Getting started:

Lessons from the first year of implementing the Community Mental Health Framework

September 2022

About Rethink Mental Illness

For 50 years, Rethink Mental Illness has been the charity for people severely affected by mental illness. No matter who a person is or how bad their situation has got, we are here to help them get the information and support they need to live a better life.

On top of this, we do our utmost to ensure people living with mental illness and their carers are listened to, treated fairly, and have easy access to the health and social care services they need.

This involves us campaigning on a local and national level and working with a wide range of organisations, including other charities, private businesses, the NHS and local authorities, to create communities that care.

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Introduction

The Community Mental Health Framework represents a once-in-a-generation opportunity to change community mental health care and support for the better. The Framework was launched in 2019 following landmark commitments made within the NHS Long Term Plan, with a small number of early implementer sites getting started later that year. In April 2021, the Framework began rollout England-wide, with all remaining Integrated Care Systems (ICSs) beginning their journey of community mental health transformation.

Rethink Mental Illness is strongly supportive of the Community Mental Health Framework and are keen that its ambitions are realised across the country. Our dedicated Community Mental Health Unit has been involved in supporting the rollout of the Framework in 13 ICS areas across England, supporting co-production with those who have lived experience of mental illness and aiding collaboration both among voluntary, community, and social enterprise (VCSE) sector organisations and between these organisations and the NHS.

Through this extensive work and researching our two previous step-by-step guides[1,2] designed to support rollout of the Community Mental Health Framework, we have identified factors that are crucial to the success of community mental health transformation. Each chapter of this report explores how rollout of the Framework is progressing across the country in its first full year through this lens. We have identified ground-breaking successes and good practice, as well as common barriers and potential solutions to overcome these. Inevitably in its first year, challenges have emerged, but there has also been tremendous progress.

The research analyses the findings of a survey and 37 in-depth interviews undertaken in Spring 2022. Interviewees included national stakeholders and those working locally on the ground across 11 ICS areas. (A breakdown is provided in the appendix.) They also represent a cross-section of key stakeholders involved in transformation, including NHS, local authorities, experts by experience and VCSE (Voluntary and Community Sector organisations). Their voices are showcased throughout this report where we have strived to illuminate the issues and identify possible solutions. To ensure a complete view of what is happening across the country, we have included both areas where Rethink Mental Illness is activity involved in supporting and delivering transformation and those where we are not; and have engaged with communities of different sizes across England.

1 Rethink Mental Illness (2020) Thinking differently: A 'first steps' guide for transforming community mental health
2 Rethink Mental Illness (2021) Keep thinking differently: continuing your journey of community mental health transformation

Chapter 1: Measuring success

Summary

Our research revealed many examples of good practice, however, there was a lack of knowledge-sharing between local leaders. In fact, 'good practice' often meant different things to different people, and arriving at a clear definition of a what constituted success in transformation – and how it could be measured – was a challenge reported by many.

This chapter examines how success is currently measured and argues that further consideration should be given to how this could be done differently.

There are three main issues around measuring the success of transformation:

- **a focus on quantitative measures** – what has been the implication of the focus on access during these early stages of the rollout?
- **the challenge of measuring quality** – how is the qualitative value of transformation services really to be determined? What is a 'quality contact' – and how is this to be identified?
- **what information to look for** – what specific information is required, and how can it be gathered at different stages along the transformation journey?

A focus on quantitative measures

Nationally, until recently, NHS England's measure for success has been based primarily on access figures - the number of people who are accessing services under the new models:

> "The Long Term Plan ambition is to see an additional 370K adults and older adults by 2023/4 in integrated models of care. This is our main metric of access progress. This is the number of people within a transformed primary care network receiving two or more contacts within an integrated model."
> **Policy Lead, NHS England**

This is an important measure that will help to quantify whether new models of community mental health care are improving access to support, in line with welcome new access standards for community mental health care. It is also a broad measure, which could cover any type of contact from long-term involvement with a community group and a therapist, ranging down to two phone calls to a helpline. This has made it more difficult for NHS England to identify which areas are delivering high quality care.

> "If we were in an ideal world, it would be all about measuring the quality of transformation, but we're not. So, the quantity is the thing that we can measure most easily and consistently – and it's also our public commitment , but the quality aspect is absolutely where I think most of the work is happening."
> **Policy Lead, NHS England**

With all of this said, it is important to acknowledge the important progress since our interviews earlier in the year to set expectations around quality at the national level.

In addition to the access target and significant progress regarding the introduction of waiting times standards for community mental health care, NHS England has set out expectations for quality of care for Primary Care Networks as they strive to reach the access target. NHS England is also in the process of introducing expectations for recording and monitoring patient-reported outcomes for all systems. The recently launched 'Transformation roadmap' (which is linked on page 35 in online PDF copies of this guide) also sets out milestones and components of transformation for local systems.

Measuring quality

In addition to the metrics outlined by NHS England, it is important for systems to understand what success looks like in their area to ensure transformation is meaningful within their local context. One challenge of this is that 'quality' is understood differently by different people. For a service user, it might be a chance to shape the health system through co-production, while doctors may want to reduce waiting times for psychological therapies. For local authorities, it may mean having more ownership over the way care is delivered in their regions, and for charities, crucial opportunities to fund their work.

Systems would undoubtedly benefit from a conversation about what defines quality. Accessible information on the dilemmas encountered and solutions found could enable different local systems to draw on each other's work.

> "I think it's really important that we begin to illustrate where it's going well. And I think we need to be really clear about the end, about the measures, about the outcomes and to be able to illustrate how the transformation program is proving effective."
> **Leader, local authority, South East**

If quality is not being captured, it cannot be shared, and there is a risk that it could end up being viewed as a 'nice-to-have' rather than a necessary principle of transformation.

What information to look for

There is some frustration amongst those working on the ground that progress they can see being made is perhaps not yet reflected via the metrics and this can feel demotivating. There was a feeling that ensuring necessary conditions are in place, such as forming new boards and engaging new participants, should be acknowledged as important achievements in and of themselves and are intended to increase the likelihood of increased access and improved patient outcomes further down the line. Some highlighted the need for realistic timescales to measure achievement, urging patience over seeing results.

> "I think there's a definite disconnect between national expectations and what's been delivered on the shop floor, wrong terminology, but you know what I mean."
> **Transformation Lead, NHS, North East and Yorkshire**

There is an outstanding question of how systems consolidate national indicators of success with others identified as meaningful at the local level. In Somerset ICS, Rethink Mental Illness is the lead accountable organisation of a VCSE alliance, working closely with the NHS, local authorities and experts by experience to deliver community mental health transformation. These partners worked together to co-produce patient-focused measures that are meaningful for service users in their area, which were then also blended with national metrics required centrally by NHS England. This had helped to direct community mental health transformation in Somerset to deliver the change people want to see across a range of factors that impact their mental health, and beyond those that the health system is held accountable for. Further details of this case study are available in Keep Thinking Differently, our second guide designed to support ICSs and their partners to deliver community mental health transformation.

Chapter 2: Leadership and Collaboration

Summary

Finding a shared vision, becoming equal partners and combining work cultures are some of the key challenges to partnership working. A common factor identified as key to success was a shared belief that improving patient outcomes can be a driving force underpinning collaboration. Enthusiasm and 'buy in' were not always enough. Austerity, the pandemic, legal responsibilities and a range of local and national pressures have all put integrated working under significant pressure.

In this chapter we discuss three issues around leadership and collaboration in transformation:

1. **Finding a shared vision in the system** – why should everyone want transformation? What is in it for them?
2. **Becoming more equal in status** – making decisions together, how do partners share problems?
3. **Combining work cultures** – how can different organisational styles, values, and interests be managed?

The Community Mental Health Framework describes leadership as the "first and most important step"[3]. Integrated Care Systems are asked to create new governance structures which feature different organisations, who come together to deliver a common vision for mental health support. Together, these bodies are responsible for the design, delivery, and strategic development of new models of community mental health care. As per the framework, these organisations should include[4]:

- Clinical Commissioning Groups
- local authorities (social services, drug and alcohol services, education, housing and employment, public health)
- mental health services
- physical health services
- primary care, including Primary Care Network representatives
- service users and carers
- VCSE organisations

Many of our interviewees felt that getting this collaboration right was the most significant challenge of transformation. Different organisations, with their own priorities, pressures and funding models, who may not only have worked separately but in opposition to one another, must now join forces. The process demands sacrifice, patience, and compromise. In these early stages, cross-organisational working can feel unstructured and reliant on good will. It needs to be recognised that building up the trust and understanding to make this work will take time.

Reaching a shared vision

Stakeholders must first be able to reconcile competing aims and priorities. Members of Transformation Boards typically attend strategy meetings alongside their regular jobs. At this early stage it can feel like an extra demand on time, rather than something helpful or practical.

> "One of the team managers said, 'this is all great', but we're dealing with Armageddon here, and you are walking around sprinkling glitter and talking about what colour the car will be. People have extreme staff shortages, especially during COVID, and they are wondering how we get from here to this new place of glitter."
> **Transformation Lead, NHS, Midlands**

The pandemic and pressures on bed availability have led to fatigue in the system. Some stakeholders are also understandably sceptical given various attempts at system reform in the past, which have produced mixed results. Some interviewees we spoke to in the NHS were aware of this and what they had to do to combat cynicism.

3 NHS England (2019) The Community Mental Health Framework for Adults and Older Adults
4 NHS England (2019) The Community Mental Health Framework for Adults and Older Adults

> "Those of us in the NHS need to really make it clear that this isn't just about the NHS trying to make a change for the sake of making a change."
> **Manager, NHS, North East and Yorkshire**

High level concepts and strategic plans appear not to be motivating in and of themselves. However, the *philosophy* of transformation – the aim to transform the experience of those suffering from severe mental illness by offering a broad, seamless set of resources to enable people to improve – is well understood and accepted. Real commitment and energy came from those who were more focused on this objective.

Lessons can be taken from those areas that were driving this change before the Community Mental Health Framework appeared.

The Living Well Alliance in Lambeth was formed in 2019, building on prior collaborations and discussions between key stakeholders within the borough over the previous decade. Lambeth's story demonstrates the need for local ownership and a shared vision from the ground up. (See Appendix 1: Case study – Lambeth Alliance)

> "We started those [collaborations] years ago and rather than just seeing a strategic framework that needed adhering to, our starting point was a belief in really wanting to make things better for service users."
> **Manager, NHS, London**

Becoming more equal in status

The movement toward a more equal status and shared decision-making across stakeholders can be uncomfortable. Non-NHS partners can feel a tension that funding sits with the NHS, while some NHS decision makers and health professionals can struggle to overcome long-held assumptions about the value of the social model of mental health support.

Factors such as differences in pay for operational staff across sectors were also highlighted as contributing towards the perception that the clinical model is superior:

> "There is a lack of parity of esteem between those supporting people in the care and VCSE sector compared with those that sit within the NHS. You see this at every level of the workforce and how it's valued – support workers commissioned by local authorities or VCSEs are not given the same pay structures or professional development opportunities. At the moment, there isn't parity across health and care, to support those in the community this isn't sustainable, or right."
> **Leader, social care, national**

Non-NHS partners we spoke to often did not always feel a sense of ownership. Some remarked that this is an NHS initiative, with more piecemeal involvement of other sectors.

As commissioners and providers of mental health social care support and a range of other non-clinical services, local authorities have a key role to play in delivering community mental health transformation. However, unlike the NHS and VCSE organisations, there is no specific funding set aside to support their involvement. This is a barrier to their involvement in a number of areas across the country, even where there is recognition of this role by local authorities and enthusiasm about the Framework. In other areas, local authorities still have a journey to travel in terms of recognising and fully embodying their role in supporting those living with mental illness.

> "We start from a position where, probably for a host of reasons, a lot of local authorities have historically abrogated a lot of the responsibility, expertise and knowledge around the delivery of mental health services through various arrangements with the NHS. I think local authorities have been quite passive in too many areas around it."
> **Leader, social care, national**

Substantial weight is placed on the power of personal relationships to establish trust between partners. A board meeting involving many different professionals and organisations, some of whom may hold historically fractious relationships, does not lend itself to the sharing of problems or vulnerabilities.

In some areas, lack of confidence in the process has at points led to stakeholders retreating into traditional professional identities and not sharing problems with one another. For example, there were reports of medical professionals slipping into old prescribing habits, even consulting in private, away from partners.

> "There's a real tension where there are gaps in the services available. For example, with eating disorders, the clinician will say, "well, you need to fund more of my service" even though VCSE organisations can help with this. They said they wanted to support VCSE working but in practice a shift in power and control is difficult."
> **Transformation Lead, NHS, Midlands**

> "There is a reluctance by statutory services to try something new. They want to pour money into services that exist, but that don't necessarily work."
> **Expert by experience**

> "In transformation meetings, we are talking about involving service users and third-party organisations, but people [often have the] view that we need to get things sorted first and then we'll involve them."
> **Leader, social care, national**

There is no simple answer to this, apart from helping partners to become more aware of the valuable resources in other sectors. The philosophy of transformation requires partners to look at ways to address issues together. This feels like a grand task, and the challenge will be finding small ways to do this in practice.

> "Where I've seen things work well, is where things are happening at a smaller level, we can try things out, test things out, involve various different people and kind of keep quite dynamic. And then use that learning to apply elsewhere."
> **Policy Lead, NHS England**

An excellent example of this approach to confidence-building is in Tees Esk and Wear Valleys has begun discussing live patient cases between partners, with the consent of patients. This allowed partners to collaborate by looking at the situation and exploring solutions together. This has also allowed clinical partners to appreciate the support that voluntary sector and local authorities have to offer in context.

> "We have gone on to this journey and forged that relationship with partners, and now we started discussing live cases together. I'm amazed how much one or two sectors have to offer how much is out there, other than medicalising every problem that comes our way and saying either: 'medications or therapy".
> **Transformation Lead, NHS, North East and Yorkshire**

This will involve an element of interoperability – in skills and knowledge. It can be hugely satisfying for sectors to pool knowledge and address the service user as a whole person.

Different cultures

Even where there are strong pre-existing relationships, organisations still need to become accustomed to each other's ways of working. The variety of processes, values and behaviours was a common difficulty, with culture deeply ingrained and established over decades of working practices.

> "You're bringing together a number of different cultures and approaches – and asking them to work together and collaborate around individuals. Traditionally people have been: 'well, I can do this bit behind my border, and then you can do your bit… but don't interfere with my bit.'"
> **Leader, local authority, South East**

Even in early implementer sites where partners are entering their third year of transformation, there remains an ongoing need for stakeholders to become more accustomed to each other's cultures.

> "Culture is ingrained and changing this is one of the last things to happen."
> **Manager, NHS, London**

> "I think bringing working cultures together is probably one of the areas that we've lacked that sense of policy. I think that is an area that we need to do a bit more work around."
> **Policy lead, NHS England**

Bridging the cultural gap was often talked about in terms of leaders having the right personality; open-minded doctors and inclusive transformational leaders were given praise and often considered 'the secret' behind the system working well together.

Additionally, we found that leaders who were more successful at negotiating culture had often previously worked across sectors including local authorities, VCSE sector, and the NHS. This overview allowed them to mediate between perspectives and clarify misunderstandings from a more neutral position. Lambeth has built on this with deeper forms of integration, such as staff from one sector reporting into management within another (see Appendix 1: Case study – Lambeth Alliance).

> "I've worked in the local authority and the VCSE sector previously. When something is so obvious to me, I think this is where it goes across the culture that someone's ingrained in."
> **Manager, NHS, London**

> "I think and hope our team have been quite successful in keeping their identity, but still keeping a common goal. For instance, even though the social workers have a practice manager, in terms of how they do things, they still come to me or my deputies and ask for advice. For me, that's really showing that we can do this in a different way."
> **Manager, NHS, London**

With that said, we heard from leaders who want to be more collaborative but still sometimes felt held back by the structures and interests of their own organisations. For example, NHS workers often reported feeling bound by governance, and restrictions on information sharing that stopped them engaging with VCSE organisations in the way they wanted to.

> "We are bound by so much governance; you can't always share as much information as the voluntary agencies would want. And I think they think like, oh, well that's an injustice, stopping us from doing what we want to do."
> **Manager, NHS, North East and Yorkshire**

> "If our VCSE partners saw the data return we have to put in to show impact of our partnership work, they'd be horrified. Even I'm horrified when it comes through – about ten tabs of data that we've got to put back."
> **Transformation lead, NHS**

In Somerset, partners recognised early on that for transformation to succeed, it would not suffice to require VCSE organisations to crowbar NHS ways of working into their practice.

For example, in relation to data collection, partners recognised early in the process of transformation, they would struggle to retain or increase engagement from smaller VCSE organisations if the administrative burden was too significant (e.g. – if providers were expected to undertake large amounts of data collection.) For this reason, the partnership adopted the mantra of 'record once and report light.'

Working as an alliance of VCSE organisations can also aid smaller VCSE organisations in navigating and complying with remaining NHS governance structures. Rethink Mental Illness is the lead accountable organisation for an alliance including VCSE organisations of various sizes and remits, which works collaboratively with the local NHS Trust and local authority to deliver Somerset's new model of community mental health care. As a larger charity, Rethink Mental Illness is able to offer infrastructure and knowledge that aids them to do so. This has enabled all partners involved in Open Mental Health to have access to a brand new, joined-up patient system that works for all partners. More detail on Somerset's approach to data is available in our second guide designed to support ICSs and their partners to deliver transformation, 'Keep thinking differently.'

Chapter 3: VCSE sector involvement

Summary

While engagement of the wider VCSE (Voluntary, community and social enterprise) sector is gathering pace across the country, involvement of smaller VCSE organisations in the process of transformation remains a challenge. The participation of these organisations, and particularly those who work within and are led by minority groups poorly served by the current system, is a cornerstone of meaningful involvement and crucial for addressing health inequalities. Those who have found ways to involve a diverse range of charities and local organisations have been able to create inventive community-run solutions, such as community hubs.

In this chapter we discuss three themes around the involvement of the VCSE sector in transformation:

1. **Funding small VCSE organisation**s – why have many found it challenging to access transformation funding?
2. **Building community hubs** – how community hubs can bring the community organisations together, giving a platform to VCSE services
3. **Addressing health inequalities** – how meaningful involvement of ethnic minority VCSE organisations can be achieved in transformation?

In the best examples of transformation, VCSE organisations play a key role in covering gaps and preventing people with unmet need from dropping out of the system.

> "I think some volunteer organisations have really proved their worth. They're so agile and flexible and able to respond to the needs of individuals, commissioners and the local authorities, who are obviously bound by huge amounts of regulation and bureaucracy."
> **Leader, local authority, South West**

The application of the Community Mental Health Framework provides additional funding of almost £1 billion in cash terms by 2023/24. This funding is distributed to Integrated Care Systems (ICS) in each area to be used for local needs – such as bolstering community mental health teams, and primary and secondary care. What is unique about NHS transformation money is that a proportion of it (usually around 25%) is ring-fenced for VCSE organisations, to fund their work and participate in transformation.

Funding small VCSE organisations

There is a vast spectrum of the scale and type of VCSE organisation that could be involved in transformation – from national charities who address mental health in a broader sense to smaller grassroots VCSE organisations that are focused on specific issues and communities. Their involvement is key to achieving the Framework's aim of deep community engagement. There was a broad sense from interviewees that, while involving larger charities had gone well, getting smaller and more local VCSE organisations was a challenge.

Some commissioners report feeling under pressure to build services quickly, which means some can favour larger charities which tend to have the infrastructure to deliver at short notice.

> "As commissioners, we were not aware of the number of charities that are out there until recently. When we need something and need it now, we think – who do we know?
>
> There are also benefits to economies of scale, as commissioners we do things by number games so looking at which VCSE organisations can reach the most people and can deliver against objectives. It also comes back to the time constraint; we know you can give a large charity 10k last minute and they will deliver."
> **Transformation lead, NHS, Midlands**

Smaller VCSE organisations also seemed to be less aware of the opportunities to be involved in transformation.

> "Most people I work with do not know about transformation and I am struggling to know how I could be involved in it. In my work we analyse what needs to be done within the community and work with volunteers, but I am struggling to link up with formal healthcare."
> **Leader, grassroots charity, London**

These organisations may provide high quality and specialised services, but as organisations they are often stretched. Many have a very small workforce (sometimes as few as one or two members of staff) which makes it difficult for them to find the time needed to put together a funding bid and meet reporting requirements. In many cases, smaller VCSE organisations are looking for modest smaller amounts of money (for example, to hire an extra peer support worker on a part time basis or purchase the equipment they need) but the administrative burden remains high.

> "It is not easy to bid as a small charity – we have capable volunteers with experience who could create bids, but not the paid resources and machinery to do it easily. It is a shame because faith-based charities could collaborate and play a much larger role in community mental health care and represent a large local population."
> **Leader, grassroots charity, London**

At the same time, commissioners and transformation leads consistently reported not being able to spend the money they were allocated. The reasons for this are complex. In some cases, they related to broader workforce challenges (see chapter five). Additionally, being in the earlier stages of transformation and specific challenges surrounding prioritisation during the second year of the COVID-19 pandemic were also reported as significant factors impacting the ability to use allocated funds.

> "We are underspending this financial year due to workforce recruitment issues and having capacity within the ICS to mobilise transformation plans whilst managing pandemic response."
> **Commissioner, NHS, South West**

> "The innovation pot was meant to be £198k for year 1, but we haven't launched it yet, and we want to see if we can carry it forward to next year, and then year 2 and year 3. As it's a £300k pot, if we can carry over, it will be £498k next year, which is a big amount for VCSE providers."
> **Programme Lead, NHS**

Removing bureaucratic barriers to allow grassroots charities to access transformation funding is one key way in which this can be addressed.

In Coventry and Warwickshire, a new process of accepting video applications to lower the barriers of applying is being tested.

> "We want to make access to these pots as light as possible. We are looking at accepting video applications and not scoring based on how well written the application is. We look for any evidence as to why there is a need and their reach to the local community. What they would use the money for against national priorities, and how do they think they would measure impact. Keeping it that simple, especially when it is someone applying for a small amount like for a peer support worker. This way we can utilise the micro level providers and the small faith-based groups, right up to our traditional and regular VCSE providers."
> **Transformation Lead, NHS, Midlands**

Areas that worked with small as well as large charities generated more of a community buzz about transformation, as we saw in Hartlepool and elsewhere (see appendix 2: case study – Hartlepool). The Hartlepool NOW website[5], run by the local authority, puts together a database of community organisations in the town, which can include local businesses and charities whose activities involve reducing social isolation.

Organisations can upload their own profiles and descriptions, whilst a full-time website manager regularly updates the directory to include all the well-being related support happening in the town that day. The website acts as a first point of contact for service users of Hartlepool, and a place for commissioners to broaden their knowledge of fundable initiatives.

> "Providers can put their information on there and it has become very much like a local directory. You've got everything on there from archery to zumba! If you were looking for something in the community of Hartlepool, you can create an account and search 'mental health' and it will give you 175 hits."
> **Leader, local authority, North East and Yorkshire**

Building a community hub

Of course, a strong online presence is not enough by itself – transformation must be as physical as possible if it is to connect with the community. Our recent research[6] with the Nuffield Council on Bioethics identified a number of barriers to the use of digital technology in delivering mental health care, including access to technology or digital skills, and many grassroots organisations primarily operate in offline and in local spaces.

Community hubs were identified as a key enabler of involving local VCSE partners. A community hub is a 'one stop shop' where a service user can have access to a large variety of support under one roof to suit their needs – inhabited by the therapeutic support, local authority services, and wide range of VCSE initiatives. Hartlepool, for example, uses a local library as one of three community hubs around the town. Lambeth (see Appendix 1: Case study – Lambeth Alliance) have implemented a similar model, calling it the SPA (Single Point of Access).

> "The one thing that came up very strongly in our area was that people want a one-stop shop where they could come and talk to people, you know, get advice, get involved in different things and I guess maybe that model is kind of what we're trying to implement public wide."
> **Manager, NHS, North East and Yorkshire**

> "There wasn't a clear route for navigation for the user. So that the SPA (Single Point of Access) was created, that has social work mental health colleagues and VCSE in there. So, the SPA is the single point of access for people coming in from the GP, police, self-referral etc."
> **Manager, NHS, London**

5 www.hartlepoolnow.co.uk
6 Rethink Mental Illness for the Nuffield Council on Bioethics (2022) Summary paper: Engaging experts by experience about the role of digital technology in the future of mental health care

This also appears to be a crucial ingredient in successful partnership building. COVID-19 restrictions halted the development of hubs across many systems, meaning the community offer has mostly taken place in online spaces, through meetings on Microsoft Teams, or Zoom. This has been a significant challenge for most.

"There was a lot of the voluntary sector who wanted to work alongside us and there's a lot of community momentum… but then when COVID came, it all kind of stopped… we picked things up a year later."
Manager, NHS, North East and Yorkshire

"Once we're in the community hubs, it will be easier to know what's out there, because we'll all be under the same hub."
Expert by Experience, North East and Yorkshire

People spoke of the real momentum that was achieved when organisations came together in person. Interviewees in Tees, Esk and Wear Valleys talked about using the hubs in Middlesborough, Hartlepool and Stockton as places to test out ideas and collaborations using trial and error, developing an understanding of what the community wants.

"Stockton was probably one of the biggest ones – so many people in one room at one point they were literally lining the walls, there was real interest and real momentum. And that was great because we started off by talking about the framework and talking about the principles of what we wanted to do. It is still small compared to what the transformation needs to be. But in my eyes… it's a good example of what we can do with scale."
Manager, NHS, North East and Yorkshire

Hubs are often treatment focused, but in Tees, Esk and Wear Valleys the hubs are looking at wellbeing more broadly.

"Everyone coming in goes through the single point of access (SPA). This will move you to the part of the system that helps you with what you need. Some might have a crisis and we can use our crisis outreach service which can come within four hours. Other people felt they needed mental health support, but they actually didn't, and they used community resources."
Manager, NHS, North East and Yorkshire

This turns care from a crisis exercise to a preventative model. It offers a blank canvas for community initiatives to test out their own ideas – a genuine example of community ownership in mental health care. The result is somewhere that feels part of the everyday community, absent from the stigma of mental illness.

"I actually had an offer of funding from Teesside Family Foundation, it's run by the estate agents in the Northeast. They don't really have anything to do with us from a mental health point of view. They heard about what we were doing in public health. And they said can we support you guys? So, they provided new furniture and activities, so it does have a real feel that the community own it, and that is what I like about it."
Manager, NHS, North East and Yorkshire

Addressing racial health inequalities

Engaging VCSE organisations can represent an opportunity to address stark inequalities in mental health. The Framework puts forward addressing health inequalities in mental health care as a priority.[7] These differences can be in relation to prevalence, access to, experience and quality of care and support, as well as opportunities and outcomes. Health inequalities can mean reduced quality of life, poorer health outcomes and early death for many people.

VCSE organisations that support underrepresented communities have a strong understanding of factors that might impact on mental health or create barriers to individuals accessing support. In the case of race, this can include coping with cultural expectations, racism, and discrimination.[8] However, we found that involvement of VCSE organisations led by and focused on supporting black and minority ethnic communities is rare.

"Black and minority ethnic communities are not fairly represented in transformation – this is a massive issue. Currently there's huge barriers around involving BAME VCSE organisations and they're all historical."
Manager, NHS, Midlands

"One amazing way that you could reach black men would be barber shops. But no black-led organisation got any of the first round of funding."
Leader, grassroots charity, North East and Yorkshire

7 NHS England (2019) The Community Mental Health Framework for Adults and Older Adults
8 Royal College of Psychiatrists (2018) Racism and mental health

The engagement of ethnic minority led VCSE organisations which has happened, is sometimes perceived as tokenistic.

> "It's not good enough to meet with ethnic minority organisations. Real investment needs to be put into black-led organisations. We know that's disproportionately where cuts have happened across the voluntary sector and its time funding was put back in."
> **Leader, grassroots charity, North East and Yorkshire**

More involvement of VCSE organisations that are led by the communities they serve would enable use of their networks and expertise to remould mental health care and to capture cultural differences. An example of this is the Living Well Alliance in Lambeth, who commissioned a black-led VCSE organisation, Black Thrive, to co-produce culturally appropriate forms of care by working with ethnic minority service users in the community.

> "We have commissioned an organisation called Black Thrive which is working with us to develop services in community and inpatient. They've done a lot of co-production work with local service users and communities, so that that's been absolutely brilliant. It has empowered service users and they've been applying for roles. This has been a really big part of the work locally over the past year and it is going to be a really big part of the future, to embed that way of working."
> **Manager, NHS, London**

Involvement of these organisations was naturally a high priority in Lambeth, where close to half of the population is Black, Asian or from another minority ethnic background. Lambeth's demographics differ from some other areas of the country – around 15% of England's population is from a Black, Asian and other minority ethnic background. It can be challenging but nevertheless remains crucial to engage these communities. Where there are smaller black and minority ethnic populations, there may be fewer high-profile organisations working with these communities. Some areas are taking steps to identify and raise the profile of relevant community-based organisations and are considering innovative ways to bring them into the process of transformation:

> "Recently, I met with other commissioners and transformation managers and asked if they were willing to pledge to support a BAME engagement collaborative – to draw in all of those BAME charities and communities. We know these communities are not accessing our services – they are going to these VCSE organisations. We can create a pool of funding to acknowledge our need for them and their expertise, which can hopefully feed into them engaging with the wider system and feel included."
> **Manager, NHS, Midlands**

Chapter 4: Co-production

Summary

There is a sense of excitement about the idea of co-production. However, this is also accompanied by frustration about how to make it happen in practice. Those achieving successful co-production have done so by establishing a strong foundation of trust between experts by experience and experts by training. Equally important has been creating workstreams with joint accountability, and measurable outcomes.

This chapter will explore the following elements of co-production in transformation:

1. **Making the vision a reality** – how does the idea of co-production work in practical terms?
2. **Building trust and relationships** – how can collaboration be fostered with those who lack trust in the system?
3. **Building accountability** – how can there be joint responsibility and meaningful coproduction?
4. **Clear and achievable outcomes** – how is co-production evidenced?

Co-production brings experts by experience around the table with health and social care leaders to craft a new version of mental health services – one where patients will now have ownership and direction of their own care that enables individual choice and control. Co-production which considers "all of a person's needs" is recommended as part of the Community Mental Health Framework. Service users and carers (Experts by Experience or EbEs) work alongside health and social care professionals (Experts by Training or EbTs), to deliver transformation and mould services together. The result is that someone who enters a 'hub' (see chapter three), can assume that what they are offered has been shaped, not just by medical professionals, but people, who like them, have lived experience of mental illness.

At its best, co-production can be enlightening and humanising for all parties – creating solutions that draw on both clinical and social care expertise – alongside the perspectives of people who have experienced services and illnesses first hand. While the idea of co-production of care has existed in the voluntary sector for some time, the Community Mental Health Framework represents a major opportunity to scale its use in mental health at a more strategic level.

> "The expertise that they [Experts by Experience] bring and the things that they ask and question, which sometimes, even I don't think about, because our way of thinking as a clinician may be very different to what a service user or a carer thinks about."
> **Transformation Lead, NHS, North East and Yorkshire**

Making the vision a reality

The Community Mental Health Framework advocates for co-production in local systems. There are a range of views regarding how well this is happening on the ground, but a common thread was that systems are currently in a 'trial-and-error' phase, and still working out how to get co-production right.

It appears that almost everyone grasps the idea of co-production, but not many have translated this into a set of concrete structures, processes and everyday actions.

> "What evidence do I see of co-production happening? There are notable examples, but I still think it's peripheral. And I think there's still a lot of frustration out there, so I think there are really good examples on a personal level of strength-based practice and person-centred planning, but systematically I still think we're on the nursery slopes."
> **Clinical Lead, NHS England**

Systems have been encouraged to find local solutions to the challenges and issues they face, but this philosophy seems to be the most tested when it comes to co-production. For some, the encouragement of 'trial and error' feels like a lack of direction.

> "I'm not sure what the standards of involvement and engagement are, and I'm not sure how they're measured. There's not been any lessons learned from anywhere else that can be pinched."
> **Engagement lead, NHS, North West**

There is scope for the application of co-production across many parts of the process, however there is a limit to this due to constraints on time. There is also a degree of debate around what parts of transformation should or might not be co-produced.

In areas where Rethink Mental Illness has been involved in supporting local transformation, we try to encourage co-production at all levels of transformation. For example, in Cheshire and Wirral, eight expert by experience leaders have been heavily involved in the transformation programme throughout its duration. This has included designing engagement strategies and logos, developing the core model and vision and supporting each of the workstreams. Co-production has positively impacted the transformation programme in many ways, with EBEs acting as valued leaders within the process and providing constructive critical challenge to the team.

Building trust and relationships

Historically, service users have lacked certain rights in mental health care. For some, imbalance of power is a defining characteristic of their experience of mental health care, particularly for those who, in the past, have received treatments without their consent due to lacking capacity or having been detained under the Mental Health Act. These negative and sometimes traumatic experiences can have an impact on the way that experts by experience see practitioners today, and their ability to work in collaboration with them.

> "We saw clinicians as the enemy, you know, because of waiting lists, being in the wrong service or assessment, after assessment, after assessment and never getting anywhere. You know what I mean? And because we need somebody to blame."
> **Expert by experience, Midlands**

As with organisational collaboration (see chapter three), good co-production did largely rely on strong personal relationships between experts by experience and experts by training. It can take time to build familiarity, with some reporting improvements as time went on.

> "If we had this interview before Christmas, I would have said co-production isn't going to be successful… but what helps is that slowly but surely we are building up quite a rapport with professional clinicians. A lot of us are finding that we're having these conversations, where they are very much in agreement with us."
> **Expert by experience, Midlands**

For co-production to work, experts by experience need to feel comfortable enough to share their own, sometimes difficult, experiences of going through the system and their ideas for improvement, as well as general perspectives of other experts by experience. It also requires experts by training to be honest about the challenges they face, and where they and the system may have got things wrong. This means being able to reflect and speak honestly about things that can similarly feel uncomfortable to them. Some of our interviewees talked about this in terms of showing vulnerability. When experts by training were frank about the challenges they had faced professionally, it helped experts by experience understand the difficult realities of their jobs and enabled more effective collaboration.

"I've got a reputation for being fair and assertive and saying what needs to be said. We've got some lived experience voices who feel frustrated. But because of the work I do I can see people are overstretched, so I can see things are not down to intent, it is capacity."
Expert by experience, North East and Yorkshire

"They were the enemy. But to now see them as actual people, as kind and caring and compassionate and realistically they only work in mental health because they're passionate about it, you know, co-production has given us a whole different point of view on what a clinician is."
Expert by experience, Midlands

Building accountability

A clear tension that emerged in our interviews was a lack of shared accountability. In many co-production workstreams, health and social care professionals are paid staff, working alongside experts by experience who can be volunteers, or paid on a day rate.

The consequence of this is that experts by experience may be involved in suggesting ideas, but it is usually experts by training that are responsible for their execution and therefore their successes or failures. This means experts by training may be considered to be within their right to refuse to accept some proposed ideas, but this in turn creates an imbalance of power in the co-production process.

"I think it's based on accountability. Where there is sole accountability, it is impossible to have co-production."
Service user and carer engagement lead, NHS, North West

"The person who makes that final decision is the person who's got complete accountability for something. And I think that that's where sometimes the tension can lie."
Transformation Lead, NHS, North East and Yorkshire

The danger is that this dynamic constitutes a much lower level of participation than the co-production that the framework requires. Participatory theories often rely on the metaphor of a ladder with co-production at the top and other related activities such as consultation, engagement or co-design lower down.[9]

Hiring people with lived experience into NHS roles can make a significant difference in terms of producing shared accountability and addressing workforce shortages (see chapter five). Roles can include Lived Experience Practitioners and Peer Support Workers. Creating paid Expert by Experience leader roles where participants are not only paid for their time but can also receive specific training and learning opportunities associated with the responsibilities involved is another way to formalise and add weight to the involvement of experts by experience.

"When our lived experience directors get into post, business planning meetings will move from consultation to closer to co-production. Because there is a director on the board making the final decisions on what goes into the business plan."
Expert by experience, North East and Yorkshire

9 Think Local Act Personal (2021) Ladder of co-production

Clear and achievable outcomes

Perhaps the single most difficult question we asked is: 'how is co-production going?'

High-quality co-production takes time, structural change, and a certain degree of trial and error. There is a danger that many can feel disappointed and disillusioned if they expect this straight away, leading to more tension in the system.

> "I think one of the problems we've got at the moment is everything that involves the service user is called co-production. A lot of it isn't. It's involvement for people. We need to be absolutely clear in terms of what we are doing and that there are different levels of involvement from that engagement right the way to service user led."
> **Clinical Lead, NHS England**

Local systems are all at different points in the journey towards co-production – some were practicing delivering co-production long before the Community Mental Health Framework came along, whereas others have just started. Some may need to first work through the ladder of involvement and reach a high-level of engagement with experts by experience before moving to a co-produced model. Others may benefit from developing a good co-produced model on a small number of manageable projects before expanding this out to other workstreams.

> "A lack of time is actually the biggest constraint we have to delivering co-production."
> **Policy Lead, NHS England**

> "The barriers to co-production in my mind are always time and money."
> **Expert by experience**

This means it is essential to be transparent with experts by experience and experts by training that co-production is a journey in its early and experimental stages. It is important that co-production has a clear framing which enables clarity and keeps it manageable and allows systems the licence to experiment. One way to do this is by being specific about decisions – which decisions are to be influenced, where is the potential for change, and what type of change is possible, as well as what scope there may be in the future.

This is exemplified by Coventry and Warwickshire ICS, where co-production is being assisted by activity trackers, providing experts by experience with a clear map and understanding of the decisions that can be influenced.

> "Now every single work stream that many of us are a part of and they use in activity trackers. So, it's not only to track the activity that's already happened, and we can see obviously what's been completed. We can also see further down what the scope is, what the aim is, what we're planning for, what time schedules are working to. So that's a big help that we weren't having before."
> **Expert by experience, Midlands**

Chapter 5: Workforce

Summary

A countrywide workforce shortage in the mental health sector has significantly reduced the ability of local systems to meet targets and deliver specialised services, such as psychological therapies. This chapter identifies some imaginative solutions, to reach new audiences and diversify the workforce.

This chapter will discuss four key themes of the transformation workforce:

1. **National workforce shortage** – how can we tackle the national workforce shortage?
2. **Access to psychological therapies** – how can be provide better access to psychological therapies without enough specialised therapists?
3. **Recruitment Process Challenges** – how can recruitment processes move faster?
4. **Workforce strategies** – how can job adverts attract people from outside the NHS?

National workforce shortage

Delivering community mental health transformation successfully necessitates a strong workforce comprised of new and existing roles. A difficulty recruiting for these roles was reported from all areas.

> "I think the demand on the mental health services, particularly in regard to the pandemic, has kind of led to an enormous amount of disruption to workforce development."
> **Leader, local authority, South East**

Although the COVID-19 pandemic was cited in particular as a disrupting force, challenges around workforce are not a new phenomenon. The British Medical Association reported figures in 2022[10] suggesting that the mental health workforce had stagnated throughout most of the last decade amid a picture of raising demand.

This makes delivering community mental health transformation very difficult. There are new vacancies to fill for those running community hubs, facilitating co-production groups, commissioning VCSE organisations, shortening therapy waiting lists and managing new partnerships. A lack of staff in place means money cannot be spent, pathways cannot be set up, cultures cannot be merged, not out of a lack of will, but, out of a lack of people.

As a result, local systems are inevitably in competition to recruit the same qualified mental health staff around the country. One area would fill its vacancies at the expense of another, making it difficult for everyone to succeed at once.

> "I know that every single system is basically fishing from this very small pond that has got a limited amount of people. So, in effect, they're competing with each other, which makes it quite tricky as well. The early implementors really got their head start. They put jobs out for this new and shiny thing and then everybody else came on line two years later. A lot of people would have been available, but they'd already been taken."
> **Policy Lead, NHS England**

Access to psychological therapies

The workforce shortage has made it particularly challenging to deliver psychological therapies. NICE recommended psychological therapies are a key part of any community mental health offer, and the Framework describes improving the access to psychological therapies as critical.[11] This requires a team of therapists with different specialisations, which has been particularly challenging to assemble in the current workforce climate.

> "Less than 5% of people get offered an evidence-based psychological therapy, even though we know it can make a huge difference."
> **Clinical Lead, NHS England**

The result of this is that a lot of Community Mental Health Teams are functioning with a psychologist who is obliged to act as a generalist, instead of offering different specialised therapists.

10 British Medical Association (2022) Mental health workforce report
11 NHS England (2019) The Community Mental Health Framework for Adults and Older Adults

The Framework lists ensuring better access to psychological therapies as a key goal of new community models of mental health care. However, there was some concern that the document's particular emphasis on the social model of mental health may have unintentionally underplayed the continued importance of clinical interventions:

> "The psychological therapies element of the programme is underdeveloped, and I think part of that links back to recruitment and the need to build a more psychologically-aware workforce. I'm reminded regularly that psychological therapies needs to be seen as one of the core parts of transformation."
> **Policy Lead, NHS England**

> "So we're thinking much more about things like housing and loneliness and all of that stuff is absolutely essential. However, I worry that we've done this pendulum swing from a biomedical model to a social model, and we've missed out the psychological."
> **Clinical Lead, NHS England**

One potential answer to the national shortage of therapists may be to train existing staff to deliver therapies – a policy intervention that is currently being explored on a national level. Not all therapies need to be delivered by a psychologist; sometimes others with the right aptitude and experience can train to do this, such as a mental health nurse for example. Moreover, the current underspend in the system might be a possible source of funding for this retraining. This also represents a creative use of current underspend.

> "We've got transformation money that goes to the ICS which is meant to be for new therapist posts and there is money available for people who want to go off and train as therapists. We need to move away from just psychologists delivering therapy. Anyone can train as a therapist, it should be a core skill for any mental or health professional if you want to do it."
> **Clinical Lead, NHS England**

The creation of new roles represents an opportunity to free up workforce capacity. In North East Lincolnshire, Rethink Mental Illness (as one of the four organisations that makes up Mental Health UK) has developed a model for a mental health navigation service based in primary care. Mental health navigation is an enhanced and specialised service designed specifically for people with mental illness, building on the social prescribing model by offering emotional support, alongside help with engagement on unmet social needs. Healthcare staff report that the introduction of the mental health navigator has allowed them to spend less time addressing non-clinical needs.

There are also opportunities to bring community leaders or experts by experience into the statutory workforce and there are a wide range of benefits to doing so (see chapter four). These include that they are often well-suited to roles due to their awareness of the local area and services. There is also a benefit to having a workforce made up of people with experience of more than one sector in that this aids a greater appreciation of the different perspectives people have.

Recruitment process challenges

A separate workforce challenge is that NHS hiring processes are not well suited to the recruitment needs associated with transformation. Transformation leads need to bring staff in on a flexible basis, as systems evolve to meet local needs. This means transformation roles are often more fluid than traditional NHS jobs. At least in the earlier phases of transformation, job descriptions often need to be more open-ended to reflect the uncertainty associated with the transformation process.

Transformation leads shared that getting job descriptions signed off by various different internal departments was often a slow process, which held up systems from meeting their targets.

> "Sometimes there are some real blocks with just getting a job description out. As a system we will tinker with an admin band 3 post, and then once we agree the job description it's got to go to job evaluation and matching, then to finance, and it's very bitty and not as quick as we need it to be."
> **Transformation Lead, NHS, Midlands**

There may be a case for additional flexibility to be introduced to NHS processes, to enable recruitment to move quicker. This could draw on learning from the novel solutions that transformation leads have fostered in the interim:

> "We have found some quick wins with hiring staff. Previously you couldn't be offered a start date or a contract until you had completed all your statutory training. Staff were having to do this in their own time before they started. This can last a good month. But that can now be done when staff are in post as part of their induction."
> **Transformation lead, NHS, Midlands**

Workforce strategies

We found that in recruitment, posts associated with transformation within the NHS tend to be filled by existing NHS staff. This creates a displacement effect, with each post filled creating a new vacancy elsewhere in the system.

> "A lot of our hires will come from existing staff. At the same time, we have to recruit to backfill the posts – we might take 3 band 5s from a team and then we'll go out to recruit. So that interdependency is tricky."
> **Transformation lead, NHS**

Local systems may need to become more inventive with recruitment strategies to make appointments from outside the NHS grow. Currently, jobs linked to transformation tend only to be advertised on NHS websites. However, they could be displayed on alternative platforms to reach other audiences.

> "Some of our recruitment processes are very traditional – we will put a post on NHS Jobs and on Trac [a specialist public sector recruitment management system]. We've talked for a good two months about having a radio campaign around vacancies and using social media, and yet we still haven't started this. But that should be standard bread and butter."
> **Transformation lead, NHS, Midlands**

Our research suggested that there is a lack of awareness of transformation among staff and volunteers in smaller, community based VCSE organisations (see chapter three). This suggests there may be a significant number of people who could be interested in new roles, if they knew about them. Their skills and knowledge could be a great asset, not least because we found the perspectives of those who have worked across sectors were particularly valued in collaborative working (see chapter two).

> "There was a plan that we would put on a jobs fair to get local and young people interested in the new support worker and transformation jobs that are going to be coming up. These are great opportunities for people, but many don't know about them, or would need to be approached in their community rather than on an online job advert. Unfortunately, we could not put this job fair on with our limited resources, but I think it could have been really successful."
> **Leader, grassroots charity, London**

Conclusion

The creation of the Community Mental Health Framework, and the introduction of the ICB architecture to deliver it, represents a once-in-a-generation opportunity to change community mental health care and support for the better. It has taken courage, determination and vision, and we must remain patient about achieving it. We are only one year in and it is too early to truly evaluate the extent to which its potential is likely to be fully realised. There is an enormous amount to be encouraged about as well as some long-standing challenges to overcome in order to guarantee radical change in the quality of care.

Our research suggests there is not yet a clear understanding of exactly what successful transformation should look like from all the perspectives of all the different stakeholders involved. But stories of good practice are emerging and what is clear is that arduous but extremely important groundwork is taking place across the country. There are undoubtedly areas making huge progress with cross sector collaboration and our research engaged with dynamic leaders who understand how to speak to different parts of the system and unite them around the shared goal of making things better.

Our case studies demonstrate that even greater success can be achieved when transformation is visible, and power and investment is able to reach all parts of the system. This includes small VCSE organisations, and particularly those working with minority groups. ICSs and their partners are grappling with new governance arrangements and how best to break down administrative barriers that stand in the way of real collaboration.

Systems are at different stages on their journey towards co-production, with progress notable where stakeholders have taken difficult steps to build trusting relationships and to legitimise the contribution of experts by experience (and indeed, all of the partners involved in the process of community mental health transformation.)

While we have encountered a wealth of innovative local solutions, it is clear that challenges such as with workforce cannot be fully addressed at a local level. There is a significant enthusiasm, both cautious and boundless, to be found across the system, but equally there are challenges and a need for areas to learn from one another by sharing their experiences, practice, challenges and how they are tackling them.

Our research highlights some of these experiences and paints an encouraging picture of effort and determination to make transformation happen. All players in the system, large or small, national or local, new or long-standing have a role to play in continuing to lean in and make the Community Mental Health Transformation programme the success it deserves to be.

Acknowledgements

Our thanks to the 37 participants who were so helpful in giving their views, experiences, and insights on community mental health transformation.

A particular thank you to Monica Geraghty and Allison Cook who helped us finalise our case studies on Lambeth and Hartlepool respectively.

Further resources

NHS England – Community Mental Health Framework (September 2019)

NHS England – Community Mental Health Roadmap (March 2022 – requires login)

Rethink Mental Illness – Thinking differently: A ‘first steps’ guide for transforming community mental health (October 2020)

Rethink Mental Illness – Keep thinking differently: Continuing your journey of community mental health transformation (February 2021)

Support from Rethink Mental Illness’s Community Mental Health Unit

Appendix 1

Case Study – Lambeth Alliance

Supporting a diverse and underserved community through collaboration and organic change

"The proof of the pudding is in the eating."

Lambeth is in the unique position of having begun transformation before the Community Mental Health Framework was published. As a case study, it suggests a number of useful lessons.

Three key factors have been crucial to Lambeth's success:

1. There is a tradition in the borough of agencies working together to deliver health and social care to the local population.
2. The system has developed organically over a number of years, with the focus clearly on delivering what is required to improve the lives of people with mental illness in the community.
3. There are people in place whose role is to encourage joint working across disciplines and constantly evaluate outcomes and how resources are deployed.

Staff can be employed by any of the five partners but have a role which ranges across the Alliance; this appears to be helpful in promoting understanding of operations across stakeholders from different sectors.

It's noticeable that many key people involved have experience of being employed in several sectors. This ability to understand the different cultures, to 'speak the language' of the NHS, local government or the VCSE sector is likely to be an important ingredient in breaking down some of the cultural barriers which many people have referred to in our interviews. Managers exhibit significant skill in their ability to manage people employed by a different organisation, for example a person from a charity managing someone employed by a local authority. The core shared value of improving outcomes for service users is a key lever in overcoming potential cultural issues.

The voluntary sector is 'inside and part of the transformation'. This contrasts with the traditional role of charities as an extra resource and a provider of non-core services. Allied to that is a cultural shift in the status of voluntary workers, who can gain the respect of clinical professionals and are consulted in the process of creating treatment plans.

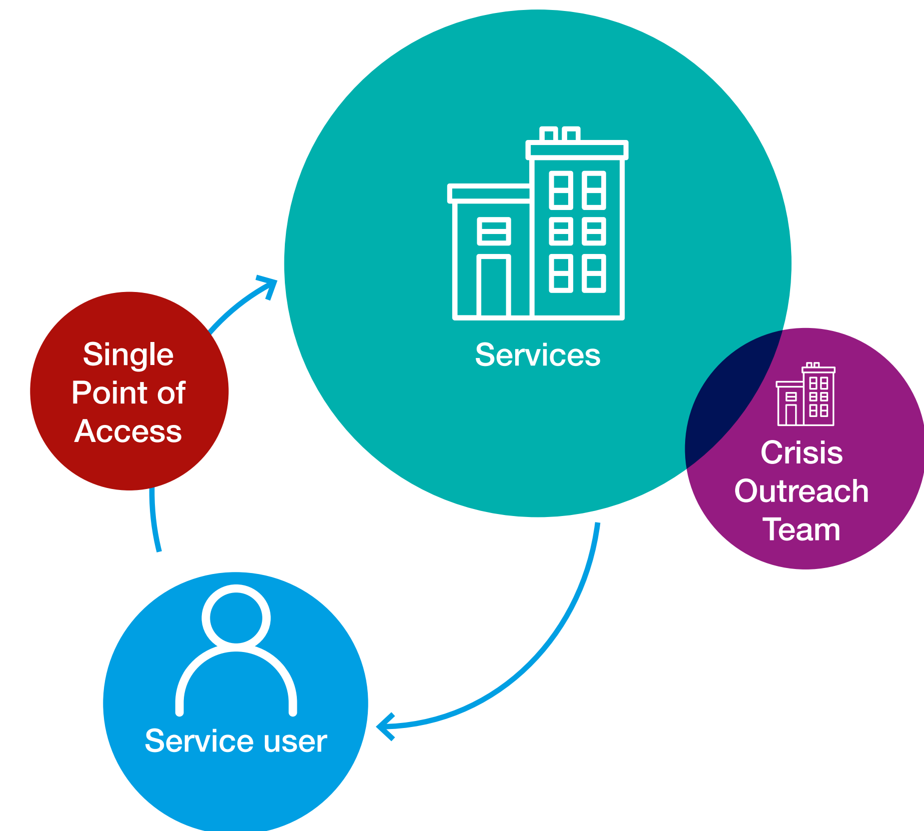
The system in Lambeth has been in place long enough for an umbrella body to have a strong identity and presence. This is something that staff identify with and look towards, with staff often identifying themselves as working for the Alliance, as well as or instead of their respective organisations.

Key areas for further improvement:

Faster delivery – With a number of partners involved and consultation required to come to agreed decisions, those involved note that decisions can often be made slowly.

Workforce – Creative thinking is required to address the long-standing problem of recruiting suitable staff (see chapter five). Long-term retention is also a key factor.

Risk – Aligning the perspectives on risk. NHS staff might have a different view on risk than other partners, which is an issue of accountability, which we discuss elsewhere in this report (see chapter four).



Resources

- Commissioners who have brought the five partners together over a number of years
- Alliance Leadership Team
- Regular breakfast meetings with service users and local charities
- Teams sharing offices
- Involvement of Black Thrive
- Program manager
- Project manager

Culture

- Commitment to the borough to improve lives of service users
- Building on history of working together
- Co-production
- Open to mixed working and leadership
- Commitment to delivery and cost efficiency
- Active liaison with partners in other London boroughs, sharing best practice

Appendix 2:

Case Study – Hartlepool

Utilising community assets to drive change from the ground-up

"Build it and they will come."

Hartlepool shares many of the same characteristics as Lambeth, but grew from activity on the ground up rather than beginning with higher-level strategic planning.

Ingredients for success in Tyne, Esk and Wear Valleys (TEWV) include:

- Public buildings provided freely serving as a hub and focal point to attract a wide range of organisations and services.
- Key individuals in Hartlepool who bring a culture of energy, enthusiasm and the communication skills to act as catalysts – inspiring and motivating others with their transformation vision.
- The creation of a large number of pilot initiatives demonstrate success and produce learning that provides others with the confidence to come on board and launch their own initiatives.

The approach begins with the broadest brief – helping any person who is seeking support through the wide collection of services delivered through the community hubs. These services are brought together in a directory on the Hartlepool NOW website.

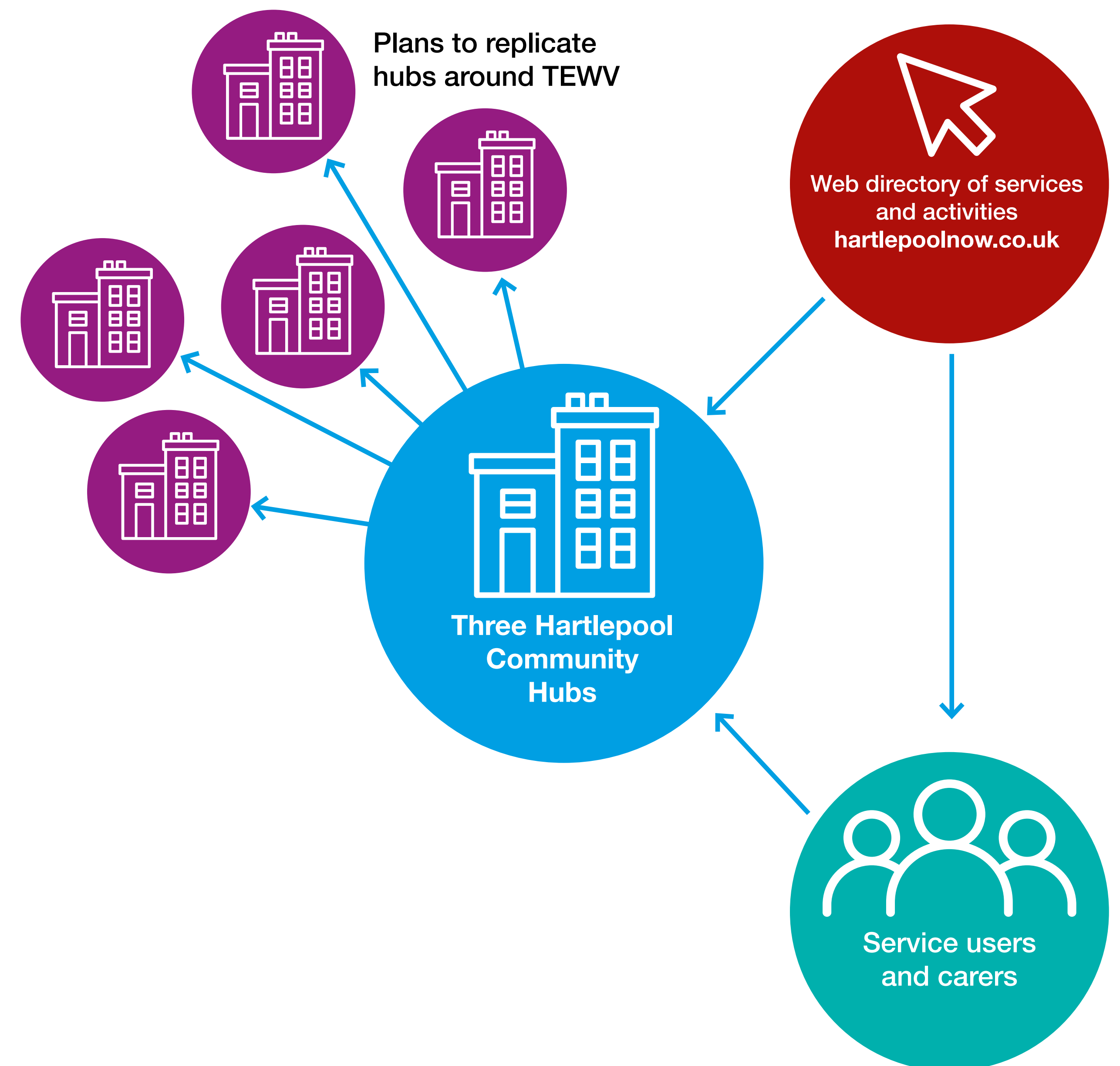
This has the obvious advantage of making the process easy and welcoming for the service user, but also plays an important function in enlisting small charities, businesses and individuals who want to contribute. Hartlepool has been particularly successful at including smaller grassroots charities in this work, by providing small grants to help start initiatives and offering help to those bidding for funds.

A particular advantage of the hub brings together professionals from different organisations on neutral territory, to help to create something much broader than clinical therapies, accessed by a broad range of people in the community. Clinical staff can witness first-hand the benefits of providing ways to empower those with severe mental illness and reduce their social isolation.

Working in such close proximity has assisted clinicians and community staff to better recognise and respect each other's strengths.

Key area for further improvement

Incorporating a broader range of support to the hubs – This is a particular challenge in such a large and sparsely-populated region.



Resources

Funding successfully channeled from the ICS to VCSE sector Use of former library buildings as hubs provides space at no cost to wide range of potential users	Website with information on where to go to get support Large number of charities, businesses and social groups participating	Large number of small projects ongoing grants available for small schemes Assistance for small charities in making bids for funding

Culture

Not branded as an NHS or NHS-led project Welcoming all in the community to participate Defining mental health in the broadest sense	Spirit of collaboration Aim to build resilience in users Attitude of openness to new initiatives	Welcome contributions from small local charities Recognise value of small grassroots charities

Appendix 3: Participant table

Type of participant	Number of interviewees	Areas of the country (ICS)
Experts by experience	5	North East and North Cumbria, Coventry and Warwickshire, Norfolk and Waveney, and Cheshire and Merseyside.
Clinicians	4	Cheshire and Merseyside, Southeast London, and North East and North Cumbria.
Transformation leads (NHS)	6	South Yorkshire and Bassetlaw, Coventry and Warwickshire, South East London, and Hampshire and the Isle of Wight.
Local authorities/social care	8	National, Cheshire and Merseyside, Mid and South Essex, Greater Manchester, Hampshire and Isle of Wight, Nottingham and Nottinghamshire, North East and North Cumbria
VCSE organisations (medium to large)	6	Buckinghamshire, Oxford and Berkshire West, South Yorkshire and Bassetlaw, South East, London, Cheshire and Merseyside
VCSE organisations – smaller organisations and grassroots charities)	3	North East London, Cheshire and Merseyside, North West London, South Yorkshire and Bassetlaw
NHS operational staff	4	South East London, Cheshire and Merseyside, North East and North Cumbria.
NHS England	3	National

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