ADULTS AND HEALTH SELECT COMMITTEE

THURSDAY, 15 JUNE 2023

SURREY COUNTY COUNCIL

MENTAL HEALTH IMPROVEMENT PLAN: UPDATE

Purpose of report: To provide an update to the Adults and Health Select Committee on progress since the October 2022 meeting.

1. Introduction

1.1 An update on the delivery of Surrey's Mental Health Improvement Programme (MHIP) was provided to the Committee in October 2022.

1.2 We agreed to provide a further update in the first quarter of 2023 and this report describes the collective system work to deliver the MHIP.

1.3 Delivery of the MHIP is set against a background of continuing pressures within the mental health operating environment, especially with sustained high demand for crisis and inpatient services across children's and adult services, ongoing workforce challenges and financial pressures.

1.4 The Surrey mental health resourcing review undertaken as part of the MHIP in 2021 has given us a better understanding of need within our system and the capacity available to meet it. The recent Joint Strategic Needs Assessment 2023 adds further depth to this picture and identifies some specific areas for action to promote good emotional wellbeing and prevent poor mental health.

2. Context

Our ambition is articulated in the coproduced vision:

> *'Together we will build and nurture good mental health and emotional well being for all. If anyone needs help, they will find services on offer for themselves, their famly and carers, which are welcoming, simple to access and timely. No-one is turned away from a service without being given support to get the help they need'.*

2.1 Since the update to the committee last October there has been a range of system wide work underway to deliver this vision and address the 19 MHIP recommendations. The priority programmes of work have particularly focused

around early intervention and prevention, no bounce, and crisis and flow, all supported by specific data and workforce enabling workstreams.

2.2 It is important to recognise the context in which we are aiming to deliver the improvements set out in the plan relating to wider operational and resourcing pressures.

3. Context – Covid and Cost of Living

3.1 We have seen a significant demand for mental health crisis support across all services since the onset of the Covid-19 pandemic in 2019/2020. The destabilising emotional impact of the pandemic has been further exacerbated by the cost-of-living crisis and global political unrest.

3.2 Citizen's Advice Heartlands past quarterly report "The Cost of Living is resulting in exceptional pressures on everyone, and for those who are on the lowest income those pressures are greatest. The consequent impact on mental health is well documented, and during this quarter we have been working on a separately commissioned research project, investigating the local impact of the cost of living". Citizens' Advice Runnymede & Spelthorne have been piloting a dedicated Primary Care Mental Health Caseworker Service to people referred by GP Integrated Mental Health Service (GPimhs) Primary Care Network (PCN) teams in SASSE networks 1, 2 & 3 and COCO (primary care mental health transformation see also section X) since 2022 which has been extended to end 31 March 2024. Funding for Surrey Heartlands coverage to extend to all areas of deprivation was not agreed. Frimley South in contrast has a commissioned dedicated primary care service within its existing Citizens Advice Rushmoor contract for secondary care.

3.3 The newly published '**Emotional and Mental Wellbeing in Surrey Adults'** JSNA chapter **(**Emotional and Mental Wellbeing in Surrey Adults | Surrey-i (surreyi.gov.uk) includes a section on 'Socio-economic, Cultural and Environmental conditions: The Current Context' which details the cost of living crisis.

See below for specifics.

4. Food Insecurity

4.1 Estimated increase in the rates of people experiencing food insecurity at 4.7 million across the UK (Kings Fund 2022) with wider factors such as increase in energy prices, combined with rising inflation, stagnant wages and uncertainty about benefits further leading to an increase in people living with food insecurity or fuel poverty.

4.2 These factors combined with the uncertainty can cause considerable anxiety. People already experiencing poor mental health (for example those living with an severe mental illness (SMI) or living with a disability are more likely to be affected. In addition, the uncertainty of the benefits system, and the negative

emotions such as stigma associated with accessing food banks further lead to poor mental health.

4.3 Fuel poverty has been found to correlate with a variety of well-being outcomes, even when controlling for lifestyle factors. Two thirds of therapists in a national survey say cost of living concerns are causing a decline in people's mental health. British Medical Journal research says that the surge in prices over recent months is exacerbating insecurity and harming people's mental health.

5. Debt

5.1 Another issue related to financial uncertainty is debt; significantly linked to poor mental health. Those with problem debt are three times more likely to consider suicide. Around 60 per cent of those who had three or more debts experienced mental health problems.

5.2 The Health and Wellbeing Board has identified 21 priority areas across Surrey where substantial opportunities for population-wide health and wellbeing improvements exist. We know poverty and its associated effects are a key health and wellbeing risk factor, so the importance of understanding these communities has only become more acute as a result of the rising cost of living.

5.3 There are already a lot of health and wellbeing interventions active in these communities. Surrey County Council will be undertaking mixed methods research in early 2023 to better understand health and wellbeing issues in these communities as well as understand what assets they define as valuable. This will help us develop a measure for healthy and thriving neighbourhoods to help us focus our resources on what will have the most impact.

5.4 As findings become available, they will be published within the JSNA website and used to inform planning.

6. Context: The Emotional and Mental Wellbeing in Surrey Adults JSNA

6.1 The newly published chapter outlines the most up to date intelligence of expressed and expected need for mental and emotional wellbeing in Surrey. There remains a considerably higher prevalence of mental health problems among the general population than the number of people receiving treatment (Adult Psychiatric Morbidity Survey).

6.2 There was a predicted 1.3 per cent increase in mental disorder (diagnosed and undiagnosed) in those aged 16-64 years between 2017/ 2020 (prior to impact of COVID and cost of living challenges). We expect this figure to increase further in the wake of the pandemic (and see above regarding the cost of living crisis). A recent report published by the National Audit Office in February 2023 indicates that there was a 44 per cent increase in referrals to mental health services between 2016-17 and 2020-2021, going from 4.4 million to 6.4 million. The same

report estimates that there are 8 million people with a mental health need not in contact with services nationally.

6.3 Primary Care QOF data shows the prevalence of recorded depression almost doubling across Surrey in five years (from 6.2 per cent in 2014/15 to 11.1 per cent in 2020/21).

6.4 In 2020/21 6,765 individuals were registered Serious Mental Illness (SMI), 0.73 per cent compared to 0.95 per cent nationally and the prevalence of SMI was 28 per cent higher in the most deprived decile compared to the least deprived decile.

6.5 Nationally we know there is life expectancy gap of about 20 years for people with SMI compared to peers and a recent report by the Office for Improvement and Disparities published in January 2023 suggests that this gap is increasing not reducing. Excess mortality for people with SMI is significantly higher in Surrey compared to the national average, underpinned by higher rates of cardiovascular, respiratory, and liver disease.

6.6 Whilst below England figures, age-standardised suicide rates in Surrey have grown from 9.6 to 10.0 per 100,000. When taking a closer look at the Surrey data, there is clear economic influences with problem debt featuring three times more amongst those likely to consider suicide. Other identified risks include existing mental illness and/or history of self-harm, relationship problems and bereavement.

6.7 The JSNA recommends a number of key actions:

Area 1: Population prevention: Promote place-based population wellbeing approaches, including the determinants of wellbeing.

Area 2: Communities. Work with communities, people with lived experience and VCSE to co-produce community-based wellbeing and mental health solutions.

Area 3: Address current and predicted unmet need with further equality impact assessments in key areas.

Area 4: Develop pathways that support holistic approaches.

Area 5: Ensure seamless read across with children and young people's needs assessment to inform whole family responsive pathways.

6.8 Under 'Area 1', place-based plans are being presented to the Mental Health System Delivery Board to ensure alignment starting in June 2023.

6.9 Under Area 3: Address current and predicted unmet need with further equality impact assessments in key areas has been taken up by the Early Intervention

and Prevention Programme has been picked up within Programme One Early Intervention and Prevention under Work Area 2 and Work Area 4 (more later in the report). However, the results of the findings and further equality impact assessments will be used to inform the entire plan and all programmes including the cost of living data and in section

6.10 Under area two, working with communities, the Independent Mental Health Network (IMHN) and Surrey Minority Ethnic Forum (SMEF) ran an insight survey into the effect of covid 19 on the mental health of people from minority ethnic communities in Surrey and NE Hants in 2020 (finished 2021) which highlighted barriers to engaging with services and ways the system could work better with these communities. It produced wide ranging co-produced recommendations.

6.11 The Mental Health peer research and IMHN team are currently doing a 2nd research piece. This research projects explores the cultural, religious and language barriers South-Asian adults' and their carers may experience in Surrey and North-East Hampshire's mental health services. They are currently fully immersed in the focus group stage of this (Pathways to Change Survey - Surrey Coalition of Disabled People).

6.12 Finally, Surrey Coalition for Disabled People are also supporting SABP Community Transformation work which includes a focus on improving access for minority ethnic communities to Gpimhs/mhics and they run a bi-monthly mental health stakeholder group for people which can also offer feedback and be used to raise discussions.

7. Context: Competing operational pressures

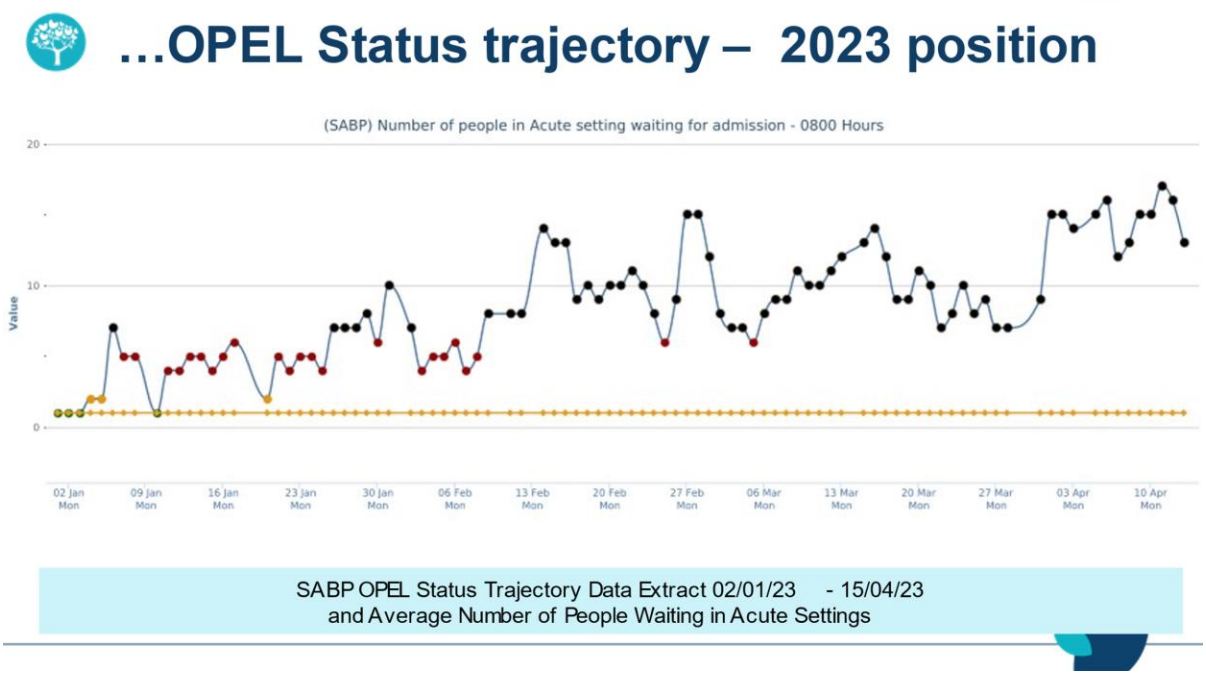
7.1 The commissioned Carnall Farrar report (Recommendation 7: Resourcing review) into resourcing for the MHIP in December 2021 indicated:

- Approximately 63,000 people were in contact with mental health services during 2020/21 but 180,000 people in Surrey would benefit from contact with mental health services

7.2 Waiting lists for all services and a detailed analysis of these can be provided at a later date.

7.3 However, the **urgent and emergency mental health pathway** in Surrey continues to experience a significant and unsustainable demand and capacity gap in meeting the needs of people experiencing a mental health crisis, with a forecast additional 25% growth in referrals to SaBP by 2025/26, compared to 2019/20 levels.

7.4 The graph below shows Surrey and Borders' OPEL trajectory between January and April 2023. OPEL is a measure of operating pressures used across the NHS, with OPEL Black being the highest level of pressure. The graph shows a sustained period of OPEL Black within the mental health system.



7.5 High demand and increasing complexity for the mental health urgent and emergency care pathway is resulting in ~30 patients identified at the threshold of acute mental health admission on a regular basis and impacting flow through inpatient services. Delays in discharging people once they are clinically ready is adding to the pressures. We know that 3 in 10 people do not return to their original accommodation following admission which increases length of stay (LOS) and reduces flow. The median length of stay where people go back to their usual place of residence is **28** days but if their accommodation needs change the length of stay increases to **39** days for temporary accommodation (typically District & Borough emergency accommodation) and **106** days for Local Authority (typically supported living).

7.6 There are significant challenges identifying appropriate discharge options for a number of vulnerable individuals with complex needs, including those who are neurodiverse, leading to very long stays in hospital which is not the right setting to meet their needs (see the vulnerabilities panel and accommodation with care and support section later). This situation is not unique to Surrey and neighbouring systems are experiencing similar issues, considering local provider and demographic differences. However, in Surrey Heartlands we have approx. half the number of beds per 100k than average and are the 2nd lowest funded MH system in England

7.7 Significant work is underway as part of the Crisis and Flow Programme to divert/develop alternatives to admission, improve support for people in crisis to wait safely at home, and improve flow through mental health acute services.

7.8 We are also experiencing very high year on year demand for our children and young people's emotional wellbeing and mental health services, with a continuing upwards trend. In response there has been significant additional non recurrent funding in the last two financial years to purchase additional capacity to undertake assessment for diagnosis and to provide additional capacity for early intervention across partners. This level of demand creates a bottleneck at the service access point leading to increased waiting times for the services.

7.9 The children and young people's emotional wellbeing and mental health services known as Mindworks Surrey closing year 2 position (April 2022- March 2023) demand and activity level as a total alliance was:

7.10 Referrals - YTD M12 Mar 2023: total alliance position at 34,731 referrals against total annual contracted target of 19,074 (+82%)

7.11 Activity - YTD M12 Mar 2023: total alliance position at 166,376 of total annual contracted activity of 135,703 (+22%)

7.12 Demand at Partnership Level

- Learning Space- Demand has exceeded Annual Contracted levels at 710 referrals received YTD. M12 position YTD Variance +107%
- National Autistic Society (NAS) - Demand has exceeded Annual Contracted levels at 1,828 referrals received, M12 position YTD Variance +110%. However low volumes received for ASD 1:1 service at -72% YTD Variance
- Barnardo's - In general demand has exceeded Annual Contracted levels at 2,469 referrals received YTD. M12 position YTD Variance +98%
- Surrey Wellbeing Partnership (SWP) - Demand at 8,783 referrals received, M12 position YTD Variance -5%.
- SABP - Demand at 20,941 referrals received, M12 position YTD Variance +74%.

7.13 Activity at Partnership Level

- SABP - YTD M12 a total of 7,210 (4,201) assessments carried out at +117% (+26%) of annual contracted target of 3315 Assessments. YTD M12 total of

72,204 treatments delivered YTD variance +36%. YTD M12 a total of 79,414 assessments and treatments delivered YTD variance +41%.

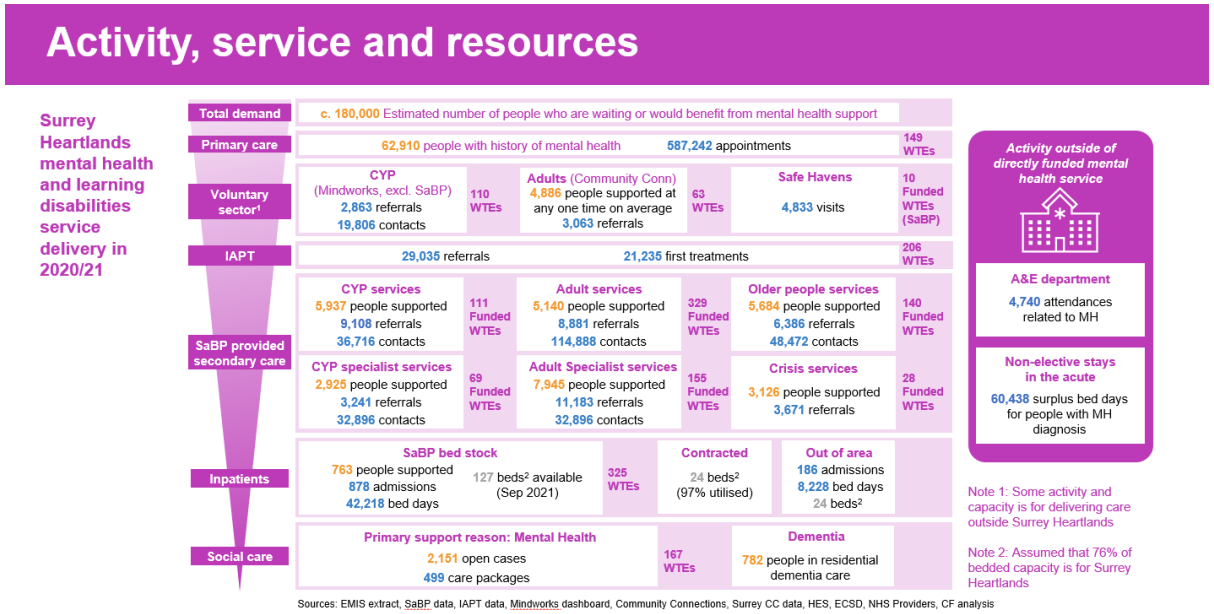
- Learning Space - In general activity is at 5,523 YTD variance +64%
- NAS - In general activity is at 5,298 YTD variance +2%.
- Barnardo's - In general activity is at 6,647 YTD variance -13%
- SWP - In general activity is at 69,560 YTD variance +11%

8. Context: Resourcing challenges to meet the need

8.1 Based on the resourcing review undertaken in response the MHIP recommendation 7, it is estimated that in Surrey we are only reaching 63,000 people out of an estimated 180,000 who need support (based on national Adult Psychiatric Morbidity Survey). Of the 63,000, using 2020/21 data, 6,765 individuals were registered with serious mental illness (SMI). When looking at the IMD Mood and Anxiety Disorders indicator, the five Lower super output areas (LSOA's) with the highest levels of mental health needs are in Reigate and Banstead. Future reports can consider these against the 21 Health and Wellbeing priority areas.

8.2 We recognise that workforce supply and retention remain particular challenges for all partners in Surrey and Nationally. SABP continue to see pressures recruiting to specialist roles such as Nursing, Psychiatry and Psychology. Recruiting to other roles within the VCSE and the Talking Therapy services has also become more challenging. There is a range of creative work underway to address vacancies, including working with Health Education England and our local Integrated Care Systems to develop new roles such as Graduate Mental Health Workers and developing our lived experience workforce.

8.3 The infographic below shows a summary of activity, services, and resources available in the mental health system and is taken from the 2021 Resourcing Review.



8.4 The funding position within Surrey remains a critical part of the context, particularly given the financial challenges which we are facing as a system:

- Compared to other systems, Surrey receives less funding from the national allocation formula, due to an assessment of low complexity and population need. Surrey Heartlands ranks 130 out of 134 ICBs in the national needs assessment for mental health; whilst Surrey Heath has the lowest index in the country.

- Resource allocation is a function of deprivation levels and historic population health. The formula used to set national resourcing levels is based on the prevalence of Serious Mental Illness (SMI). Surrey averages 0.78 and all of its 6 geographical "Places" rank in the lowest quartile of need in this model. Consequently, this limits resources to 43% below the national average (Second lowest for all MH providers).

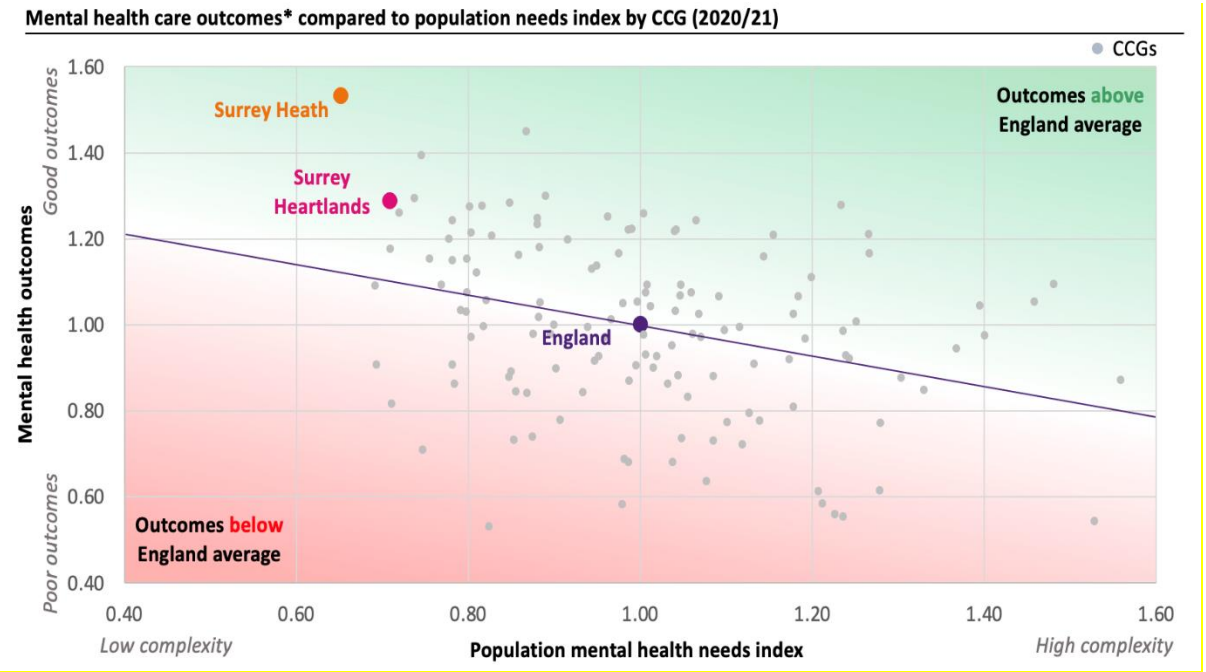
8.5 Consequently, Surrey spends less on mental health per GP registered population, £161 compared to the national average of £202. However, as the table below shows Surrey delivers more resources per service user for less funding.

National Funding £ per head	Surrey Heartlands	England Average	Surrey Heartlands vs England Average %
Real Purchasing Power	£161	£202	80%

Market Forces Factor adjusted	£142	£189	75%

8.6 Despite this, in absolute terms, Surrey achieves comparatively good outcomes even after adjusting for population need.

8.7 Mental health outcomes index for Surrey and most of its peers are higher than the national average. Compared to peers, Surrey generally has good service delivery. However, there are lower outcomes for people with SMI, and service delivery is lower than the national average for perinatal mental health and general children's mental health services.



9. Context: Scale of Transformation

9.1 There is a considerable amount transformation work underway both within and outside the context of the MHIP and a limited resource of programme support to manage the scale of change. Resourcing challenges as outlined above mean we need to prioritise best use of our resources which is under review by the Mental Health System Delivery Board as it moves forward with the development of a unifying transformation plan for Surrey Heartlands.

10. Context: Staff Wellbeing

10.1 Our people continue to feel the emotional pressures of covid as well as the ongoing cost of living challenges and unrest within the sector related to pay awards etc. Anxiety and depression is one of the leading causes of sickness absence and it

is critical that we prioritise support for our workforce. The 'Here for you hub'.is part of the package of support to staff to support their health and wellbeing and over a two year period (Jan 2021-Jan 2023) the service provided support to c4500 staff across Surrey. They see people with unmet & complex needs, some of whom present with significant risk and who have no other service they can use.

10.2 NHSE funding ceased on 31st March 2023 and SABP were unable to secure funding by all ICS partners. However, SABP offer developed with options for partners to buy into the service with funding secured post April 2023. Partners which have secured further funding to access the offers include Surrey County Council, SABP, some of the Acutes, Primary Care Networks and the voluntary sector.

11. Context: Culture

11.1 Changing and developing our system culture to align with the recommendations of the Linguistic Landscape's review will take time and requires the senior leadership to prioritise time investment in relationship building. We are making good progress with the development of new alliances and collaborations but there is more to do to create a more inclusive and valuing environment across our partnership.

12. Context: Digital and Data Insights

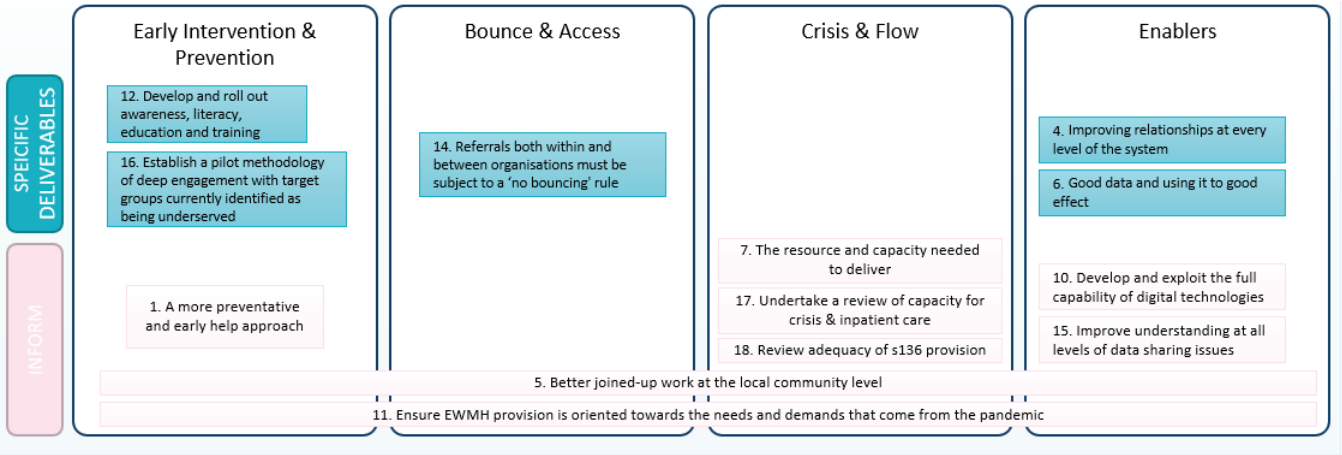
12.1 This report has demonstrated areas of progress and innovation to improve our use of digital and data insights. However, we are conscious that significant gaps remain in our understanding of population need and our ability to report population level impact. Digital fragmentation still creates challenges for people using services and those delivering support.

13. Update on MHIP progress since October 2022

13.1 Programme Architecture

The original 19 recommendations were mapped into four overarching programmes, mapped to other parts of the system or closed where they were completed.

This mapping exercise was signed off by the Mental Health System Delivery board in February 2023 and is detailed below.



The four priority programmes are:

13.2 Programme 1: Early intervention and prevention

Mapped to this were:

- Recommendation 1. A more preventative and early help approach
- Recommendation 12. Develop and roll out awareness, literacy and training
- Recommendation 16. Establish a pilot methodology of deep engagement with target groups identified as underserved

13.3 Programme 2 Bounce and Access

Mapped to this was:

- Recommendation 14. Referrals both within and between organisations must be subject to a 'no bouncing' rule

13.4 Programme 3: Crisis and Flow

Mapped to this were:

- Recommendation 7. The resource and capacity needed to deliver
- Recommendation 17 Undertake a review of capacity for crisis and inpatient care
- Recommendation 18. Review adequacy of s136 provision

13.5 Programme 4: enablers (culture, data and digital and workforce)

Mapped to this were:

- Recommendation 4. Improving relationships at every level (culture)
- Recommendation 6. Good data and using it to good effect (data)
- Recommendation 10. Develop and exploit the full capabilities of digital technologies (digital)
- Recommendation 15. improve understanding at all levels of data sharing issues (data)

13.6 Mapped across and to inform all 4 programmes were recommendation 5 (better joined up work at the local and community level) and 11 (ensure EWMH provision is oriented towards the need and demands that come from the pandemic) and subsequently the cost-of-living crisis.

13.7 In regard to wider recommendations, some of these have been picked up and incorporated into existing "in flight" system programmes including (not exhaustive):

- Recommendation 3. Resilience, early support and helping people understand and access it (P2 of the HWBB)
- Recommendation 8. Engaging and supporting schools (part of wider CYPS work)
- Recommendation 19. Review the funding, commissioning, and provision of the six IAPT services (part of wider integrated commissioning work)

13.8 The closed recommendations were:

- Recommendation 2: A shared co-produced vision
- Recommendation 7: Resourcing review
- Recommendation 9. Simplify and streamline MH governance (this is detailed later in the paper as work in ongoing)
- Recommendation 13. Surrey-wide communication campaign

14. Progress made across the key 4 priority programmes

14.1 Programme 1: Early intervention and prevention

14.2 Outline of the work

During 2022 it was decided that the early intervention and prevention recommendations from the MHIP be integrated with the Health and Wellbeing (HWB)

Strategy's Priority 2, 'Supporting the mental health and emotional wellbeing of people'.

The Priority 2 Outcomes, following the summer 2022 refresh, are:

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

A Mental Health Prevention Oversight & Delivery Board (MHPODB) was established in September 2022 to oversee and drive forward this programme of work and ensure alignment with the emerging Integrated Care Strategies for Surrey Heartlands and Frimley.

14.3 **Funding**

This Board does not have a budget beyond allocated officer and members' time but aims to influence and coordinate spending to align with Priority Two outcomes, including steering the targeting of the £9.5m Mental Health Investment Fund. The Board will also contribute to the proposed system wide prevention spend mapping exercise being proposed for mental health by the population health management team in Surrey Heartlands.

14.4 **What we have done**

The MHPODB has developed a Work Plan which sets out specific priorities of work and activities operating through four work areas, focused on Surrey's Priority Populations, informed by Place and draws on public mental health evidence of preventative interventions which will impact:

- Work Area 1 - Steer and oversee the HWB Strategy Implementation Plans for Priority Two projects and programmes, in alignment with the MHIP's early intervention and prevention deliverables.
- Work Area 2 - Identify gaps in provision or under-developed support for Surrey residents as priorities for investment, including through working with communities, based on an enhanced understanding of Place, HWB Strategy Priority Populations and Key Neighbourhoods.

- Work Area 3 - Continue to develop improved and shared approaches to measuring, monitoring and reporting impact of projects and programmes for preventing mental ill health, within and across the HWB Strategy and MHIP.

- Work Area 4 - Assess, share and use new regional, national or international research and report findings as appropriate, within the Surrey Data Strategy approach.

14.5 **What Have We Achieved**

The JSNA 2023 has been completed for mental health and sits under Work Area 2. The outputs and recommendations from the JSNA are included in appendix one. Prevalence data and recommendations align with the detail in this report.

14.6 **Impact**

The following are examples of work drawn from December 2022 – June 2023 Highlight Reports to HWBB demonstrating change and improvement linked to the 4 Priority 2 outcomes:

- AFloaT is a new service taking professional referrals in the Surrey Heartlands area to support those affected by moderate to severe mental health difficulties as a result of maternity experiences (Outcome 1)

- SABP has recruited 6 Surrey Additional Reimbursement Roles Scheme Mental Health & Well Being Practitioners in September, through the new ARRS in primary care networks to be embedded in primary care practices to support people with mild to moderate mental health needs. (Outcome 1)

- Dementia Strategy delivery resulted in new, accessible resources for targeted groups, following a review mapping all voluntary services around dementia and part of a wider campaign (Outcome 1)

- Extensive consultation took place during 2022 on the refresh of the Emotional Wellbeing and Mental Health (EWMH) Strategy for Surrey's children and young people, and an action plan has been established across its six themes (Outcome 2)

- A Draft Best Start for Surrey Strategy 2022-27 has been published on where we need to work collaboratively to improve outcomes for pregnant people, babies, children, and families in the earliest years (Outcome 2)

- End Stigma Surrey has published its toolkit on how to reduce stigma, a directory for how to challenge discrimination and blogs of Lived Experience Champions' stories (Outcome 3).

- Through the HWB Strategy's implementation plan refresh, support was given to developing a logic model to re-design the Green Social Prescribing programme into a broader Surrey-wide approach to Green Health & Wellbeing (Outcomes 3 & 4)

- A Future NHS Green Health Collaboration Platform was launched on 3 November 2022 to build a strong, skilled and connected network of Green Health and Wellbeing professionals across Surrey (Outcome 4)

- A Prevention (Mental Health) working group for key neighbourhoods in Reigate and Banstead (incorporating ICB, SCC and R&B Community leads) has been set up to understand the key issues for residents and current provision (Outcome 4).

14.7 Next steps

MHPODB meeting 22nd May 2023 is considering key priorities and projects in the context of the HWBS Implementation Plan Refresh including continued discussion on the alignment with the other priority areas of the Health and Well Being Strategy which also impact mental health.

The MHPODB will continue to update the HWB Board on progress.

15. Programme 2: Bounce and access

15.1 Outline of the work

The bounce programme was developed from 'Recommendation 14. Referrals both within and between organisations must be subject to a 'no bouncing' rule' and 'Recommendation 5. better joined up work at the local and community level'.

15.2 What we have done

Scoping of the programme began in detail in January 2023 including mapping other major programmes addressing 'bounce'.

A series of focus groups and workshops took place which defined the problem and identified potential solutions on areas if improvements.

The initial focus group in January 2023 was led by Surrey Coalition's Independent Mental Health Network (IMHN) comprised of people with lived experience (including broader written feedback), followed up with conversations within the placed based independent mental health networks comprised of people with lived experience and front-line staff and clinicians.

People with lived experience told us:

15.3 What have we achieved

- Recognising that although this is a much debated and long-standing phenomenon within Surrey, that no definitive definition existed a working definition was co-designed, which is:

"*Bounce occurs when a person (and their carers/family):*

- *Has difficulty getting into services;*
- *Is passed between services; and/or*
- *Is 'dropped' by services*

in a way which results in that person's needs not being met and an accompanying feeling of rejection."

- A new 'no bouncing' principle has been drafted:

"If the first point of contact can't meet your needs, someone will hold responsibility for getting you to the place(s) where your needs can be met, and you and your carers/family will know who that person is and be able to contact them."

- Mapping of work and identifying particular places in the systems where there are challenges and opportunities for focussed work

- A logic model has been developed which provides the framework on how outcomes and impact can be measured going forward. The identified areas of focus include:
    - Culture shift – Services supporting person centred approach
    - Increase expertise to provide care (Knowledge)
    - Communication & collaboration across services
    - Further service resourcing & funding

Against each of the impacts above are draft outcomes and activities.

15.4 Evidence of impact

An evaluation framework for the programme is being developed by Unity Insights to ensure current programme and projects addressing bounce plus any additional areas of focussed work/projects needed to address bounce have the desired impact of reducing if not eliminating bounce.

As part of the mapping work, 2 specific projects have been identified already actively addressing bounce. These are detailed below.

15.5 Changing Futures: Bridge the Gap Trauma Informed Outreach: working with people experiencing Multiple Disadvantage

Changing Futures is a funding programme to improve systems and services in order to achieve better outcomes for people with multiple disadvantage. Surrey was awarded £2.8M (August 2021 – 31 March 2024) and SCC public health are currently preparing a bid for a further year of funding against a funding offer of 70% of full year funding.

15.6 Bridge the Gap reducing "bounce" around Surrey's systems:

Bridge the Gap (BTG) offers a place-based prevention service by offering a Trauma Informed relational model of intervention with our valuable VCSE partners who are embedded within our communities. The BTG workers work to build a therapeutic relationship with their client so that positive facilitation can be conducted included 'navigating' appropriate support for their client collaboratively with pertinent multiagency partners.

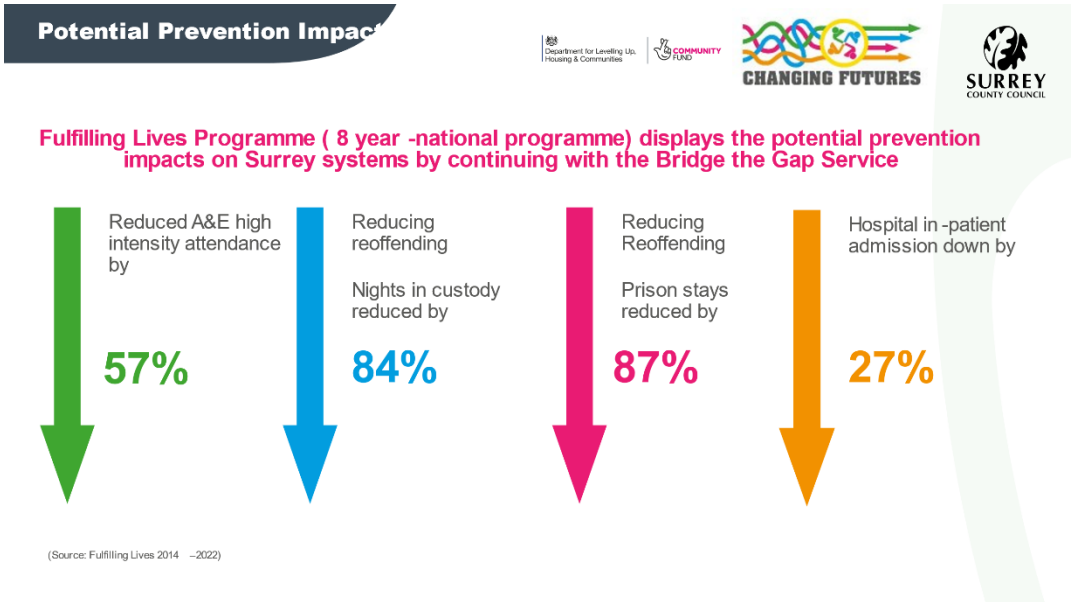
Anecdotal reports demonstrate positive outcomes including reduced:

- Accident and Emergency attendances
- Antisocial behaviour orders

- Ambulance Call outs
- Criminal justice issues
- Drug related deaths
- GP attendances
- Emergency police and fire service call outs
- Failure through accessing wrong doors – mental health if neurodivergent
- Failed appointments
- Pharmacy emergencies

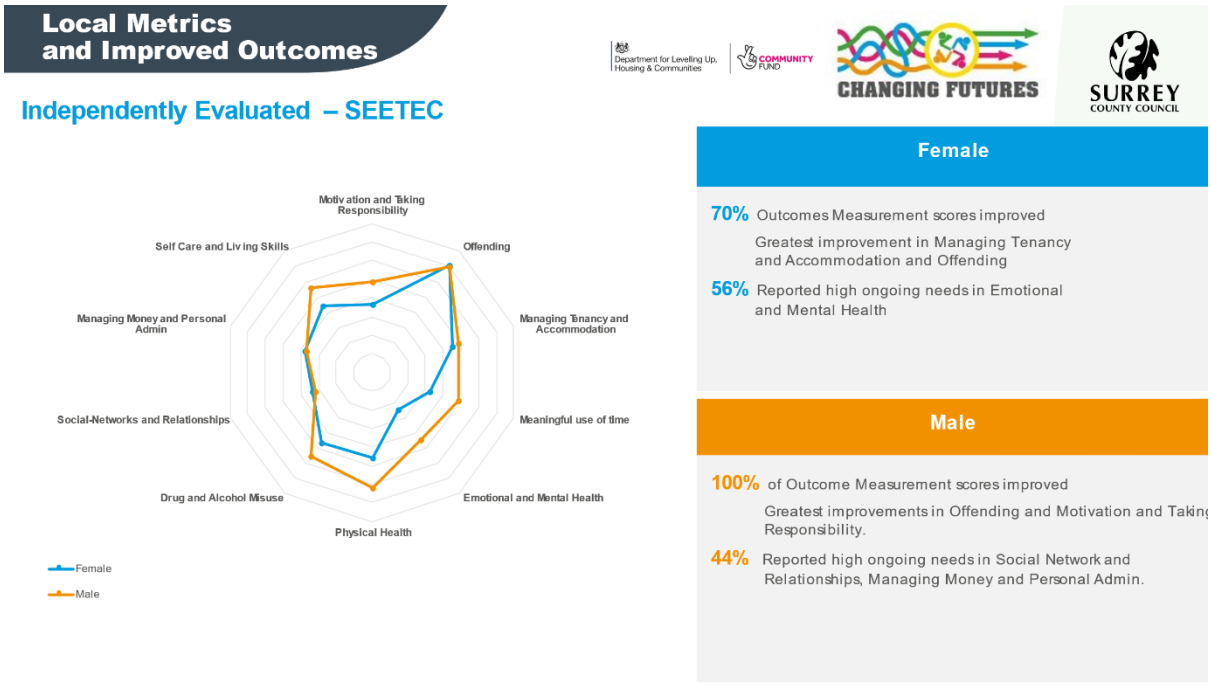
And improved accommodation sustainability, reduced homelessness and rough sleeping, substance use reduction, engagement into planned treatment and health care services, harm reduction / Suicide prevention, health benefits (including wound care, dentistry, chiropody, respiratory issues, immunisation, smoking cessation, cardiovascular), VCSE partnership and workforce skills and development and community connections.

Published evidence from a similar national programme (Fulfilling Lives) which operated for eight years across 12 areas of the country (excluding Surrey) demonstrate the following reductions for people with multiple disadvantage:



To date we have been focussing on recording improved outcomes for the 65 beneficiaries in receipt of the Bridge the Gap Trauma Informed Outreach Services.

The slide below is an extract from an independent local evaluation of the Bridge the Gap service.



Some of the measures above in are already recorded. The team will shortly be working with system analysts within the Public Health Intelligence Team and Surrey Heartlands to apply the measures to a costing formula to provide a local picture.

15.7 **Community Transformation:** GPimhs

- A first independent evaluation report (of a series) was received in March 2023 and provides preliminary insight into the impact and efficiency of GPimhs within Surrey Heartlands.
- Results indicate an overall decrease in estimated bounce from the GP to the Community Mental Health Recovery Service (CMHRS) at the stage of referral via SPA, as presented in Figure 28.
- This demonstrates that GPimhs is likely to reduce the effect of patients bouncing around services and redirected back to primary care without receiving support. It should be noted that the Community Transformation Programme is due to complete roll out in 2023/24 and that more mature sites are having a greater impact given the time it takes to embed this new way of working.

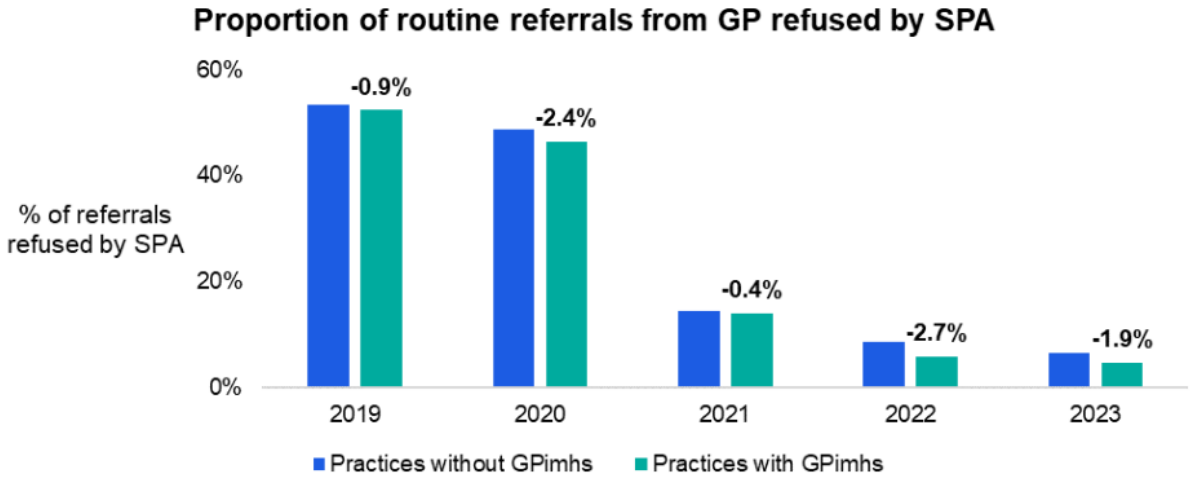


Figure 28: Chart showing the proportion of routine referrals from GPs that were refused by SPA, comparing referrals from practices with and without GPimhs (SystmOne).

15.8 **Funding for GPimhs**

NHS Long Term Plan 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).

With regard to the overall MHIP 'no bounce' priority, there are currently no further resources allocated to this programme to manage delivery and any new identified projects will need to be funded.

15.9 **Next steps**

- Continue to socialise the definition and the 'no bouncing' concept and principle.
- Share the logic model and begin an iterative process with stakeholders including people with lived experience to share and finalise the model which will then drive the focussed work/ projects for delivery to address 'bounce'.

- By June 2023 develop an evaluation approach for the programme to include a critical assessment through various robust and real-world processes to understand whether solution meets its objectives/aim, offer greater insight into the effectiveness, efficiency, acceptability, equity, and feasibility and help to show real-world impact to accelerate the spread and adoption i.e., evidence-based practice.

16. **Programme 3: Crisis and Flow**

16.1 **Outline of the work**

The Crisis and flow programme was set up as a formalised programme in October 2022, led by Surrey and Borders Partnership Trust working collaboratively with system partners e.g., Community Connections, Surrey County Council, and the ICB.

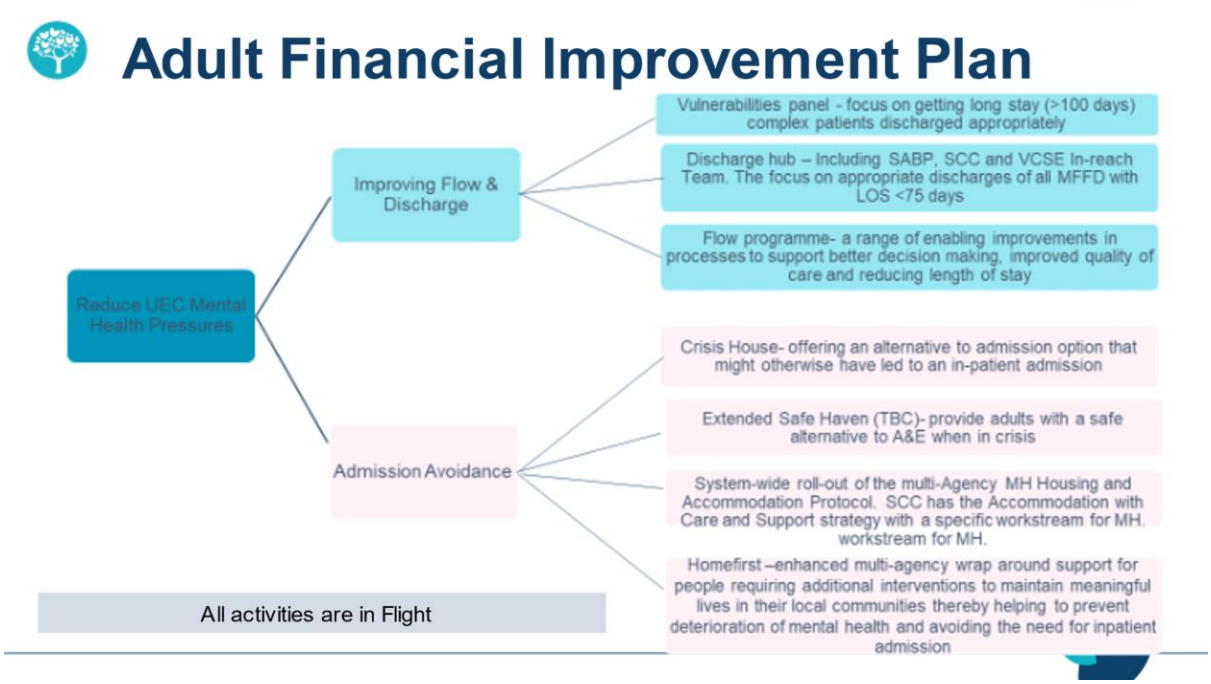
This addresses 'Recommendation 7. The resource and capacity needed to deliver', 'Recommendation 17 Undertake a review of capacity for crisis and inpatient care'; and 'Recommendation 18. Review adequacy of s136 provision'.

This programme also forms the basis of the adult Financial Recovery Plan and aims to:

- Reduce demand pressure
- Improve patient flow processes
- Reduce Length of Stay (LOS)
- Eliminate out of area placements
- Reduce spend on private sector beds and agency premium
- Development of workforce competencies to support gatekeeping/ signposting
- Develop clear and effective discharge processes
- Optimisation of opportunities through digital-enabled technologies/processes

16.2 **What We Have Done**

The driver diagram sets out the programme of work:



Adult basis for financial recovery:

We are using significantly more in-patient beds above our plans (40-50 people at any one time) an seeing continued high demand for in-patient services, and increased acuity and complexity of needs.

As a result, we are:

- Spending more on inpatient beds
- Commissioning more beds from independent providers at higher bed day rates (c 3 x higher than NHS bed)
- Spending more on agency staff to meet rising demands
- Impacting negatively on poor patient experience

(The children and young people narrative '*Mindworks Surrey challenges ahead'* is included as Appendix Two).

16.3 Prevention HOMEFirst

HOMEFirst launched in early 2023 and provides an increased level of intervention for people with complex mental health needs who require enhanced levels of support to live in the community to enable people to live well at home; preventing any future deterioration in their mental health, or the need for in-patient admission.

We know supporting people to live well with their families and friends in their local communities is the best way of managing any decline in mental health and aid recovery and those with a long-term mental illness who have experienced repeated episodes of mental ill health or have a history of inpatient admission, can fare better with the right care and support at home.

HOMEFirst provides the means for a wide range of agencies to work successfully together to offer enhanced levels of care and support that will help people maintain a stable condition for longer. This includes SABP, Surrey County Council and Community Connections.

16.4 **Evidence of Impact**

Since March 2023, weekly multi-agency My SharedCare Forums are now operational in 3 localities across the whole of the Surrey Heartlands footprint.

- 31 clients are now under the care of the HomeFirst approach
- A further 32 planned new cases are being taken forward into a My SharedCare forum to develop a personalised care package
- 2 clients have had a potential admission prevented
- 1 client has had a reduced length of inpatient stay with HomeFirst working with the discharge hub to prepare an enhanced package of care and facilitate early discharge

16.5 **Next Steps**

1. Working with colleagues to develop an automated reporting dashboard to track impact of HomeFirst as it moves from project mobilisation to business as usual.
2. Recruitment is underway to build the core HomeFirst team to include Lived Experience practitioners, Carer support, dedicated pharmacy support, housing advisor, additional clinical and administrative support.
3. Ongoing engagement with system partners to socialise the HomeFirst approach and build on the success to date.
4. Develop further the supported housing outreach model
5. Discussions underway to rollout out the HomeFirst approach into Frimley South, working with Hampshire County Council and Frimley ICS

16.6 **Funding for this project**

The programme has been built into the existing community transformation work already underway. Some additional funding has been invested to accelerate the work.

The financial recovery interface with HOMEFirst is based upon admission avoidance.

16.7 Crisis House

The 'Maple Tree Lodge Retreat' opened in December 2022 and offers a short-term, intensive community-based 6 bedded crisis house as an alternative to hospital admission for people who find themselves in significant mental distress, which is recognised to be potentially less stigmatising, coercive and institutionalised.

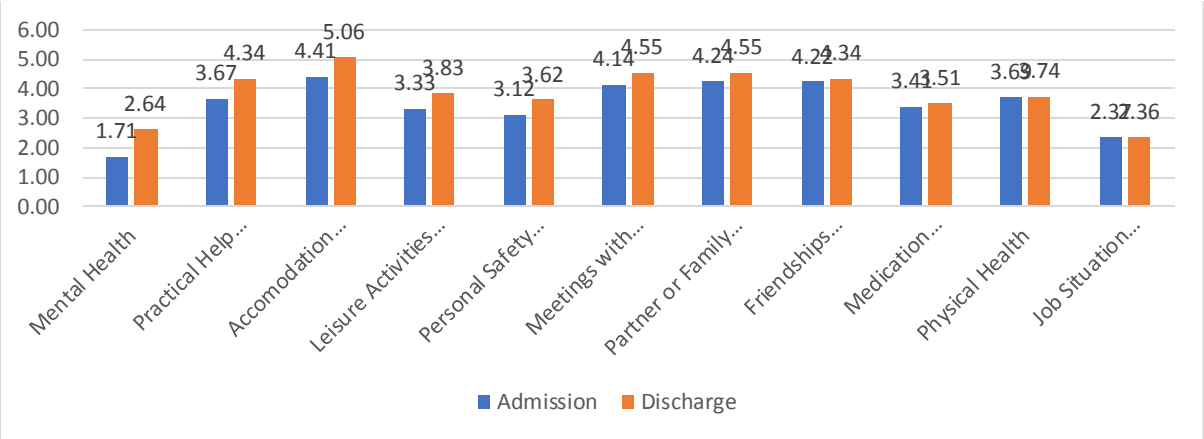
This is provided by Surrey and Borders NHS Foundation Trust in partnership with Comfort Care Service and is based in Knaphill, Woking, catering for people across the whole of Surrey, offering 3-to-7-night stays, 24/7, 365 days a year.

Suitability for admissions is based on assessment of risk, level of disturbance, consent and co-operation with the service offer against eligibility criteria.

16.8 **Evidence of Impact:**

From the 2nd December 2022 to 3rd April 2023, 49 people have completed their admission to the Retreat.

We are already seeing evidence of improved outcomes and on average, patients experience improvements across nearly all sub-domains of the DIALOG scale*, but the first five on the left are those with the greatest improvements.



* *DIALOG is a scale of 11 questions. Patients rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. DIALOG provides a score for subjective quality of life and a score for treatment satisfaction.*

16.9 **Funding**

Funding has been agreed for 12 months to demonstrate return on investment and it is anticipated that 6 crisis beds will save the cost of 9 contracted beds with cost savings attached through 3,285 contracted beds days saved per annum (linked to the financial recovery programme).

16.10 **Next steps**

- Continued development of the service to increase occupancy rates
- Continued development of outcome measurements and measuring admission avoidance

16.11 Flow Programme

The workstreams outlined below sit under the Flow Programme (see driver diagram). These enabling projects are a critical part of the wider improvements to crisis, flow 16.12 and inpatient transformation and will support operational and financial efficiency.

16.12 Admission Avoidance & Gatekeeping

The Admission & Gatekeeping workstream supports a number of key-enabling workstreams that make up the wider Crisis, Flow & Inpatient Transformation Programme (covering working age adults).

16.13 **What have we done to date**

The workstream includes operational improvements and reviews including:

- Development of new digital products/tools to support improved admission gatekeeping operational processes (i.e. Reducing the use of Out of Area Placements, development and)
- Improving functionality and optimisation of SystmOne (SABP Electronic Patient Record) to improve the patient pathway, develop better record keeping and aid better decision making. This also supports releasing time to care by reducing the admin burden on clinical teams.
- Identification of new ways of working where flow of patients and transition of patients can be improved with patients being managed better in the community through the introduction of virtual wards (for CMHRS/HTT teams)
- Redesigning diagnosis pathways to ensure that patients are only admitted to an acute inpatient ward when absolutely appropriate.
- Improving Home Treatment Team services through the introduction of new digital tools to manage caseloads better and to review/increase capacity of skills across the service (including implementation of the HTT SBAR, HTT workforce structure and operating model, HTT Springboard on S1)

16.14 **Evidence of Impact**

- Since July 2023 when there was a targeted focus to reduce OAPs, we have consistently been at 0 OAPs since February 2023.

- In April 2023, a working group led by a specialist doctor have begun to map out the Emotionally Unstable Personality Disorder pathway. Whilst this is early on in the discovery phase, it is felt that some people admitted with EUPD could be redirected to an alternative setting. The SABP Patient Flow dashboard suggests that of people admitted to an Adult Acute/PICU bed, 15% of these people were diagnosed/coded as having personality disorder (which is comparable to other Trusts who report between 12-20% of people admitted as having personality disorder). We are working through this in more depth to support defining a high-level condition-specific pathway. This feeds into other work we are doing around condition-specific pathways to focus on improving and optimising patient journey's and facilitating more meaningful and effective admission and discharge.

- HTT SBAR went live in November 2022. The data suggests that the MDT meetings have been reduced by 30-60 minutes on average, which for just one HTT team equates to upwards of 3,500 hours of potential clinical time saved per year, meaning staff have more time to prioritise patient care. Entering the MDT updates directly into SystmOne has also removed the time spent by Administrators copying information from Excel into SystmOne at the end of each MDT (previously around 2 hours per day), removing the need for overtime and the associated costs.

- The CFIT leadership team are working with the Locality teams and HTT lead to identify what the ideal team structure would look like. We are working with HR colleagues to explore ways to support recruitment and retention in this space. This will support sustainability of new ways of working culminating in a clearly defined operating model.

16.15 **Next steps**

- To continue to develop the diagnosis pathway mapping identifying opportunities to improve operational efficiency and patient experience

- To continue to monitor benefits realisation for the digital products that have been implemented across SABP

16.16 **Funding for this project**

This work is part of the wider Crisis, Flow and Inpatient Transformation Programme that to date has been funded through the Digital Directorate.

As this is an enabling project, there is not a true 'cost saving' attached to this, however the work contributes to the wider financial recovery work and is expected to support reduction in overspend and support ongoing financial efficiency.

16.17 Enhanced Bed Management

The Enhanced Bed Management workstream supports a number of key-enabling workstreams that make up the wider Crisis, Flow & Inpatient Transformation Programme (covering working age adults).

16.18 **What have we done to date**

The workstream includes operational improvements and reviews including:

- Improving Bed Management team structure and operating model to support improved operational management and optimisation of bed flow across WAA beds at SABP.

- Review of existing digital processes to support data validation (i.e. electronic transfers of care/readmission rates)

- Rollout of eObs to monitor and record patient observations. This helps clinical teams to manage inpatients more effectively

- Optimisation of smartboards following implementation on inpatient wards to support MDT, improved ward rounds and improved visibility/visualisation.

16.19 **Evidence of Impact**

- Data validation work is underway to analyse our readmission rates. This to understand true readmissions vs transfers of care (either from contracted beds to SABP beds or from PICU to Acute beds). The CFIT programme has requested this data regularly so that we can track and monitor.

- Initial work with the bed management team around structure and ways of working has proven positive. We are having a team away day in June to develop the operating model further with a view to improving operational processes.

- Smartboards were implemented on Juniper, Mulberry, Magnolia and Rowan wards. Whilst these are being used well, there is opportunity to fully optimise the use of these. The team are working to support teams with use of these. We are also updating the Clinical MDT room on a ward to be an MS Teams room which will improve operational processes and handover.

16.20 **Next steps**

- Continue to develop the bed management operating model.

- To identify further opportunities to optimise the smartboards working with clinical teams.

- Scale and adoption of eObs and to include physical MH observations in this work.

- Scoping of SAFER+/Red2Green work and benefits realisation work

16.21 Improving Discharge

The Improving Discharge workstream supports a number of key-enabling workstreams that make up the wider Crisis, Flow & Inpatient Transformation Programme (covering working age adults).

16.22 **What have we done to date**

The workstream includes operational improvements and reviews including:

- Design and implementation of Discharge Planning Tool to help improve admission and identify early on, barriers to discharge. The information capture has also been streamlined supporting improved operational efficiency.

- The 'Medically Fit For Discharge' nationally reported metric was recently changed to Clinically Ready for Discharge (CRFD).. Digital work was undertaken to mobilise this change and data capture requirement in the patient EPR.

16.23 **Evidence of Impact**

- The Discharge Planning Tool was piloted in February & March 2023 and has now been fully implemented. This has had a positive impact on identifying barriers to discharge as well as individual's personal circumstances much earlier in the patient pathway. The digital tool has been well received and adopted well and is proving positive in recording this information.

- 'Clinically Ready for Discharge' (CRFD) has been live since April 2023, however it is still going through the process of outlining the reporting and data representation, as the old 'DTOC (delayed transfers of care) needs to be closed off from a reporting perceptive. The Impact has been positive in outlining cases that are clinically optimised for discharged and has aligned itself to the inpatient operational processes that enables barriers to be unlocked with system partner. This is evidenced and gives the system an easy process to easily identified those CRFDs in 4 broad categories that can be used to improve the system and gain more awareness/ improvement within the discharge pathway

16.24 **Next steps**

- To continue to fully implement initiatives including those that support the financial recovery (i.e. discharge hub and vulnerabilities panel for complex patients)

- To explore Discharge to Assess Pathways and identify potential impact opportunity for SABP

17. Discharge Hub

17.1 **Outline of work**

The discharge hub brings together team members from **Surrey Social Services** (Social Services Manager and Social Workers), Community Connectiond **In-reach Team** (In-reach manager and workers) and **SABP staff members** (bed management team, including but not limited to Bed Flow Administrators, Discharge Co-ordinators, Bed Flow Managers), Administrators, Matrons, HTT Discharge Facilitators and our Associate Director of Flow and Bed Optimisation

This co-located multi-disciplinary team of professionals, focus on supporting people who are currently admitted to an SABP funded inpatient bed who may have potential barriers to a timely and safe discharge.

The aim of the hub is better help and manage the capacity of our inpatient SABP funded beds and support safe and timely discharges of people who are currently admitted.

17.2 **What have we done**

The team co-located in early 2023 and brought together relevant and appropriate external and internal team together into a physical space to enhance collaborative working

The team have developed better ways of taking practical steps to resolve the barriers that have been delaying safe and timely discharges.

What have we achieved:

- An identified physical space, located at Fern Lodge to benefit from the engagement, communication and accountability from in-person presence.
- Act on the known assumption that early identification and action on potential barriers can prevent unnecessary delays
- Multi-agency commitment to resolve the identified barriers to discharge, including regular updates from in-reach and social services
- Improve information flow between partner organisations through regular contact
- Improve access to our wards for our external partners through fob access and car parking
- Week-day morning meetings where the teams focus on the early discharge planning of people newly admitted to SABP funded inpatient beds. The meeting focuses on actions with attention on following up on those actions and the action owners. the team is now starting to address required actions for some people who have been in hospital a while and will focus on 5 people each week, and the daily associated actions to progress their safe and timely discharges.

- The Team review one case-study each week and what led to the admission of the person using our services (to start soon)
- Encourage, (and encourage more) the specific ownership of actions through the meeting.

17.3 **Evidence of impact**

The hub is aiming to:

- Reduce variation in the number of discharges per week
- Increase in the number of safe discharges per week
- Reduce length of stay upon discharge
- Reduce number of people with a length of stay over 75 days
- Early signs are already showing that reduction in length of stay of between 13-26 days:

17.4 Next steps

- Focus on people already admitted as well as new admission
- Aim to have input from brokerage in the hub meetings
- Newly appointed HTT Discharge roles

18. Vulnerabilities panel

18.1 **Outline of work**

A new cross panel comprised of senior leaders and commissioners has been set up facilitate immediate decision making around discharge for people with the most complex needs who have very long length of stays (100+ days) and require bespoke and complex individual community packages of support.

18.2 **What have we done**

There have been 3 panels which have reviewed 8 people who have been referred predominantly through the complex discharge panel.

18.3 **What have we achieved**

- Signed off terms of reference and confirmed the right system leadership attendees

- Recognised that the required support for people with presenting complex needs and circumstances are complex and as such require bespoke solutions which requires strategic commissioning support (which has been instigated)

18.4 **Evidence of impact**

- All of those seen by the panel have discharge plans in place/ have been discharged.

18.5 **Next steps**

- Expanding the panel to look at those known to be at risk of admission with similar profiles (including those on the dynamic support register)

- Strengthening the complex package of care through more innovative approaches. This includes working alongside strategic commissioning to further explore the market to identify providers who can offer bespoke packages of care under the Improving accommodation programme (see below)

18.6 **Funding**

There is no funding attached to the panel.

19. Improving accommodation with care and support for people with mental health needs

19.1 **Outline of work**

A Surrey County Council (SCC) programme of work is now in flight which builds on the formal approval of the inclusion of mental health into the accommodation with care and support (AwCS) programme. The programme focus is on prevention and addressing service gaps; alongside improving outcomes for people with mental health needs.

There are three key areas of work to help achieve the above:

1. A place to call home – accommodation that meets people's long-term needs

2. Support to recover - medium term accommodation to help people recover and become more independent

3. Short-term support - accommodation with support options to help prevent a hospital admission, manage a crisis or to avoid homelessness

19.2 **What have we done**

- Analysis of projected demand for supported independent living (SiL) for people with mental health needs indicates we will need an additional 185-210 units of SiL by 2030

- Analysis also indicates we need SiL specialisms for people with more complex needs and individual self-contained units and also outlines geographical gaps in service provision

- Workshop held with ASC, ICB and SABP colleagues in April 2023 with key actions arising around:

    - Further joint analysis with SABP of admissions/discharge data to be clear on what we need to approach the provider market to provide for the more complex and long stay cases

    - Joint work on the supported independent living specifications with new dynamic purchasing system to be in place by April 2024

    - Joining up of data around home treatment/home first team to demonstrate the need to invest further and scale up the offer to keep people in their accommodation and avoid unnecessary admissions

- Developed our Mental Health Accommodation with Care and Support Delivery Strategy which was approved by Cabinet in April 2023

19.3 **What have we achieved**

- Recruited a dedicated mental health supporting independence team to review people in existing SiL

- A review of in-house SiL, the Move to Independence service, and agreement to expand the provision

- Review of housing related support funded services, which provided greater certainty for providers and increased their commitment to working together to improve services

- Significant co-production to inform and develop new service specifications for SiL, with a new working age adult SiL dynamic purchasing system being tendered from September 2023, which will cover mental health and

disabilities. Proposal to separate services into support to recover and a place to call homes services.

- Exploring the opportunity to develop council owned land for SiL

- Agreement for the Sunbury hub development to include 6 units of self contained units of SiL for people with mental health needs

- Five sites have been allocated capital funding for feasibility assessments and allocated as in-principle for Supported Independent Living. These future developments are subject to successful feasibility assessments, full business cases and approval by Cabinet. The site names and locations are confidential and not in the public domain.

19.4 **Next steps**

- Continue to work with partners including SABP, the ICBs, District and Borough councils, providers and people with lived experience to deliver the strategy

- Bring together a task and finish group across health and social care to agree the action plan and any follow up task and finish group activity to progress the work identified in the April workshop

- Conduct feasibility studies on the 5 sites identified to confirm if they are suitable for mental health SiL

20. Extended Safe Havens (see annex also)

Under the financial recovery programme and on behalf of VCSE partners a funding bid to the Mental Health Investment fund was submitted unsuccessfully for additional resource to increase the daytime offering of the Safe Havens for three years to extend hours to deliver the service between 8am and 6pm at the Leatherhead and Woking sites at an annual cost of £585K.

21. Additional Update for Children and Young People

Under Recommendation 8. 'Engaging and supporting schools (part of wider CYPS work)'.

21.1 Mindworks Schools offer in District and Borough Clusters

- **Surrey's Mental Health Support Teams (MHST):** Overall planning and recruitment for next teams has commenced and remaining 4 MHST expected to start September 23. This will expand the team's growth and bring the total number of MHST up to 13 across Surrey.
- **School Based Needs Team:** School based needs team consist of Primary Mental Health staff, Community Wellbeing Practitioners, Early Intervention

Co-ordinators and MHST. Latest report from Primary Mental Health Teams: (Q4 23/24 data) Consultation sessions: 1325 of which 943 on direct CYP issues, top three being anxiety 14%, school refusal 13% and anxiety/ND 9% - self harm ~6%. There is a current caseload of 162 and all are being seen within 16 weeks. High satisfaction scores and lots of examples of positive feedback. Issues: access points / staff retention and recruitment / outcomes reporting.

21.2 Emotional Well Being and Mental Health Wider Strategy

- **EWMH Strategy**: The launch of the strategy was delayed due to staff sickness and delays in some engagement / feedback from NHSE / Stakeholder. It is now scheduled for mid-May following final agreement through CFLL LT on May 17th and Mental Health Prevention Oversight Board on 22nd May.
- **18 – 25 Transitions:** The YP Mental Health Transitions group have finalised the criteria for the Service Development Funding (SDF) investment for 23/24 to ensure there is a needs-based approach to improvement. Awaiting confirmation of SDF value and implementation process.

22. Progress against the 3 enabling workstreams

22.1 **Culture**

Under Recommendation 4. 'Improving relationships at every level (culture)'.

22.2 **Outline of work**

The quality of care we deliver, our openness to learning and improvement, and the degree to which our workforce feels valued and supported are all underpinned by our culture and approach to leadership. As such, culture change sits at the heart of the Surrey Mental Health Improvement Plan as a key enabler. As part of the wider MHIP, the MH Delivery Board are overseeing this workstream championing and supporting a reset of attitudes, values, goals, and ways of working.

The committee will be aware that Linguistic Landscapes were commissioned to undertake an independent review of culture with a focus on the fracture points in the system which impacted care delivery back in 2021/22.

A series of key findings and recommendations were made relating to 3 specific areas of change needed:

- Make relationships better: Relationships are not a 'nice to have' – they are essential to our work

- Have honest conversations: We need to interact differently to creatively solve problems together

- Remember we all care about the same thing: We all care about the individuals we're supporting – it's good to remember we're all in this together

22.3 **What have we done**

Given the resourcing constraints relating to this workstream and the ability to take the work forward, the areas of work where we have been focussing effort has been on:

1. MHIP programmes each to a identify culture priority
2. Evaluation framework (explore with Unity Insights)
3. Introduce system Schwartz rounds
4. Share findings widely with key partners
5. Scope and plan OD programme for MHSDB

22.2 **What have we achieved**

Changing culture and ways of working takes time. However, we have through the formation of the MHIP seen evidence of positive impact and greater collaboration across the system. Some examples are given below:

- **Surrey Heartlands Provider Collaboration:** A new Provider Collaborative involving three of the acute providers, Surrey and Sussex Healthcare NHS Trust, Royal Surrey NHS Foundation Trust, and Ashford and St Peter's Hospitals NHS Foundation Trust, and the mental health provider, Surrey and Borders Partnership NHS Foundation Trust has now been set up to look at better ways of integrating physical and mental health.

by:

- Transforming the experience of people with a long-term physical health condition who are twice as likely to have a mental health problem as their peers
- Improving the experience of people in mental health crisis who also require urgent and emergency physical health support
- Taking concerted action to address health related conditions and behaviours leading to a 20+ year life expectancy gap that persists for people with a serious mental illness.
- Working to ensure that people in mental health crisis are treated with the same degree of care and compassion as those requiring urgent and emergency care for a physical illness.

Change ideas have currently been developed which are now being worked through in detail to inform what rapid work can start and what longer term areas can be improved over time.

- The **Surrey Adult Mental Health Alliance** brings mental health provider organisations together around the shared vision of building good mental health and wellbeing for all the people of Surrey. Members of the Surrey Mental Health Alliance include VCSE, NHS and Local Authority delivery partners, local commissioning bodies of mental health services, and organisations representing people with lived experience. The purpose of the Surrey Adult Mental Health Alliance is to enable cooperation and joint working, at both strategic and operational delivery levels, ensuring that if anyone needs help, they will find services on offer for themselves and their family and carers which are welcoming, simple to access and timely. A key commitment of the Alliance is that no-one is turned away from a service without being given support to get the help they need. First established in 2021, the Surrey Adult Mental Health Alliance was formally constituted in March 2023 with the signing of an Alliance Agreement and the formation of the Adult Mental Health Alliance Board.

- The **Mindworks Alliance** has brought together statutory health and social care partner and voluntary sector partners to deliver emotional wellbeing and mental health services for Surrey children and young people.

- The **Coproduction and Insight Group** brings together a broad spectrum of system partners and people with lived experience. The monthly meeting always starts with a story from someone with lived experience where there is an opportunity to learn from both good and poor experience, including enabling closing the loop around escalations where needed.

23. Data and Digital

Under Recommendation 6. 'Good data and using it to good effect (data)' and Recommendation 15. 'Improve understanding at all levels of data sharing issues (data)'.

23.1 **Outline of work**

A recommendation from the October 2022 paper was '*For the Chair of the Mental Health System Delivery Board, the Joint Strategic Commissioning Convenors and Surrey and Borders Partnership, to use quantitative and qualitative data to direct the decision making process of the Mental Health Improvement Programme; and to update the Adults and Health Select Committee in a future formal meeting, on imminent/ensuing Mental Health System Delivery Board decisions on how to plan*

the delivery of the Mental Health Improvement Programme Plan, and on what data was utilised to direct these decisions'.

As part of the recently published JSNA chapter the Senior Responsible Officer noted caveats that big gaps remain in the data and the chapter and SRO recommendations include both a review of place based data and a commitment from the Surrey Analytics hub to take a key objective to manage availability and sharing of mental health data.

23.2 **What have we done**

To kick start this work an initial data pack was developed for the Mental Health system delivery Board (MHSDB) which collated and mapped all the system data where we record on mental health activity. Given the temporary withdrawal of support from the Analytics hub, the data pack was simply there to describe what data is available rather than undertaking any analysis of need.

The data included the key performance indicators for the NHS Long Term Plan deliverables for mental health. This is included as Appendix One.

However, the JSNA (despite noting there are gaps) has provided a significant pack of data and progress has been made on the patient record (see below).

23.3 **Patient Record**

The committee had previously requested details on the patient record, so the following explains and updates progress in the Surrey Care Record (SyCR).

The SyCR draws together and presents patient information from a range of settings including primary, secondary and community care, mental health and social care to provide an overview of a citizen's health and care status.

SABP are sharing the following data for MH:

- Demographics
- Referrals
- Care Programme Approach
- Diagnosis
- Mental Health Act
- Early intervention in psychosis

SyCR is currently accessible to the following organisations for Surrey Heartlands patients:

- All of our acute hospital trusts
- All of our main community providers
- Surrey Heartlands GP practices
- Our mental health provider
- Our 111 & OOH provider
- Surrey County Council (social care)
- A number of hospices
- The SECAmb control room records

SyCR does display ethnicity this data under 'demographics' when it is sent through by partners. The quality of this data is a question for those managing the EPRs where the data is captured e.g. SABP. The PSC completed a review of the recording of protected characteristics for the South East region and have had subsequent conversations with SABP to progress this.

There are plans to enable to VCSE colleagues to view SyCR. This is part of the Integrated Digital and Data Platform outline business case (which details future developments for key digital capabilities including SyCR) which got approval from the ICB Executive Board to move to full business case (FBC). We are anticipating the FBC being approved in September 2023 which will enable providing the resource to do so.

23.4 **Next steps**

- As a next step, the MHSDB has requested that a 'use case' approach is adopted to help navigate the available data when analytics capacity is identified.
- System leaders are currently trying to address the data issues and have now planned a Hackathon in June 2023 including population health management colleagues to further develop the 'use case' approach.
- To follow through on the JSNA SRO recommendations to complete a review of place based data and the commitment from the Surrey Analytics hub has taken a key objective to manage availability and sharing of mental health data.

24. Digital

Under Recommendation 10. ‘Develop and exploit the full capabilities of digital technologies (digital)’.

Adults and Health Select Committee in October 2022 received a paper title ‘MENTAL HEALTH IMPROVEMENT PLAN TECHNOLOGY UPDATE’ which provided the Committee with an update on use of technology and digital tools in the Mental Health Improvement Plan.

25. Workforce

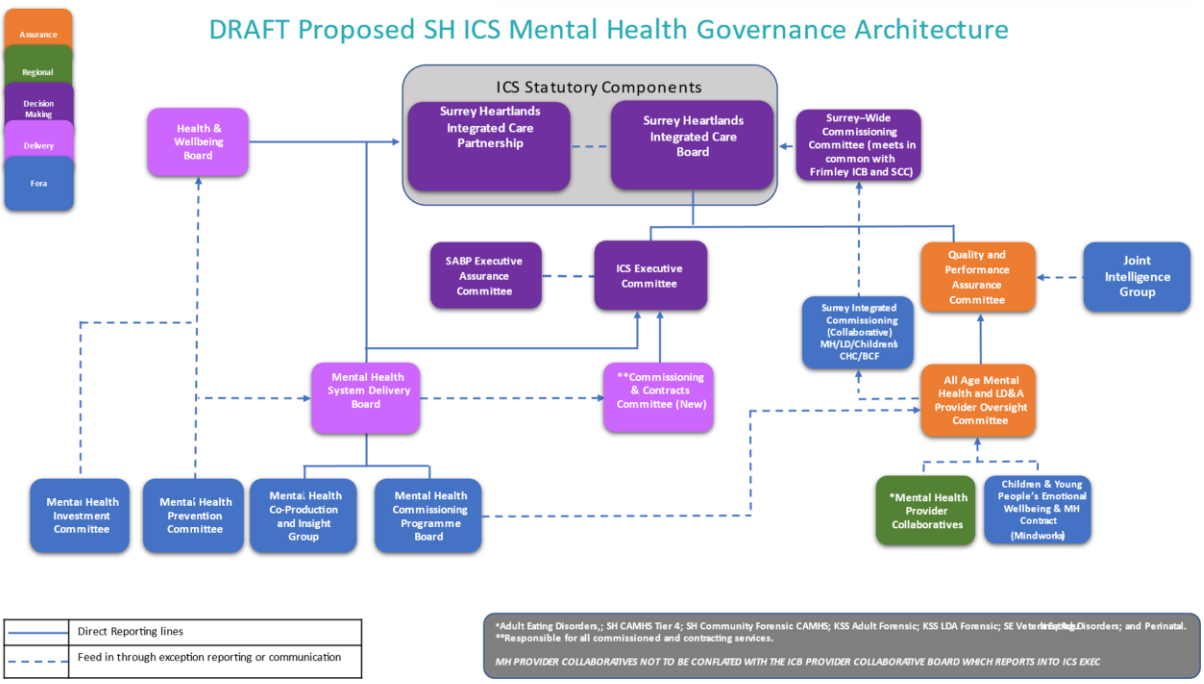
Workforce recruitment and retention remains a challenge across the Integrated Care System.

Mental Health System Delivery Board have set aside a significant slot for a workforce deep dive for the June Board and requested an update inclusive of data from all system partners in regard to mental health workforce including their current position in regard to recruitment and retention and work being done to address challenges. The MHSDB membership also requested that workforce wellbeing be considered.

This will build upon and add additional detail to the regular updates all partners submit to the Surrey Heartlands People’s Committee and the NHS focussed workforce data submitted as part of the annual operating plan 2023/24. Commitment was made by all partners including SABP, SCC (operations and commissioning) and the VCSE and providers.

26. Governance

Recommendation 9 was to ‘simplify and streamline MH governance’. The ***draft*** proposed entire SH MH system architecture is below and work is continuing to simplify and streamline the governance as also outlined below:



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The **Mental Health System Delivery Board** (the 'Board') oversees the improvement and transformation of mental health and emotional wellbeing in Surrey.

The scope of this work covers the full range of these services for all ages in Surrey. In particular, it includes the following existing and sometimes overlapping areas of work:

- The 19 recommendations underpinning the Mental Health Improvement Programme published in 2021 ('MHIP');
- 'Priority 2' of Surrey's Health and Wellbeing Strategy;
- Sustainability and financial recovery requirements of the health systems in Surrey;
- Delivery of the NHS Long Term Plan; and
- System ambitions around place, in line with local priorities and the recommendations of "Next steps for integrating primary care: Fuller stocktake report" published in 2022.

The remit of the Board includes all ages and covers the whole of the county of Surrey.

The Board does not have a role in assuring 'business as usual' delivery of mental health services or the awarding or management of contracts for these services. This function is performed by All Age MH and LD&A Oversight Committee.

System leaders continue to draft and develop the architecture.

Liz Bruce verbally presented the following suggested improvements to May MHSDB 2023:

1. Consider retitling the MHSDB to clarify the 'transformation' aspect of the Board remit.

2. MHSDB to report All Age MH and LD&A Oversight Committee as a formal Board (which in turn reports to Quality & Performance Assurance Committee 'QPAC') and up to the Integrated Care Board. The aim is to empower the board with more authority and reporting lines, and to be able to influence funding prioritisation and gaps in commissioning.

3. Rebalance the Board to ensure it does all ages (recognising that the Board business to date has been predominantly focused on adults).

4. Continue to develop and strengthen the remit of CPIG as a group that enables the voice of lived experience and stakeholders to feed into MHSDB

27. Programme Challenges (risks/mitigations/Table of risks)

During the context section risk were highlighted but are revisited below:

- Competing operational pressures
- Resourcing challenges to meet the need
- Funding position
- Scale of Transformation

- Staff Wellbeing
- Culture
- Digital and Data Insights

28. Conclusion

- The current **context** including the **funding allocation** is and continues to pose a significant challenge.

- The **Early Intervention and Prevention** programme is integrated and progressing.

- The **Bounce** Programme is a multi-faceted programme in development taking into account a vast array of pathways, stakeholders and experiences. It is at an early stage and will remain critical to deliver against.

- The **Crisis and Flow** Programme continues to deliver both projects and enabling projects to enable better flow and crisis response, led by SABP.

- Access to **data** remains a high risk. The planned Hackathon will enable the 'use case' approach to be articulated and bring together system partners including population health management and the Surrey Analytics hub to ensure the plan has the data needed.

- **Workforce** deep dive is scheduled for June 2023.

- Strengthening and streamlining **governance** will ensure a more direct route into the ICB for decision making, escalation and discussions on allocating of resources. This will improve the visibility of mental health priorities at a system level.

- In addition to the summary above, we recognise there is a significant amount of transformation work within mental health being undertaken outside of and in addition to the MHIP led by SABP, Surrey County Council, Mental Health commissioning, the VCSE, across our Acute Trusts and wider blue light services in response to the NHS Long Term Plan (LTP) deliverables and year on year operating planning and in response to emergent system challenges. **One integrated system mental health plan** would simplify this and support delivery and is agreed as the right approach by all system leaders.

- The **one integrated system MH plan** is proposed as multiyear to enable investment and resource planning, and to ensure opportunities such as those afforded by strategic commissioning and procurement can be planned in and realised.

- The one integrated system mental health plan would benefit strongly from being mapped against all other major health and social care programmes relevant e.g. Core 20+5; physical health and there are opportunities to articulate this approach e.g. within the aspirational Joint Forward Plan. As this report indicates, **programme and project management resource** is vital to deliver the broad range of mental health transformation under way in Surrey and the MHSDB Char and Deputy Chair recognise the need to resource adequately the all age MH transformation. There is a proposal for strengthening the Mental Health commissioning/programme capacity to

deliver on the MHIP and NHS LTP as well as developing Mental Health Integrated Commissioning Priorities and funding is being sought. There has been a formal request from Joint Executive Director **Adult Social Care & Integrated Commissioning** for time limited resourcing via underspends of vacant MH convenor role (vacant for over a year) and underspends in section 75 posts (previous requests have not been successful).

29. Recommendations

The Select Committee is asked to:

- Acknowledge the current challenging context.
- Offer any support to address the issue of funding allocation.
- Acknowledge and support the bringing together of all mental health transformation into one system Mental Health plan with allocated programme management resource.
- Acknowledge the progress made to date on the three major programmes and enablers.

Report contacts

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Contact details

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Sources/background papers

Emotional and Mental Wellbeing in Surrey Adults | Surrey-i (surreyi.gov.uk)

Pathways to Change Survey - Surrey Coalition of Disabled People

Surrey Minority Ethnic Forum (SMEF) and the Independent Mental Health Network (IMHN) Surrey & NE Hants: 'The Mental Health impact of Covid-19 on people from BAME groups and barriers to accessing services and support'.

Appendices

1. NHS Long Term Plan Year end data pack

SHICB Mental Health Report APRIL-23_v3.p

2. **Children and Young People:** *Mindworks Surrey challenges ahead*

- *In response to increasing number of referrals and activity, Intensive Support Services increased the workforce numbers to help meet the demand and needs of children and young people. The impact has left SABP in a deficit position making it unsustainable to continue running the Intensive Support service at the current cost. We are working with the Surrey Heartlands ICB, and plans are in place to address the cost pressures and look at how Mindworks may be able to meet the needs of children and young people in other ways through early intervention and support.*

- *SABP are working through this challenge as an Alliance and a children's system and remain committed to delivering the Mindworks vision and objectives. However, the impact of the plan is likely to result in the agency workforce in SABP decreasing and children needing clinical intervention may well have to wait longer before an assessment or treatment.*

- *To manage this situation further, transformation in the current offer is required. Mindworks partners are collaboratively working together with schools and families to see how a more robust and comprehensive family resilience offer can be developed, offer more intervention packages for under 10's / primary school /CYP in transition, expand the use of groupwork as well as strengthening work collectively with wider partners to have a Surrey wide early intervention support approach and embed THRIVE more firmly so that risk support is available from Mindworks to teams within schools and wider Children's services so they can be confident in their response to risk. How these ideas will be funded has not yet been agreed but one of the avenues to be explored is the new Mental Health Improvement Fund launched this year and funded by Surrey County Council and the Health System.*

- *Acknowledging this current context along with the financial deficit position described earlier requires significant transformation, to bring the contract costs back into balance otherwise managing down the spend will simply result in costs and care being shunted to other organisations in Surrey and worse outcomes for children and young people. Further thought regarding investment to these services and what radical transformation, such as how all schools could receive an offer like MHST that wraps around them and their children, could have influence on the lives of CYP, families and partner organisations. These matters are being explored through the Financial Recovery process overseen by the Surrey ICB.*

Annex:

Safe Havens

Within the admission avoidance section of the financial recovery driver diagram we included the extension to the safe haven offer to support people during daytime working hours and act as a diversion, particularly for the mental health liaison services based in the Surrey acute hospitals.

Four Safe Havens in Surrey and one in Frimley ICB continue to be run in:

- Aldershot, (NE Hampshire Place)
- Guildford, Surrey (Guildford & Waverley Place)
- Epsom, Surrey (Surrey Downs Place)
- Woking, Surrey (North West Surrey Place)
- Redhill, Surrey (East Surrey Place)

The Safe Havens in Epsom, Guildford, Redhill and Woking are open every day, including public holidays and operate between 18:00 and 23:00. The Safe Haven in Aldershot operates between 18:00 and 23:00, Monday to Friday and between 12.30 and 23:00 on weekends and bank holidays. Operating as an out of hours walk-in service, individuals can access the service through self-referral and signposting from a variety of organisations and services including but not limited to:

  - Community Connections
  - Child & Adolescent Mental Health Services (CAMHS)
  - Community Nursing Services
  - Talking Therapies

- Community Mental Health Recovery Service (CMHRS)
- General Practice Staff
- Citizen's Advice Services
- Employment Support Services
- Acute Hospital A&E including Psychiatric Liaison Services
- Police Services
- Ambulance Trusts
- Patient and Carer Representatives
- Housing Associations
- Homeless Centres
- Drug and Alcohol Services

The aims of the Safe Haven service are to reduce emotional and psychological distress by:

- Providing a safe environment, as an alternative provision to attending ED, for anyone experiencing or at risk of escalating to a mental health crisis
- Offering a safe, supportive and therapeutic environment, promoting independence, opportunity and recovery for all adult mental health service users in the community
- Promoting empowerment of service users by giving them the opportunity to identify their own needs; making their own choices about what will help them; develop their own coping strategies and tools, recognise their own strengths and talents; encourage hope and to work towards improving their own emotional wellbeing
- Developing partnerships with service-users, carers and statutory and non-statutory organisations, in order to provide more integrated preventative and crisis management provision
- Providing an environment which is physically and emotionally safe and welcoming for service users, carers and staff

- Encouraging service users to make use of their own social network and link into and be signposted to local services
- Delivering this service in an equal partnership between statutory health and social care services and the voluntary sector

The service is available for anybody aged 18 years and over.

A no 'wrong door' approach to access will be in place.

Any young people aged 17 and below that accesses the service are offered immediate support according to operational protocols and sign-posted to the appropriate Child and Adolescent Mental Health Services (CAMHS).

Anyone between the ages of 18-25 are able to access the Young Adult Safe Haven (YASH) in Guildford. The co-produced model is non-clinical with access to the Third Sector MH Practitioner at the adjoining service, if required, and will run 365 days a year from 17:00 – 21:00.

Each of the five Safe Havens also offer people experiencing a mental health crisis access to an out of hours virtual service. This means people are able to receive expert guidance and support from mental health nurses and trained mental health practitioners at a Safe Haven without leaving home. The virtual Safe Havens open from 18:00 – 23:00, seven days a week – the same hours as the Safe Haven sites. The Aldershot Safe Haven is open longer at weekends, from 12.30 to 23:00.

Evidence of current impact

The data below shows that in February 2023:

- Aldershot supported just over 120 individuals where the majority of support provided was to individuals experiencing a crisis
- Epsom supported 80 individuals where the majority of support was for crisis prevention
- Guildford supported 120 individuals where the majority of support was for crisis prevention
- Woking supported 80 individuals where the majority of support was for crisis prevention
- Redhill supported around 75 individuals where the majority of support was a mix between crisis and preventative support

Funding

Funding for Safe Havens will continue as planned. Each Safe Haven costs £250K per year to operate.

Under the financial recovery programme and on behalf of VCSE partners a funding bid to the Mental Health Investment fund was submitted unsuccessfully for additional resource to access when in crisis by increasing the daytime offering of the Safe Havens for three years to extend hours to deliver the service between 8am and 6pm at the Leatherhead and Woking sites at an annual cost of £585K.

Next steps

Surrey Heartlands ICB are currently continuing to explore additional funding which can be invested into this service.

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