ADULTS AND HEALTH SELECT COMMITTEE

Wednesday, 5 October 2022

# MENTAL HEALTH IMPROVEMENT PLAN TECHNOLOGY UPDATE

**Purpose of report:** To provide the Committee with an update on use of technology and digital tools in the Mental Health Improvement Plan.

**Introduction:**

1. Technology can be a key tool in improving mental health and emotional wellbeing, both through directly delivering support and services through digital or technologically enabled means and by augmenting and improving existing services. The Covid-19 pandemic accelerated the roll out of digital tools as we adapted to meet the needs of residents. As in-person services and support have returned, we have looked to harness the value of digital tools where they can add most value, while recognising the vital importance of face-to-face interactions.

2. Mental health support and services are delivered as a system, with NHS, local authority and voluntary sector organisations working together in partnership. Our work on digital and technology is done in the same way. Working in partnership creates opportunities to deliver better support to our residents and also presents challenges in terms of data sharing, pathways, relationships, funding and digital approaches. These can be relational as well as technical. Working in partnership can be as simple as a shared sign-posting or as complex is navigating the challenges of data infrastructure across multiple organisations and sectors. The examples of technology cited later in this report are drawn from across the system.

3. The purpose of this report is to provide an update on how technology is helping us deliver the Mental Health Improvement Plan (MHIP) and addresses the following recommendation following the Adults and Health Select Committee meeting on 23 June 2022:

   *"For Surrey Heartlands, SABP and Mental Health leads in Surrey CC to provide a future update and report to the AHSC on the technology being sought, and the progress being made in rolling out technological systems to improve Mental Health Services in Surrey."*

4. Across England, each local NHS system is currently developing a 3 year Costed Investment Digital and Data Roadmap, in line with guidance set by NHS England. In Surrey, our digital and data strategy for mental health is embedded within this work. A brief summary of this strategic work and associated national policy is

included in Annex 1 but is not the focus of this report. The timing of this is currently uncertain, having been recently delayed.

## Digital and Data workstream of the Mental Health Improvement Plan

5. The Digital and Data workstream was set up to deliver three of the 19 recommendations which underpin the MHIP (see Annex 2). Digital is a key enabler of other work. For example, our Prevention, Signposting and Self-Help work supports delivery of the key outcomes of Priority 2 of the Surrey Health and Wellbeing Strategy (see Annex 3).

6. We have identified six delivery and outcome areas which align to the Mental Health Improvement Plan alongside national policy and the Costed Investment Digital and Data Roadmap.

   a) Prevention, Signposting and Self-Help
   b) Integrated Analytics (including population health management, demand and capacity)
   c) Flow and Proactive Prevention
   d) Virtual Care
   e) Improving Access to Psychological Therapies (IAPT) – new models of care
   f) Programme Resource to co-ordinate, shape and lead this ambitious area across the system including embedding people with lived experience and carers as funded resource

7. These areas align with the wider objectives within Surrey. Annex 4 shows how the 6 delivery and outcome areas map to the original 19 MHIP recommendations, highlighting how Digital and Data is an enabler across the whole MHIP. These areas also inform the MH element of the system digital and data plan.

8. Success will be subject to appropriate investment to get it right, alongside having a cohesive system plan which Surrey wants to action and implement collectively. Decisions on local and national investment applications are subject to the conclusion of the Costed Investment Digital and Data Roadmap.

9. Technology moves so fast; we need to be prepared to be flexible and iterative. We will also be horizon scanning what works well elsewhere from other health and care systems, inclusive of our Voluntary, Community and Social Enterprise (VCSE) partners, across the country. We also need to be mindful technology is not the answer to everything (see 'Challenges' section, below).

## Where we are already making a positive impact as a system

10. Across Surrey, technology is being applied in a wide range of ways to support the mental health and wellbeing of residents. Some of this is at individual organisational level and some of this is at a multi-agency or system level. A selection of examples is provided here – drawn from across the health and care system, including VCSE partners – to illustrate the various types of tools being deployed and the impact we have seen or expect to see through using them.

11. Examples have been aligned to the 6 delivery and outcome areas outlined in paragraph 6 above, though it should be noted that individual examples can often sit across more than one area. Future examples in Integrated Analytics will depend on future investment.

12. Annex 5 provides further detail and examples, although an exhaustive list is beyond the scope of this update.

**Prevention, sign-posting and Self-help**

13. For children and young people, Kooth provides an online mental health and wellbeing support service which aims to reduce the stigma associated with receiving MH support whilst allowing young people to find the support that's right for them. The platform functions include a magazine, journal and goal setting, live text chat (with immediate access to qualified counsellors) and drop-in/booked text chats, pre-moderated safe peer-to-peer forums and an activity hub (to support self-expression and healthy coping strategies). In the first quarter of 2022/23, there were 6,822 log ins by 952 users accessing a range of services.

14. Our perinatal mental health service offers a 12-week maternal coping skills course available online. This means that support is more accessible for mothers who may find travelling difficult, for example following a caesarean section.

15. Surrey Virtual Trips has supported 200 individuals facing the most barriers to getting out, by facilitating virtual tours or visits. For some participants, these trips have acted as a stepping-stone towards visiting in real life.

16. As use of technology increases, we are aware of the potential for health inequalities to be increased. Tech to Community Connect is a digital inclusion service which provides devices, digital literacy training and confidence-boosting support to people from all over Surrey. The service has supported approximately 5,000 residents to date. Residents are offered a device, data (a 6-months free Vodaphone sim), matching with a volunteer Tech Angel and a menu of training modules to work through.

17. We are working with ORCHA (the Organisation for the Review of Care and Health Apps) to deliver an online Health Apps library focussed on supporting young people in Surrey. The aim is to make it quicker and easier to access safe and accredited health & wellbeing apps.

18. There are a variety of online platforms including Healthy Surrey (where three of the top ten most popular pages related to mental health), the Surrey Information Point and the Surrey Virtual Wellbeing Hub. Further details are included in Annex 3.

**Flow and Proactive Prevention**

19. Following a QI project at SABP's Juniper ward exploring a number of digital solutions to support bed flow, in the data up to January 2022 there has been a 22% decrease in the average total weekly bed days and an 18% decrease in the average length of stay of those admitted to Juniper Ward. Flow is an important

area in delivering and managing services effectively when people need them, with knock on effects impacting the whole system.

20. Social workers are utilising the 'S12' (section 12) app to support with assessments under the Mental Health Act 1983. S12 has helped connect Approved Mental Health Practitioners (AMHPs) with a local and available doctor, with 262 assessments created on the platform in July, 246 of which had a doctor booked against the assessment. This avoids the increased delays and distress which can be caused by inefficient and slow processes.

21. Our Proactive Prevention of Crisis project aims to proactively identify and support people who are at high risk of experiencing a mental health crisis, to improve patient outcomes and experience for this population group. People with mental health challenges are significantly (3.6x) more likely to experience a potentially preventable emergency admission than those without such challenges. Areas such as Learning Disabilities services have demonstrated the potential to implementing operational and digital solutions to prioritise intervention and prevent admission and we hope to apply this learning to improve outcomes and experience for those with mental health challenges.

**Virtual Care**

22. Oxehealth (a contact-free, vision-based patient monitoring platform for use in hospitals) has so far prevented 8 ligature, 6 self-harm and 8 serious incidents. Alongside saving 8 lives, 3776 hours were saved on serious investigation work. In addition, time to take observations have reduced from a minimum of 4 minutes to 1 minute. All of this gives time back to clinicians, and has allowed them more time to engage with people using their services.

23. In residents own homes, the technology integrated health management service (TIHM) has supported 550 residents through smart technology. Impact includes a 42% reduction in care home admissions, 60% of users feeling less anxious and a 32% reduction in emergency admissions. We are currently seeking sustainable funding for TIHM.

24. A variety of services run virtual appointments or sessions as all or part of their support offer. Examples include virtual carer support groups within Early Intervention In Psychosis, which led to an increased 20% in attendance.

**Improving Access to Psychological Therapies**

25. Improving Access to Psychological Therapies (IAPT) is a well-established programme for treatment of adult anxiety disorders and depression. Our virtual IAPT offer includes a fully text-based service. As well as broadening the service offer, the transcripts from the text-based service also help us maintain and improve the quality of care we provide.

26. 'Limbic' is a web-based tool to aid self-referrals using a 'chat bot', which aims to improve our service by increasing the speed and number of referrals. It can also benefit staff by reducing the clinical and administrative time required to make preliminary assessments on referrals.

**Other examples: using technology and data to support clinical and/or operational work**

27. Mi-Fi devices have been rolled out to support specialist mental health colleagues working in the GP Integrated Mental Health Services (GPiMHS). This workaround addresses existing connectivity issues could have previously led to cancelled appointments or staff working from home, defeating the purpose of providing mental health support from within a GP surgery.

28. We have tested the use of the SystmOne system to record patient information across the Mindworks alliance, as part of the National Autistic Society (NAS) and Barnardo's new out-of-hours call lines service. This is to address the challenges of partners in the Mindworks alliance using different systems and processes. The co-designed interface has a high level of satisfaction and is delivering an excellent user experience and optimised clinical pathway, reducing clinical risk while facilitating accurate and efficient data capture.

**Challenges**

29. Although the strategic element of our digital development is not the focus of this report, delivering an ambitious digital and data strategy is inherently challenging. Fragmentation, digital literacy (for both users and our workforce), lack of system interoperability, digital exclusion and the risk of increased health inequalities are all significant challenges for us to overcome.

**Where we need to focus, build capability and capacity**

30. While there is a lot of positive work already underway, things can be fragmented, duplicative and not joined up. As a system, we still need to put in more effort to best align and locate the relevant scale-up opportunities. As part of this, we have identified three key enabling foundations:

    a) **Development of Data Infrastructure** to allow us to flow data more easily, getting the right data to the right person for the right need, with easier system information governance and ethics processes in place. This needs to include people with lived experience of mental ill-health and carers, alongside VCSE partners who currently face barriers accessing data. We are on the start of this journey and key developments include the Surrey Care Record programme, the Adapt+ Programme (Electronic Patient Record evolution for both SABP and partners) and the Surrey Data Strategy.

    b) **Mental Health Data Analytics**, once we get the data infrastructure and flows right, we need to optimise that data to develop a system view, understand the gaps and develop insight to make informed decisions (recognising there may also be shorter term work involving more manual processes as the appropriate infrastructure is developed). This may be at an individual level (e.g. we need to expand on the work underway in the Mindworks programme where we are making a real difference to the safety of children and young people) or population health management. This must also include how people

with lived experience of mental ill-health and carers can make better use of their own data to influence and inform their care.

c) **Service Redesign Capacity** to allow us to really understand the problem we are fixing, ensuring the best technological solutions are being implemented, can be iterated, and have the best opportunity to succeed in improving outcomes for both people who need our support, carers and clinicians. We will need to enhance existing service redesign capacity and capability to deliver this effectively. This needs a true system lens approach and must include a person centric design approach and both digital and clinical experts working together:
    - A person centric design approach is needed to ensure the co-creation of solutions which address the real issues faced by people with lived experience of mental ill-health and carers
    - A Surrey Heartlands-wide, cross organisational forum of Chief Clinical Information Officers and Chief Digital Information Officers starts later this month. Its aims are to: better understand system level cross-organisational care pathways; identify the associated requirements of technical architecture; integration; and exploit available digital and data systems. This will support health and care professionals in accessing timely & right information, as well getting the appropriate access and tools/apps for patients.

31. Surrey Heartlands is also currently completing a 'digital maturity' self-assessment, which will help inform the areas we need to focus on.

**Resources**

32. Our ability to fund dedicated resource continues to be a limiting factor. The current programme of work to deliver system level digital and data capacity (as a whole, not just for mental health) is in early stages with funding not secured beyond Outline Business Case development. While funding arrangements are yet to be confirmed, we know that national digital funding has been reduced and we are not yet clear on the impact on Surrey. It is likely that many initiatives will need to be funded via clinical transformation programmes' monies.

33. As the funding picture develops, both locally and nationally, we will be able to determine how we can ensure that we secure the required resources and maximise them to the best effect for those who need our support.

34. As in other areas of health and social care, workforce pressures can impact the utilisation of technology. There are challenges both nationally and locally recruiting in digital roles, and both the capacity and digital expertise of the wider workforce are critical to the effective design and implementation of new products.

35. As we continue to emphasise the role of the Voluntary, Community and Social Enterprise sector, we need to recognise the specific resourcing challenges they face. Digital infrastructure and data sharing arrangements can be particularly significant barriers for this sector and dedicated digital resource, including workforce, is typically more limited than is available to public sector partners.

**Learning from other areas**

36. Digital mental health is a growing community with both formal (e.g. via NHS England) and informal (e.g. via social media) mechanisms to share from others as well as work in the open. Examples include understanding patient portal work done by other local authorities or how different systems are using dashboards to support physical health checks for individuals with serious mental illness. Working with Academic Health Science Networks also provides an additional route to engage with the market, including our own Health Tech Accelerator site in Surrey.

37. Several of the examples in this paper, both cited above and in Annex 5, reflect learnings taken from other areas. For example, our work on proactive prevention of crisis takes learning from Learning Disabilities services and applies it to mental health. Third party tools such as OxeHealth have been brought in to support Surrey residents after being used effectively elsewhere. These tools will be purchased after assessing the options available on the market and how well they meet the need we are trying to address.

**Conclusions:**

38. Technology is, and will continue to be, a core part of delivering the best support and care to our users and residents. This report sets out a number of examples of the impact these tools as well as the foundations we are hoping to lay to continue improving services and user experience.

**Recommendations:**

1. That the focus of the Digital and Data workstream is refreshed following conclusion of the phasing of the wider MHIP and the Costed Investment Digital and Data roadmap.

**Next steps:**

1. Conclusion of the phasing exercise within the wider Mental Health Improvement Plan will enable alignment of Digital and Data with agreed system priorities

2. Assessment of the resource required to deliver Digital and Data elements of system priorities and the scale of potential funding sources as they emerge, and the size of any potential shortfall.

3. Ongoing alignment of mental health digital and data with system-wide (i.e. all healthcare) system plans and governance, including the Costed Investment Digital and Data Roadmap and aligned to upcoming NHS mental health ten year plan

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**Sources/background papers**

A Plan for Digital Health and Social Care

Digital Mental Health Priorities

Mental Health Improvement Plan

Physical health competency framework for mental health and learning disability settings

About the National Clinical Audit of Psychosis (NCAP) (rcpsych.ac.uk)

NHS England » Adult Improving Access to Psychological Therapies programme

Innovative new primary care-based mental health services nominated for HSJ Award : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)

NHS England » Perinatal mental health

Early Intervention in Psychosis : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)

**Annex 1: Broader Digital & Data Policy and Work – National and System**

Surrey Heartlands 3 year Costed Investment Digital & Data Investment Roadmap

There is a national ask for every Integrated Care System (ICS) to develop a three year digital and data investment roadmap. The Surrey Heartlands work is underway and to date has identified 192 potential initiatives across the ICS.

Eight strategic areas, mapped to What Good Looks Like, have been identified. These are (1) electronic and shared care records (2) ICT enterprise infrastructure (3) cybersecurity (4) digital workforce and passport (5) Personal health records and portals (6) ICS Clinical redesign (7) integrated digital and data platform (8) Other including pharamacy. This work has built new and positive system relationships key to future delivery, which will help to accelerate this agenda.

Prioritisation to take place in Q3. A parallel piece of work has recently commenced across the Frimley Health & Care Partnership. We are also expecting the recruitment of digital mental health leads at a regional level.

National Policy

Recent policy and national guidance includes A Plan for Digital Health and Social Care and the Digital Mental Health Priorities which are included below. The refreshed Long-Term Plan and Mental Health 10-year plan is expected in coming months. We have considered the national mandate and recommendations in developing the P7 digital and data workstream of the MHIP.

| **Priorities for digital mental health** |
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1. Ensuring the digital basics are in place
2. Enhancing data sharing
3. Improving how people get the support they need
4. Supporting the workforce to deliver the highest-quality of care
5. Embedding digital products and services in mental health pathways

| **Guiding principles for digital mental health** |
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To deliver on these priorities and achieve effective digital transformation in mental health, these principles must underpin everything we do.

**1. Personalise where possible** - Provide people greater choice of how they access and share information and use services
2. **Identify and design for the excluded** - Identify who is being missed and design services and support to meet their needs
3. **Make the journey intuitive** - Make the care journey easy to understand and navigate, so people know where they are and what comes next
4. **Inform decision making** - Make sure people have access to high-quality evidence and information to make the right choice for them or their patients
5. **Ensure its safe and secure -** Build services and products that support safe and secure care, building trust with service users and clinicians

6. **Collect good data once -** Collect high quality data, in a timely way that can be appropriately shared to avoid duplication
7. **Meet people where they are -** Acknowledge varied digital literacy and poverty for service users and staff and tailor support accordingly
8. **Breakdown and bridge silos** - Support data flow, connected systems, collaboration and the sharing of learnings across the system

**Annex 2: MHIP Recommendations in scope of the Digital and Data workstream**

Recommendation 10 (Technology): Develop and exploit the full capability of digital technologies (e.g., online consultations, emotional wellbeing apps, Health Tech Lab) in supporting emotional wellbeing and mental health outcomes and preventing ill-health, especially capitalising on the positive applications that have been introduced during the Covid19 pandemic.

Recommendation 6 (Consistent Data and Outcomes Focus on): good data and using it to good effect creating a system-wide team and resource to agree what information is needed to understand need, monitor demand, identify priorities, assess and improve performance and outcomes, and make better informed decisions for the mental health system as a whole. This team should execute a mapping exercise to establish and redress the capacities and approaches necessary to ensure all partners can collect, house, share, and analyse the data necessary in such a way as to deliver the information and insight identified by this team as essential.

Recommendation 15 (Information and Data Sharing Arrangements): Improve awareness and understanding at all levels of data sharing issues, arrangements, protocols, and agreements (e.g. the Surrey 'Multi Agency Information Sharing Protocol') to ensure the appropriate and necessary free flow of data across the system to benefit outcomes.

**Annex 3: Priority 2 of the Health and Wellbeing Strategy**

## WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?

**Priority Two** of the Health and Wellbeing Strategy focuses on enabling our citizens to lead emotionally healthier lives. This priority area is focused on prevention, removing barriers, and supporting people to become proactive in improving their emotional health and wellbeing.

## OUTCOMES By 2030:

- Adults, children, and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources
- The emotional well-being of parents and caregivers, babies and children are supported
- Isolation is prevented and those that feel isolated are supported
- Environments and communities in which people live, work, and learn build good mental health

**Priority Two** aims to impact in the following ways:

- Ensuring the right early help and resources are available to support mental health across life stages
- Support during pregnancy and for young families
- Recognising and addressing the impact of isolation
- Building good mental health in the range of spaces and places including schools and workplaces

Our refreshed HWB strategy 2022, highlights a focus on reducing health inequalities to ensure no-one is left behind. In addition to the needs of those experiencing mental illness of some sort, which is itself a priority population in our recently refreshed health and wellbeing strategy, across the priority populations (of identity and geography), it is recognised that many of these groups will have increased needs with regards to mental health.

## Annex 4: Delivery and outcome areas mapped to MHIP 19 recommendations

### Appendix – mapping to 19 recommendations

| | Prevention, Signposting & Self-Help | Integrated Analytics | Flow & Proactive Prevention | Virtual Care | IAPT – New Models of Care | Programme Resource |
|---|---|---|---|---|---|---|
| 1. Commitment by all agencies | | | | | | |
| 2. Shared Vision | | | | | | |
| 3. Access to, mapping and navigation of services | | | | | | |
| 4. Relational Diagnostics | | | | | | |
| 5. System Model | | | | | | |
| 6. Consistent Data & Outcomes | | | | | | |
| 7. Funding | | | | | | |
| 8. Engagement | | | | | | |
| 9. System Governance | | | | | | |
| 10. Technology | | | | | | |
| 11. Covid 19 Focus | | | | | | |
| 12. Training & Awareness | | | | | | |
| 13. Communication, Resilience & Preventative Strategy | | | | | | |
| 14. Preventing Gaps in Service & Improving Transition for people | | | | | | |
| 15. Information & Data Sharing Arrangements | | | | | | |
| 16. Engage with and improve access, reduce barriers to groups that do not engage with traditional services. | | | | | | |
| 17. Review Capacity of Mental Health Crisis and Inpatient Services | | | | | | |
| 18. s136 health based place of safety & follow | | | | | | |
| 19. Improving Access to Psychological Therapies | | | | | | |

**Annex 5: How the system is making an impact**

| Initiative | Background | How the system is making an impact |
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| Early Intervention In Psychosis – virtual carer support groups | The Early Intervention In Psychosis (EIIP) teams provide specialist treatment and care for people aged between 14 and 65 who have signs of psychosis. These multidisciplinary teams provide a range of treatment and support to individuals and their family/carers. The service has utilised digital platforms as a means for engagement for carers support groups, running monthly friends and family groups. | An increase of 20% in attendance demonstrates that virtual has made it easier for carers to attend. Recognising the need to explore a blended model going forwards. |
| Epilepsy Sensors | Epilepsy sensors in Learning Disabilities homes can prevent serious injury or even death by alerting staff to a seizure.<br><br>An epilepsy sensors trial (using AlertIT epilepsy sensors) took place in Rosewood. A subsequent evaluation concluded that the sensors enabled staff to provide safer and more effective care than the previous solution. By using a system which does not disturb or require checking of the service user, it also promotes dignity and respect. As a result, the SABP Learning Disabilities directorate chose to rollout the sensors across all SABP learning disabilities care homes. This is currently in implementation, with rollout to further care homes (Kingscroft and Larkfield) complete in June 2022, and trial care homes are transitioning to BAU. | Care home staff involved in the trial reported an increased confidence in the new alert system. 4 in 5 found the alerts faster and the system easier to use. |
| Flow Project – SABP Juniper Ward | People must often become so unwell before they are able to access a bed, once people become unwell | In the data up to January 2022, there has been a 22% decrease in the average total weekly bed days (this is the |

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| | and require hospital admission, they are often left waiting, as there are no beds available. People who are in beds are often left waiting to leave, even though they are medically fit for discharge. Using the IHI Model for Improvement and Agile Project Management, a variety of digital solutions were tried and tested to improve flow, paying particular attention to setting SMART actions every day to progress with discharges. These included smartboard, training on smartboard, alerts for discharge pathway, digital walk around, smartboard as single source of truth for meetings and virtual management for community teams. | total number of days that each person has spent on the board divided by the number of bed occupied) and an 18% decrease in the average length of stay of people who use our services and have been admitted to Juniper ward. On average there is a reduction in the total bed days of 296.<br><br>A recent flow workshop with system partners was held in May 2022 with a Flow Programme now underway. |
| GP Integrated Mental Health Services (GPihms) with Mi-Fi Devices and a PCN dashboard. | GP Integrated Mental Health Service (GPimhs) is an innovative primary care based mental health service which provides people with specialist care at their GP surgery. They are providing people who have significant mental health needs with quick and easy access to help in primary care.<br><br>The nature of multidisciplinary teams has driven a range solutions to support a one team approach. This includes:<br>1) The rollout of Mi-Fi devices to support SABP staff working in GP practices. This was due to a variety of problems all leading back to internet connectivity issues..<br>2) Replacing the unstable platform with an interim PCN dashboard | Since rollout of Mi-Fi devices (portable, wireless devices that use mobile phone networks to create a mini broadband hotspot), zero connectively issues have been raised. This could have previously led to cancelled appointments or staff working from home, which defeated the purpose of providing mental health support within a GP surgery.<br><br>The development of the PCN dashboard from an Interim Tactical Solution which was unstable to an in-house interim solution built on SystmOne. This provided a more user-friendly and intuitive product meeting the neds of the service, as well as reducing clinical safety risk reduction. |

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| Healthy Surrey | The Healthy Surrey website "can help you lead a healthier life, whether you want to be more active, drink less alcohol, stop smoking, and more". It is supported by the **Health and Wellbeing Board**, helping both people with lived experience and professionals find self-care information, as well as signposting to local services available as Surrey residents.<br><br>The Healthy Surrey website recently underwent a re-design and an evaluation took place following this. | Following re-design, within the top ten most popular pages, those relating to mental health had over 5,700 more visits. Three of the top ten most popular pages related to mental health and collectively had 36,800 visits:<br>"Local Mental Health Services" (21402)<br>"Adult Health and Wellbeing" (9162)<br>"Virtual Wellbeing" (6236)<br><br>320 referrals via Healthy Surrey (accounted for 50% of all Healthy Surrey referrals) =ACTUALS: 325 49.5%<br><br>There is also work underway to track usage of referral forms embedded within the re-designed website, these can be used by both Surrey residents and professionals. In the year post re-design, over 650 events were recorded and referrals for mental health services accounted for nearly 50% of all events with 325 events logged. Drug and alcohol services accounted for a third of all events logged. These are not currently integrated however signpost to the relevant referral page. |
| IAPT virtual delivery | Nationally, the Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England (see more on the NHS website).<br><br>There are six IAPT providers working across Surrey, many if not all providing a virtual offer.<br><br>This includes ieso which is a fully online IAPT. ieso therapists provide 1:1 text-based cognitive | Surrey Heartlands ICB has seen that where patients self-refer to ieso, choosing text based therapy from the outset, they respond very well. Recovery has shown a 55% reliable improvement 68% (since April 2022)<br><br>"This was an excellent service, especially my therapist, who was very understanding, clear and didn't rush me at any point. I have already recommended this service and would HIGHLY recommend my therapist, she was |

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| | behavioural therapy (CBT) informed by insights from 300,000+ hours of transcripts which have been analysed to show give us a reliable understanding of recovery rates for different conditions. Our therapy insights model has also allowed us to rely more on therapists who are seen to adhere to CBT principles and identify training needs for those therapists who are deviating from the typical CBT principles and protocol. This helps us deliver a consistently quality service. Therapy transcripts remain available for patients to access even after therapy is completed. | outstanding. Not to be too dramatic, but this service literally saved my life." Surrey patient's PEQ comment in June 2022 |
| Kooth | Kooth provides online mental health and wellbeing support for young people and young adults aged 10-25. Kooth's overarching principles are anonymity and therapeutic choice. They strive to reduce the stigma associated with receiving MH support whilst allowing young people to find the support that's right for them. The service in Surrey is commissioned for 10-19th birthday.<br><br>Key features of Kooth include being available 24/7 including out of hours, free at the point of sign up, and a humanistic integrative, 'whole-person' approach to online therapeutic support. Users are the central decision-makers in their journey towards well-being<br><br>The platform functions include a magazine, journal and goal setting, live text chat (with immediate access to qualified counsellors) and drop-in/booked text chats, pre-moderated safe peer-to-peer forums, | Usage of Kooth during the first quarter of 22/23 includes:<br>227 Chat sessions (111 service users)<br>3242 messages (433 service users)<br>1209 articles (285 service users)<br>7510 forums (392 service users)<br><br>634 new registrations<br>6822 log ins (952 users)<br>70.21% logged in "out of hours" (i.e. not 9am – 5pm)<br>67.22% returning log ins (i.e. more than once in the period)<br><br>Awareness of Kooth, where feedback was given, was most likely via the GP, School/Teacher or CAMHS (Child and Adolescent Mental Health Service). |

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| | activity hub (to support self-expression and healthy coping strategies). | |
| Limbic 'chat bot' in IAPT | Limbic is an automated web-based system using artificial intelligence 'bots' to complete preliminary assessments and aid self-referrals.<br><br>This tool makes referrals easier and quicker for users and improves the number of IAPT referrals which can be processed. It is available 24/7 and reduces the processing and assessment times for clinicians and administrators. | Limbic was launched as a secondary referral option for Mind Matters IAPT service in July 2021 and became the primary option in September 2021. A validation study in summer 2022 found that Limbic was one of several changes which led to improvements in the service in the period, both for users and for staff.<br><br>Further work, including research with current and former users, is required to demonstrate the benefits specific to Limbic and suggest areas for further improvement. |
| Mindworks Dashboard | Mindworks Surrey is an emotional wellbeing and mental health service that supports children and young people across Surrey. Together as partners, they deliver targeted and specialist services, connecting with universal services to ensure support is available at entry level, from primary mental health in schools through to urgent needs.<br><br>A Mindworks PowerBI Dashboard has been developed, which replaces a manually monthly produced Excel spreadsheet. This dashboard provides information refreshed daily from SABP and alliance partners. | The dashboard was used to analyse the number of referrals waiting over 1.5 yrs for a first attended appointments. 435 were identified in December and, by using the 'drill through' and working with operational and Digital colleagues, the number has been reduced to circa 200, with the balance all clinically reviewed for discharge. This work has now been extended to all waiting times over 6 months.<br><br>The dashboard provides an up-to-date view of performance without any manual data production. |
| Orcha Apps Library for Young People in Surrey | Surrey & Borders Partnership Foundation NHS Trust (SABP) are working with ORCHA (the Organisation for the Review of Care and Health Apps) to deliver an online Health Apps library focussed on supporting young people in Surrey. The aim is to make it quicker and easier to access safe and accredited | An evaluation of this solution within children's services is in development (postponed due to the recent extreme heat) and there is ongoing work as part of the Surrey Digital and Data investment roadmap to explore expanding this including to support people with learning disabilities who have obesity. |

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| | health & wellbeing apps. Health Apps is an opportunity to provide people with important health information and help them live healthier and happier lives.<br>ORCHA carry out independent reviews of health and care related apps, assessing apps for clinical validity, data security and user experience – providing assurance that the apps people with lived experience choose are of high quality. Use of ORCHA for people with lived experience is completely free without the need to create an account. An optional account can be created to save details of favourite apps, or to track app recommendations, favourites and downloads as a health professional. | |
| National Autistic Society & Barnados out-of-hours platform | As part of the vision for Mindworks Surrey, being able to share data easily and safely, between partners, is important. But at the time the alliance was formed, many partners were using different systems or using simple tools like MS Excel to record patient information. This project tested the use of SystmOne to record patient information across the alliance, as part of the National Autistic Society (NAS) and Barnado's new Out-Of-Hours call lines services. This was an opportunity to test on a relatively small scale the implementation of SystmOne Units. This was not just about developing a technical solution, but exploring ways to collaborate as system partners. | The new co-designed interface has a high level of satisfaction and is delivering an excellent user experience and optimised clinical pathway, thereby significantly reducing clinical risk while facilitating accurate and efficient data capture. Feedback quotes include:<br><br>"It's been really easy to navigate and access...it's been really easy to use."<br><br>"…it was good again to be able to see the other services that are recording on the patient file and where the child's been in terms of assessment and diagnosis and the time frame for that"<br><br>"It is fit for purpose. What has been delivered by Design Team is really positive" |

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| | | "The Design Team did it at the pace and they did it with the understanding that us as a team needed, and they were just really lovely... They were really supportive. It was a good team to work with."<br><br>Quantitative feedback is not available because the call volumes and usage of the tool was very low, this mirrors the out of hours call volumes received and both organisations are now increasing promotions and comms around the service. The piece of work has however enabled learning in a number of areas including but not limited to testing, training, functionality, information sharing. |
| OxeHealth | Oxehealth's Oxevision is a contact-free vision-based patient monitoring platform for use in hospitals. It gives ward teams the early warning signs and risk factors they require to plan patient care and proactively intervene to help their patients. Oxevision uses a secure contact-free optical sensor to monitor pulse rate, breathing rate and activity of an individual in a room – serving up warnings, alerts, reports and observations to clinicians at the right time. It empowers the clinical teams to deliver proactive care, which results in fewer incidents and injuries, improved quality and operational savings. | Impact data based on March 2022 evaluation<br><br>Lives saved and serious incidents<br>• 8 ligature, 6 self-harm and 8 serious incidents prevented<br>• Average Legal costings over the last 3 serious incidents have been at £360,652. This does not include any of the insurance costs.<br>• Oxehealth has been involved in stopping 8 potential serious incidents = 3,776hrs saved (based on a mapping of 472 hours (conservative estaimate) / 4 months per serious incident<br><br>Observations<br>• Before Oxehealth: observations take a minimum of 4 minutes per person (from floorwalking exercise), post Oxehealth observations take 1 minute per person.<br>• 83% of survey responders felt that Oxehealth made observation rounds faster, allowing for more time to engage with persons who use our services. "Saves time |

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| | | and resources – reduction in physical checks which gives a bit of time back. Can give time back for planning for the assessment." Non-Medical Prescriber, 136 Suite, ACU "<br><br>Qualitative feedback – experience and safety:<br>• "One patient asked a member of staff why they weren't using Oxehealth and informed them that other staff used it and they should use it as they were disturbing them"<br>• "I was monitoring a patient with high blood pressure, taking pulse, and breathing vitals. As their signs were fluctuating, we were able to check regularly and often" |
| Perinatal Mental Health – virtual consultations and support | Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions. (NHS England Website).<br><br>Throughout the pandemic, Attend Anywhere was used to facilitate assessments (face to face continued where necessary). The service has recently used to the Airmid solution within SystmOne.<br><br>The service also offers a 12 week maternal coping skills group, for women with emotion dysregulation difficulties who are pregnant and/or just had a baby who would like to learn skills to deal with emotions and relationships more effectively. The sessions are virtual and tend to run out of school pick up hours. | Enabling video consults enables face to face contact to continue in comparison to a telephone call. The service is performing better with women being seen quicker. There is also increased data quality on SystmOne including outcomes due to streamlined processes.<br><br>Benefits of running the maternal coping skills group virtually:<br>• Running sessions out of school pick up hours enables more people to attend<br>• Babies are welcome during the group, recognising their attention will be needed during the session<br>• Can support those who may find travelling difficult or inconvenient (for a range of issues including for example recent caesarean section) |

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| Point of Care Testing – Physical Health Checks in Serious Mental Illness | Improving access to physical health checks for people with severe mental illness (SMI) is part of the NHS Long Term Plan, with the aim of 390,000 people with SMI receiving physical health checks by 2023/24. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease.<br><br>Point of Care testing is a technological solution which can support with equipment and devices for diagnosis, monitoring and screening, with a number of products on the market. It can support the uptake of physical health tests. One pilot to date has been the Cardiovascular Monitoring in Mental Health (*CARMEN*) project) which included funding to roll out Point of Care technology to Early Intervention in Psychosis (EIP) services across the South East of England and Surrey & Borders Partnership (SABP). This projected aimed to establish if introducing point of care testing for blood glucose and cholesterol can increase the number of physical health checks in patients with severe mental illness. | Following the Point of Care Testing rollout as part of the CARMEN project, National Clinical Audit of Psychosis (NCAP) results (Nov 21) showed an increase with those with completed health checks from 72% to 81%.<br><br>There are opportunities to use point of care testing to support Physical Health Checks more widely and work is underway across the system to understand options for wider community teams broader than Early Intervention In Psychosis. |
| Proactive prevention of crisis | This project aims to proactively identify and support people who are at high risk of experiencing a mental health crisis, to improve patient outcomes and experience for this population group.<br><br>People with mental health challenges are significantly (3.6x) more likely to experience a potentially preventable emergency admission than | Following implementation we hope to be able to demonstrate reduced admissions and improved outcomes in this population group. |

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| | those without such challenges (Nuffield Trust). Areas such as Learning Disabilities services have demonstrated the possibility of implementing operational and digital solutions to prioritise intervention and prevent admission (although risk stratification is not recommended in predicting specific outcomes such as suicide or self-harm).<br><br>Supporting and encouraging professional curiosity must be central.<br><br>A secondary purpose of this work is to provide an additional potential user case for the Mental Health Digital Roadmap, feeding into the ICS Costed Investment Digital & Data Investment Roadmap. | |
| S12 App (for Section 12) | Mental Health Act assessment teams can often rely on inefficient paper processes. Inefficient processes can cause delayed assessments, and increased distressed for the person waiting. S12 Solutions is a platform which connects AMHPs with local, available, section 12 doctors. | July 2022 report – July – 262 were assessments created. 246/262 of these had doctors booked against the assessment. |
| SABP Application Development | The Application Development Team are part of the Design and Solution Department within SABP Digital, creating new applications and platforms based around the Microsoft Power platform to provide better processes and compliance for the Trust. | Some case studies include:<br><br>**Ligature Audit App** Previously a ligature audit was completed on paper and then entered in an Excel Spreadsheet. Our App enables automation of the ligature audit process, replacing a series of complex spreadsheets and adding robust data validation. The app also includes integrated reporting giving an overview of audit compliance and enabling staff to identify key risk areas. |

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| | | **The LD Day Planner** provides a digital view of the week ahead, promoting well-being and providing a routine, vital to some of our residents' wellbeing. Staff use the admin side of the app to build custom plans of activities and day events. Residents then access the Day Planner via a large format display in communal areas, by selecting their name and avatar. Designed for our LD care homes, the app replaces a manual solution using laminated paper and Velcro stickers and provides and improved experience for residents and care staff alike.<br><br>**Flu Hub** It's of vital importance our staff receive the option to have a Flu Jab, assisting in the safety and protection of our local population. Previously this vital service was recorded on paper forms and updated to a spreadsheet. The Flu Hub enables users to book their flu vaccination and record the uptake of the Flu vaccinee. Plans for a re-design for winter 2022-3 are already underway and promise to make a great app even better with enhanced reporting and reminders for staff with booked vaccinations.<br><br>**COVID Risk Assessment** This was a paper form and email service previously, the COVID Risk Assessment generated a lot of data, which need to be recorded in a safe and secure manner. During the height of COVID, all staff were asked to complete a COVID Assessment on their personal risk, family risk and needs around COVID. This App enabled staff to securely record information and enable the Trust to assist staff as required. This App provides clear reporting and secures the data |

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| Surrey Care Record | The Surrey Care Record is an Electronic Health Record (EHR) linking system that brings together patient information across health and care systems in a secure manner, giving a summary of your information which is held within a number of local records | The following data is from the SCR 2022 annual survey (this comprised of 1413 replies). Of the respondents:<br><br>90% would recommend the Surrey Care Record to others<br>60% used the Surrey Care Record every day or a few times a week<br>20% used the record less than once a month<br>74% described the record as 'essential', 'very useful' or 'useful'<br>73% said that the record had improved the way they deliver care<br>66% felt that the record had improved decision making at the point of care<br><br>Top benefits from those with a clinical role:<br>1. Increases patient safety/reduces clinical risk<br>2. Influences care/treatment provided<br>3. Facilitates a timelier patient journey<br>4. Informs a more joined up pathway when moving across health and social care<br>5. Influences prescribed or administered medication<br><br>The use of the Surrey Care Record across the system including at SABP continues to grow. Note there is not impact data available beyond provider level. There is further work to do in raising the awareness of specific data sets available relevant to different teams.<br><br>"Having the Surrey Care Record where details of past psychiatric history is given, whether somebody had admissions in the past, was detained, previously prescribed |

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| | | antidepressants, or whether there was any past history of deliberate self-harm, really helps me do assessments.<br>I found that having this facility has improved my ability to care for my patients, manage my time and have a good management system for patients which is safe, robust, and also evidence based.<br>The Surrey Care record is a very good example of the interface between mental health and physical health. Historically, they are considered two separate things and getting access to medical notes can be a difficult thing from a psychiatrist's point of view, and for consultants in hospitals it can be difficult to access mental health notes. The Surrey Care Record helps you look at a patient holistically.<br>I believe it is a very good way of working together and should be the way things move forward." - **Kapil Kashyup, consultant psychiatrist, older adults** |
| Surrey Information Point | For anyone living in *Surrey* for local care and support, health and wellbeing *information* for adults. With lots of information on mental health | • On Surrey Information Point, there were **178 page views to the Mental Health landing page in June 2022**.<br>• On the Surrey CC website, there were **256 page views on the Mental Health landing page in June 2022**.<br>An exercise is currently underway to evaluate both current and potential new Surrey Information Point to inform the future service. |
| Surrey Virtual Wellbeing Hub (Surrey wide via VCSE (residents – adults focus) | With lockdown looking likely, this platform was set up to provide digital connections across VCSE organisations in one place. It continues to provide details for online offers. | The visibility of offers helps providers to collectively consider where there is a need to fill gaps (e.g. at the weekend or in the evenings). There are opportunities to evolve and develop this product. |

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| Surrey Virtual Trips | Via the voluntary sector, a selection of virtual trips have been provided. These have been to an array of different locations, in Surrey and beyond, including Monkey World in Dorset, Hever Castle in Kent and Brooklands Museum in Surrey. | Approx. 200 Surrey residents facing the most barriers to getting out and about again have joined group live virtual trips. These have, in some instances, acted as a stepping stone for people to build confidence to attend in real-life and 'practice' before they do so. |
| Technology integrated health management service (TIHM) remote monitoring | TIHM is a remote monitoring service that utilises smart technology to aim to improve quality of life for vulnerable people, as well as allowing them to live more independently in their own homes. It also offers support to families and informal caregivers and has supported 550 people living in the community.<br><br>Due to the impact of COVID-19 on vulnerable people, including those with dementia, TIHM was adapted to help support those who were isolating and may have felt uncomfortable with attending hospitals. It is based on the award-winning TIHM for dementia system developed by Surrey and Borders Partnership, University of Surrey and Howz. The service combines digital devices installed in homes with data analytics and a dedicated NHS Monitoring Team monitoring care. | Evaluation data – based on collection Dec 2020 – Jan 2021<br><br>Social outcomes:<br><br>42% reduction in care home admission and also quality of life benefit<br>60% of users feeling less anxious.<br>0kg of C02e emissions saved per TIHM user per year<br><br>Patient outcomes:<br><br>32% reduction in emergency admissions<br>13% reduction in ambulance callouts<br>23% Reduction in inpatient stays in hospital<br>27% Reduction in attendees that required no treatment<br><br>Financial outcomes:<br>£6.7 million Potential gross saving to local authorities over 5 years by reducing care home placements<br><br>£1.10 5 year ROI for every £1 spent |
| Tech to Community Connect | Tech to Community Connect is a digital inclusion service Surrey wide via the VCSE. "We provide devices, digital literacy training and confidence-boosting support to people from all over Surrey" | Impact of intervention measured against 1) digital exclusion and 2) loneliness (measure designed by Surrey University). For both outcomes, the service has delivered over 90% of respondents showing a decrease after 3-months. |

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| | The service has supported approx. 5, 000 residents to date. Residents are offered a device, data (a 6-months free Vodaphone sim), matching with a volunteer Tech Angel and a menu of training modules to work through. | |
| Workforce development – smart technology and independent living | System workforce groups have received training, both to become 'Tech Angels' and also in smart technologies that are commercially available and their applications for independent living. | |