The Community Mental Health
Framework for Adults and
Older Adults: Support, Care
and Treatment

Part 2
The framework in practice

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Contents

1. Introduction

This part of the guide looks at how the community mental health framework would work in practice for adults and older adults with different complexities of needs. It also provides information, advice and resources to support implementation of the framework.

Section 2 describes the structure of community mental health provision at the local and wider community level, proposed governance structures, and how support, care and treatment would be delivered.

Section 3 applies the framework to a community in which the people and places are fictitious, but it has been based on real data. We then look at four of the people whose stories we presented in Part 1 and demonstrate how the development of an integrated community mental health service would lead them to have more effective care and better outcomes.

In Section 4, we describe the key stages involved in effective implementation of the framework, which includes understanding the mental and physical health needs of communities, knowing what assets are available in the community, undertaking an analysis of current gaps in provision, and developing a place-based model of community mental health care.

Section 5 sets out how to select and use outcome measures, which will be fundamental to implementing then evaluating the new framework.

In Section 6, we present what we anticipate as the main challenges in implementing the framework, and, based on the expertise and experience of the Expert Reference Group, we suggest ways of overcoming these.

Finally, in Section 7, we have collated publications and other resources that we hope will be helpful when implementing the framework.

2. The structure of community mental health provision

The primary organising principle of the framework is local community, place-based care1 for a population of between 30,000 and 50,000 people – the population of a Primary Care Network's (PCN's) geographical footprint. Local needs, local geography and specialist service arrangements may, among other factors, contribute to variation in population size. However, typically this will relate to between five and 12 GP practices.

It is likely that economies of scale mean that more targeted, intensive and longer-term input for people with more complex needs will be provided at the wider community or 'place' level (of around 250,000–500,000 people).

2.1 The core community mental health service

At the centre of the new team structures will be an integrated unitary core community mental health service. This will bring together what is currently provided in primary care for people with less complex as well as complex needs with that provided by secondary care community mental health teams and in residential settings (including supported housing and care homes). It can be built around existing GP practices, neighbourhoods and community hubs – elements that make up the new PCNs. The capacity to deliver effective care will be further enhanced by their integration with social care services (including, if appropriate, housing and employment services) and physical health care services. The teams will be multidisciplinary (see Section 3.2.3 for the range of staff expected to be involved in such a service).

The central functions of the team will be to effectively treat, care for and support people with the full range of mental health problems in the community setting. This will involve:

1. assessment
   ○ and advice or brief treatments
2. specific psychological and pharmacological interventions
   ○ and care planning and coordination
3. support to access community assets

Out of necessity, the services will likely operate as a network with a core group of primary care and mental health specialist staff, social care staff and community connectors, but with strong and regular participation by voluntary, community and social enterprise (VCSE) organisations and physical health sector staff. This will require effective leadership and may (subject to local determination) require sub-teams to operate within the core service, to address specific needs, geographic areas or sub-populations. The core service will operate to the principles in the box on the right.

> **Core service principles**
>
> 1. Having multiple points of access
> 2. Carrying out the minimum number of assessments
> 3. Implementing common pathways for specific needs or problems
> 4. Having agreed protocols for the delivery of care and shared protocols for the management of specific problems (for example, the responsibility of care between primary care and specialist mental health practitioners).

2.2 Mental health services for people with more complex needs

While the framework sets out the case for the majority of people with mental health problems to have their needs met in integrated core community mental health services, certain functions require a different organisational system which will be provided at the wider community level. Services that provide these functions will be part of the same system of care and have close links with local communities, plugging in and providing consultation and advice to the new 'core' model services, but will have the expertise and capacity to deliver care to people with more complex needs. These services include:

- **Specialist community mental health teams,** which will provide support, care and treatment for people with more complex needs, in particular for people with disabling psychotic disorders or people with disabling complex mental health difficulties associated with a diagnosis of 'personality disorder'.

- **Rehabilitation teams** for people with long-term complex needs who may need additional support with activities of daily living. This support includes the provision of community supported accommodation, care coordination, and additional support and planning tailored to meet specific rehabilitation needs.

- **Crisis resolution and home treatment services and inpatient care** for people in crisis who need urgent and emergency high-intensity support, care and treatment.

- **Specialist treatment services** for people whose needs cannot be effectively met by core community mental health services, for example perinatal mental health services, eating disorder services or community forensic mental health services.

- **Support for those who may be at risk of exclusion from their community** including socially excluded people, rough sleepers, and people leaving the criminal justice system or people with multiple vulnerabilities frequently in contact with the police.

Stepping up people's support, care and treatment to this level, or stepping it down to that provided in the local community, should be simple and supported across the system.

Services for people with more complex needs will have close links with core services and will operate within the same protocols for the delivery of care and will have shared governance arrangements.

2.3 Governance

The first and most important step in implementing the framework will be initiated by a group of leaders with a shared vision, who can drive change and establish strong relationships. The leaders should be experienced clinicians, commissioners, practitioners, managers and people who have used and have experience of services, who can work effectively across organisational and professional boundaries.

Sound clinical governance under the framework is critical to its successful implementation within systems that promote cross-professional and organisational safety and learning approaches.

Agreed governance structures will be required for the effective operation of all services in the framework, including the development of systems to support the integration of primary care, secondary care mental health, social care, VCSE organisations and housing and community services.

2.3.1 Bodies represented in governance structures

The component bodies of the mental health governance structure will need to establish robust links with, and be overseen by, Sustainability and Transformation Plans (STPs)/integrated care systems (ICSs) and develop a joint common vision. They should then agree principles and key outcomes for local systems. Representation should include (in alphabetical order):

- clinical commissioning groups (CCGs)
- local authorities, including:
  - social services
  - drug and alcohol services
  - education
  - housing and employment
  - public health
- mental health services
- physical health services
- primary care, including PCN representatives
- service users and carers
- VCSE organisations.

These bodies will be responsible for the design, delivery and strategic development of new models of community mental health care. This design will include the implementation of systems for reviewing performance and outcomes at all levels (system, service, individual service user) to enable a focus on the quality of community mental health care provision as well as timely access.

2.3.2 Integrated commissioning

Integration of commissioning processes at the local system level will facilitate collaborative working by providers, leading to improved patient outcomes and experience.

Advancing Mental Health Equality: Governance

Governance and accountability are of great importance across all of healthcare, but especially in tackling in. Most governance equality duties are set out within the legislation such as the Equality Act and the Health and Social Care Act. Commissioners and service providers should also consider building additional governance structures into their plans to ensure actions taken are justifiable and effective.

See Table 3 for solutions to challenges in commissioning.

One way of achieving this is through multi-year **alliance contracting**. An overarching contract across organisations means that each member organisation is contractually mandated to achieve the same objectives. Members of the alliance could co-produce a set of shared values and agree a local vision and principles for the community mental health service, which would ensure a focus on priorities (for example, continuity of care and trusted assessments). Local partners agreeing a multi-year alliance contract with in-built flexibility could also help to focus efforts on the quality of care and help smaller VCSE organisations to operate on a surer, sustainable basis.

2.3.3 Local collaboration

In this context, health and social care commissioners will collaborate with all providers on a sustainably funded partnership basis – that is, without recurrent short-term tendering cycles and complex contract management processes. This will help to make the use of existing resources more efficient, combined with substantial additional resources directed into community-based services according to agreed local priorities, including greater investment in prevention and early intervention.

> The Local Government Association and NHS Clinical Commissioners have developed guidance on how to best achieve integrated commissioning. NHS England has developed a practical guide on leading large-scale change and the Health Foundation has published a learning report setting out lessons from the new care models programme.

2.4 Delivering support, care and treatment

The organisation of care, treatment and support in the framework builds on the existing models for delivering care, treatment and support in primary and secondary care.

Generally, the care outlined in this framework will not differ greatly from the care currently provided by well-delivered community mental health services. However, this framework allows the delivery of good social work, good community nursing, good community support work and good community psychiatry, which current systems often work against.

The key difference in the new framework is the aforementioned integration of community mental health services with primary care, social care and VCSE services, which will ensure that all aspects of a person's care are managed within an agreed framework with common protocols and shared governance.

In these services, assessment can be undertaken by different members of the core community mental health service at the point at which a person seeks access, though staff must be suitably qualified and experienced. (The structure of these assessments is set out in Part 1 of this guide.)

2.4.1 Assessment and interventions

Assessment will vary according to the needs of the individual and the complexity of their problem(s). Assessment can be a relatively brief initial contact in which an understanding of the person's current problems and a shared view of an intervention have been

developed and agreed with them. The intervention itself may comprise a simple, short advice session that enables the person to obtain help for themselves, or perhaps no further help will be required.

However, for a significant proportion of people there will be an intervention detailed in a mutually developed and agreed personalised care and support plan (subject to the person's capacity). For people with less complex problems, care plans will be brief and often uni-professional, and may set out, for example, a psychological intervention, support to join a community group, help in resolving a difficulty at work, or initiation of a treatment with medication and subsequent follow-up. As can be seen from the example of Louise (see Section 3.3.1), routine outcome monitoring and review might, depending on the outcome of treatment, lead to further intervention.

2.4.2 Assessment and interventions for more complex problems

For people with more complex problems the assessment will be comprehensive, as described in Section 6.1.2 of Part 1. Interventions for people with more complex problems are likely to be multi-professional in nature,[a] with one person having responsibility for coordinating the care and treatment. This coordination role can be provided by workers from different professional backgrounds.

In the example of Ashik (Section 3.2.2), he may benefit from an initial psychological intervention to help with his anxiety, and some psychoeducation for his drug and alcohol use. If his drug and alcohol use is more severe than initially assessed, further combined drug and alcohol and psychological interventions may help.

The intention in establishing this integrated community service is to remove the need for further referral when specific advice or additional interventions are required. This is because the majority of people's needs can be fully met by the core community mental health service, with input from specialist clinical expertise when needed.

2.4.3 Integration of community support and assets

The other significant difference in the new framework is the integration of community support and the role of community assets as central to the provision of effective care. In Louise's example, a large part of the care is provided at a community level, with the support of a community connector, which will play a central role in making sure that Louise feels a part of university life and makes the most of the assets available to her that she might otherwise find difficult to engage with. This would help Louise consolidate the progress that she has made since the therapy for her post-traumatic stress disorder (PTSD).

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a Interventions for people with complex problems are also likely to involve a number of professionals and require coordination.

3. The framework applied to a community

3.1 Westside and Eastside: an example wider community

To illustrate how the framework could work, we have applied it to two fictitious neighbouring towns that form a wider community. 'Westside' and 'Eastside' are based on actual places and data.

Geographical features and 50 miles lie between Westside and Eastside (see Figure 1), meaning that the health services in these two areas operate relatively independently of each other. Eastside is ten times larger in area than Westside and has overall low deprivation levels, whereas the smaller Westside has high levels of deprivation.

Both populations have mid-range levels of ethnic diversity. Some neighbourhoods in each area have high numbers of eastern European immigrants. In Westside, there are large Pakistani communities, and in Eastside there is a smaller area with a predominantly Chinese population. See the demographics box for more information.

3.1.1 Mental health services in Westside and Eastside

Each local neighbourhood population is between 30,000 and 80,000, each supported by clusters of three to seven GP practices. It is at this neighbourhood level that most mental health services would operate, with services becoming well-integrated with both the local communities and GP practices. Each mental health service would likely serve a population of 30,000 to 50,000 people. In this example area, larger neighbourhoods would be served by more than one mental health service.

Across the two towns, there are certain population groups that may find it difficult to access health care. Westside has a significantly larger homeless population compared with Eastside, which is due to fewer options for housing and supported housing. Eastside has a large student population owing to its university campus located across several neighbourhoods, and is home to a higher number of refugees and asylum seekers.

Westside and Eastside each have a number of neighbourhoods that vary in terms of degree of mental health need (see Table 1 and Table 2, respectively). Even in the relatively prosperous Eastside area, Hayes and Eastside City North are more deprived and have high rates of depression and severe mental illness (SMI). NHS Digital Quality and Outcomes Framework, Achievement, prevalence and exceptions data for 2017–18 estimated the national prevalence of depression to be 9.88%.

Figure 1: Westside and Eastside

This is the percentage of people on the GP practice register over the age of 18 who are recorded as having depression, so the actual prevalence may be greater than this. The three neighbourhoods in Westside have depression prevalence figures lower than, or similar to, the national average (ranging from 7.49 to 9.31%), however Eastside has a wide range of prevalence rates for depression (5.99% in Eastside City, compared with 12.04% in Hayes).

NHS Digital Quality and Outcomes Framework, Achievement, prevalence and exceptions data for 2017–18 estimates the national prevalence of SMI to be 0.94%.[2] The range of prevalence rates for SMI is, again, wider for the neighbourhoods in Eastside than in Westside. There is one neighbourhood in Westside, Fourie Hill, which has a prevalence rate lower than the estimated national prevalence (0.59%), while the other two neighbourhoods have prevalence rates similar to the national estimate (0.81% for Westside Central and 0.98% for St Christopher). Eastside also has neighbourhoods with prevalence levels lower than the national average (Springfield 0.58% and Sriland 0.59%); however, it also has the highest prevalence levels across the entire geographical area, with 1.13% prevalence in Eastside City and 1.07% prevalence in Eastside City North.

Although, on the whole, health determinant indicators for Westside and Eastside collectively are similar to the national levels, Westside has some wider health determinants that are significantly poorer. This includes overcrowding, violent crime and educational attainment. Conversely, some of these indicators are much better in Eastside than the national picture.

Demographics

Westside

- 3 neighbourhoods
- Total 18+ population: 156,000
- Population over 65: 42,800
- 37% deprivation
- 9.2% Asian
- 10.6% white other

Eastside

- 11 neighbourhoods
- Total 18+ population: 551,000
- Population over 65: 171,200
- 4% deprivation
- 3.6% Asian (Chinese)
- 10.6% white other
- 8.9% mixed other

Table 1: Westside neighbourhood. Prevalence of depression and SMI

Westside neighbourhoods	Local population	Prevalence of depression (%)	Population with a diagnosis of depression	Prevalence of SMI (%)	Population with a diagnosis of SMI
Westside Central	71,000	7.49	5,318	0.81	575
St Christopher	55,000	8.11	4,461	0.98	539
Fourie Hill	30,000	9.31	2,793	0.59	177

Table 2: Eastside neighbourhood. Prevalence of depression and SMI

Eastside neighbourhood	Local population	Prevalence of depression (%)	Population with a diagnosis of depression	Prevalence of SMI (%)	Population with a diagnosis of SMI
Eastside East	53,000	7.94	4,208	0.85	451
Eastside South Villages	32,000	7.76	2,432	0.63	202
Eastside North Villages	33,000	7.80	2,574	0.79	261
Eastside City	81,000	5.99	4,852	1.13	915
Eastside City North	74,000	8.46	6,260	1.07	792
Tiffintown Central	48,000	9.46	4,541	0.74	355
St Bode	28,000	9.37	2,624	0.65	182
Isle of Bailey	45,000	8.50	3,825	0.67	302
Springfield	51,000	8.73	4,452	0.58	296
Hayes	60,000	12.04	7,224	0.7	420
Sriland	46,000	7.85	3,611	0.59	271

3.2 Provision of community mental health support, care and treatment

3.2.1 Provision before the implementation of the framework

Westside

Westside is relatively small, with only three local neighbourhoods, each of which is in an urban setting. It is centred around one town, where the majority of the community assets lie. However, the town has high levels of deprivation, which limits the opportunity to access some of these resources because affordable public transport options are limited, and engagement with services and resources is low.

Each local neighbourhood has its own community mental health team but the only neighbourhood where the primary care teams and community mental health team have built a relationship is in Fourie Hill. People feel that the GPs in Fourie Hill can provide them with advice on how to manage their current needs, including medications management, and facilitating access to other services that could support other worries such as housing and debt advice. The GPs in Fourie Hill say that this has only been

possible because they have support from the community mental health team, who regularly have clinics within the GP surgery and are available to help the GPs make care decisions around mental health needs. The community mental health teams will often see the people presenting to their GP with complex mental health needs, meaning that the local GPs have more time to devote to providing care for a larger number of individuals.

Although the provision of care has successfully integrated in Fourie Hill, leading to residents reporting an improvement in care and experience, other residents of Westside have a different experience. Often, people who live in Westside Central and St Christopher are referred to secondary care mental health teams, but they say that they have been referred so many times and have to go through so many assessments that they do not want to go back for help. The restrictions introduced because of the COVID-19 pandemic led to a rise in student mental health needs, which services worked to accommodate by making the best use of digital resources including alternatives to face-to-face assessments and treatment.

There is a wide pool of community resources in Westside Central, but residents and staff report not knowing what is available, or how to access them. GPs and primary care nurses frequently signpost people to other resources and encourage them to make use of community debt and welfare advice services, and other voluntary and community sector groups, but they are not sure what the uptake of these is.

Eastside

Eastside is an extremely large area made up of 11 neighbourhoods, the majority of which are located in rural areas. There are two very densely populated areas (Eastside City and Eastside City North) where much of the student population lives, meanwhile many of the rural areas have a population that is significantly older in average age.

The primary care teams that work in Eastside City and Eastside City North have good links in with their local community mental health teams, with several GP practices having mental health practitioners co-located within their team. This means that despite the higher prevalence of SMI, many of these people receive their care in the community, through their GP surgery. Primary care staff report feeling relieved that they had support to care for people's mental health needs, and people feel happy to be cared for closer to home. Despite the positive links in these two neighbourhoods, student mental health problems are on the rise and primary care and mental health teams do not appear to be meeting their needs.

Rural areas in Eastside struggle to meet the mental health needs of the community as many people are geographically isolated. Residents rely on the support of their local communities, including faith communities, book clubs and other interest groups. The mental health teams are not in contact with a large number of these people and many of the residents here are not engaged

with their GP, though some might be receiving social care support. Mental health teams have not yet explored the use of digital alternatives to support care and do not know how to make use of these.

3.2.2 Provision after the implementation of the framework

Rural areas

The community mental health teams in the rural parts of Eastside still struggle to connect with the more isolated residents due to the residents' lack of contact with GP surgeries. However, they are noticing a small increase in informal mental health conversations locally after they increased their presence in the community, through local libraries. The team are considering offering more digital options to care, to improve engagement with people who they might not see regularly.

Community connectors

Each neighbourhood has trained members of staff in community connection. These staff members know the local and wider area well, as well as the available resources. The community connectors have built relationships with voluntary and community sector organisations, local authority organisations and other community groups, so that they can continue to learn about the area and identify additional resources.

Mental health and primary care staff can now link people to a community connector if they feel there would be a benefit from engaging with other assets in the community. This community connector can help each person identify resources that meet their own individual interests, goals and needs, aided by the locally developed community assets map. The community connector can introduce the person to the chosen community asset/s and support them throughout their involvement. People report feeling that they now have someone by their side who is interested in helping them with other aspects of their life, aside from their health, which might help them fulfil their individual goals.

Although on the whole, connection with community assets has improved significantly, community connectors have found it challenging to connect geographically isolated people with a wider range of assets beyond those available in their immediate community. However, after identifying this need, the community connectors are now working together with the local authority and local commissioners to identify better (or dedicated) transport options, to support access to community assets for a wider range of people.

> **The impact of the framework**
>
> Since the implementation of the framework, local community mental health teams have built strong relationships with each of their local GP surgeries across both Westside and Eastside.
>
> Now, every member of the primary care team knows who to contact when they require advice on mental health care and treatment and knows what steps to take should the person require additional support from a member of the mental health team, or from a specialist mental health service.
>
> Additionally, the mental health teams are now more visible in the community across both towns, advertising the primary care mental health offer in local libraries, community halls and faith group centres.

Local authority and voluntary and community sector involvement

The local mental health trust now has significant local authority and voluntary and community sector involvement on the board, and all are equal partners in the governance of community mental health care. The board members have contributed to the development of shared goals and a shared vision for the future of the integration of community mental health care in the local area. Through alliance contracting, commissioners expect that each organisation should contribute equally to meeting these goals and vision. This expectation has led to more integrated decision-making, including:

1. the streamlining of assessment processes such that there is one trusted assessment for all agencies
2. the agreement of local protocols for care
3. discussions around what complexity looks like locally.

Together, the board are working towards looking at how to integrate systems digitally.

People's response to the implementation of the framework

People feel:

- confident that they can be encouraged to access activity and advice groups that can help them to stay well in the community
- their social care needs are quickly identified by mental health staff, primary care staff and staff and volunteers in community groups, and that these staff know exactly how to begin to get them help
- more certain that their mental health needs will be met because the mental health team are now more present in the community.

> People who have been trialling the framework now feel that they are able to receive support for their needs, regardless of how complex they are.

3.2.3 Workforce

The full range of staff in multidisciplinary services within each local community should collaborate to deliver effective mental health care. The starting point for this workforce would be staff currently working in secondary care community mental health services. However, to realise the joined-up approach this framework sets out, these teams would fully integrate their working with other local services, including PCNs, employment and housing support staff, key VCSE organisations in the area and social support services. Care will be planned and delivered across this wider partnership.

While this list is not exhaustive, key roles in local place-based, multidisciplinary services could include (in alphabetical order):

- administrative staff
- clinical psychologists
- mental health nurses
- mental health pharmacists
- occupational therapists
- primary care staff
- psychiatrists
- psychological therapists
- social workers and other local authority workers (for example, housing support workers and debt advisers)
- support workers
- team managers.

Services should also make full use of newer roles, including:

- community connectors/social prescribing link workers
- paid peer support workers/experts by experience.

The information in Table 1 and Table 2 does not mean that a service should simply be replicated across each neighbourhood. Each area has different needs and assets that services should be built around, and services will require scaling up and down according to population needs. In some of the larger neighbourhoods (such as Eastside City), there might be two core community mental health services, each working with a population of around 40,000.

Social prescribing link workers

NHS England has committed to fund the recruitment and training of over 1,000 social prescribing link workers to be in place by the end of 2020/21, rising further by 2023/24.

Advancing Mental Health Equality: Workforce development

Commissioners and service providers should ensure that the workforce reflects the value of advancing equality by:

- Training staff to a high standard of cultural competence, including understanding of equality and diversity and their duties and obligations under the Equality Act 2010
- Training staff to deliver age- and developmentally appropriate care
- Ensuring that the workforce is adequately supported and resourced so that the risk of only select people getting help can be reduced
- Ensuring that staff skills and competences reflect the needs of the local population
- Ensuring that the workforce is adequately supported to seek help, guidance and advice from colleagues about any issues that may affect equality of access, treatment or outcomes
- Co-delivering staff training with lived experience experts, families and carers
- Including people with lived experience on interviewing panels
- Giving staff access to and training in digital tools to support people adequately
- Making sure that people from Black, Asian and Minority Ethnic backgrounds have equal access to career opportunities, adhering to the Workforce Race Equality Standard (WRES)

3.3 The framework in practice at the individual level

In this section, we look at four of the people introduced in Part 1 and using fictitious conversations illustrate how an integrated and place-based model of community mental health care would lead to more effective support, care and treatment and better outcomes.

3.3.1 Louise (aged 18)

Louise, 18

Location: Busy university town with a population of 77,000.
Wider population = 148,000.

Louise is a white British woman living in university accommodation, having recently moved away from home to study. She was mugged and assaulted 10 months ago. Louise was diagnosed with PTSD and had a course of psychological treatment with a therapist (Ivor) in her home town over 200 miles away. This appeared to be effective and she started going to a ceramics class and a self-defence class with her friends and girlfriend at the time. They thought it might help to rebuild her confidence. She enjoyed this; however, since moving to a new city she is anxious about socialising. Louise has had minor hearing problems since the assault, for which she is seeing a GP in her university town. She has also talked a little about her anxiety and low mood. She feels isolated because she is nervous about going out, especially at night, so she does not socialise with university friends much and feels like a burden to her friends at home. She has not told her father about her low mood so as not to worry him. He is a widowed, single parent with three young children living at home.

Louise's care under the new framework

The majority of Louise's support, care and treatment can be provided at the local community level. Her journey starts with her GP (Fariha). Fariha is concerned about Louise's anxiety and avoidance, and with Louise's consent, makes contact with her therapist (Ivor), who works in a service in Louise's home town. Their conversation goes like this:

Fariha contacts Louise and asks if she might like to talk to the local community connector. Louise seems uncertain about what to expect but agrees to try. After this conversation, Fariha speaks to the local community connector linked to the practice (Ellie):

Fariha: I have a patient, Louise, who is a student at Eastside university, and I'm concerned that she's a bit isolated. She doesn't seem to have many friends here.

Ellie: Ok, no problem. What kinds of things does she like doing?

Fariha: She mentioned that she went to ceramics classes and started a martial arts class when she lived at home. I should mention that Louise was physically assaulted 6 months ago and this has had a big impact on her confidence.

Ellie: Is there anything else I need to know?

Fariha: Yes, she has some residual hearing problems from the assault.

Fariha (GP): I have a patient, Louise, who is a student at Eastside university, who was treated by you for PTSD around 5 months ago. I am concerned that she seems quite avoidant, and that it is getting worse. Can you advise me on next steps please.

Ivor: Louise responded well to therapy, but it sounds like the move to university has been destabilising for her. I wonder if instead of more therapy, that she would benefit from some community activities.

Fariha: Great. I will ask Louise if this might be of interest. If she agrees I will have a chat with our community connector.

Fariha arranges to see Louise again and together they develop a brief care plan, and Ellie meets Louise to discuss local groups she might be interested in joining:

Note that Ellie has had to be quite proactive here, given Louise's current social isolation. The groups that Ellie is connecting her to may be located either in her university community or local community of Eastside. They aim to provide a space for Louise to take part in activities she enjoys, and possibly build friendships with local people who share similar interests, ideally within her community at university. She seems to feel more comfortable with online options at present and Ellie is able to recognise this, and provide her with signposting and support to access, but also acknowledges that in the future Louise may wish to look for an option that requires her to be present in person.

Support, care and treatment

Louise is still experiencing high levels of anxiety related to the assault, so may also benefit from a specific community support group for victims of crime. Fariha might also consider referring her to the local Improving Access to Psychological Therapies (IAPT) service for brief psychological therapy.

Louise may also need specialised support to address the physical consequences of the assault related to her hearing, and the impact this will have on her ability to engage in her learning and meet her social needs. Ellie would be able to identify these groups if they exist or support Louise to access similar care elsewhere. Fariha may also provide advice about medication. But Ellie would be the one who provides a consistent point of contact and support in a place where Louise currently feels disconnected and isolated.

Implementing the framework in this way will help Louise to build connections with her new local community and support her mental health needs by reducing the current barriers to access and receiving care and treatment according to need, in a timely manner.

Further support

If Louise did not respond well to this support, care and treatment as indicated by routine outcome measurement (including her experience of care), the core community mental health service would be able to provide advice to Fariha, Ellie and the IAPT service, and, if needed, further assessment, support, care and treatment could be provided.

Louise's care without the framework

It is likely that Louise would have been referred back to Ivor in her home town for further sessions of treatment for her PTSD. If Louise had been sent back during term time this would have interrupted her studies. If she had waited and returned after the term had ended, her symptoms might have worsened.

Without a community connector, Louise would probably have become more isolated, and her confidence levels might have dropped further.

Ellie: Fariha tells me you are interested in ceramics and self-defence classes. Would you like me to help you to make contact with a few groups? Or maybe there's something else you would like to do, too?

Louise: Thanks, but I really don't feel up to that right now. I'm scared to leave my room, and sometimes I struggle to hear what people are saying.

Ellie: I understand. When you stay at home, is there anything in particular you like to do?

Louise: I guess these days I have a lot more time to draw because I don't go out as much. I have been looking at online tutorials for different illustration styles.

Ellie: That sounds really interesting! How about, for now, I help you find some online art groups you can connect with, and maybe also some digital resources to help with your mood?

Louise: Yes, maybe I could try that.

Ellie: Sure, I can send you a list of online groups and then we can sit together and go through the options.

Louise: Would you be able to explain them to me the first time?

Ellie: Yes of course. Maybe we could also look at details of a few clubs that might interest you. Eastside University has some great resources, you know. And there are also loads of things going on in Eastside itself.

Louise: I just wouldn't feel comfortable going to these by myself, and maybe not yet.

Ellie: That's ok, whenever you are ready, I can go with you until you feel more confident and have met a few other people.

3.3.2 Ashik (aged 32)

Ashik, 32

Location: Small, diverse neighbourhood in a densely populated region of a major city. Local population = 16,000. Wider population = 323,000.

Born in Bangladesh, Ashik moved to the UK with his family aged 2. He was diagnosed with bipolar disorder 11 years ago, for which he takes medication, and is managing this well with support from specialist mental health services. Ashik works in the financial sector and was recently promoted, which has increased his workload. This is contributing to chronic and ongoing anxiety. Ashik sometimes manages his anxiety by drinking too much and sometimes taking cocaine. Ashik has an understanding partner and two primary school-age children, whom he rarely sees on weekdays due to work. Ashik is happiest when he can spend time with his family at weekends. While he has a good relationship with his parents, Ashik has struggled to explain his current problems to them and worries that, as devout Muslims, they might disown him if they found out about his drinking and drug use. Ashik also worries that his parents will not understand his mental health problems. While he has a supportive GP, Ashik recognises that he needs some more help for his problems but does not know who else to talk to.

Ashik's care under the new framework

At an appointment with his psychiatrist (Kim), Kim is aware that Ashik seems more anxious than usual and asks him questions from the GAD-2.[b] Here is an excerpt from their subsequent conversation:

Support, care and treatment

During his meeting with Kim, Ashik has a review of his medication to optimise treatment of his bipolar disorder and help with mood disturbance. He and Kim discuss other treatment options including psychoeducation (for the drug and alcohol use) and psychological therapy (for the anxiety), both of which he will be able to access locally. Kim asks Ashik whether it would be okay to speak with his GP about their discussion and he agrees. After this appointment, Kim contacts Ashik's GP, Reece (see conversation on the next page).

Depending on the outcome of the psychoeducation, Ashik might need a more focused intervention for his drug and alcohol use and support from a community group such as Alcoholics Anonymous or Narcotics Anonymous, and long-term coordination of his support, care and treatment to retain employment.

Kim: Your answers suggest that you are quite anxious. Are you able to talk about what's making you feel this way?

Ashik: I guess things are just getting on top of me at work and I can't deal with it anymore.

[They talk about his workload and his family, and how things have got worse over time]

Kim: I am interested in why things have worsened recently – why you are no longer able to cope?

Ashik: I find it hard to talk about it, but when I get anxious I tend to drink more than I should to reduce the stress. Some people at work also take worse things…drugs… to keep going, and I sometimes do the same. I know it's wrong, but it helps. My family don't know about this and I don't want them to find out.

Kim: It sounds like things are quite difficult for you right now. I do think you would benefit from some treatment for both your alcohol and drug use and the anxiety. How would you feel about that?

Ashik: Does my family need to know?

Kim: This can remain confidential, but I would say that having a family member support you during treatment can be a good thing.

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b. The GAD-2, or Generalized Anxiety Disorder scale, is an instrument composed of two questions used to screen for anxiety disorders.

Ashik's care without the framework

Without the framework, Ashik would probably not be able to access the psychological treatment he needs locally, and if he were able to he would probably be on a waiting list for 9 months. He would also in all likelihood be excluded from services for which he did not meet the criteria – for example, from an IAPT service because of his diagnosis of bipolar disorder, and from primary care because of his drug and alcohol use.

Kim: I have just met with Ashik and he told me that he has been recently taking drugs and drinking a lot, His drug and alcohol use is concerning me. I am worried he is self-medicating. He and I agreed that some psychoeducation would be the best course of action right now. That might be all that he needs, but let's review it afterwards. We also talked about Ashik having psychological therapy to help him identify coping strategies.

Reece: Is there any other support that Ashik needs that we can provide locally?

Kim: He might benefit from a peer support programme. He is very reluctant to have his family involved in his treatment, so this might be an extra level of support for him. He is also likely to need support with work and managing his workload and his relationship with his employers. This is something that a psychological therapist could help him with.

3.3.3 Diane (aged 82)

Diane, 82

Location: Affluent village on the outskirts of a small city.
Local population = 10,000. Wider population = 175,000.

Diane is a widow whose physically abusive husband died 8 years ago. She has four children and nine grandchildren, almost all of whom live nearby and have close relationships with her. Usually very independent, Diane's physical health has worsened over the last few years, with a recent diagnosis of chronic pulmonary obstructive disease. She had a mental health crisis aged 20 and was diagnosed with bipolar disorder and spent many years in and out of hospital, often detained under the Mental Health Act. Fluctuations in mood affect her relationship with her family, as she will either isolate herself or telephone them non-stop. She has had negative experiences as an inpatient and is wary of mental health services. She was prescribed lithium but stopped taking this by mistake during a hospital admission for her emphysema and, as a result, deteriorated. She is currently well, but is starting to forget things. Diane enjoys spending time with her family and friends and she has a dog, but she struggles to walk him as frequently as she used to.

Diane's care under the new framework

The primary care nurse (Cheryl) at Diane's local GP surgery is giving Diane her flu jab, and during their conversation Cheryl becomes concerned that Diane seems confused, and that she is struggling to remember recent events. Cheryl speaks to Diane's GP (Tony) about her concerns, and with Diane's permission Tony phones Diane's daughter, Jennifer (see part of their conversation below).

Tony wonders if the problem might be related to Diane's medication, so she calls her psychiatrist (Ignacio). Ignacio confirms that this is possible and arranges to see Diane for a lithium review.

After this conversation Tony calls Diane to talk through options, and to arrange an appointment for a joint assessment involving both Tony and Ignacio.

Tony is also concerned that Diane is becoming a little isolated again, and wonders whether the community connector, Rachel, might be able to help. Rachel then makes contact with Diane. After introductions, Rachel discusses possible activities with Diane (see the grey box below).

> **Rachel**: I understand you haven't been able to do the things you like doing of late, and you have been on your own a fair amount?
>
> **Diane**: Yes, that's right. I have had a lot of health worries and I just haven't been able to get out and about like I used to. My dog is putting on weight because I haven't been able to walk him.
>
> **Rachel**: OK, well there are lots of people who could help with that. I could out you in touch with a trustworthy dog walker
>
> **Diane**: I'd much rather walk him myself.
>
> **Rachel**: Of course. There's a local community group that meets up regularly to walk their dogs. Would that interest you?
>
> **Diane**: Is it on the other side of town?
>
> **Rachel**: Actually, it's quite close to where you live, but if you are interested and would rather save your energy for walking your dog, I can arrange transport for you both to get there.
>
> **Diane**: That would be fantastic.
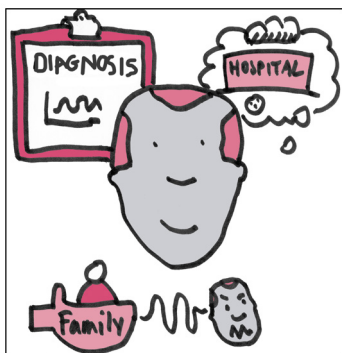
Support, care and treatment

Even though Diane's physical and mental health history is quite complex, she has been able to lead a fairly independent life. She enjoys other people's company, so a dog walking group would be ideal for Diane as it would encourage her to remain physically active while opening up new social possibilities for her. Additionally, if Diane ever felt that she was unable to walk her dog, she would have built relationships within her community with people who she could ask to walk her dog for her.

Tony and Ignacio will keep the memory loss under review, while Diane's lithium regimen is adjusted. If her memory problems persist, and other causes have been ruled out, Tony will refer Diane to the local memory clinic, and make sure Diane and the family are supported throughout the process.

Diane's care without the framework

Without the framework, it is likely that Diane's care would be very fragmented. She has a complex set of needs, and it is possible that no one would take responsibility for making sure that all of those needs are addressed.

> **Tony**: Jennifer, I just wanted to check if you've noticed any changes in your mum recently? I'm a bit concerned about her memory, have you noticed anything different or unusual about her?
>
> **Jennifer**: Now that you mention it I suppose I have, but I didn't want to think about it – because of everything Mum's been through.
>
> **Tony**: Of course, I understand. I recommend that we do some further investigation and find out if it's anything's happening. Has your Mum seemed confused and forgetful? When did you first notice?
>
> **Jennifer**: I guess, if I'm honest, it was after she left hospital for her emphysema – she just didn't seem herself. She kept doing silly things, like putting the kettle in the fridge.
>
> **Tony**: OK, well, it's probably nothing to worry about, but I'd like to talk to your Mum's psychiatrist, and I'll call you straight back.

3.3.4. Frank (aged 51)

Frank, 51

Location: Small coastal village, with good transport links to larger towns nearby. Local population = 5,600. Wider population = 181,000.

Frank is a white British male with schizoaffective disorder. He also drinks alcohol and uses cannabis at times. His first episode of psychosis was following smoking cannabis aged 19 years old, when working in a garden centre. Frank has had several psychiatric hospital admissions due to the severity of his illness – he has tried to harm himself in the past and is vulnerable to being exploited financially, when unwell. As Frank's symptoms haven't responded to first and second-line antipsychotic medication, he is on clozapine, which means he must have blood tests and physical health checks once a month. Before being on clozapine, Frank was unwell for a long time. His symptoms, risks and difficulty with managing his daily activities, meant that he was unable to leave the hospital ward and needed a longer stay on an inpatient rehabilitation ward. Before being admitted he had been living with his mother in her home. However his mother is now elderly and frail and unable to support

Frank's needs and how the framework would help

In the new framework, Frank is able to access inpatient rehabilitation care in his local area (Westside). This helps to stabilise and optimise his mental health and improve his functioning. After 10 months, his psychiatrist and community mental health team feel that he is ready to be discharged to the rehabilitation team.

The care plan that was developed while Frank was still an inpatient (see Section 4.5.1) is put into place and, before his transition out of inpatient services, he has already been supported to engage with his local community mental health rehabilitation team. They are a multidisciplinary team supporting everyone in Westside who has a long-term serious mental illness and those in 24-hour or 9–5 supported accommodation. They are located in a hospital rehabilitation placement, and have an in-reach service for people with rehabilitation needs in acute wards. This team has arranged a funded placement for Frank in accommodation with 24-hour staff support. Because Frank was given the opportunity to engage with the team before discharging from the rehabilitation ward, he feels that he has knowledge about what the next steps are for his care, who the team are and what to expect.

The team work with Frank, his mother (Anne), the staff at the housing project, his GP and other relevant agencies, to ensure person-centred, personalised, recovery-focused working to support Frank to achieve his goals. On the right is part of a conversation between Frank, Anne and a member of the community mental health rehabilitation team (Paul), when Frank was still on the mental health rehabilitation ward.

Anne: …I'm really worried that Frank won't eat properly if I'm not around to cook for him. Or he'll forget to go for his blood tests.

Paul: There'll always be someone at the flat who can help Frank. They can help him prepare meals, and remember his doctor's appointments. They can go with him, too.

Frank: Can you help me sort out my money too? I've been terrible with it lately.

Paul: Sure, we can do that. Is there anything else you think you need support with?

Frank: I'd like to get out of the house more than when I lived with mum.

Paul: OK, and is there anything in particular you would like to do?

Frank: I'm not really sure – one time they brought animals into the wards and someone was telling me about work at the animal shelter. Do you know if I can do something with them? And I'd really like to get back into gardening.

Anne: He loves animals, and he was always ever so green-fingered!

Paul: That's great. Lots to work with there. I can set up a meeting between you and Ellie. She's our community connector, and she can help you get in touch with the animal shelter and a gardening group.

Support, care and treatment

Frank has regular support on a daily basis from the support staff in the housing project, to help with managing his daily self-care, managing finances, eating well and exercising, and also to attend his regular daytime activities.

Frank was also diagnosed with diabetes mellitus, probably due to his being overweight, being sedentary when unwell and also due to his antipsychotic medication. With an integrated multidisciplinary team, Frank is able to receive care for his diabetes from his GP (who is being supported by a diabetes specialist).

Previously, Frank did not like to spend much time in other people's company. However, he is now more sociable, has a couple of friends he sees regularly at the gardening club and also at the animal shelter. He also visits his mother once a week.

Further support

Frank is working towards moving into his own council flat with a permanent tenancy and a package of support. He is also going to start paid work two afternoons a week at the animal shelter.

Frank's care without the framework

Frank would most probably have been placed in a ward far away from his community, his mother and local care team, which would have had a negative effect on his health and likely have led to him to have to stay in inpatient care for longer.

Without community connection, Frank would most likely have struggled to build on the progress he made while being supported by the community rehabilitation team and may have struggled with identifying transport options to help him access the resources in nearby towns.

In an unintegrated team, Frank's diabetes care would not have been available in his local community, and he would have had to have travelled to Eastside to see a specialist.

Frank's social care needs are met because his care coordinator, Paul, has the relevant skills, and being in an integrated team can draw on social care expertise when needed. However, without the framework, Frank would almost certainly have been referred to a social worker, which would have led to delays in receiving benefits and required Frank to have to repeat his story multiple times.

4. Supporting the implementation of the framework

4.1 Key stages of implementation

The effective implementation of this framework involves the following key stages:

- an understanding of the mental health and associated physical health needs of the communities for which providers and commissioners are responsible; these communities include both the local and the wider communities, as described in Part 1
- an understanding of the assets of the communities (community assets mapping)
- a description of current service provision by locality, and an assessment of provision against identified need and the new framework (a 'gap analysis')
- the development of a place-based model of community mental health care founded on the effective integration of current primary, secondary and community mental health services.

Implementing the framework, will take time, requiring careful joint working across STP/ICS geographies by providers, commissioners, local authorities, local VCSE organisations, people who use services and their families and carers, and the local community. Some components are already being implemented in certain areas, though not in a systematic or wholesale way, so testing of these new models in selected areas is seeking to address this.

4.1.1 Testing and evaluating the framework

Implementation will be an iterative process. The new models mentioned in the NHS Long Term Plan, which this framework describes in more detail, are being tested in areas that have been in receipt of new NHS England transformation funding since 2019/20. The learning is being fed back within regions and across the country, to inform the development of proposals in all STP/ICS areas, who will begin implementation of new models from April 2021 supported by a further 3 years of NHS England transformation funding. This testing phase is an opportunity for commissioners and service providers to work closely in setting out a vision for better mental health care that all ICSs can bring about. The experiences of people who use mental health services, as well as their families, friends and carers, will be an essential part of the evaluation process.

After describing the key stages of implementation, this section explains how digital technologies can be used to improve community mental health services.

Implementation support

NHS England has put in place implementation support for those 'early implementer' sites testing new models in line with this framework to ensure that the new system operates effectively.

Advancing mental health equality: Evaluating services

Commissioners and providers should ensure that people in the community, those with lived experience and families and carers have the opportunity to contribute to the service evaluation process. Engagement and involvement should be meaningful (not tokenistic) and inclusion of such initiatives should be part of the commissioning plan, resource and budget. A forum or meeting for feedback could be held in an appropriate local community setting, or be held virtually, to encourage attendance and enable people to contribute openly, in a safe space.

Quality of care and patient safety

Throughout the implementation process, commissioners and providers should ensure that there are protocols in place for maintaining high-quality care and ensuring patient safety.

4.2 Understanding the needs of communities

To be effective, the planning and delivery of mental health care should be informed by a comprehensive assessment of local context and need, and by monitoring referrals and interventions for people who may need mental health care. The assessment should:

- estimate the numbers of people who may need mental health care from a particular service, including patterns of presentation, informed by a gap analysis
- include multi-agency, whole-system development plans across health, education, social care, third sector and local authorities.

At the commissioning level, Health and Wellbeing Boards, supported by the Local Government Association for Health and Wellbeing Systems, should ensure that the following resources are used (alongside a local and health in analysis) as the key drivers for establishing the level of service needed:

- Joint Strategic Needs Assessment, Fingertips
- Joint Health and Wellbeing Strategy
- local sustainability and transformation partnerships
- local transformation plans (for children and young people)

They should specifically address parity of esteem between mental and physical health services.

4.3 Mapping community assets

Having a map or database of local community assets is a key part of sharing knowledge about how the wider community can support people to live and stay well within the community. It is recommended that commissioners and providers work together with local authorities and other stakeholders to commission a map or list of local community assets, and that time is made for staff to maintain and update it. The map will become a tool for the community, enabling locally available resources to be identified and logged.

This will be particularly useful when care plans are being developed jointly by the person and staff, to begin to identify local assets that may increase the person's social capital in the community. It will also allow providers and commissioners to see what resources are available in the communities they serve, and identify any gaps in resources and services.

Advancing Mental Health Equality: Identifying in

The use of data on population demographics, epidemiology and service use is pivotal for identifying inequality issues. However, it is also important to work with the community to identify needs. This provides an opportunity for a richer and deeper understanding of the mental health in that exist as well as offering a means of identifying and developing innovative solutions to tackling these.

See also the NHS Advancing Mental Health Equalities strategy.

4.4 Assessing current provision against identified need

Most service providers will have a good idea of the existing services available in their wider community. They should be able to use this knowledge to assess how well their existing services meet the needs of their community. Estimation of the local and wider community need can be used to determine the requirement for local integrated services and also specialist services at the wider community level. For certain specialist services, for example for eating disorders, it may be more resource efficient to offer the service across two wider community areas (a population of 500,000).

4.5 Developing a place-based model of community mental health care

The King's Fund[1] has published ten design principles and NHS England has published guidance on providing integrated care. Using these as guidance, organisations can collaborate to manage the common resources available to them. The framework proposed here applies the collaborative model to the delivery of community mental health care. In this case, providers include VCSE organisations, the local authority and other providers of social care, as well as statutory primary and secondary healthcare providers.

This section focuses on a key aspect of the development of the place-based model of community mental health care – the structures to provide effective personalised care.

4.5.1 Coordination and planning of care

The Care Programme Approach

A key component of the new framework is a method for coordinating and planning care that will replace the Care Programme Approach (CPA). The CPA has had a central role in the planning and delivery of secondary care mental health services for almost 30 years. It was introduced by the Department of Health in 1990[3] as a means of targeting resources to those who are severely mentally ill, and as a means to improve the coordination and continuity of their care. However, from early on, doubts were raised about its utility[4,5] – principally, that it attempted to unite a model of resource allocation with one for clinical care delivery and planning, and that it created a two-tier system in which a person is either 'on' or 'off' CPA. Its role has been further complicated by its close association with risk management.

A number of attempts have been made to evaluate its impact but have failed to provide convincing evidence for its effectiveness.[6–8] This is perhaps not surprising as it is as much a policy document as an intervention that could be subject to formal evaluation.

The CPA's key elements are a needs assessment, a care plan, regular review and care coordination. Increasingly it has become a tool for the organisation not only of care but also of care meetings, and for the structure of team working and meetings, rather than the delivery of care and treatment. Considerable debate has centred around who is eligible or not for the CPA, which usually focuses on diagnostic, cluster or complexity-based tools. It has also become viewed as a bureaucratic, time-consuming process that diverts staff attention away from the delivery of care and treatment onto the organisation and review of care.[9,10] A recent internal NHS England scoping exercise conducted in support of the development of this framework confirmed widespread dissatisfaction with the CPA.
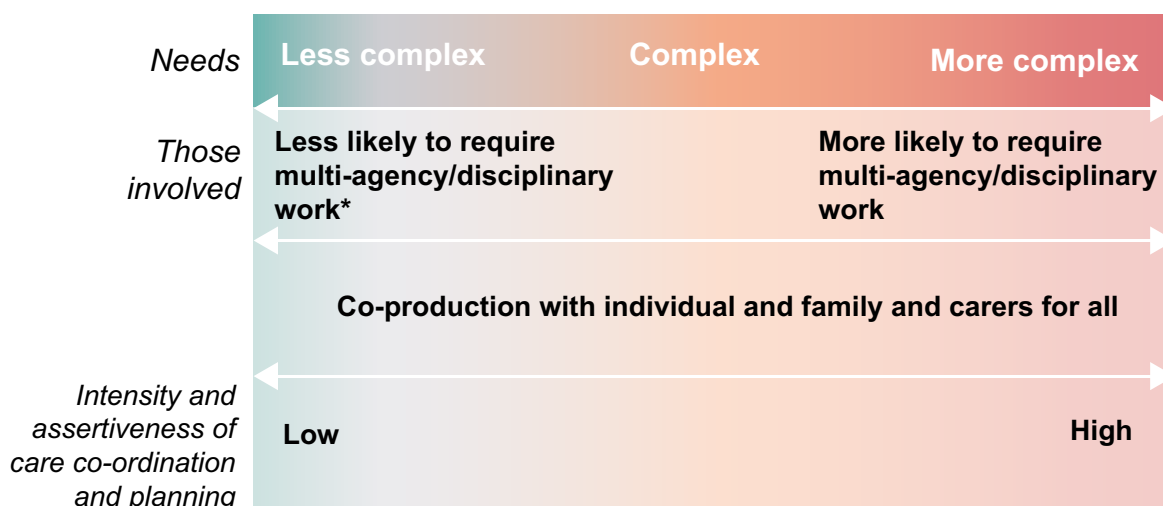
The Care Quality Commission recently reported that 'there is a large variation in the proportion of people on the CPA between trusts, which suggests that there are systematic differences in how trusts individually interpret and apply the CPA policy', with figures that 'ranged across trusts from a low of 3% of respondents on the CPA to a high of 73%' among a sample of service users from different mental health trusts who responded to their annual community mental health survey.[11]

Care planning in the framework

The framework set out in this guide subsumes those important aspects and principles of the CPA, including care planning and care coordination, and reframes them in a system that will work for everyone, will focus on improved outcomes and will deliver place-based integrated mental health care to people whatever their level of need.

Figure 2 outlines who, in the new framework, might be involved in the coordination and planning of care for people depending on the complexity of their mental health needs, and what level of intensity and assertiveness might be required to achieve this.

> *Sometimes you just need to sit down with a person and talk to them and see what they know and what they need.*
>
> Source: Person with lived experience

Figure 2: The level of intensity required to plan and coordinate for people of differing complexity of needs

Needs	Less complex	Complex	More complex
Those involved	Less likely to require multi-agency/disciplinary work*		More likely to require multi-agency/disciplinary work
	Co-production with individual and family and carers for all		
Intensity and assertiveness of care co-ordination and planning	Low		High

* As complexity increases the requirement for multi-agency/disciplinary work is more likely but people with less complex needs may also require multi-agency/discipline involvement.

The model of delivery of care in this framework is that every person who requires support, care and treatment in the community should have a care plan, for which the level of assessment, treatment, planning and coordination of care will vary, depending on the complexity of their needs.

People with greater needs will require increased support with the coordination of their care plan. This role is often currently performed by a care coordinator, which is a role that a number of people can carry out.

During the engagement work with the Department of Health's Voluntary, Community and Social Enterprise Health and Wellbeing Alliance (see Appendix 5 for a list of members of this group), we explored people's experiences of care coordination and what would help them stay well in the community, and plan their care better.

The Health and Wellbeing Alliance's views on what works and what does not in care coordination have been collated into a list of principles and practice that care coordinators can follow when planning a person's care and supporting them in the community.

1. Be respectful of a person's individual goals, wishes and needs. Focus on what is important to the person. Celebrate successes and encourage independence. Empower the person to have choice and freedom

2. Work collaboratively with the person, involving them in every decision and discussion and sharing care plans with them. Involve family and carers at the person's wishes

3. Listen, be sympathetic, be reassuring and validating. Be warm, understanding, patient and caring. Be non-judgemental, compassionate, open and honest. Believe in the person and advocate for them. Be approachable and contactable and be trustworthy and reliable

4. Be flexible in approach and tailor the style of engagement, place of contact and method of communication based on the needs and wishes of the person. Recognise that needs and wishes change, so the approach may need to adapt. Be proactive to encourage progress

5. Be in regular communication with the person, at a frequency that is agreed with the person. Some people would like more frequent contact than others

6. See the person holistically and see their mental health in the context of their life. Ensure that they provide advice and support for the person to stay well, including taking medicines, attending appointments, filling out forms and supporting with daily living. This might also include support with family life, finances, life skills, housing, immigration, employment, volunteering and benefits. See the person as a whole, not a diagnosis or clinical case, but be person-centred

7. A person should be able to have the same care coordinator for a longer period so there is the opportunity to build rapport and trust, and so that the care coordinator can look at a long-term approach to care planning

8. Explain care and support without jargon and help the person to understand any clinical terms. Explain to the person about their rights

9. Care coordinators should be from diverse backgrounds so that they can understand the populations they support and take an approach that meets the needs of many, especially those with protected characteristics

10	Have knowledge of mental health problems and have the ability to recognise these and respond to them
11	Have knowledge of resources in the community and the system in which they work
12	Provide support in a crisis, or provide practical steps around how to seek help during a crisis
13	Provide a clear structured plan for the person around their week and how to get support
14	Link to pharmacy, mental health teams, GPs and other health teams to discuss health outcomes
15	Be supported with time to reflect on their practice and be part of a strong supportive team

The care plan

A care plan is a concise and collaboratively written summary of what the person wants to achieve or improve, and the steps required to get there. It should include who will be providing support, care or treatment and the actions to take in a crisis.

The care plan should also summarise the community assets that the person might find helpful to achieve their goals. Referring to Figure 6 in Part 1, which shows the resources and assets of a community and how different people are connected to them, can assist with this.

For people with less complex problems, a care plan should be a simple document detailing a person's goals and the people involved in their care, and it is likely that the support, care and treatment will be time-limited.

Support may be from family, neighbours, friends or people in local community groups. Some people may benefit from support from, for example, peer support workers who have had similar experiences of mental and/or physical health problems. Others may need support via advice, care or treatment from mental health professionals or other health and social care staff. The care plan needs to contain information about a person's protective factors as well as their needs.

See the box on page 22, Care planning using the example histories, for examples of care planning in people with mental health needs of different levels of complexity.

When they are well enough to do so, people should be encouraged to be owners of the information within the care plan, be familiar with its content and feel confident to request reviews and amendments should circumstances change.

NHS England and NHS Improvement describe the features and benefits of Personalised care and support planning, in which people, and their close friends and family, are encouraged to actively participate in the exploration and management of their health and wellbeing.

The Personalised Care Institute have developed a curriculum for personalised care and a Shared Decision Making Summary Guide for leaders of the local implementation of shared decision-making.

'My care plan will never be written without me. It will reflect my needs and how they can change over time.'

This is because…
- Some people have care plans written without them, some have never seen a care plan, some have had negative or defamatory content recorded in their notes
- People need the opportunity to update their care plan, correct any mistakes or inaccuracies, or add further relevant information
- Some people have not been asked for any contribution or input of their views into their notes

How using the framework can make this happen:
- Care plan written with the person when they are well enough; if they are unwell and do not have a care plan, try to agree a crisis care plan for them with someone that they trust who can advocate on their behalf
- Giving the person the space, time and encouragement to develop the skills to write their own care plan
- Services that co-produce care plans as much as possible
- Full involvement of the person in all reviews of goals, medication or diagnosis wherever appropriate, with any resulting changes to the care plan being made with the person
- Care records and clinical notes that can be accessed and viewed by the person
- People empowered to take responsibility for meeting the goals in their own care plan
- Single care and support plans that are Care Act 2014-compliant, where appropriate
- Joint ownership of care plan when the person is not well
- Care plans that are kept up to date
- Care plans that include a person's:
    - strengths
    - goals
    - current situation (including housing, work, relationships and finances)
    - advance directives that protect the person's wishes when they are not well (written by the person with a professional and documented clearly in their notes, then communicated with their family, carer and relevant support people)
    - can also include references to, for example, crisis plans, recovery plans and Wellness and Recovery Action Plans (WRAPs)

'I want enough time to talk about my care plan: what I need and what I want. I want to know what the next steps are.'

This is because…
- Sometimes there is not enough time to talk about a care plan – or the conversation is postponed – and it ends up never changing
- Sufficient time needs to be included to review medication, care plans and goals, not just at the set times but when people need it

How using the framework can make this happen:
- Services and professionals that understand the importance of a care plan to the person, importance of autonomy and of owning the care plan
- Professionals need to be accountable to their own role in enacting the care plan and supporting the person
- Clear follow-up for people after leaving a service, with clear next steps and signposting to ongoing support if needed
- Clear exit or discharge plan from the moment a person enters a service
- Care/exit/discharge plans shared with the person and between professionals and services
- Clear exit or discharge plan from the moment a person enters a service
- Care/exit/discharge plans shared with the person and between professionals and services

In any event, care plans should include (revisable) timescales for review, rather than an absolute standard. Instead, the review period should be discussed and agreed with the person and those involved in their care at the outset. One way to do this is to hold a planning meeting at the start of care, followed by shorter reviews as necessary, although people with less complex needs may not require this.

Reviews should involve a discussion with the person about whether they feel that they are receiving the agreed care and whether their care is delivering what they need. If this is not happening, then the care plan should be modified to reflect fluctuating or changing need or any changes in a person's circumstances, including changes to protective factors to better support the person to achieve their goals and outcomes.

When care coordinators change, plans that have been made are often not followed through by their successor. To prevent this, the transition period should be managed well with clear handovers and the opportunity for the person to get to know the new coordinator before their existing coordinator leaves.

Care planning recommendations

The following recommendations were developed by the service user and carer focus group:

- Put the person at the centre, specifying what they would like to achieve and what their goals are.
- Consider the person's strengths and weaknesses, and jointly develop a plan based around them.
- Treat care planning seriously: review the language that is used and have genuine engagement from the professional involved.
- The care plan should consider all aspects of a person's life and community – such as housing, jobs, relationships and finances.
- The care plan should be an easily available working document that is continuously reviewed to an agreed timeframe, to ensure that goals are relevant and being met. The care plan should be balanced, not only considering crisis and medicine-management but also social aspects and other life events/circumstances affecting the person.
- Ownership of the care plan should be taken by the person, with appropriate support from a professional, advocate or family member/carer.

The following recommendations were provided by the national advisers with expertise in social care and mental health nursing, who were involved in the development of the framework. The following are supplementary to those developed by the service user and carer focus group:

- There should be a form of care planning for all people who require mental health support, care and treatment, but the type of plan and the level of support needed will depend on the person and their individual needs.

Care planning using the example histories

Dave

Dave will only require help from his GP, and together he and the GP will agree his ongoing care (such as advice from the GP about cutting down alcohol, treatment from IAPT, and then review). Dave's care plan would be a short summary plus a brief treatment plan, signed off by Dave and his GP. The review period would be 10 weeks, at which time Dave would discuss with his IAPT therapist or GP whether or not it had achieved the desired outcome.

Frank

Having recently been discharged from an inpatient rehabilitation ward, Frank's support, care and treatment will be provided primarily by the community rehabilitation team. Planning for his life in the community would have started while he was an inpatient, at the earliest possible point. His initial planning meeting would be multidisciplinary in nature and would involve Frank, the community rehabilitation team, the staff from the supported living team, his GP (to help manage his diabetes at a local level) and his mother Anne. At that meeting, Frank is assigned a care coordinator (Paul from the community rehabilitation team) and a care plan to address Frank's needs is developed. It identifies the other services and agencies that will be required to support him in the community (such as community connection and employment services). As care coordinator, Paul will engage other agencies, support Frank's connection with the community (directly and with support from the local community connector) and provide or organise access to interventions.

See Section 2 of Part 1 for more on the example histories

- The care plan should support easy access to all relevant support, care and treatment options to meet the person's specific needs.
- The care plan should promote support, care and treatment that is in line with the law, especially adhering to the legislative requirements set out in the Care Act and the Mental Health Act.
- The care plan must be accessible and usable by all agencies or organisations involved in a person's care (in line with information sharing and consent processes), and the content agreed with the person.
- There should be an efficient, sensible and effective administrative process for care planning.

Sharing care plans

People should be included in decisions about who their care plan is shared with. Sharing the plan would help the person to communicate with professionals working with them (especially at transition points in care). This will also help the person to feel a sense of ownership over their care and information. This can be done by whatever means the person finds most helpful (digitally or as a paper copy). Permission should always be sought from the person before sharing the care plan with anyone.

Personal budgets

One vehicle for planning care could be the use of personal budgets, which allows people to consider the personal funding of different services or approaches to ensure that their individual needs are being met. Although this could be useful, it is recognised that at present the process for this might not be sufficiently established to be beneficial on its own.

Support for carers, families and support networks

The families, carers and support networks of people using services may also require support. Services should ensure there are adequate structures and processes in place to meet their needs. This may include psychosocial education, carers' assessments, and support for young carers and carers of older age. Under the Care Act, all carers are legally entitled to an assessment of their needs. A carer's assessment may be completed by the local authority to consider the person's mental health, physical health and social support needs, as well as their resources and ability to support the person in care. All services should work together with the local authority to ensure that carers who may be entitled to this assessment receive it in a timely manner.

> **Advancing mental health equality: Care plans**
>
> Ensure that care plans are appropriate for diverse groups, considering whether they need to be translated or provided in another format (for example Easy Read for people with learning disabilities), and that they are:
>
> - discussed with the person in advance so that they understand their purpose
> - developed collaboratively with the person and any family members or carers they wish to have involved
> - tailored to and fully representative of what the person wants and needs, as well as their goals and what is important to them.

'I want to choose who is involved in my care plan.'

This is because…
- Sometimes better relationships are made through non-professionals and the voluntary, community and social enterprise sector, so alternatives to 'staffing' should be considered for support. It's the relationship with the person you are seeking support from (to build and best co-produce plans) that matters, rather than the qualification

How using the framework can make this happen:
- People being asked whether they have a trusted person (may be outside of the service) whom they wish to include, who may help facilitate or advocate for them
- A service should facilitate a care plan that is co-produced, with a trusted person (if needed)

'I want access to my care plan, so I can share it with anyone important to me or with other services.'

This is because…
- People have sometimes not been able to see what was in their care plan
- Having some control over who the care plan is shared with is important to people

How using the framework can make this happen:
- Care plans to be shared with the person and between services
- Professionals to read and familiarise themselves with the plans before the person arrives

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'As a parent, family member, carer or friend, I want to receive the right level of information about mental health and ways I can support my loved one.'

This is because…
- Families, carers and friends want to be able to support their loved one in the right way, and to be given this information without having to search for it on their own

How using the framework can make this happen:
- Providing parents, families, carers or friends with clear and accessible information in a range of formats about possible diagnoses and how they can support and help their loved one

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'As a parent, carer, family member or friend, I want to be a part of, and have access to, the care plan for my loved one, and be involved in care review or family network meetings (with agreement).'

This is because…
- Services to have clear processes around confidentiality and make their processes known to people
- Services need to have a good working knowledge of the Triangle of Care and the Care Act 2014, and how this applies to families and carers, particularly around confidentiality

How using the framework can make this happen:
- Confidentiality is a significant issue for those involved in a person's care, such as friends, family and carers
- Friends, families and carers should be able to express their concern for the person, and the professional should take the concerns seriously and respond appropriately

4.5.2 Involvement of carers, families and support networks

It is also important to consider the views of family members, carers and members of the support networks throughout care and ensure that they are involved in decisions about care, informed about outcomes and have been given appropriate support and guidance throughout, according to the key elements of the Carers Trust's Triangle of Care[12] (see also the information box). There is also guidance for mental health professionals regarding the Triangle of Care for Young Carers and Young Adult Carers[13] and the Department for Health and Social Care has also developed a Carers Action Plan to outline the cross-government programme of work to support carers in England from 2018 to 2020.[14]

> **Also see these resources:**
> - NHS England and NHS Improvement, Supporting carers in general practice: a framework of quality markers
> - NICE guideline NG150, Supporting adult carers

4.6 Using digital technologies to improve community mental health services

There are a range of ways in which digital tools can be used to improve people's experience and outcomes of community mental health services, and to improve service quality:

1. **Assessment** – asking people about their access (smart devices and broadband) and use of digital technologies in their everyday lives and to understand how they may use them in respect of their mental health – whether that may be in a way that is positive or is problematic. Point of care blood testing and self-monitoring machines can support assessment of physical health in people with mental health conditions.

2. **Information** – providing information about useful online information and resources – from useful everyday digital tools (for example, a map to help plan journeys) as well as mental health specific digital tools from the NHS Apps Library, online peer communities such as Elefriends, the British National Formulary app or National Institute for Health and Care Excellence (NICE) guidelines. Individuals may also be motivated to get involved in online campaigns such as Time to Change which aims to influence public attitudes towards mental health.

3. **Digital inclusion** – helping an individual develop their digital skills and confidence through connecting them to learning opportunities in local libraries or online centres.

4. **Care planning** – including use of digital technologies in an individual's care plan. This might include planning a digital inclusion course or using an app together (for example, an exercise app) as a collaborative tool for setting goals and implementing a plan to increase exercise. It may be possible for an individual to have a copy of their care plan and/or safety plan electronically via an online personal clinical record which is connected to the electronic shared patient record.

> **The six principles of the Triangle of Care**
> 1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
> 2. Staff are 'carer aware' and trained in carer engagement strategies.
> 3. Policy and practice protocols regarding confidentiality and sharing information, are in place.
> 4. Defined post(s) responsible for carers are in place.
> 5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
> 6. A range of carer support services is available.

> Further information on digital transformation relating to the Long Term Plan can be found in Chapter 7 of the NHS Long Term Plan Implementation Framework, and in the NHS Mental Health Implementation Plan 2019/20 – 2023/24.

5. **Communication** – working out the best tools to facilitate communication between an individual and a mental health practitioner in line with organisational policies. This may include text messaging, emails, using teleconsultations instead of face-to-face appointments or app messaging, such as with Healthlocker.

6. **Delivery of treatment** – for example an online cognitive behavioural therapy programme, including those that blend with in-person care.

7. **Measuring outcomes** – digital tools, such as an online personal clinical record owned by users, or embedded into electronic health records systems, can be used to enable self-reporting of experience and outcome measures.

8. **Sharing knowledge** – improving digital technologies to facilitate information and knowledge sharing between staff and support remote working in rural areas.

'Services can talk to me to figure out the best way to contact me or work with me. I might prefer to email someone or text, instead of talking face to face or on the phone.'

This is because…
- People have different communication preferences
- Some services get stuck with only offering one appointment type (that is, only face-to-face or only telephone) and not explaining why that is

How using the framework can make this happen:
- Having a range of communication options available (such as text services and Skype sessions)
- Explaining what the contact options are, and why some options may not be available (if that is the case)
- Use appropriate language for the person, and culturally relevant ways of working

5. Outcomes

Implementation and evaluation of the framework require the routine collection of good-quality outcomes data. This section sets out how to select and implement outcome measures. It also presents a summary of key recommendations regarding the use of outcome measures in practice.

The information in this section is based on a review of the literature pertaining to the use of outcome measures in mental health.

5.1 Selecting outcome measures

Deciding which outcomes are relevant and selecting appropriate measures requires a good understanding of what their intended use is.

The following should be considered when selecting which outcome measures to use:

- Does the outcome measure address the key issue? What does it measure – symptomatology, functioning, experience, process?
- Who is it for? If it is for the person, is it acceptable for them?
- Is the outcome measure valid and reliable?
- How is it used routinely?
- Financial considerations such as licensing, costs, additional tools required.[15]

When selecting outcome measures, it is important to consider having measures at:

- population level
- service level, and
- individual level.

Figure 3 shows the basic steps that should be considered when selecting outcome measures.

Figure 3: Algorithm for selecting outcome measures

1 Decide the purpose of the measure	**2** Define desired outcomes for your specific purpose	**3** Choose appropriate measure/ indicator	**4** Implement outcome measure	**5** Evaluate use of outcome measure
Consider aims and objectives of what you are measuring	Reach a consensus on your criteria for the agreed, specific purpose	Consider: • Existing measures that can be used: are they feasible? • Developing your own indicators	Consider: • Is the measure easy to use? • Collection of data: - Is it adaptive? - Is it responsive to change?	• Interpret and analyse results • Implications of findings
Consider what you are trying to achieve – such as whether it is a change to service, policy, procedures or other	Various domains are covered by outcome measures; agree on the defined criteria applicable to your purpose	Quality assess selected outcome measures Consider their validity and reliability	How and when are data collected? Are they in digital or paper form? Will the data be collected in clinical care, for audit purposes or for research?	Consider: • What you do with the data • Whether more data are required • Adjustments in the service • Changes to implementa-tion tools

5.2 Implementing outcome measures

When using outcome measures, the following points should be considered:

- Whether the measure represents meaningful change to the person
- Whether interpreting the measure requires specific training
- The ease of use and availability of standardised instructions on how to carry out and score the measure
- The amount of time it takes to carry out and score the measure
- Whether the data will be collected digitally or in paper format
- Whether the measure can generate knowledge to inform performance monitoring and the strategic development of services

Staff should be trained and competent in using and in supervising the use of outcome measures, including knowledge of when (and when not) to use them, their strengths and limitations, and how to integrate outcomes to guide clinical decisions and interventions. See Appendix 3 for recommendations from on the use of outcome measures from the following guidance:

- Outcome Measures Implementation Best Practice Guidance (National Institute for Mental Health in England, 2005)
- Improving Access to Psychological Therapies (IAPT) Outcomes Toolkit 2008/9 (NHS, 2008)
- No. 18: Measuring Patient Experience: Evidence Scan (The Health Foundation, 2013)
- 'How to' Guide: The BCF Technical Toolkit. Section 3: Outcomes and Impact Measurement (The Better Care Fund, 2014)
- The NHS Long Term Plan (NHS England, 2019).

6. Challenges and solutions

Table 3 outlines challenges to implementing the framework that were identified by mental health service commissioners when developing the framework. It is designed to help other commissioners and providers anticipate problems in advance and put in place the suggested solutions. It has been organised into the following sections:

1. Challenges for people who use services
2. Challenges for commissioners
3. Challenges for those working in primary care
4. Challenges for mental health trusts
5. Challenges for VCSE organisations
6. Challenges for those working in social care
7. Challenges to advancing equality

Table 3: Challenges to implementing the framework, with suggested solutions and ways to measure change

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
1. Challenges for people who use services		
Difficulties in knowing what is available in their communities, and how to access it Services are reactive not proactive People are unable to find services that meet their needs	• Commission the development of a directory of quality-assured community resources, and ensure that it is designed to be accessible by different groups of people, kept up to date and is the sole source of such information for a particular community • Develop flexible community connector roles and hubs that help people access the things that they want and offer them choices • Ensure clinicians know their communities and the resources available within them by using the directory and through close communication with community connectors • Look at what services are provided in the local and wider populations and ensure that all services that are commissioned deliver person-centred care and focus on individual goals	• An up-to-date directory of services accessible by all populations • A communication strategy to promote the use of the directory • Quantitative evidence of use (e.g., number of website hits) • Number of mental health community connectors • Service user/carer/staff feedback survey focusing on directory of services, person-centred services and equality of access
People may experience fragmented services if they receive support, care and treatment from a variety of providers, leading to poor use of resources, duplication and omissions or failures of care Care planning is often incomplete and done without the involvement of individuals and families	• Providers have an awareness of their part in a diverse whole-system of services via a service 'map' • Encourage cross-organisational working through clear mental health governance structures supporting integrated working. This should also include appropriate organisational representation at all levels of the commissioning process • An agreed ambition between all health and social care providers to deliver comprehensive support, care and treatment, which includes attention to the physical, psychological and social aspects of a person's life • Ensure each person has a comprehensive care plan used by all health and social care providers, which has been developed in full and open collaboration with the person and is reviewed regularly and benchmarked against the needs of the person • Ensure the same trusted assessment process between all commissioned community mental health services • Ensure people will know who to contact if needed and have contacts included in their care plan • Move away from having single points of access towards having accessible services available within people's local communities • Ensure clear information is provided on how mental health services operate, what can be expected of them and what they do and do not offer	• Provider representation or involvement in relevant commissioning, contracting or STP* meetings • Clear care planning processes or protocols with reasoning for all services • External audit (with consent) of the quality of co-produced care plans and evidence that the care plan has been adhered to. This could be done by local service user networks, if available • Service user and carer feedback surveys on experience of care planning and whether they received the support, care and treatment outlined in the care plan • Number of repeat assessments per episode of care for each person • Clear, up-to-date and accessible service user information on mental health services, such as leaflets and a survey to confirm the use of these

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
People may fear that changes to the way services operate are more attempts to reduce and withdraw support for people with mental health problems	• Demonstrate that the service is better able to meet their needs by providing quality, person-centred care that focuses on better outcomes • Explain to the community what the potential significant cost savings are, which offers the potential to resource future service developments • Ensure that services remain effective with appropriate capacity during this time	• Individual service key performance indicators, CROMs, PROMs and service user, carer and staff experience measures, and measures of crisis avoidance can be collected • Higher level system outcomes have been collected, including health and social care indicators, e.g. measures of health care utilisation, employment status and so on • Joint strategies or processes in place by commissioners and providers for informing service users and carers about service developments and the economic case • Activity measures in place for monitoring productivity and efficiency of the service, such as DNA rates • Clear processes and structures in place for performance monitoring and improving performance
2. Challenges for commissioners		
Current fragmentation of commissioning in health and social care services means that joined-up working and commissioning is difficult	• Hold regular meetings with the various commissioners of services and ensure that they are represented on any decision-making or delivery board for community mental health care • Draw up a memorandum of understanding which outlines how integrating commissioning can be achieved • Mental health service contracts should not exclude people with drug and alcohol problems just because these services are commissioned differently	• Regular meetings with appropriate representation from stakeholders have taken place • A memorandum of understanding is in place • Mental health services and substance misuse service contracts include clauses that specifically state that people with a dual mental health and alcohol problem cannot be excluded from either service, as well as a statement on collaborative working • All service user experience surveys include questions confirming that the person has received help for both a mental health and substance misuse problem, if appropriate

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
Creating stable partnerships between mental health trusts, primary care, local authorities and VCSE organisations	• Build on existing partnership arrangements and develop a robust governance structure for the local mental health system (this includes STPs* and ICSs) • Bring all care providers and stakeholders together to make decisions about community mental health care • Commissioner should develop a contractual framework that supports a partnership approach to care delivery • Encourage the development and testing of innovative approaches to care delivery at a local community level, possibly supported by a separate transformation budget • Co-design and co-deliver services with local communities and providers throughout the commissioning cycle	• Full stakeholder representation at relevant meetings. This includes service user and carer elected representatives • A robust mental health governance structure for both commissioning and contracting functions • Consistent KPIs and outcome measures across commissioned providers where possible, monitored by commissioners and STPs • Links with local research organisations such as Collaboration for Leadership in Applied Health Research and Care or Academic Health Science Networks
Lack of reliable data to base decisions about levels of care on	• Use best available information via the PHE Fingertips tool • Use PHE guidance to develop Joint Strategic Needs Assessments • Use existing information from providers of support, care and treatment • Link in with the Mental Health Services Data Set to understand what data is available and facilitate its use • Support approach to test ideas locally and learn and adapt • Moving towards outcome reporting rather than exclusively relying on more traditional process measures • Look at the trusts that have been awarded Global Digital Exemplar status to see how data can be made available at an individual, team, service and system-wide level.	• Measures of staff and service user engagement with data, such as data dashboards • Data on patient safety are used • Data to improve quality of care, such as physical health monitoring, are used • There is joint working with local public health teams around developing locally relevant outcomes • Local Joint Strategic Needs Assessment and data informing commissioner operational plans are used • Dashboards to monitor defined outcomes based on available data are used
Lack of system-wide, high-level sign-up to the case for change	• Set up robust mental health governance structure with system-wide, multi-agency senior representation and board-level approval. • Ensure the whole system signs up to a shared vision and common principles so that individual teams can implement these at local level • Encourage senior sign-up to the framework • Identify and task local leaders and champions • Give all staff information and training as needed to foster a workforce which shares a common vision, common aims and an understanding of principles of the community mental health service model • Use existing frameworks (for example, STP/ICS mental health networks) where possible and understand the levers that will help this change to be implemented	• There is robust mental health governance structure, which includes clear links and reporting or communication process to STP, including an officer at board level who is responsible for delivery of the new framework. • There are regular updates and communications from mental health delivery teams to STP and commissioner executive boards • There is robust mental health leadership provision by commissioners, STPs and PCNs as they develop • There is staff training development around community mental health and team building that includes primary care

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
Lack of integration of community mental health services with other community services or community resources	• CCGs and providers have a clear responsibility for mapping of local services and for sharing of information about them with all providers	• There is a single dataset of SMI cross primary and secondary care • Robust mental health governance structure with all stakeholders represented • All commissioners and providers have looked at the number of people entering treatment • There are consistent KPIs or service user outcome measures across commissioned providers, with shared ownership where possible • Clinical records are shared between providers with the person's consent • There is an integrated pathway including shared operational processes and functions, co-location of services and joint training
Current contracting processes do not support effective best value service delivery. Short-term funding arrangements mean smaller organisations, including those that rely on a volunteer workforce and are unable to build effective relationships or plan service delivery in the longer term	• Move away from transactional contracts with providers based around activity to ones based on communities and populations outcomes • Contract durations and tender processes need to be designed in such a way that it is possible for smaller organisations such as social enterprises, charities or user-led organisations to bid for contracts or be part of local alliances seeking to deliver contracts • Commissioners can provide assurance around equality and access by mapping local needs against voluntary and community sector service provision at a local level • Every contracted provider must have robust measures to show that the service they provide is an effective one and evidence the ways in which it is of benefit to the people who use it • Have a transparent pricing system so all can see what is being paid for within the local population	• Evidence from provider contract structure, process, delivery and monitoring • Commissioners have mapped local needs against voluntary and community sector service provision at a local level and ensured equality of access

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
It may be difficult to provide good cohesive and holistic care, support and treatment in the context of providers in competition for limited funding	• Use NHS Long Term Plan funding for community mental health, to uplift both Mental Health Investment Standard funding in CCG baselines, as well as central transformation funding • Base decisions about funding allocations on the needs of individuals and communities • Make strategic commissioning decisions in a collaborative way that involves all stakeholders, including people in the community • Good-quality, efficient and cost-effective services should be celebrated and made widely known, including how they reduce referrals and prevent crises or the need for acute care services • Encourage joint commissioning by health and social care services to support each other with funding and infrastructure • Encourage providers to share resources with other, smaller providers to enable the delivery of the framework • Seat commissioning decisions and resource allocations in the principle of parity of esteem and the interrelation between physical and mental health	• Commissioners to evidence mental health programme spend as a percentage of total programme spend • Mental health commissioners to evidence that mental health programme spend is mapped to their local population need and patient flow (the number of people accessing services) and includes commissioning of services from both statutory and non-statutory providers • Mental health commissioners to evidence transparent collaborative commissioning and effective communication, including around outcomes collected by all providers
Not enough staff to deliver aspects of the framework	• Draw up a clear workforce planning strategy with Local Workforce Action Boards that considers flexible working across organisations so that skills, expertise and resources can be shared • Train and upskill staff to deliver quality care in line with the framework and relevant competence frameworks. This will require close working with Health Education England and Local Training Educational Boards • Support the ageing workforce with any work adjustments such as flexible or part-time working if they require this • Ensure there are enough resources to allow staff to deliver the functions they have been trained to provide, rather than additional functions	• A mental health workforce strategy action plan is in place at local system level • There is joint working with all partners around workforce planning • A robust governance structure is in place to deliver the action plan • Workforce trajectory (staffing numbers) based on the workforce plan is monitored • Vacancy rates and staff sickness rates and changes over time are being monitored
3. Challenges for those working in primary care		
A perception that the framework increases the workload for GPs and primary care who are already struggling to manage demands	• Ensure that mental health specialist expertise is more accessible in primary care by removing some of the traditional barriers to accessing advice and support • Data collection that focuses on healthcare utilisation in the local population should be owned and led by all services in the community, particularly GP and wider primary care so that information on workload is known, understood and used appropriately • Ensure that those in leadership roles can manage the primary and secondary care interface issues	• Measurement and monitoring of healthcare utilisation across local systems, including primary care consultation rates, length of consultations and any additional work outside of consultations

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
Co-location of mental health professionals in primary care –potential lack of space such as consultation rooms in which mental health primary care/mental health liaison workers can see service users	• Link with primary care commissioning contracting teams to help them to lobby and raise awareness of the benefits of co-location of mental health staff in primary care and multidisciplinary teams who require space in GP practices • Ensure communications between services and foster relationships that advocate joint and integrated working • Build trusting relationships such that space is offered • Draw on existing positive practice examples and evidence where integrated service models have been implemented successfully	• The percentage of GP practices and networks with mental health staff co-located in their building is being monitored
Lack of clarity on what specialist community mental health expertise is available to primary care healthcare staff and how they can access it Changing landscape of wider system and primary care, such as in the GP Forward View and via PCN development, makes it difficult to implement or adhere to consistent operational models	• Provide GPs with clear information on what service provision is and how to access services • Have a clear protocol on processes for communication between primary care and community mental health services at GP practice or network level • Ensure that passionate leadership is in place to drive change for better population outcomes regardless of uncertainties in landscape • Mental health governance structure and delivery boards need to include representatives from primary care to optimise good communication	• Evidence of mental health delivery or governance structure including representation from primary care
Possible GP stigma towards mental health meaning that the system does not change	• Providing joint mental health training with primary and secondary care, using case-based discussions and reflecting on individual practice. • Having shared education and training for staff. Link in with Health Education England around the development and delivery of this • Co-producing local resources and training to bring a human focus to the training delivered	• In a primary care survey, questions on change in attitude and approach towards people with mental health needs have been included
Difficulty delivering training to primary care staff, particularly finding resources to deliver training and paying for staff time	• Jointly work with the primary care and workforce or training commissioner leads to identify resource to deliver this • Look at how primary care time is currently resourced and take actions to identify resource for this	• There has been GP training, including the number of sessions

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
GPs and primary care may be concerned about where their clinical responsibility lies	• Effective communication between community mental health teams and primary care teams to discuss service users and agree responsibilities. It should always be clear and documented which service is accountable for someone's care and for decision-making	• Number of serious incidents are being monitored and the ones that are related to community or primary care mental health are scrutinised
Difficulty finding and resourcing primary care mental health leadership	• Use a primary care quality and engagement framework (QEF) to include a requirement that each GP practice nominates a mental health lead. The QEF can be funded through Personal Medical Services	• The number or percentage of GP practices with a nominated mental health lead are being monitored

4. Challenges for mental health trusts

Administrative burden placed on them by commissioners and national targets and data collection	• Develop performance indicator or outcome data dashboards that are agreed with all stakeholders and developed with a clear rationale for each indicator and how it will be measured • Foster a more effective use of data, which captures what is important and evidences the safety and efficacy of services • Ensure effective reporting resources, systems and processes are in place which result in service improvements, as required. This includes making full use of publicly available data • Agreement between commissioners and service providers about what data are currently not available but would be helpful • Measures of the effectiveness of care are based on outcomes that are meaningful to the individual • Work with local authorities to align Care Act assessments and health care planning processes • Joint working between commissioners and providers to ensure effective reporting resources, systems and processes are in place • Effective joint working between provider contracting and operational teams to ensure meaningful interpretation of every reported measure • Ensuring there is sufficient data analytic capacity • Ensuring that all data are owned and used by frontline staff on a regular basis • Encourage Chief Clinical Information Officers to work towards translating data into clinically meaningful information and reducing the collection of unnecessary data that might not improve care	• There are performance indicator or outcome data dashboards • Effective reporting resources, systems and processes are in place that result in service improvements as required • The percentages of missing data on local data dashboards are being monitored and there are actions to address the missing data

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
Staff and managers have change fatigue following numerous service reorganisations	• Educate frontline staff and managers on the benefits of this new way of thinking about community mental health support, care and treatment, which puts more emphasis on community services and makes it easier for mental health professionals to make full use of diverse community resources. Ensure that there is a clear vision and staff can see what is in it for them • It is important to recognise that change is difficult. When there is genuine uncertainty about the right way forward, commissioners and providers should consult widely and share the nature of the challenge with the community and those who use services. New services should be introduced using genuine co-production with staff, service users and carers • Strong leadership by experienced clinicians, practitioners and managers who can work effectively across organisational and professional boundaries • Ensure that the 'offer' from community mental health is clear, defined and equitable • Change needs to be evaluated from the beginning, with appropriate data collection processes in place so that regular readjustments can be made, and with the involvement of service users	• There is a robust mental health leadership structure at all levels (ideally at every level leading down to individual GP practice level) • There is a clear vision, co-production and effective communication. This can be evidenced through PROMs, *CROMs, crisis avoidance, staff experience, staff sickness and vacancy rates, KPIs and PREMs for both service users and carers
Focus on moving care to local communities shifts the focus away from the care of people with very complex needs	• Monitor outcomes to ensure that there is no deterioration in the mental health of people with mental health needs in the community as there will still be individuals who need long-term care. The framework will make it easier for them to connect to other sources of support in their community, complementing statutory services • Potentially ring-fence resources for people with complex needs, ensuring that these demonstrate value for money • Allocate sufficient resources on the need for long-term care with assertive models of care	• Outcomes for people with complex needs do not deteriorate (and ideally show improvement) • Outcomes could include access (waiting times), PROMs, CROMs, PREMs, healthcare utilisation (admission and crisis rates, and safety measures) and numbers of serious incidents

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
Unable to recruit staff required	• Ensure that there are robust workforce planning processes in place • Work with others to develop new types of roles (for example, peer support workers, wellbeing workers, community connectors and volunteers) • Use competence frameworks to support training and definition of these roles • Follow the principles of values-based recruitment • Contribute to campaigns to make mental health careers attractive • Have regional integrated planning so that there can be available staff and expertise for the community across all agencies • Consider how to train staff and offer them support to continue developing in their career • Offer portfolio job roles	• There is a robust mental health workforce strategy, which includes the statutory and VCSE workforce • There are measures of staff wellbeing such as staff surveys and an action plan to address concerns • Staff absence rates are monitored and steps to tackle absence due to illness have been implemented • Staff vacancy rates are monitored, and steps have been taken to fill posts
Shift in resources away from secondary mental health care into the community increases financial pressure on providers and services who may already be struggling to achieve financial balance	• There is a need to commission mental health services at a system level rather than individual provider level • Funding allocations should be based on best value care across the local system • Contractual changes (such as alliance contracting) to facilitate a system-wide approach to mental health provision of community services	

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
💡 **5. Challenges for VCSE organisations**		
Variations in geographic coverage create gaps in availability of VCSE community provision	• Fully map mental health provision (both statutory and non-statutory) by area to identify any gaps and in • Compare map of service provision with local mental health needs, using public health data • Realign services or extend current service coverage to ensure local area and needs are fully provided for within existing resources. This may require amending contracts so may take time • NHS voluntary and community sector grants targeted to support the development of community mental health services in areas where they are lacking • Early engagement with voluntary and community sector infrastructure bodies (Association of Chief Executives of Voluntary Organisations, Association of Mental Health Providers, National Association for Voluntary and Community Action, National Council for Voluntary Organisations) to secure their expertise and support in developing diverse local sources of support • Commissioning plans are reconfigured to focus additional resources in the community. Commissioners should take a 'community first' approach to commissioning to ensure that the community is properly resourced	• There is equity of provision over local geographic area
People may not view the voluntary and community sector as equal partners with statutory services	• Encourage multi-agency local teams, joint training, regular meetings, common-to-all trusted assessments and robust governance and safety processes • Common KPIs* and outcome measures for both VCSE and statutory providers and encourage sharing of data and outcomes across the whole system • Alliance contracting	• There is joint working between statutory and VCSE staff • There are surveys of statutory and VCSE staff focused on how they work in partnership
VCSE services may fear they are struggling for capacity to support people in the community	• Ensure that services evidence their value, including productivity and outcomes, to support the business care for investment in their services • Encourage joint commissioning by health and social care services to support with funding and infrastructure, as well as opportunities to share resources • Build strong relationships between VCSE and statutory organisations to ensure flexible and joined-up working so that services can communicate with each other easily when support is required	• Providers have produced evidence relating to the value of their services, including productivity and outcomes, which will justify any request for further investment

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
6. Challenges for those working in social care		
Lack of resources in social care leading to dis-integrated services	• Look towards a joint commissioning approach between CCGs and local authorities and consider shared budgets • Work hard to build trusting relationships that make best use of all resources • Evidence the potential cost benefits accessing these services can have to the whole health and social care system • Create efficiencies through joint working, shared and useful data collection and a care plan format and approach that is common across health and social care	• Health and social care outcomes have been monitored using a shared dashboard
Responsibilities of Care Act disproportionately borne by local authorities	• Ensure that all community mental health services deliver against the Care Act principles and responsibilities without increasing paper work or bureaucracy • Integrate social care roles or functions into the community mental health service	• Social care and Care Act functions are included in the community mental health model • The number of people identified as carers and the percentage of people offered Care Act assessments are being monitored
7. Challenges to advancing equality		
Some services are mainly accessed by people from a particular demographic	• Locally identify groups who find it harder to access services e.g. Black, Asian and Minority Ethnic groups, travellers, LGBTQ+* groups and others • All services and providers should have a policy and action plan on promoting equality, and it should be monitored • Ensure there is diversity in the workforce • Provide guidance and methods on the co-design and co-delivery of services that meet the needs of people who use them and those who do not currently use services but could benefit from doing so • Provide guidance and methods to improve and increase accessibility to all services that meet a range of needs, including mental and physical health and social care needs • Services need to work together to promote access by certain groups through contract clauses referencing joint working arrangements, as well as joint or aligned commissioning arrangements	• Groups who find services harder to access have been identified • Policy and action plans are in place to increase access by these groups • For each hard-to-reach group that has been locally identified, the percentage accessing the service has been calculated (the numerator will be a service figure, the denominator will be a public health figure) • The percentage of the workforce that come from hard to reach groups has been scrutinised and there are plans to diversify the workforce

Common issues related to the current provision of community mental health care	Suggested solutions to be implemented by providers and commissioners	Evidence of implementing the solutions
Lack of awareness of some in issues	• Collect robust data that look at diversity and in in terms of demography, service use and outcomes from mental health support, care and treatment • Raise awareness about existing in • Attempt to address workforce and leadership in so that the care that is provided can best meet local population needs and so that the use of staff skills and experiences are maximised in the delivery of care • Include quotes and input from people with lived experience in all written service materials	• Evidence of data collection, awareness raising, campaigns and staff diversity

*Key: CROM = clinician rated outcome measure; DNA = did not attend; ICS = Integrated Care Systems; KPI = key performance indicator; LGBTQ+ = lesbian, gay, bisexual, transgender, queer plus; PHE = Public Health England; PREM = patient rated experience measure; PROM = patient rated outcome measure; STP = Sustainability and Transformation Partnership; VCSE = voluntary, community and social enterprise

7. Publications and resources

7.1 National guidance and policy

Care and Treatment Reviews: Policy and Guidance [PDF, NHS England, 2017]

Carers and personalisation: improving outcomes [PDF, Department of Health, 2010]

CCG improvement and assessment framework 2016/17 [PDF, NHS England, 2016]

The Crisis Care Concordat [PDF, Department of Health, 2014]

Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 [PDF, NHS England, 2015]

Achieving Better Access to Mental Health Services by 2020 [PDF, NHS England, 2014]

The Five Year Forward View for Mental Health [PDF, Mental Health Taskforce, NHS England, 2016]

Future in mind [PDF, NHS England, 2015]

Guidance for reporting against access and waiting time standards: Children and Young People with an Eating Disorder and Early Intervention in Psychosis [PDF, NHS England, 2016]

Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16 [PDF, NHS England, 2015]

Implementing the Five Year Forward View for Mental Health [PDF, NHS, 2016]

Local Transformation Plans for Children and Young People's Mental Health and Wellbeing [PDF, NHS England, 2015]

NHS Long Term Plan [website, NHS]

NHS Mental Health Implementation Plan 2019/20 – 2023/24 [PDF, NHS England, 2019]

NHS Operational Planning and Contracting Guidance 2019/20 [PDF, NHS England, 2019]

The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations (2013) [website, The National Archives]

GMC's Personal beliefs and medical practice [website, General Medical Council]

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies [PDF, Department of Health, 2013]

Stepping Forward to 2020/21: The mental health workforce plan for England [PDF, NHS, 2017]

Universal personalised care: Implementing the Comprehensive Model [website, NHS England]

7.2 Legislation

Care Act 2014

Equality Act 2010

Health and Social Care Act 2012

Mental Capacity Act 2005

Mental Health Act 1983

Mental Health Act 2007

Mental Health Act 1983: Code of Practice (2015)

Public Services (Social Value) Act 2012

7.3 Commissioning

Alcohol and drug treatment: quality governance guidance [PDF, Public Health England, 2015]

Asset based places: A model for development [website, Social Care Institute for Excellence, 2017]

Being mindful of mental health – The role of local government in mental health and wellbeing [PDF, Local Government Association, 2017]

Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers [PDF, Public Health England, 2017]

Building healthy communities: A community empowerment approach [PDF, Community Development Foundation, 2010] – how to involve local people in making decisions about health provision in their community

Commissioning fact sheet for clinical commissioning groups [PDF, NHS Commissioning Board, 2012]

Commissioning for Effective Service Transformation: What we have learnt [PDF, NHS England, 2014]

Delivering the Five Year Forward View for Mental Health: Developing quality and outcome measures [PDF, NHS England, 2016]

Developing an integration scorecard [website, Social Care Institute for Excellence, 2017]

Digital inclusion for health and social care services [website, NHS Digital] – for commissioners of digital inclusion services by NHS Digital

A framework for collaborative commissioning between clinical commissioning groups [PDF, NHS Commissioning Board, 2012]

A guide to community-centred approaches for health and wellbeing [PDF, Public Health England, 2015] – accompanied by Public Health England's repository of positive practice examples of community-based approaches

Guidance for commissioners of financially, environmentally, and socially sustainable mental health services (future proofing services) [PDF, Joint Commissioning Panel for Mental Health, 2015]

Guidance for commissioners of mental health services for people with learning disabilities [PDF, Joint Commissioning Panel for Mental Health, 2013]

Guidance for commissioners of older people's mental health services [PDF, Joint Commissioning Panel for Mental Health, 2013]

Guidance for commissioning public mental health services [PDF, Joint Commissioning Panel for Mental Health, 2015]

Guidance for commissioners of primary mental health care services [PDF, Joint Commissioning Panel for Mental Health, 2013]

Guidance for commissioners of rehabilitation services for people with complex mental health needs [PDF, Joint Commissioning Panel for Mental Health, 2016]

Guidance for implementing values-based commissioning in mental health [PDF, Joint Commissioning Panel for Mental Health, 2013]

Health matters: community-centred approaches for health and wellbeing [website, Public Health England]

Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Guidance for CCGs [PDF, NHS England, 2018]

Influencing mental health services – A guide to values-based commissioning [PDF, Mind, National Survivor User Network, 2014]

Integrated commissioning for better outcomes: A commissioning framework 2018 [PDF, Local Government Association, 2018]

Joint Strategic Needs Assessments [PDF, Department of Health and Social Care, 2011]

Leading Large Scale Change: A practical guide [PDF, NHS England, 2018]

Mental health crisis care: Commissioning excellence [PDF, Mind, 2012]

Mental health in primary care – A briefing for clinical commissioning groups [PDF, Mind, 2016]

MINDSet quality improvement toolkit [website, MINDset QI]

Modelling the Interface between Primary Care and Specialist Mental Health Services [PDF, College Centre for Quality Improvement, 2015]

NHS Benchmarking [website, NHS Benchmarking Network]

NHS Standard Contract [Word document, NHS England, 2019]

Prevention concordat for better mental health [website, Public Health England, 2017]

Primary Care Home – National Association of Primary Care [website, National Association of Primary Care]

Public Health England Fingertips tool (mental health profiles) [website, Public Health England]

Public Health England resources to address social and wider determinants of health [website, Public Health England, 2017]

Reimagining community services: making the most of our assets [PDF, The King's Fund, 2018]

Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services [PDF, Association of Directors of Adult Social Services, London Government Association, NHS England]

The Collaborating Centre for Values-Based Practice in Health and Social Care [website, The Collaborating Centre for Values-Based Practice in Health and Social Care]

7.4 Mental health

Listening to experience – An independent inquiry into acute and crisis mental healthcare by Mind [PDF, Mind, 2011]

Local suicide prevention planning: A practice resource [PDF, Public Health England, 2016]

Mental Health Pack [website, Widgit.com] – A communication tool using symbols, for mental health assessments in psychiatric or physical health care settings, for use with individuals who may have communication or language difficulties

Resources for healthcare professionals on physical health in for people living with mental illness [website, Rethink]

Right here, right now [PDF, Care Quality Commission, 2015] – Care Quality Commission report with good practice examples

7.5 Transitions between services

Data tools for managing transfers of care [website, Local Government Association]

HSIB Investigation Report – Transition from Child Mental Health Services to Adult [PDF, Healthcare Safety Investigation Branch, 2018]

Model Specification for Transitions from Child and Adolescent Mental Health Services [PDF, NHS England, 2015]

Transition Between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs (NG27) [PDF, NICE, 2015]

Transition Between Inpatient Mental Health Settings and Community or Care Home Settings (NG53) [PDF, NICE, 2016]

CQUIN Guidance and Indicators for 2017/2019 [website, NHS England] – includes transitions from child and adolescent to adult services

Understanding and Improving Transitions of Older People: A User and Carer Centred Approach [PDF, National Institute for Health Research, 2012]

7.6 Social care

7.6.1 Housing

Housing and Health: Mental Health and Housing. Housing on the Pathway to Recovery [PDF, National Housing Federation, 2015]

Mental Health and Housing [PDF, Mental Health Foundation, Mental Health Providers Forum, 2016] – Types of housing that exist that meet the needs of mental health populations.

7.6.2 Homelessness

Pathway – Healthcare for homeless people [website, Pathway] – Website for charity with a model of integrated healthcare for single homeless people and rough sleepers

Mental Health Service Interventions for Rough Sleepers: Tools and Guidance [PDF, Pathway, 2017]

Health Standards for Commissioners and Service Providers [PDF, Pathway and The Faculty for Homeless and Inclusion Health, 2018]

7.6.3 Employment

Individual Placement and Support [website, Centre for Mental Health]

Making Individual Placement and Support Work: An Evaluation of Implementation and Sustainability [PDF, David Gilbert and Rachel Papworth of Centre for Mental Health, 2017]

Mental wellbeing at work (PH22) [web page/PDF, NICE, 2009]

Advice for employers on workplace adjustments for mental health conditions [PDF, Department of Health, 2012]

7.6.4 Benefits

Benefits FAQ [website, Mind] – A list of commonly asked questions about Benefits, developed by Mind

Money, benefits and employment [website, Rethink Mental Illness] – Additional benefits advice

Welfare advice for people who use mental health services [PDF, Centre for Mental Health, 2013] – Guidance on welfare

7.6.5 Safeguarding

Adult Safeguarding: Roles and Competencies for Health Care Staff [PDF, Royal College of Nursing, 2018]

Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework [PDF, NHS England, 2019] – An accountability and assurance framework developed by NHS England

Care and Support Statutory Guidance (Chapter 14) [PDF, Department of Health, 2014]

7.7 Community assets mapping

Map assets in your community: Factsheet [PDF, Brighter Futures, 2012]

The Community Mapping Toolkit: A guide to community asset mapping for community groups and local organisations [PDF, Preston City Council]

7.8 Advancing mental health equality

Advancing Mental Health Equality strategy [PDF, NHS England and NHS Improvement, 2020] – A report summarising core actions for mental health equality. It is an important element of the NHS plans to address health inequalities in the next stage of responding to COVID-19

Better practice in mental health for black and minority ethnic communities [PDF, Race Equality Foundation, Mental Health Providers Forum, 2015] – A report by the Mental Health Providers Forum and the Race Equality Foundation

Evidence and Ethnicity in Commissioning [website, Evidence and Ethnicity in Commissioning] – A commissioning resource that sets out evidence-based approaches to addressing ethnic inequalities

Green Light Toolkit [PDF, National Development Team for Inclusion, 2017] – A set of resources to audit and improve mental health services' suitability for people with autism/learning disabilities

Green Light Work: Reflections on examples from five NHS Trusts [National Development Team for Inclusion, 2018]

Guidance for commissioners of mental health services for people from black and minority ethnic communities [PDF, Joint Commissioning Panel for Mental Health, 2014]

Guidance for commissioners of older people's mental health services [PDF, Joint Commissioning Panel for Mental Health, 2013]

Guidance for NHS commissioners on equality and health in legal duties [PDF, Joint Commissioning Panel for Mental Health, 2015]

Inequality among lesbian, gay bisexual and transgender groups in the UK [PDF, National Institute for Economic and Social Research, 2016] – A review of evidence concerning LGBTQ+ inequalities, including mental health

Mind Infoline [website, Mind] – Legal information and general advice on mental health-related law

Rainbow Alliance [website, Leeds and York Partnership NHS Foundation Trust] – A good example of a mental health and learning disability service that is actively engaged in addressing LGBTQ+ inequalities

7.9 Co-production

A Co-production Model: Five values and seven steps to make this happen in reality [PDF, NHS England, Coalition for Collaborative Care, 2016]

Co-production in social care: What it is and how to do it [PDF, Social Care Institute for Excellence, 2013]

Embedding co-production in mental health: A framework for strategic leads, commissioners and managers [PDF, National Development Team for Inclusion, 2016]

Progressing transformative co-production in mental health [PDF, National Development Team for Inclusion, 2016]

7.10 Populations that need special consideration

7.10.1 Refugees and asylum seekers

City of Sanctuary resource pack for mental health [PDF, City of Sanctuary, 2017]

Improving mental health support for refugee communities – An advocacy approach [PDF, Mind, 2009]

Solace [website] – Leeds-based charity providing psychotherapy and mental health support for refugees and asylum seekers

7.10.2 Travelling communities

Friends Families and Travellers [website] – Advice and consultancy, training and information on good practice when working with people from traveller communities

Progress report by the ministerial working group on tackling in experienced by gypsies and travellers [PDF, Department for Communities and Local Government. 2012] – How mainstream services can work more effectively with traveller communities to improve outcomes

7.10.3 Young carers

Include: Supporting young carers and their families [website, The Children's Society] – Provides information and resources for professionals and services on how to support young carers and their families

'There's nobody is there – no one who can actually help?' The challenges of estimating the number of young carers and knowing how to meet their needs [PDF, The Children's Society, 2016]

Young carers, parents, and their families: Key principles of practice [PDF, Jenny Frank and Julie McLarnon, The Children's Society, 2008]

7.11 Capacity, information sharing and safeguarding

Centre of Excellence for Information Sharing – Safeguarding [website, Centre of Excellence for Information Sharing]

Information sharing and suicide prevention, consensus statement [PDF, Department of Health, 2014]

Information: To Share or not to Share. Government Response to the Caldicott Review [PDF, Department of Health, 2013

7.12 Resources for families and carers

Care Programme Approach (CPA) factsheet (Rethink) [PDF, Rethink Mental Illness, 2017]

Carers Action Plan 2018 – 2020: Supporting carers today [PDF, Department of Health and Social Care, 2018]

Carers' assessments – help for parent carers [PDF, Contact a Family, 2016]

Carers UK Assessment factsheet [PDF, Carers UK, 2014] – looks at the different ways caring can affect life, including physical, emotional and mental health, as well as work, leisure, education and wider family and friend relationships

Information for professionals: resources for working with carers [website, Cause]

MindEd for Families [website, NHS Health Education England] – a free learning resource about the mental health of children, young people and older adults

The Triangle of Care [PDF, Carers Trust, 2013]

The Triangle of Care for Young Carers and Young Adult Carers [PDF, Carers Trust, 2015]

7.13 Competence frameworks

Accreditation for community mental health services [website, Royal College of Psychiatrists]

AIMS Rehab: A quality network for mental health rehabilitation services [website, Royal College of Psychiatrists]

A Competence Framework for Liaison Mental Health Nursing [PDF, The London Liaison Mental Health Nurses' Special Interest Group]

National Mental Capacity Act Competency Framework [PDF, eds: S Eales, N Wilson and J Waghorn, The National Centre for Post-Qualifying Social Work and Professional Practice, 2014]

Self-harm and Suicide Prevention Competence Framework [website, University College London]

Skills for Health Core Skills Education and Training Framework [website, Skills for Health]

Skills for Health National Occupational Standards [website, Skills for Health]

7.14 Digital resources

Big White Wall [website] – A 24/7 anonymous online service for people in psychological distress, where individuals are supported by other members to self-manage their mental health

Digital literacy [website, NHS Health Education England] – Information and resources from the Health Education England led programme to improve the digital literacy of the workforce

Digital therapies for IAPT [website, NICE] – NICE are assessing digital therapies for the IAPT programme. The findings of these evaluations can be found online, and those which are recommended may be of use in wider community mental health care

Doteveryone [website] – A think tank promoting responsible use of technology for a fairer society

Good Things Foundation [website] – A national charity promoting digital skills and inclusion

Learn My Way [website] – Free courses on using a computer, browsing the web, sending an email and finding work online

NHS Apps Library [website, NHS] – A resource of digital tools to help people manage and improve their health

The Mix [website] – Provides support for children and young people under the age of 25 years with a variety of means to access support, including phone, email, live message, peer-to-peer and counselling services, or online articles and video content.

On Your Mind [website, NHS] – Provides advice and support for young people on mental health issues. The website provides local support options for young people living in Gloucestershire, but also provides options for self-help.

Online Centres Network [website, Good Things Foundation] – A networking of community organisations supporting people to overcome social challenges and improve their lives through digital

Side by Side – Mind's online community [website] – Formerly Elefriends, a supportive online community

Social media toolkit for the NHS [website, NHS Employers] – Tools to get the most out of social media for NHS organisations

Student Minds [website] – Provides support and information for students on looking after their mental health

Understanding formulation for young people [PDF, The British Psychological Society and Division of Clinical Psychology, 2019] – Factsheet for young people

Widening Digital Participation – Information about the NHS Digital programme to improve digital inclusion [website, Good Things Foundation]

What Works Wellbeing [website] – Provides evidence, guidance and discussion papers on a variety of topics linked to wellbeing and living well, including, but not limited to housing, community wellbeing, physical activity and unemployment

Youth Wellbeing Directory [website, Anna Freud Centre for Children and Families] – Provides a list of local and national organisations and other information, for people up to the age of 25 years

7.15 Other resources

10 Keys to Happier Living [website, Action for Happiness]

Advocacy for Mental Health [PDF, World Health Organization, 2003]

Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services [PDF, Department of Health, 2007]

Bringing together physical and mental health [PDF, The King's Fund, 2016]

The Community Paradigm: Why public services need radical change and how it can be achieved [PDF, New Local Government Network, 2019]

Compassionate Mind [website, The Compassionate Mind Foundation] – training and resources around applying a compassionate approach

Developing peer support in the community: A toolkit [PDF, Mind]

New Roles in Mental Health [website, HEE] – New and expanded roles in HEE's Mental Health Programme

The Mental Health Five Year Forward View Dashboard [Excel spreadsheet, NHS England]

Mental capital and wellbeing: Making the most of ourselves in the 21st century [PDF, Government Office for Science, 2008] – Foresight report looking at how to improve mental resources and mental wellbeing through life

Mind: Five ways to wellbeing [website, Mind]

The NHS Choice Framework: What choices are available to me in the NHS? [website, Department of Health and Social Care, 2016]

Person-centred care: implications for training in psychiatry CR215 [PDF, Royal College of Psychiatrists, 2018]

The Point of Care: Measures of patients' experience in hospital: purpose, methods and uses [PDF, The King's Fund, 2009]

Positive and proactive care [PDF, Royal College of Nursing, 2016]

Referral to treatment consultant-led waiting times: Rules Suite [PDF, Department of Health, 2015]

Social determinants of health and the role of local government [PDF, Local Government Association, 2010]

Service Framework for Mental Health and Wellbeing [PDF, Health and Social Care in Northern Ireland, 2018]

8. Abbreviations

Abbreviation	Full term
CCG	clinical commissioning group
CPA	Care Programme Approach
IAPT	Improving Access to Psychological Therapies
ICS	integrated care systems
IT	information technology
LGBTQ+	lesbian, gay, bisexual, transgender, queer plus
NICE	National Institute for Health and Care Excellence
PCN	Primary Care Network
PTSD	post-traumatic stress disorder
SMI	severe mental illness
STP	Sustainability and Transformation Partnership
VCSE	voluntary, community and social enterprise

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