Keep thinking differently

Continuing your journey of community mental health transformation

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Rethink Mental Illness.

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Foreword

from Will Higham, Associate Director of Programme Innovation, Rethink Mental Illness

"There can feel like a wall between you and the health professional". This was said a few weeks ago by a service user at one of our community mental health transformation co-production sessions in… well, it could have been anywhere. Every conversation is different, but the themes are clear: timely help, support to lead a full life in the community, no wrong door to seek help and more people 'like me' supporting me.

NHS England and NHS Improvement's transformation funding is a recognition of the historic dearth of care and support funding in community mental health. In our hundreds of peer groups around the country we hear the same issues: people are told they're too ill for Improving Access to Psychological Therapies (IAPT) but not ill enough for secondary care until in crisis. At the same time, they find it incredibly difficult to find the support needed beyond the NHS to underpin recovery: on housing, keeping social and busy, debt and benefits. We profoundly welcome the Community Mental Health Framework as a mixed medical and social model bringing the right interventions to people at the right time.

While the Community Mental Health Framework (CMHF) was always the best plan, after COVID-19 it is now the only plan. 79% of people severely affected by mental illness[1] say they now feel worse and with surging insecurity and unemployment we are expecting a bullwhip effect of rising distress bringing new people into the system. There are not the clinical hours available to deal with this. Without a deep partnership approach to bring care and support into the community and get ahead of this, we risk creating clinical citadels with rationed treatment.

The Voluntary, Community and Social Enterprise (VCSE) sector has a vital role to play in this, although the transformation the VCSE needs to go through is as profound as it is for NHS colleagues. For a start, much of the support needed will not come from mental health charities alone. We will only succeed if we work with charities who can help on housing, debt and other social factors to build a holistic offer. Second, we need to be much better at working with the whole diverse population, including under-served communities and the small organisations that work with them. And while the voluntary sector rightly argues the necessity of co-production in the NHS, do we apply it enough ourselves to our own services? Because there is a queue for our services, we assume that we need more resource to provide more of the same. Perhaps most of all, we in the VCSE need to work together, put aside our rivalry and competition for funding and form a sustainable innovation partner to the NHS.

The steer from NHS England is clear: the vast majority of the transformation funding should go to provider staff and contracting the VCSE sector. And, of course, this all needs to be done hand-in-hand with social care.

This guide builds on our first, Thinking differently. There we detailed some practical first steps for Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). This guide moves on to commissioning, evaluating and recruiting, with a particular focus on peer working. We know how challenging this transformation would be at any time, let alone this one. As such, April 2021 won't be a big bang moment, where we step out of one system into another. But if we work together, we can ensure it will be a station in a journey of many years.

Background

New funding for transforming community mental health services

The NHS Long Term Plan and subsequent Community Mental Health Framework sets out a bold vision for transforming community mental health care for adults. By 2023/24, all Sustainability and Transformation Partnerships (STPS) / Integrated Care Systems (ICSs) will be delivering holistic care through integrated primary and community services and in arrangements with local authorities, housing and voluntary community and social enterprise (VCSE) services, underpinned by an additional £975 million in funding per year for adult and older adult community-based mental health care. A new four-week waiting time is being trialled and more than 370,000 people moderately to severely affected by mental illness per year can then expect to receive the right treatment at the right time by 2023/24.

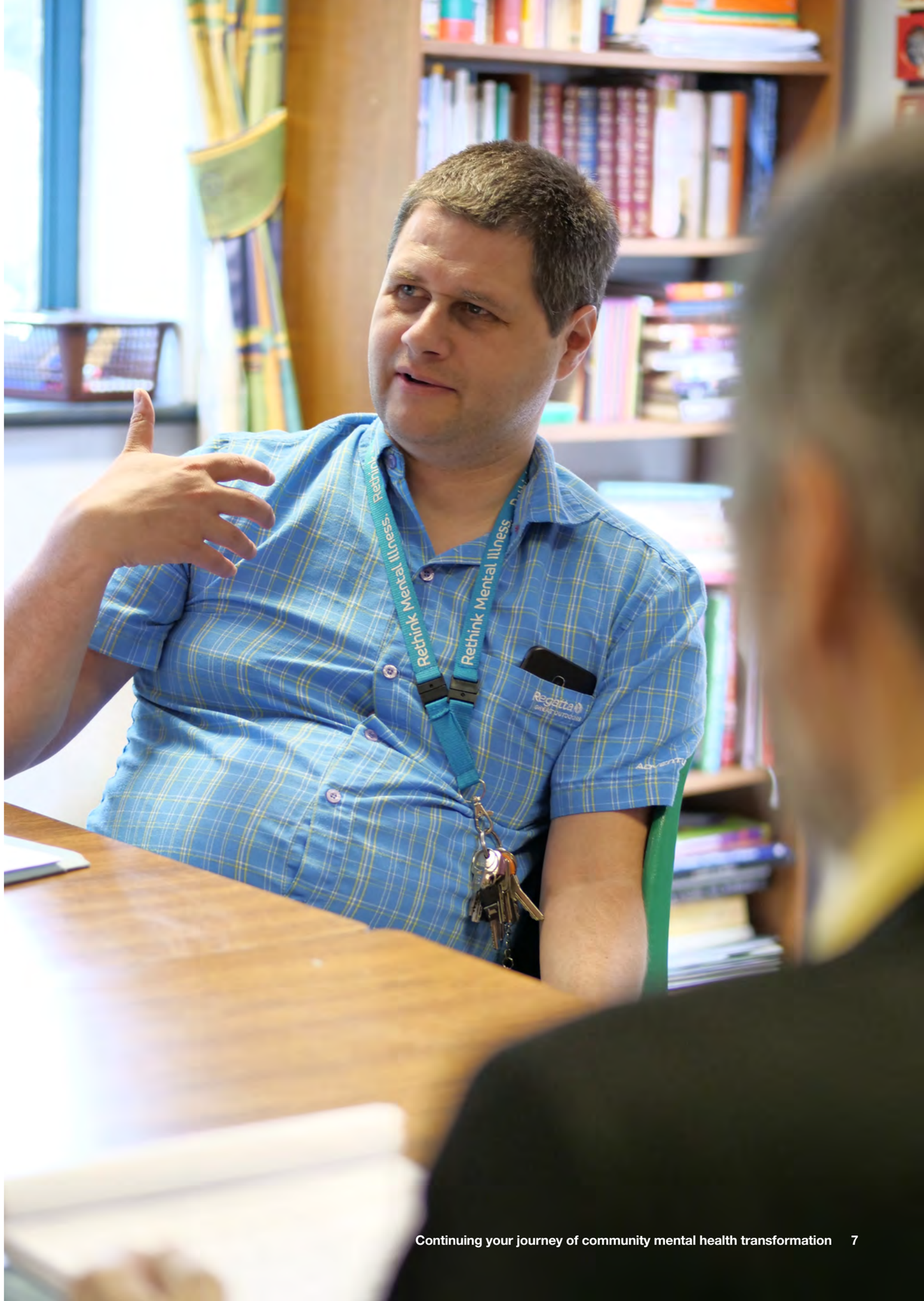
What should the new model of care look like?

This is set out in the NHS England and Improvement (NHS E and I) Community Mental Health Framework[2]. This is a new place-based and personalised community model designed to support your local population of adults and older adults affected by moderate to severe mental illness and their carers, including those with complex needs, even if they do not have a clinical diagnosis. It must support the population's clinical, practical, social, financial and physical health needs to help prevent mental health crisis and help people live to their full potential.

Time is short to deliver this redesign and the surrounding circumstances are unlike anything we have known in recent memory. Responding to the needs arising from the COVID-19 pandemic is urgent and takes limited resource away from delivering transformation. Yet, if time and space is carved out to deliver this, and links are made with other bodies who can add capacity, such as the VCS and local authorities, then it will significantly improve the outcomes of people severely affected by mental illness during this crisis and beyond.

What is the process that STPs/ICSs need to undertake to receive this funding?

NHS E and I launched the planning process and issued accompanying guidance for this work via regional NHS E and I teams in Autumn 2020 (also available on the FutureNHS platform). At the time of the launch of this guide (February 2021), most STPs/ICSs should have submitted final proposals to the relevant regional team and started receiving feedback from NHS E and NHS I.



How to start your transformation

In October 2020, Rethink Mental Illness launched our first guide, Thinking differently setting out the first five steps needed to deliver real transformation of community mental health services.

By now, or within the next few months, you should complete these first five steps:

1. Leadership and governance

A leaders group of experts by experience and staff who can sign off decisions.

2. Co-production

A co-production project group of people with lived experience and staff gaining local insights, co-producing a new model and feeding back to the community.

3. Mapping community assets

An understanding of who is currently delivering support for people severely affected by mental illness and their clinical, practical, social, financial and physical health needs.

4. Alliance-building

An alliance of voluntary and community organisations coming together, ready for procurement.

5. Workforce

A new model of community mental health care forming (but not necessarily finalised) and a workforce plan and recruitment starting with role adverts published.

What are your next five steps?

6. Addressing and overcoming barriers

Work to overcome hurdles in completing the first five steps before moving ahead to finalise your model of community care.

7. Measurement and evaluation

Co-produce a person-centred model of evaluation with experts by experience to measure the efficacy of your model.

8. Commissioning and contracting

Use new and innovative models of commissioning and long-term contracting to jointly create a new, alliance-focused system of community mental health care.

9. Recruitment and skills development

Ensure that the right roles are in place and that new and existing staff are equipped with the right knowledge and behaviours to deliver your new community model.

10. Co-delivery of your new model

Spread the word about your new model of support and begin co-produced delivery of services. Continue to meet as a partnership to build and evolve your model.

Need further support?

Rethink Mental Illness has established a Community Mental Health Framework unit – a team of experts who can help you and your colleagues implement these steps.

Get in contact with us at CMHFsupport@rethink.org if you would like to work with us to deliver any aspects of this transformation.

INSIGHT

A transformative approach

Insight from Beccy Wardle, Head of NHS Collaboration at Rethink Mental Illness

Beccy has been involved in the trailblazing work that has taken place in the Somerset early implementer site. Rethink Mental Illness is the lead accountable organisation within a new VCSE alliance that is working closely with the NHS and local authority to transform community mental health care in the STP.

What did the first months of the transformation look like in Somerset?

It is so important that you deliver the first five steps before moving onto anything else. You may be worried by how iterative things feel, but laying the groundwork, building the relationships and trust and establishing a common purpose through alliance building and co-production are absolutely critical. We learned that it was important to begin to feel comfortable with ambiguity if we were going to avoid falling into the trap of setting something up before we had properly co-produced our service transformation. We agreed our vision and aspirations before we designed our model, whilst recognising that it didn't have to be set in absolute stone from the beginning – we just needed to start somewhere!

The beginning of this process was all about doing that groundwork. The natural tendency of all of us is to want to have everything set in stone early on – but this has been an iterative process, with the building up of trust, relationships and a shared ambition for culture change being key, alongside a road map and a process to support us to arrive at our transformation model.

If you could give one message to STPs, what would it be?

Clinical Commissioning Groups (CCGs) and Trusts have to be supported by a strong VCSE alliance on this. Building a strong VCSE alliance takes a lot of work on the ground locally to build trust between organisations that have been used to competing in the past. The alliance must continue evolving to include more sources of support, especially smaller local groups and grassroots organisations based in the community. To get this right, it really shouldn't be about working with just one big VCSE provider – the micro-providers are critical to successful transformation and implementation of the CMHF.

It is vital that the VCSE partners involved are all working to the same objective to ensure the success of the Community Mental Health Framework, as opposed to simply wanting to compete for delivery funding. Only then will we see genuine transformation.

For more on co-production see Thinking differently pages 11–12

For more on alliance-building see Thinking differently pages 14–15

The next five steps

6 Addressing and overcoming barriers

Pinpointing barriers and mitigating issues will be vital in developing your new model. There is a step-by-step guide in our previous resource, Thinking differently, setting out how to go about working in partnership with stakeholders and experts by experience to co-produce the model, along with tools such as an expert by experience role advert.

However, time is short to deliver this redesign, and you may have experienced a number of challenges when trying to complete these steps. You are not alone and common barriers exist across many areas trying to enact this level of change. Through our webinars, interviews and meetings with STPs we have identified these particularly common roadblocks:

Scepticism and resistance to change

- Some staff, particularly those who have been involved in change processes previously, may feel cynical about the possibility of real transformation – and understandably so, as past 'transformations' have often been prompted by funding cuts. Others may resist change, perhaps because they are concerned about the risks involved, or that such a move will make their work more challenging or workload heavier.

Limited notions of what is possible

- Many of those responsible for this transformation will have spent years working in the existing under-funded system – with such familiarity with the way things have been within significant financial constraints, it can be hard to imagine how they could look different.

Concerns about the cost or difficulty of delivering better care

- Some believe that better care will ultimately be more expensive to deliver!

COVID-19 pandemic

- Of course, the pandemic has taken vital time, resource and attention away from many members of staff, reducing capacity to focus on this. Clinicians and commissioners are also telling us they are seeing increased demand and more complex cases.

Hierarchy

- This redesign involves dismantling long-held notions by some that the medical model of care is superior to other forms of mental health support. People have told us that respect doesn't always exist between different professions, and different sectors frequently use language that can exclude others. We have also heard about significant concerns regarding sharing power, decision-making and funding with other sectors.

Lack of trust

- Poor levels of trust can hinder the early, relationship-building stages of this transformation. It may be that historically poor relationships exist between one or more of the agencies instrumental to the transformation process, or that those with lived experience lack trust in the direction of the transformation due to previous negative experiences of support or attempts at co-production.

Prevalence of single organisation agendas

- VCSE organisations are, in particular, used to operating in a competitive funding environment – this will be particularly prevalent with the COVID-19 pandemic significantly impacting on the sector's funding.

Putting off involvement of certain groups until later in the process

- We have heard some STPs considering delaying working with other groups, whether that's experts by experience, VCSE organisations, or the local authority, until their own house is in order first. However, this goes against what the Community Mental Health Framework is trying to achieve and ultimately will not lead to joined up support that improves outcomes for the local population.

- We have also heard some areas considering delaying engaging with certain populations or communities until further down the line. For example, delaying co-producing a model for older adults because commissioning processes with other older adults services aren't aligned, or finding certain BAME community groups 'hard to reach'.

"Budget was often brought up as a reason that my care couldn't be more person-centred – I found this really unhelpful."
Expert by experience

"I've seen a housing support worker make suggestions for care plans that were not taken as valid information by clinical staff – this isn't just wrong but it devalues that person in the eyes of the person they are trying to help."
Expert by experience

"If there is one thing I would change about what we've developed, I would have begun co-production with experts by experience and the VCSE sector earlier than we did."
NHS Trust

Tips for overcoming these barriers:

1. Use evidence to articulate positive changes that can emerge as a result of the transformed system

- Demonstrate the cost and demand within the current system, versus reduced costs possible by providing more proactive care and investing in expanded teams and services that can reduce pressures.

2. Demonstrate what is possible

- Share case studies included in this guide and elsewhere and consider working with a person or organisation to facilitate co-production with experts by experience to innovate and think outside the existing system. Engender a culture of positive risk-taking and willingness to make and learn from mistakes.

"Getting out there, seeing what works and understanding the contributions of local neighbourhood and community organisations is the most effective way of encouraging the NHS to relinquish control."
Clinical Commissioning Group

"You are going to make mistakes and you are going to get things wrong. The model will evolve and, in a year, it shouldn't look like what it looks like now. You have to be open to learning together – from when you get things wrong as well as when you get them right."
NHS Trust

3. Appeal to what motivates staff

- Encourage leaders to reflect on what motivated them to get involved in this area of work in the first place, particularly moral and emotional motivations such as overcoming injustice and ensuring public value.

4. Actively dismantle the hierarchy

- Host collaborative groups involving people at all levels – commissioners, CEOs, clinicians from across primary and secondary care, carers and service users – but ensure "lanyards are left at the door". Encourage "human-to-human" interaction and use the space to develop beliefs and values that the group share as citizens, rather than as services, service users or decision makers. Commit to using language that all can understand.

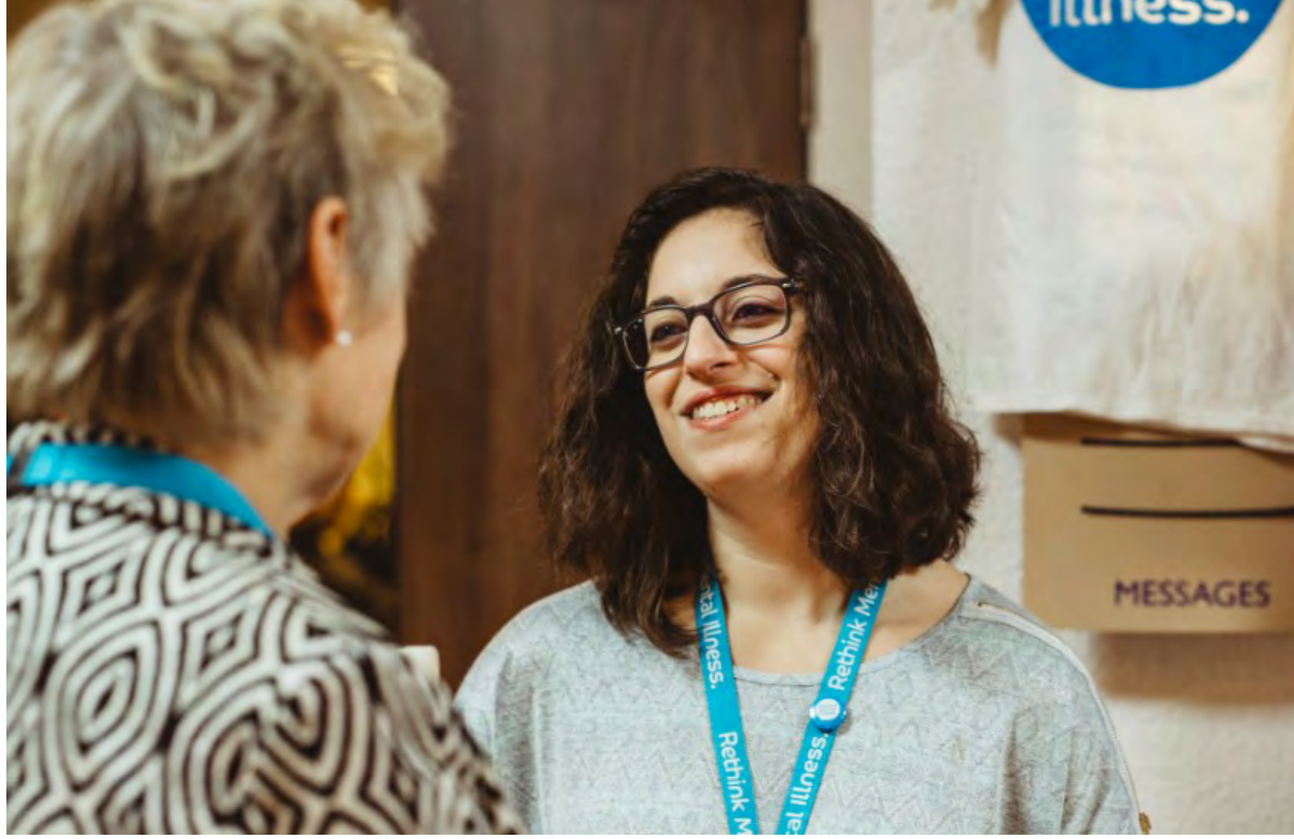
Example: In Somerset, they have sought to embed a 'one team' approach across their model. They have a whole-system strategic leaders huddle including both VCSE and statutory sector colleagues working across all workstreams and within locality teams. Teams, working groups and meetings can be led or chaired by the local authority, VCSE sector or the NHS.

"We found that doing this has levelled the playing field and changed some of the conversations."
VCSE organisation

Example: Partners in Lambeth began holding monthly breakfast meetings in 2010 following the development of the Lambeth collaborative, a group of commissioners, providers of mental health services, people with lived experience of mental health issues and their carers, in order to initiate a conversation about mental health and what good could look like. What began as something to navigate diary constraints turned into a catalyst for important conversations. Out of these, partners have developed peer support schemes, community-options schemes and an evening sanctuary, and continue to be a powerful driver for mental health services in Lambeth virtually during the COVID-19 pandemic.

These have proven a vital forum for relationship building and a humanising experience for participants of all backgrounds.

"The breakfast is symbolic – the fact that we are all there to have breakfast is a small thing that unites us. The fact that we use the social enterprise café rather than our offices as a meeting space is also a great equaliser."
Clinical Commissioning Group



5. Create buzz and momentum around the transformation

- It is important to generate excitement – this is a once in a generation chance to use a large pot of money to get community mental health right. Connecting with staff elsewhere in your region and beyond can support learning and help staff to feel part of something bigger.

6. Building trust

- Reflective practice is vital in recognising what has and hasn't gone right in the past. Good governance and agreeing ways of working that promote transparency and accountability are all key for bringing down walls between agencies.

7. Be open and honest about how people may feel and address barriers head on

- Sweeping issues under the carpet could ultimately hinder your transformation process in the long term – be real with staff about how they are potentially feeling about the proposed changes. Strong leaders at all levels of the partnership have a role to play in doing this.

8. Bring people together digitally

- Due to the COVID-19 pandemic, many early implementer sites have had to make use of technology to bring together transformation partners. In Somerset, they have found that this has made it easier for all parties, particularly smaller VCSE organisations, to find the time to participate. Ensure that digital inclusion is considered when recruiting expert by experience leaders.

9. Think about how everyone can be involved from the start

- To ensure balance and avoid gaps further down the line, it is important to involve a range of partners from the off and consider how you will reach your whole population. Its worth taking a moment to reflect from the perspective of those in need of care, support and treatment. People and communities are often described as 'hard-to-reach', but that is how these people feel about mental health services.

Example: In Somerset, they are beginning to co-produce an Equalities Impact Assessment with experts by experience and local equalities groups. Following the assessment, a locality-based equalities action plan will be owned by an expert by experience leader based in each locality team.

7 Measurement and evaluation

It will be vital to measure and evaluate the efficacy of your model, without rigid targets undermining the person-centredness of what you are trying to achieve. Ensuring sufficient resource now should result in evidence on what works and what doesn't in the community to secure resources beyond the three year transformation.

Measurements should include service user experience, recovery metrics, time-to-access metrics (such as four-week waiting times), and system focused measurements (e.g. reduction in A&E admissions). These will enable the model to work for service users and carers, as well as helping organisations demonstrate its effectiveness and identify where further work is needed. It is important to consider how different treatments (including evidence-based psychological therapies – more detail below) are resulting in clinical improvement and progress to recovery. Of course, to deliver this in practice, your evaluation will need to be co-produced.

Some examples of aims and measurements that you could use to evaluate your community model are available in the appendix.

Example: Mersey Care NHS Foundation Trust has developed a new service designed to plug the gap between GPs, IAPT and community mental health teams. They are developing a flexible outcomes model to ensure that they are able to adapt as the service is rolled out and developed with experts by experience and the VCSE sector, who haven't yet been involved in shaping the service. Launched in October 2020, the Trust believes system key performance indicators will focus on reduction of presentation at A&E, reduction of attendance at GPs and an improvement in access to relevant voluntary sector services.

It is crucial in the new joined-up local system that all providers involved, including local authority providers and those from the VCSE sector, share measurements and are able to input into the same system. Ensure that the administrative commitments with regard to outcomes are manageable for all sizes of provider – this will encourage inclusion of micro-organisations and support groups within your VCSE alliance as it continues to evolve.

You may consider investing in additional resource within your system to support data collection.

For more on co-production see Thinking differently pages 11–12

From Rethink Mental Illness – Right Treatment, Right Time (2018):

What sort of treatments should people with severe and complex mental illnesses be receiving?

People should be able to access evidence-based therapies based on their diagnosis and/or needs.

These can include, but are not limited, to:

- Cognitive behavioural therapy for psychosis, bipolar disorder or eating disorders
- Dialectical behavioural therapy for borderline personality disorder
- Family therapy
- Cognitive analytical therapy for borderline personality and eating disorders
- Psychodynamic therapy
- Psychotherapy
- Group therapy.

CASE STUDY

"Our model leads the evaluation, rather than the evaluation leading the model" – measuring impact of redesigned community mental health services in Somerset

In 2019, Somerset STP became one of 12 early implementer sites selected to plan and deliver integrated primary and community care for adults and older adults with moderate to severe mental illnesses. Rethink Mental Illness are the lead accountable organisation within a VCSE alliance that is working closely with the NHS, local authority and VCSE organisations in Somerset to deliver a redesigned model of community mental health care.

Having co-produced a new model, partners in Somerset were keen to develop an evaluation that is led by the model. The area has adopted a long-term perspective for their evaluation, focusing on population health through a mental health lens and has resisted being led by the objective to reduce demand on the system.

The approach has involved the blending of national metrics required centrally by NHS England and NHS Improvement with co-produced, patient-focused measures that are meaningful for service users in their area.

Partners worked with experts by experience to co-produce a longlist of possible outcomes based on their experiences and priorities. A series of calls with sector representatives then provided the opportunity to review and discuss the longlist, and narrow this down to what were seen as the most important measures.

"It can be initially challenging to explain and sell to colleagues in performance and finance, and not all STPs will be working in a context where these other, vital parts of the system are supportive of your transformation from the get-go. I'd say it is important to give these colleagues enough, while making the case for the time and space to test and prove the efficacy of your approach. The additional, dedicated investment for this transformation and accompanying national policy narrative are helpful tools in gaining buy-in and tipping the balance towards innovation."

From the outset, Somerset's mantra has been "record light and report once." It was recognised early on that the Somerset VCSE alliance would not retain engagement from smaller VCSE organisations if said providers were expected to undertake large amounts of recording. This has been dealt with via a pragmatic approach, examining what would ideally be recorded and assessing with different partners what they deem achievable and proportionate.

Considering how data can be gathered in a joined-up way has been a major challenge. Granting access for all partners to the existing NHS system was considered as an option, but this was deemed by all partners as harbouring a specific power dynamic and entrenching hierarchy. Equally, developing a new platform and granting partners read-only access would have been an easier option. Instead, a new care and support planning and outcomes recording digital system that integrates with both EMIS and Rio (popular healthcare records systems) is being developed building on infrastructure already being developed in the county. VCSE and statutory colleagues will have equal access to initiate and contribute to an individual's personal plan, meaning one plan, even if accessing support from multiple organisations. Phase two will involve development of a patient portal, giving the individual the ability to meaningfully own their own personal plan.

The partnership continues to consider how it can capture the impact of the full mental health ecosystem – from large-scale NHS providers to micro-providers and peer support groups.

8 Commissioning and contracting

At the heart of the Community Mental Health Framework is a shift away from solely clinically-run services to VCSE-led services. This requires giving away some leadership, power and funding for the greater good!

The commissioning process is important in ensuring that this funding and power reaches the right places, including VCSE providers who may be small but very much represent their communities. In Somerset, this has been achieved through the development of a VCSE alliance – more details on this are available within our first guide.

It is vital also that a co-produced model is in place to provide a strategic foundation for funding and power-sharing that is based on an agreed future direction between partners.

Example: In Somerset, funding flowed from the CCG, to the Trust and then to Rethink Mental Illness as the accountable organisation for the VCSE alliance. This was then shared out depending on which partner is leading on delivering which part of the co-produced model.

What is alliance-contracting?

Alliance-contracting is a contractual agreement between the commissioner(s), Trust and an alliance of providers delivering a project or service. These contracts usually exist over a longer-term period of delivery and help to guard against the dominance of any single provider by embedding unanimous decision-making into the model.

Other benefits of alliance-contracting:

- **Aligns providers on outcomes** – Providers are collectively accountable for delivery and achievement of outcomes. All providers are working to a single performance framework, meaning risks and rewards are shared based on performance across providers.
- **Flexibility in terms of outcomes** – Unlike traditional bilateral service contracts where outcomes are usually strict and predetermined, change and innovation in delivery is both expected and encouraged.
- **Active role for commissioners** – Unlike other models (e.g. lead provider), in which the majority of responsibility is handed to one provider, commissioners are an active and equal member in alliance structures and can influence change during the contract.

Successful alliance-contracting relies on the VCSE sector working in a united way. Commissioners being clear from the early stages of transformation that they will be looking to procure services via an alliance model provides both permission and impetus for VCSE providers to begin engaging in a different, partnership-focused way.[3]

This aligns with the direction of travel for Integrated Care Systems and the role of VCSE partners within them, as set out by NHS E and I in their recent publication 'Integrating care: Next steps to building strong and effective integrated care systems across England'.

For more on alliance-building see Thinking differently pages 14–15

INSIGHT

The Innovation Partnership approach

Insight from Tim Baverstock, Deputy Director of Adult Social Care at Somerset County Council

It is clear that all public sector bodies have to use a robust approach to commissioning services. However, it is also clear that traditional approaches do not always deliver the most innovative way of working when new and transformational change is required. There are alternatives and pragmatic approaches which provide an auditable process but support more discussion with potential bidders during the process. Commissioners should strive for relational commissioning – honesty and discussion as services are being developed gains buy in, avoids damaging rifts between providers and makes for a partnership model where commissioners and providers share the same aims.

The Public Contracts Regulations 2015 include a new route to market in the form of an innovation partnership (IP), which offers a variation on the competitive with dialogue procedure. Typically this procedure is pitched more at the development of innovative products, but the Somerset STP's ambitious vision to redesign community mental health care made the innovation partnership an ideal procurement route for the service. The IP process:

- Offers a more flexible process for both procurer and bidder. It includes several stages, allowing the requirements of the service to be honed and suppliers' capabilities to be understood.
- Allows co-production and development of the detailed service requirements, using the shortlisted bidders' expertise at the innovation stage to jointly explore potential service delivery models.
- Is more accessible to VCSE sector organisations. The bureaucracy and volume of paperwork involved in public procurement processes can discourage VCSE sector organisations from bidding. They are also less likely to have the resource of a specialist bidding team and, if they do bid, are less likely to perform strongly in the evaluation. We also specifically encouraged bids from consortia, which would better enable VCS and/or SMEs to join together and submit a bid.
- Will result in the appointment of a service delivery partner, rather than the conventional procurer/contractor relationship. Again, the flexibility of setting broad, outcome-based goals at the specification stage, allows for innovation to continue for the life of the contract.

Encouraging partnerships or consortia, provider alliances and a strong VCSE role is not anti-competitive and can offer better outcomes and better value for money. Working together with people and providers with a transparent investment envelope will generally make the money go further and stretch the reach and scope of the support that results – penny pinching or relying on cost as a lever will rarely do that. Design with and not to, work with and not do unto and trust your providers to help you deliver the best services possible.

CASE STUDY

“The clear message is that alliancing is the optimum way of bringing the system together” – utilising alliance-contracting to transform service delivery in Lambeth

Lambeth’s story started 10 years ago. The mental health provision in the borough was not in a good place, with high spend, poor outcomes, adversarial relationships between statutory services and service users and their carers, and limited involvement of the VCSE sector.

“Mental health wasn’t high on the agenda when this work began.”
Clinical Commissioning Group

The first step was to establish a group of commissioners, providers of mental health services, people with lived experience and their carers to come together to initiate a conversation about mental health and what good could look like. The initial focus was on co-producing a wide range of support aimed at enabling people to access help much earlier including peer support, an out-of-hours crisis service and localised integrated community support including primary care, social care, VCSE and secondary care. All were on board with working towards key principles such as co-production and collective risk sharing.

A few years down the line in April 2015, Lambeth formed the Integrated Personal Support Alliance, which became the prototype for alliance-contracting in the borough with a local budget of £12 million focused on those with high support needs.

“The commissioning role was to enable and help facilitate collaboration between all key partners in order to co-produce better person-centred services and outcomes with users, carers and local communities.”
Clinical Commissioning Group

In forming an alliance, Lambeth CCG and Council invited proposals from providers from the VCSE to demonstrate how their organisations could work collaboratively and are aligned with the three primary (“big 3”) outcomes developed by the Lambeth Collaborative:

- To recover and stay well and experience a greater quality of life with improved physical and mental health.
- To make their own choices and achieve personal goals.
- To participate on an equal footing in daily life.

A series of alignment workshops helped to build relationships between providers and design the service model and delivery arrangements. Shadow governance was set up to finalise details of an outcome-based contract and commercial arrangements, with final detail agreed by the Alliance leadership team.

In three years, this service moved over 70 people previously living in rehab facilities and residential care into more independent living arrangements and provided evidence that it was possible to create a more whole-system approach ultimately focused on outcomes that matter to people. The success of the Alliance, and the progress made, led to an expansion to encompass all adult (working age) investment in Lambeth.

The whole-system alliance was established from July 2018. The provision delivered by this alliance covers £70m of the annual budget, including acute, community, primary care and more via a long-term contract.

They issued a prior information notice in 2017 and had various expressions of interest, but only one credible application emerged, from the partnership involved in delivering the Integrated Personalised Support Alliance. Commissioners then issued a voluntary exemption transparency notice, which articulated that there was no coherent alternative to this group of providers.

Negotiations then began, finally getting over the line in July 2018. The Alliance has recently produced a two-year progress report, with the highlight being the creation of local area community integrated/ multi-disciplinary services in accord with national community health guidance.

“Co-production, collective responsibility, unanimous decision-making and genuine open-book accounting are amongst the key principles that underpin the success of the Alliance.”
Lambeth Alliance

More resources on commissioning:

Kings Fund – Alliance contracting

Hempsons – Can alliance contracting help deliver integrated care?

Social Care Institute for Excellence – Joint commissioning for integrated care

9 Recruitment and skills development

Those with lived experience of moderate to severe mental illness make it clear that when they have received good support, it has rarely been the responsibility of a single person or service. A number of varied roles and wrap-around support from a joined-up team are vital components of keeping people well. Community support should complement, not replace, clinical care.

"My psychiatrist, peer-support group and recovery college are all important to me."

"My employment and support adviser is the driving force in my life. I also have a psychiatric nurse who I speak to less often, but it is good to know I can call her if I need her."

"My GP made a big difference initially in terms of making sure I got the help I needed. Now, I would say my occupational therapist."

"My social worker was vital in terms of changing my experience of support."

"I have a good psychiatrist, good care-coordinator and a support worker I see two or three times a week."

Quotes from experts by experience

Your workforce requirements will be based on the co-produced model of care. It is likely they will include a much-expanded multidisciplinary workforce, including new roles such as peer support workers and embedded staff members employed by VCSE organisations.

Health Education England's mental health programme sets out these new and expanded existing roles in more detail.

For more on workforce requirements see Thinking differently page 16

Social prescribing and care navigation

It's important to link up with other local priorities, such as the social prescribing roll out within Primary Care Networks (PCNs) and ICSs. Social prescribers can play a role in linking people up to the broader range of local, non-clinical services identified in your earlier asset-mapping exercise which should be available and integrated in a new community mental health system.

For more on asset mapping see Thinking differently page 13

More resources

Health Education England – New roles in mental health

Royal College of Psychiatrists – Long Term Plan for the NHS in England: information for psychiatrists

CASE STUDY

"It's about being that in-between person" – mental health navigation in Grimsby.

In Grimsby, North East Lancashire, the NHS, working with Rethink Mental Illness and NAViGO, a social enterprise service provider and funded by Johnson & Johnson, is trialling the use of a mental health navigator to improve the community support for people severely affected by mental illness.

The mental health navigator post has been established to assist and empower people to access the right support to manage a range of needs and social distresses that can affect an individual's mental health. This builds on the well-established social prescribing model, offering a dedicated capacity within the primary care network to offer personalised support and signposting with a focus on maintaining independence, wellbeing and quality of life whilst reducing demand on primary care and mental health services.

Navigator Teresa began in post in May, and her work is already taking the pressure off overstretched medical services. Whether people need support with money issues, employment, housing, physical health or social connections within their community, she is making a difference. She describes herself as an "in-between person", providing prompt support for service users and supporting GPs to reduce appointments.

"GPs can say to the patient 'we've got someone here who is trained in mental health, would you like me to refer you to them? They can spend that time with you and make sure you're getting the wider support you need'. They have been really pleased with the work that I do and they are really lovely to work with."

Within the context of COVID-19, her support for some people has been nothing short of life-saving. "We once had a lady that was blind who had recently broken a wrist, she hadn't gone out because she was concerned about social distancing and she hadn't been contacted for support. That meant that she had been eating finger food for three months because she couldn't cook."

"I did everything I could to help. I got her meals on wheels so that she was able to have hot food. I provided her with audio books so that she had things to keep her occupied. I even helped her with her heart monitor and got it all fitted and working at home for her. I arranged her transport to help her get to and from her hospital appointments. I referred her to a befriending service so she was getting a weekly call from someone to check in on how she was – and she also had a bit of emotional support from me."

CASE STUDY

“We think about medicines and integrate that into someone’s overall health and wellbeing” – introducing dedicated clinical pharmacy support into adult community mental health teams in Nottinghamshire

Matthew Elswood, Chief Pharmacist at Nottinghamshire Healthcare NHS Foundation Trust, has become a key fixture of the Trust’s support offer in Rushcliffe, working one day a week running two types of medication clinic within the team.

The short-term clinic was established to provide dedicated time and expertise to discuss changes to medication, having recognised that consultants were often lacking time to discuss medication meaningfully within their consultations.

“You have got a half hour or 45 minute appointment with someone, where you have to review everything about their mental, physical and social needs. You might realise towards the end of an appointment that they would benefit from a possible change in medication. You sometimes feel like you don’t have the time to talk someone through it and help them make a capacitous decision.”

Dr C. Iheonu, Consultant

Now, the consultant refers service users to the short-term medication review clinic to work with the pharmacist and consider options that might work for them. This involves considering new options, considering medications that have had some degree of effectiveness in the past or, in a number of cases, stopping medication altogether. In the short-term clinic, Matthew has the ability to see the service user more frequently than the consultant, guiding patients through the process, and making necessary adjustments.

The long-term medication review clinic serves patients who are generally stable and well but on medication that means they cannot be discharged safely to primary care. This clinic allows Matthew to work with patients to review their mental and physical health through a pharmaceutical lens. He is able to look holistically at a person, recognising factors that might hinder their recovery and health.

He is able to educate patients on medication, considering side effects and whether alternatives could lead to better outcomes long term. If an alteration in medication is agreed, he can refer people back to his short-term clinic to manage that change more intensively. This has resulted in improved outcomes such as improved physical health monitoring, identification of health problems and, for many patients, simpler and more tolerable medication regimes.

“The long-term clinic has been such a huge help to a significant number of people, and the service frees up my time to see the most unwell patients.”

Dr C. Iheonu, Consultant

Matthew works closely with the rest of the multi-disciplinary team (MDT). In his clinics, he is able to recognise issues and signpost to appropriate specialists within the MDT, whether those relate to worsening health or wider challenges such as employment, as well as advocating for completion of physical health checks where appropriate.

He is also available as a source of expertise and training on medication to the consultant and wider team. A number of referrals will come straight from GPs when they feel a course of action isn’t working, and some GPs have found this support and expertise useful.

The Trust is considering how to expand this model across the county, with the expectation that around four of the eleven areas will have a pharmacist replicating Matthew’s work by the end of 2021. The local group overseeing their community mental health transformation are looking at how they can make this part of “business-as-usual” within all adult community mental health teams in Nottinghamshire.

Training

A transformed community model of care will involve a culture change in how support is delivered. Training and learning opportunities are imperative in ensuring that staff are equipped with the necessary knowledge, confidence and ethos to successfully deliver your new model of care.

For example, even if dedicated link workers exist within your staff team, it is important for all of those on the front line to be aware of what is available in the community. This is particularly important for staff who frequently serve as a first point of contact for those entering the system.

“There is a lot of ignorance, assumptions and a lack of knowledge among both those seeking support and those who are supposed to provide. This can lead to apathy and resignation on the part of providers and frustration among those seeking help.”

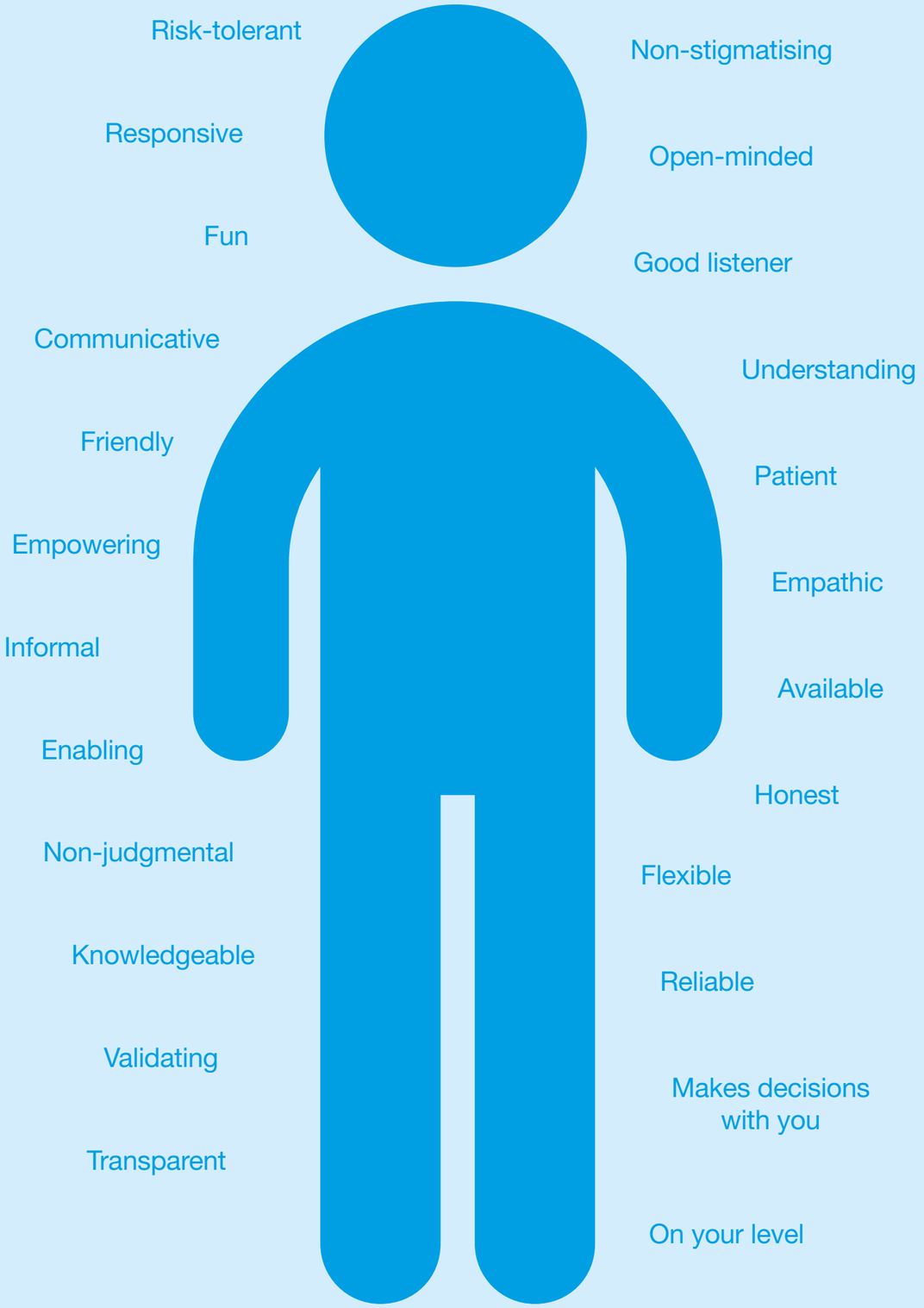
Expert by experience

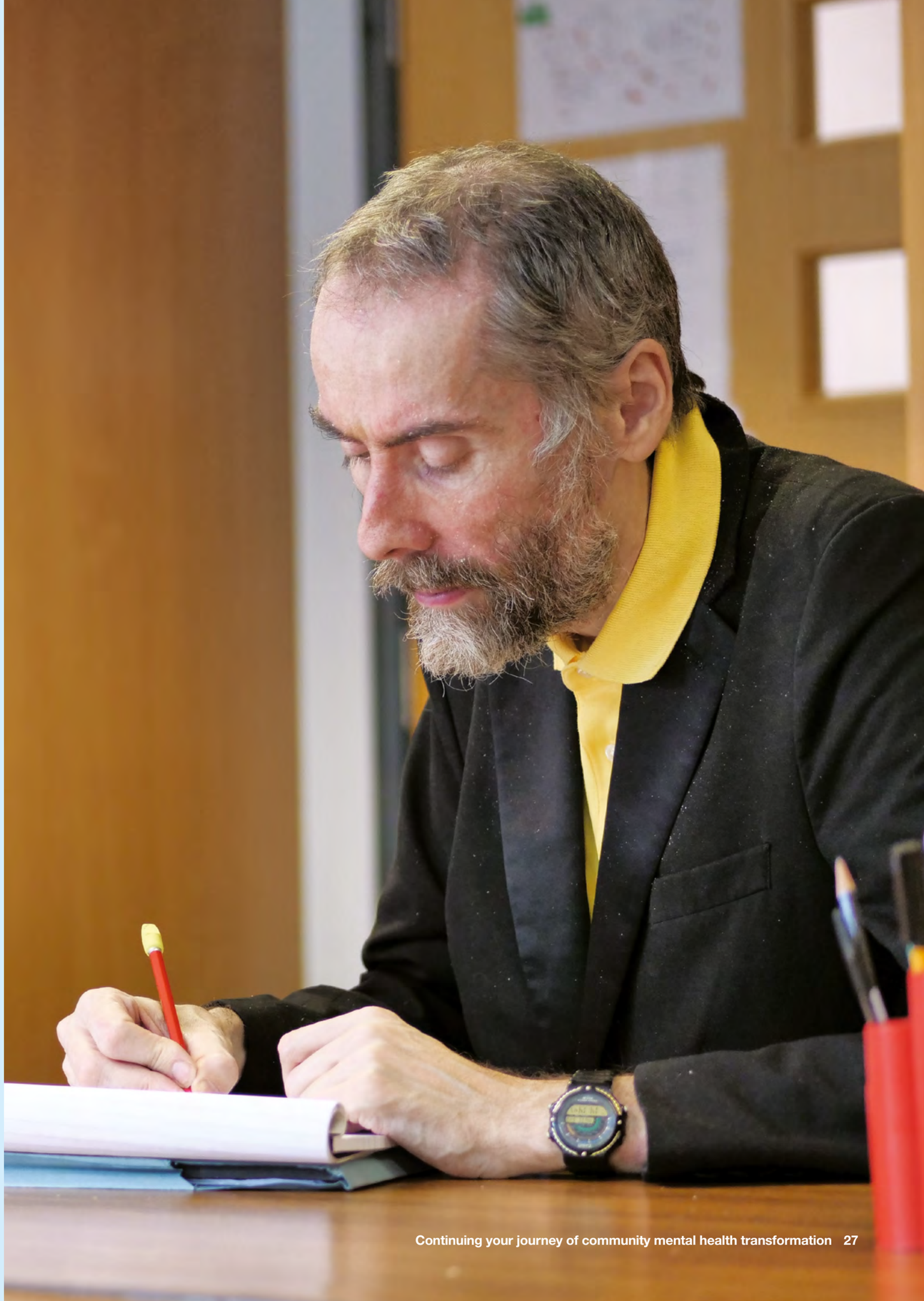
Building understanding of mental illness is particularly important for staff in services who do not traditionally specialise in mental health, whilst tackling stigma and removing preconceptions, particularly those which relate to certain diagnoses, remains crucial to the delivery of holistic, person-centred care.

Example: In Somerset, they are developing a common induction and shared training for NHS and VCSE staff. Throughout this, experts by experience share their lived experience of severe mental illness across disciplines. All colleagues who join Open Mental Health will attend the same induction webinar, introducing them to Open Mental Health, what it means, what their key principles are and beginning to embed our shared culture. The induction webinar itself has been co-produced, and expert by experience leaders are working with them on further developing shared training and development opportunities for staff.

We are also implementing quarterly learning webinars for NHS, VCSE and LA front line staff to build on our ‘one team’ culture. Teams across sectors are encouraged to feel part of something bigger, transformative, exciting and that is really changing things for people with severe mental illness. We are finding that some colleagues that have been working in the system for years are now saying this is the most exciting time in their career. It is this momentum and enthusiasm that will enable culture and system change to continue, be long lasting and have a real impact.

Positive workforce qualities and behaviours highlighted by experts by experience include:





10 Co-delivery of your new model

Having successfully navigated the previous steps, your partnership should now be ready to start delivery.

Your co-production group should continue to meet and communicate to keep developing and evolving your model, assess its efficacy and address any blockages that arise during the early stages of delivery.

Spreading the word about your new model

It is crucial that you not only spread the word about your new support offer, but do so in a way that is accessible and will reach those in need both in and outside of the system. For the aspirations of this model to truly be realised, all of those with moderate to severe mental illness must be made aware of what is available and what they are entitled to.

Work with experts by experience and the VCSE to co-produce communications around the model with consideration of how these communications will reach different groups with particular needs, such as older adults, BAME communities and those facing digital exclusion.

Experts by experience can help to share plans for change with their networks to begin to raise awareness amongst existing and potential service users.

Example: NAViGO in Grimsby has recently taken steps to utilise their local asset mapping to create a search function on their website. This is easy-to-use and provides comprehensive information about what a service offers, where the service is based and how to access this support.

"I was given a sense of their options and possible journey – a chance to hear about what is on offer and how it works. Knowledge about what is there gave me some hope, and some power back, you know? I felt confident and less frightened."

Expert by experience

Providing support during the COVID-19 pandemic

This transformation is taking place against the backdrop of the unprecedented circumstances created by the COVID-19 pandemic. It is understandable that the agencies involved in this transformation may be concerned about capacity and, indeed, about how joined-up, person-centred support can be delivered in this context.

However, given the increased mental health need emerging during this pandemic, the Community Mental Health Framework provides the solutions to address the challenge ahead.

Many early implementer sites and other areas spearheading good practice have found that the pandemic has provided impetus for them to spring into action in terms of delivery, in order to meet the demands of the crisis.

"I had the option of attending online support groups but didn't need them – phone calls and emails have ensured I haven't felt alone."

Expert by experience

"Digital and remote support has been working well, although some people need face-to-face. As a navigator, I can help people to access support to address digital exclusion. We also work more closely with others than we could have imagined before because of the regular cross-service huddles."

VCSE organisation

"In Somerset, we established a 24-hour helpline which has been fantastic. People can now be transferred seamlessly to our home treatment team, and are finally getting support they asked for years ago."

VCSE organisation

"COVID-19 has unleashed the power of the neighbourhood model. It has always been there but has come into its own during the pandemic."

Clinical Commissioning Group

"I think attitude is key. Service users like me understand that things are difficult due to the pandemic, but kindness and a non-judgmental attitude has an enormous impact on people with poor mental health and costs nothing!"

Expert by experience

CASE STUDY

‘What do you want and how can we help you get it?’ – delivering personalised care in Gloucestershire

The NHS England and Improvement Personalised Care Mental Health & Social Care team for the South West have changed how personal budgets are delivered to people living with severe mental illness, especially those under Section 117 or experiencing a ‘revolving door’ of A&E visits, hospital stays or police custody. A new self-assessment tool has also been co-produced with service users, in their own language, to be used alongside their care programme approach, which is asset and not deficit-focused.

A focus has been put on service users to use their personal budget on ‘what makes them happy’ whether that be a gym pass, season football tickets or respite for carers.

To deliver this new approach it has been key for health and social care teams across NHS, local authority and local VCSE organisations to work together to care for the service user as a whole person and integrate/collaborate their different budgets.

The new system has proved a success, with both costs saved for the system and the positive impact on service users being demonstrated. On average, a saving of £600 per person has been found so far.

Service users now have the chance to build local networks outside of mental health and the opportunity to do what makes them happy. For example, a service user with cerebral palsy and emotional unstable personality disorder says that this was the first time she had been asked “What matters to you?” and how her mental health had impacted her physical health and vice versa and was able to speak freely and without judgement.

She was able to co-produce her care plan to help facilitate her recovery and meet personal goals. These included getting fit and healthy in a way that took into consideration the limitations of her physical disability and choosing people to support her.

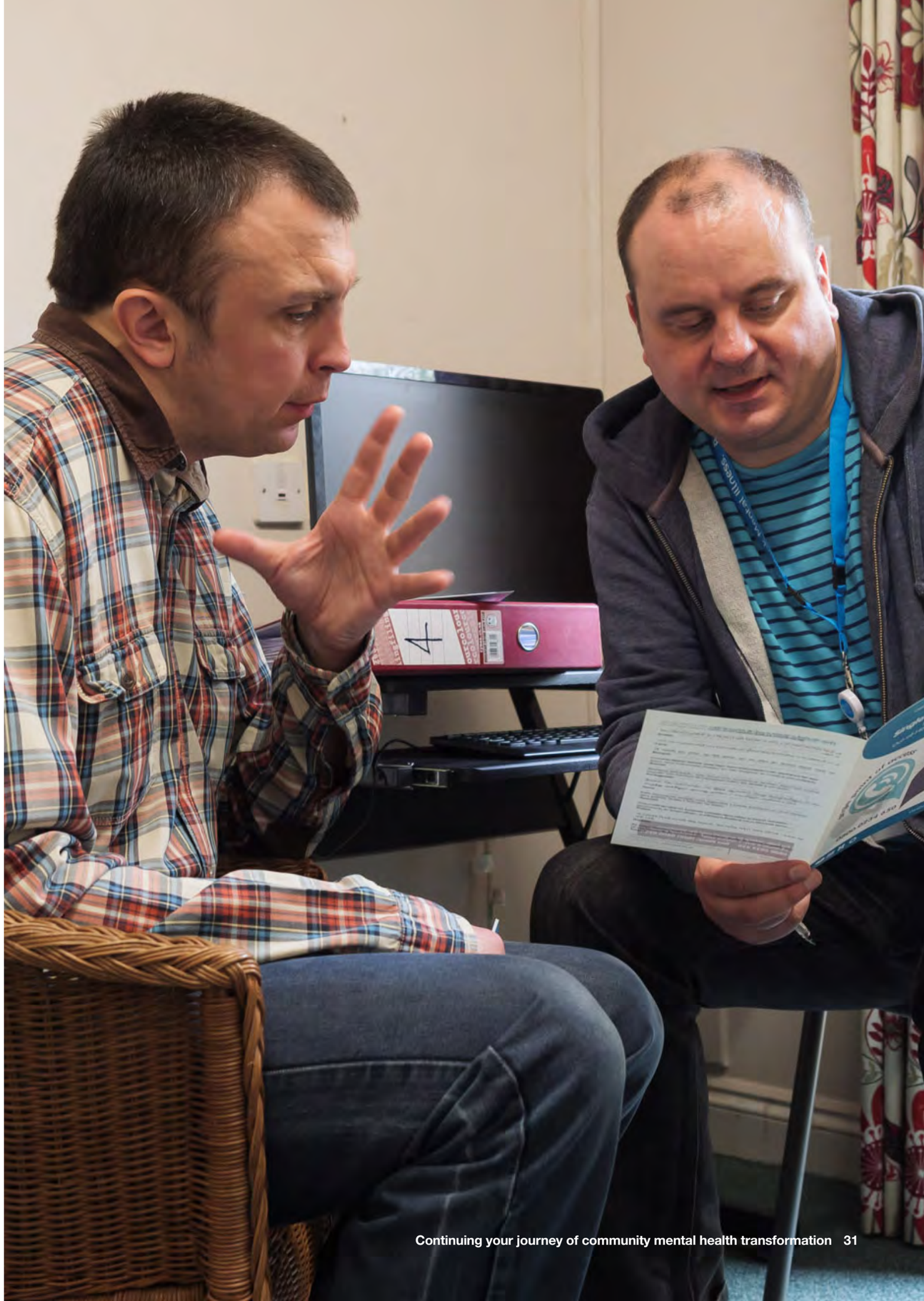
She decided to use her personal health budget to pay for two personal assistants (one of whom was a personal trainer) who treated her “as a person.” She appreciated having someone to speak to and rely on outside of her family, as it reduced the pressure on these relationships.

Her physical disability had previously been an afterthought in decision-making by clinicians regarding her mental health, which had contributed towards worsening physical health. Now, her personal budget has paid for a gym membership and specialist physiotherapist, helping her to lose five stone in weight and gain new mobility and confidence. She has also been offered a personal health budget for longer-term therapy in the community and is on the waitlist for a disability assistance dog.

“Having a personal budget and co-produced care plan focused on my future and my goals has helped me reconnect to the person I am. This is an organic approach that grows and changes with a person as their needs and aspirations change. Person-centred care should be a given, not a blessing.”

Expert by experience

Find more information on use of personal health budgets in a mental health context here: https://www.england.nhs.uk/personal-health-budgets/personal-health-budgets-for-mental-health/



CASE STUDY

“Our aim is to provide a sustainable, person-centred system of mental health care” – supporting physical health alongside mental health in Cambridgeshire and Peterborough.

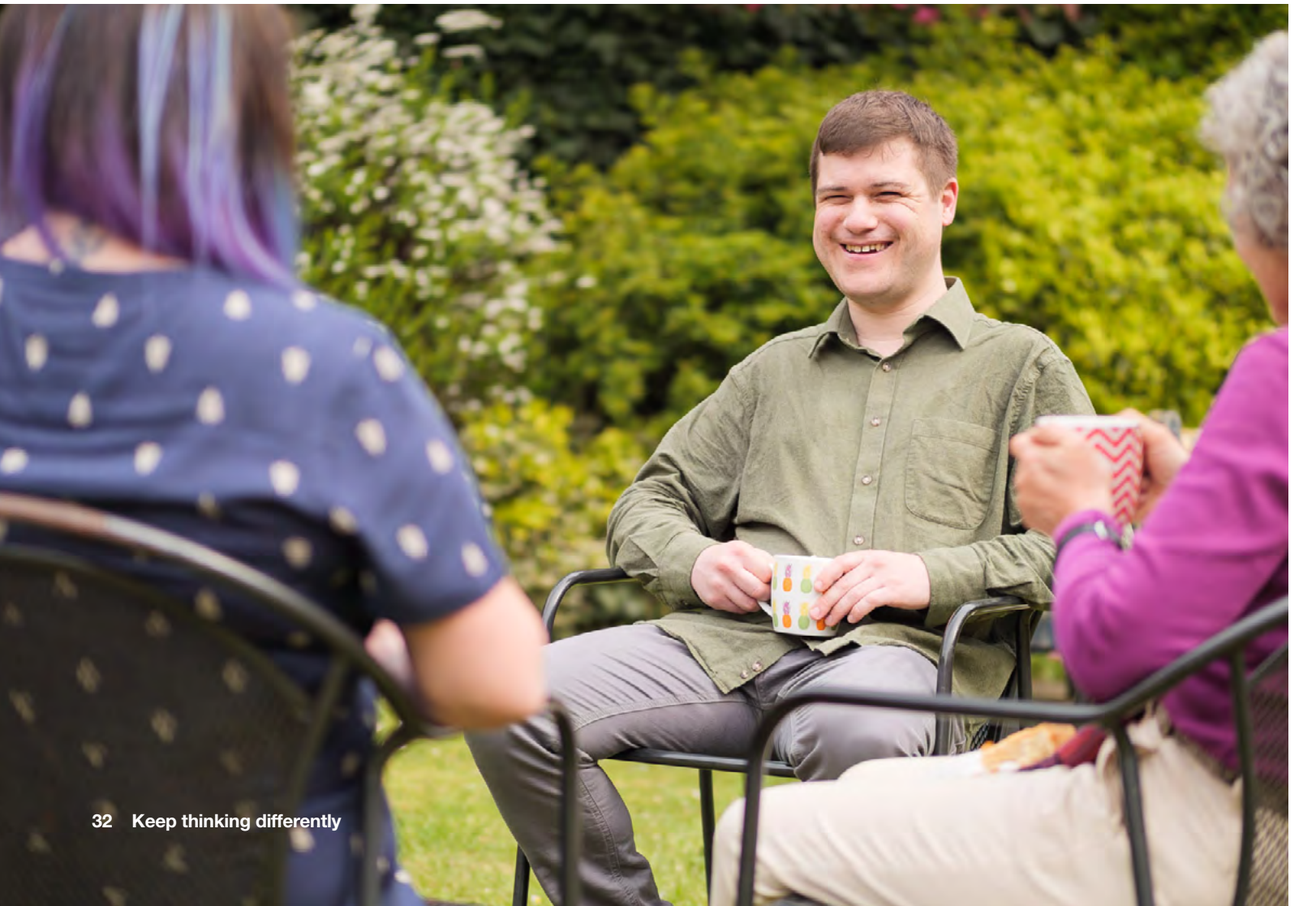
Cambridgeshire and Peterborough STP is an early implementer site and part of their focus for improving community care for their population of people severely affected by mental illness is to pilot an innovative model to increase uptake of physical health checks.

The Greater Peterborough Network GP Federation has recruited trained specialist health care assistants with the time and skills to provide annual health checks, as well as supporting people to engage with follow up interventions and other physical health long-term condition reviews (e.g. asthma, diabetes) as required.

The staff will also carry out medical monitoring for mild to moderate eating disorder service users in the New Year.

The model also includes time for engagement and outreach, particularly for under-served groups of people. The specialist trained staff will work with people from black, Asian and other ethnic minority groups to increase the uptake of health checks. There are robust pathways, including with the VCSE, to facilitate behavioural change services such as smoking cessation, weight-loss services and lifestyle management.

“Our aim is to provide a sustainable, person-centred system of mental health care which delivers better access to a broader range of care options, reduced demand for high-level interventions, greater service efficiency, and improved patient experience and outcomes.”
Clinical Mental Health Lead



CASE STUDY

“One of the main ambitions for this model was to reduce health inequalities” – transforming services to better support older adults in Sheffield.

One of 12 early implementer sites, Sheffield has established new integrated community mental health teams at impressive speed. Beginning work in November 2019, there were a mere 146 working days between the approval of their bid to beginning delivery in June 2020 on the backdrop of the COVID-19 pandemic. Between June and October 2020, the new model has supported 500 people with previously unmet needs.

In this test phase, they worked within four primary care networks representing a third of the city’s population. One important goal of the city’s community mental health is to address health inequalities, so areas were selected at least partially because of their high prevalence of black and minority ethnic communities, young families and adults, students, and older adults.

The Partnership states that certain key behaviours and actions have ensured their success in better reaching this group:

- Referencing the Community Mental Health Framework’s specifications regarding older adults across their documentation.
- Ensuring that there are older adult champions at all levels of the transformation.
- Moving past assumptions that the needs of older adults are either different or the same as the working-age population.
- Clearly defining and reflecting the need to work with older adults within contracts, particularly in secondary care.
- Use of older adult population health data and clinical data held by partners to inform service design.
- Recruiting staff with expertise across the lifespan and involved older adult experts by experience in shortlisting, interview questions and panels.
- Testing the evidence base around psychological interventions for those in later life and/or living with co-morbidities.

Other Rethink Mental Illness resources

You can find further Rethink Mental Illness resources relating to this work, including our first STP guide and accompanying webinars, on our website: www.rethink.org/stpguide

Methodology

We based the development of this guide on interviews with people who are delivering community system redesign around England.

We spoke to staff, leaders and experts by experience to understand the barriers and enablers to redesigning community mental health.

Alongside this we had oversight from our communities advisory group.

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Appendix
Example: Aims and measures to evaluate your model

Tip: consider what systems or processes will be used to capture data (e.g. systems like RIO, DIALOG+ or surveys) and what level they will be captured at (e.g. primary care network level, local authority level) – this will vary between different measures

Aim	Example measures	What type of measure?
"No wrong door" for service users	Percentage of patients waiting for four weeks or less for support	Process
	Do staff across the system and service users know how to access the service?	Process
People with severe mental illness have improved physical health	Percentage of people with severe mental illness who have received an annual physical health check	Process
	Percentage of people living with severe mental illness who smoke	Outcome
People are able to access better quality services regardless of demographic	Percentage of people with different characteristics accessing support from primary care network (those aged 65 and over, those with particular diagnoses, those from black and minority ethnic backgrounds)	Outcome
	Staff feel able to support people regardless of age, background or other protected characteristic	Process
End silo-working in primary and secondary care	Staff content with quality of service	Outcome
Person-centred care – support service users want, where and when they want it	Is the service user content with: their mental health, housing, personal relationships, hobbies?	Outcome
	Percentage of people living with severe mental illness in paid employment	Outcome
	Do family members and friends supporting the service user feel supported, listened to and valued?	Process
Service users share their story once	Cost difference between new single assessment and previous multiple assessments	Process

References

1 Rethink Mental Illness (2020) COVID-19 briefings – access to mental health services for people living with severe mental illness. Available at: https://www.rethink.org/media/3793/access-to-mh-services-final-040220.pdf

2 NHS England (2019), The Community Mental Health Framework for Adults and Older Adults. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

3 Lambeth Council (2017) Health and Wellbeing Board – 29 June 2017. Report title: Living Well Network Alliance – progress report. Available at: https://moderngov.lambeth.gov.uk/documents/s89683/LWN%20Alliance%20HWBB%20report%20FINAL%2016%2006%2017.pdf

Rethink Mental Illness.

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

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