# Community Mental Health Early Implementer Learnings

# July 2021

NHS England and NHS Improvement

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# Definitions

| Abbreviation | Definition |
|---|---|
| SMI | Severe Mental Illness - SMI covers a range of needs and diagnoses, including but not limited to; psychosis, bipolar disorder, ‘personality disorder’ diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use. |
| Core Model | This refers to the new and integrated model of care which spans primary and secondary care |
| AED | Adult Eating Disorder – this should be a dedicated pathway or function which is fully integrated into the core model |
| MH Rehab | Mental Health Rehabilitation – this should be a dedicated pathway or function which is fully integrated into the core model |
| PD | ‘Personality Disorder’ – this should be a dedicated pathway or function which is fully integrated into the core model. New models should focus on building capacity in the ‘core’ model to support this cohort, as well as the development of a dedicated function. |
| CEN | Complex Emotional Needs – usually in reference to ‘personality disorder’. We refer to ‘personality disorder’ in speech marks to reflect the stigma related to the diagnosis. |
| KUF | Knowledge and Understanding Framework |
| ARRS | Additional Role Reimbursement Scheme – provides funding for additional roles to create bespoke multi-disciplinary teams working to integrate primary and secondary care |
| EPR | Electronic Patient Record |
| MHPs | Mental Health Practitioners – funded via the ARRS scheme, these will be joint primary and secondary care roles |
| OPMH | Older People’s Mental Health |
| PT - SMI | Psychological Therapies for people with severe mental illnesses |

# The Long Term Plan includes ambitious targets for community mental health

## Key deliverables in the Long Term Plan by 2023/24

### Core model

A new, inclusive generic community-based offer based on redesigning community mental health services in and around Primary Care Networks, contributing to 370k minimum access number by 23/24

### Dedicated focus areas

Improving access and treatment for adults and older adults with a diagnosis of ‘personality disorder', in need of mental health rehabilitation and eating disorders, contributing to 370k minimum access number by 23/24

### Physical health

Increasing the number of people with SMI receiving a comprehensive physical health check to a total of 390,000 people per year

### Employment Support

Supporting a total of 55,000 people a year to participate in the Individual Placement and Support programme

### Early Intervention in Psychosis

Maintaining the 60% Early Intervention in Psychosis access standard and ensuring 95% of services achieve Level 3 NICE concordance

# 12 early implementer sites have been testing the new models of care throughout 2019/20 and 2020/21

## SEPTEMBER 2019

The Community Mental Health Framework, sets out an ambitious vision for improving community mental health services for adults and older adults. This short video sets out the changes to be achieved by this transformation.

## SEPT 2019 - MAR 2021

12 early implementer sites across England begin testing the development and delivery of the new models.
Many E/I sites were due to go live with their new models in April 2020, but the pandemic significantly disrupted plans. However, all 12 sites were able to go live with their new models from at least October 2020, showing genuine transformation is possible even in challenging circumstances.

## MARCH 2021

The early implementer sites were not required to deliver against any set trajectories, rather they were asked to test and develop integrated models of primary and community mental health in order to share insights and learning with all other systems embarking on their transformation from 2021/22.We collected key quantitative data points to assess the impact of the transformation funding. Some of this data has been included in this report.
In the absence of trajectories, they should not be viewed as “positive” or “negative”, rather they provide a benchmark for progress to expect in all ICSs through the national roll-out.

## APRIL 2021

Following a national planning process, all ICSs in England have been allocated over £120 million transformation funding to begin implementing their new models of integrated primary and community mental health care.
By 2023/24, an additional £1 billion will be invested into community mental health services per year.
The pandemic has highlighted key treatment gaps which make this transformation even more vital.

## JULY 2021

This programme has the potential to deliver significant benefits to people with severe mental illness.
This slide deck summarises what the early implementer sites have been testing and shares learning for other systems embarking on their transformation journeys.
Each section details the specific national ask of all systems undertaking transformation. For further information please visit the Future NHS space.
We will continue to gather learning and insights and cascade these via regional teams as further learning emerges, especially on impact.
When available, we will share further data on impact, drawing on site level evaluations which are underway.

# Early Implementer sites

**North East and Yorkshire :** england.ney-mh@nhs.net

**North West :** england.mentalhealth-North@nhs.net

**Midlands**: england.midlandsmentalhealth@nhs.net

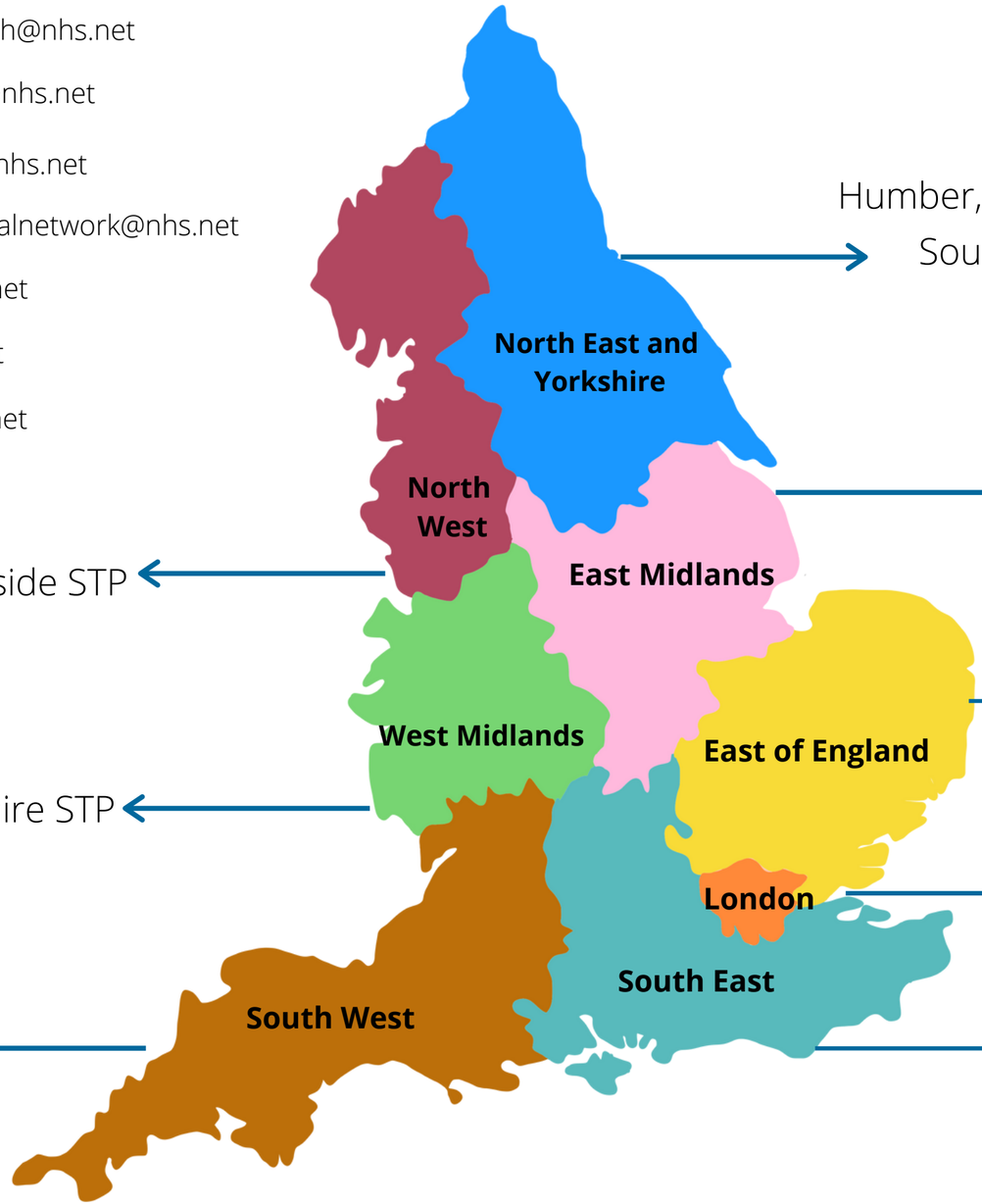
**East of England:** england.mentalhealthclinicalnetwork@nhs.net

**London**:england.londonmentalhealth@nhs.net

**South West**: england.southwestmh@nhs.net

**South East**: england.mhldasoutheast@nhs.net

**National**: england.adultmh@nhs.net




Humber, Coast and Vale Health and Care Partnership STP
South Yorkshire and Bassetlaw ICS

Lincolnshire STP

Cheshire and Merseyside STP

Cambridgeshire and Peterborough STP
Hertfordshire and West Essex STP

Herefordshire and Worcestershire STP

North West London STP
North East London STP

Somerset STP

Frimley Health and Care ICS
Surrey Heartlands Health and Care Partnership

# Key messages from all systems

**Recruitment and contracting needs to happen as early as possible**. Given the significant amounts of funding being invested into community mental health services, systems should be prepared to spend transformation funding quickly to avoid large underspends later in the year.

**Co-production and equalities should be at the heart of the programme**. Genuine co-production takes time and effort, this needs to be prioritised at the beginning of the programme and embedded in governance structures as well as in the design and ongoing delivery of models. Co-production should include a range of diverse groups to ensure equalities are being advanced.

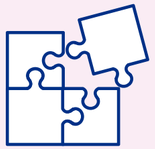
**Robust governance and joint ownership between partners.** System partners need to all be signed up to deliver the transformation together and the programme should be underpinned by strong and robust governance structures which include all partners to support this.

**Data driven services**. Systems should flow nationally-agreed KPIs for national and regional reporting requirements, and embed outcome measurement as standard, to measure progress and the impact of investment into community mental health services. Data across the health and social care system can be used to hone in on the greatest health needs, and tailor services to specific service user groups.

**Integration with primary care and PCNs.** The new models will need to sit at PCN-level and systems should carefully consider the best ways to ensure PCNs and CMHTs are fully integrated and delivering as one team. This includes joint roles across primary and secondary care providers, integrated real-time information-sharing, and co-location where appropriate.

**Plan workforce development strategically.** Expanded workforce configurations should include both clinical and non-clinical workforce, with a big emphasis on expanding peer support workforce. Plans should ensure staff are appropriately supported with supervision, and have capacity to undertake training, and practice what they learn on the job.

**Maximise partner expertise and skills in delivery of services.** Integration of services across NHS and non-NHS partners, including local authorities and the third sector, is at the heart of this transformation programme. Systems should identify where partners can bring the most value and embed them in design and delivery of new and existing community mental health services. This includes joint commissioning or integrated workforce planning.



**Leadership.** This programme is ambitious in its scope for change and should have visible sponsorship from senior system leaders to give it the necessary momentum and profile. Leaders needs to model a number of important behaviours including openness to feedback and learning, advocacy, and inclusiveness.

# Integrated care pathways

At the heart of the transformation, systems need to radically rethink the care offer available to people with severe mental health problems so they can access care where and when they need it.

This section provides detail on the core, eating disorders, complex emotional needs associated with a diagnosis of 'personality disorder' and mental health rehabilitation pathways that have been implemented, and summarises learning for other sites embarking on pathway redesign.

NHS England and NHS Improvement

# Core community model (1/3)

## The ask of all systems embarking on transformation:

- A fully transformational model that spans primary and secondary care community mental health services for adults and older adults
- Current thresholds and barriers to care should be removed to create a more inclusive, flexible model of care
- The new model will be based on cross-sector collaboration and integration across the NHS, local authorities and VCSE services
- Ensure there is no prospect of a cliff-edge of lost care and support by moving away from current approaches based on referral and discharge and towards care being “stepped up” and “stepped down” according to need, not diagnosis
- Ensure timely, flexible and easy/clear means of access to the new model, working towards a maximum four-week waiting time from initial contact with any primary, secondary care or other service to receipt of appropriate mental health support
- Ensure the new model addresses non-clinical and social needs alongside clinical needs, using innovative commissioning across the NHS and local authorities

## Preliminary analysis of 12 returns highlights some early insights

**27.7k** people received 2 or more contacts within the new model of care during 2021/22.

Per LTP trajectories, 126k people should be seen in 2021/22 in the new models. Scaling up the EI access data suggests this is an attainable target for the national rollout

All 12 systems defined a local **4 week waiting time standard** and began testing against this in order to inform the national clinical review of standards programme

**786** new roles (clinical and non-clinical) have been recruited to within the new model over 2019/20 and 2020/21

Of the 11 sites able to report VCSE spend over 2019/20 and 2020/21, an average of **16%** of their total funding envelope was spent on contracting with the VCSE.

This is lower than the national recommendation of a minimum of **25%** of transformation funding to be spent on VCSE contracting.

### Of the people seen in the new model:

**25%** accessed financial or debt advice

**7%** accessed peer support

**3%** accessed education or skills support

**72%** accessed other services from the VCSE

# Core community model (2/3)

## SPOTLIGHT - North East London

The North East London Early Implementer site has created n**ew blended, multi-disciplinary and multi-agency neighbourhood level teams, organised around PCNs.**

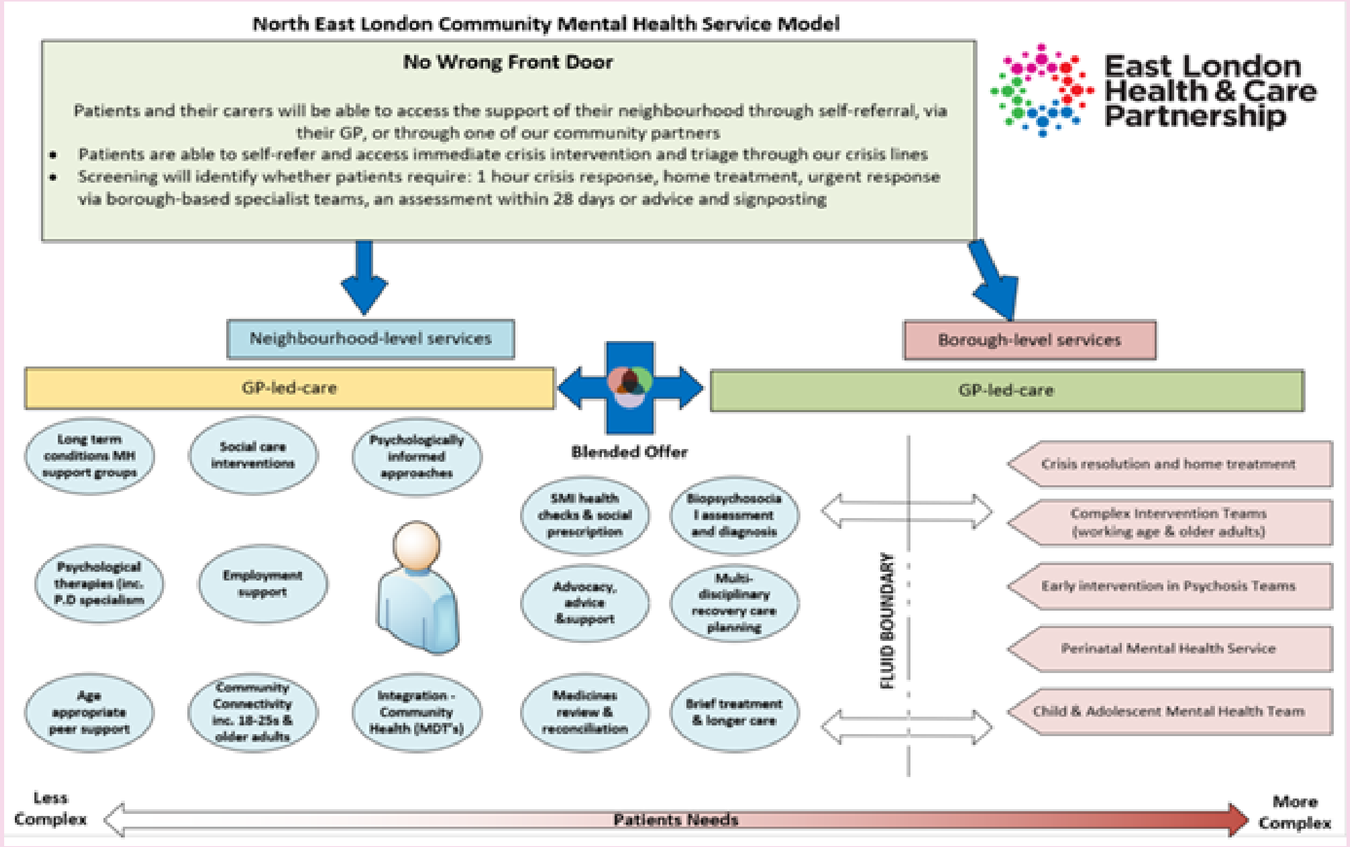
These teams include psychiatrists, psychologists, nurses, social workers, peer support workers and community connectors, working in partnership with primary care clinicians, social prescribers, clinical pharmacists and community health services.

For people newly identified as needing Mental Health support via their GP, the extended PCN network, or through self-referral; t**heir local neighbourhood team will undertake a biopsychosocial assessment, incorporating, where appropriate, Care Act assessment.**

These teams will then provide wraparound support for people with varying levels of need, including those with longer-term and complex requirements. **Named workers follow service users** throughout their care pathway to keep the therapeutic relationship at the centre of care.

Key to the model is a **trauma informed approach**, developed by training PCN staff and staff in new teams to work relationally and holistically, maintaining an understanding and awareness of trauma and its importance at all times

The E/I site has fu**nded dedicated GP leadership roles in all PCNs**, to lead design and roll out of new models and engage with PCN peers.




***Systems should also consider specific interfaces with Children and Young People's Mental Health and Older People's Mental Health**

*North East London's service model*

# Core community model (3/3)

## SPOTLIGHT - Cambridgeshire and Peterborough

The Peterborough E/I site built on primary care mental health service initiated in 2016, and aims to deliver better care for people with SMI by **closer working between mental health services, primary care, the local authority and voluntary sector**.

The new service model includes the following roles:

- a community consultant liaison psychiatrist – with specific remit to improve clinical communication across the system
- severe mental health illness physical health workers (SMI)
- social workers, and support, time and recovery workers (STR) to link with the social workers and social prescribers within the GP surgeries
- Psychologists and psychology assistants
- pharmacist roles (clinical and strategic)
- Personality Disorder Specialist Liaison Lead
- Digital and comms team to build awareness of and integrate community assets in Peterborough

The E/I site appointed a **GP mental health lead (with one session per week)** to lead the work around developing closer integration with PCNs across the patch.  This lead supported GP engagement across the patch, by setting up a series of meetings with representatives from each of the PCNs to listen and respond to any concerns about mental health care pathways. There are now **additional 6 Mental Health Lead GPs to represent each of the PCNs** where the model of care is being transformed and this has been key to the partnership working.

The new model now means:

- GPs now have **direct access to consultant and PD specialist**s and can refer directly into groups that are offered for a range of different needs including for those with a diagnosis of PD and complex trauma.
- GPs can also help patients to access support **via the Health Connector team, for those who need something other than a clinical intervention.**

# Complex emotional needs associated with a diagnosis of ‘personality disorder’

## The ask of all systems embarking on transformation:

- Develop a dedicated function, which provides supervision, consultation and training to generic services and primary care
- Co-produce models from design to delivery, recognising the sensitivities around diagnostic labelling
- Embed lived experience roles at varying degrees of seniority in the MDT;
- Improve timely access to evidence-based psychological therapies and tackle long-waiting lists for adults and older adults
- Deliver care in line with NICE guidelines for 'personality disorder'
- Provide care for people with co-existing needs, including substance use ensuring that information is shared between services so people do not get lost in the system
- Embed a compassionate, trauma-informed ethos and reject punitive approaches to care

## Preliminary analysis of 12 returns highlights some early insights:

**12**

The number of EI sites focused on transforming care for people with complex needs

**9 sites** were able to report investment into dedicated personality disorder services. An average of **£760k** per site was invested into dedicated ‘PD’ services over 2019/20 and 2020/21

By 2020/21, **100** new ‘PD’-focused roles were created across **10 sites** that were able to report workforce figures for ‘PD’

**7**

By April 2021, **7** sites had a live dedicated function, and **5** were currently in the process of testing and refining their models

Of the sites with a live dedicated ‘PD’ service in place, **67%** seen in the dedicated pathway people received a Psychological Therapy

# Learning and insights for complex emotional needs associated with a diagnosis of ‘personality disorder'

## Consistent reflections from systems were:

Building relationships with primary care and the VCSE is vital to successful implementation, including developing innovative approaches to workforce configurations

Commence recruitment as soon as possible as many sites have experienced recruitment delays, consider the function of roles rather than job titles (e.g. MH social worker performs similar functions to a MH nurse)

Co-production from the very early stages of model development are essential. This includes open discussions with people with lived experience about service terminology and diagnostic labels. Several sites have recruited specific Service User Networks and Participation teams

Strategic relationship building across primary care and secondary care is vital, as well as a clearly defined shared, clinical strategy

## SPOTLIGHT - Surrey Heartlands and Frimley

- Have re-developed the pathway to cover three areas: Managing Emotions Programme (MEP), Service User Network (SUN) and Psychologically Informed Consultation and Training (PICT) service.
- This is a flexible model which operates on a **‘easy in, easy out’ approach** to supporting people to access the right care, in the right place at the right time.
- MEP is a co-produced, co-designed and co-delivered suite of psychoeducational courses. The SUN comprises **paid peer support workers to provide access to community based, open access support groups**. The PICT is a PCN system wide training and consultation offer available to staff working in the wider model.
- The new expanded pathway has seen **318 people since going live**.

## SPOTLIGHT - North West London

- The CNWL Early Implementer site has established community based mental health hubs, aligned to PCNs. The Hubs include all relevant provision from the CMH offer, and i**ndividuals are assigned to an intervention based pathway based on their need.**
- Specifically, Early Implementer funding was used to **implement a standardised care pathway** for people with Complex Emotional Needs (CEN) to raise the standard of care people receive.
- The initial round of transformation funding was used to establish a CEN pathway in Hillingdon as well as central leadership via **a CEN clinical lead, operational lead and Lived Experience CEN lead** to co-develop the pathway with local CEN service users. The pathway will aim to provide more consistent, evidence-based care and close the gap between primary and secondary care services .
- The pathway covers :
  - **Assessment and care planning:** which is collaborative and outlines the type and duration of support offered. Includes a risk management plan and services to contact if in crisis.
  - **Psychoeducation and community engagement:** Generally brief, can be delivered at scale and address the broader skills and needs of service users.
  - **Low intensity interventions:** Focused, individually formulated, problem and outcome orientated therapies. Includes individual and group-based approaches.
  - **High intensity interventions:** Including 12 or 18 month DBT, SCM and MBT programmes and day Therapeutic Community services.

# Adult eating disorders

## The ask of all systems embarking on transformation:

- Transform local AED services in line with the published guidance by 2023/24;
- Be clear on the arrangements for medical monitoring in partnership with primary care to manage the physical health needs of people with eating disorders;
- Not employ or eliminate treatment thresholds (e.g. based on BMI or weight);
- Commission VCSE partners to deliver integrated services within the model; this could include joint work to deliver treatments or support services while people prepare to enter statutory services or after they have been discharged
- Meet NICE guidance and pathways;
- Ensure timely direct access for all levels of need, by maximising access and minimising waits to improve patient care, and facilitating self-referral and carer-referral (i.e. offering direct access to expert advice);
- Embed an early intervention model within their overall adult & older adult community eating disorder model e.g. the First Episode Rapid Early Intervention for Eating Disorders (FREED) model for young adults aged 18-25 year olds;
- Provide consultation and support, supervision and training to primary care and generic community mental health services; and ensure information to support patient care is routinely and seamlessly shared across the whole pathway

## Preliminary analysis of 8 returns highlights some early insights:

**8**

The number of EI sites focused on transforming care for people with eating disorders

**9** sites were able to report investment into dedicated eating disorder services. An average of **£580k** per site was invested into dedicated AED services

By 2020/21, **48** new AED-focused roles were created across the **8** sites that were transforming their AED pathways

By April 2021, **4** sites had a live dedicated function, and **4** are currently in the process of testing and refining their models

Of the sites with a live dedicated AED service in place, **9%** of all contacts with the new model were in dedicated AED services

Of the sites with a live dedicated AED service in place, **44%** seen in the dedicated pathway people received a Psychological Therapy

# Learning and insights for adult eating disorders

## Consistent reflections from systems were:

There are increased service pressures and often long wait times. Finding solutions to manage this and ensure support is provded for mild/moderate and severe cases, whilst transforming the service is a priority.

Developing medical monitoring pathways remains a challenge and key focus for all areas. Cambridge and Peterborough have appointed a GP to provide support to the local PCN and develop medical monitoring agreements in region and operate a GP helpline.

Working with VCSE or 3rd sector organisations to provide services and ensure no gaps in the pathway and address workforce issues.

There is a need to strengthen professional confidence and skills across the system rather than being reliant on discrete specialist eating disorder services.

## SPOTLIGHT – South Yorkshire and Bassetlaw

- South Yorkshire and Bassetlaw (SYB) have developed an **integrated eating disorder support offer**, to improve patient outcomes and transitions. An eating disorder collective is being developed that will span, adult, CYP and VCSE ED providers called the All age Eating disorder Recovery Team (ASERT). Underpinning this transformation SYB have **invested in the leadership and infrastructure of their programme** by employing additional project management support and clinical capacity in VCS.
- The ASERT pathway aims to improve service user experience by providing continuity of care, reduce waiting times and prevent duplication of assessments. To support this integration work is happening to:
- Align record management systems so information can be shared with clinical teams across the pathway, promote collaboration and this will support the services to become "needs-led" rather than age led.
- Develop a new tool that will support i**mproved personalised care planning**, as patients outcome measures will be monitored; allow patient progress to be reviewed and care adapted as needed.
- To support transformation, **upskilling staff** has been prioritised and all-ages ED training was delivered to 798 professionals, non-professionals between June 2020 - June 2021.
- Recognising the importance of coproduction SYB have recruited a patient and public involvement group to support the work designing and developing this service model.
- In 2020/21, 252 people were seen in SYB's newly expanded CED service, of which 98 where 16-25 year olds.

## SPOTLIGHT – Hertfordshire and West Essex

In 2020/21 Herts and West Essex established a community AED service focusing on **early intervention**. This transformation has resulted in i**mproved access for service users, by reducing waiting times**.

- FREED (First Episode Rapid Early Intervention for Eating Disorders) has been fully operating in West Essex since March 2020 and provides a service to those aged 18-25 years. Despite implementation challenges due to the pandemic, Essex Partnership University Trust (EPUT) has been able to manage demand during the pandemic and improve access to their service.
- During the pandemic, the service **adapted provision to provide a flexible and efficient service**, using a mix of video calls and face-to-face appointments based on USER preference and clinical need. As COVID restrictions begin to ease, they are continuing to use a more flexible model.
- The FREED pathway has allowed EPUT to work with people with a range of eating disorder diagnoses, providing support to them as quickly as possible. Currently the majority of referrals accepted into the FREED pathway are waiting less than 4 weeks from referral to start treatment, with **100% of FREED referrals in Q1 2021 starting treatment within 4 weeks.**

# Mental health rehabilitation

## The ask of all systems embarking on transformation

- Invest in and drive the transformation of dedicated community mental health rehabilitation functions as part of the wider new model
- End out-of-area placements and minimise the need for restrictive inpatient care, including so-called 'locked rehabilitation' placements. Evidence from the CQC suggests the average cost of a bed is £129k per year, and costs for out of area placements are much higher
- Consider the potential need for enhancing or creating new services or functions that aim to optimise the likelihood of inpatient service users with complex needs being able to reside in the community and access care in the least restrictive setting to meet their needs, stopping patients escalating on the (bedded) rehab pathway, and ensuring their care is "stepped down" back into the community after a long inpatient stay
- Implement with local authority partners a supported housing strategy for this cohort
- Evidence an understanding of their local population currently placed out of area and the cross-sector partnership working required to address this, e.g. with local authority adultsocial care, housing, public health (drug & alcohol), VCSE sector.
- Be fully linked to 'core' CMH transformation for adults and older adults, not separate and fragmented from it ensuring that information is shared across the whole pathway
- Focus on maximising people's independence and supporting them to self-manage as far as is possible
- Undertake co-produced, personalised care & support care planning

**3** The number of EI sites focused on transforming care for people with MH rehabilitation needs

**76%** of people in a dedicated community MH rehab pathway had a paired outcome score of the models that were live

By 2020/21, **52** new MH rehab-focused roles were created across the **3** sites that were transforming their MH rehab pathways

## Learnings and good practice

**Lincolnshire**
Started with a purely bed-based model. Community rehabilitation team now in place. Trauma-informed MDT model led by clinical psychologist with MDT (MH nurses, OT, Social Workers). Peer support is planned once the team is established and can fully support these roles. Housing is a key barrier and a partnership with local housing provider has been established.

**North West London**
Established 'Community Access Service' which is an OT-led model based on the CWP 'CRAC' model - OT lead, consultant, specialist social workers, VCSE support workers, with peer support workers currently being recruited.

**Humber, Coast and Vale**
Closed 18 beds in last 12 months (5 remaining) and moved staff into community. Currently recruiting larger MDT team after challenges with VCSE commissioning.

## Learn More

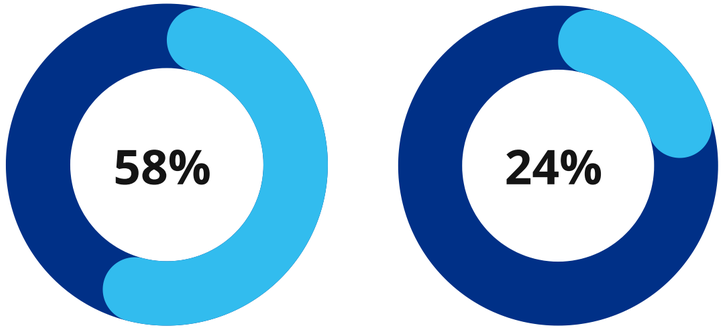
- Rethink Mental Illness: In sight and in mind: Making good on the promise of mental health rehabilitation
- NHS Confederation Mental Health Network supported housing briefing
- NHS Improvement, Getting It Right First Time: mental health rehabilitation
- NICE guidance on rehabilitation for adults with complex psychosis only
- Royal College of Psychiatrists: Faculty of Rehabilitation Psychiatry resources

# Physical health for people with SMI

## The ask of all systems embarking on transformation

- Deliver comprehensive, annual physical health-checks (PHC) and follow-up interventions to 60% of adults and older adults with severe mental illnesses
- Partner with VCSE sector to commission holistic health and wellbeing services for people with SMI e.g. healthy eating, team sports, gym membership, home exercises.
- Real-time integration of data and care records across primary and secondary care to ensure full interoperability, including ensuring data is mapped correctly against Read codes in general practice systems for data extraction of physical health checks
- Co-own transformation programme with primary care, to establish strong partnership and joint accountability, including co-location where possible and appropriate
- Develop stronger service user outreach to engage service users to achieve better uptake (more details on next slide)
- Design services to meet user needs incorporating digital tools and services where appropriate.

**Delivering comprehensive annual physical health-checks for people with SMI - Q4 2020/21**




**City and Hackney CCG (NEL)** **England**

**(Against standard of 60%)**

## Learnings and good practice

**City and Hackney (North East London STP)**

- North East London has developed **an alliance model for improving physical Health for people with SMI** comprising: CCG, East London Foundation Trust, C&H GP federation, PCNs, the VCS and the Clinical Effectiveness Group (CEG). CEG is a university based organisation that collates and analyses primary care data and shares with the Alliance and all GP practices.
- In this model the **checks are completed by dedicated Health Care Assistants (HCA)**. This model has allowed City & Hackney to deliver in line with the national ambition –see graph to right.
- Where individuals meet specific thresholds they are referred onwards to Core Sports for ongoing support. Core sports is a third sector organisation which provides lifestyle and exercise advice and support to people with SMI.

**Frimley**

- In this E/I site, **"community prescribers" employed by MIND connect people with SMI** with wider community resources such as health groups and activities, following completion of their physical health check.

**Cambridgeshire and Peterborough**

- The E/I site has employed **Band 4 Physical Health workers within primary care** to complete a Physical Health Check for people with SMI plus medical monitoring for people with an Eating Disorder.
- This has been beneficial in a number of ways including: proactive engagement process, flexiblity (e.g. offering home visits), continuity /offering PHCs at person's GP surgery, working across the primary and secondary care interface, training of staff to ensure quality, and time to support people to access interventions e.g. smoking cessation.

**South Yorkshire and Bassetlaw**

- **Band 3 Health Coaches have been employed to work as part of the PCN Team** to support people to access Physical Health Checks and to provide behaviour change interventions (eg access nutrition and physical exercise schemes).

# Physical health for people with SMI - tailored outreach

## The ask of all systems:

- Commission tailored outreach for people with SMI to support access to comprehensive annual physical health-checks, covid-19 vaccinations and flu vaccinations (where eligible). This builds on an initial allocation of £4.4M as part of the mental health and wellbeing winter plan in 2020.

- Report on delivery via the centralised SDF assurance return, which will measure increased activity as a result of the outreach funding, as well as how existing inequalities in access were addressed.

## Learn More

- Future NHS space for SMI tailored outreach
- Co-produced quick guide for engaging with people with SMI to access their flu vaccination and PHC (Cambridge and Peterborough)
- SMI health-check invitation letter (North West Region)
- Equally Well resources on access to flu vaccinations, materials for people with SMI, carers and professionals

## Learnings and good practice

**Somerset STP**

- In order to deliver tailored physical health outreach, Somerset STP has commissioned **peer support workers** through Rethink. These peer support workers are working with patients to provide **pre, during and post- health check support,** to help increase access and improve experience.
- Meanwhile Somerset Foundation Trust have been commissioned to deliver physical health checks for underrepresented groups.
- **The STP also worked with experts by experience** to co-produce a **suite of resources and training** to support all organisations working with people with severe mental illness to improve their physical health.

**Hertfordshire and West Essex:**

- Herts and West Essex has taken a proactive approach to identifying and engaging with people who had not yet engaged in the vaccination and health check programme, using **home visits, text messages** and **written information to improve engagement.**
- **Primary care providers have co-ordinated activity in order to** provide both the covid vaccination and the physical health checks at a single appointment.
- The availability of **weekend and extended duration appointments** has also improved engagement amongst people with SMI.

# Improving access to psychological therapies for those with severe mental health problems

## The ask of all systems embarking on transformation:

Overhaul the current offer of care to people on CMHT caseloads, moving from transactional contacts to meaningful, therapeutic, goal- and outcome-oriented care. This should include a specific focus on significantly improving access to a range of evidence-based psychological therapies for adults and older adults with severe mental health problems, by:

- Ensuring there is capacity within teams to deliver psychological therapies by recruiting staff with the potential to take up training opportunities who will then have dedicated time to deliver therapies; or by freeing up therapists' time by recruiting staff who can take on some of their existing responsibilities (e.g. Clinical Associate Psychologists or new Mental Health and Wellbeing Practitioners).
- Ensuring staff are released to take up new nationally-funded training opportunities, and supported to deliver evidence-based therapies once trained within their job plans through having protected time and adequate supervision;
- Understanding current access and waiting times, and tackle long waiting lists, including through improving the completeness and quality of SNOMED data that provider teams submit to the MHSDS regarding psychological therapies*;
- Measuring and recording outcomes as well as interventions relating to psychological therapies via SNOMED in the MHSDS19**.

Over **12,500** people with SMI receiving psychological therapies from trained staff

**1,100 places** to train new psychological therapists and develop wider workforce knowledge and competence offered in 20/21

## Learn More

- NHSEI has produced implementation guidance on how to develop the workforce and deliver psychological therapies for severe mental health problems
- HEE has further information on the national training offer and how to access places Psychological therapies for severe mental health problems | Health Education England (hee.nhs.uk)

*This should build on the outputs of the NHSE/I Psychological Therapies for Severe Mental Illnesses Baselining Exercise. These are available via the FutureNHS Collaboration Platform: https://future.nhs.uk/AdultMH/view?objectId=21605552.
**NHSE/I is developing guidance to help providers use SNOMED coding in the MHSDS to record key psychological therapies data items relating to access, interventions and outcomes. This will be made available in due course.

# Person-centred care planning

## The ask of all systems embarking on transformation

- Radically improve care planning processes by moving away from the Care Programme Approach (CPA) and implementing fully co-produced, integrated, personalized care and support planning for adults and older adults
- Care planning should be based on individual goals and outcomes, with dynamic, regular review and updating as needed rather than blanket, arbitrary review timeframes
- A flexible, responsive and personalised approach using shared decision making, following a high-quality and comprehensive assessment means that the level of planning and coordination of care can be tailored and amended, depending on:
  - the complexity of an individual's needs and circumstances at any given time;
  - what matters to them and the choices they make;
  - the views of carers and family members; and
  - professional judgment
- A consistent approach to recording care planning information nationally, so that care plans can be effectively shared between service users, carers and all the health and care professionals no matter where a person is receiving care. To support this PRSB have produced Personalised Care and Support Plan Standards

## Learn More

- NHS England and NHS Improvement commissioned the PRSB to develop care plan standards to support information sharing across different services.
- The new standards have now been published and sets out what information should be included in the personalised care and support plan for people with SMI.
- It will ensure that the right information about a person and their needs is available in a tailored care plan that can be shared digitally with health and care professionals and individuals themselves wherever and whenever care is needed.
- The new standard can be found here

## SPOTLIGHT - North West London

- CNWL is piloting the **use of DIALOG+ outcomes and care planning tool**, to support a more person centred and outcomes focussed approach to care planning. https://dialog.elft.nhs.uk/

- The aim is for the system to **show a change in DIALOG scores over time in a clear and easy to read manner** so service users, carers and staff can see patients' progress over time.

- Incorporating DIALOG+ and delivering intervention based care plans will require a change to clinical systems, and clinical practice which is being piloted by a selection of staff in each NWL borough. Following a period of testing and feedback, this will be rolled out to all teams.

- When this change is embedded the **Trust will complete its move away from the old CPA framework**; focussing instead on use of the new DIALOG+ assessment and care planning process for all patients receiving care and treatment.

# Older adults

## The ask of all systems embarking on transformation:

- Dedicate proportional increases in funding allocation to improve care, support and treatment for older adults and carers.
- Increase the OPMH workforce by recruiting new OPMH-specific expert staff, older adult peer support workers and OPMH new roles, for example OPMH advanced clinical practitioners.
- Implement HEE's interim OPMH core competency framework for all CMHT staff across all disciplines, social care, VCSE and colleagues outside of the MH sector.
- Contract with VCSE organisations to improve the mental health care of older adults specifically.
- Drive integrated working with Ageing Well/Frailty teams locally and ensure that information is shared across the diverse range of providers offering mental health support for older adults.

**14%** of all people seen within the new models were older adults

**9** The number of EI sites able to report age breakdowns in their activity figures for older adults (65+)

## SPOTLIGHT – South Yorkshire and Bassetlaw

- An Older Adults CMHT already exited in Sheffield prior to the transformation which had a strong team and low waiting times The Sheffield E/ I site has maintained a strong focus on improving pathways for older adults through its transformation of the CMHS offer.
- This has been achieved by:
  - **Undertaking engagement work with older adults** at the design phase which demonstrated the need to have universal services opposed to separate and siloed, age based pathways. Older adult service users expressed the importance of being able to **access groups, activities and social support that were all age** because they enjoyed the mix of age ranges.
  - Including **older adult champions at all levels of governance**
  - Ensuring recruitment processes achieve **a blended skill mix of staff** with expertise working across the lifespan. Including recruitment of older adults peer supporters
  - Within their VCSE commissioning, Sheffield ensured **all contracts and specifications reflected older adults across all areas of social need.** Age UK were commissioned in a number of PCN networks to provide a dedicated VCSE resource for older adults.
  - **Collaboration and integration with Ageing Well / Frailty Team** and mental health support being provided into care homes
- Sheffield saw **73 older adults within the new model during the early implementer phase**

# Young adults

**10** The number of EI sites able to report age breakdowns in their activity figures for young adults (18-25)

**17%** of all people seen within the new models were young adults

## The ask of all systems embarking on transformation:

- Improve existing pathways across both adult and children and young people's mental health services with joint governance to improve necessary transitions across services.
- Understand local levels of need and demand for young adults, including but not limited to young adults with:
  - Needs currently deemed 'sub-threshold' for access to secondary adult services
  - Co-existing mild to moderate learning or neurodevelopmental conditions
  - SMI and leaving care
- Improve early intervention in parallel with the transformation of relevant adult services, e.g. young adults with an 'at risk mental state', emerging difficulties that may in future lead to a 'personality disorder' diagnosis, or eating disorders
- Co-production at all stages including design, delivery and any local evaluation
- Commitment to promote equality in access to services, plans to address health inequalities, including consideration of young adults from vulnerable groups
- Additional Spending Review funding is available to accelerate all existing commitments to support young adults, including students, who fall through the gaps of services

## Learning and insights from The King's Fund action learning process

Using the transformation as an opportunity to improve interfaces between services

Transitions sits across adult mental health services, Child and Adolescent Mental Health Services (CAMHS) and wider services provided by the VCSE - in **Surrey Heartlands** the team focusing on younger adults have tried to frame their new offer not as a therapy service but as a 'bridging' service that provides a short intervention and then connects people with other services.

The experience of not being listened to can be a major issue for people in this age group. Some sites had used part of their transformation funding to support engagement of young adults in the programme – providing appropriate reimbursement for their time and involvement.

Engaging young adults in the design of services

## SPOTLIGHT - Frimley

- The Frimley Early Implementer site had a specific focus on improving pathways for young adults.
- **Multi-stakeholder engagement events** were carried out to raise awareness of the specific issues young adults face when transitioning between mental health services and co-produce a range of service developments and improvements for young adults which are now being implemented. For example:
  - **Improved transitions processes** including engagement with educational settings to support young adults in education to transition. A mental health transitions pack has been established to support young people to understand what happens at each step and who to contact, and ensuring young people only have to tell their story once
  - **Specific roles developed for young adults**, for example Young Adult Peer Workers who will work as navigators and advisors in the new model
  - Improvements to the way in which the offer is communicated, e,g, development of a young adults webpage
  - **Co-produced training** with young people – the training aims to enhance communication skills, support development of awareness of young adults needs across a range of pathways.
  - Development of courses specifically for parents and carers within the Recovery college model
  - **Adjustments to crisis havens and cafes** to ensure accessible to young adults.
- Further information can be found here.

# Workforce

Systems have consistently told us that building and recruiting the right workforce is a key challenge.

This section focuses on how early implementer sites have approached these challenges and have started to deliver a workforce to support the implementation of their plans.

# Recruitment

## The ask of all systems embarking on transformation:

- The majority of the investment into community mental health should be on recruiting new staff to work in the integrated models.
- This includes developing innovative work configurations by expanding MDT approaches across clinical and non-clinical roles, including peer support roles.
- This should be supported by a tailored recruitment strategy including mitigations for risks and delays.
- Approaches to recruitment should take into consideration the diversity of local patient cohort and the general population.
- Systems should adopt integrated or other partnership approaches to workforce planning with local authorities and the VCSE that result in integrated service delivery.

## SPOTLIGHT - North East London

- North East London has established relationships with local and national VCSE organisations in NEL **to expand the E/I workforce, by incorporating VCS capacity.**
- Around **30% of the E/I funding** has been dedicated to VCSE contracts and roles, and new partnerships with small hyper-local organisations have been developed via the embedding of the new 'Community Connector' role.
  - East London Foundation Trust funds a mixture of VCSE organisations to provide the community connector roles, which are embedded in our new PCN neighbourhood MH teams, including:
  - Mind in Hackney
  - Newham Community Links
  - Coffee Afrik CIC
  - Women's Inclusive Team (they work specifically with BAME and especially Somali communities)
  - The Bromley By Bow Centre

## SPOTLIGHT - Humber, Coast and Vale

**Preparation**

- Within the **HCV programme governance structure there is a workforce working group**, and recruitment and training of each staff group was assigned to named individuals.

**Recruitment**

- The Humber Teaching NHS Foundation Trust developed a **recruitment campaign Humbelievable and released promotional videos** which went out on social media https://youtu.be/Iitq_sUBRYc ; https://youtu.be/DlkOm_xyuC4; https://youtu.be/LUYTPwd9IAY https://youtu.be/w1foAfNoTCA ; https://youtu.be/05vfe_uwCAY
- Word of mouth once we had people coming into post was really powerful.
- All recruitment activities are **monitored and performance managed on a weekly basis.**

**Retention**

- Once staff were in post, there was an **intensive engagement strategy** to ensure involvement in the shaping and transformation of the service, to support high levels of retention.
- Established staff from other parts of the service were brought in alongside newly recruited staff, on an secondment basis – to **support transfer of organisational knowledge and culture**.

## Learn more

For example job descriptions, please visit the Future NHS Collaboration Platform.

# Workforce development

## The ask of all systems embarking on transformation:

- Develop, educate and train your community mental health MDT workforce to be able to support people with specific needs as well as any relevant co-existing needs.
- Build a more psychologically-informed workforce so that all staff are better able to understand and support the needs of those with severe mental health problems.
- Ensure teams employ (or train) sufficient psychological therapists to provide timely access to a range of evidence-based psychological therapies to meet population needs.
- Support staff working across the system to be able to take up relevant local, regional and national CPD training opportunities.
- Consider how transformation will impact on all professional roles and how to support them to move towards values-based, outcomes-focussed meaningful care based delivering a range of biopsychosocial interventions to individuals in the context of their communities.
- Ensure all teams are trained to be confident in using digital solutions and supporting service users to access digital channels (see slide 46 for resources)

## National training offers

- Psychological Therapies for severe mental health problems training- NHS England, NHS Improvement and HEE commission psychological therapy training for suitably qualified and competent staff who are either already in post or recruited into training posts, as well as training for teams and individuals to deliver more psychologically informed support. Further information on the next slide.
- Knowledge and Understanding Framework – to support staff to develop the capabilities, skills and knowledge of the multi-agency workforces that are deadline with the challenges of working with people affected by 'personality disorder'
- Eating Disorders training - training in CBT for ED, whole team training and further offers around MANTRA and guided self help in train.
- Mental Health and Wellbeing Practitioners (in development) - A new Band 5 role that will support collaborative care planning and deliver brief, wellbeing-focused psychologically-informed interventions. Centrally funded salary support will be available for trainees, with first cohort starting in March 2022.

## Learning and insights from The King's Fund action learning process

In **Cambridgeshire and Peterborough**, physical health workers have been provided with an extensive training package delivered jointly by programme partners, which included time spent shadowing staff in the primary care mental health team.

**Develop a robust training package for people starting in new roles**

**Ensure there is regular supervision to support staff to work in new ways**

Early implementer sites identified a concern about people in social prescribing or similar roles becoming 'burnt out' as a result of working with people with more complex needs than they may traditionally have worked with, but good supervision and support can help mitigate this risk. It is also important in helping people to establish the boundaries of their role, particularly given that the model of care may not always be fully specified from the outset.

In developing training and educational packages, programme leads should draw on the skills and expertise of all partners involved in the transformation work. For example, some early implementer sites suggested that voluntary and community sector partners can often be highly sensitised to the needs of specific groups and that it would therefore be worth involving them in designing and delivering the training.

**Draw on the skills and expertise of partners for specific training needs**

# Embedding Mental Health Practitioners in Primary Care

## The ask of all systems embarking on transformation:

- From April 2021, every PCN will become entitled to a fully embedded FTE mental health practitioner, employed by the PCN's local provider of mental health services

## Employment and funding

Funded jointly between MH provider and PCNs (50:50 split on salary, NI/pension)

Employed by CMH provider and fully embedded in PCN MDT via service agreement

PCN contribution funded by ARRS scheme

By 23/24 PCNs may choose to have up to 3 WTE staff (1 WTE is available per annum between 21/22 - 23/24)

## Benefits

Integrated pathway for adults and older adults with SMI

No formal referral process required for support

MHPs act as a bridge between primary care and specialist MH providers, as well as direct triage and care, where appropriate

Deployment of ARRS roles should be aligned to wider ICS CMH transformation and a building block to deliver

## The role of Mental Health Practitioners

- Work with patients to support shared decision-making about self-management; facilitate onward access to treatment services; and provide brief psychological interventions, where qualified to do so and where appropriate
- Work closely with other PCN-based roles to address wider patient needs, e.g. PCN clinical pharmacists for medication reviews, and social prescribing link workers for access to community-based support
- Operate without the need for formal referral from GPs, including accepting some direct bookings where appropriate, subject to agreement on volumes and booking mechanism between PCN and provider
- Provide a consultation, advice, triage and liaison function, supported by the local community mental health provider through robust clinical governance structures to maintain quality and safety, including supervision where appropriate.
- For further information, please visit the Future NHS Collaboration platform. This includes an FAQ document and example job descriptions.

# Peer support and lived experience roles

## The ask of all systems embarking on transformation:

- Embedding peer support workers within the new models is a key component of the new approach to community mental health.
- Employ peer support workers at varying degrees of seniority, and ensure they receive appropriate support, supervision and fair remuneration.
- Recruit specific peer support/live experience roles from minority groups with protected characteristics

## Learn more

- HEE have a number of resources on peer support which can be accessed here.
- An example peer support worker job description can be found here.

## Learning and insights from The King's Fund action learning process

Expanding access to peer support is a key component of the new approach to community mental health, and early implementer sites shared some specific lessons in relation to this.

**Expanding access to peer support is key**

**Be clear about the scope of the roles**

A key lesson is to be clear about what is (and is not) included in the scope of the peer support worker role. In **Hertfordshire and West Essex**, the principle adopted has been that peer support workers focus on sharing their lived experience of recovery and are not involved in assessment or the delivery of clinical interventions. However, they should be trained to understand risk and to seek help and advice and escalate concerns as necessary.

It is also important to ensure that peer support is fully embedded within the team, particularly where peer support workers are employed by a separate organisation (e.g. in the voluntary sector). Measures to promote this can include:

- *Ensuring peer support workers have an equal voice within team meetings and other decision-making processes*
- *Providing peer support workers with access to the same training, equipment and resources as other staff*
- *Ensuring mentoring/clinical supervision and line management arrangements are in place*
- *Ensuring honorary contracts are in place early on*

**Ensure peer support is fully embedded within the team**

# Delivering the new model

There are a number of key enablers which all systems need to have in place to have the best chance of success in delivering the new models.

This section sets out some of the main enablers, including partnership working, and how early implementer sites have ensured these are embedded at every level of the programme.

NHS England and NHS Improvement

# Leadership and Governance

## The ask of all systems embarking on transformation:

- Robust local governance structures with appropriate Board-level representation and Executive-level oversight which feeds into overall ICS governance.
- Representation from all relevant NHS and non-NHS partners and people with lived experience.
- Given the scale of change needed and the significant amounts of funding going into this programme, it needs to be visibly sponsored by senior ICS leadership and positioned relative to its national profile in local systems.

### Learning and insights from The King's Fund action learning process

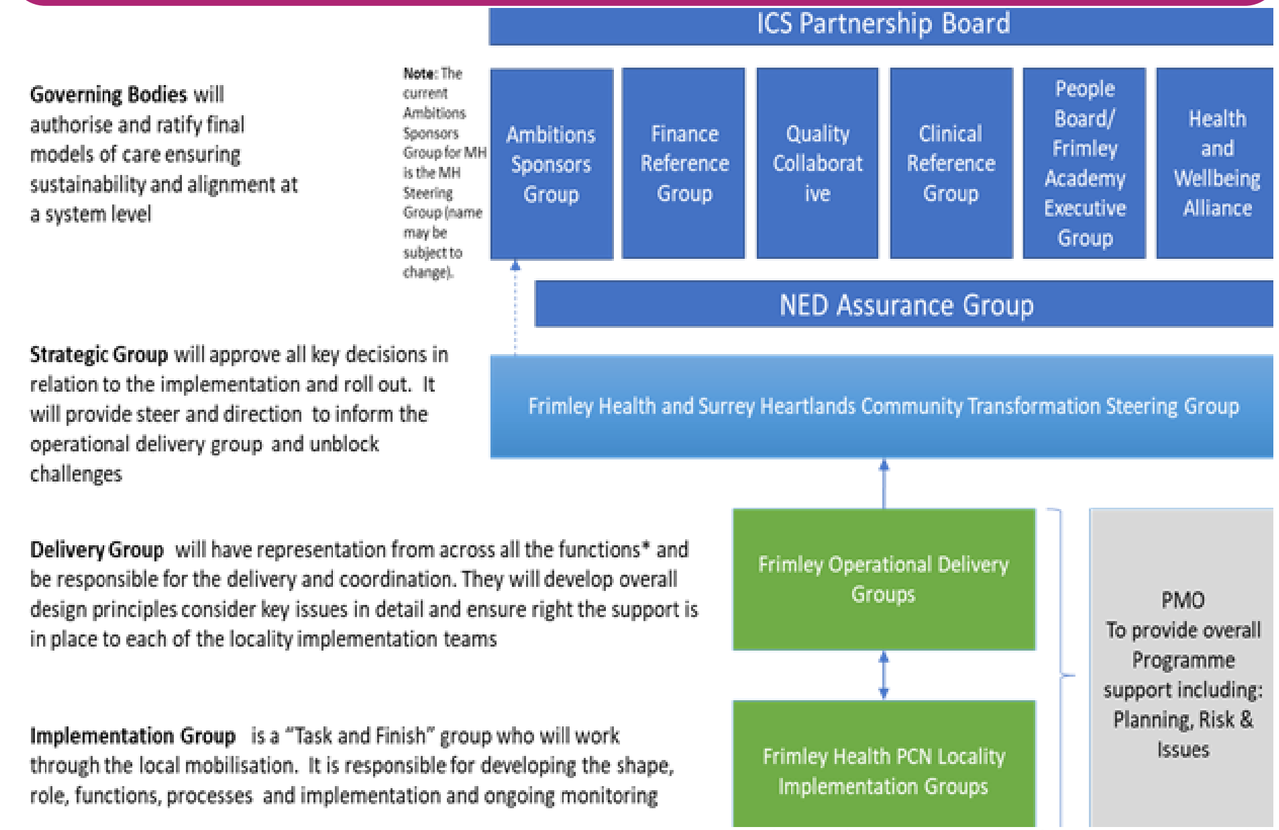
Clear governance arrangements are needed to bring partner organisations together, but we heard that governance must not become an end in itself. The most effective examples of programme governance were those that built out from existing structures, networks and relationships, as part of ongoing processes of stakeholder engagement.
For example, in **South Yorkshire and Bassetlaw** the programme governance arrangements built on an existing Joint Executive Board established between Sheffield Health and Social Care NHS Foundation Trust and Primary Care Sheffield.

**Build governance from existing structures, networks and relationships**

**Ensure that there is engagement from integrated care systems leaders**

Governance arrangements need to ensure that there is engagement from integrated care system leaders. Community mental health transformation may be one of several change programmes happening within a local system, and as such will require routine advocacy and socialising of its goals at the most senior levels.

## SPOTLIGHT - Frimley and Surrey Heartlands




*Frimley and Surrey Heartlands' governance model*

# Co-production

## The ask of all systems embarking on transformation

- Ensure lived experience voices are incorporated into governance structures underpinning and overseeing the mobilisation and delivery of the new modes, including senior/Exec-level structures.
- Dedicate specific funding to support co-production activities, including reimbursing services users appropriately.
- Develop specific mechanisms for ongoing engagement, involvement and co-production activity throughout the lifecycle of the transformation programme.
- Ensure minority and seldom-heard groups are supported appropriately to access any co-production opportunities.

## Learn More

Early implementer sites highlighted that there are a number of external resources which systems are able to draw on for inspiration, including:

- Nesta's work on co-production (Boyle et al 2010)
- National Survivor User Network outputs on national involvement standards (2015)
- National Voice's principles for engaging people and communities (National Voices 2016)
- NHSE/I's statutory guidance for involving patients and the public (NHS England and NHS Improvement 2017a)
- National Collaborating Centre for Mental Health's work (2019) on co-production in mental health commissioning
- NICE guidelines for shared decision making

## Learning and insights from The King's Fund action learning process

Consider differential engagement mechanisms to reach your target audience. For example in in **Hertfordshire and West Essex** working with voluntary and community sector organisations with established networks helped to include the voice of younger people. Similarly, the **Surrey Heartlands** and **Frimley** sites have developed a number of mechanisms to ensure the voice of young adults is at the heart of the programme, including a young adult reference group.

**Tailor mechanisms to reach the target audience**

**Think innovatively so seldom-heard groups can be involved**

It's important to consider how to engage people whom statutory services have not engaged with well in the past.
In **Cheshire and Merseyside** community liaison posts have been created to support innovative engagement work with specific communities such as black and minority ethnic groups.

In **North East London** a team of five People Participation Leads have been recruited to ensure there is involvement of people with lived experience across the breadth of the programme. Alternatively, there are a range of external organisations with expertise in facilitating service user involvement which can be commissioned to support the programme

**Draw on the skills and expertise of people with experience in effective co-production**

# Working with primary care

## The ask of all systems embarking on transformation:

- Establishing lead GPs in each PCN who will provide strategic leadership on mental health and maintain strategic relationships with mental health providers and VCSE partners.
- Ensure ownership of the transformation programme is shared jointly between primary and secondary care partners for adults and older adults
- Improve physical health outcomes for people with SMI via physical health checks, medical monitoring and any other evidence-based intervention delivered within primary care
- Drive integration across primary and secondary care by ensuring the transformation encompasses primary care roles
- Embed additional mental health practitioners in every PCN as per the NHS Standard Contract

## Learning and insights from The King's Fund action learning process

In order to maximise success in building an integrated model of care, EI sites have been building relationships with senior leaders working in primary care. For some, like **Cambridge and Peterborough,** that started by proactively involving PCNs in the process of strategic direction setting within the transformation programme. On an ongoing basis, PCN clinical directors were identified as key stakeholders who have credibility and influence among local clinicians and can support change.

**Proactively involve PCNs in the transformation programme**

**Work with PCNs to review service changes and promote alignment**

Some sites, such as **Humber Coast and Vale**, use regular workshops with PCNs to review service changes and to promote alignment over time. Some systems also have GP federations or super partnerships aggregating primary care functions alongside PCNs. Where these exist, early implementer sites found that their organisational capacity can make them valuable partners too.

## SPOTLIGHT - Cambridgeshire and Peterborough

Key to the success of the new model in Cambridgeshire and Peterborough is **closer working between primary and secondary care.**

To achieve this, the E/I site:

1. Initially appointed **one GP mental health lead** (with one session per week) to lead the work around developing closer integration with PCNs across the patch.
2. Delivered an extensive programme of GP engagement, led by the above mentioned GP mental health lead. **There was a series of meetings with representatives from each of the PCNs** to listen and respond to any concerns about mental health care pathways.
3. And then **expanded the number of GP mental health leads** in post, as the model spread. There are now additional 6 Mental Health Lead GPs to represent each of the PCNs where the model of care is being transformed and this has been key to the partnership working.

Every PCN across the patch will have its own primary care mental health team to work alongside, which will ensure:

- A **range of new service options** can be accessed by patients directly from primary care
- **GPs have access to virtual clinics with specialists** to access advice and guidance on supporting patients
- Primary and secondary access **shared data dashboard** to understand key trends in service use and progress towards KPIs

# Working with local authorities

## The ask of all systems embarking on transformation

- Ensure senior local authority figures, including Directors of Adult Social Care, Directors of Public Health and housing leads, are fully engaged and represented in governance structures.
- Strengthen/improve formal or informal partnership arrangements, including integrated commissioning and integrated workforce planning.
- Ensure all partners are working together to facilitate integrated, Care Act-compliant care and support planning for people with SMI.
- Embed mental health social work and the principles of strengths/asset-based approaches.
- Ensure the new models can address social needs of adults and older adults with SMI, including housing, financial advice, substance use issues and carers' support.

## Learning and insights from The King's Fund action learning process

Working closely with local authorities to tackle long-standing inequalities in mental health outcomes and ensuring this programme is aligned to any wider work to promote equalities and inclusion in the local community.

**Promote equalities and inclusion in local community**

**Build political understanding and legitimacy**

Early implementer site leads also noted that working closely with local authorities can help to build local political understanding and legitimacy – and that this can be vital in ensuring there is wider support for the transformation process. For example, some sites have engaged local authority overview and scrutiny committees in the transformation work.

## SPOTLIGHT - Hertfordshire and West Essex

- The Hertfordshire and West Essex programme team are working in partnership with the local authority to access public health intelligence to identify population-specific needs, and are using the local equalities strategy to inform the design of initiatives within the programme.
- The team have also made efforts to align their approach to community mental health provision with existing services commissioned by Hertfordshire County Council. Aligning with the "Connected Lives" model ensures mental health services can make full use of the assets and resources available in local communities.

## SPOTLIGHT - North West London

- West London NHS Trust has launched a partnership with the Thriving Community programme run by the London Borough of Hounslow. Through this partnership they are providing funding for local voluntary and community sector organisations that support the mental health and wellbeing of people in Black, Asian and minority ethnic communities, people with disabilities, people who have experienced trauma related to migration, or people who identify as being lesbian, gay, bisexual or transgender.

## SPOTLIGHT - Herefordshire and Worcestershire

- Focused work is needed to ensure the new model of community mental health meets the needs or socially excluded or marginalised groups, and again this work needs to build on the wider work that local authorities do with these groups. For example, in Herefordshire and Worcestershire the programme team is working with local government colleagues to improve care delivered to rough sleepers with mental health needs.

# Working with the third sector

## The ask of all systems embarking on transformation

- Ongoing engagement, involvement and funding of a range of VCSE organisations including smaller/micro-VCSE, grassroots, local community/faith and user-led organisations that provide care and support to adults and older adults with SMI.
- Create or expand a local VCSE MH organisation alliance model and ensure VCSE voices are represented at senior levels in governance structures and delivery boards.
- Move from recurrent short-term tendering cycles to longer-term contracting to support the sustainability of the local VCSE sector, and ensure contracting/procurement processes are dynamic and flexible in order to support local VCSE MH organisations.
- Ringfence a proportion of transformation funding to invest in contracting with the VCSE with consideration given to how best to transfer information for direct care.

## Learning and insights from The King's Fund action learning process

A focus on collaboration, rather than the competition usually instigated through procurement processes, can both support VCSE stakeholders and improve outcomes for service users and carers.

**A focus on collaboration can support improvement of outcomes**

**Involvement and dialogue with VCSE partners is key to embedding culture change**

Ongoing dialogue and involvement of VCSE partners is key to embedding the culture change around integration across services. For example, in **Hertfordshire and West Essex**, NHS and VCSE partners have used collaborative recruitment processes, co-located staff and joint supervision arrangements to aid this effort.

## SPOTLIGHT - Somerset

- In Somerset, a partnership between the MH Trust, CCG, VCSE and local authority has established an alliance of VCSE organisations called 'Open Mental Health' so that anyone with a mental health problem can access local specialist interventions whenever needed.
- The alliance is made up of local VCSE organisations and Rethink Mental Illness was elected as the accountable body to oversee delivery of the service.
- Funding to support this model flows from the CCG to the MH Trust and from there is divided up depending on which organisation is best placed to deliver the required service.

# Inequalities

## The ask of all systems embarking on transformation:

- Proactively ringfence a proportion of transformation funding in line with local demographic profiles to directly target at addressing inequalities, particularly ethnic and racial inequalities.
- Commission local organisations which can address the needs of specific demographic groups, and potentially building infrastructure and capacity where such organisations are non-existent or under-developed.
- Recruit peer support / lived experience roles from minority groups with protected characteristics, ensuring these roles receive appropriate support, supervision and fair remuneration.
- Develop metrics to help measure the demonstrable impact on addressing mental health inequalities.
- Develop strategies to improve digital inclusion within their care pathways, linking to the broader system level strategy for building inclusive digitally enabled care pathways.

## SPOTLIGHT - North East London

### Addressing the impact of social determinants of health

**Digital Exclusion**

- There has been a redistribution of equipment and setting up of Access hubs for service users as part the Future of Work workstream. Reshaping the future sessions look at digital exclusion as part of the assessment across services.

**Employment**

- We are aiming to increase the number of ELFT service users in meaningful employment, education or training.
- Programmes of work planned including
  - SU developing their gold standard employment service standards
  - Job and volunteering page to be developed as part of ELFT internet site
  - Developing a support package with and for service users addressing areas identified by SU, including explaining gaps in CVs and dealing with rejection.
- We are also in discussion with East London Business Partnership around increasing support and opportunities for people experiencing poor mental health.

**Ensuring a representative workforce**

- A significant proportion of the new workforce is non-registered voluntary sector roles which is in recognition of the fact that these organisations are often embedded in communities with strong links to other grass-roots, faith, community and charitable organisations and therefore highly agile in engaging with people facing health and social inequalities.
- The North East London Patient Participation and Leadership Committee (NELPPLC) has chosen this year to focus on creating a faculty of citizen trainers who can deliver cultural awareness training to frontline staff across the health and social care system.  We will ensure that every member of our new PCN Mental Health Teams receives this service user-led training as part of their induction

# Data driven transformation

## The ask of all systems embarking on transformation:

- Ensure ability to monitor and report progress against key performance indicators in the quarterly mental health SDF & Spending Review (SR) assurance process for the PCNs covered in your transformation footprints
- Flow data on routine community mental health performance metrics via MHSDS for all community mental health services (not just the transformation footprints)
- Supplement national reporting with local data collection to tailor services to patient groups with the greatest needs and evaluate new approaches to delivering services
- Flow data to measure the agreed national 4 week waiting (4ww) time definition, and improve data quality to substantially reduce the number of open waits
- Ensure outcomes data is being routinely collected and flowed to the MHSDS

## SDF/SR assurance asks and routine performance

- Key performance metrics for transformation footprints have been agreed and shared with systems for Q1 reporting. The community section of the assurance template can be found here.
- Any future iterations of the assurance asks will be shared and can also be found in the Future NHS collaboration platform.
- All systems will also need to report against routine performance metrics which cover all community services via MHSDS. This includes:
  - Number of people with 2+ contacts in community mental health services
  - % of admissions with no previous contact in community services
  - % of rejected referrals

## 4 week waiting times definitions

- The national 4ww definition has been informed by local definitions developed and tested by early implementer sites.

- This definition will go through a public consultation in July-August 2021, and will then be tested in shadow form by all systems in 2021/22.

## SPOTLIGHT - South Yorkshire and Bassetlaw

**4 week wait definition**

- We propose to measure our 4ww time from the point an individual decides they require support to when an evidence-based intervention is formally commenced and we can be assured the individual is starting to receive support.
- The waiting time definition has strong correlation against what the patient would describe their experience of a wait to be and is intentionally more challenging to meet so that it encourages wider parts of the local MH system to refine and transform service provision.

## Collecting and flowing outcomes data

- Systems are expected to routinely collect and flow outcomes data to the MHSDS
- Further details and examples of how systems have used different outcome measures can be found here.

# Data sharing and interoperability

## The ask of all systems embarking on transformation:

- Drive interoperability between different EPR systems – specifically between primary and secondary care, local authorities and the VCSE where possible/appropriate.
- Work to ensure real-time integration of data and care records across all partners.
- Ensure all users of community mental health benefit from the implementation of full shared care records across all systems by 2021/22, as set out by NHSX. Systems should ensure that high quality, personalised and co-produced care and support plans for people with SMI are integrated within these full shared care records, in line with the PRSB Personalised Care and Support Plan standard

## SPOTLIGHT - South Yorkshire and Bassetlaw

- Mental and physical health care records have been joined up and made interoperable for the first time. This has improved the overall experience of care, support and treatment for people using the new integrated services.
- Integration has been achieved between the SystmOne and EMIS clinical systems. Respective systems now have a live 'read only' view of the other system embedded within a patient's record.
- Community Connectors working for Sheffield Mind have been given honorary NHS contracts to enable them to access NHS equipment and clinical systems.
- City wide, PCN and individual practice population health profiles have been created mapping multiple data sets to enable the prioritisation of resources to areas of greatest need and inequalities.

## Learning and insights from The King's Fund action learning process

The speed at which progress can be made on this issue is dependent on mature relationships and trust between partner organisations, so it is important to be candid about mutual expectations at the outset and to build trust over time.

**Explore data sharing with partners as early as possible**

**Ensure you know who needs to access data**

Map the stakeholders involved who need access to data and understand the issues experienced by each before developing any plans.

Find ways of bringing technical experts together with clinical and managerial leads and service users to build a common understanding of what the requirements are for data systems now and in the future.

**Technical experts need to be aligned with clinical and managerial leads**

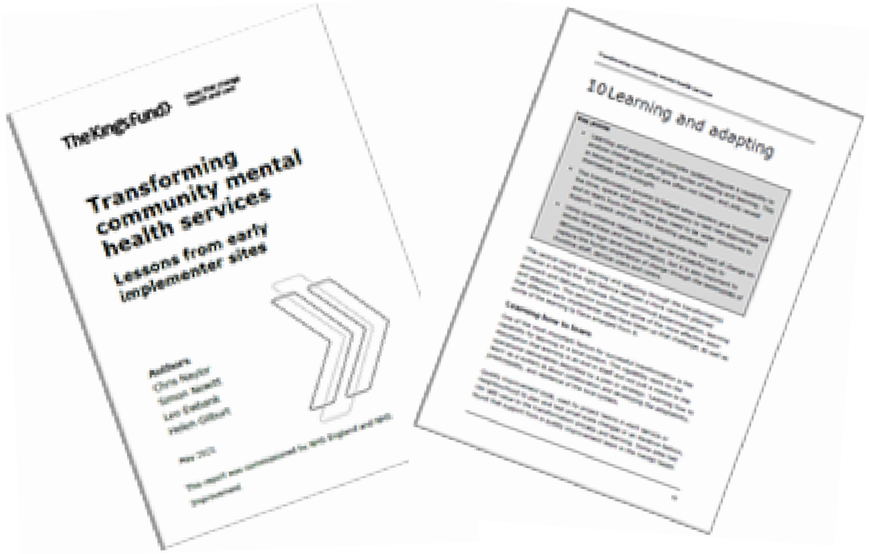
**Use a mixed methods approach to evaluating impact**

Sites have found it helpful to take a mixed methods approach to understanding impact, using staff and service user testimony and stories alongside quantitative measures.

# Test, Learn & Communicate

## The ask of all systems embarking on transformation:

- Transformation is a 3 year journey from 2021/22 – 2023/24.Funding uplifts are phased over the transformation term. Use the early years to test and learn from new approaches.
- Small scale pilots can help to build greater momentum for wider change by building confidence.
- Testing small scale pilots allows you to learn and refine models and new approaches prior to rolling out more widely.
- Learn to tailor your offer to the needs of each PCN community. The standards of care will be consistent but the operational processes may look different in each PCN.
- Invest time and resource in communications that involve primary care, secondary care, local authorities, VCSE organisations and service users.
- Tailor your communication for each key audience.




## Learning and insights from The King's Fund action learning process

Terminology is a potential pit fall. We think we are talking about the same term but terminology can differ in primary and secondary care. For example, a care plan will look different in primary care versus secondary care. And therefore, the need to sit down early and agree what terminology means and how to tackle core technology issues such as interoperability and how to share information between systems.

Communication is not only about who we are talking to. It is important to consider who is not involved in conversations who should be included.

Communications with the team gets harder as the team grows. The transformation is complex with so many stakeholders involved who each have their own specific lens. I'd recommend to anyone embarking on their transformation journey to invest some dedicated time in communications.

## Learn more

The full King's Fund report can be accessed on the Future NHS Collaboration platform.

# Annex

This section contains additional information on Individual Placement and Support, Early Intervention in Psychosis, care planning, older adults and psychological therapies.

# Individual Placement and Support for SMI

## The ask of all systems embarking on transformation:

- Increase funding and investment into IPS services and commission services to meet increased access to IPS in line with LTP access targets.
- Ensure that all IPS providers flow data to the MHSDS and improve the quality of data and flow data to the MHSDS
- Ensure that commissioned services provide “high fidelity” and that regular fidelity reviews are undertaken as part of the IPS contract
- Improved integration of IPS into CMH transformation through MDTs and joined up pathways for SMI
- In line with the fidelity scale Trusts should establish IPS Steering committees to support IPS implementation, sustainment and expansion.
- IPS needs to be seen as a core component of new service models, rather than included in wider third sector partnerships
- Use the Long-Term Plan commissioning resources, including the IPS Grow workforce and outcomes calculator to inform local commissioning discussions.

## Learnings and good practice

- Central and North West London The Trust has implemented IPS services across five London boroughs.
- Funding for the services was initial provided via **IPS transformation funding**, and it is now funded via increases in CCG baseline funding.
- The service has 6 Team Leaders who support 25 Employment Specialists & four Peer Employment Specialist who are **all integrated into community mental health teams** with an emphasis on developing an Multi-Disciplinary approach to IPS.
- During the transformation funding period, **1995 people with SMI** were supported to access employment support, with 713 job outcomes reported.
- The service has **regular fidelity reviews**, most of which have demonstrated good or exemplary at the time of the review.
- The service regularly reviews user experience. In a recent survey, 95% of service users reported they felt ‘very’ or ‘quite’ satisfied with the provision.
- Delivery is overseen by IPS steering groups across BLMK and NWL which drive good practice, quality and performance.

**10**

The number of EI sites able to report IPS data as part of their new models

**24%**

Of people seen in the new model were supported by IPS services

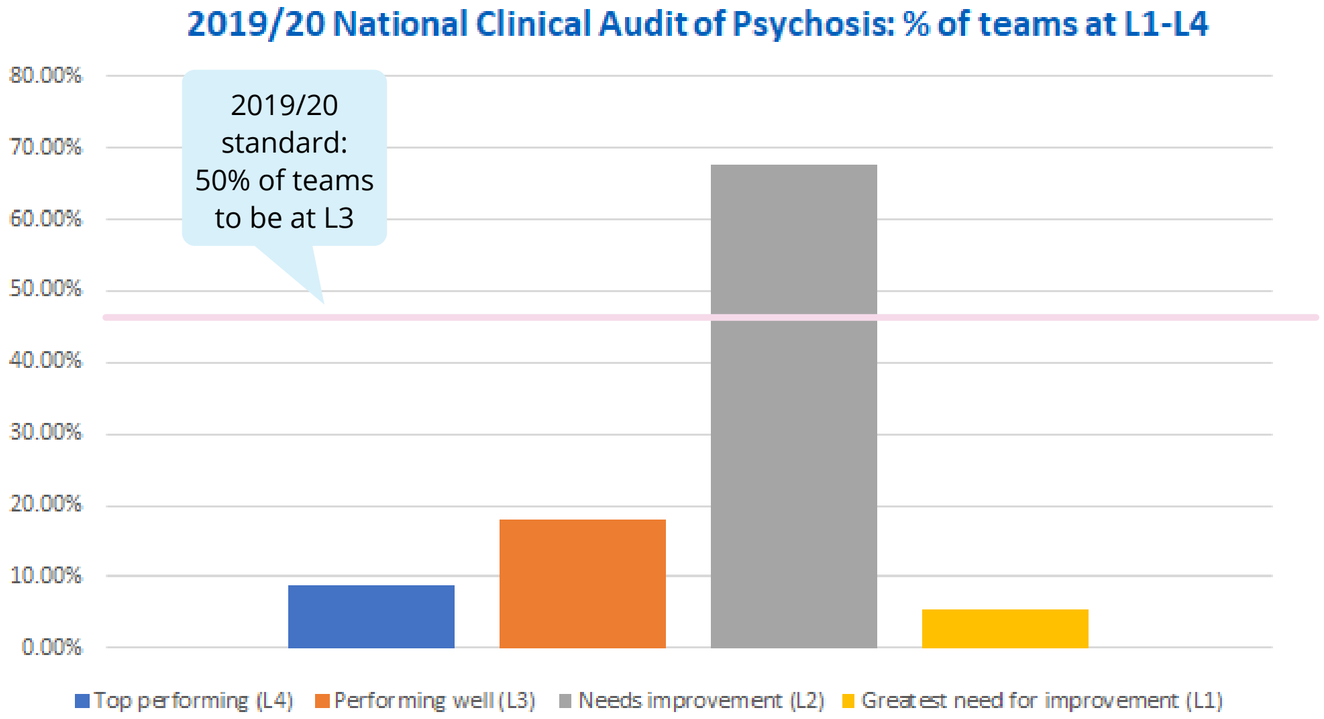
## Learn more

- IPS workforce and funding resources
- IPS Grow Recommended Key Performance Indicators and Outcomes Framework
- Reporting and data guidance and resources
- Ensuring fidelity to the IPS model
- Integration - Resources and Top Tips

# Early Intervention in Psychosis

## The ask of all systems embarking on transformation:

- Provide care and support for people experiencing First Episode Psychosis aged 14-65. All people experiencing FEP should have access to a NICE recommended care package within two weeks of referral, this is measured via flowing data to the Mental Health Services Data Set (MHSDS) and the annual bespoke National Clinical Audit of Psychosis (NCAP)
- Services should deliver increases in NICE concordant care, as set out in the Mental Health Implementation Plan
- Services should also extend provision to people aged 35+ and those experiencing an At-Risk Mental State (ARMS).
- Fund expansion to EIP provision via increases in CCG baseline funding, as set out in the LTP analytical tool.




## Learn more

- Updated Early Intervention in Psychosis Commissioning Guidance, reflecting NHS LTP commitments can be found on the NHS Futures Platform.
- The Early Intervention in Psychosis Triangulation Tool, brings together data on EIP access and waiting time data and National Clinical Audit of Psychosis (NCAP) data annually.

# Principles for good quality care planning

## Care Programme Approach (CPA): NHS England and NHS Improvement Position Statement

**The new approach is based on the following five broad principles**

A **named key worker for all service users with a clearer multidisciplinary team (MDT) approach** to both assess and meet the needs of service users, to reduce the reliance on care coordinators and to increase resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles.

A shift from generic care coordination to **meaningful intervention based care** and delivery of high-quality, safe and meaningful care which helps people to recover and stay well, with documentation and processes that are proportionate and enable the delivery of high-quality care

**High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community**: a live and dynamic process facilitated by the use of digital shared care records and integration with other relevant care planning processes (e.g. section 117 Mental Health Act); with service users actively co-producing brief and relevant care plans with staff, and with active input from non-NHS partners where appropriate including social care (to ensure Care Act compliance), housing, public health and the voluntary, community and social enterprise (VCSE) sector.

**A much more accessible, responsive and flexible system** in which approaches are tailored to the health, care and life needs, and circumstances of an individual, their carer(s) and family members, services' abilities and approaches to engaging an individual, and the complexity and severity of the individual's condition(s), which may fluctuate over time.

**Better support for and involvement of carers** as a means to provide safer and more effective care. This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice.

# Older adults

## Older adult top tips

Review your population data considering local demographic profiles to assess potential demand and highlight any potential inequalities of access so that your plans can address them

Access baseline information from mental health providers as this will help with assessment of current capacity. NHS Benchmarking carried out a stocktake of Older People's mental health, including a section on older adult's community mental health provision. It would be worth accessing and sharing this benchmarking data across your system to help identify variation in current practice at place level.

Drive integration of services for older people. Older people with SMI are likely to be living with a range of other co-morbidities so services should be joined up across mental health and physical health (for example, Frailty, MH support in care homes and Ageing Well Urgent Community Response).

Develop a funded plan to deliver ongoing OPMH education and training for staff in other services to support them to meet any competency gaps.

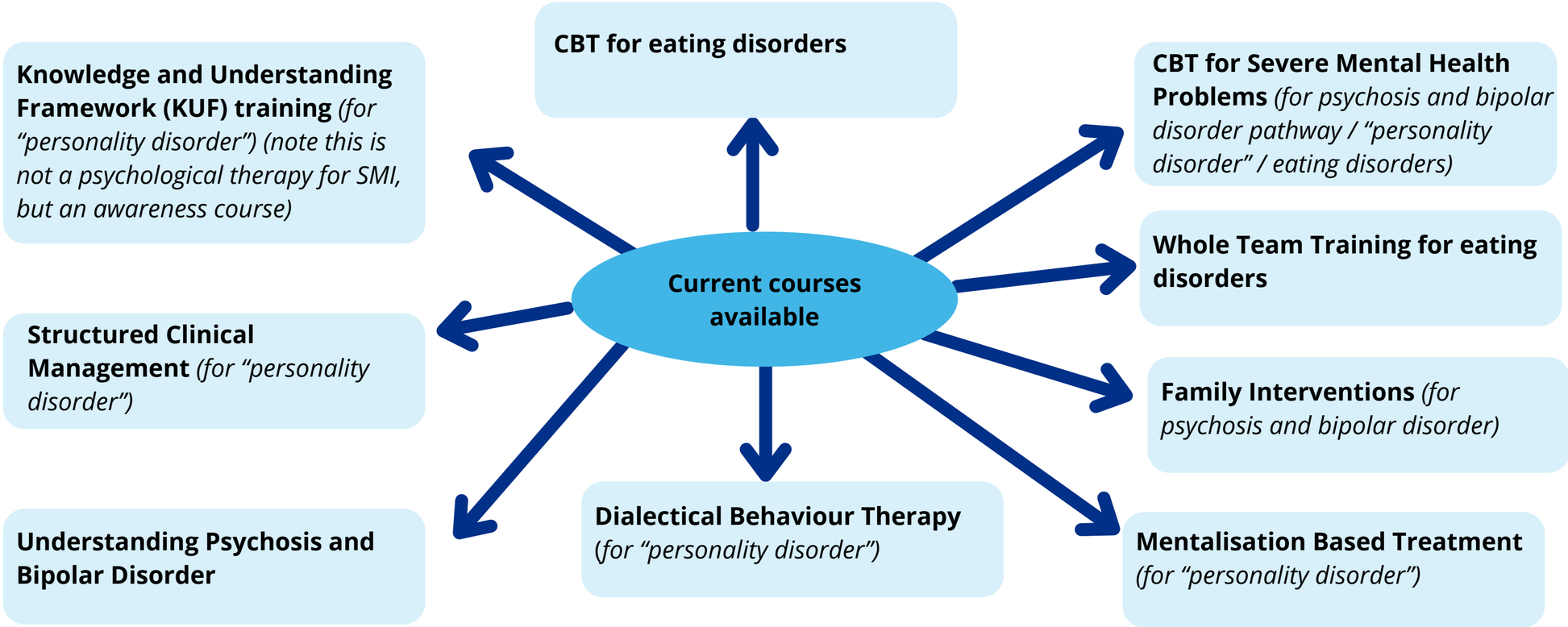
Ensure OPMH clinical expertise is used to deliver proposals by having a named ICS-wide lead for improving OPMH care

Develop a workforce plan to address older adult mental health needs based on local demand/capacity.

Identify potential VCSE providers of older people's mental health support early and engage and fund them from the outset.

Ensure all plans are co-produced with older adults, PCNs, local authorities, public health and VCSE and information is recorded in line with PRSB **Personalised care and support plan standards.**

# The national training offer: psychological therapies




## Future courses in development

- Mental Health and Wellbeing Practitioner training (new role)
- Maudsley Model of Anorexia Nervosa Treatment (MANTRA)
- Eye Movement Desensitization and Reprocessing
- Cognitive Analytic Therapy
- Supporting Guided Self Help for binge eating and bulimia

## Learn more

More information via HEE website

- https://www.hee.nhs.uk/our-work/mental-health/psychological-therapies-severe-mental-health-problems

# Digital Innovation

## The ask of all systems embarking on transformation:

- Ensure that people with SMI are not excluded from care pathways due to lack of digital access, confidence or skills, and support them to benefit from digital technologies by increasing the digital inclusivity of services.
- Ensure that ICS digital strategy and investment plans align to community transformation plans, working with digital leads to ensure that digital transformation addresses the top clinical pressures in local community pathways.
- Ensure alignment across system-led digital transformation work programmes, prioritising shared care records and interoperability across the integrated community pathway.
- Work to implement the PRSB Personalised Care and Support Plan standards
- Learn from regional plans to implement remote technology to deliver physical health checks in 2021/22 and explore opportunities for remote physical monitoring.
- Consider offering a range of community services such as self management apps, digital consultations digital care plans, and digitally enabled models of therapy alongside traditional face to face modes of delivery.
- Make use of digital services and interventions where appropriate, but still maintaining traditional face to face services, particularly where this is clinically appropriate and takes into account patient choice. Services should be dynamic and be able to flex according to patient need and choice.

## Learn More

### Examples of best practice

- Future NHS Collaboration Blueprinting hub showcases Global Digital Exemplars
- Association of Mental Health Providers and NHS Confed guide to supporting digital inclusion
- Future NHS Collaboration case study hub includes examples of digital innovation

### Supporting digital leadership and skills

- Joint NHS Confed and mHabitat interactive digital skills in mental health guide
- HEE's e-learning hub resource repository for digital skills in mental health
- NHS Providers' digital boards programme

### Incorporating digital tools into pathway

- NHSX guidance on designing and building digital products and services
- NHSX guidance on assessing digital tools for usability, data protection and technical security
- Additional national resources on implementing the PRSB Personalised Care and Support Plans and digital inclusion will be published later this year

# Additional Resources page

**For more information on community mental health transformation, please visit:**

- The Community Mental Health Framework for Adult and Older Adults
- NHS Mental Health Implementation Plan 2019/20 – 2023/24
- The NHS Community Mental Health Transformation animation video
- RETHINK STP guides: Thinking differently a 'first steps' guide for STPs on transforming community
- RETHINK Keep thinking differently : Continuing your journey of community mental health transformation
- Adult Community Mental Health Transformation Resource Repository

# Contact us

- National adult mental health team: **england.adultmh@nhs.net**