ADULTS AND HEALTH SELECT COMMITTEE

13 April 2023

UPDATE ON PROGRESS AND EFFECTIVENESS OF COMMUNITY MENTAL HEALTH TRANSFORMATION FOR ADULTS & OLDER ADULTS

Purpose of report: To provide the Adults and Health Select Committee with an update on progress and effectiveness of community mental health transformation for adults and older adults with significant mental health needs across Surrey Heartlands ICS and part of Frimley Health and Care ICS (Surrey Heath and Farnham)

Introduction:

1. Surrey Heartlands and Frimley Health and Care Integrated Care Systems (ICSs) are 2 of 12 early implementer sites in receipt of 5 years' transformation funding since 2019/20 to test new integrated models of primary and community mental health care built around Primary Care Networks (PCNs), in line with the NHS Long Term Plan (LTP) and NHS Community Mental Health Framework for Adults and Older Adults. This model also aligns with the more recent Fuller Stocktake and the recommendation to create multi-specialty neighbourhood teams.

2. At the Committee meeting on 3 March 2022 a report on the Community Mental Health Transformation Programme (CMHTP) was presented Report (surreycc.gov.uk). The report focused on the significant work underway across Surrey to fully implement by the end of 2023/24, the LTP vision for a new integrated model of primary and community mental health care for adults and older adults with significant mental health needs.

3. The Committee recognised the role of the CMHTP in delivering Priority 2 of the Surrey Health and Wellbeing Strategy: Enabling the emotional well-being of people by focusing on preventing poor mental health and supporting those with mental health needs so people have access to early, appropriate support to prevent further escalation of need.

4. This document provides the Committee with further detailed information on transformation progress, including impact/effectiveness of the new primary care mental health service known as GPimhs (General Practice Integrated Mental

Health Service) in Surrey Heartlands ICS and MHICS (Mental Health Integrated Care Services) in Frimley ICS.

National Context

5. The need for mental health services is likely to rise due to increases in the mental health needs of the population, particularly due to the unprecedented impact of COVID-19 and the cost of living crisis. A recent survey across the UK found that nearly half of adults say the cost-of-living crisis is impacting their mental health. Additionally research has shown an increase in recorded mental health prevalence across the COVID-19 pandemic, with people that had poor mental health before the pandemic experiencing greater disruption to their lives.

6. The LTP commitment to grow investment in mental health services faster than the NHS budget overall for the period 2019/20 to 2023/24, is enabling each of the 42 area-based ICSs across England to redesign and reorganise core community mental health teams. The Community Mental Health Framework describes how the LTP's vision for a new integrated model of primary and community mental health care for adults and older adults with significant mental health needs, can be realised and how community services should modernise to offer whole-person, whole-population health approaches aligned with PCNs. NHS England and NHS Improvement (NHSEI) have developed a short video that describes the principles of the Community Mental Health Framework as per the LTP vision, and how different organisations need to work together to develop new integrated models, with service users, carers, and other experts by experience.

7. The CMHTP is responsible for achieving key LTP deliverables 1 and 2 for community mental health– core model and dedicated focus, by the end of 2023/24 (see Appendix 1). This includes contributing towards the national target that new models of care, underpinned by improved information sharing, will give 370,000 adults and older adults with significant mental health needs greater choice and control over their care, and support them to live well in their communities.

New Integrated Model of Primary and Community Mental Health Care

8. The NHS Community Mental Health Framework recognises that community mental health services have long played a crucial role in the delivery of mental health care, providing vital support to people with mental health problems closer to their homes and communities since the establishment of generic community mental health teams for adults 30 years ago - however, this traditional service model is in need of fundamental transformation and modernisation to address fragmentation and discontinuity of care, historic timely access and quality gaps.

The Framework supported by LTP investment, provides a ‘once in a generation’ opportunity to address these gaps to achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services towards joined up care and whole population approaches, and establishing a revitalised purpose and identity for community mental health services.

9. New models of care are the vehicle for enabling a way for the NHS to transform and integrate health and social care services by dissolving the barriers that historically exist between primary and secondary care. More than redesigning or introducing new services, new models of care enable whole system transformation to improve the way services are delivered to support people being able to remain independent, safe and well as close to home as possible. Surrey and Borders Partnership NHS Foundation Trust (SABP) is leading on transformation of community mental health services on behalf of Surrey Heartlands ICS and Frimley South (part of Frimley ICS), working in partnership with PCNs, as well as local authorities and the Voluntary, Community and Social Enterprise sector (VCSE), service users, carers, and local communities themselves.

10. Implementing any new model of care is inherently challenging due to the scale and complexity of changes in how separate organisations within a health and social care system work together differently to support the needs of the local population. An additional challenge is that unlike other industry sectors, health and social care services cannot temporarily shut down to make the changes then reopen as the new transformed model. Appendix 2 shows the NHS key components of the new integrated model of primary and community mental care for new models of care. Access to the new integrated model is at PCN level, each of the 27 PCNs in Surrey typically serving a local population size of between 20,000 to 100,000. It is for these reasons, supported by national guidance that the new integrated model of primary and community mental health care is being implemented in phases, adopting a continual PDSA (Plan-Do-Study-Act) cycle approach to ensure safer and less disruptive changes for patients and staff - by testing out changes on a small scale, building on the learning from these test cycles in a structured way before wholesale implementation. Embedded within the phasing of community mental health transformation is (i) co-production of new service models with people with lived experience of significant mental health needs and their carers, and (ii) co-development of the strategic, tactical and operational requirements for the long term, short-term and day to day running of the new integrated model of primary and community mental health care.

Funding

11. LTP funding for community mental health is the biggest investment in mental health since the inception of the NHS, because of historic timely access and quality gaps. Across Surrey Heartlands and all of Frimley South (North East Hampshire and Farnham) the NHS is investing £35.9 million, in 5 years of transformation (2019/20 to 2023/24), to recruit new workforce and radically redesign community-based mental health services in partnership with PCNs as well as local authorities and the VCSE sector, service users, families and carers. By 2024/25 the new recurrent services implemented during transformation, will be fully operational in business as usual. The majority of spend is on new workforce across both the NHS and VCSE commissioned partners (Andover MIND, Catalyst, Mary Frances Trust and Richmond Fellowship). Table 1 below shows the annual allocation of funding.

Table 1: Annual allocation of transformation funding

Surrey Heartlands ICS

Year	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	£000	£000	£000	£000	£000	£000
Total Transformation Spending	**1,524**	**2,055**	**5,090**	**6,162**	**11,348**	**10,975**
NHS Allocation	1,351	1,508	3,614	4,535	9,624	9,611
VCSE Allocation	173	547	1,476	1,375	1,404	1,364
SCC Allocation				199	398	
Other Allocation				145	40	

Frimley South (part of Frimley ICS)

Year	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	£000	£000	£000	£000	£000	£000
Total Transformation Spending	**414**	**791**	**1,956**	**1,974**	**4,570**	**4,432**
NHS Allocation	414	726	1,375	1,410	4,120	4,115
VCSE Allocation	0	65	581	472	332	317
SCC Allocation						
Other Allocation						

12. The aim of NHS investment in transformation is to drive measurable improvements in people's experience of community mental health services across three themes:

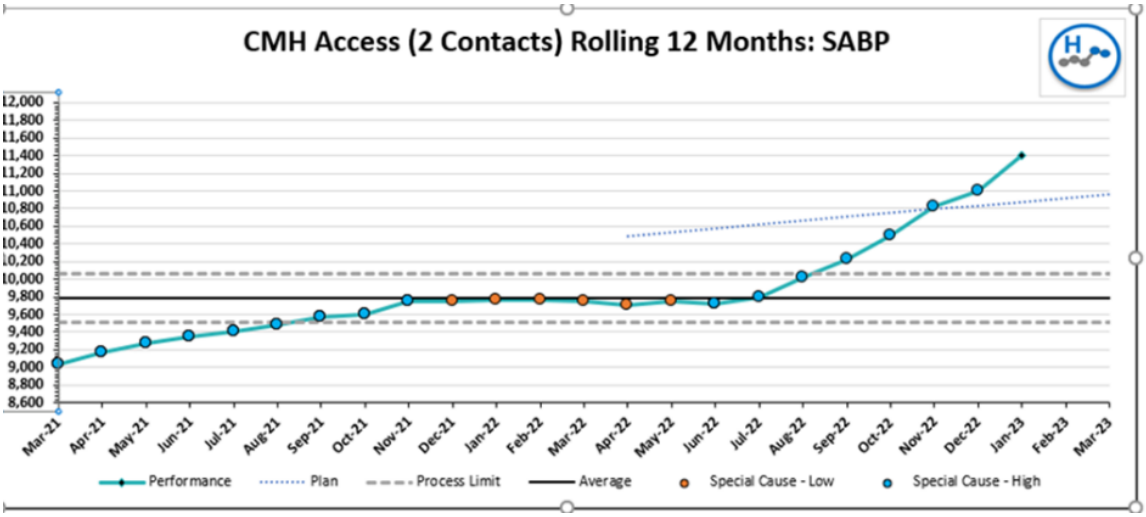
    a) **Access**: Increasing the number of people able to access services in the first place, so a greater proportion of estimated prevalence are being seen by services.

b) **Waiting times**: Reducing the amount of time people have to wait to be seen and receive help such as a clinical or social intervention.

c) **Quality of care**: Improving the quality of treatment and care people receive when they access services.

13. Chart 1 shows the positive impact of NHS investment in achieving the local LTP target to expand access in all transformed and traditional community mental health services across Surrey Heartlands. The positive step change in July 2022 reflects the phased migration of GPimhs and the Managing Emotions Programme (MEP) onto SystmOne from ITS (see para 17h). The upward trend from April 2022 is reasoned to be above the planned trajectory because the current national Mental Health Services Data Set (MHSDS) v5 definition, excludes a category of appointment data that has caused ~10% reduction in volume of 2 or more contacts that in previous versions of MHSDS would be included in the chart.

Chart 1: NHS LTP Commitment Figures in SystmOne based on MHSDS v5



Core community offer and dedication functions

14. The Community Mental Health Framework allows for a significant level of autonomy in terms of the precise place-based model of community mental health care developed by each local ICS. SABP and system partners have been innovative and bold in their approach to transformation, including:

a) Challenging the language of severe mental illnesses (SMI) used by NHSEI, instead focusing on ‘significant mental health needs’ to allow a much broader approach when identifying need in primary care. NHSEI are in support of this local approach.

b) Embedding in the day to day practice of all teams, an ethos/philosophy of relationships and partnership working to support people to access the right help, at the right time, closer to their own communities or neighbourhoods.

i. **Direct support** for individuals experiencing significant mental health difficulties. Working with people to identify their needs and taking a recovery focused, strength-based, patient centred approach that supports people in achieving their mental health and wellbeing goals.

ii. **Knowledge sharing**. Developing relationships across health and social care system partners, promoting a more mental health 'friendly' landscape within which our communities reside. This can range from supporting services to make use of the excellent Psychologically Informed Consultation and Training (PICT) service, to sharing knowledge and providing consultations to help primary care and other services we work alongside feel more confident in supporting people with significant mental health needs.

iii. **Identifying and highlighting barriers** to access and working together with a wide range of partners across health, social care and VCSE commissioned partners, including lived experience, to identify creative solutions to addressing these barriers.

15. The new transformed and transforming services that encompass the inclusive core community-based offer and the dedicated functions linked to the core offer are described in Appendix 3. Table 2 lists these news services, their geographical coverage and funding type.

Table 2: List of the new transformed/transforming service

	New Transformed/Transforming Service	Geographical Coverage	Funding Type
New Integrated Core Community Offer	**GPimhs (General Practice Integrated Mental Health Service) / MHICS (Mental Health Integrated Care Services)**	PCN Level (across all of Surrey and NE East Hampshire)	Recurrent funding (ongoing)
	Primary Mental Health Practitioners (ARRS)	PCN Level (across parts of Surrey and NE East Hampshire)	Recurrent funding (ongoing)
	Lived Experience Practitioners Service	PCN Level (across parts of Surrey and NE East Hampshire)	Recurrent funding (ongoing)

	New Transformed/Transforming Service	Geographical Coverage	Funding Type
Dedicated Functions Linked to New Offer	**Dedicated Citizens Advice Mental Health Caseworker Service**	Frimley South and Spelthorne	Recurrent funding (ongoing) in Frimley South Pilot funding (non-recurrent) in Spelthorne
	Primary Care Enablement Pilot Service	NW Surrey	Pilot funding (non-recurrent)
	SUN (Service User Network)	Across all of Surrey and NE East Hampshire	Recurrent funding (ongoing)
	MEP (Managing Emotions Programme)	Across all of Surrey and NE East Hampshire	Recurrent funding (ongoing)
	PICT (Psychologically Informed Consultation and Training)	Across all of Surrey and NE East Hampshire	Recurrent funding (ongoing)
	AEDimhs (Adult Eating Disorders Integrated Mental Health Service)	Across all of Surrey and NE East Hampshire	Recurrent funding (ongoing)
	HOMEFirst – enhanced community mental health rehabilitation	Across all of Surrey and NE East Hampshire	Recurrent funding (ongoing)

Transformation Progress

16. There are now more than 18 workstreams running concurrently within the transformation programme, to fully implement the new integrated model of primary and community mental health care for adults & older adults with significant mental health needs. With a dedicated transformation programme delivery team based in SABP consisting of a range of expertise across the strategic, operational, project, digital, finance and contracting requirements of transformation.

17. Key highlights of progress over the last 12 months:

    a) GPimhs/MHICS play a key role in supporting carers and take the whole family's needs into consideration when engaging with a person. A model of support has been co-developed (see Appendix 4).

    b) The difficulty in recruiting ARRS primary care mental health practitioners in each PCN, is reflected nationally across all ICSs. This ongoing challenge is successfully being mitigated across Surrey, by new approved arrangements with Health Education England (HEE), who are fully funding course fees and first year salary of graduate trainee Health and Wellbeing Practitioner roles, with Sussex University as the course provider.

    c) Integrated partnerships with PCNs, GP practices, VCSE commissioned partners and adult social care providers are continuing to be strengthened by the new Pathways Forums that enable 'easy in/ step up' access from primary care to evidence-based treatment in specialist secondary community mental health care services; and 'easy out/step down' safe and well-supported transfer of people back into primary care from specialist secondary community mental health care services.

    d) A written local strategy has been co-developed for implementing increased access to NICE-recommended psychological therapies for psychosis, 'personality disorder', eating disorders and bipolar disorder. This is in response to national recognition that less 10% of those who could benefit from evidence-based psychological therapy are accessing help. Further engagement with experts by experience and system partners will be undertaken before the strategy is finalised. Age inclusivity is an important and quite complex element to this strategy, particularly in regard to appropriate psychological therapy services for older adults (65+ years).

    e) A dedicated Community Transformation Lead for Older Adults joined CMHTP last year to co-develop a range of approaches to ensure there is no difference in access to the new transformed services for older adults. Recognising there are differences based on presenting issues, needs and risks a deep dive into the service offer by Community Mental Health Teams for Older Peoples (CMHTOP) is underway.

    f) Significant progress has been made in supporting Young Adults (age 18 to 25):

        i. Stronger partnership working is now in place with CYP Mental Health Services to better support individuals transitioning to adult mental

health services or transitioning out of CMH services back into their local community.

ii. Young Adults are now the highest proportion age range referred into GPimhs/MHICS (see Appendix 5), meaning they have quicker access to a range of specialist mental health early interventions and are bridged into community assets, that were historically not being offered.

iii. Surrey Heartlands Young Peoples Mental Health Strategy Action Board has commissioned a dedicated Transitions Champion clinical role to support young adults transitioning from the specialist community Children's Eating Disorders Service to the specialist community Adult Eating Disorders Services.

iv. The FREED pathway, promoted by South London and Maudsley NHS Foundation Trust in partnership with King's College London, has been embedded to give young people who have had an eating disorder for three years or less, rapid access to specialised evidence-based treatment and support tailored to their needs. This innovative treatment approach is to help young people with eating disorders as early as possible for a better chance of full recovery.

v. The Citizens Advice Mental Health Caseworker service is supporting young adults referred by GPimhs/MHICS with a range of issues that could otherwise have triggered a mental health crisis. Such as preventing homelessness and supporting return to university through novel student financing.

g) To further build GP relationships and confidence in managing mental health in primary care, a new improved Advice and Guidance service was launched on 1st March 2023.

h) SABP Digital Transformation Team have successfully migrated all GPimhs/MHICS and Managing Emotions Programme (MEP) records (more than 14,000) from the Interim Tactical Solution (ITS) onto SystmOne used by all traditional SABP community mental health services. Bespoke SystmOne units have also been built for all VCSE commissioned partners – Richmond Fellowship, Catalyst, Mary Frances Trust and Andover MIND. The key benefits realised by this migration are:

i. Improved accuracy of nationally reported performance against LTP targets, because ITS data could not be submitted to the national Mental Health Services Data Set (MHSDS).

ii. Historic challenges of NHS recording access data from VCSE commissioned partners has been overcome.

Mental Health Needs in the Community

18. There are inherent challenges in accurately quantifying mental health needs of a local population, more so for the new integrated model of primary and community mental health care because access is not dependent on diagnosis - anyone aged over 18 who is registered with a GP and is experiencing difficulties in life that are significantly affecting general emotional wellbeing and mental health that impacts on level of everyday activity and personal relationships, can be referred by their GP to GPimhs/MHICS.

Mental health equity

19. To better understand and respond to the mental health needs of the local population:

    a) A team of 3 Co-Production & Community Engagement Officers, employed by Surrey Coalition for Disabled People's Independent Mental Health Network (IMHN), joined CMHTP in January 2023 to collectively work across 5 days a week until 31st March 2024. The main purpose of these roles is to empower people with lived experience of mental health issues, to utilise their expertise to improve the way community mental health services in Surrey are developed, reviewed and delivered through co-production and involvement with local people in the community. Over the coming months they will be exploring innovative community engagement approaches, including with groups who are often under-served/or un-heard, to identify and develop recommendations for improvement.

    b) The CMHTP has also commissioned Surrey Public Health to recruit a Public Health Lead for 12 months with a dedicated focus on addressing mental health equalities. This Public Health Lead role will be embedded across GPimhs/MHICS to co-develop and deliver strategies to tackle inequalities in adult community mental health to improve access, experience and/or outcomes; particularly for groups of people who historically experience inequalities in accessing community mental health services.

Pressure on primary care services

20. NHSEI states that nine out of ten adults with mental health problems are supported in primary care. Prior to the transformational changes outlined in the Community Mental Health Framework, the arrangements for mental health in primary care for people with a wide range of mental health conditions, including people with high levels of need and complexity did not serve the interests of patients or professionals.

21. Traditionally when multiple services provide care, multiple assessments can be common. This is distressing for the person, increases the chance of drop out, delays treatment and is a poor use of resources. This in turn puts pressure on primary care services as people with legitimate care needs have in the past been excluded from mental health teams as they do not fit rigid service specifications or meet often arbitrary thresholds.

22. GPimhs/MHICS is the new front door for adults and older adults with significant mental health needs and is helping to relieve pressure on primary care services – by supporting people in primary care who historically could not access community mental health services because they were 'not ill enough' to meet the high threshold for the traditional community mental health teams and/or were too complex for IAPT (now known as NHS Talking Therapies) services.

Impact & Effectiveness of GPimhs/MHICS

23. Whole system transformational change typically takes upwards of 3 to 5 years before measurable benefits are realised. The impact of Covid19 and the cost of living crisis also presents new challenges in demonstrating impact due to the unprecedented upsurge in mental health difficulties faced by local populations. This report is focusing on the indicative impact and effectiveness of GPimhs/MHICS because this new primary care mental health service, is the fundamental building block for the new integrated model of primary and community mental health care.

24. GPimhs/MHICS is now operational across 22 out of the 27 PCNs. See Appendix 6 for a map showing spread of GPimhs/MHICS across Surrey.

25. Since launching in 2019, 19,478 Surrey citizens have been referred to GPimhs/MHICS up to end February 2023 (see table 3). The majority of these referrals are likely to have been people whose needs would not have been met before the introduction of GPimhs/MHICS PCN teams: a major achievement against NHSEI's aim of reducing unmet mental health need and breaking the cycle of people 'bouncing' from referral to referral around the health and social care system.

Table 3: GPimhs/MHICS Launch Dates & Referrals (up to Feb 2023)

SURREY HEARTLANDS

GPimhs Team	Launch date	Referrals since launch (to Feb 2023)	Proportion of total referrals
BANSTEAD HEALTHCARE PCN	Oct-19	1,795	0.105
COCO PCN	Oct-19	1,536	0.090
NORTH GUILDFORD (GPIRC) PCN	Oct-19	2,288	0.134
GUILDFORD EAST PCN	Mar-20	718	0.042
SASSE NETWORK 2 PCN	Mar-20	1,907	0.112
LEATHERHEAD PCN	May-20	1,454	0.085
NORTH TANDRIDGE PCN	May-20	1,113	0.065
WOKING WISE Team A	Jul-20	1,205	0.071
WOKING WISE Team B	Jul-20	1,186	0.070
EPSOM PCN	Sep-20	1,347	0.079
INTEGRATED CARE PARTNERSHIP PCN	Sep-20	948	0.056
CARE COLLABORATIVE PCN	Apr-22	495	0.029
EAST ELMBRIDGE PCN	Apr-22	271	0.016
WHAM PCN	Apr-22	220	0.013
EAST WAVERLEY PCN	Aug-22	226	0.013
SASSE NETWORK 3 PCN	Sep-22	249	0.015
SASSE NETWORK 1 PCN	Nov-22	71	0.004
SOUTH TANDRIDGE PCN	Feb-23		
HORLEY PCN	Mar-23		
REDHILL PHOENIX PCN	Apr-23		
DORKING PCN	TBD		
WALTON PCN	TBD		
WEST BYFLEET PCN	TBD		
WEST WAVERLEY PCN	TBD		
Total		**17,029**	**1**

FRIMLEY SOUTH (Surrey only)

FARNHAM PCN	Apr-20	891	0.364
SURREY HEATH PCN	Jun-20	1,558	0.636
Total		**2,449**	**1**

26. Primary Care colleagues continue to provide positive feedback on the difference GPimhs/MHICS are having on addressing traditional unmet need and stopping people "bouncing" around services. The GP Mental Health Lead for COCO PCN says that:

"GPimhs has made a difference on multiple levels for us. One of the main differences is that patients are actually leaving [GP] consultation room feeling that they have been listened to and that they actually have a plan and they are going to see a professional who is going to help them through their journey. It has reduced their waiting times of actually getting help so from seeking help to

getting help on average used to take 3 to 6 months to get through to Talking Therapies yet alone any psychiatric input and now they are being contacted and spoken to within 2 weeks….what I love about it the most is when a patient turns round to me and says 'I am fine I don't need you they are meeting all my needs' and that is genuinely an amazing feeling because as a GP a lot of the time the struggles that we face as clinicians is that we feel frustrated that we can't get a patient to where they need to go and the bouncing [so] the reward of a patient saying 'they are in the right place I don't need you to call me back' is a good feeling to know they are getting the care they need as quickly as possible"

Specialist mental health pharmacist medicines optimisation service for people under primary care

27. The Royal Pharmaceutical Society has recently published a service evaluation into the GPimhs specialist pharmacist role. A retrospective review of medical records for people supported by the GPimhs specialist pharmacist between September 2021 and March 2022 was undertaken. The aim was to evaluate the input and impact of the specialist pharmacist for one GPimhs PCN site - specifically the level of medication review, type of recommendation and whether the advice was accepted or rejected. Recommendations comprised of advice on mental health treatment and/or physical health monitoring.

28. The evaluation found that of the recommendations made 89% were accepted. Requests contributed to reduced number of referrals to secondary care specialist community mental health teams, where there is no specialist pharmacist provision. Most recommendations related to switching antidepressant treatment, an area which could form part of training for primary care teams. The nature of the significant recommendations highlighted the importance of holistic review of physical and mental health medications.

Managing Emotions Programme (MEP)

29. GPimhs/MHICS have supported 2,851 people coping with complex emotional needs or traits of a 'personality disorder' (no diagnosis needed), by bridging them to the Managing Emotions Programme that offers psychoeducation courses and empathic support. Those completing MEP courses have reported feeling less judged, an increased understanding of their emotional distress, confidence to move forward with their lives and more techniques to manage their emotions. Table 4 shows a consistently positive paired PROM (patient reported outcome measure) for emotional confidence, with the 'I can look after my emotions' scoring the highest before and after difference for people completing a MEP course. Additionally this table shows a consistently positive patient reported experience measure (PREM) with 'treat you kindly' and 'listen and explain' on average scoring the highest.

Table 4: Managing Emotions Programme outcome and experience measure

	Sep 20 – Jan 23			Jan 2023		
Measure	Before	After	Diff	Before	After	Diff
Emotional Confidence	40 (n251)	62 (n251)	+22**	44 (n9)	71 (n9)	+27**
I know enough about my emotions	38	62	+24**	33	67	+34**
I can look after my emotions	19	48	+29**	22	63	+41**
I can get the right help if I need it	42	63	+21**	52	74	+22**
I am involved in decisions about me	62	73	+11*	67	81	+14*
Service Experience	-	94 (n395)	-	-	97 (n19)	-
Treat you kindly	-	96	-	-	98	-
Listen and explain	-	95	-	-	98	-
See you promptly	-	92	-	-	98	-
Well organised	-	92	-	-	95	-

Very low 0-39 | Low 40-59 | Moderate 60-79 | High over 80 | Difference: * between 10 and 20, ** over 20.

30. Carers can also self-refer onto a co-produced MEP carers courses. Since it was launched in April 2021, more than 109 carers of people with complex emotional needs have self-referred to this carers course, giving consistently positive feedback:

"The presenters were excellent - they went through the coursework methodically and in a logical format but their greatest skills were the personal experiences that they shared with the group. They imparted such insight into the minds and lives of sufferers that I, as a carer, cannot get from the person I care for. And the biggest gift is the evidence that allows me to hope that my daughter does have the possibility of a happy and fulfilled life".

Primary Care Citizens Advice Mental Health Caseworker Service

31. GPimhs/MHICS supports people coping with practical problems such as debt, housing, employment and immigration, by bridging them to the primary care Citizens Advice Mental Health Caseworker service. Client groups include refugee, student, bereaved, newly released from prison, single parents. Many of the issues that this dedicated Citizens Advice service supports individuals on can be a trigger for a mental health crisis. The results of paired goal based outcomes reported for clients, consistently shows an improvement after being supported, and monthly case stories from Citizens Advice consistently report positive outcomes:

"Client A suffers with Bi-Polar Disorder and we determined that her circumstances meant that she and her children could be classed as legally homeless and in priority need. She was listened to, she was supported through the process of getting into a refuge in a few hours. She was supported through the complex repercussions on her benefits. She was supported with her long

term housing options. The impact on her mental health has been immensely positive. She now says that her confidence has improved. She said that she felt the only people who wanted to help were Citizens Advice and the MHICS team"

32. The Frimley South Citizens Advice primary care mental health caseworker service has been in business as usual since 2020. Total referrals received so far this financial year between April 2022 to December 2022 is 58, including 3 repeat referrals; compared to 151 referrals to the similar established secondary care mental health caseworker service [caveat: the primary care service has only recently become fully operational across all of Frimley South]. See Appendix 7 for key statistics for quarter 3 (Oct to Dec 2022).

GP practice non-urgent referrals to specialist community mental health services

33. A positive impact of GPimhs/MHICS on the number and quality of GP practice routine (non-urgent) referrals to Community Mental Health Recovery Services (CMHRS) for working age adults (18 to 64 years old), is demonstrated when comparing GP referral activity in PCNs that have an operational GPimhs/MHICS teams compared to PCNs without GPimhs/MHICS. Table 5 shows:

    a) 20% reduction in the number of routine referrals from GPs to the SABP Single Point of Access (SPA) for referral to CMHRS. This indicates that GPimhs/MHICS is helping to reduce demand on the SPA, enabling a release of capacity to help the SPA handle the high level of referrals from health and social care professionals.

    b) 24% reduction in the number of onward referrals after triage from the SPA to CMHRS. This indicates that GPimhs/MHICS is helping to reduce demand on very stretched secondary community mental health care teams, enabling a release of capacity to help them focus on providing more specialised interventions for those with higher complexity of need.

    c) 17% reduction in the number of referrals from SPA back to the GP. This indicates that GPimhs/MHICS is helping to improve the quality of referrals, ensuring people get seen in the right place at the right time without 'bouncing' back to their GP.

Table 5: Comparison of GP routine referrals to CMHRS in PCNs with GPimhs/MHICS vs PCNs without GPimhs/MHICS

Activity for the period Jan21 - Oct22	GP Practices with GPimhs/MHICS	GP Practices without Gpimhs/MHICS	
Number of Practices	96	31	
Practice list size	1,084,875	332,207	
			% reduction if Gpimhs/MHICS in place
Number of routine referrals from GP's to SPA	10,196	3,922	
Average number of referrals per 1,000 list size	9.40	11.81	**20%**
Number of SPA routine referrals to CMHRS	5,800	2,336	
Average number of referrals per 1,000 list size	5.35	7.03	**24%**
Number of SPA referrals back to GP	1,005	369	
Average number of referrals per 1,000 list size	0.93	1.11	**17%**

Independent evaluation

34. The National Association of Primary Care (NAPC) recently conducted a GP practice audit across North Guildford PCN to evidence impact/effectiveness of GPimhs. The audit analysis is across 4 domains: (1) Profile - to see a demographic and general health profile for patients, (2) Medical - to see a clinical profile for patients and their long-term conditions, (3) Patient - to see the impact of GPimhs on proxies for patient mental health, and (4) System - to see the impact of GPimhs on the system. A positive impact trend appears to be emerging in the subsequent 3 years after being seen by GPimhs in 2019 – including suggesting improvements in sleep problems, anxiety or depression, as well as fewer GP appointments and A&E attendance. The overall audit findings will feed into Unity Insights 1st interim evaluation report.

35. Unity Insights are currently preparing their 1st interim evaluation report for Surrey Heartlands CMHTP, focused specifically on the impact & effectiveness of GPimhs. The report findings will be circulated to the Committee in April. Table 6 lists the areas of interest to be addressed in the evaluation report and the associated challenges.

Table 6: Areas of interest in the 1st interim independent evaluation report

Area of interest	Associated challenges
How many people are accessing GPimhs compared to numbers that should be accessing GPimhs based on the needs of the local [PCN] population?	Quality and Outcomes Framework (QOF) data will be used to understand the estimated prevalence of patients on the registers for mental health and depression. The estimated prevalence is anticipated to be greater, given the rise in mental health needs in recent years.
How do we know the value of GPimhs?	Value can be discussed in multiple different ways, for example, value to patients, value to staff, value to the system, and economic value. Preliminary insights into value will be discussed in the 1st interim report, whilst further analysis will be required to understand wider impact. The other interim reports later in 2023 will capture insights from further analysis, including the views of patients and their carers, as well as health economic modelling.
Is GPimhs a geographically more accessible service, reducing unwarranted variation?	As GPimhs is still undergoing implementation across Surrey Heartlands ICS, not all PCNs have access to this service. Future analysis when fully rolled out will support insights into geographical variance. The other interim reports later in 2023 will capture insights from this future analysis.
Is there a reduced A&E usage and acute care bed overspill following implementation of GPimhs?	Surrey Heartlands ICS aggregated data has been provided to track the before and after patient journey across the healthcare system for a cohort of people referred to GPimhs in 2022/23. Data quality issues exist within the data e.g. A&E attendances.
Are there reduced referrals to specialist services (NHS, Local Authority)?	Due to the number of specialist services available across the ICS, core services have been focussed on in the report. Where there is a rising mental health need, volumes of appropriate/inappropriate referrals may provide more useful insights.
Is there a reduced burden on GP Practice staff and GP visits?	Stringent data sharing agreements are in place with Unity Insights Ltd for this independent evaluation to ensure they do not have access to patient identifiable data. This presents a challenge with 3rd party access to GP Practice datasets, due to the time/skills needed

Area of interest	Associated challenges
	to anonymise/pseudonymise patient datasets. To partially overcome this challenge, the NAPC have supported this independent evaluation by undertaking a GP Practice Audit in North Guildford PCN to provide aggregate insights for their GPimhs cohort. Future qualitative approaches with primary care staff across all PCNs in Surrey Heartlands could further explore impact, for inclusion in other interim reports later in 2023.
How does GPimhs fit into the bigger landscape?	Future activities, such as system dynamics modelling, and exploration of specific new transformed and transforming service areas will help to further identify this. The other interim reports later in 2023 will capture insights from these future activities.

Next Steps

36. Continued roll out and implementation of all the new transformed and transforming community mental health services across the whole of Surrey to achieve the key NHSEI deliverables and goals by 31st March 2024.

37. Over the next 12 months shaping the "One Team Approach" for wrapping services and resources around the mental health needs of local PCN populations is a main priority. This includes completion of a workforce remodelling strategy aligned with a review of demand & capacity across all the new transformed services, and working with the system to articulate the vision for beyond the NHSEI transformation programme on 31st March. It is also recognised that transformational change will continue beyond March 2024.

38. Co-develop with system partners the new way of doing business to strategically, operationally, contractually and financially manage the new integrated model of primary and community mental health care from 1st April 2024 onwards.

39. Continue to implement the comms & engagement strategy to raise awareness of the new integrated community based care and support offer available to all Surrey Citizens aged 18+ years with significant mental health needs.

40. Ongoing monitoring, continuing local focus and accountability to sustain the new integrated model of primary and community mental health care from 1st April 2024 and beyond. Including reviewing the impact of the new integrated

community mental health offer on the experience and outcomes for patients/service users/clients, adjusting practices to optimise access; final evaluation of economic, staff and system outcomes; and knowledge management to share lessons learned with system partners.

Recommendations

41. The Select Committee is asked to:

a) Note the significant progress and effectiveness of the new integrated model of primary and community mental health care across Surrey, as it continues to mature during transformation.

b) Support the long term sustainability of the new integrated model of primary and community mental health care for adults & older adults with significant mental health needs - as a key contributor to achieving Priority 2 of the Surrey Health and Wellbeing Strategy: Enabling the emotional well-being of Surrey citizens by focusing on preventing poor mental health and supporting people with poor mental health to have access to early, appropriate support to prevent further escalation of need, including care givers.

c) Receive the 1st interim independent evaluation report for Surrey Heartlands CMHTP being circulated to system partners in April 2023.

d) Request a detailed report to be brought to the Committee in 13 months time on completion of the national community mental health transformation programme.

Report contacts:

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Sources/background papers

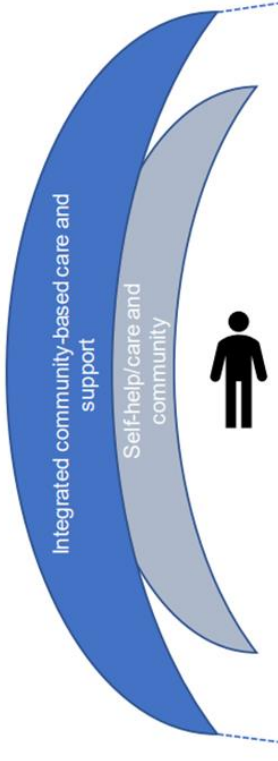
Minutes of the meeting of the Adults and Health Select Committee held on 3 March 2022

NHS Long Term Plan: Chapter 3: Better care for major health conditions - Adult mental health services

NHS Community Mental Health Framework. NHS England » The community mental health framework for adults and older adults

Evaluation of GPimhs Pharmacy: a specialist mental health pharmacist medicines optimisation service for people under primary care International (Journal of Pharmacy Practice, 2022, Vol. 30, No. S2). https://academic.oup.com/ijpp/article/30/Supplement_2/ii50/6854517#.Y4elFJd6XeY.mailto

Appendix 1: The NHS Long Term Plan national ambitions for community mental health



Key LTP deliverables and targets by 23/24 for community mental health			
1	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 those with SMI	Access to 370k people in transformed models + Expanding access in all (transformed / non-transformed) community mental health services
2	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 ' as part of wider action to improve support for 370k adults with SMI per year by 23/24.	
3	Physical health	Delivering an annual six-point comprehensive physical health check and follow up interventions as required to people with severe mental illness	390k people receiving annual physical health check
4	Individual Placement & Support	Providing employment support to people with severe mental illness via the Individual Placement and Support programme	55k people per year seen in IPS services
5	Early Intervention in Psychosis	Ensuring timely access and quality of care for people supported by Early Intervention in Psychosis	60% of people seen in 2 weeks 95% of services achieving Level 3 NICE concordance

Appendix 2: NHS key components of the new integrated model of primary and community mental care

Appendix 3: Description of New Transformed/Transforming Services in Surrey

	New Transformed/Transforming Service	Service Description	Geographical Coverage
New Integrated Core Community Offer	**GPimhs (General Practice Integrated Mental Health Service) / MHICS (Mental Health Integrated Care Services)**	First port of call for GP practice staff in seeking support for managing their patients with mental health presentations that do not meet criteria for secondary community mental health teams or NHS Talking Therapies (formerly IAPT). Taking an assets-based approach to building on people's skills and strengths, it focuses on significant mental health needs of adults and older adults, including people who: a) Access and utilise health and care services in a potentially chaotic pattern. b) Find it difficult to access the right service within communities to meet their needs. c) Have physical health concerns, medication dependence, substance misuse, or co-morbidity. d) Have physical long-term conditions that contribute to their poor mental health status e) Are 'held' by GPs resulting as frequent attenders and providing excessive proportions of nonmedical short-term prop-up interventions. GPimhs/MHICS aims to improve the patient journey of accessing community mental health services by removing the unnecessary barriers between primary and secondary care, providing quick and easy access to patients and their carers. 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. This is an opportunity for early intervention before patients may become further destabilised and unwell. Each PCN teams consists of: a Clinical Lead, Community Mental Health Practitioner, Community Connector (employed by VCSE commissioned partners), Administrator, Consultant Psychiatrist and Mental Health Pharmacist.	PCN Level (across all of Surrey and NE East Hampshire)

New Transformed/Transforming Service	Service Description	Geographical Coverage
Primary Mental Health Practitioners (ARRS)	This is a new role that sits within a PCN to provide support at GP practice level for day to day footfall. They see people contacting the GP practice requiring additional support but with lower complexity than seen by GPimhs/MHICS. These roles complement and are integrated with the GPimhs/MHICS service model, working as a part of the GP practice team providing mental health advice, referral screening, assessments, and bridging support in a timely way, to connect a person to the most appropriate mental health care service. The nature of the presenting mental health needs will vary from mild to moderate presentations to much higher levels of acuity. The ARRS (Additional Roles Reimbursement Scheme) was originally introduced by NHS England to provide additional funding to support PCNs expand their workforce with bespoke multi-disciplinary teams based on the physical health needs of the local population. In March 2021 NHS England introduced a new ARRS role – the primary mental health practitioner to support the new integrated community- based care and support offer. SABP employs the ARRS primary mental health practitioner, with funding split equally between the PCN (50%) and SABP (50%).	PCN Level (across parts of Surrey and NE East Hampshire)
Lived Experience Practitioners Service	The Lived Experienced Practitioners Service is provided by VCSE commissioned partners. The new co-produced roles work as an integral and highly valued member of GPimhs/MHICS. Through sharing wisdom from their own experiences of mental health difficulties or of caring for loved ones experiencing mental health difficulties, the Lived Experienced Practitioners aim to inspire hope and belief that recovery is possible in others. They provide formalised peer support and practical assistance to people using the service in order for them to regain control over their lives and their own unique recovery journey. In particular, the Lived Experienced Practitioner will	PCN Level (across parts of Surrey and NE East Hampshire)

New Transformed/Transforming Service	Service Description	Geographical Coverage
	support the smooth transition of people using the service to other mental health services, for example by helping them to complete recovery and crisis plans. Within a relationship of mutuality and information sharing, they will promote choice, self-determination and opportunities for the fulfilment of socially valued roles and connection to local communities.	
Primary Care Citizens Advice Mental Health Caseworker Service	This is a dedicated service integrated with GPimhs/MHICS for people aged 18+ receiving primary mental health care support. The service is fully operational across Frimley South and is currently being piloted with GPimhs teams in SASSE 1,2,3 and COCO PCNs. Citizens Advice (CA) has evidence that people suffering from mental health problems struggle to access the general public CA service and other statutory services for the following reasons: ▪ Anxiety that makes it hard to manage waiting rooms/phone queues. ▪ Fear of strangers making the general CA service model that uses multiple volunteer advisers unsuitable. ▪ Behaviours which may be perceived as challenging which require additional training to understand and manage. ▪ Requirement for extra support to address complex mental health issues. ▪ Lack of integration across support workers and services ▪ Ongoing casework and support is not provided by our generalist service The aim of the Primary Care CA Mental Health Caseworker service is to: ▪ Improve the quality of life for adults with mental health needs, through access to a specialist service tailored to the client group, providing free, independent, confidential and impartial advice for people who due to their mental health needs are inhibited from using general CA advisory services at that point in time.	Spelthorne (pilot) and Frimley South

New Transformed/Transforming Service	Service Description	Geographical Coverage
	▪ Support, educate and raise awareness to ensure people with mental health problems are appropriately supported within general CA advisory services, and with other stakeholders. ▪ Obtain additional and appropriate benefits for the clients, to assist independence, and support their recovery. ▪ Manage and reduce the debt burden of clients with a mental illness. ▪ Support resolution of housing or employment issues that may have a negative impact on their independence and mental well-being. ▪ Raise local and national awareness of the types of problems encountered by clients of the service. ▪ Reduce anxiety and stress by ensuring that clients that would benefit from support are able to access an advisor, or supported to do so, prior to escalation of their issues having a detrimental effect on their mental health. The dedicated CA Mental Health Advisor: ▪ Provides personalised advice and support to enable people to maintain their daily living activities by removing barriers which cause hardship whilst working in partnership with local PCNs and partner organisations. ▪ Supports people with practical advice and additional support to deal with unmanageable debt, to maximize their incomes through accessing benefits, to resolve issues such as risk of losing housing or employment. ▪ Offers holistic support across issues [CA research shows clients with mental health problems have on average 5 separate advice problems]. ▪ Provides consistent follow up support rather than one-off intervention.	
Primary Care Enablement Pilot Service	CMHTP has commissioned Surrey County Council to employ a team of social care Enabling Independence Workers (EIWs) led by an Occupational Therapist (OT), to provide this new pilot service integrated with GPimhs PCN teams acting as a local hub for integrated health, social care and support in primary care for individuals experiencing mental health and/or substance use issues. Whilst the focus is on	NW Surrey (pilot)

New Transformed/Transforming Service	Service Description	Geographical Coverage
	early intervention and prevention, the team agree pathways to step-up intervention and support to secondary care and the local authority when required. The service provides a strengths-based, short-term support offer, with the aim of making a positive and measurable difference to the wellbeing and recovery of those in need of support, providing an early intervention response that reduces the need for ongoing or high-level service intervention. 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: ▪ To promote independence. ▪ To reduce the need for ongoing or high level statutory services. ▪ To include support to focus on coping techniques, self-help approaches to social inclusion, building self-esteem, goal setting and accessing the community. ▪ To ensure individuals are supported to live the way they wish with participation in work, education, training and recreation. ▪ To provide a goal focused, strengths- based short term support that aims to increase levels of independence The goal of this pilot project is to: a) Review the development of mental health/substance misuse enablement in primary care and the impact of OT with skills gains to enhance recovery in a strengths based model. b) Provide strong evidence for a business case, planned to be put forward in 2024 for a new enablement service in primary care. Originally piloted for 6 months in 2021 covering Woking Wise 1, 2 & 3 PCNs, the review found that 46% of referrals were enabled i.e. no longer needing Adult Social Care support. Whilst the evaluation findings were very promising, it was recognised that the sample size was small. In order to further test the concept	

	New Transformed/Transforming Service	Service Description	Geographical Coverage
		and gather stronger evidence for this case for change, the pilot was restarted in October 2022 for 18 months over a larger geographical area integrated with GPimhs PCN teams in Woking Wise 1,2,3, SASSE 1,2,3, COCO, WHAM, East Waverley, Walton and West Byfleet.	
Dedicated Functions Linked to New Offer	**SUN (Service User Network)**	SUN is an evidence-based co-produced peer support network for adults experiencing difficulties with complex emotions often associated with personality disorder. The aim is to empower individuals to take self-responsibility for their wellbeing, to provide an open access service that has 'easy-in and easy-out' approach and also to reduce inappropriate access to crisis services. SUN blends ideas of the Therapeutic Community model with cognitive and psychoanalytic concepts to form its ethos, providing daily open access to peer support groups co-facilitated by a Mental Health Practitioner and a paid Peer Support Worker with lived experience recruited by VCSE commissioned partners. SUN is a self-referral, confidential service for GP registered adults promoted via: ▪ signposting by GPs, GPimhs/MHICS, VCSE commissioned partners, CMHRS, Safe Havens, A&E, Social Services and any service that has information about SUN. They would ideally have leaflets and posters about SUN with information on how to self-refer. ▪ libraries, public places and community venues – SUN staff have not only done outreach to primary and secondary care services, but has also displayed leaflets and posters at libraries, train stations, community venues etc. Some of the issues a person may be experiencing, include ▪ How they think about themselves: o low self-esteem, o consistent feelings of emptiness and/or a lack of or uncertain sense of self,	Across all of Surrey and NE East Hampshire

New Transformed/Transforming Service	Service Description	Geographical Coverage
	○ difficulty in connecting with their own emotions, ○ setting themselves unrealistically high standards ○ difficulty with intense, ○ overwhelming or fluctuating emotions, or difficulty recognising or expressing emotions ○ feeling of behaviour being out of control and difficulty in setting and working towards goals ▪ How they relate to other people: ○ difficulty in coping with or resolving conflicts ○ difficulty connecting or empathising with others ○ difficulty finding a balance between own needs and needs of others ○ current or previous use of alcohol or drugs to cope with difficulties Attending a SUN peer support group helps people to get the support they need and gives them the opportunity to share their experience to help others. Each group meeting follows the same three stage format with breaks in between each stage: ▪ Check In: People can talk about how they are feeling and what they would like to get out of the group. ▪ Support Forum: A discussion about topics or themes raised at the Check In so people can share experiences and provide one another with advice. This is where new members complete a Resource and Support Plan (RASP) with the help of the group. The culture of SUN is for group members to share ownership of the service, so really promoting the formation of a therapeutic community where members feel valued, understood, validated and appreciated.	

New Transformed/Transforming Service	Service Description	Geographical Coverage
	SUN runs virtual events on the first Thursday of every month open to all professionals, carers and potential members who would like to find out about the SUN and how it operates. Watch SUN's recorded virtual event.	
MEP (Managing Emotions Programme)	MEP is a co-produced pathway for adults experiencing rapidly fluctuating and intense emotions that significantly impact on their wellbeing, relationships, and quality of life. It offers easy access to a blended approach of face to face/online psychoeducational courses, designed to equip people with a range of tools and skills to enable them to manage their emotions more effectively. It is a 'co-designed and co-delivered' service, meaning that the team is made up of a mixture of Clinicians, Expert Trainers and Recovery Coaches, who have lived experience or are carers of those with emotional difficulties, including personality disorders. Anyone struggling with managing their emotions and emotional regulation within primary care can be referred to MEP by GPimhs/MHICS. No diagnosis is needed. MEP offers three courses facilitated by two or three members of the team: ▪ Course 1 - Understanding emotions - an introduction ○ Is a one session course lasting 2.5 h, that introduces group members to the concept of understanding emotions and their function, as well as to some basic emotion regulation coping skills. This course is suitable for anyone who struggles with emotion management and demonstrates some readiness to engage in the recovery process and may be suitable for those that are new to group work. ▪ Course 2 - Learning strategies to manage emotions ○ Is a four session course (each session lasts 2 hours) that helps group members begin to understand emotions in greater depth and to learn how emotions affect us in mind, body and behaviour. Group members also learn strategies to help them manage and regulate their emotions.	Across all of Surrey and NE East Hampshire

New Transformed/Transforming Service	Service Description	Geographical Coverage
	○ This course is suitable for people who require a more intensive, in-depth intervention, and who are ready to commit to the four sessions course. This course may be suitable for those who have completed Course 1 and want to build on their understanding of managing intense emotions and go into more depth. ▪ Course 3 - Developing skills to manage and regulate emotions ○ Is an eight week course that helps group members to gain a greater awareness of their triggers, as well as their emotional and behavioural responses to challenging situations. The sessions are drawn on evidence based psychological theory and practice to help develop skills that enable group members to consider how to regulate their emotional responses. The sessions content covers: raising emotional awareness, understanding schemas, identifying values and goals setting, recognising and challenging unhelpful thinking patterns and a range of other emotional regulation coping skills. ○ This course offers the highest level of intervention for people with the greatest level of need who are in primary care. This most intensive course may be suitable for those who have a good level of awareness about their emotions and emotional regulation, and may also be suitable for those who have completed specialist interventions around emotional regulation training such as DBT or STEPPS and would like a refresher. MEP also co-produced a self-referral course for anyone registered with a GP who is caring for or supporting somebody with emotional regulation difficulties or personality disorder: ▪ Carers Course ○ Is a four session course (each session lasts 2.5 hours) that suggests strategies to help carers cope and manage their own wellbeing as well as better understand the person they care for. The course has is co-	

New Transformed/Transforming Service	Service Description	Geographical Coverage
	delivered by carers and people with lived experience of mental health difficulties ○ The course is suitable for carers that are supporting anyone age 16 or over with emotional regulation difficulties. It may also be useful for those carers who are supporting a younger age group but is not able to address the specific needs of younger age groups or the needs of other mental health conditions.	
PICT (Psychologically Informed Consultation and Training)	PICT improves the relationship between health & social care agencies and adults with traits or a diagnosis of personality disorder - by educating and upskilling professionals through consultation, support, supervision and training. In this way, PICT aims to give a range of professionals access to skills and insights for increasing their confidence and enhancing their day to day practice. ▪ PICT Training - Improving a team's knowledge and understanding of personality disorder ○ Depending on the needs of the service, tailored training sessions are offered to help staff work more effectively with adults who have emotional instability and personality disorder. ○ Training is co-facilitated by a Lived Experience Facilitator and a Clinician. ○ Training is optional and by request. Staff may be encouraged to attend the 3-day KUF (Knowledge and Understanding Framework) training – attendance on all 3 days is mandatory. ○ Training is to a range of staff groups e.g. GPs, Mental Health Practitioners, Receptionists/Administrators, Family Support workers, Citizen Advice Workers, Enabling Independence Workers, Housing Workers, British Transport Police, Adult Social Services, Safer Neighbourhood Teams ○ Topics covered include:	Across all of Surrey and NE East Hampshire

New Transformed/Transforming Service	Service Description	Geographical Coverage
	✓ Working effectively with adults who present with traits or diagnosis of Personality Disorder ✓ Working with self-harm, suicide and risk. ✓ Developing relational skills: validation, empathy and reflective practice ✓ How to set effective boundaries ✓ Training for GP reception staff and administrators on understanding personality disorder and managing difficult interactions ▪ PICT Consultations - via online session for advice about a patient o Primary care consultation slots are run every week through Microsoft Teams, for any GP or GPimhs/MHICS professional who would like to discuss challenging or complex cases. o Consultations are co-delivered by a clinician and a PICT Trainer with lived experience. The consultee submits a request for consultation via the PICT webpage outlining what they are seeking consultation about – might be an individual client/patient or an issue associated with working with people with Personality Disorders. o An hour slot is booked and the consultee discusses the issue and receives advice/guidance and knowledge to inform their understanding of working with that person or issue. Recommendations can be made. It is up to the consultee whether they follow these and if needed a follow up consultation can be booked.	
AEDimhs (Adult Eating Disorders Integrated Mental Health Service)	AEDimhs is a new primary care specialist community eating disorders service to address the significant unmet need of adults held in primary care with low medical risk or early onset eating disorders, who do not reach the threshold for the existing moderate to severe specialist adult community eating disorders service (AEDS). The aim is to ensure that adults with a diagnosable eating disorder, are able to access specialist evidenced-based interventions. This	Across all of Surrey and NE East Hampshire

New Transformed/Transforming Service	Service Description	Geographical Coverage
	includes FREED (First Episode, Rapid Early Intervention for Eating Disorders) for young adults (18 – 25 years) who are within the first 3 years of their illness duration. AEDimhs works closely with colleagues in the specialist adult community eating disorders service (AEDS) to 'step up' patients within their care if the medical risk associated with their eating disorder increases. Additionally, AEDimhs are currently working on a 'step down' pathway to support patients whose eating disorder risk reduces following treatment within AEDS. An online carers course provided by BEAT (formerly Eating Disorders Association) is also offered to support parents and carers in the first 5 years of illness duration. The course aims to help cares find out more about eating disorders, gain an understanding of the driving forces behind them, and learn some techniques to help their loved one in recovery, and look after their own their wellbeing.	
HOMEFirst – enhanced community mental health rehabilitation	HOMEFirst provides the means for a wide range of agencies to work successfully together offering enhanced levels of community care and support, intensive interventions, and outreach services designed for people with long-term and complex mental health needs - helping to support people to stabilise their mental health for longer periods in their local communities. The focus is on the small but significant proportion of people who develop severe mental health conditions, such as psychosis, relapse and need long term care. They often have a high risk of suffering from significant physical illness as well as being impacted by the wider social determinants of health. This cohort is often at risk of repeat inpatient admissions and requires intensive and ongoing support, often from CMHRS teams. Newly launched in 2023 HOMEFirst is underpinned by collaborative care planning across health, social care, VCSE and local government organisations; enabling individualised packages of care to be delivered across multiple agencies. Once	Across all of Surrey and NE East Hampshire

New Transformed/Transforming Service	Service Description	Geographical Coverage
	referred to HOMEFirst, an individual care plan is agreed which may include an intensive period of intervention of up to 12 weeks delivered by one of the HOMEFirst Alliance Members. The person accessing the service then remains open to HOMEFirst for as long as needed. In this way we can keep people living well at home and help to prevent any future deterioration of their mental health, or the need for repeat admissions to an acute/specialist inpatient unit locally or out of area. A model of outreach support is currently being co-designed with housing providers which is aimed at reducing the risk of people's tenancies from breaking down. The HOMEFirst team blends virtual and in-person team working. Although drawn from different organisations, each member of the team collaborates to produce a single, shared plan of care and support based on individual needs. Decisions about individual care plans and reviews of plans are made regularly via a virtual My Shared Care Forum. A Lead Key Worker in the team has access to resources via members of the HOMEFirst Alliance. As a result, there's no need for referral screening and repeat assessments around HOMEFirst interventions. The dedicated HOMEFirst team comprises: ▪ Alliance Lead – an Occupational Therapist facilitating successful collaborative partnerships, while providing clinical leadership, oversight, and whole-person care . ▪ Lead Key Worker – has access to resources via members of the My Shared Care HOMEFirst Alliance (see page 7). As a result, there's no need for referral screening and repeat assessments around HOMEFirst interventions. ▪ Recovery and Connect Worker – employed by VCSE commissioned partners, reporting to the Alliance Lead. ▪ Lived Experience Practitioner – providing advice and support based on their personal experience, reporting to the Alliance Lead	

New Transformed/Transforming Service	Service Description	Geographical Coverage
	People are eligible if they have complex and long-standing mental health needs and a history of repeat admission to an acute/specialist inpatient unit, locally or in another area. They may additionally: ▪ suffer severe and enduring mental health problems impacting on daily life ▪ be repeat users of other crises services, such as Accident and Emergency, ▪ Safe Haven, or Crisis House ▪ have complex needs requiring multi-agency management ▪ need support with their medication: how to take it, manage any side-effects, ▪ maintain and take ownership of their treatment ▪ have difficulty socialising or managing daily activities because of their impairment ▪ experience loneliness and/or have limited social contact ▪ live independently in community or supported accommodation ▪ be resistant to treatment, engage in self-harm or have self-harmed historically, or have a possible dual diagnosis ▪ require a more intensive care plan or support	

Appendix 4: GPimhs/MHICS Model of Support for Carers

Primary Care

GP Carers Quality Markers

- timely identification and registration of Carers makes it easier to offer practical things (like health checks and 'flu jabs) to maintain good physical health
- improved physical health and emotional wellbeing of Carers can lead to reduced demand on services
- timely identification and referral of young Carers can help reduce the impacts of inappropriate caring during childhood
- having an up-to-date carer register helps to target health screening for particular areas of risk, such as depression, high blood pressure, etc.
- early identification of carer health problems can lead to faster treatment and improved health outcomes
- improved support for the carer can lead to better care planning and more effective implementation of the subsequent care plan
- the improved physical health and emotional wellbeing of Carers may lead to savings in a general practice's prescribing budget.

<<< <<< *GAP IN SERVICES* >>> >>>

CMHTP → Integrated Mental Health Services

e.g. GPimhs / MHICS

"People with mental health problems will have fewer assessments, will not be required to repeat their histories, and will not fall through the gap between services. Moreover, they will be supported to live as well as possible in their communities."

Opportunity for these integrated teams to have an emphasis around the following aspects of the NICE guidance, which are key for those Carers falling in the gaps between services.

1. **Information and support for Carers** - the right to information and support; sharing information with Carers; working with and involving Carers.

2. **Identifying Carers** using recommendations for health and social care organisations and practitioners. (Ensure that the Carer/s are willing and able to care)

3. **Assessing Carers' needs** - using the overarching principles of Carers assessments; preparing for and supporting access to a Carer's assessment; work, education and training considerations; support following on from a Carer's assessment.
    - Surrey Carers Prescription link → https://fs4.formsite.com/surreygp/form8/index.html
    - Healios online support for mental health Carers www.healios.org.uk

This means that Carers can benefit from more holistic support within primary care and other through accessing other providers.

involves the following:

- GPimhs / MHICS staff are Carer aware and trained in engagement strategies.
- Additional support provided to the team around working within the principles of the Care Act.
- Identification of Carers & Young Carers as defined aspects of the core recording documentation.
- Key aspect of the model is bridging people to get the support they need, including Carers Support, identification of appearance of need, and support around accessing social care assessments.
- Can support Carers to understand the options that are open to them in terms of what is available.
- Staff can link in Carers of people with a presentation of personality disorder with a primary care based Carers intervention (developed by the Recovery College).
- Should a patient be supported into adult secondary care, then information about caring responsibilities and support needs can be clearly communicated reducing the need for repeated assessments.

Adult Secondary Care

Triangle of Care Standards

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.

2. Staff are carer aware and trained in carer engagement strategies.

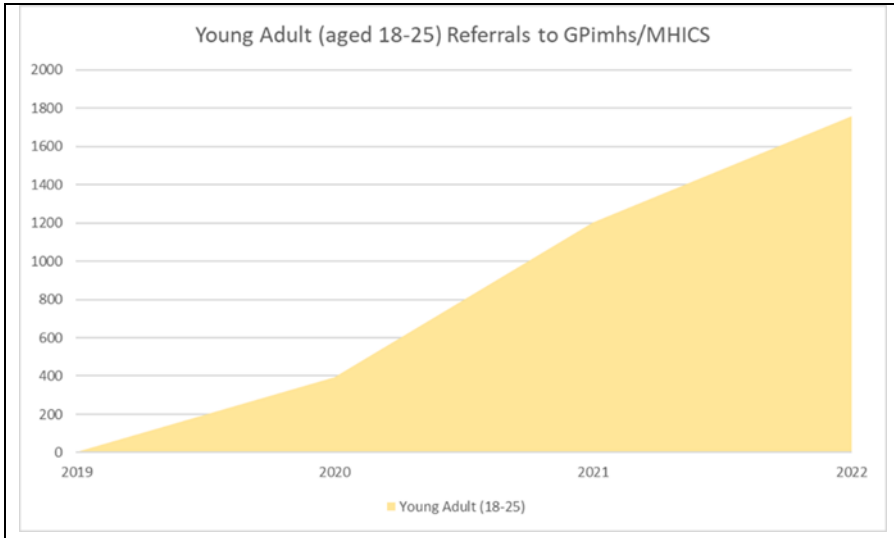
3. Policy and practice protocols re: confidentiality and sharing information, are in place.

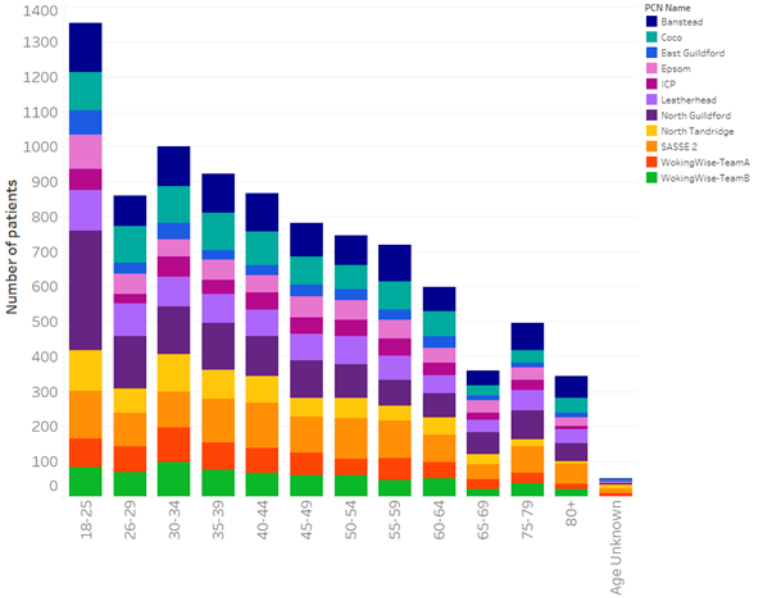
4. Defined post(s) responsible for carers are in place.

5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.

6. A range of carer support services is available.

Appendix 5: Young Adult (aged 18-25) Referrals to GPimhs/MHICS





Appendix 6: Map showing spread of GPimhs/MHICS across Surrey

Appendix 7: Frimley South Report - Primary Care Citizens Advice Mental Health Caseworker Service (Oct to Dec 2022)

Key Statistics

Citizens Advice Heathlands MHICS Service

03/10/2022 22/12/2022

citizens advice

Summary

Clients	48
Quick client contacts	
Issues	223
Activities	380
Cases	23

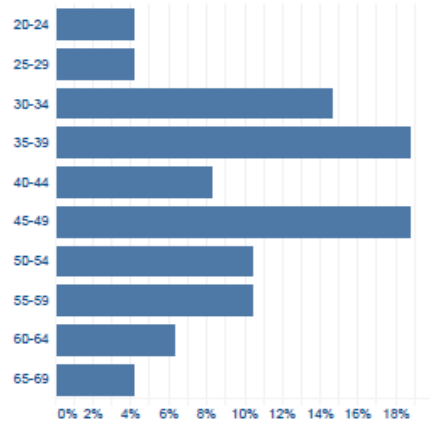
Outcomes

Income gain	£40,326

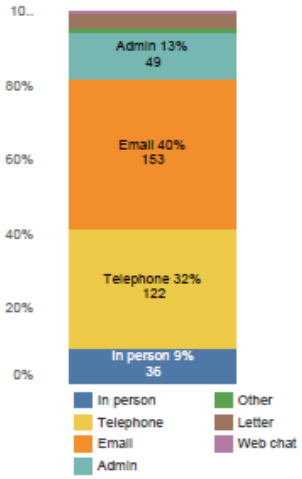
Issues

	Issues	Clients
Benefits & tax credits	73	30
Benefits Universal Credit	31	10
Charitable Support & Food Ban..	10	4
Consumer goods & services	1	1
Debt	51	12
Employment	4	3
Financial services & capability	5	5
GVA & Hate Crime	8	3
Housing	13	7
Legal	5	2
Relationships & family	4	2
Travel & transport	4	3
Utilities & communications	14	3
Grand Total	**223**	

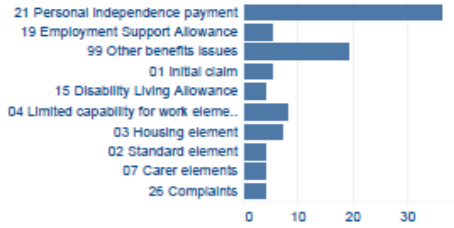
Age



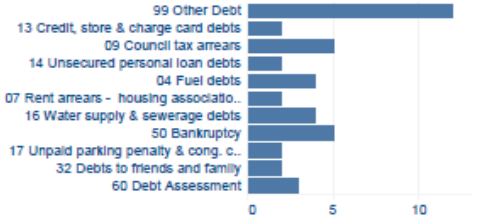
Channel



Top benefit issues



Top debt issues



Gender

Disability / Long-term health

Ethnicity