Year	National total of transformation funding available to all ICSs across England in each year
2021/22	£121m
2022/23	£295m
2023/24	£366m
Total over the 3 years	*£782m*

58. The process that ICSs need to undertake to receive this funding is set out by NHSEI who annually launch the planning process and issue accompanying guidance via their regional NHSEI teams. The planning process for allocation of funding for 2022/23 is reduced from the extensive proposal development process last year– focusing on plans for expansion of the new models in additional PCNs and specific elements of transformation that require further development.

59. There are targets for planning and delivery in 22/23, supported by increase in investment for community mental health. Surrey Heartlands ICS and Frimley ICS submitted transformation plans for 2022/23 to NHSEI South East Regional team on 28th January 2022 for review. In February, the NHSEI National team will confirm and share funding award letters for ICSs where regions have approved plans.

60. The majority of the costs of transformation are recurrent. Surrey Heartlands ICS and Frimley ICS have provided assurances to NHSEI that newly expanded and improved services funded through transformation monies will not be cut in future years or subject to Cost Improvement Programmes or local efficiency drives to plug deficits.

Workforce

61. Building and recruiting the right workforce is a key challenge. Innovative work configurations have been developed by expanding integrated team approaches across clinical and non-clinical roles, including peer support and lived experience roles and contracting with national and local VCSE partners.

62. To support staff retention, established staff from other parts of the community MH service have been brought in alongside newly recruited staff, on an secondment basis – to support transfer of organisational knowledge and culture.

Impact and Benefits

63. Having GPimhs/MHICS in place should reduce the number of routine referrals from GPs to the Single Point of Access (SPA). It should also reduce the number of onward referrals from the SPA to CMHRS. Similarly, it should reduce the number of referrals from SPA back to GPs.

    63.1 Evidence is emerging for this impact when comparing referral rates for the period January 2021 to December 2021, between PCNs that have a GPimhs team compared to PCNs that do not yet have a GPimhs team:

    a) 24% reduction in referrals to the Single Point of Access (SPA).

    b) 25% reduction in referrals from the SPA to CMHRS.

    c) 30% reduction in referrals being sent back to GPs after being screened by the SPA.

64. We are currently using R-Outcomes, an online self-reported measure about how confident the person accessing GPimhs/MHICS feels about managing their mental health as well as capturing their experience of using our service. The results of this survey are essential for demonstrating the effectiveness of new service provision and to identify areas for development to improve the quality of care people receive. See appendix 7.

65. We have also used R-Outcomes to capture feedback from GPs who have referred patients to GPimhs/MHICS, and feedback from GPimhs/MHICS staff. See appendix 7.

66. We currently have a gap in measuring impact and benefits realisation across the whole community Mental Health transformation programme. We are addressing this in 2022 by beginning an independent evaluation of the new primary and secondary integrated model. This will enable us to explore, develop and implement better ways of measuring impact, including increasing the reporting of paired outcome measures. During the independent evaluation we will share learning and challenges with Frimley ICS and Buckinghamshire, Oxfordshire & Berkshire West (BOB) ICS.

Recommendations:

67. The Select Committee is asked to:

    a) Note the significant work underway to fully implement the new integrated model of primary and community mental health across Surrey, by 2023/24.

b) Recognise the role of the Adult Community Mental Health Transformation Programme in delivering Priority 2 of the Surrey Health and Wellbeing Strategy.

c) Receive the following reports at future meetings:

- Individual Placement Support (IPS) – employment support and collaboration with local businesses to support their own staff.

- Update on progress and impact of community mental health transformation in 12 months time.

Report contacts:

Georgina Foulds, Associate Director for Primary and Community Transformation, Surrey and Borders Partnership NHS Foundation Trust (Georgina.Foulds@sabp.nhs.uk)

Professor Helen Rostill, Director for Mental Health Services, Surrey Heartlands ICS and SRO for Mental Health Frimley ICS (Helen.Rostill@sabp.nhs.uk)

Sources/background papers

Minutes of the meeting of the Adults and Health Select Committee held on 3 March 2021

NHS England and NHS Improvement short film on the NHS Long-Term Plan commitment on community mental health transformation The NHS Community Mental Health Transformation - YouTube

NHS Community Mental Health Framework for Adults and Older Adults https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

NHS England and NHS Improvement Community Mental Health Early Implementer Learnings, July 2021
NHSEI_Community_Mental_Health_Early_Implementer_Report

National funding profiles: NHS Mental Health Implementation Plan 2019/20 – 2023/24.

Appendix 1: The Long Term Plan targets for community mental health

The Long Term Plan includes ambitious targets for community mental health

Key deliverables in the Long Term Plan by 2023/24

Core model

A new, inclusive generic community-based offer based on redesigning community mental health services in and around Primary Care Networks, contributing to 370k minimum access number by 23/24

Dedicated focus areas

Improving access and treatment for adults and older adults with a diagnosis of 'personality disorder', in need of mental health rehabilitation and eating disorders, contributing to 370k minimum access number by 23/24

Physical health

Increasing the number of people with SMI receiving a comprehensive physical health check to a total of 390,000 people per year

Employment Support

Supporting a total of 55,000 people a year to participate in the Individual Placement and Support programme

Early Intervention in Psychosis

Maintaining the 60% Early Intervention in Psychosis access standard and ensuring 95% of services achieve Level 3 NICE concordance

Appendix 2: Early Implementer Learnings

Early Implementer sites

North East and Yorkshire : england.ney-mh@nhs.net

North West : england.mentalhealth-North@nhs.net

Midlands: england.midlandsmentalhealth@nhs.net

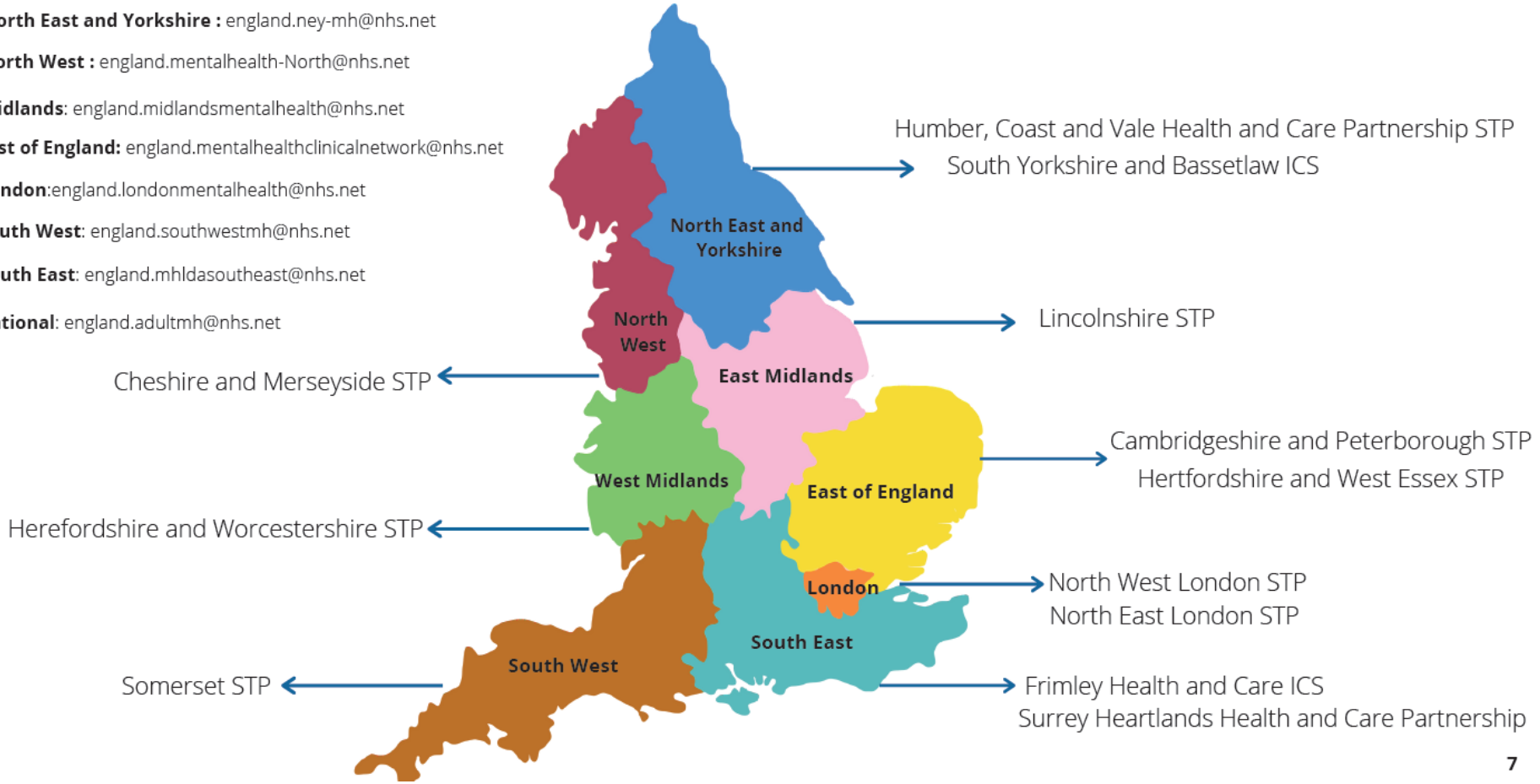
East of England: england.mentalhealthclinicalnetwork@nhs.net

London:england.londonmentalhealth@nhs.net

South West: england.southwestmh@nhs.net

South East: england.mhldasoutheast@nhs.net

National: england.adultmh@nhs.net



7

Key messages from all systems

Recruitment and contracting needs to happen as early as possible. Given the significant amounts of funding being invested into community mental health services, systems should be prepared to spend transformation funding quickly to avoid large underspends later in the year.

Robust governance and joint ownership between partners. System partners need to all be signed up to deliver the transformation together and the programme should be underpinned by strong and robust governance structures which include all partners to support this.

Integration with primary care and PCNs. The new models will need to sit at PCN-level and systems should carefully consider the best ways to ensure PCNs and CMHTs are fully integrated and delivering as one team. This includes joint roles across primary and secondary care providers, integrated real-time information-sharing, and co-location where appropriate.

Maximise partner expertise and skills in delivery of services. Integration of services across NHS and non-NHS partners, including local authorities and the third sector, is at the heart of this transformation programme. Systems should identify where partners can bring the most value and embed them in design and delivery of new and existing community mental health services. This includes joint commissioning or integrated workforce planning.

Co-production and equalities should be at the heart of the programme. Genuine co-production takes time and effort, this needs to be prioritised at the beginning of the programme and embedded in governance structures as well as in the design and ongoing delivery of models. Co-production should include a range of diverse groups to ensure equalities are being advanced.

Data driven services. Systems should flow nationally-agreed KPIs for national and regional reporting requirements, and embed outcome measurement as standard, to measure progress and the impact of investment into community mental health services. Data across the health and social care system can be used to hone in on the greatest health needs, and tailor services to specific service user groups.

Plan workforce development strategically. Expanded workforce configurations should include both clinical and non-clinical workforce, with a big emphasis on expanding peer support workforce. Plans should ensure staff are appropriately supported with supervision, and have capacity to undertake training, and practice what they learn on the job.

Leadership. This programme is ambitious in its scope for change and should have visible sponsorship from senior system leaders to give it the necessary momentum and profile. Leaders needs to model a number of important behaviours including openness to feedback and learning, advocacy, and inclusiveness.

Appendix 3: Community Mental Health Transformation Programme Governance Structure

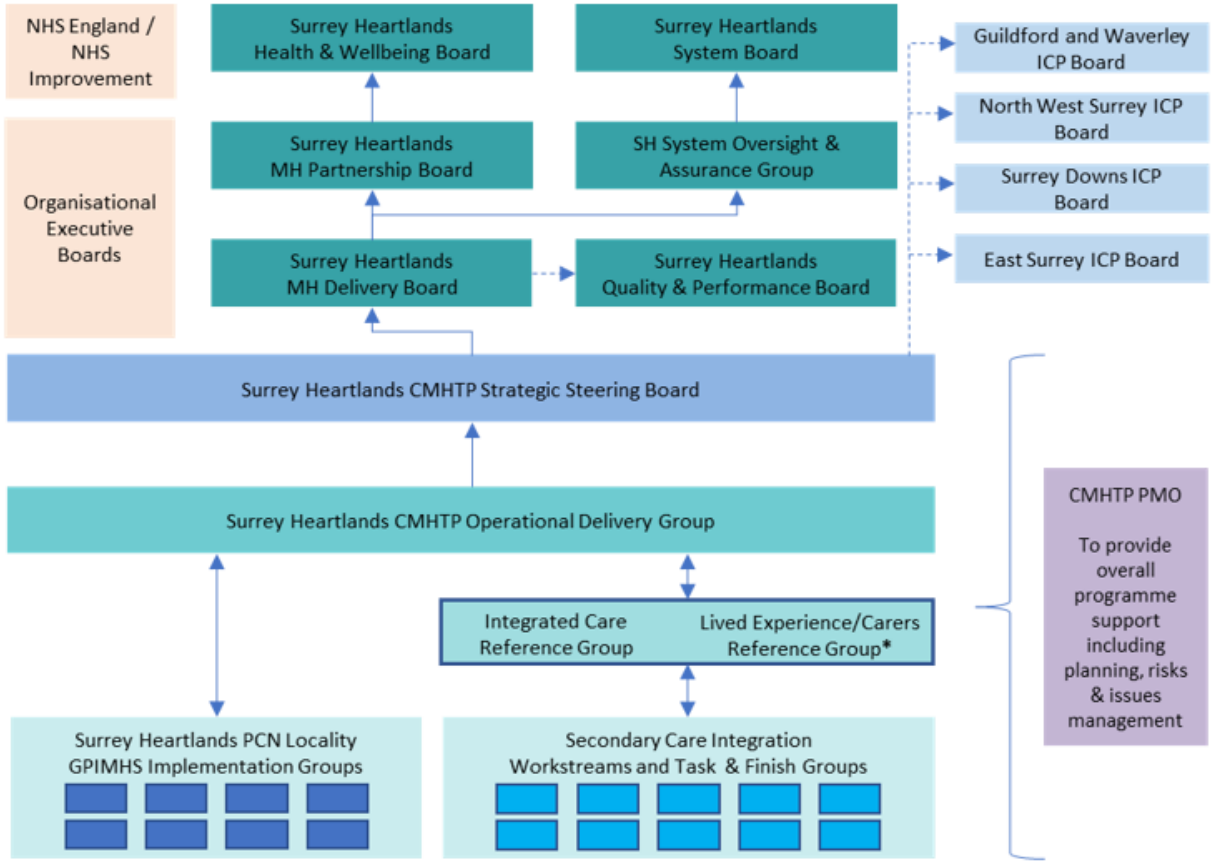
Surrey Heartlands ICS

The Governing Bodies will authorise and ratify final models of care ensuring sustainability and alignment at a system level.

The Strategic Group will approve all key decisions in relation to the implementation and roll out. It will provide steer and direction to inform the operation delivery group and unblock challenges.

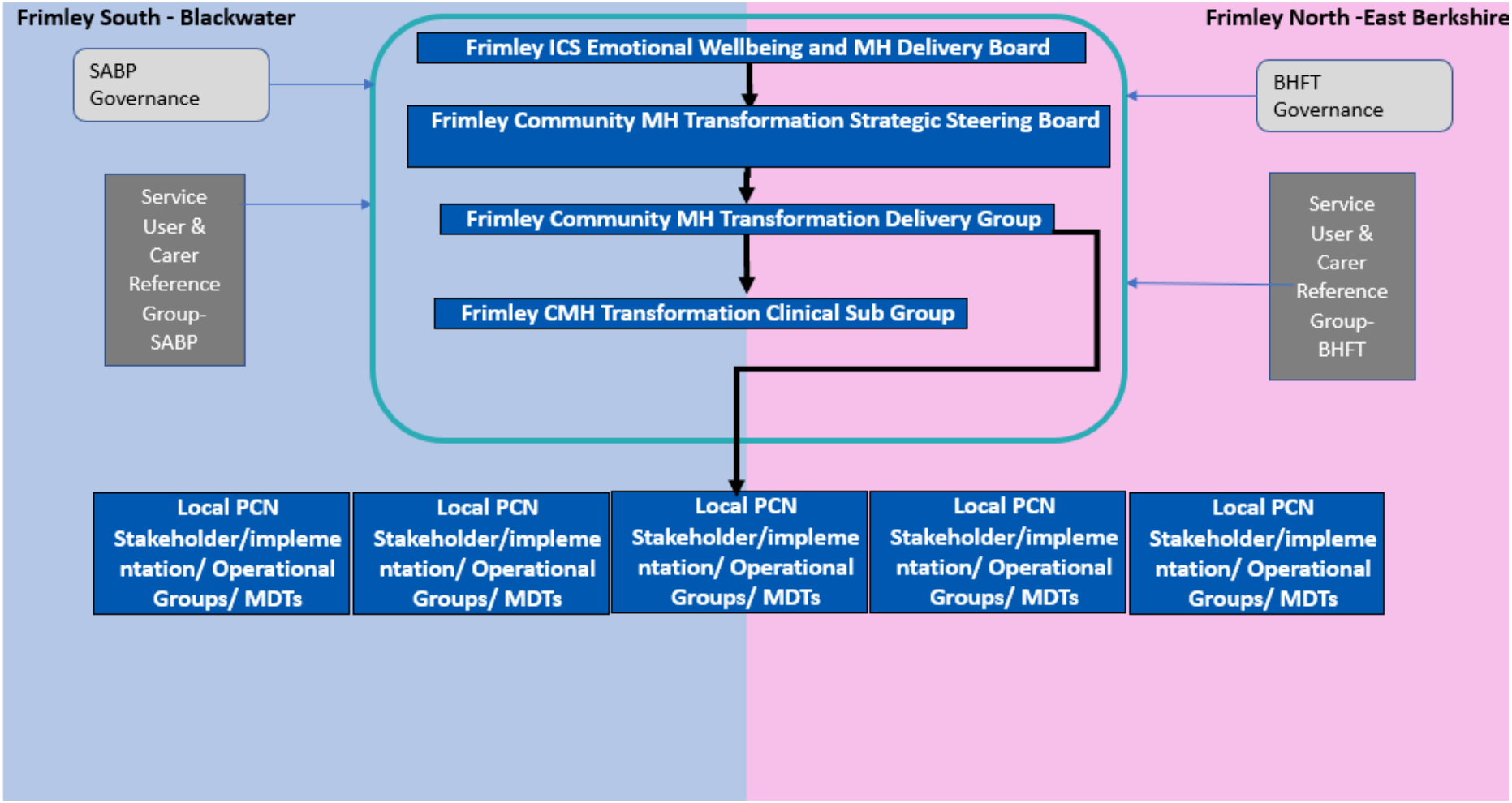
The Delivery Group has representation from across all the functions and is responsible for the delivery and coordination. They will develop overall design principles, consider key issues in detail and ensure the right support is in place to each of the locality implementation teams. This group will be utilised to support the delivery and implementation of clinical pathways and the wider Adult Mental Health Community Transformation.

The Implementation Group is a 'Task and Finish' group who will work through the local mobilisation across the ICS. It is responsible for developing the shape, role, functions, processes and implementation and ongoing monitoring. Representation from all PCNs.

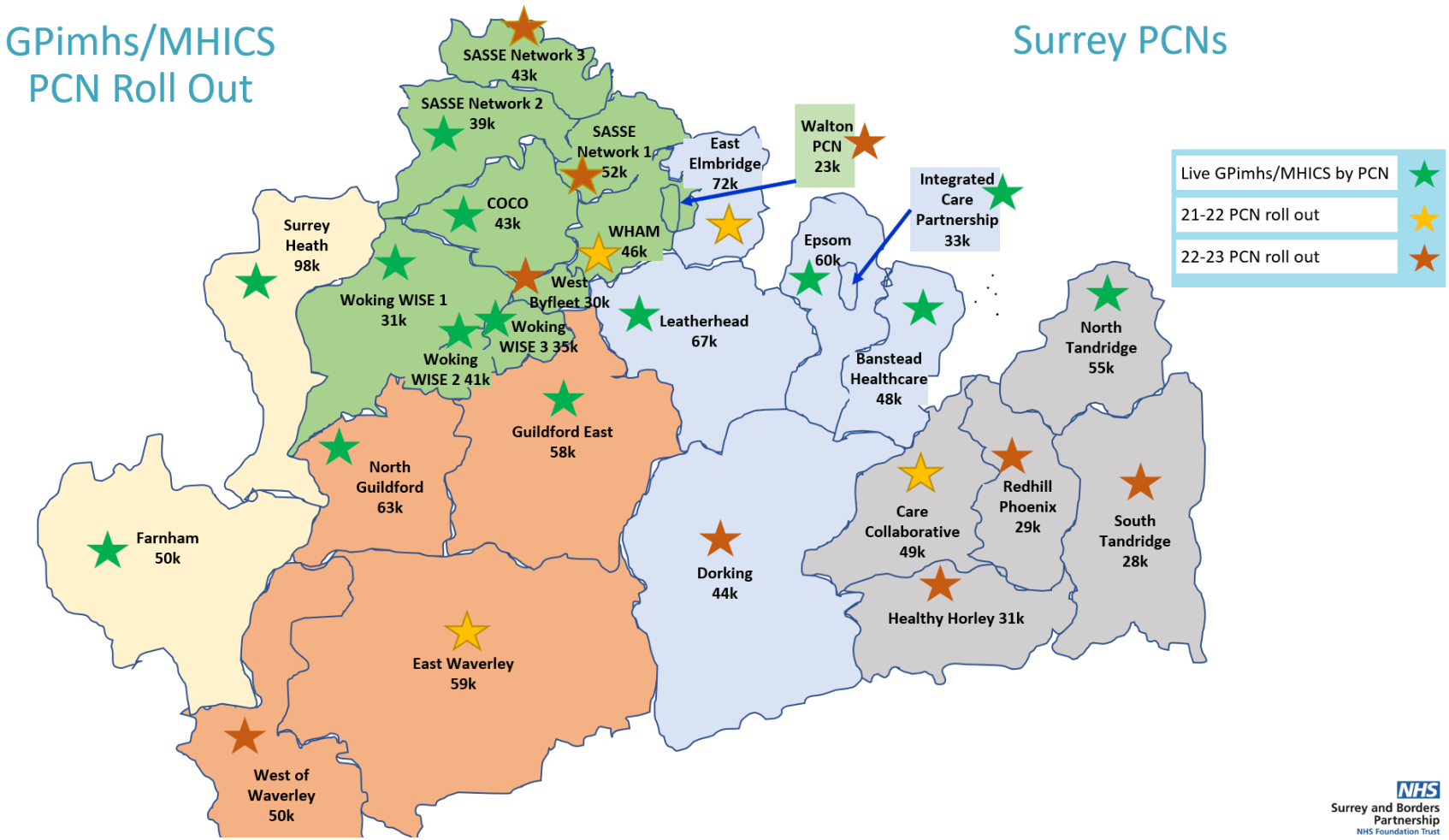


*Jointly chaired with Independent Mental Health Network (IMHN)

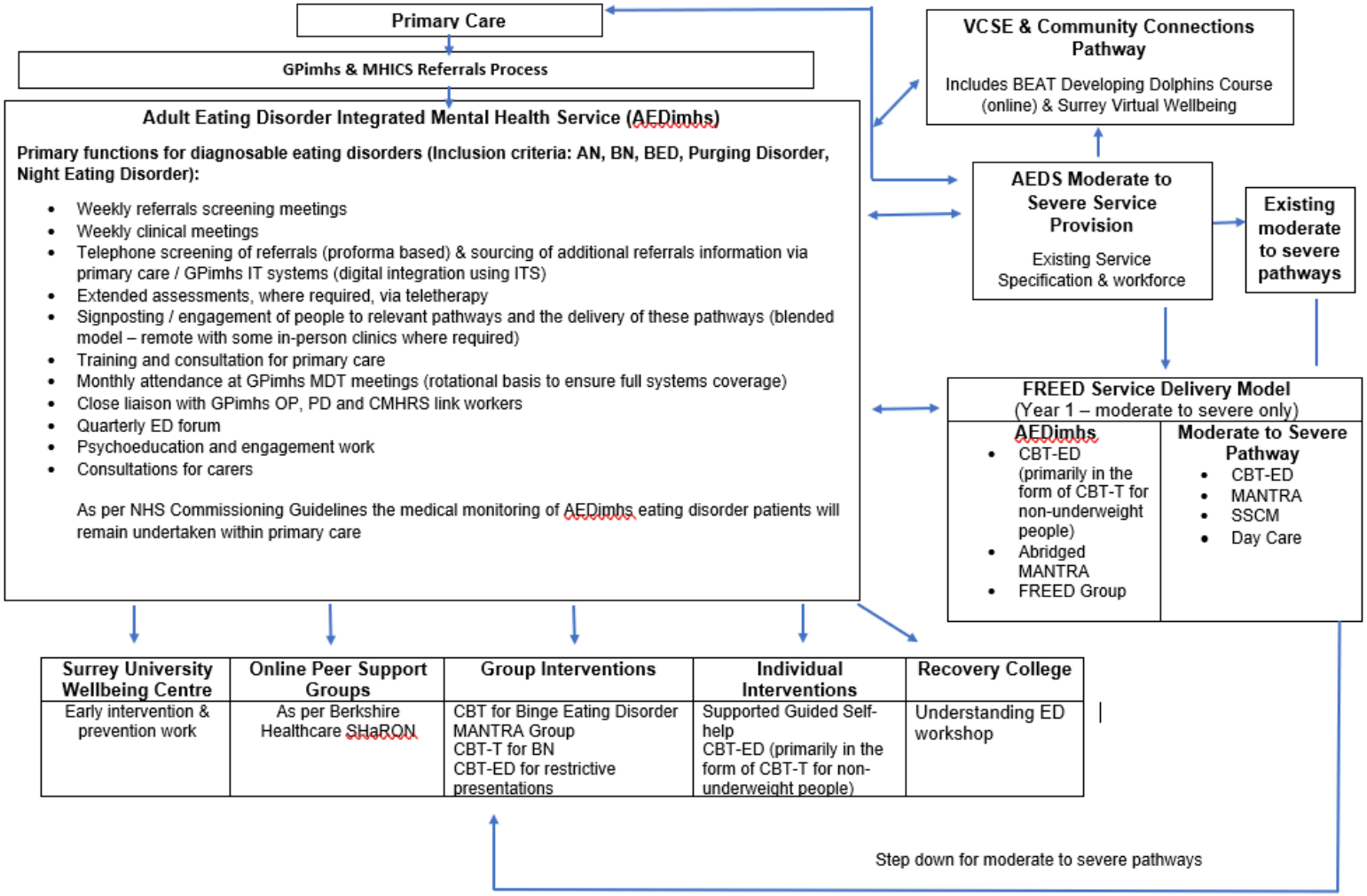
Frimley ICS


Frimley South - Blackwater
Frimley North -East Berkshire
SABP Governance
BHFT Governance
Frimley ICS Emotional Wellbeing and MH Delivery Board
Frimley Community MH Transformation Strategic Steering Board
Frimley Community MH Transformation Delivery Group
Frimley CMH Transformation Clinical Sub Group
Service User & Carer Reference Group- SABP
Service User & Carer Reference Group- BHFT
Local PCN Stakeholder/implementation/ Operational Groups/ MDTs
Local PCN Stakeholder/implementation/ Operational Groups/ MDTs
Local PCN Stakeholder/implementation/ Operational Groups/ MDTs
Local PCN Stakeholder/implementation/ Operational Groups/ MDTs
Local PCN Stakeholder/implementation/ Operational Groups/ MDTs

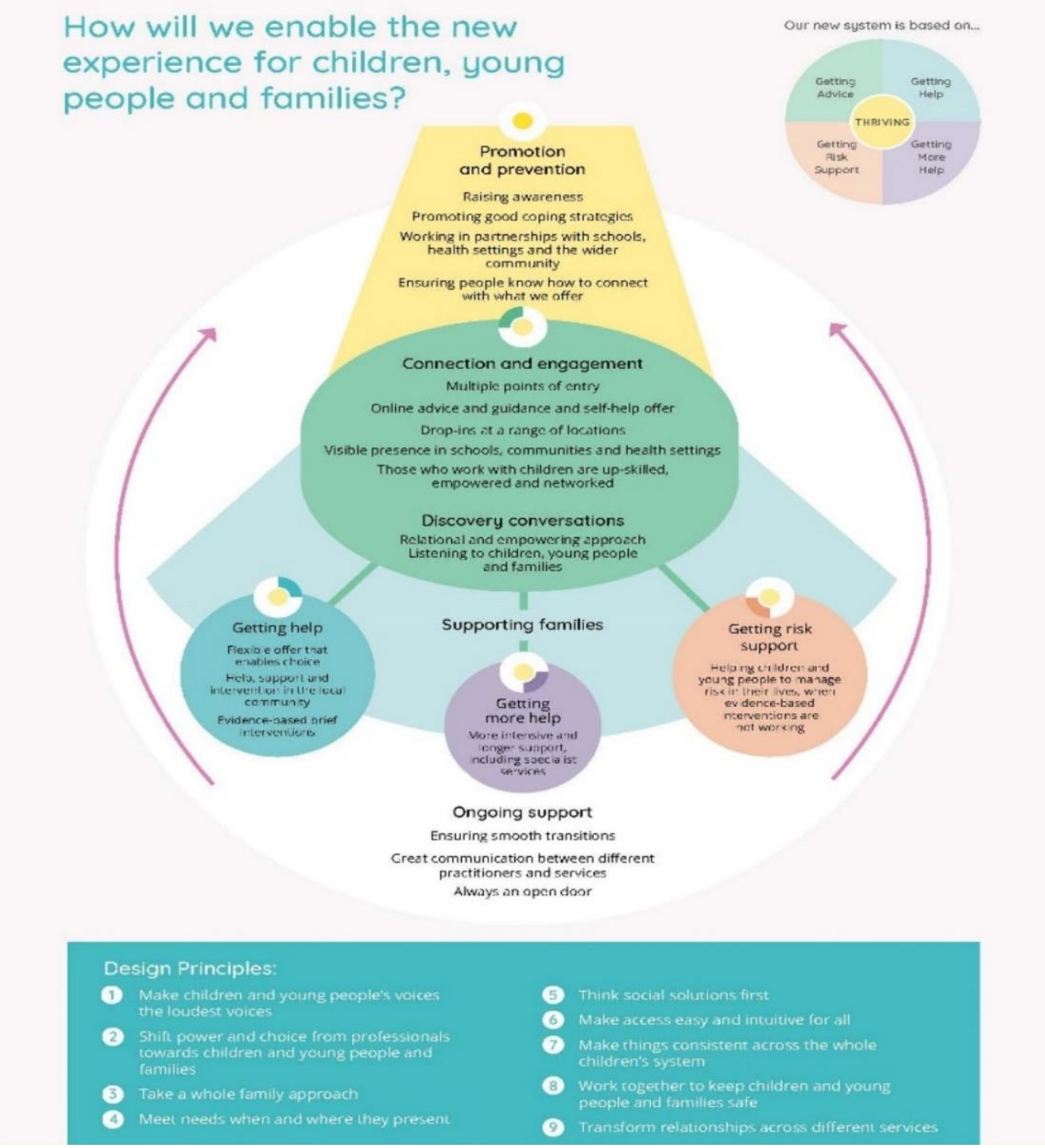
Appendix 4: Map of GPimhs/MHICS rollout across all Surrey PCNs



Appendix 5: The AEDimhs Model



Appendix 6: Mindworks service model



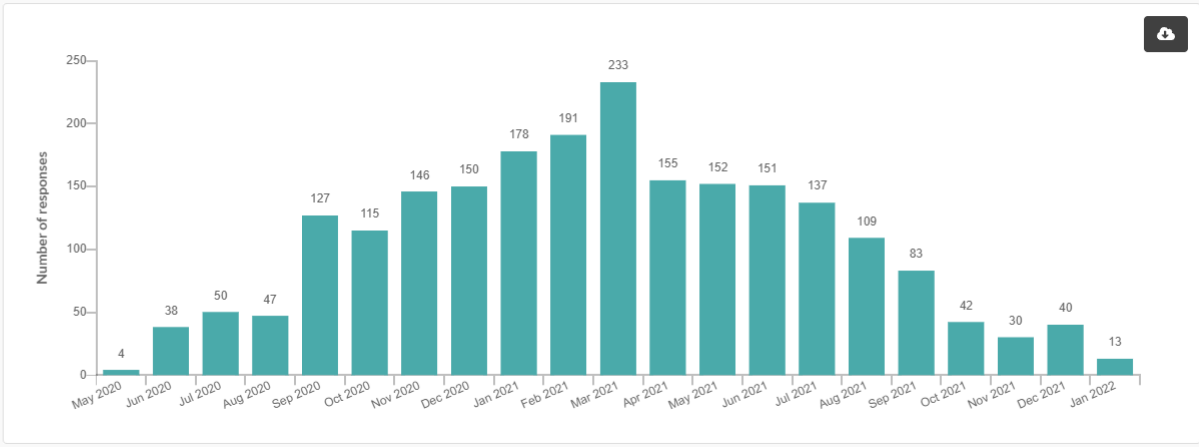
Appendix 7: Young Adult Safe Haven Pilot (Guildford)

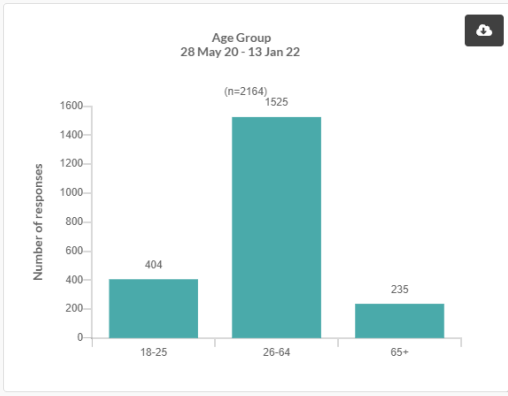
Appendix 8: R-Outcomes Survey Results

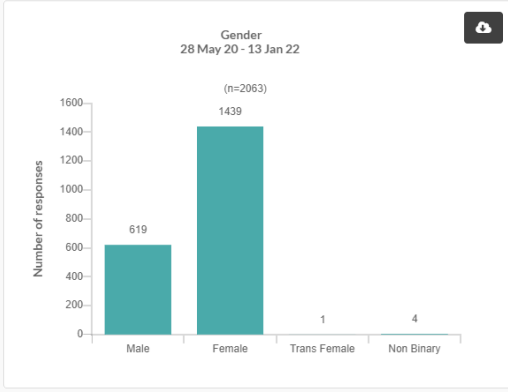
GPimhs/MHICS Service Users

Total Responses

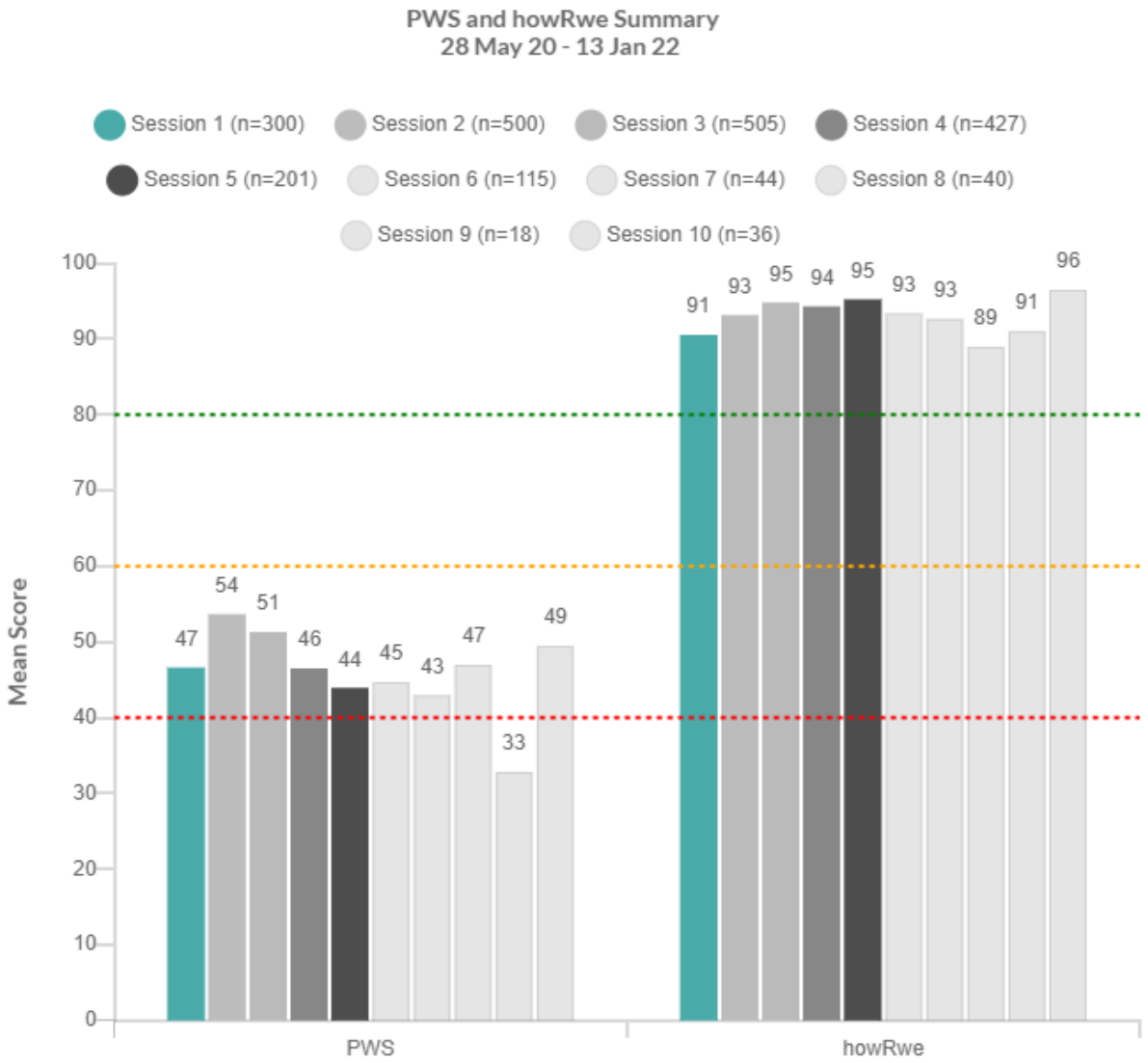
2191







- PWS (Wellbeing Score)
- howRWe (Experience Score)



Very low 0-39	Low 40-59	Moderate 60-79	High over 80

View: Default Data

Surrey Health Mental Health - Patients - TELEPHONE	28 May 20 - 31 Dec 21	1 Dec 21 - 31 Dec 21
Measure	All Data	Range Data
Mental Health Confidence	68 (n163)	54 (n38)
I know enough about my mental health	63	45
I can look after my mental health	53	35
I can get the right help if I need it	73	60
I am involved in decisions about me	82	77
How are we doing	94 (n1720)	85 (n38)
Treat me kindly	95	88
Listen and explain	95	84
See me promptly	91	86
Well organised	93	83
Personal Wellbeing	49 (n1573)	- (n0)
I am satisfied with my life	50	-
What I do in my life is worthwhile	56	-
I was happy yesterday	49	-
I was NOT anxious yesterday	39	-

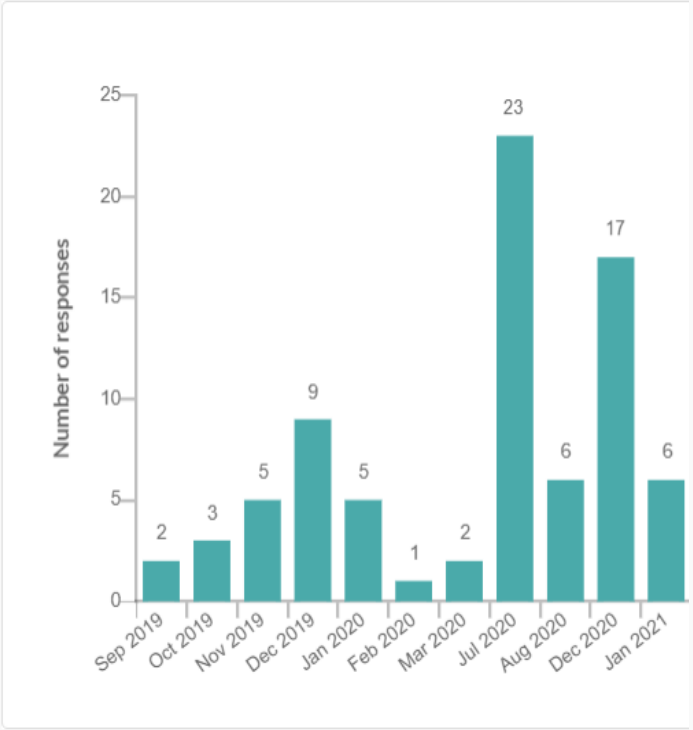
GPimhs/MHICS Service User Comments

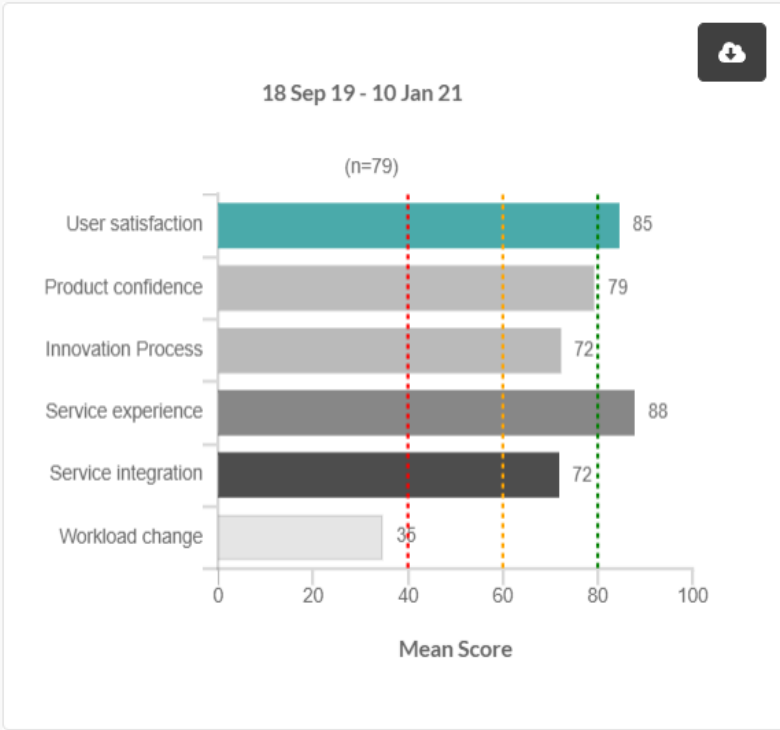
Thank you for today, I knew within a few minutes of speaking to you that I would feel comfortable, it is just a vibe you get from some people - you've been brilliant.
I think overall it was good
I like having someone to talk to about what is going on. it had been really helpful
Really appreciate all your help – you've been amazing. I have hope now.
I think an independent prospective has been most helpful, a focus on me as an individual and identifying what recourses would be helpful and appropriate in my situation.
I have learned a lot in these 4 sessions of how to be kinder to myself.
I am grateful of all the support
The Community Connector has been first class and made me feel a valued person without a hint of any patronisation, which is key. She allowed me to waffle but brought me back to point and over the three sessions we have achieved a great deal. So much so I feel ready to take the advice of Jemima and Jan of Richmond Fellowship Employment Service, who she signposted me to, and proceed to get myself back into work early in the new year. Jemima also gave me assurances that if I did have a blip, she and the service are still there for me which is very reassuring.
Your are very good at explain stuff and making me feel comfortable.
A good service but no specific comments. Time between appointments cold have been shorter.
It was good that you were able to offer face to face appointment.
Since I've been talking to you I've learned so much about how I feel and how to talk to my kids about their feelings too. I've come such a long way.
Its nice to know there are things I can follow up on now and its not just "meh we can't do anything"
I've had a really good experience with this service and wish it was around when i was younger.
Very quick process and amazing service from GPIMHS! Feel listened to.
I really like the way this service works. It helps me work on one thing at a time. I feel more involved in my care now than I have done in the past.
Nothing could have been done better, you advice was helpful with telling me about all the support services and with asking the IAPT service for a different approach because I am not good with writing was really helpful, they are changes how they will work with me and I would probably just have not bothered.
Client's father was very grateful of one-off carer psycho-education session. Said it was very helpful and improved his understanding considerably. He felt the would subsequently be more understanding and support his daughter better.
Think it was really encouraging to have a service that i could access so easily , it all went through really quickly, I feel that my issues were made to feel significant enough to be recognised as needing support. It has been helpful to have it spread out to capture different times.
Community Connector has been brilliant
I didn't realise this was short term as well but it is reassuring to know I can come back, thanks for everything you've done
Whilst it's been hard not seeing people in person (due to covid), I think it's all been done very well. It helps that (my clinician) has such a calm and lovely voice.

GP Survey (R-Outcomes, Jan 2021 report)

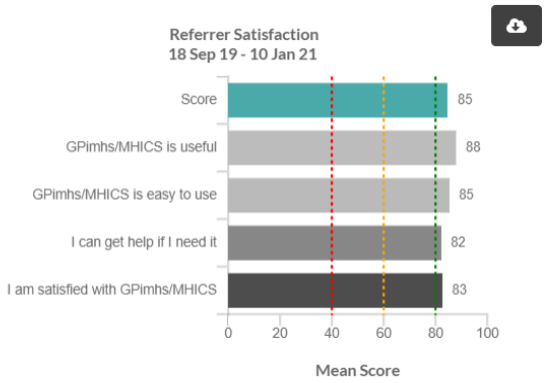
Total Responses

79

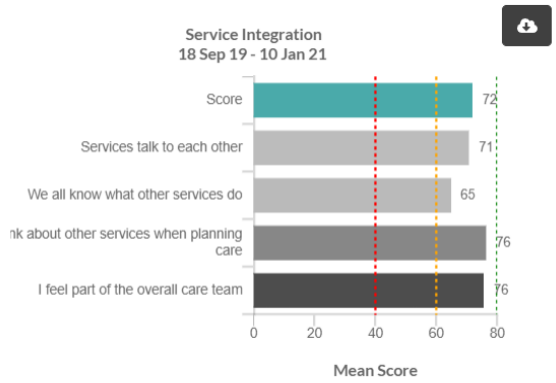




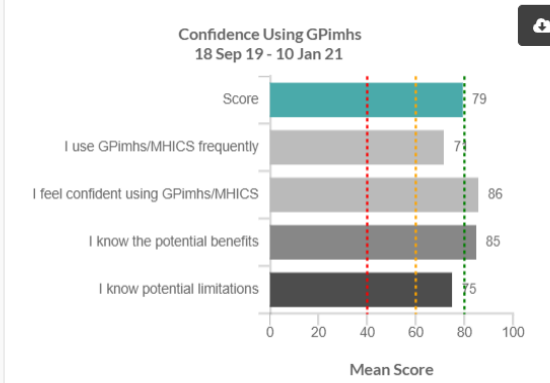
Referrer Satisfaction



Service Integration

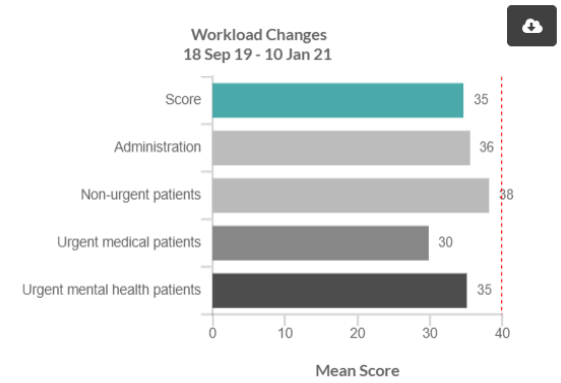


Confidence Using GPimhs



Service Provided

Workload Changes



Innovation Process

Very low 0-39	Low 40-59	Moderate 60-79	High over 80

GP integrated mental health service STAFF	18 Sep 19 - 31 Dec 21	1 Dec 21 - 31 Dec 21
Measure	All Data	Range Data
User Satisfaction	85 (n74)	- (n0)
GPimhs is useful	88	-
GPimhs is easy to use	85	-
I can get help if I need it	82	-
I am satisfied with GPimhs	83	-
Product Confidence	79 (n77)	- (n0)
I use GPimhs frequently	71	-
I feel confident using GPimhs	86	-
I know the potential benefits	85	-
I know potential limitations	75	-
Innovation Process	72 (n74)	- (n0)
The original vision is being followed	73	-
We all thought about how to make it work	72	-
We all act to make it work	72	-
We all think about how to keep it going	73	-
Service Experience	88 (n71)	- (n0)
Treat people kindly	90	-
Listen and explain	89	-
See people promptly	88	-
Well organised	84	-
Service Integration	72 (n75)	- (n0)
Services talk to each other	71	-
We all know what other services do	65	-
I think about other services when planning care	76	-
I feel part of the overall care team	76	-
Workload Changes	35 (n76)	- (n0)
Urgent mental health patients	35	-
Urgent medical patients	30	-
Non-urgent patients	38	-
Administration	36	-

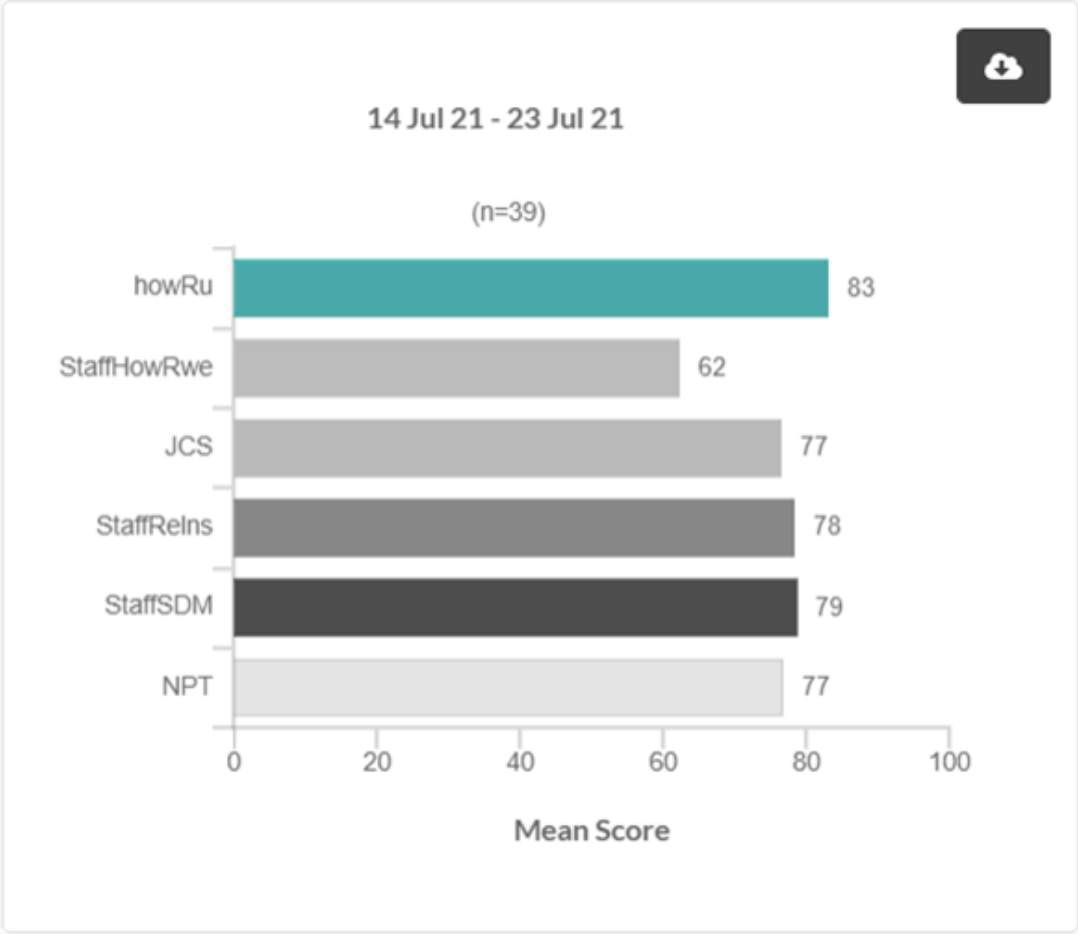
GP Practice Comments

Keep up the good work! We need to extend primary care mental health provision eg first contact MH practitioners and integrate with PCNs & MHICS
Great service, really positive feed back from patients too. Well done.
The workload question needs context. Covid-19 pandemic and associated lockdowns has increased patients consulting with mental health problems, so mental health patient workload has gone up. To an extent MHICS has been part of the solution to this.
I value the promptness of appointments. I know patients have been seen but it might be good to have some communication directly back to the GP to say they have been dc and plan and where to check records for update. Otherwise a great addition to the primary care team!
Really impressed to date with positive feedback from service users.
Only really positive things to say so far. Too early to have seen the real benefits work their way through, but already been great to have somewhere to direct some challenging patients.
Think the service may be useful bt I don't think it has significantly reduced the urgent/on the day MH cases I see.
an excellent service especially for these heartsink patients
I have utilised the consultant psychiatrist most - getting advice on diagnosis and medications has been a massive help and has definitely reduced referral to secondary care for a lot of these patients
Excellent community mental health service ! Wide scope of referrals taken Easy access for patients and less stigma Good quality holistic psycho social care provided and been very helpful with support for patients through lockdown and going forward Proactive cold calling of patients on SMI register ..well received by patients at this time Excellent recorded feedback to GP Complex patients can be discussed with mental health practitioners via email or phone Regular PCN update to inform future planning with collaborative involvement Starting pilot on bridging with SPA and CMHT
Very useful service for patients who have both social and mental health needs, especially where CMHRS say patients don't meet their criteria, but IAPT say too severe for their service.
Its wonderful to have a source to refer patients with chronic, long term conditions, as we do not have the time during our appts to attend to that aspect.
Very valuable service for patients who don't meet CMHRS criteria and need something more than the usual IAPT. Reduces time pressure on GPs as this service allows more time for patients when they need it. Thank you.
Fantastic service, well liked by patients
Great service, offering timely support to patients with mental health difficulties, working well with the voluntary sector within the community.
A refreshing addition to primary care mental health services The service fills a well needed gap of patient care that we struggle to manage optimally in General Practice due to lack of expertise and time The service is responsive The service provides a holistic biomedical psycho social model and links well with the ' local community offer ' de medicalising and de stigmatising mental health It also focuses on emotional health and wellbeing alongside physical conditions It is easy to refer into and feels already like an ' extension of General Practice ' There are many patients that frequently visit GPs 'where we are at a loss as to what to do next ' . This service has provided a new perspective on helping these patients to move forward in their lives and prevent escalation of their mental health needs ,thereby needing CMHT or secondary care . I feel it is a valuable and exciting provision for our community and needs to develop inline with our local population needs
Feel it is an excellent service and allows pts with mental health concerns quick access to specialist help and support
excellent service good communications. helps our patients. GREAT alternative to CMHRS
GPimhs offers a very important service to the patients in Banstead.
real step change to supporting the gap between IAPT and CMHT Easily accessible ,integrated medical record Patients love the informality and locality of the service ..less threatening / stigma The team are great ..always willing to help and provide high quality holistic service for patients needs supports hard to reach / complex patients with social issues really good feedback from my patients Thank you GPimhs for making my patients life somewhat better and mine also !
Really helpful service that is very accessible with passionate staff
Useful service that is very much needed Patients seen quickly which is important

GPimhs/MHICS Staff Survey (R-Outcomes, July 2021 report)

Total Responses

39



Very low 0-39	Low 40-59	Moderate 60-79	High over 80

SABP GPimhs Staff	14 Jul 21 - 31 Dec 21	1 Dec 21 - 31 Dec 21
Measure	All Data	Range Data
How are you today	83 (n38)	- (n0)
Pain or discomfort	83	-
Feeling low or worried	81	-
Limited in what I can do	83	-
Require help from others	85	-
Work Wellbeing	62 (n38)	- (n0)
I was NOT anxious yesterday* at work	62	-
Job Confidence	77 (n38)	- (n0)
I know enough about my job	74	-
I can manage my work	77	-
I can get help if I need it	84	-
I am involved in decisions that affect me	71	-
Staff relationships	78 (n37)	- (n0)
We know each other	74	-
We rely on each other	74	-
We share information	83	-
We help each other	83	-
Shared decision-making	79 (n38)	- (n0)
They know the possible benefits	79	-
They know the possible downside	71	-
They know that they have choices	85	-
They are fully involved	80	-
Innovation process	77 (n38)	- (n0)
The original vision is being followed	65	-
We all thought about how to make it work	75	-
We all act to make it work	83	-
We all think about how to keep it going	83	-

GPimhs/MHICS Staff Comments

loving my role. i am really enjoying being apart of something so beneficial to the community. SABP is a lovely trust to work with
Equipment issues limit my ability to work but otherwise the team works well together to provide the best service and the work is fulfilling.
I enjoy my job and feel we are making the difference for many patients which gives me a good sense of job satisfaction. When I have highlighted issues such as not being trained to handle difficult calls, this was heard and a workshop to support us was set up. The biggest thing for me was the fact that there is no backup for sickness, which caused a lot of problems for me, but I enjoyed working with the team and believe in the principals behind the model. I understand that soon support will be made available with floating bank staff to cover sickness and holidays, so that is great. Another key stress for admin is that although we are not a crisis service, patients do call in crisis and if you don't have someone to call to unload the risk, that can be upsetting, even if you feel the patient will be ok when you get off the call.
Do not feel supported at times Role feels very demanding and deflating at times Often needing to work extra hours to meet demand No formal base to work from - often do not feel 'part' of anywhere - also IT access has been difficult when working remotely
I think that the GPimhs model itself is good and makes a lot of sense however, I find managing patients expectations quite an exhausting part of my role and I find it really difficult to have to tell people about the criteria's and waiting lists thresholds etc on a regular basis. It sometimes feels as though we are only as good as the system behind us which in my view, needs an overhaul but hopefully that is happening slowly.. Another comment I would like to add is it would be good if we could maybe have a monthly drop in with the service leads to hear about changes and to contribute our views/input a bit more if possible.
There is some variability / inconsistencies in how the model is enacted, which can cause some confusion within the system. Comms is needed around the service etc. Work-loads will hopefully feel more manageable as additional resource comes onboard.

This page is intentionally left blank