ADULTS AND HEALTH SELECT COMMITTEE

3 MARCH 2021

GENERAL PRACTICE INTEGRATED MENTAL HEALTH SERVICE (GPIMHS) OVERVIEW AND SERVICE MODEL

Purpose of report: To provide the Adults and Health Select Committee with a detailed report on the General Practice Integrated Mental Health Service (GPIMHS).

Introduction:

1. The purpose of this document is to provide detailed information on the Community and Mental Health Transformation (CMHT) within Surrey Heartlands, Surrey Heath, and Farnham.

2. The CMHT Programme is implementing General Practice Integrated Mental Health Service (GPIMHS) across Surrey Heartlands and Mental Health Integrated Care Services (MHICS) across Surrey Heath and Farnham. The GPIMHS and MHICS teams are embedded into selected Primary Care Networks (PCN) through the NHS England (NHSE) early implementor CMHT funding.

3. Surrey Heartlands and Frimley Care are 2 of 12 early implementer sites to receive funding to transform the way Mental Health Services are delivered with the aim of enhancing mental health care and diminishing the boundaries that exist across primary and secondary care.

4. Within each PCN an integrated multi-agency GPIMHS/ MHICS team is deployed, including representation from health, social care, the 3rd sector and people with lived experience of mental health needs. Each team consists of:

   a) Clinical Lead,

   b) Mental Health Practitioner,

   c) Community Connector (employed by the Voluntary Sector),

   d) Administrator (Employed by the GP Federation or Lead GP Practice),

   e) Consultant Psychiatrist (1 Session per week (cover being sourced internally from SABP),

f) Mental Health Pharmacist 1 Session per week (cover being sourced internally from SABP).

5. The community mental health transformation journey began in 2018 with the successful field test of 3 GPIMHS teams providing integrating mental health support for people with complex and severe mental illness into Primary and Community Networks. £1m of Surrey Heartlands transformation funding was invested within the following PCN areas: COCO (Crouch Oak, Chertsey and New Ottershaw), Banstead and North Guildford.

6. The model was co-developed with a range of system partners, including mental health practitioners, people with lived experience and their carers, GPs, Voluntary Care and Social Enterprise (VCSE) providers (including Mary Frances Trust and Catalyst) and Improving Access to Psychological Therapies (IAPT) providers.

7. Building on learning from these initial field tests, Surrey Heartlands has successfully extended the model to a further 8 PCNs, and another 4 Frimley sites in Surrey Heath and Farnham making a total of 15 operational teams.

8. The transformation funding received from NHSE to implement the 8 PCNs within Surrey Heartlands is shown within table 1:

Year	2019 / 2020	2020 / 2021
Transformation Funding	£2,492,000	£3,599,159

Table 1: Surrey Heartlands Transformation Funding

9. The transformation funding received from NHSE to implement the 4 PCNs within the Surrey patch of Frimley is shown within table 2:

Year	2019 / 2020	2020 / 2021
Transformation Funding	£805,130	£1.795,608

Table 2: Surrey Patch Frimley Transformation Funding

10. The ambition is to scale the model and expand to all 25 PCNs in Surrey Heartlands and 7 PCNS in Surrey Heath and Farnham by 2024 through new national funding.

11. The service has been fortunate to be able to recruit to all posts in our first phase of the programme. We recognise recruitment is going to be a challenge as we continue to expand the service to other PCNs. We have considered this in our planning and plan to implement the services steadily over a two to three-year programme.

The Service Model

12. An overview of the model is shown within figure 1:

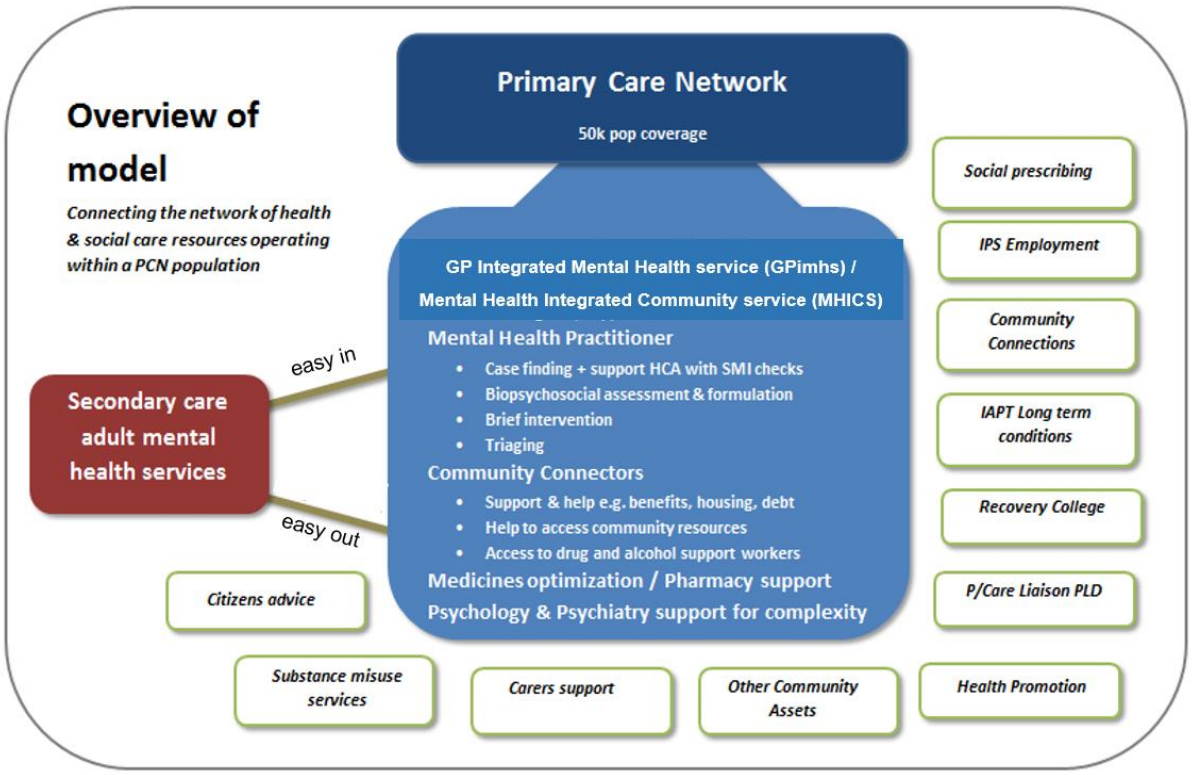

Figure 1: Service Model Overview

13. The ethos behind the GPIMHS model focuses on providing support for people with Significant Mental Illness (SMI) through close working within a primary care setting.

14. GPIMHS is the first port of call for GPs in seeking support for managing their patients with mental health presentations that do not meet criteria for existing VCSE, IAPT and secondary care mental health services. GPIMHS takes an assets-based approach to building on people's skills and strengths and:

    a) Provides screening, triage, assessment and formulation of need and care plans for patients identified by GPs.

    b) Provides brief therapeutic interventions.

    c) Provides support to people and carers/ family members to access the most appropriate community-based services, and not just signposting to other services.

    d) Provides Carers assessments as part of the service provision.

e) Comprises a multi-disciplinary team to include health and social care professionals working together to deliver the different components of the service in primary care.

15. The service focuses on significant mental health needs of people living within the specified PCN populations including those that:

    a) Do not meet criteria for accessing secondary care Community Mental Health Recovery Services (CMHRS) or are not appropriate for IAPT.

    b) Access and utilise health and care services in a potentially chaotic pattern.

    c) Find it difficult to access the right service within communities to meet their needs.

    d) Have physical health concerns, medication dependence, substance misuse, or co-morbid.

    e) Have physical long-term conditions that contribute to their poor mental health status

    f) Are ‘held’ by GPs resulting as frequent attenders and providing excessive proportions of nonmedical short-term prop-up interventions.

16. People currently in secondary care mental health services who are stable and would be well placed to alternatively receive recovery focused and integrated mental health care services in primary care, with seamless ‘easy in’ and ‘easy out’ as required, and with a potential shared care arrangement.

    a) For medication utilising the Local Contracted Service arrangements.

    b) People with Serious Mental Illness who are cared for in primary care who require physical health checks.

17. The model delivers support closer to people’s communities by wrapping services around PCN populations, building on community assets and involving voluntary sector, housing & social care partners.

    a) The model will improve access to National Institute for Health and Care Excellence (NICE) recommended interventions where required with increased and easy access in and out of highly specialised psychological therapies for people with SMI.

    b) ‘Easy in, easy out’ approach will remove unhelpful referral thresholds and barriers using a trusted assessor model.

c) Care can be stepped up and stepped down flexibly without cumbersome referrals and multiple assessments.

d) There is a focus on support for younger people (18-25): young people who transition from children and young people's mental health services (CYPMHS) and are accepted by adult mental health services.

e) Those who do not meet the criteria for adult mental health services but have continuing needs and require care.

f) People presenting for the first time.

18. The model creates better links to support in the community with issues such as housing, employment, training, with support accessible directly through primary care (Community Assets & Resilience).

19. The model provides better support for carers and families and additional training for those providing services.

20. Appendix 2: Provides further information about the service through the form of a patient information leaflet.

Carers

21. As a Primary Care integrated Mental Health Service GPimhs & MHICS is designed to be easily accessible to both Patients and Carers. Given that these teams sit between GPs (who have the GP Carers Quality Markers) and Adult Secondary Care (who have the Triangle of Care Standards) GPimhs/MHICS holds an emphasis on the following aspects of NICE Guidance which are key for Carers who so often fall in the gaps between services (i.e. Information and support for Carers; Identifying Carers; Assessing Carers' Needs). In recognition of the valuable role GPimhs/MHICS has in identifying and supporting people to access care, both Appearance of Need and Caring status (is the person a Carer, do they have a Carer, do they have a young Carer) is explored and recorded in the initial appointment with a practitioner from the team. These Carers records include GP codes (SNOMED) so that this data is then accessible through the GP EMIS system, and there is quick access to the Carers Prescription via the online portal (which is on the front page of the electronic system used by GPimhs/MHICS (Integrated Tactical Solution - ITS)) and another portal to access the Surrey County Council Adult Social Care where there is an appearance of need.

Personality Disorders

22. GPIMHS also provides a focus on people improving the pathway for people with Personality Disorder traits and their carers/families. The new model includes 3

new pathways: Managing Emotions Program (MEP), Service User Network (SUN) and Psychologically Informed Consultations and Training (PICT). An overview of the model is shown within Figure 2:

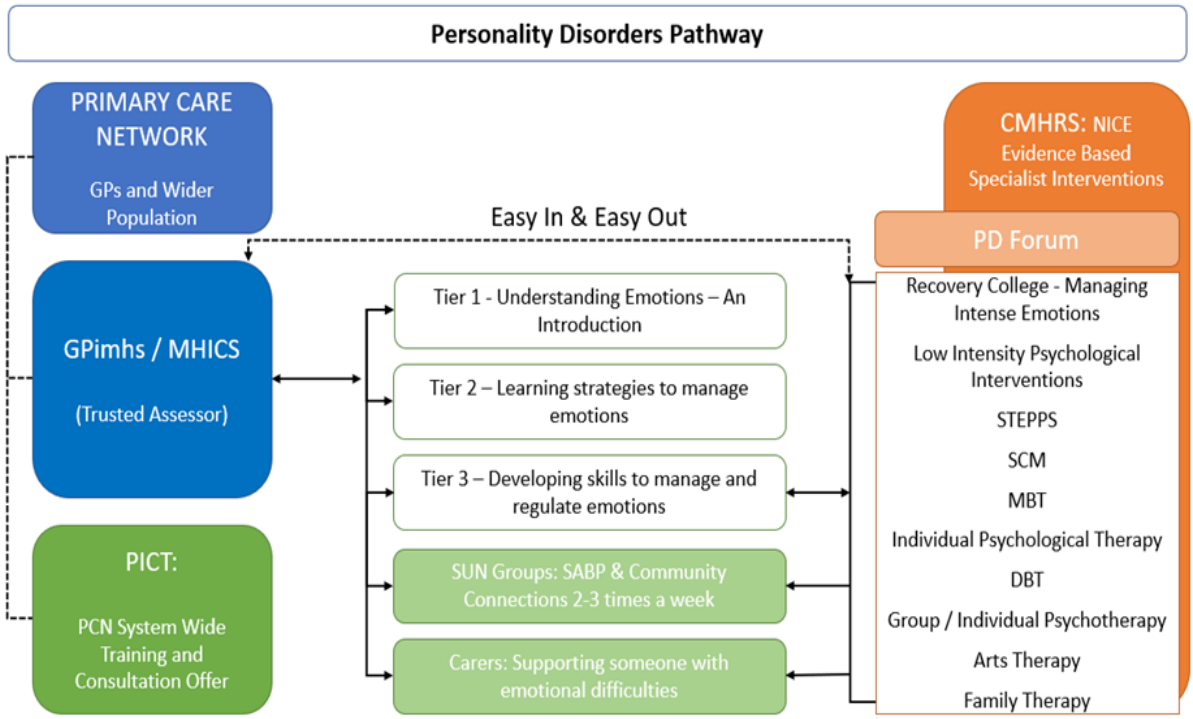

Figure 2: Personality Disorders Model Overview

23. The Personality Disorder Pathway is being rolled out across all the PCNs, with the ambition of having all the personality disorder models operational by March 2021.

The Voluntary Sector

24. Across Surrey (including Surrey Heath) there is already strong partnership working with the VCSE sector and robust commissioning arrangements through an umbrella contract with three main VCSE Providers (Catalyst, Mary Frances Trust & Richmond Fellowship) under the 'Community Connections' contract. The model provides a biopsychosocial approach in primary care and VCSE colleagues in the form of Community Connector roles that are fully integrated into the 15 teams in Surrey Heartlands, Surrey Heath and Farnham.

25. CMHT Funding is provided to each of the VCSE partners to employ the Community Connector roles. The VCSE organisations we work with are Catalyst, Mary Francis Trust and Richmond Fellowship. SABP utilise standard NHS contracts with each VCSE partner which allows the Community Connector to co-locate themselves within each of the GPimhs/ MHICS teams. Additionally, three new VCSE roles in the form of Service User Network (SUN) peer co-facilitators have been employed to support the Personality Disorders pathway.

26. As part of our Developing Community Assets work programme we are also in the process delivering a peer support model which would be CMHT funded and delivered through our VCSE providers in the form of Peer support workers and funding for existing services.

Reablement Pilot – Social Care

27. We are excited to field test a new innovative reablement offer in our Woking PCN-GPIMHS area for people with complex mental health needs. Working closely with Surrey County Council across health and social care and voluntary sector. This service will better support people to recover quicker and reduce their reliance on statutory services, creating a greater feeling of independence and wellbeing.

28. GPimhs will provide mental health support to the people that use of the reablement service and require additional support. This involves working closely with the reablement team to identify people that may benefit/ require the additional support. CMHT funding provided £100k to Surrey County Council to deliver the reablement pilot/ test site in Woking.

29. The learning from the reablement filed test would need to be evaluated and additional funding sourced if the reablement offer was to be extended to other PCNs where GPimhs has been implemented.

PCN Locations and Service Impact

30. The MHICS PCN locations within Surrey Heath and Farnham are shown within table 3: The GPIMHS PCN locations within Surrey Heartlands are shown within table 4:

31. PCN name	Population	Number of GP Practices
Surrey Heath	60,000	7
Farnham	46,000	5
Aldershot	44,000	4
Farnborough	60,000	6

Table 3: Surrey Patch Frimley Care PCN sites

PCN name	Population	Number of GP Practices
Banstead	47,000	5
COCO (Chertsey, New Ottershaw and Crouch Oak	43,000	3
North Guildford	56,000	4
North Tandridge	42,000	4
SASSE Network 2	44,000	5
East Guildford	57,000	6
Leatherhead	64,000	8
Woking Wise 1	31,000	5
Woking Wise 2 and 3	59,000	7
Integrated Care Partnership	33,000	4
Epsom	58,000	7

Table 4: Surrey Heartlands PCN sites

32. Prior to the introduction of GPimhs / MHICS there were limited arrangements for people to be seen within a primary care setting. The 'operational / go live' dates for each of the PCN's is shown within figure 3:

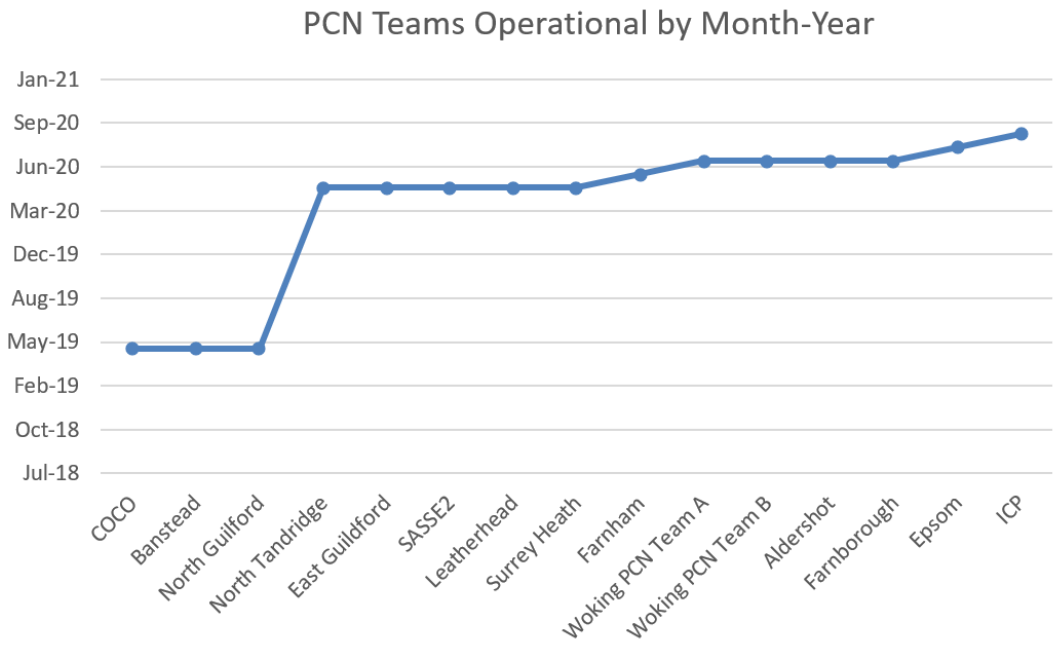

Figure 3: PCN Teams Operational by Month – Year

33. Since May 2020 through to January 2021, the total number of referrals and consultations GPIHMS/ MHICS teams have delivered is shown within figure 4:

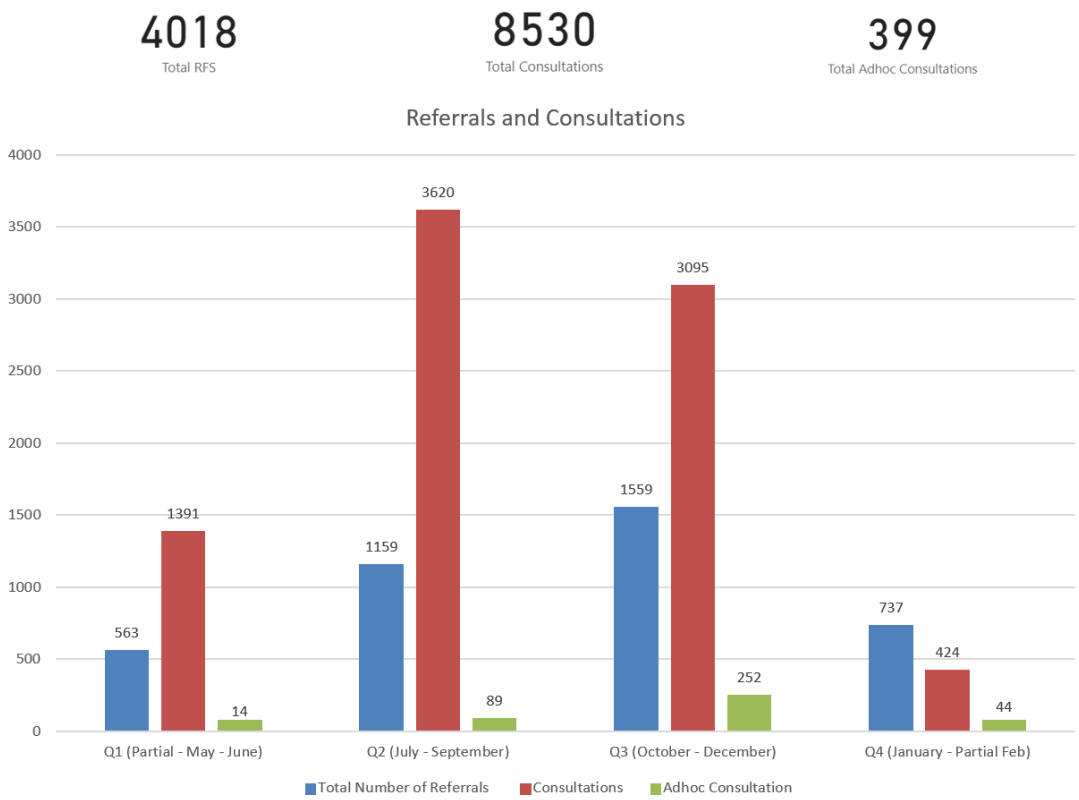

Figure 4: Referrals, Consultations and Ad-hoc Consultations

34. COVID has meant that some teams have received significantly higher number of referrals. To date the service has received a (Request for Service) RFS for over 4,000 patients presenting with significant mental health issues in primary care, 20% of whom were younger adults (18-25) and 10% older adults (65+), with 15% of all requests for service for people identified as Carers.

35. Outcome measures: For patients attending GPimhs appointments, Patient Rated Experience Measures (PREMS) are completed through an R-Outcomes online survey. This has shown very high patient satisfaction of the service, which aligns to increased access to community resources being reported by Community Connections partners in the project and anecdotal reports of positive impacts in primary care. Identifying impact across the system (e.g. reducing the number of referrals being rejected by adult secondary care) will demonstrate current benefits guide the future service provision, whilst further involvement of service users in co-production will play a key role in ongoing service developments.

36. Recent PREM examples are listed below:

a) *really impressed with how good things have been - wasn't expecting it to be like this - you've done everything you can for me and gone above and beyond - really grateful for your help - there are so many small barriers that just get overwhelming but you've helped me with things even small like registering with a dentist that I haven't seen for the past 15 years and printing my PIP form as I haven't got a computer and linking me with some great support services that I didn't know existed. It's great to know that I can come back if I need to as well as a "safety net".*

b) *Great service with really genuine supportive staff. this service helped me work through a nervous breakdown and i am so grateful for the help i have received*

c) *Helpful to talk about my issues. Helpful to refer to carer support [carer prescription] and to talk to mental health services [about her husband's needs and her carer burden].*

37. Recent feedback from GPs who have referred patients to GPimhs are listed below:

a) *real step change to supporting the gap between IAPT and CMHT Easily accessible, integrated medical record Patients love the informality and locality of the service ..less threatening / stigma The team are great ..always willing to help and provide high quality holistic service for patients needs supports hard to reach / complex patients with social issues really good feedback from my patients Thank you GPimhs for making my patients life somewhat better and mine also !*

b) *Excellent community mental health service! Wide scope of referrals taken Easy access for patients and less stigma Good quality holistic psycho social care provided and been very helpful with support for patients through lockdown and going forward Proactive cold calling of patients on SMI register ..well received by patients at this time Excellent recorded feedback to GP Complex patients can be discussed with mental health practitioners via email or phone Regular PCN update to inform future planning with collaborative involvement Starting pilot on bridging with SPA and CMHT*

38. Appendix 1: Provides some case studies which describe the difference the service is making.

Future Transformation Funding

39. The Community Mental Health Transformation programme is in the process of bidding for an allocation of NHSE Fair share funding, the final bid was submitted 29 January 2021.

40. The transformation funding will allow the expansion of the GPIMHS/ MHICS model to an additional 12 Surrey Heartlands PCNs as shown within table 5:

PCN name	Population Coverage	Number of GP Practices
Care Collaborative	48,000	3
Dorking	39,000	4
East Elmbridge	54,000	7
East Waverley	50,000	5
Healthy Horley	25,000	3
Redhill Phoenix	17,000	3
SASSE Network 1	53,000	4
SASSE Network 3	16,000	4
South Tandridge	24,000	2
West Byfleet	26,000	3
West of Waverley	41,000	4
Weybridge and Hersham	58,000	8

Table 5: Surrey Heartlands Expansion PCN Sites

41. The transformation funding will allow the expansion of the GPIMHS model to an additional 3 Frimley PCNs as shown within table 6:

PCN name	Population Coverage	Number of GP Practices
Yateley	27,000	1
Fleet	46,000	5
Surrey Heath (Expansion)	37,000	7

Table 6: Surrey Patch Frimley Care PCN Expansion Sites

42. In addition to the GPIMHS Expansion to PCNs, we are also implementing the following care pathways:

a) Younger Adults (18 to 25)

b) Older Adults

c) Adult Eating Disorders

d) Mental Health Rehabilitation

43. A high-level timeline of the GPIMHS expansion is shown within Figure 5:

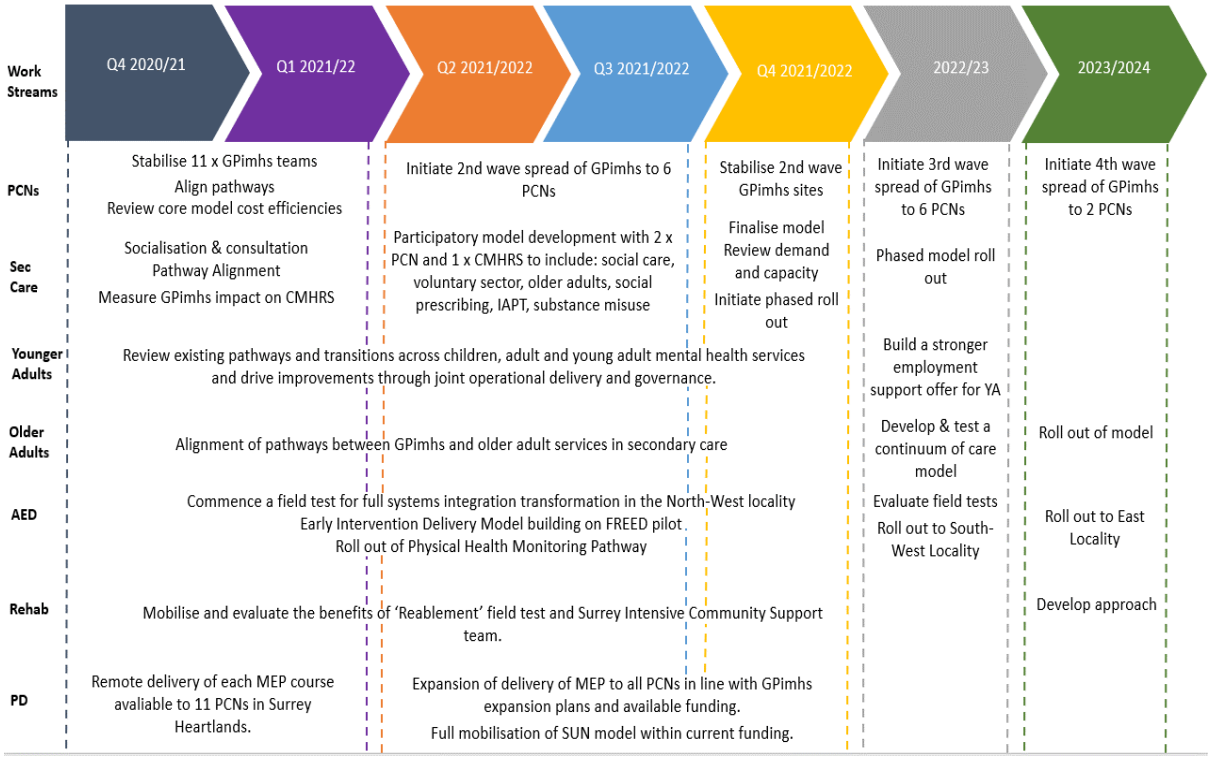

Figure 5: GPIMHS and Care Pathways Expansion

44. The transformation funding which is available to expand the service within Surrey Heartlands is shown within table 7:

Year	2021 / 2022	2022 / 2023	2023 / 2024
Transformation Funding	£1,578,105	£2,270,272	£921,604

Table 7: Transformation Funding

45. The CCG Baseline uplift for each year is shown within table 8:

Year	2021 / 2022	2022 / 2023	2023 / 2024
CCG Baseline Uplifts	£221,337	£768,688	£3,266,743

Table 8: Surrey Heartlands Expansion PCN sites

46. The approximate transformation funding which is available to expand the service within Surrey Heath and Farnham is shown within table 9:

Year	2021 / 2022	2022 / 2023	2023 / 2024
Transformation Funding	£441,537	£634,242	£255,724

Table 9: Transformation Funding

47. The CCG Baseline uplift for each year is shown within table 10:

Year	2021 / 2022	2022 / 2023	2023 / 2024
CCG Baseline Uplifts	£59,030	£202,250	£857,097

Table 10: Surrey Heartlands Expansion PCN sites

48. In addition, we are taking on a whole transformation programme approach to enhance the connections between primary and secondary care, this will look across all services and transform the way Mental Health care is delivered.

Recommendations:

49. The Select Committee is asked to:

a) Offer its support for the GPIMHS and MHICS approach

b) Acknowledge that in Surrey Heartlands conversations are happening about the acceleration of the GPIMHS rollout, but that this would require additional investment beyond that outlined for the CMHT Programme and would be dependent on identifying the workforce

c) Receive a further update on the progress made regarding funding and workforce at a future meeting

Next steps:

Identify future actions and dates.

Report contact

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Appendix 1: Case Studies

GPimhs/MHICS - Anonymised examples of work with patients and carers.

Working with patients with significant mental health issues and their carers; the role of integrated mental health teams to facilitate support addressing the social determinants of mental health and aid easy-in & easy-out access to evidence-based interventions.

Case Study A

Mrs Smyth was referred to GPimhs with anxiety and depression, which transpired to be associated with continuous infections resulting from damp in her home and frequent visits to her GP for support and medical attention. She reported feeling socially isolated and depressed and was struggling physically and mentally to engage with the community. GPimhs discussed with her about contacting the Council's Estate Offices, and guidance on how to access Safe Haven for emotional support, with follow up with GPimhs. With Mrs Smyth's consent GPimhs made arrangements for a Housing Officer to visit to assess property. At the GPimhs follow up appointment, Mrs Smyth reported that her home had been refurbished by the council, and said she was feeling better and had found the GPimhs support very helpful.

Case Study B

I met with an unemployed client in her 50's who suffers from severe arthritis and has difficulty climbing stairs, in addition she disclosed that she was acting as a carer for her husband who also had a physical disability. She was living in a two-story rented property which had no adaptations in place and was not suitable for her and her husband's needs. The stress of her caring role in addition to financial pressures was placing a significant strain on this client to the point that she reported difficulty sleeping and suffering from generalised anxiety. The client had previously been unaware that she would be entitled to claim carers allowance and, dependent upon the outcome of a Care Act assessment, additional funding in order to make adaptations to her home. Over the course of three sessions with the client we completed a referral for a Care Act assessment, an application for carers allowance and also completed some Cognitive Behavioural Therapy (CBT) work around managing anxiety before referring on to an IAPT service for further support.

Case Study C

Jerome experiences anxiety around his weight which he directly links to his diagnosis of Chronic Obstructive Pulmonary Disease (COPD). He had a recent breakdown of marriage and struggles to go out and meet his friends as he is the only singleton and worries people with judge him for his illness and his weight. We

discussed health anxiety and Jerome found it helpful to know that he is having what he reports a 'normal' response to his situation. We did a piece of work around smoking cessation and he reports he has significantly cut down from 30 cigarettes day to 4 a day over the last month. A referral to IAPT Long Term Conditions (LTC) service was made for Jerome to manage his anxieties relating to his COPD diagnosis. He is currently still working with IAPT; however, he reports it is going well and feels he is learning new coping mechanisms and 'can notice a change' in his thought processes.

Case Study D

Renata was referred to GPimhs for support with addressing a complex presentation involving low mood, anxiety, migraines and functional neurological symptoms, leading to impaired speech, difficulty walking and fatigue. Renata was at times accessing emergency services with concerns about physical symptoms and latterly having numerous GP consultations where she expressed distress and thoughts of suicide. Renata has been turned down for CBT due to the complexity and did not feel able to attend wellbeing workshops. Renata has had 4 face-to-face appointments and 3 booked phone calls over the last 2 months. There has been communication with her usual GP, sharing information about risk and forward planning.

GPimhs appointments have focussed on discussing the relationship between her physical symptoms and emotions – for example that she is more likely to experience intense emotions when fatigued, that she feels upset by her speech and walking difficulties, and more likely to experience slurred speech following distress. She is starting to understand and address a longstanding pattern of trying to ignore her mind and body, which has caused a boom-bust approach to life. Following discussions in sessions, Renata has been practicing relaxation strategies to positive effect. She is pacing herself better and adapting her expectations of herself with a more self-compassionate approach. This has led most recently to fewer episodes of extreme distress and a quicker recovery time from distress. By spending fewer days recovering in bed from emotional and physical difficulties, she is more able to care for herself consistently, such as eat regular meals and scheduling activities. Renata is now feeling able to consider a voluntary role as a step towards employment. She is also feeling more able to engage with talking therapy and wellbeing workshops following this initial period of engagement under GPimhs. She potentially may be offered psychology through GPimhs regarding mind-body links with Medically Unexplained Symptoms.

Case Study E

Elijah is an older man who recently had a closed head injury from a fall and has ongoing cognitive changes that both he and his wife, Sylvia, are needing to adapt to such as difficulty with memory and information processing. Since returning home

from hospital, he has struggled with low mood, thoughts of being useless and lack of motivation. The social services community occupational therapist has discharged him with little progress as he did not act on her advice. He has been assessed for IAPT interventions and despite scoring highly for depression and anxiety, found not suitable due to the memory difficulties and difficulty generating ideas. He is awaiting assessment from the memory clinic.

Elijah has been seen for a brief intervention by the GPimhs link worker and chose to include Sylvia in the sessions. These involved discussion about his current and past values, and strategies to increase Elijah's role in the household towards his own goal of being more independent. They are managing to go out more and meet friends. Elijah: "I have really valued these sessions. We get to talk about things that really matter to me. I feel more positive that I am a person – and have a future." Sylvia: "It has been so useful to get Elijah talking about what is going on – and to be part of the sessions myself. I have been floundering on my own and feel I have more structure of what to do. It has been great to see Elijah more positive."

Case Study F

John reported experiencing low mood and social isolation due to being unemployed. He had been misusing alcohol, which has been worsening, as a way to 'blank off' his issues and would normally present to his GP for support. We discussed what would help; John was interested in going back to work however he was unsure if he could manage. We talked about a referral to Richmond Fellowship, and filled in the forms together and bridged up to the service. John was happy and ready to address alcohol misuse and gave consent for me to refer to Catalyst for support with alcohol addiction and counselling. Follow up appointment with GPimhs John reported having had contact and appointment with Richmond Fellowship and Catalyst re referral. He was happy to engage with these services and was hopeful interventions will improve his physical and mental health. John reported at the follow up appointment that he had not needed to see his GP in 4 weeks as he was happy with GPimhs interventions and receiving the right support for his issues.

Case Study G

Steve was referred to GPimhs for Depression, Anxiety and previous thoughts of suicide. He reported that he was homeless as his long-term partner had asked him to leave due to excessive drinking.

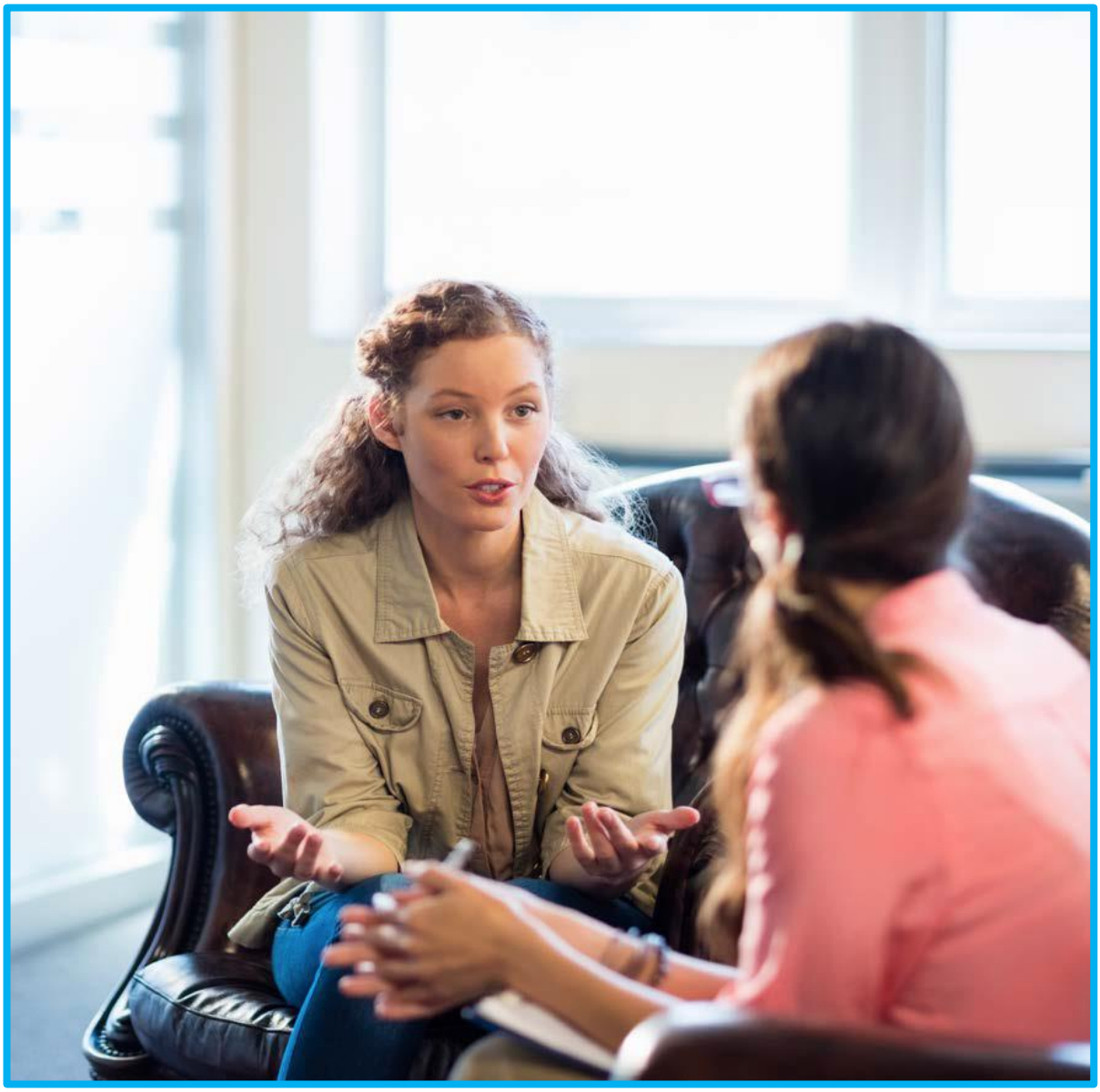
Steve had a panic attack earlier in the year, which led to his relatives taking him to A&E where he was admitted and seen by the Crisis Team, who discharged him and referred him onto IAPT. Steve was seen by an IAPT service who told him that he was not ready for CBT; he attended one session and did not return. Steve moved back to Guildford to live with a sibling who supported him to sign up for Universal Credit and to contact HOST (a Charity in Guildford that support individuals with

accommodation) for assistance with securing accommodation. The plan agreed during the session with GPimhs involved a counselling referral to Catalyst and to attend SMART (Self Management and Recovery Training) Groups with ongoing support from GPimhs.

For structure and to reduce isolation and loneliness, a discussion about the benefits of engaging with Oakleaf for social engagement and their upholstery course to learn new skills was identified. Safe Haven information and the Crisis Line as well as Samaritans was provided. The counselling assessment appointment with Catalyst was attended and Steve maintained drink diaries as he felt he needed to address his drinking to move on. He drinks socially now and does not drink to suppress his emotional pain. Steve said that he can still have low mood and experience days where he feels upset, but feels he is making progress and has support in place, attending Safe Haven now as well as maintaining his sessions with the counsellor. Steve reported that having GPimhs and counselling services had made a real difference in his life and felt more settled knowing there was support for him and said he might be moving in to a flat.

Appendix 2: GPimhs / MHICS Information Leaflet

Primary Care Networks



GP Integrated Mental Health Service (GPimhs)

Mental Health Integrated Community Service (MHICS)

What is the GP integrated mental health service/ Mental Health Integrated Community Service?

GPimhs/ MHICS brings expert advice and guidance for people experiencing a wide and potentially complex range of mental health & emotional wellbeing issues into your GP practice, working to understand your needs and connect you with services to provide the support you need in the community.

We all experience difficulties in life. Sometimes we need more help in understanding and coping with these difficulties, especially when they begin to affect our general wellbeing, level of everyday activity and personal relationships.

Due to the current outbreak of COVID-19 we have adjusted the way we work for the time being and face to face appointments are not currently available. Our staff will be able to discuss the best method to support and communicate with you when they ring to arrange your initial appointment. This could be by telephone or a secure online video call if that option is available to you. We hope to be able to offer face to face appointments in your GP Practice in the future as the guidance changes.

What can the service offer you?

- An initial assessment which gives you enough time (around 30 minutes) to discuss what is going on for you and we will work with you to make a plan.
- Quick, easy access to practical advice, guidance and if required support to connect you into services and/or treatments that can help you achieve your goals

Who can use this service?

GPimhs/ MHICS for anyone over 18 experiencing mental health problems or difficulties that are impacting their everyday life would benefit from this service. You don't need a diagnosis to be supported by GPimhs/ MHICS and once we talk if it is felt that another service might better meet your needs, or if you are already getting support from elsewhere, we will work with you to think about this and find the best solution that works for you. We will also seek to ensure that people's wellbeing and independence is enhanced by involving their family, friends and anybody who supports you in keeping you well.

What can you expect?

Telephone/ virtual (online) appointments generally last for around 30 minutes and we may offer you more than one session. Each appointment is an opportunity for you to talk about what is happening in your life and how this is making you feel. We can then help you make sense of that and support you to make a plan to address the things that matter to you.

This plan won't just cover your mental health and physical health but will include supporting you with things that may be impacting your life and mental health such as finding a job, getting out of debt, managing relationships or ensuring you are linked to the appropriate housing advice services.

You may be put in touch with a different member of the GPimhs/MHICS team who will be best placed to support you.

Who works with us?

GPimhs/ MHICS consists of a team of practitioners from different NHS and community backgrounds who are experienced in helping people with their mental health and emotional wellbeing. We work closely with your GP.

You may in the first instance receive a telephone call from our team administrator and be offered a phone appointment with a member from the team, such as a mental health

practitioner or community connections link worker. They will work with you so that you are supported with your difficulties in a way that feels best for you.

We can provide support in the following areas, which will be agreed in discussion with you:

• Information and guidance around emotional and physical wellbeing.

• More time to help make sense of difficulties.

• Practical support to access community resources.

• Brief interventions around ways of coping with stress and anxiety.

• Access to mental health pharmacist.

• Links to other mental health services and providers of therapy.

• An ongoing plan that is shared with your GP.

How can you get in touch with GPimhs/MHICS?

You will be referred to GPimhs/MHICS by your GP or Practice Nurse. If you have an appointment and need to reschedule, please email the PCN email address or call the Administrator

We are not a therapy service but work closely with providers of talking therapy. If you wish to access talking therapies for common mental health problems, we can provide you information about this

This service is provided through Surrey and Borders Partnership NHS Foundation Trust who are the lead data controllers, for more information on how we use your data please visit our website https://www.sabp.nhs.uk/our-services/advice-guidance/sharing-your-info

If you're in crisis

Please note, this is not an emergency service. There are other ways to get urgent help if you or your loved one is in a mental health crisis.

Crisis helpline

Open 24 hours a day. 7 days a week: 0800 915 4644

If you have speech or hearing difficulties text 07717 989024.

Safe Haven

Open for people experiencing a mental health crisis: 6pm to 11pm, daily

During the Covid-19 outbreak the Safe Haven remains open but has shifted its focus to supporting just those experiencing a mental health crisis.

For other Safe Havens across Surrey visit https://www.sabp.nhs.uk/our-services/mental-health/safe-havens

If you would like this information in another format or another language, please call 01372 216285 or email communications@sabp.nhs.uk

Surrey and Borders Partnership

NHS Foundation Trust

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