Rethink
Mental
Illness.

Building community into the integrated care system

A practical toolkit for building robust community mental health care

Contents

Leading the way to a better quality of life for everyone severely affected by mental illness.

Foreword

Will Higham
Director of the Community Mental Health Unit, Rethink Mental Illness

At Rethink Mental Illness, our ultimate goal is to improve the lives of the half a million people living with mental illness, and the million or so who care for them[1].

The introduction of the Community Mental Health Framework was the biggest moment of opportunity to make a difference at that scale for a generation or more. Since then, with the pilot that led to Open Mental Health Somerset, we've done our best to help make the plan a reality and to share our learning along the way.

We know that it is possible to create communities that care – to do the deep listening to what people say they need for their wellbeing and recovery, to knit together the assets in the community with the expertise of the NHS and social care, to create a system that is built around the individual person and where there is no wrong door for those who ask for help. Many examples of this are laid out in this report. We also know there are huge challenges to making the vision become the new reality. No one designed the current system in bad faith. If it were easy to do things differently, we would have done so already. So, this report also shares in detail how to overcome blockers.

Our charity will continue to develop and innovate in places around the country. There is no way to meet our aim other than transforming systems and opening up all the assets in the community to those living with mental illness. No charity could be big enough to do it on its own, and often the best help is already there in the community, it just needs connecting up.

This is now also a national imperative. Beyond even the human suffering of those people and families waiting for help, mental illness has become a strategic issue for the country. The biggest segment of the 2.5 million people out of the workforce because they are unwell is those living with mental illness[2]. We can't afford as a country to be as unwell as we are, and so vulnerable to shocks.

The work shown here, not all from Rethink Mental Illness, demonstrates there is a way forward, different in each area but with the same underpinning values. The transformation to a community-led approach, a preventative approach was always the best approach. Following covid, the cost-of-living crisis, and the general pressure on the health service, we believe that it is now the only sustainable approach.

William Higham

Will Higham

1*. Office for Health Improvement & Disparities (2022), 'Wellbeing and mental health: Applying All Our Health'
2*. IPPR (2022), 'Revealed: Mental health problems 'most common condition' among the sick forced out of UK workforce''

Executive summary

High-quality community mental health care continues to be vital in enabling people severely affected by mental illness to have a better quality of life. It is more important than ever that Integrated Care Systems (ICSs) invest urgently in community mental health. No one should have to reach crisis before they can access support, and no one who asks for support should fall through the cracks.

Investing in prevention, and in community mental health care in particular, also has cost-saving benefits for the whole system.

In Somerset, Somerset Foundation Trust is partnered with the Open Mental Health alliance. Open Mental Health operates through a joined-up, place-based model to ensure an individual receives the right support, at the right time, and in the right place.

Between April 2019 and December 2022, the Somerset area saw a 15% decrease in Emergency Department mental health presentations for adults and 24% for older adults. Across all ages there was a 30% reduction in admissions for a mental health need.

It is possible to work together to keep people well within the communities that they live in.

Furthermore, in the long term, investing in community mental health can help achieve the aims of the integrated care systems, and improve the health of the public.

In this publication, we start by laying out the changing context of the healthcare system. The introduction of Integrated Care Systems is an opportunity which should not be wasted.

In **section 1**, we discuss the crisis in mental health demand. There is a crisis, which must be met with innovative new ways of working.

In **section 2**, we provide practical, workable solutions to some of the key blockers to improving community mental health care. Some of the key learnings can be summarised as follows:

Engaging with the Voluntary, Community and Social Enterprise (VCSE) sector: Getting started

- Start working with the local VCSE sector, for example by using our framework for community microgrants.
- Go to where people are, building on existing community assets.

How can local authorities be an equal partner in the ICS?

- Work together to agree a joint approach to delivering duties under the Mental Health Act.
- Use the Better Care Fund to pool mental health budgets and move towards integrated commissioning.

Contracting and funding

- Develop a shared set of principles between all system partners, including the VCSE sector, for partnership working.
- Ensure contracts are of sufficient length to enable sustainability and as flexible as possible.
- Recognise the true costs that the VCSE sector bears when delivering services.

Data and reporting

- Work with VCSE organisations to make reporting possible, following key principles to make this easier.
- Find technical solutions to facilitate reporting, as systems across the country are beginning to do.
- Expand the way we look at outcomes, including coproduced and population-level outcomes.

"It's like pushing yourself in the best way, and also pushing for change."

Alicia Clarke on her experience as an Expert by Experience Leader in North-East Lincolnshire

Coproduction

- Build collective lived experience priorities based on lived experience evidence that is diverse and representative.
- Engage with a wide range of people, who are representative of the area, along key lines of enquiry.
- Employ strategic lived experience partners who have a role in decision-making and making sense of lived experience information.
- Prioritise safety and support of people with lived experience who are involved in coproduction.

Alliance building

- Work with VCSE alliances to harness the full diversity of the sector in the area.
- Use our checklist for alliance building to set up a VCSE alliance.

Integrating delivery

- Create open channels of communication between services to enable smooth transitions between organisations.
- Set up forums to enable cross-sector working where people need support from multiple agencies.
- Establish a procedure for sharing personal data (with consent) to avoid people having to repeat their stories.

Finally, in **section 3**, we elaborate on the role of the VCSE sector in achieving the four aims of Integrated Care Systems: improving outcomes in population health and healthcare; reducing inequalities in outcomes, experience, and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development. In doing this, we explore how the VCSE sector can work strategically to tackle the priority issues facing ICSs today, including waiting lists, preventing the need for hospital admission, and allowing people to leave hospital safely and on time.

We hope that this publication will serve as a call to action to systems to embed the positive changes made through the community mental health transformation, and to keep investing in community mental health. If you are interested in speaking to our team about any of the issues discussed in this publication, please contact **cmhfsupport@rethink.org.**

Context: the changing health system and mental health delivery

The introduction of Integrated Care Systems (ICSs) devolves the running of mental health systems to 42 areas in England. It also tasks them to invest strategically in improving their public health, including their public mental health and to tackle health inequalities. The Integrated Care Board (ICB) is the statutory body that is responsible for the planning and funding of most NHS services in an ICS area.

The ICS and ICB integrate all the different parts of the health service alongside local authorities, housing, lived experience groups, and the Voluntary, Community, and Social Enterprise (VCSE) sector.

This provides the possibility for local areas to reframe and develop community mental health in a positive way that is based upon prevention and recovery rather than crisis response and hospital care.

Mental health has had a head start on integrated working. NHS England's Community Mental Health Framework (CMHF), launched as part of the NHS 10-year plan, already seeks to bring together health and social care; primary and secondary care; and the statutory and VCSE sectors. As transformation funding stops being ring-fenced in March 2024, it will become even more important to embed the positive changes

that have been made over the last four years into business as usual.

Over the last few years, since the publication of the CMHF, Rethink Mental Illness has been working with many of these areas across the country to develop new approaches to community mental health. We have conducted new research into the progress of the implementation of the CMHF and worked to develop experts by experience groups that take a lead role in working alongside professionals and communities. From this applied work and a number of publications and webinars we have developed various tools and learning which we will share here. Every area is different, so these are about how to ask the right questions and how to apply the values needed to work across sectors and engage with communities. They show both the rewards and challenges of embedding integrated working, particularly with the VCSE sector.

We are especially excited about the ambition for VCSE-led Alliances taking on more responsibility for community mental health support and redesigning services with experts by experience, who have been severely affected by mental illness and understand what's on offer in the area and how it has to change. As we set out in our publication Building Communities that Care, at the beginning of the community mental health transformation, we will know we are succeeding when every place has a plan for how it can be the best place it can be for someone's recovery and wellbeing – and when the whole place takes pride in how well it delivers on it.

This publication outlines a positive vision for ICSs and communities to continue on their transformation journey and beyond – developing the role of the VCSE and challenging the blockers to new models of community care. This vision looks beyond the end of the formal period of community mental health transformation, and addresses how the principles of community mental health continue to allow ICSs to meet their aims.

What are the four aims of ICSs?

To bring together partner organisations to:

1. Improve outcomes in population health and healthcare.

2. Reduce inequalities in outcomes, experience, and access.

3. Enhance productivity and value for money.

4. Help the NHS support broader social and economic development.

NHS England, 2020, 'Integrating care: Next steps to building strong and effective integrated care systems across England.'

1. Help in the current crisis

Integrated Care Systems have a once in a generation opportunity to improve community mental health services. This is not an easy task. They must work towards their aims against a backdrop of extreme pressures, on all parts of the system from primary care to A&E.

Across the country, we hear about the incredible pressure on the acute trusts within the NHS and how this is crowding out time and resources from improving mental health and mental health services.

While this is completely understandable, it creates further, future pressure. Many areas report finding it difficult to get mental health onto the agenda of their Integrated Care Board, with the pressure elsewhere. This is not only unsustainable in the long term, we will also argue that increasing community mental health capacity is one of the most direct routes to reducing overall system pressure.

This report starts by exploring the ways that community mental health care can relieve the immediate pressures that they face, particularly in areas like A&E, hospital discharge and workforce. Heading into another winter with the NHS already under such pressure elsewhere, we know the limits

of engaging the wider system on achieving long-term goals until we are navigating the current crisis.

The early data from our work is promising. In Somerset, Somerset Foundation Trust is partnered with the Open Mental Health alliance. Open Mental Health operates through a joined-up, place-based model, where the NHS, local authority, and VCSE sector work together to ensure an individual receives the right support, at the right time, and in the right place. The alliance structure and flow of funds is maintained by Rethink Mental Illness, as Lead Accountable Body.

Between April 2019 and December 2022, the area saw a 15% decrease in Emergency Department mental health presentations for adults and 24% for older adults. Across all ages there was a 30% reduction in admissions for a mental health need[1]. New ways of working based on community-based models of prevention and support means that people are instead supported by phone lines or crisis safe spaces.

1. Figures provided by Somerset Integrated Care Board, 2022

The pressure on mental health care and the wider system

Workforce shortages

18%
vacancy rate

In December 2022, there was an 18% vacancy rate in NHS mental health nursing[2].

Avoidable admissions

In 26% of cases where people are admitted to acute hospital, there have been missed opportunities to make interventions that would have avoided the need for admission[3].

26%
missed opportunities

Barriers to discharge

40%
increase in delayed discharge

We know from Experts by Experience that **people often have to stay in hospital longer than they need to because of barriers to discharge**[4]. There was a 40% increase in delayed discharge between July 2021 and July 2022[5]. Discharging people from inpatient care is a complex process, that requires a range of agencies with legal responsibilities to work together.

Cost-of-living crisis

Over half reported having suicidal thoughts

In a 2022 survey of people severely affected by mental illness, more than half of respondents reported having panic attacks, and just over half reported having suicidal thoughts as a result of money worries[9].

Health inequalities

Black, Asian, and minority ethnic people, disabled people, and people living in deprived areas continue to experience worse outcomes in mental health services[7]. Black people are more than four times more likely than white people to be detained under the Mental Health Act[8].

People from minority ethnic backgrounds experience worse mental health outcomes.

Pressure on A&E

Long waits for people with mental health needs in A&E are increasing, and **people with mental health needs often report poor experiences**[6].

Long waits are increasing

2. BMA (2022), 'Mental health pressures in England'
3. Local Government Association (2016), 'Efficiency opportunities through health and social care integration.' This statistic refers to all admissions. No mental-health-specific statistics exist in the public domain.
4. Rethink Mental Illness (2021), 'Mental Health Act White Paper engagement report: Service users currently detained under the Mental Health Act', p20-21
5. NHS Digital (2022), 'Monthly Statistics, Performance July, Provisional August 2022'.
6. NHS England (2023), ' Delivery plan for recovering urgent and emergency care services - January 2023'
7. Centre for Mental Health (2020), 'Commission for Equality in Mental Health Briefing 3: Inequalities of experience and outcomes'
8. Gov.uk Ethnicity Facts and Figures (2023), 'Detentions Under the Mental Health Act'
9. Rethink Mental Illness (2022), 'Cost of living survey 2022'

What does good community mental health care look like?

One of our local leadership groups of Experts by Experience defined it for us. High-quality community mental health care is:

- Personalised to the needs of people.
- Coproduced with local people and experts by experience.
- Provided as much as possible in the communities that people live in, with an emphasis on prevention and early intervention.
- Integrated and delivered in partnership across agencies, making it easy to access care.
- Based on equality of delivery and access for all[10].

For this to work, all parts of the system must work together. We must look at mental health holistically, focusing on the social determinants of mental health as well as clinical care. This means thinking about housing, finances, physical health, work and volunteering, and social connectedness.

How can investing in community mental health help?

Ensuring that care is personalised and coproduced focuses the system on what matters most to people.

This improves experiences and outcomes in healthcare. Bringing people who are the most disadvantaged into the system as equal partners is key to tackling inequalities.

No one should have to reach crisis before being able to access care. Prevention is a key statutory responsibility of local authorities under the Care Act 2014 – although one that many areas have struggled to implement due to budget pressures. Equally, one of the core recommendations of Patricia Hewitt's review of Integrated Care Systems was that the 'share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years'[11]. While the government did not accept this specific recommendation, it did accept the need for a shift towards improving prevention[12], as did the NHS Long-term Workforce Plan[13].

Investing in prevention and early intervention in the community enhances productivity and value for money. It relieves the pressure on A&E and acute care, as we are seeing in Somerset. Looking towards the social determinants of mental health – such as housing – also supports the broader social and economic development of the area.

Integrated working between the NHS, local authorities, and the VCSE sector allows the system to tackle specific pressures. For example, systems can work jointly to avoid costly out of area placements, reduce waiting times, or allow safe discharge from hospital[14]. In Leeds, the VCSE sector has been commissioned to provide people with specialist mental health provision such as the Aspire Early Intervention service run by Community Links[15].

Partnering with VCSE services to support more people should free up NHS trusts to do what they do best: delivering evidence-based clinical care. A key strand of the community mental health transformation is improving access to appropriate psychological therapies.

10. Principles based on work done by Cheshire and Wirral Community Wellbeing Alliance, using the Community Mental Health Framework
11. Rt Hon Patricia Hewitt (2023), 'The Hewitt Review: An independent review of integrated care systems', p21
12. Department of Health and Social Care (2023), Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 on 'Integrated care systems: autonomy and accountability' - GOV.UK (www.gov.uk)
13. NHS England (2023), NHS Long-term Workforce Plan, p99
14. Centre for Mental Health (2016), 'We need to talk about social care. Social care and mental health forward view: ending out of area placements'
15. Community Links aspire | Community Links (commlinks.co.uk)

Improving psychological therapies for people severely affected by mental illness

The development of mixed models of psychological therapy and practical support in the community offers the chance to provide effective support to people in their communities.

Psychological therapy provision often focuses on short-term and lower-level CBT-based support, often delivered alongside primary care. This has led to an issue where some people have fallen through a gap where their needs are too high for NHS Talking Therapies, but they are not able to access more specialist complex care and rehabilitation services. A significant group of people are living in the community with serious and long-term mental health issues such as psychosis, paranoia and trauma-based mental health issues that can lead to complex presentations, regular crises and difficulty accessing social needs such as family contact, work and housing.

Psychological therapies can be very effective for this cohort. The NICE guidance recommends specialist CBT and Family Intervention for people with psychosis and bipolar disorder. People presenting with problems associated with a diagnosis of personality disorder should also have access to psychological therapies including specialist CBT, Dialectical Behaviour Therapy, Mentalisation Based Therapy and Cognitive Analytical Therapy.

These psychological therapeutic approaches need to be delivered by trained professionals, with access to high-quality clinical supervision, so need investment. VCSE organisations are increasingly able to have a role in this when working in partnership with NHS Trusts and councils. The NHS Long-term Workforce Plan acknowledges the need for growth in the NHS workforce in this area, planning for an increased number of training places for psychologists and psychological therapists[16].

Table of NICE-recommended psychological therapies for common diagnoses

Psychosis and Bipolar Disorder	Personality Disorders	Eating Disorders	PTSD
CBT for Psychosis and Bipolar Disorder	CBT for Personality Disorder	CBT for Eating Disorder	CBT for PTSD/complex trauma
	Dialectical Behavioural Therapy (DBT)		
Family Interventions	Cognitive Analytic Therapy (CAT)	MANTRA	EMDR
	Mentalisation-Based Therapy (MBT)		

16. NHS England (2023), NHS Long-term Workforce Plan, p99

The Listening Place: how volunteers can deliver one-to-one support

The Listening Place is a volunteer-led service based in London.

The service exists to address unmet need for people who are suicidal. Often, people have nowhere to turn but A&E. The Listening Place's model offers confidential, one-on-one support to prevent escalation to crisis.

The team supports over 4,600 visitors per year[17]. Each visitor is assigned a specific volunteer who they see on a regular basis, building a trusting relationship over time.

The Listening Place measures impact rigorously using the Colombia Suicide Severity Rating Scale (C-SSRS).

On average, feelings of suicide decreased significantly (by 33%, as measured the by C-SSRS) while feelings of support increased by 42%[18]. Some at-risk groups were particularly likely to find support at the Listening Place. For example, 16% of all referrals were LGBTQ+, compared to 5.8% of the UK population[19].

Volunteers are highly trained and supervised by a team of clinical professionals, such as psychiatrists and clinical psychologists. Recently, staff, service users and volunteers collaborated to develop further training to allow volunteers to provide extra support to high-risk visitors. Using direct feedback from visitors, staff insight and a forum theatre exercise, they trained 40 volunteers in the delivery of additional support, building the charity's capacity to support those individuals at greatest risk. The Listening Place works with the NHS, which makes the majority of its referrals, but is independent from it.

Volunteers are highly trained and supervised by a team of clinical professionals.

17. The Listening Place The Listening Place report.pdf, p7
18. The Listening Place The Listening Place report.pdf, p13
19. The Listening Place The Listening Place report.pdf, p9

2. Blockers

Our experience of the past few years of working across multiple systems towards community mental health transformation shows one clear finding: visionary leadership from within the NHS is vital. We would argue it is essential to develop cross-sector system leadership training to embed transformation and the prevention agenda.

The government has responded positively to a similar recommendation made in the Hewitt Review[20]. However, individual leadership and vision is not enough on its own.

Collaboration is essential to providing high-quality community mental health care. Different parts of the ICS need to work together at all levels, from commissioning to delivery of services. This must include all parts of the ICS: primary and secondary care, local authorities, and the VCSE sector. The voice of lived experience must be a core part of decision-making.

Working across sectors exposes blockers, particularly within the NHS. And that is not wholly surprising, where the emergent and complex ecosystem of an individual community meets the large and systemic bureaucracy of a health system.

This section is a practical guide to overcoming blockers to collaboration. Here we focus on the following blockers that we have identified through working with partners in the VCSE sector, NHS, and local authorities:

- Engaging with the VCSE sector: getting started.
- Ensuring the local authority is an equal partner in the ICS.
- Contracting and funding.
- Data and reporting.
- Coproduction.
- Alliance building.
- Integrating delivery.

Engaging with the VSCE sector: getting started

Recommendations

- Start working with the local VCSE sector by moving money into the community through microgrants.
- Go to where people are, building on existing community assets.

Getting started can be a challenge. We know that ICSs want to start working more closely with the VCSE sector, particularly with local grassroots organisations. It is these groups that have the closest connection with the communities that they work with, particularly those that have been historically underserved, making them invaluable in reducing inequalities in access. One in eight people in the community are currently receiving support from a mental health provider charity[21]; its contribution cannot be ignored.

However, many ICSs report that they are struggling to engage with the VCSE sector, other than the larger organisations that they already work with.

Grassroots organisations, meanwhile, feel that it is hard to find a way into work with the ICS, as they struggle to access funding.

The clock is already ticking for community services that effectively work as part of the system, but are not funded by the local authority or the NHS. This puts these organisations at immediate risk from the funding dearth that's affecting the voluntary sector, with UK charity income predicted to drop by £8bn this year[22]. In several places where we work, we know of smaller charities closing their books to new clients or even shuttering their doors at a time of palpably growing need. Even if those services were not formally connected to the health system, the loss of capacity in the community risks putting even greater pressure on A&E and other parts of the health system.

So, how can the ICS start engaging with the VCSE sector?

- **Start moving money into the community.**
  For example, by using the community microgrant model (details provided on the next page). This can be added to with Quality Improvement measures and capacity building to iterate better performance over time.

- **Offer people something in return for their time.**
  This might mean paying Experts by Experience or volunteers for attending meetings, or offering free training or use of buildings and facilities. Small VCSE organisations often struggle to engage due to lack of time and personnel so payments for staff who would be otherwise on the front line to attend meetings are vital. Payments should be made promptly and those with lived experience should be directed to guidance on how their benefits may be affected[23].

- **Look at existing assets in the community.**
  Small organisations may not have the time or resources to attend meetings within the ICS. Instead, go to where people are already, such as VCSE networks, community centres, foodbanks, or places of worship.

- **Share spaces.**
  For example, VCSE organisations may have free space that can be used by primary care or mental health services. Renting this space provides a revenue stream for these organisations.

20. Department of Health and Social Care (2023) Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 on 'Integrated care systems: autonomy and accountability' - GOV.UK (www.gov.uk)
21. Association of Mental Health Providers (2023), The Association launches the first national picture of mental health service provision - Association of Mental Health Providers (amhp.org.uk)
22. Pro Bono Economics (2022), Second Wave: Charities and the Spring Statement 2022 | Pro Bono Economics
23. For guidance on the effect that payments can have on benefits, see the Social Care Institute for Excellence (2021), 'Paying people who receive benefits: coproduction and involvement'

A model for community microgrants

Microgrants are a useful way to start transferring money to community organisations.

Rethink Mental Illness partnered with North-West London ICB to distribute community grants as part of their suicide prevention strategy. Together, we developed a model for community microgrants.

Step 1: entering an area

This stage of the process is about understanding need, building relationships, and repairing trust.

This might look like:

- Using public health databases like OHID's Fingertips tool to conduct a needs assessment of inequalities.
- Deciding on joint priorities, shared by all ICS partners, for who the grants need to reach. In North-West London, this was done using data from local authorities' suicide prevention strategies.
- Building relationships with grassroots organisations by emailing, calling, and making in-person visits.

Step 2: applications

Grassroots organisations are unlikely to have dedicated fundraising teams and may lack the staff, time, and experience to go through complicated bidding processes.

Smaller organisations can be encouraged to apply for funding by:

- **Using a simple application form or other forms of simple process.**
- **Using simple assessment criteria.** In North-West London, applications had to be innovative, coproduced, and collaborative, and had to reach communities that struggle to access traditional services.
- **Holding a discussion-based panel, rather than using a points-based system.** This means that, if there are concerns about an application, these can be brought back to the applicant rather than resulting in an automatic rejection. Experts by Experience can be involved in assessing applications.
- **Maintaining a continuous dialogue with applicants, supporting them where there were concerns about aspects of their projects.** For example, if an application was generally strong,

but asked for a large amount of money for venues, the ICS may be able to help them secure a cheaper venue rather than turning the application down.

- **Completing straightforward due diligence checks to manage risk.**

Step 3: measuring impact

The projects had a wide range of different aims and impact. Each applicant was asked to develop their own framework for how impact would be evaluated. Experts by Experience worked with Nurture Development to coproduce an evaluation toolkit to support them. They also visited organisations at the beginning, middle, and end of their projects to capture evidence.

Some of the organisations that have received microgrant funding in North-West London ICB:

Step 4: wider collaboration

A community grants programme opens the doors to wider collaboration between the ICS, VCSE sector, and wider community.

In North-West London, the programme has allowed collaboration between the ICS and local organisations on a number of joint priorities. Some examples are:

- The creation of a joint safety plan for self-harm by the ICS and local VCSE organisations.
- Forums for staff working at the local authority, NHS, and VCSE organisations to share insights and resources about major risk factors for suicide.
- A 'bereavement by suicide' event, which brought together the ICS, VCSE organisations, and the police.

How can local authorities be an equal partner in the ICS?

Engagement with local authority representatives, for this publication and in previous research, tells us that local authorities are essential to community mental health care but often do not feel like equal partners within the ICS[24].

This has been a major barrier to improving community mental health care.

Local authorities have a wide range of responsibilities that have a profound effect on people's mental health, for example around housing, green spaces, social care, personalisation, suicide prevention, drug and alcohol services and commissioning of a large proportion of the VCSE sector[25]. They are a fundamental part of community mental health support, and in the social and economic development of the area. Local authority departments have different but complementary skills and experience in mental health and ICS transformation teams can use these to develop areas in which local NHS provision may be weaker – such as personalised care planning or supported housing. They also have a democratic responsibility at the level of place.

Local authorities and NHS Trusts both have key shared and separate responsibilities for mental health, and both are often under considerable financial and workload pressure. We believe they should be involved as core members when setting priorities at ICS level and that evidence from across the country shows that an integrated partnership approach is better for people and for both organisations. **Here we highlight some of the key ways that local authorities can have a greater role within the ICS.**

Working together to deliver duties under the Mental Health Act

When it works, collaboration between the NHS and local authorities can begin to solve problems that both are struggling with.

An example of this is agreeing a joint approach to section 117 of the Mental Health Act 1983 (s.117). S.117 places a statutory duty on health and social care services to provide aftercare to people who have been detained under certain sections of the Act. Coordinating s.117 is important to allow timely discharge from hospital.

This is already happening in some areas, such as in Cheshire East, where the local authority and ICB have agreed a 50/50 approach to deciding funding decisions under s.117[26]. The policy includes a procedure for resolving disputes. Disputes usually arise due to legal arguments over whether responsibility for s.117 funding falls under health or social care, especially when people have received care over a long period and with many moves.

This approach is particularly useful when supporting people to leave hospital in a safe and timely way – where both NHS community services and Care Act-based support are needed.

24. For example, see Rethink Mental Illness (2022), 'Getting started: lessons from the first year of implementing the Community Mental Health Framework,' p8
25. Centre for Mental Health (2023) 'Mentally healthier council areas 2023'
26. Cheshire Clinical Commissioning Group (2022) 'Joint Policy for the provision of After Care under Section 117'

of services such as supported housing or more suitable specialist provision where it is needed. The alternative of out of area placements is costly as multiple agencies bear significant costs. Even more importantly, out of area placements can be extremely difficult for people and their families.

We recommend this is based on government guidance that outlines how legislation supports organisations to work together and commission for place-based areas. Guidance on the preparation of integrated care strategies can be found here - GOV.UK (www.gov.uk).

ICBs can now delegate functions for joint decisions and pooling of budgets and develop provider collaboratives. Integrated commissioners working within joint committees at place level, including NHS and local authority representatives can use their delegated responsibility for commissioning to deliver local health and care services, such as reporting to Health and Wellbeing Boards. Within this, it's vital to identify specific, long-term funding resource for the local VCSE sector, including small core payments to encourage attendance and alliance building. Without the specific prize, it's all but impossible to assemble meaningful cooperation.

Integrated funding responsibilities will be increasingly important as ICBs develop. Local agencies need to agree how to develop collective approaches to raising the funding that is needed to deliver core services for which agencies have joint responsibility. This requires an approach that recognises the financial risk that is already being carried out by different organisations and shares or mitigates it.

Integrating funding

Local areas have often been concerned about the difficulties in shifting the emphasis of existing expenditure from old ways of working to more modern, personalised, integrated arrangements.

Often, there is confusion about which agency bears the cost of care and responsibility for a particular individual in need of mental health care, meaning people are stuck between agencies or placed out of area.

NHS England recommends that budgets across the commissioning and delivery organisations can be delivered more effectively in future in partnership with local authorities and housing agencies.

ICBs present a significant opportunity to support joint planning, commissioning and delivery of services between NHS and local authorities, and have a critical leadership role in developing local provision of mental health support.

This is best achieved via an approach to the Better Care Fund that includes mental health. The NHS's Better Care Fund planning requirements 2023-25 specify that mental health is integral and should be considered on an equal footing to physical health[27]. Within mental health services this works especially well for issues relating to supported housing, discharge from hospital, s.117 aftercare arrangements and community-led services to support prevention and personalised support. This money could be pooled together and used for joint commissioning

Section 75 arrangements

Section 75 of the NHS Act 2006 allows NHS bodies to enter into arrangements with local authorities to carry out health and social care related functions. This includes formal pooled budget arrangements.

The recent Hewitt Review makes some recommendations that we fully support. It recommends 'the government accelerate the work to widen the scope of s.75 to include previously excluded functions, (such as the full range of primary care services) and review the regulations with a view to simplifying them[28].' The Review also recommends expanding the range of the organisations that can be part of s.75 arrangements to include social care providers, VCSE providers and wider providers such as housing providers[29].

27. NHS England, Better Care Fund planning requirements 2023-25, p4
28. Rt Hon Patricia Hewitt (2023), 'The Hewitt Review: An independent review of integrated care systems', p78
29. As above

Contracting and funding

Questions to ask about contracting with the VCSE sector

1. Are we clear on our funding principles for working with the VCSE sector?
2. Are our contracts of sufficient length to enable sustainability?
3. Do our contracts have flexibility and options, or are they very rigid?
4. Does our funding offer/contract recognise true costs to the VCSE sector? Are there ways in which we can help mitigate the hidden costs?
5. Have we co-ordinated our resources effectively within our organisation and with our partners?
6. Are we commissioning all that the VCSE sector has to offer? How do we know?
7. How can we harness the full diversity of the sector in our area? Do we have an alliance?

Barriers to sustainable funding continue to limit the opportunity for the VCSE sector to fully contribute its skills to delivering the core strategic aims of ICSs. Long-term and persisting ambiguity around funding constrain the ability for VCSE organisations to collaborate to their full potential in key areas such as reducing inequalities, addressing the wider determinants of health and leading on prevention.

The diverse nature of ICSs across the country, coupled with the huge diversity of the VCSE sector, mean that prescriptive frameworks or standardised approaches to funding and contracting are unlikely to be successful.

Several common themes and creative solutions to sustainable funding have emerged from our experience in working with VCSE organisations across multiple ICS footprints across the country.

Funding principles

In order to play to the strengths of the VCSE sector, there needs to be a system-wide strategic approach to funding activity, services and engagement.

There is wide variation in the funding and contracting practices for the VCSE sector within and between different ICSs. Some systems provide funding solely through small, ad-hoc grants. Others use formal procurement processes and detailed contracts. Many use a mixture of both. It is important that systems do not fall into the trap of thinking these are simply different buying mechanisms. They are all different forms of engaging the VCSE sector.

Systems should have a set of funding principles which are shared by all system partners. These should be clear on coproducing outcomes based on the capacity, capabilities and potential contribution of the VCSE sector. They should be clear on how those funding principles can enable sustainability in the sector, through developing a deeper understanding how the sector works.

We recommend that ICSs:

- Develop a set of shared principles between the ICB, all system partners and the VCSE sector for partnership working.
- Seek to understand what the local VCSE sector does, what it can offer, and how the organisations work.

Contract terms and flexibility

Historical practices of short-term contracts or ad-hoc grants result in uncertainty for the VCSE sector and present challenges in sustaining their contribution to health and wellbeing.

This impacts workforce recruitment and retention, level of engagement with communities, and the planning and delivery of services. On the other hand, greater certainty

in the longer term aids improved workforce planning, makes roles more attractive, and ensures that meaningful long-term relationships can be built with communities.

One solution is to give longer contract terms, such as three years or five years. Additional flexibility in contracting, such as options to mutually extend by a further one or two years should also be considered. Longer-term relationships between VCSE bodies and the NHS bring about increased trust and a longer time frame to meaningfully participate in the agenda of ICSs and their place-based partnerships.

We all recognise the financial challenges faced by ICBs, NHS providers and local authorities – both the efficiency savings required, as well as last-minute short-term resource allocation. An example if this is the non-recurrent nature of winter pressures funding which are frequently allocated to systems at a late stage in the year, with an expectation to use the resource quickly. The VCSE sector has proven itself time-and-again to be highly adaptive and agile to requests to scale up and mobilise resources rapidly. However, complex NHS procurement processes, coupled with the degree of urgency and multiple small resources to be distributed, do not align with the narrative of building a sustainable VCSE sector.

Some systems are taking innovative approaches to the allocation of short-term pots of funding such as winter pressures funding. In one example, a CCG had a flexible contract with a VCSE alliance to allocate a short-term pot of funding. By working closely with

a VCSE alliance, high level conversations about prioritisation for potential funding were starting months ahead of funding allocation to the CCG. When funding was allocated, the partnership between the CCG and VCSE alliance already had a plan and they were able to rapidly mobilise staff and resources to help reduce winter pressures.

Cost recognition

One frustration that is often felt by VCSE organisations is that funding from statutory bodies tends not to recognise wider infrastructure costs that will need to be met by VCSE organisations.

An example of this might be providing funding for a role. Contracting and procurement teams will often limit the funding to the salary plus organisational on-costs. What is rarely considered is the additional, sometimes hidden, costs of hosting staff in the VCSE sector, such as payroll, training and supervision. In smaller organisations without a large supporting infrastructure, these additional costs have the potential to negatively impact in a proportionally greater way.

It might not always be feasible to fund additional costs. Even when it is not feasible, it is possible to recognise and support with these additional pressures. NHS bodies through the emerging Provider Collaboratives, or via ICS partnership arrangements, can reduce the impact of these extra costs by offering elements of their own infrastructure to support the VCSE sector. For example, could your organisation/ collaborative/partnership support with training provision, or supervision?

Further to the themes of grants and contracting, VCSE organisations often are not reimbursed for their time. For example, attending meetings, investing time and staff resource into co-production events. Whilst it is not always possible to fund each and every meeting attended, a budget could be arranged for involving VCSE sector representatives in the work over a period of time (eg: annually for working with ICSs, fixed over the timeframe of a project).

Multiple funding streams

Many VCSE organisations will have multiple sources of income and funding.

Fundraising, attracting grants and tendering for contracts are all time-consuming activities. One common theme VCSE organisations face when working with the NHS and with other statutory public sector bodies is the lack of coordination around VCSE funding.

All too often we hear examples of VCSE organisations having to bid for multiple small amounts of funding for seemingly related themes from NHS organisations in local areas. At the extreme end, there are examples of this occurring from different departments in the same NHS organisation!

As we head into a landscape of greater coordination between NHS bodies, and also between the NHS and local authorities, much greater emphasis should be placed on resource coordination across places and systems. Procurement approaches need to be more strategic in their nature.

Some areas in the country have worked to develop a shared 'hub' between NHS bodies and local authorities. Such hubs enable a system/partnership view of what funding is being made available, and where it could be combined for scalability. Furthermore, these types of hubs can develop into a single procurement/grant interface in a place area.

Better coordination of resources would improve VCSE sustainability in several ways. Firstly, grouping themed funding together can reduce the unnecessary burden of multiple funding bids. Secondly, resource coordination has the potential to enable greater scalability of projects and initiatives.

Commissioning approaches

Traditional commissioning approaches have been rooted in inflexible procurement laws with a heavy focus upon very detailed service-level agreements and key performance indicators.

This has resulted in a focus on activity and not a focus on commissioning for outcomes, in particular investing in prevention and factors that influence the wider determinants of health. Commissioning has often focussed on designing desired activities and has been inflexible in engaging effectively with the VCSE sector. This approach has often failed to understand the capacity and capabilities of the sector – instead commissioning based on presumption.

It is essential that future commissioning by ICBs and emerging collaborative structures is coproduced with the VCSE sector. This can be done by involving representatives from the sector in strategic discussions and decision-making forums. Importantly during the early stages of commissioning, it is important to work with local VCSE partners to understand what they can contribute. Try moving from a mindset of "what can we buy from the sector?" to "what might the VCSE sector be able to do to address the challenges we are facing?".

This will yield creative and innovative solutions. These are the things that ought to be commissioned!

Building upon this approach, ICBs can develop workstreams, such as prevention, where the VCSE sector is able to lead initiatives in their local area, or indeed across systems.

Traditional contracting and procurement mechanisms have also focussed on one-to-one relationships between the commissioning body and the provider organisation. An unintended consequence of this approach is that is tends to favour larger VCSE organisations with the infrastructure and capacity to bid for contracts, with smaller organisations picking up smaller grants. A newer approach which is gaining traction, and has been successful in several parts of the UK, is the use of collaborative and alliance contracting. By working 'at scale' as a collaboration of organisations across the sector, there is greater scope for funding and procuring services, where one organisation might not have been able to provide this alone. There are several contracting and governance frameworks which can facilitate this. We explore this further in the 'alliance building' section below.

Commissioning transformation of Somerset's Community Mental Health Services

by Andrew Keefe, Deputy Director of Commissioning for Mental Health, Autism, and Learning Disabilities, NHS Somerset

In 2019, the Somerset mental health system was successful in bidding for funding from NHS England to implement the transformation of community-based mental health support as a 'Trailblazer' site.

At that time there was a historic underinvestment in mental health in the county, meaning people often fell through gaps in community mental health support.

Mental health leaders across the system including NHS commissioners, local authority commissioners and our NHS provider Trust recognised that to address these issues we collectively had to 'own' the problems and move away from blame games. An improvement in meeting the mental health needs of the people of Somerset was our sole aim. We would speak of 'the Somerset pound' and spending it wisely.

Around the same time that NHS England invited bids for early implementers for Community Mental Health Transformation, we began talking with strategic leaders in the national Rethink Mental Illness team.

Fortunately, our thinking and planning at that time was already fully aligned to the Trailblazer's objectives, resulting in our bid being successful.

It was important to us that even though we were seen as a national pilot site, we retained our commitment to our locally developed aspirations including coproduction, the removal of artificial boundaries and being bureaucratically light. This was a real challenge, both at a local and a national level. For example, the ask for us was to transform services, but to do so in a prescribed manner and to collect and report data relating to things we did not see as adding any value – and more importantly did not align to the priorities of those people with lived experience who were codesigning the new offer. Some elements we had to accept as non-negotiable, and we were transparent about these. Other areas we stood our ground, insisting we did things differently. One such area was the whole commissioning, procuring and contracting process. The funding came from NHS England to (the then) Somerset Clinical Commissioning Group (CCG). Normal procedure would be for the CCG to design what they wanted to achieve, write a service specification, then test the market by inviting provider(s) to bid to deliver services against a pre-defined contract and its metrics.

From the start all partners, including commissioners, had committed to doing things differently; we agreed that we would have to trust each other and let go of some traditional practices if we were to deliver real change. To their credit, the CCG's Governing Body bravely agreed to share the leadership around commissioning and procurement. This meant the procurement for VCSE partner(s) would be led by the Trust, with the CCG and Local Authority as co-commissioners. The Trust held the VCSE contract as operational or tactical leads whilst also sharing the strategic commissioning space. We also decided not to have a fully developed service specification in the procurement process, preferring to appoint strategic partner(s) to co-produce the new model in line with areas of focus identified nationally, ensuring we held true to our commitment of placing people with lived experience at the centre of the process and ensuring we draw upon the different but equally valuable specialisms located in VCSE partners.

We invited bids via a formal procurement process to become a strategic partner(s) using the NHS Innovation Partnership Contract rather than the NHS Standard Contract. We wanted to be as inclusive as possible, including the option of different providers for different service elements, but we also made it clear in all our discussions with potential providers that our preference would be for an alliance approach based on meaningful relationships at a local level, not purely contractual obligations.

The procurement process was undertaken in the autumn of 2019 with the formal contract award being given by the CCG in January 2020 to what was then 'The Somerset Mental Health Alliance', subsequently to be named by those involved in it as Open Mental Health. The Alliance was led by Rethink Mental Illness as the lead accountable agency, (appointed by its peers), with around ten local and regional VCSE partners bringing a richness of diverse expertise.

The post-contract award activity was scheduled to begin immediately, starting with coproducing a service model and service specification with our new partners. This wasn't to be. In a twist of fate, the Covid-19 pandemic meant we didn't have the time to have long discussions about terms of engagement, terms of reference, roles, responsibilities, contractual frameworks, etc., we had to respond with an urgency no one had envisaged. If anything, this situation accelerated our plans rather than derailed them. Trusting relationships were quickly formed and strengthened as an imperative against a common objective of meeting the mental health needs of the people of Somerset, in the most trying of times.

On reflection, those early months of the contract really tested our commitment to working differently as a mental health system: not reverting to type; valuing every contribution from the full range of partners; and doing the right thing. This meant each agency, and person, at times had to make sacrifices and to supress their egos, but as Harry S Truman once said, "*It is amazing what you can accomplish if you do not care who gets the credit*".

Data and reporting

Community mental health transformation has brought new challenges in data collection and reporting. The VCSE sector has taken on a more important role in delivering ICB-funded community mental health services. How do we ensure that we capture the impact this is having?

Highlighting the need for VCSE reporting

In Cheshire and Merseyside ICS, VCSE organisations now support approximately 5000 people with mental health needs using transformation funding. Many of these interventions may count towards the four week waiting time standard[1] – but the data is not yet being reported.

1. Figures provided by Cheshire and Wirral Partnership NHS Foundation Trust (2023), 'Cheshire and Wirral Community Celebration Day'

Reporting is understandably very challenging. Smaller organisations may not have the resources for extensive data collection.

VCSE organisations deliver a wide range of services, and NHS metrics might not always be suitable. And, of course, different organisations use different computer systems.

Meanwhile, systems are moving towards processes where people who use services own their own data, and assess their health and recovery alongside professionals[30]. This is welcome, but presents a new way of working and therefore new challenges.

Despite this, many ICSs are making progress towards better data collection and reporting. In this section, we will explore some of the solutions they have found.

The need for data collection from the VCSE sector

There are some circumstances in which data collection is required.

- **NHS Data Set requirements.** Patient record-level data must be submitted to the Mental Health Services Data Set where care is wholly or partially funded by the NHS[31].

- **Meeting targets.** Activity by the VCSE sector often counts towards access standards such as the planned four week waiting time standard for people who present to community mental health services[32]. This data is needed to justify long-term funding.

Over time, robust data collection can have more benefits to systems.

- **Understanding outcomes.** We need to understand whether services are working for the people who use them.

- **Understanding capacity.** Modelling capacity across alliances.

- **Understanding inequalities.** Understanding which groups of people lack access to services or experience worse outcomes.

Principles of data collection from the VCSE sector

There is no one-size-fits-all approach to data collection. Requirements will vary depending on how the service is funded.

However, VCSE organisations have highlighted ways that the NHS can make it easier for them.

- **Be clear and transparent about the purpose of data collection and reporting.** Why does this data need to be collected? What will it be used for? How does it benefit the people using services?

- **Be upfront about what data needs to be collected, when, and in what format.** For example, tell organisations whether data will need to be submitted to the Mental Health Services Data Set when inviting bids for funding.

- **Help smaller organisations build capacity for data collection and reporting.** This might include awarding funding specifically for this purpose.

- **Work with VCSE alliances.** It is much easier to find practical solutions when VCSE organisations already have shared goals and ways of working. Larger alliance members can help grassroots organisations report to the Mental Health Services Data Set.

- **Agree on shared definitions.** For example, when the clock 'starts' and 'stops' for the purposes of waiting times standards.

Where organisations are awarded small grants, a proportionate reporting model, based on the value of the grant, is recommended. This enables an element of flexibility in reporting given the diversity of grants awarded, both of which are in-keeping with recent sector-wide commitments related to grant-making practice. For example, VCSE sector organisations accessing small amounts of money shouldn't be expected to provide huge amounts of data.

Finding a technical solution

Technical solutions play a part in allowing better data collection and reporting. They also help with more integrated delivery.

Dashboards can be used to show data in a user-friendly way that makes it easy to understand trends.

Partners can submit data via controlled Sharepoint access to a 'single front door', which is accessed using a username and password. This ensures consistency and means there is no need to keep track of links to shared spreadsheets.

This is a good example of how working with alliances facilitates reporting. Data is reported to a responsible person within the alliance via managed workstreams, who then consolidates the information, benchmarks for consistency and accuracy and submits reports through a single quality assured process to the NHS.

Case study

Trialling the Joy App in Sheffield

In Sheffield, the Synergy Mental Health Alliance is trialling the Joy App as a way of enabling reporting from the VCSE sector.

All VCSE organisations commissioned by the NHS will be able to participate on the platform, which is a web application. It can be accessed from any computer, meaning extra equipment is not needed.

The app has several functions. Firstly, it is a case management system. It is integrated with EMIS and SystemOne, allowing straightforward referrals from PCNs to VCSE partners. The person's basic information is automatically transferred over, with the option for the referring professional to add further relevant information. It is not necessary to transfer the person's entire medical record. Informed consent can be recorded during the referral. This way of enabling referrals avoids duplicating workload or asking people to tell their stories multiple times.

Secondly, it allows for reporting of VCSE activity to the Mental Health Services Data Set. This happens automatically when referrals are accepted and does not require additional work from VCSE partners. In Sheffield, Synergy Mental Health Alliance, as the data owner, is able to see reports from all VCSE partners. This enables them to better understand the needs of the community, allowing whole-alliance planning.

30. For example, see Department of Health and Social Care (2022), Data saves lives: reshaping health and social care with data - GOV.UK (www.gov.uk)
31. NHS Data Model and Dictionary (2023), Mental Health Services Data Set
32. NHS England (2021), 'NHS England proposes new access standards'

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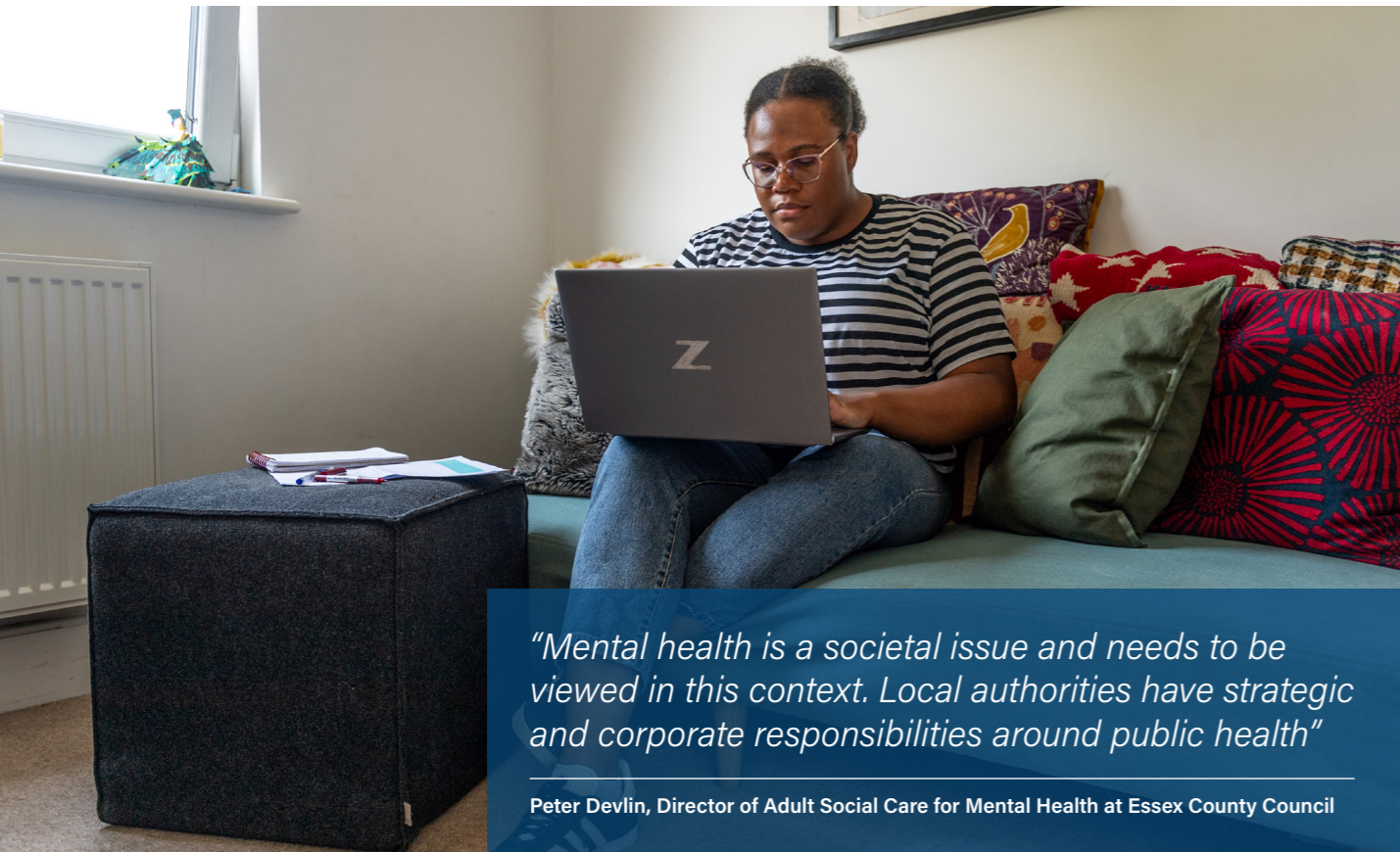
"Mental health is a societal issue and needs to be viewed in this context. Local authorities have strategic and corporate responsibilities around public health"

Peter Devlin, Director of Adult Social Care for Mental Health at Essex County Council

How do we measure outcomes and impact?

So far, we have talked about the need for data collection to meet existing NHS requirements and standards.

It is undoubtedly important to demonstrate how VCSE services can allow more people to access support.

Work should also be undertaken on how to capture other outcomes that matter to people.

We welcome the move towards focusing on what matters to people on an individual level, through the introduction of Patient-Reported Outcomes Measures (PROMS). If used properly, PROMS can help professionals plan care based on what matters to the people they are supporting.

There is also a need to look at outcomes at population level. ICSs are not only made up of NHS bodies, but local authorities and VCSE organisations as well - metrics used should reflect what matters to all these stakeholders.

Suffolk and North-East Essex ICS is a good example of how an outcomes-based approach can be used to tackle health inequalities. You can read more about their use of population health management to tackle

a range of inequalities in physical and mental health outcomes on their underline[33].

Just as people who use services are becoming more involved in assessing the outcomes of their own treatment, systems should consider what matters to people when looking at population-level outcomes. These need to be considered alongside qualitative feedback that tells us what matters to individuals. We discuss this in more detail in the coproduction section below.

Patient Reported Outcomes Measures (PROMS) are three different outcomes measures used to measure the quality of services.

- **Recovering Quality of Life (ReQOL)** measures 10 or 20 different quality of life indicators.

- **DIALOG+** provides a score for subjective quality of life, by asking people how satisfied they are in various domains.

- **Goal-based Outcomes (GBOs)** measure progress against goals set by the person using the service.

33. Suffolk and North East Essex Integrated Care System (2022), 'Population Health Management'

Coproduction

How can we put people at the heart of decision-making in an evidenced, systematic way?

The NHS has a legal requirement to involve people and communities in commissioning[34].

Doing so can help the ICB achieve its aims. By focusing on what matters to people and bringing lived experience into shared solution-finding, individual outcomes can be improved. This can also work to reduce inequalities.

We believe that strategic coproduction, where Experts by Experience work in equal partnership with other parts of the system, is key to achieving this. When

talking about experts by experience, it is important to recognise that people with direct lived experience, caring experience, and experience of being community leaders all bring distinct perspectives.

Real progress has been made towards greater involvement and coproduction. Many ICBs and Trusts now have people with lived experience involved at board level. But this is only one part of strategic coproduction. How can ICSs engage with the wider community? And how can their insights be channelled into real change?

34. NHS England (2022) 'Working in partnership with people and communities: Statutory Guidance'; section 13Q NHS Act 2006, as amended by the Health and Care Act 2022

Our coproduction framework

Rethink Mental Illness has developed a coproduction framework to show how the information we hear from people we work with can be channelled to create change.

Lived experience information

Community listening

- Engaging with people through 'trusted bridges' such as grassroots community organisations.
- Listening to people with direct relevant lived experience and caring experience, keeping track of different perspectives.
- Recording the information in a systematic way.

Lived experience insight

Community insight

- Stakeholders making sense of the data together.
- Experts by Experience e.g. lived experience advisors, should be equal partners in doing this.

Lived experience influence

Strategic influence

- Applying these insights to 'knotty issues': issues that are difficult to solve in the local area.
- Determining where more lived experience information is needed and who we need to hear from.
- Experts by Experience should be a key part of finding solutions.

Outcomes

Influence into action

- Better, person-centred outcomes can be achieved.

How coproduction can work in practice

There are lots of ways of putting coproduction into practice.

In Coventry and Warwickshire, Rethink Mental Illness and the mental health alliance use an approach called 'social mapping'. Information is captured and anonymised in regular collaborative meetings. These are grouped together into insights, and used to identify leverage points where a small change might have a big impact. For example, lots of Experts by Experience might identify the cost of travelling to appointments as an issue. Helping to cover this cost might improve access to care and also reduce number of appointments which are not attended.

Experts by Experience in Coventry and Warwickshire are now involved in coproducing new services from scratch. One example of this is the new REACH step down service. Robin Decadt, one of the Experts by Experience involved, said "we coproduced every step of the way, from the initial ideas to recruitment, and we continue to shape this service together".

For another example of how coproduction can work in practice, see the Community Listening Pilot in Devon. In this pilot project, Experts by Experience developed a method of collecting lived experience data using an online project management tool. Information was grouped based on 'buckets' – topics associated with the Community Mental Health Framework. Community listeners were recruited to speak to large numbers of people in the community and input the information people gave into the buckets. The information was then co-analysed and themes were pulled out of it.

The role of strategic experts by experience

Experts by Experience in strategic roles are integral to the process of coproduction.

They can work with the wider community, make sense of insights, and be involved in finding solutions to knotty issues. In the places we work in, we have seen Experts by Experience go on to take on leadership and governance roles, such as co-chairs.

These roles are also a chance for personal development for people with lived experience. For some people, work and volunteering are important parts of their recovery.

We believe firmly that Experts by Experience should be paid for their time. This can be done by creating paid roles for people with lived experience, or by paying people on an ad hoc basis. Organisations often worry about the
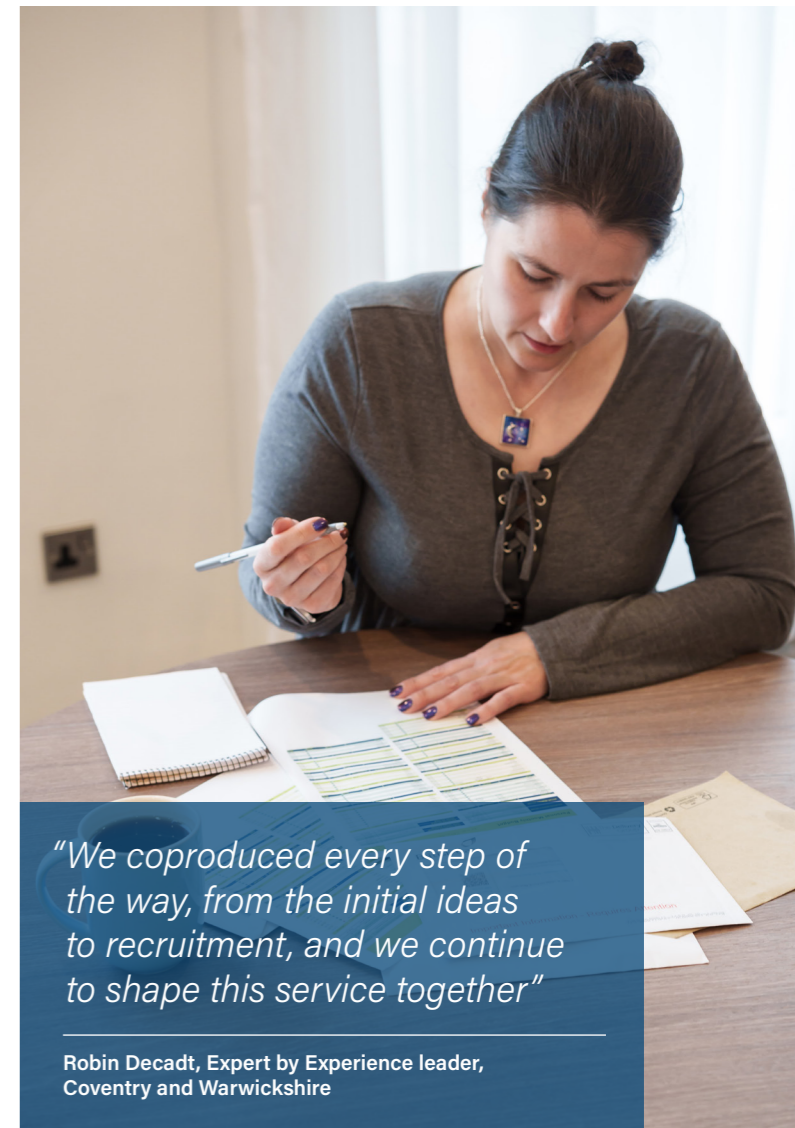
"We coproduced every step of the way, from the initial ideas to recruitment, and we continue to shape this service together"

Robin Decadt, Expert by Experience leader, Coventry and Warwickshire

effect that this may have on benefit payments that those with lived experience may be in receipt of. There is guidance about how address this, for example on the Social Care Institute for Excellence (SCIE) website.

How can the system hold itself accountable to people with lived experience?

One way of doing this is to measure progress against 'I statements' developed by experts by experience, using lived experience information.

'I statements' are statements about what a good experience of the health and social care system should look like.

An example of an I statement might be 'I experience consistent relationships with the people involved in my care.' When evaluating whether services have been improved, we could then ask whether people using services feel that this has been the case.

Alliance building

There are many advantages of working in partnership with VCSE alliances. But how can they be set up in practice?

In some areas, there is already a VCSE alliance that the ICS can work with to deliver on mental health.

This is not the case everywhere. This section is for VCSE organisations that form part of the ICS or have a relationship with the ICS, and want to bring in a wider range of organisations to make the best use of assets that already exist in the community. As the Community Mental Health Framework points out, this can reduce rivalry and increase sustainability for the whole sector.

The VCSE alliance should be considered an equal partner in the system, and should have a continuous and strategic relationship with the ICB.

Advantages of alliances

Some of the advantages of working with VCSE alliances include:

- **Rebuilding relationships with underserved communities.** For example, via grassroots organisations that have not historically had a seat at the table.
- **Enabling long-term planning.** Many VCSE organisations can only receive funding for pilots or new projects, which does not allow continuity of care for people. Partnering with alliances allows collaborative planning for different scenarios.
- **Sharing risk.** Some alliances have a 'lead accountable body' structure. The lead accountable

body is accountable for activity across the alliance Many other forms of governance that allow risk sharing are also possible.

- **Sharing infrastructure.** For example, for safeguarding, ICT, reporting or even expertise around working with people with severe mental illness.

Setting up an alliance

There is no one right way to form a VCSE alliance. Membership, governance, and funding structures will vary from area to area. However, some principles apply everywhere. We have created a checklist summarising some of the key steps in alliance building.
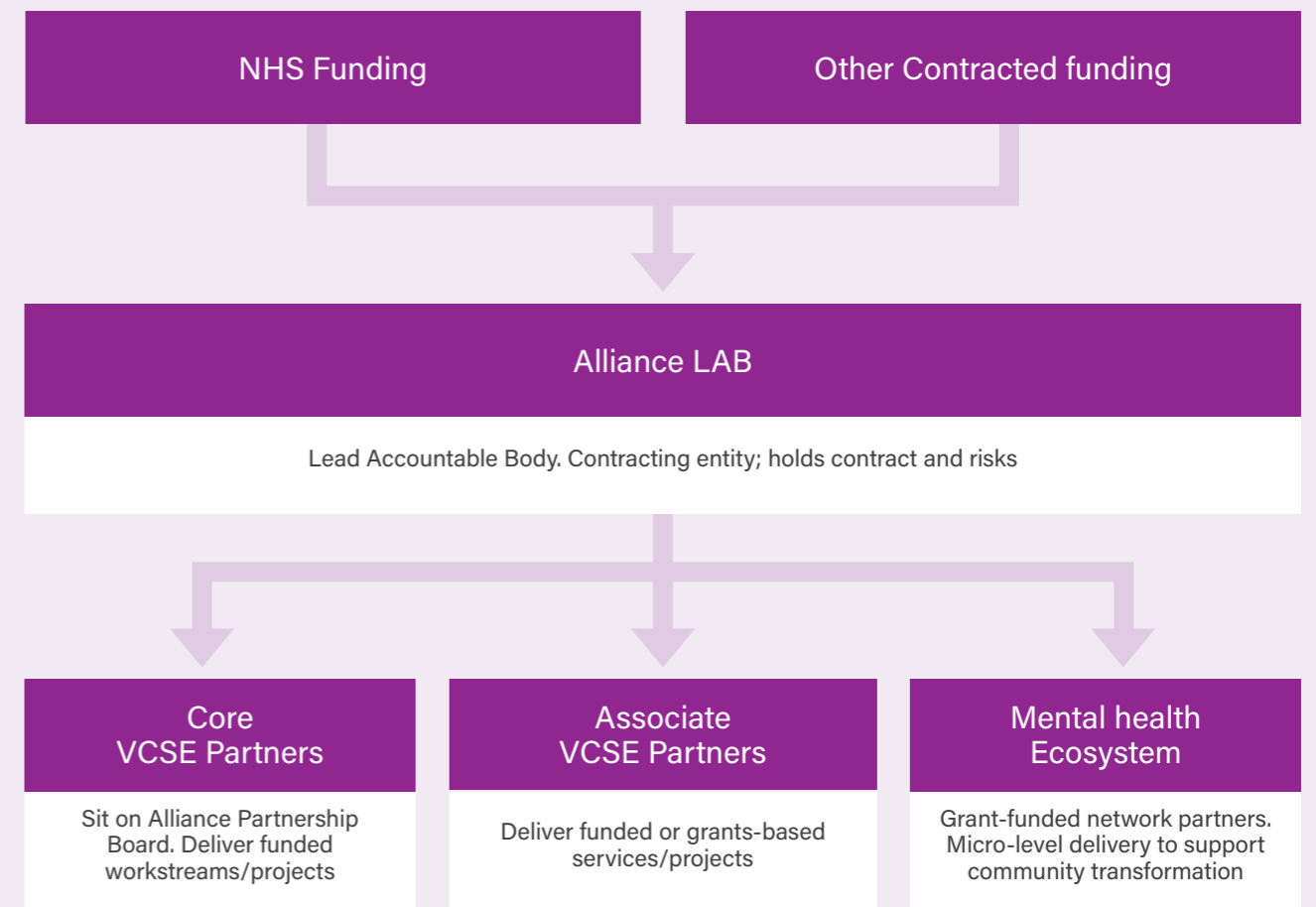
It is important that an alliance model is built from the ground up by VCSE organisations, rather than being imposed on them by the ICS. Culture and identity are important factors in bringing VCSE organisations together.

"This means a lot to us as people and organisations that did not have a voice. We didn't even know if mainstream organisations knew we were there."

Last Mafuba, on her experience joining Coventry and Warwickshire Mental Health Alliance as CEO of a grassroots organisation

Flow of funding

Diagram showing one possible alliance model, based on the Open Mental Health Alliance in Somerset

| NHS Funding | Other Contracted funding |

Alliance LAB
Lead Accountable Body. Contracting entity; holds contract and risks

Core VCSE Partners
Sit on Alliance Partnership Board. Deliver funded workstreams/projects

Associate VCSE Partners
Deliver funded or grants-based services/projects

Mental health Ecosystem
Grant-funded network partners. Micro-level delivery to support community transformation

The role of grassroots organisations

Engagement with the VCSE sector must go beyond contracting with the 'usual suspects'.

Grassroots organisations have strengths that go straight to the heart of what ICSs are trying to achieve, especially when equitably combined with the infrastructure and expertise of larger charities.

- **Embedded in the community.** They meet people in the communities that they live in. Across the country, services are delivered in community centres, places of worship, and foodbanks.

- **Specialist services.** The wide range of grassroots organisations makes them key to tackling inequalities. Different organisations can provide innovative types of care, as well as culturally appropriate support.
- **Adaptive and flexible.** Grassroots organisations are often less boundaried. During the Covid pandemic, small VCSE organisations were quick to respond to the crisis[35]. Wirral-based charity Journeymen began offering peer support to people while walking their dogs together outdoors, for example.
- **Focused on prevention.** VCSE services target the wider determinants of mental health, like finances and the cost of living, social isolation, and access to work and volunteering.

35. For example, see Kings Fund (2020), 'Tough challenges but new possibilities: shaping the post Covid-19 world with the voluntary, community and social enterprise sector'

WATCH Conservation Action Group: tackling social isolation through peer support

WATCH, a member of Open Mental Health in Somerset, was set up by peer members in 2010 to reach out to other isolated people in the community and create valuable peer friendships.

They are now partnering with local conservation charities, including Somerset Wildlife Trust, Ark Egwood, and EcoCentre South-West, to set up new Conservation Action Groups. "Many people are able to connect with each other and form lucrative peer friendships when they are out in nature," said Julie Matthews, CEO of WATCH, "it's less intense than one-to-one conversations inside".

Peer support groups are a lifeline to people in the community who are on waiting lists for clinical support. They combat isolation, helping people reconnect with their local community. However, they often struggle to resource activities for their members.

By involving conservation and community organisations as partners, groups will create a space for people affected by mental illness and isolation to do valuable conservation work in their community. Members will build confidence and skills, including accessing training to become woodland support workers. EcoCentre South-West will also support people to manage their personal budgets and energy bills. The project is a great example of how different organisations within an alliance can come together to provide innovative support for people.

WATCH was awarded additional funding through the Winter Pressures Scheme through the Open Mental Health Network which they are combining with existing funding from the Somerset Wildlife Trust. The additional funding was used to get the support groups up and running – providing support around safeguarding and boundaries – but the groups will become self-sufficient.

Empire School of Boxing and the Northumberland Mental Health Alliance: specialised support for people who need it

Empire School of Boxing, based in Blyth, was awarded funding by the Northumberland Mental Health Alliance to run a project called Passport to Wellness[37].

The project focuses on people living with severe mental illness, offering a programme of fitness sessions alongside mental health support.

Physical and mental health are closely connected. For many people, physical exercise and social connections through the boxing club have been an important part of their recovery. Empire School of Boxing now takes referrals from the Assertive Outreach Team and the Trust's community rehab services.

Having partner organisations like Empire School of Boxing on board has been key to the success of the Northumberland Mental Health Alliance, which is led by Everyturn Mental Health. Their services have been able to support people living with a diagnosis of personality disorder, for example, who would otherwise not have been able to access support.

36. NHS England (2019) 'Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance'

Integrating delivery

Recommendations

- Create open channels of communication between services to enable smooth transitions between organisations.
- Set up forums to enable cross-sector working where people need support from multiple agencies.
- Establish a procedure for sharing personal data (with consent) to avoid people having to repeat their stories.

To achieve good outcomes, there must be 'no wrong door' for people seeking help. The system must work together in an integrated way when delivering services. Otherwise, people fall through the cracks, and do not get the support they need. How can different parts the system work more closely together to deliver person-centred care?

Enabling smooth transitions around the system, with no drop offs

There is nothing worse than feeling like you are being pushed from pillar to post when trying to access support.

Appropriate, well-timed referrals are key to avoiding this.

- **Establish shared channels of communication.** While signposting directories have their place, searching a document for an appropriate service is time-consuming and soon becomes out of date. Establishing lines of communication between partners reduces the need for this. This can be as simple as a shared Teams or Slack group.

- **Build trust between different parts of the system.** To feel confident referring someone to a partner organisation, staff will need to trust that they provide high-quality care. This might mean that they have certain training. This is something that ICBs, Trusts, and larger VCSE organisations can offer to grassroots organisations to upskill people working in the community.

- **Make sure staff have the time to engage with embedding transformation**. To truly work in a more integrated way, staff at all levels need to be on board. This means having time to take part in training and involvement workshops.

Cross-sector Multi-Disciplinary Teams

Cross-sector multi-disciplinary teams (MDTs) allow primary care networks (PCNs) to work with other local organisations to deliver holistic support to people.

Rethink Mental Illness's Cross-sector MDTs were piloted at Navigation PCN in Coventry. GPs, social prescribers, and care coordinators from the PCN come together with representatives from local VCSE organisations. These organisations support people with a wide range of social needs, such as debt and money, housing, volunteering, and social connectedness.

In each session, a GP or social prescriber brings one or two examples of people who have sought mental health support from their GP. Organisations then work together to provide a 'menu' of support to the person, addressing all their needs rather than focusing only on clinical care. This avoids a need for time-consuming signposting services, instead allowing for long-term collaboration.

The scheme allows children and young people to be supported in primary care. Only 5% of contacts are referred to CAMHS[40]. It has also allowed for early intervention for eating disorders, providing support to people when they begin to experience symptoms. Children and young people also report a positive experience of the service.

Digital integration and data sharing

People do not want to repeat their stories to multiple organisations when receiving support[41]. This at best, time-consuming, and can be, at worst, retraumatising.

In an ideal world, all organisations would have access to the same computer system, giving them access to up-to-date patient records. This is possible. For example, Open Mental Health in Somerset is trialling a system called Blackpear SIDeR, which will eventually give all partner organisations access to a single care and recovery plan which is linked to primary and secondary care systems. VCSE partners will be able to initiate a record, so that wherever a person goes to access support, they won't be turned away. Rethink Mental Illness, as a larger national charity, can support grassroots organisations to meet NHS data security requirements.

This degree of digital integration can feel like a distant dream. If it is not currently possible, ICSs can still enable data sharing. For example, they can make a data sharing agreement with VCSE partners. This might include agreements about what information should be shared between partners, as well as when and how it should be shared. This agreement can be included as part of contracts with the VCSE sector. Done well, it also builds trust between individuals in the cross sector system by increasing transparency.

"The MDTs have reduced the need for referrals to IAPT or secondary mental health services. We have been able to keep people well in primary care."

Dr Nelofer Ali, GP at Navigation PCN

Making use of the Additional Roles Reimbursement Scheme (ARRS)

Using the Additional Roles Reimbursement Scheme (ARRS) to work in a more integrated way has benefits for both PCNs and mental health trusts[36].

The scheme reimburses PCNs for up to 50% of additional roles, including social prescribers, mental health practitioners, and clinical pharmacists. 62% of PCNs in England have now recruited at least one mental health practitioner.[37]

The ICB can drive the use of ARRS roles by enabling collaboration between PCNs and mental health trusts. In Kent and Medway, for example, the ICB enabled the recruitment of 31 mental health practitioners across four localities.[38]

Doing so has many benefits for ICBs. It can improve people's experience of services, while taking pressure off both primary and secondary care. Stort Valley and Villages PCN, for example, employs a social prescriber who works with children and young people with mental health needs. They work with the ARRS-funded occupational therapist within the PCN, and with local VCSE organisations[39].

3. The role of the VCSE sector in the future delivery of ICS goals

VCSE organisations can be part of achieving better population mental health outcomes in the longer term. If the aim is preventing illness in the community and making sure it is met and supported there as soon as it can be, then the voluntary sector is a key partner on the ground from the start.

It will not be possible to embed the positive changes brought about by community mental health transformation without long-term collaboration with VCSE organisations.

Wherever we work, they are supporting people in their communities.

ICSs were established through the Health and Care Act 2022, with the objective of meeting four aims:

• Improving outcomes in population health and healthcare.

• Reducing inequalities in outcomes, experience, and access.

• Enhancing productivity and value for money.

• Helping the NHS support broader social and economic development.

In this section, we discuss how the VCSE sector is key to enabling the ICS to meet each of its aims. We have already seen, during the Covid-19 pandemic, that the VCSE sector is agile and responsive to crisis[42]. Here, we lay out several case studies where the VCSE sector is already playing a role in addressing current NHS critical issues around hospital admissions, barriers to discharge, and waiting lists. The two go hand in hand; tackling the immediate pressures on the system is essential to achieve the aims of the ICS.

Improving outcomes in population health and healthcare

The ability of the VCSE sector to provide a wide range of support is key to producing better outcomes for individuals and in population health.

VCSE organisations provide support that addresses the wider determinants of mental health, such as debt and benefits advice, housing, and physical health. They also enrich communities more broadly, for example through providing social opportunities, physical activity, and recreation. This is complementary to clinical care in enabling people who are severely affected by mental illness to have the best quality of life possible and be supported on their recovery journey. Throughout this publication, we have included case studies that show the range of support offered at the grassroots, showing how they address different needs.

It is of course necessary to address the pressures on the system to provide good outcomes for people. In this section, we include case studies on how the VCSE sector is able to provide support to people on waiting lists for clinical care and address shortages in high-quality supported housing.

37. NHS England (2022), 'Mental health practitioners' NHS England » Mental health practitioners
38. NHS England (2023), 'Primary Care Networks Webinar'; Kent and Medway NHS and Social Care Partnership Trust, 'Medway Primary Care Mental Health Team' KMPT | Medway Primary Care Mental Health Team
39. NHS Confederation (2022) 'Children and young people's social prescribing service: Stort Valley and Villages PCN'
40. As above
41. NHS England (2023), 'Community Mental Health Transformation Roadmap and Annexes', p37

42. For example, see evaluations the Coronavirus Community Support Fund, which found that VCSE grant holders used their resource effectively to achieve the funding package's objectives. NatCen (2022) Evaluation of the Voluntary, Community, and Social Enterprise Covid-19 Emergency Funding Package Final report; Ipsos MORI, NPC and The Tavistock Institute (2021) Evaluation of the Coronavirus Community Support Fund - Value for Money Report

Reducing inequalities in outcomes, experience, and access

The VCSE sector, particularly grassroots organisations, is embedded in communities.

By working with diverse VCSE alliances, ICSs can reach people who may not otherwise be able to access support, improving equality of access.

The VCSE sector, which can include faith organisations, is also able to provide culturally appropriate support where the NHS cannot. For example, East London Mosque in Tower Hamlets has worked with Barts Health NHS Trust to build counselling services which were catered to the local Muslim community. In Somerset, Diversity Voice and Mind in Somerset have developed a Ukrainian-language wellbeing practitioner project to support refugees. These are just a few examples – specialist VCSE around the country have a wealth of expertise which can be used to achieve better outcomes for the people who are worst affected by health inequalities. Organisations in an area can also come together to target inequalities strategically. In Coventry and Warwickshire, Rethink Mental Illness and Coventry and Warwickshire Partnership Trust work with the Cultural Inclusion Network, a group of VCSE organisations led by Black, Asian, and minority ethnic communities to codesign strategies and services.

Workers from the VCSE sector can also be embedded within NHS services to help people navigate services. Mental Health UK piloted the Mental Health Navigator project, which established four new mental health navigator posts in local healthcare settings across the UK. The navigators were able to support people experiencing mental illness to meet their non-clinical needs, by linking them up with other services[43].

Enhancing productivity and value for money

As we have discussed elsewhere in this publication, investing in prevention, early intervention, and alternative crisis support can improve productivity and value for money in the long term.

This can be done by working with the VCSE sector to build on assets that already exist within the community. We are already seeing the results of this in many areas around the country, including in Somerset.

Of course, there are people who do need to be treated within hospital. But we know that many people stay in hospital longer than they need to due to a lack of appropriate social care or housing. We also know that people who use A&E for mental health needs report poor experiences due to long waits[44]. Community alternatives are welcome.

The case studies on community alternatives to hospital and leaving hospital safely highlight two ways the VCSE sector is already helping the NHS to improve productivity by keeping people well within the community. We also hope that new work being done around high-quality supported housing will allow for people to leave hospital when they are ready to do so.

Helping the NHS support broader social and economic development

This aim involves any measures that improve prosperity.

This might mean creating more social and economic opportunities, improving productivity, and tackling poverty in the local area[45].

The ICS must work with the full range of partners to do this, including the VCSE sector. The VCSE sector's role in tackling the wider determinants of mental health, including issues around finances, physical health, and housing, also mean it is key to improving prosperity. For example, the VCSE sector can be used to develop the supported housing offer in an area.

Another way the VCSE sector supports broader social and economic development is by delivering Individual Placement Support (IPS) services. IPS is an internationally recognised and evidence-based employment support service model that has been most successful in supporting people severely affected by mental illness into work. It is entirely voluntary, which helps prevent undue pressure to return to work, and it is accessible through secondary care (CMHTs) and some PCNs. IPS services also build relationships with local employers and provide in-work support to both the employers and service users once hired. Some IPS services in the VCSE sector, such as Rethink Mental Illness's service in Coventry and Warwickshire, supplement the original model. Rethink Mental Illness's service has peer support specialists and this supplement has shown to improve service users' experiences of IPS and employment. In addition, longer-term and permanent contracts are vital for the success of IPS services, as they allow for more time to recruit and train employment specialists as well as build meaningful relationships with service users and employers.

The VCSE sector can support economic and social development, for example by delivering Individual Placement Support (IPS) services

43. The Tavistock Institute of Human Relations (2022), 'Evaluation of Mental Health Navigator Project: Interim Report, April 2022'
44. NHS England (2023), NHS England » Delivery plan for recovering urgent and emergency care services – January 2023

45. For more about what this means in practice, see NHS Confederation (2022), 'Unlocking the NHS's social and economic potential'

Case studies

Community alternatives to hospital

The VCSE sector can provide alternatives to hospital for people in mental health crisis.

Of course, there are people who need to be cared for in hospital. However, community alternatives are more suitable for many people, and can take pressure off acute care.

In Crewe and Macclesfield, mental health crisis cafes provide a safe and supportive alternative to A&E or hospital admission for those suffering during a mental health crisis. The crisis cafes resulted from a partnership between Cheshire and Wirral Partnership

NHS Foundation Trust (CWP), Cheshire East Council, Independence Supported Living (ISL) and East Cheshire Housing Consortium (ECHC). The cafes are open 7 days a week and people can self-refer to the service by simply turning up.

The cafes have been a great example of how partners can work collaboratively to put these much-needed services in place for people in Cheshire East. Feedback from people accessing crisis cafes in both Crewe and Macclesfield has been really positive with the venues making a real impact in addressing, supporting and preventing poor mental health.

In Somerset, Crisis Safe Space is an out-of-hours service provided in partnership by Mind in Somerset and Second Step. It allows anyone struggling with their mental health to arrange a one-to-one session with a member of staff, over the phone, in person, or by videoconference. This enables people to access an appropriate mental health service directly, rather than going through primary care or A&E. On average, 11% of people attending the service said that they would have otherwise gone to A&E, with a further 7% saying they would have called 111 or 999, and a total of 16% saying they would have used other NHS services[46].

Crisis Safe Space is also playing a role in suicide prevention. In May 2023, 42 people said that, if not for the service, they would have made a suicide attempt. Investing in dedicated mental health crisis services in the community saves lives.

Leaving hospital safely

The VCSE sector also has a role to play in allowing people to leave hospital in a safe and timely manner.

The Next Steps programme, which is run by Second Step in partnership with Mind in Somerset, is a good example of this. A care navigator meets with people while they are still in hospital to identify their needs. When the person leaves hospital, the care navigator is there to help them coordinate their care package, as well as other support with housing or benefits, for example.

Each person is also supported by a peer navigator, who is a volunteer. Like all staff, peer navigators receive training on safeguarding, and on trauma-

informed support. The peer navigator provides peer support through home visits, as well as organising group meet-ups so people using the service can meet each other. Jo Poole, a peer navigator, described how brilliant it was to see the people she worked with gain a better quality of life, forming friendships, being able to look after their children, and starting to volunteer.

"We are able to do what others can't, which is share our story and our experiences, and encourage people like that"

Jo Poole, peer navigator

Tackling waiting lists in partnership with the VCSE sector

The VCSE sector can also alleviate pressure on systems by supporting people on waiting lists.

Voluntary Action Sheffield ran a project which integrated 10 VCSE sector organisations with Sheffield Health and Social Care (SHSC) and Single Point of Access (SPA). People on the waiting list for NHS mental health support were referred into the project, and supported by an appropriate VCSE organisation while staying on the waiting list. People referred into the project reported improvements in quality of life and health; most people had significantly improved ReQol scores[47]. The evaluation also found that partnering with VCSE organisations allowed them to reach communities that did not normally access support until crisis, reducing pressure on SHSC services[48].

VCSE organisations can often provide specialised support for people with specific diagnoses. For example, Mind in Bradford has been working to provide a Maastricht interview support service with the Hearing Voices Network[49]. The Maastricht interview technique can help people experiencing voice hearing and paranoia to understand and control their symptoms, supporting people to use tools to avoid future crisis responses and trauma-based approaches to feelings of distress and isolation.

Using blended financing models to unlock supported housing

People need a safe, stable and affordable place to call home, but this is far from a reality for too many people living with a mental illness.

For this cohort, quality supported housing can play an invaluable role in ensuring those who are well enough can leave hospital, and then develop their confidence and skills for independent living. However, many parts of the country are suffering from an oversupply of extremely poor-quality supported housing from rogue providers taking advantage of the benefits system, who offer terrible living conditions and little to no support.

We believe more needs to be done to improve the supply of quality supported housing in local communities. Rethink Mental Illness is working with New Philanthropy Capital (NPC) to understand and test how this can be done. In the first phase of this work, NPC has undertaken a system-modelling exercise to better understand the ways the system currently fails those living with mental illness and how and why this happens. The second phase of this work will involve working with local systems to test how provision of government funding can enable investment into supported housing through a blended finance model. We hope that this will unlock an increased supply of quality supported housing, and enable better integration between housing, health, and care.

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46. Figures provided by the Open Mental Health Alliance (2023), based on questionnaire given to all service users after each intervention. 'Other NHS services' includes GP, community mental health team, or home treatment team.

47. Voluntary Action Sheffield (2023), 'Interim Evaluation of Integrated Voluntary Sector Mental Health Support for SPA and Adult Recovery Services', p2
48. As above
49. Mind in Bradford, (Hearing Voices | Mind in Bradford

Glossary [50]

ICB: Integrated Care Board – a statutory body that is responsible for the planning and funding of most NHS services in an ICS area.

ICP: Integrated Care Partnership – statutory committees that bring together a broad set of system partners (including NHS, local authority, and VCSE organisations) to develop a health and care strategy for the ICS area.

ICS: Integrated Care System – regional partnerships that bring together the NHS organisations, local authorities, and VCSE organisations. The ICP and ICB are both part of the ICS. There are 42 ICSs in England.

PCN: Primary Care Network – networks made up of local GP practices, which work together to deliver primary care to people. There are usually several PCNs in each ICS area.

VCSE: Voluntary, Community, and Social Enterprise – also known as the 'third sector', the VCSE sector consists of a wide range of charities, community organisations, and civic institutions that work with people and communities. VCSE organisations range from large national charities to grassroots organisations and faith organisations.

Experts by Experience – individuals living with a condition over time. They understand how medical, clinical and social interventions fit in with their lives and needs – in a holistic way. Theirs is real life experience: 'lived experience'. They may have knowledge or understanding of the system, or they may not. Carers are also Experts by Experience through caring for someone with a long-term condition.

Experts by training – staff working in the health and care system. They have expertise in particular practice areas. Theirs is experience/knowledge from learning and training: 'learned experience'. They have knowledge and understanding of understanding of the health and care system. Staff may have their own lived experience. As co-production intentionally brings two different perspectives together, they need to be clear about which perspective they are bringing to a consideration or decision.

Call to action

We are asking ICSs to invest in community mental health. Now is the time to embed the positive changes made in the last few years, and to put learnings from other areas of the country into practice.

If you work for an ICS, you can use our self-assessment framework for ICSs to better understand where you are in this process. We are developing an online self-assessment tool for ICS.

If you'd like to speak to our Community Mental Health Unit about this publication or about investing in community mental health, please contact **CMHFSupport@rethink.org**

50. For more information, see The Kings Fund Integrated care systems explained | The King's Fund (kingsfund.org.uk)

Rethink Mental Illness.

We are clear on our...

Resources

1. We have a clear plan for our workforce.
2. We are on how we will invest across our partners.
3. We clear on how our partners will influence our resource distribution against our shared context, purpose and methods.

Purpose

1. We are clear on the expected outcomes for access, experience, treatment efficacy and value for money in reducing mental health inequalities in our system, places and neighbourhoods.
2. We are clear on how these outcomes will make a positive impact to the communities we service.
3. We are clear on how we will measure the impact.

Method

1. We have clear prevention actions.
2. We have clear early intervention actions.
3. We have clear treatment actions.
4. We have clear actions on the wider determinants of health and who we will work with to address these.
5. Our actions are co-produced with people who live and work in our system, places and neighbourhoods.

Partners

1. We work in partnership with NHS providers, primary care, local authorities, VCSE, Experts by Experience and wider agencies.
2. We have an environment that respects and embraces the contributions from all partners.
3. We have an agile culture and clear arrangements in place which draw upon shared vision, consensual goals, shared leadership, shared decision making and co-produced solutions.
4. We have shared accountability for our shared outcomes.

Context

1. We understand the mental health inequalities in our system, places and neighbourhoods.
2. We understand the pressures facing our system.
3. We have insight on the lived experiences of people with mental health problems (whether or not they currently use our services) in our system, places and neighbourhoods.
4. We understand the correlation between investing in mental health support and treatment in reducing emergency care use and improving hospital discharges.

People | Neighbourhoods | Places | System

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Leading the way to a better quality of life for everyone severely affected by mental illness.

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